

The transition to adult mental health services from a secure inpatient environment: An Interpretative Phenomenological Analysis of the experiences of nursing staff.

Thesis submitted in part fulfilment of the degree of

Doctorate in Clinical Psychology

(DClinPsy)

University of Leicester

By

Laura Chance

April 2016

Declaration

I confirm that this thesis and the research reported within it, comprises my own work. It was written and submitted in part-fulfilment of the degree of Doctorate in Clinical Psychology (DClinPsy). It has not been submitted for any other academic award.

The transition to adult mental health services from a secure inpatient environment: An Interpretative Phenomenological Analysis of the experiences of nursing staff.

Laura Chance

Abstract

Within the UK, there are a growing number of young people diagnosed with mental health difficulties and therefore in receipt of Child and Adolescent Mental Health Services (CAMHS). Upon reaching age 18 years, institutional and legal requirements often necessitate a transition to Adult Mental Health Services (AMHS). Despite a national, top-down commitment to ensuring transitions are smooth, well-planned and person centred, often the reality is very different. Young people and professionals frequently report an experience marked by inconsistencies between CAMHS and AMHS, lack of collaboration, poor communication and high levels of uncertainty.

The current literature review aimed to explore the experiences and perceptions of transition from CAMHS to AMHS, from the perspectives of professionals, young people and families. A meta-synthesis of eight studies revealed four sub-themes; facing identity dilemmas, needing containment and trusting relationships, changing responsibility and talking a different language. The themes were conceptualised as a line of argument demonstrating the complexity of the experience and the interplay between multiple factors. The findings offered an in depth insight into the experience of transition, reflecting previous research, that policy and recommended practice is not always experienced at the ground level.

The current research study aimed to explore the experiences and insights of nursing staff on the transition to AMHS, within the context of a secure inpatient CAMH service. Semi-structured interviews were conducted with six experienced nursing staff within the adolescent service. Interpretative Phenomenological Analysis (IPA) generated four superordinate themes and 12 corresponding sub-themes. These themes were discussed in relation to existing theory and literature. Implications for clinical practice and future research were also discussed.

The critical appraisal offers a reflective account of the research process. This aims to maximise transparency and offers a critique of the current research.

Acknowledgements

Thank you.

To the six participants who openly and honestly shared their experiences with me, and made this research possible. To my research supervisor, Dr Steve Allan, who has supported and encouraged me throughout the research process. To Dr Charlotte Staniforth, who has not only supported me throughout this research but throughout my journey in becoming a qualified clinical psychologist. Her skills, expertise and commitment to working with young people has inspired me throughout my career. Also to all those clinicians within the CAMH service who have supported and encouraged me prior to and throughout my training. Their continued support has enabled this research process to be an easier and less stressful journey.

I would also like to thank my friends and cohort, for always being there along the way. To Joe, for his unconditional belief in me. And finally to my parents, who have always supported and encouraged me in everything I do.

Word Count

(Excluding reference lists, figures and tabulated data)

Overall abstract	289
Literature review (including abstract- 290)	7,111
Research report (including abstract- 276)	12,138
Critical appraisal	3,200
Mandatory appendices	2,954
Non-mandatory appendices	3,305
Whole thesis (excluding references)	28,997

Table of contents

PART 1: LITERATURE REVIEW	1
ABSTRACT.....	2
1 Introduction.....	3
1.1 Clinical context.....	3
1.2 Previous Systematic Reviews.....	4
1.3 Aims and rationale for current review	5
2 Method.....	7
2.1 Search strategy and terms	7
2.2 Inclusion and exclusion criteria.....	8
2.3 Study Selection.....	9
2.4 Quality Assessment	11
2.5 Reflexivity	11
2.6 Method for conducting the interpretative meta-synthesis	11
3 Results.....	13
3.1 Characteristics of the included studies	13
3.2 Overall quality of the studies:.....	13
3.3 Meta-synthesis	14
4 Discussion.....	22
4.1 Discussion of findings	22
4.2 Limitations of the current review	25
4.3 Overall conclusions and implications for current policy and practice	26
5 Reference list	28
PART TWO: RESEARCH REPORT.....	33
ABSTRACT.....	34
1 Introduction.....	35
1.1 Developmental Context	35
1.2 Mental health transitions research	36
1.3 Rationale and aims of the current study	39
2 Method.....	41
2.1 Design.....	41
2.2 Epistemological position of the researcher.....	41
2.3 Research context.....	41
2.4 Recruitment	42
2.5 Materials	44

2.6	Procedure	44
2.7	Quality Issues	45
3	RESULTS	47
3.1	Feeling Powerless	49
3.2	Having a privileged perspective	53
3.3	The Impact of unsafe uncertainty	57
3.4	De-institutionalising young people.....	61
4	DISCUSSION	66
4.1	Summary of research findings.....	66
4.2	Links to existing theory and literature.....	66
4.3	Clinical implications for secure inpatient CAMH services	71
4.4	Strengths and Limitations.....	73
4.5	Recommendations for Future research.....	74
5	References.....	76
	CRITICAL APPRAISAL	84
5.1	Introduction	84
5.2	Choosing a research topic.....	84
5.3	Deciding upon a methodological approach	85
5.4	Collating data.....	87
5.5	Data Analysis.....	89
5.6	Strengths and weaknesses.....	90
5.7	Personal and professional development	92
5.8	References:	93
	APPENDICES	95
	Appendix A*- Intended journal guidelines.....	95
	Appendix B- Systematic literature review search terms.....	101
	Appendix C- Process of developing first, second and third order constructs...	102
	Appendix D- Table of first and second order constructs	104
	Appendix E- Key characteristics table.....	106
	Appendix F- CASP quality assessment results.....	108
	Appendix G- Third order interpretation of themes; “Line of argument”	109
	Appendix H*- Epistemological standpoint.....	110
	Appendix I- Participant information sheet (PIS)	113
	Appendix J- Participant consent form	116
	Appendix K- Topic guide	117

Appendix L*- Ethics correspondence	119
Appendix M- Transcription consent form	123
Appendix N- Outline of IPA analysis	124
Appendix O- Example of coding (Greg's interview)	127
Appendix P- Frequency of themes table	128
Appendix Q- Young person study	129
Appendix R- Ethics correspondence for extension of young person's study ...	133
Appendix S*- Chronology of research process	135
Appendix T- Excerpt from reflective diary.....	136

(* denotes mandatory appendices)

List of tables

PART 1: Literature review

Table 1- Inclusion and exclusion criteria.....	8
Table 2- Respondent details.....	43

List of figures

PART 1: Literature review

Figure 1- Meta-ethnography method	7
Figure 2- Flow of studies for inclusion in the review	10

PART 2: Research report

Figure 3- Visual representation of the interaction between the four superordinate themes and corresponding sub-themes.....	48
--	----

PART 1: LITERATURE REVIEW

The transition to adult mental health services and the complex needs of young people: A qualitative review of the experiences and views of young people, professionals and families.

(Guidelines to authors for journal targeted for the Literature Review can be found in Appendix A).

ABSTRACT

Aim

This paper systematically reviewed the qualitative evidence on the needs and experiences of young people during transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS). The synthesis incorporated evidence from perspectives of young people, professionals and families in order to build on the existing knowledge base.

Method

The review was designed as a qualitative meta-synthesis and follows Noblit and Hare's (1988) meta-ethnographic approach. Six electronic databases (PsychINFO, Scopus, Medline, Web of Science, CINAHL and ASSIA) were systematically searched and specified inclusion criteria were applied. The resulting studies were quality assessed, key information was extracted and the subsequent meta-synthesis was conducted.

Results

Eight qualitative studies were included in the review. All studies broadly considered the experience of or views of transition from different perspectives. A range of methods and analyses were used. The synthesis of the data revealed several overlapping and similar themes within the studies. Four superordinate themes were identified. Staying close to the primary data, key extracts and quotes from the studies were used to explain the themes. Key relationships within the sub themes were then identified and incorporated into an overall model to outline the synthesis.

Conclusions

The eight studies used in the review showed significant overlap in the key themes and findings identified. The synthesis revealed that young people in transition to AMHS have a range of developmental, social and emotional needs. At the point of transition these needs can often become neglected. This is due to poor communication, lack of consistent relationships and culture divides between CAMHS and AMHS. The findings provide evidence for the ongoing need for a youth mental health model where services are able to address the unique needs of late adolescence and early adulthood.

1 INTRODUCTION

1.1 Clinical context

1.1.1 *Transitions during adolescence*

Transitions are a natural part of life and can occur at many stages in the life cycle. Adolescence entails multiple changes in areas of education, work, social and emotional development. They can at times be difficult to manage, even for adolescents who are psychologically robust. Many professionals now contend that late teens to early twenties is a developmental stage in its own right. “Emerging adulthood”, defined by Arnett (2004), has been described as a distinct developmental stage, consisting of five key features; “*it is the age of identity explorations, the age of instability, the self-focused age, the age of feeling in-between, and the age of possibilities*”, (Arnett, 2007, p.69).

1.1.2 *Transitions in mental health services*

Given the density of this time frame in an individual’s life, it is unsurprising that the addition of mental health problems makes the progression into adulthood a particularly vulnerable time. Ideally, child mental health services would fully prepare the young person for the world of adulthood and the transition to AMHS would be person-centred and needs-driven. However, as Mallory (1996) outlined, there are typically two types of transition at this time; “developmental” and “institutional”. Developmental transitions incorporate moral, social and emotional development that is culturally and contextually defined and form part of an “adult” identity (Gilmer *et al.*, 2012). However, “institutional” or healthcare transitions are predominantly dictated by the labelling of ongoing healthcare problems and the reaching of an age milestone, typically 16 to 18 years (Vostanis, 2005). They are governed by bureaucratic and legal guidelines which can conflict with an individual’s natural developmental trajectory (Gilmer *et al.*, 2012; Vostanis, 2005). Davis (2003) has outlined how the developmental transition for youth with mental health problems is fraught with difficulty. The psychosocial development of this population can often be delayed, yet despite this, most mental health institutions label them as an “adult” at age 18. This brings with it the expectation of matured social and emotional functioning. However, this can be an extremely vulnerable time for young people. Often, existing mental health difficulties can become

more severe and the likelihood of developing new mental health problems such as psychosis or eating disorders increases (Department of Health, 2011). According to Hiles *et al.* (2014) both young people and professionals supporting them can feel powerless and frustrated due to the pressures to move young people on at age 18 years, when they are not yet ready developmentally or emotionally.

1.1.3 Existing transitions research

In the UK many young people transition from CAMHS to AMHS due to ongoing clinical need. Despite much published guidance (e.g. NHS Act 2006, the Children Act 1989, Children Act 2004) previous research has suggested that the experience of transition can be difficult at this age for young people, their families and service providers (Singh *et al.*, 2010).

The reported reasons for these difficulties include a lack of joint working, joint care and good transfer of information (Paul *et al.*, 2013). The National CAMHS Review (Department for Children Schools and Families and Department of Health, 2008) reported concerns regarding significant cultural and service criteria differences between CAMHS and AMHS. Differences in eligibility thresholds often result in young people being discharged from CAMHS and not accepted by AMHS; Singh *et al.* (2010) reported that adult services accepted 93% of all referrals but of these, 25% were then discharged without being seen. Very few cases experienced an “optimal” transition where joint meetings and good planning and pace of transition occurred (Singh *et al.*, 2010). This could be explained by the lack of standardized practice nationwide coinciding with a lack of awareness of transition policies and protocols (McNamara *et al.*, 2014). However, Young *et al.* (2011) recognised that policies and protocols do exist but reported they are not translatable to practice at the ground level. Poor transitions have significant implications for continuity of care, increasing the likelihood of poor mental health outcomes into adulthood (Singh, 2009).

1.2 Previous Systematic Reviews

Existing systematic reviews have examined the impact of transitioning from child to adult oriented care services on young people. A recent review by Embrett *et al.* (2015) examined how health care services support transitions. They focused on evaluation and outcome data and concluded that there is a lack of research evidence for transition programs in youth mental health. The limited evidence does suggest a clear lack of collaboration, coordination and an absence of transition planning (Embrett *et al.*, 2015). Paul *et al.* (2015) also looked at transitional care models in a systematic review with a focus on young people and families' views of transition. The systematic review incorporated quantitative (N= 7), qualitative (N= 7) and mixed methods (N= 5) studies. The findings suggested the experience of transition is difficult for young people. A lack of preparedness, complexity of needs and inadequacy of services were amongst various factors that impeded effective transitions.

Beyond the mental health literature, similar reviews have been conducted in physical health contexts. Fegran *et al.* (2014) conducted a qualitative meta-synthesis examining the experience of transition from paediatric to adult hospital care. The dominant themes were similar to the mental health literature with young people experiencing health transitions as a pivotal time for changing relationships and responsibility and support and services needing to adapt to the needs of this age group.

1.3 Aims and rationale for current review

Despite clear top-down guidance and evidence-based recommendations, recent evidence suggests that transitions are often poorly managed and can be a difficult experience for those involved (Embrett *et al.*, 2015; Paul *et al.*, 2015). It is clear that young people, families and service providers can offer valuable insight into this topic area. Transitions are a human lived experience and as such qualitative research can offer valuable evidence. Previous reviews on the transition to adult mental health services have simultaneously examined quantitative and qualitative research. Although this offers a broad overview of the limited evidence base, no attempt has been made to systematically integrate and interpret findings exclusively from qualitative research. The value of this would be to offer an in-depth interpretation within an interpretive paradigm. Fegran *et al.* (2014) demonstrated such an insight in focusing on the

experience of paediatric healthcare transitions. Therefore the aim of this synthesis is to integrate qualitative findings which illuminate the experiences of and views of young people, families and professionals involved in the transition from CAMHS to AMHS. Although Paul *et al.* (2015) also considered similar qualitative findings, they broadly considered all primary research regardless of methodology. The qualitative synthesis of this review is therefore limited. The present review aims to expand on the qualitative findings on the experiences and views of young people, professionals and families regarding the transition to adult services and offer a new, integrated interpretation in the form of a meta-synthesis. It is hoped that an integrated understanding might help develop improved patient centred care.

2 METHOD

The review was designed as a qualitative meta-synthesis and follows Noblit and Hare's (1988) meta-ethnographic approach (Figure 1).

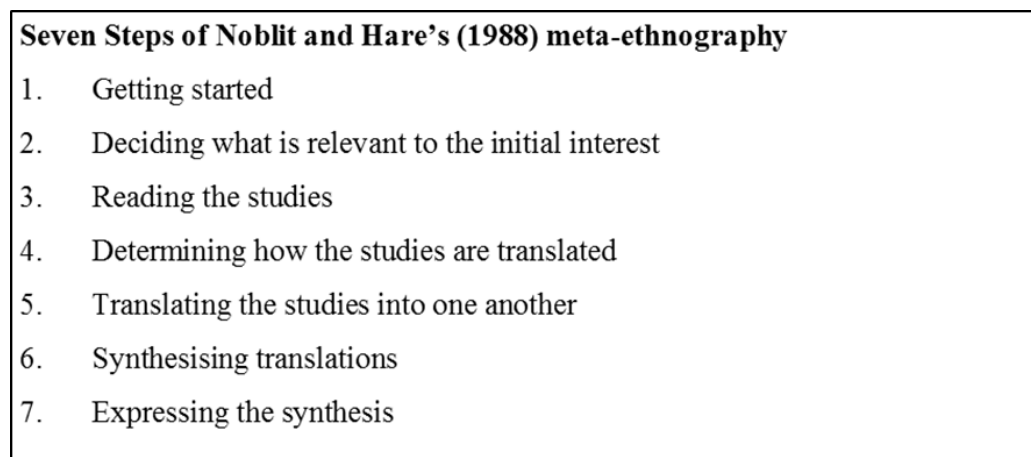


Figure 1- Meta-ethnography method

This method was chosen to align with the aims of the review, to develop the current understanding of the needs of young people transitioning to adult mental health services from the perspectives of young people, families and professionals. Meta-ethnography is one of the most well developed methods for the synthesis of qualitative data. It involves induction and interpretation, both of which resemble the methods used in qualitative research (Britten *et al.*, 2002). The method is more fully described below (2.1).

2.1 Search strategy and terms

The identification of qualitative research papers for this review involved a systematic search of six electronic databases; PsychINFO, Scopus, Medline, ASSIA, CINAHL and Web of Science. These databases were selected according to their relevance to the topic area and their use in similar reviews (Fegran *et al.*, 2014; Paul *et al.*, 2015).

Search terms were selected based on initial scoping searches of the literature, identification of similar reviews (Embrett *et al.*, 2015; Fegran *et al.*, 2014; Paul *et al.*, 2015) and consultation with a specialist librarian. The search terms were selected to incorporate the broad topic of transition and mental health service use specifically for

young people. It was important to avoid the possibility of a narrow search given that there is restricted literature in the current topic area. A broad search ensured that relevant literature was not unnecessarily missed. The search terms were chosen to target the three subject areas of “young people”, “transition” and “mental health services”. The search terms used are detailed within

Appendix B.

2.2 Inclusion and exclusion criteria

The inclusion and exclusion criteria for the review can be found in Table 1.

Table 1- Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> ➤ Primary data pertaining to the experience of or views of transition in mental health services and/or the perceived needs of young people in transition ➤ Young person, family and/or professional perspectives ➤ Consideration of young people¹ transitioning to AMHS ➤ Age range 16 to 20 years (based on variation in the literature) ➤ Published in English language ➤ Qualitative studies or mixed methods with a substantial qualitative component 	<ul style="list-style-type: none"> ➤ Non-primary data ➤ Quantitative only ➤ Physical health, foster or psycho-social transitions ➤ Studies looking at continuity of care (within the same services) ➤ Studies with a limited qualitative component, e.g. results and discussion consisting of limited surface level descriptions of themes

Due to the paucity of qualitative literature in this area, papers were not restricted to peer-reviewed articles (where this was a database option) in order not to miss valuable research that could add further insight into this topic area. However, a quality assessment was completed by the researcher. Papers published up to August 2015 were considered. A lower date limit of the year 2000 was applied. This was deemed

¹ The term “young person” will hereafter be used to denote those of transition-age.

appropriate given that studies pre-dating 2000 were unlikely to align with current healthcare systems. Consideration of the political context informed this decision. For example, the Human Right Act (1998), the reform of the Mental Health Act (Department of Health, 2000) and the UK governments White Paper, “Modernising Mental Health Services” (Tyrer, 1999) all resulted in major changes in service structure and provision. This cut-off was therefore deemed particularly important given the context of the current review.

2.3 Study Selection

The literature search was carried out in August 2015 by the researcher. After exporting all references to bibliographic referencing software, an initial screening of titles and abstracts was conducted including the removal of all duplicates. The remaining articles were considered by examining the full text and checking against the inclusion and exclusion criteria. A final hand search of references in existing reviews and primary research was conducted. The search strategy is summarised in Figure 2.

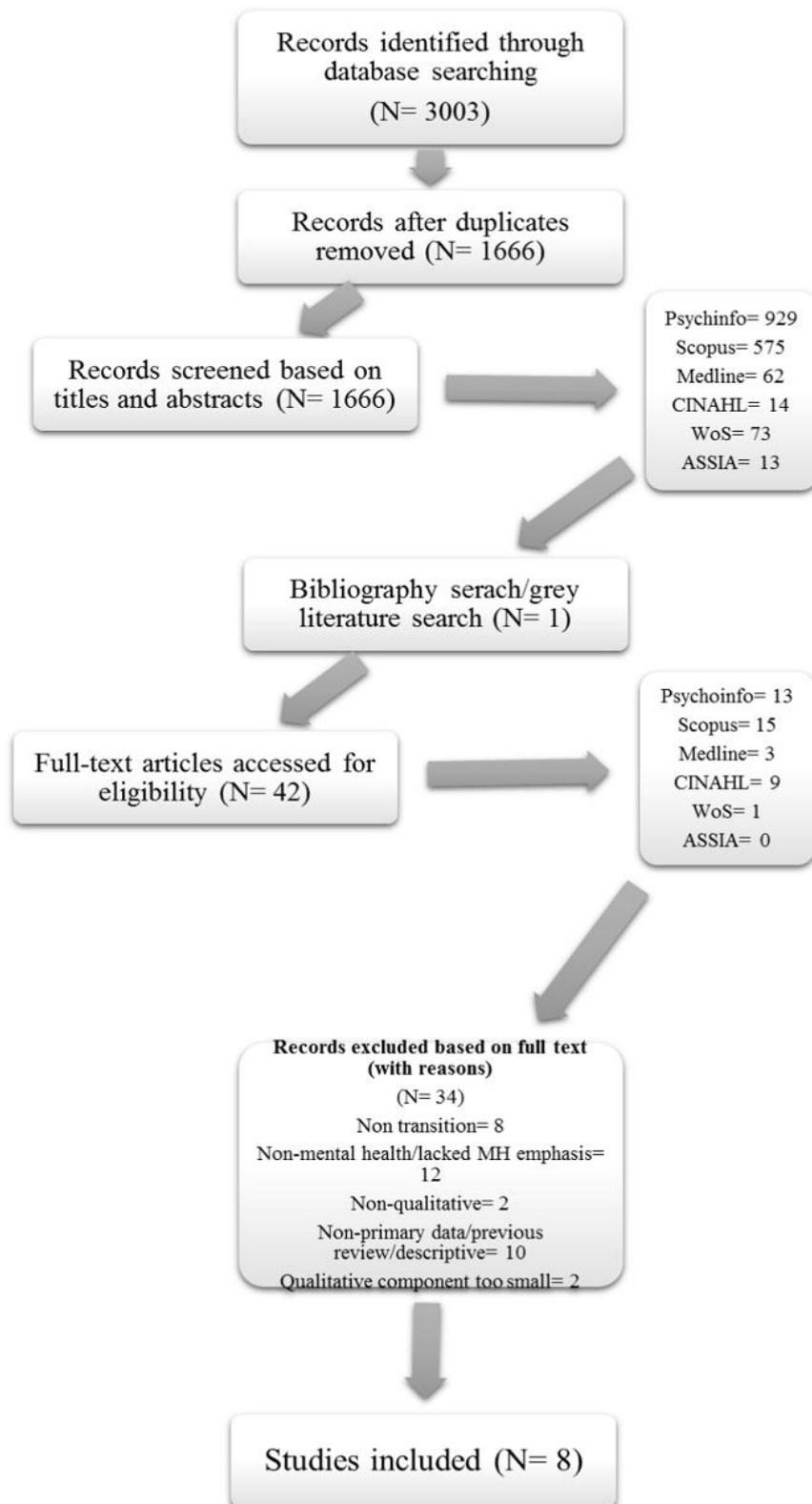


Figure 2- Flow of studies for inclusion in the review

2.4 Quality Assessment

The final studies were appraised for quality using the Critical Appraisal Skills Program (CASP). Although the application of quality criteria to qualitative studies is widely debated (Pope *et al.*, 2000) it was important to consider the quality of the studies and potential gaps in their descriptions in order to inform the meta-synthesis. An a priori decision was made to not exclude any papers based on the quality assessment alone due to the risk of being over-rigorous and potentially missing important data in what is a very limited field of research. Further, appraising the studies could be considered as an “exercise in judging the quality of the written report rather than the research procedure itself” (Atkins *et al.*, 2008, p.5). However should the identified papers present with very “low” quality according to the CASP tool, this could be considered in the limitations of the meta-synthesis and highlight areas for future research.

2.5 Reflexivity

Alongside the quality assessment, the researcher considered their role and influence on the meta-synthesis. For example, the researcher’s a priori experience and knowledge as a clinician working in CAMHS was held in mind throughout. It is possible that the researcher could take a more sympathetic view towards CAMHS when reading the studies and synthesising the key themes. This was managed through use of a reflexive diary and careful consideration of the papers, e.g. through re-reading the studies and thorough cross-checking the findings with the themes identified.

2.6 Method for conducting the interpretative meta-synthesis

The meta-synthesis was guided by Noblit and Hare’s (1988) seven step approach (Figure 1) and adapted according to more recent developments of meta-ethnography. Noblit and Hare (1988) originally suggested between four to six papers for a meta-synthesis, all of which must have the same epistemological standpoint. Given these criteria are not always possible and possibly over-stringent, necessary adaptations and developments have since been made to this approach (Barnett-Page & Thomas., 2009; Britten *et al.*, 2002). Such adaptations have included integrating wider concepts from differing approaches (Sandelowki & Barroso, 2007) and providing a more structured

way of building on the levels of interpretation within a synthesis (Britten *et al.*, 2002). Therefore, aspects of these approaches were combined within the current review, based on these more recent uses of the meta-ethnographic approach.

In order to synthesise the final papers in a meaningful way, steps four to six (Noblit & Hare, 1988) were performed using the method of Reciprocal Translational Analysis (RTA). This involved an iterative process whereby overlapping themes from the individual studies were translated into one another to produce overarching concepts or metaphors. Further, following the approach outlined by Britten *et al.*, (2002), the use of “first”, “second” and “third” order constructs were also incorporated into the analysis process. In order to explain this process further, the stages have been summarised within [Appendix C](#) and [Appendix D](#), to highlight the increasing levels of interpretation used in the current review.

3 RESULTS

3.1 Characteristics of the included studies

The key characteristics of each study are presented in Appendix E. All eight studies incorporated the broad aim of qualitatively investigating the experience of or views of transition in youth mental health services. Three studies examined the service user perspective only (Burnham Riosa *et al.*, 2015; Lindgren *et al.*, 2015; Swift *et al.*, 2013), four studies looked at professional's views only (Kaehne, 2011; Lindgren *et al.*, 2013; McLaren *et al.*, 2013; Richards & Vostanis, 2004) and one study examined multiple perspectives including families (Hovish *et al.*, 2013).

All studies focused on youth transitions and as such considered a similar age range. The studies generally considered mainstream mental health services however two studies specified a specific group of young people, those with Intellectual Disabilities (ID) (Kaehne, 2011) and those with Attention Deficit Hyperactivity Disorder (ADHD) (Swift *et al.*, 2013).

All but one focus group study (Lindgren *et al.*, 2013) used semi-structured interviews as the data collection method. For those studies that examined young people's perceptions, three used mixed gender participants (Hovish *et al.*, 2013; Lindgren *et al.*, 2015; Swift *et al.*, 2013) and one study did not specify (Lindgren *et al.*, 2013). Studies examining professional's views used a range of professionals with different working backgrounds, working both in child and adult services. Two studies (Burnham Riosa *et al.*, 2015; Swift *et al.*, 2013) employed a mixed methods design. Five studies were conducted in the UK, two in Sweden and one study in Canada.

3.2 Overall quality of the studies:

The results of the CASP quality assessment can be found in * For example, naming epistemological standpoint/ discussing the researcher's influence on the findings

Appendix F. The overall quality of the papers varied but was generally good. Positively, all the included studies demonstrated a clear research aim and appropriate qualitative methodology to align with the aims. However there was a consistent lack of reporting on the theoretical position of the authors and their potential influence on the research. In some studies, it is clear that a priori policy relevant questions were considered (Kaehne, 2011; Hovish *et al.*, 2013; McLaren *et al.*, 2013) and this appeared to influence how the findings were presented. The analysis component of these studies tended to have less emphasis/description making these papers more difficult to evaluate. Therefore potential researcher biases may have been present, particularly given that these studies were related to wider research projects.

Studies focusing on the young person's experience tended to include more detail of the analysis and a richer description of the findings (Burnham Riosa *et al.*, 2015; Lindgren *et al.*, 2015). It is noteworthy that the papers varied greatly in terms of length and depth of analysis. However shorter papers did not appear to indicate significantly lower quality ratings.

Limitations were discussed in all of the individual studies and the findings were generally considered in light of these limitations. These included potentially biased sample sizes (Richard & Vostanis, 2004) and small sample sizes for the methodologies used (Kaehne, 2011). However despite these limitations the studies individually appeared to add value to the research field with clear conclusions and appropriate recommendations for future research.

3.3 Meta-synthesis

The meta-synthesis considered the views and experiences of young people, families and professionals surrounding mental health transitions. The qualitative findings were synthesised into four superordinate themes; facing identity dilemmas, needing containment and trusting relationships, changing responsibility and talking a different language. The main themes outlined below have been formulated by staying close to the data, using the original language and quotes from the data where appropriate. Each

superordinate theme has been divided into further conceptual headings to highlight the different concepts reflected within each theme.

3.3.1 Facing identity dilemmas

3.3.1.1 Understanding a young person's uniqueness

Identity during the transition to adult oriented care is a critical factor that may contribute to increased or decreased suffering for young people. Identity formation and becoming a young adult is a vulnerable time period for any young person. However those with mental health problems in receipt of mental health services are especially vulnerable due to their complex and “multi-faceted” needs (Richards & Vostanis, 2004, p. 118). Young people in the mental health system experienced several issues with respect to their sense of personal identity.

“They’re in a period of transition so issues around identity in all its forms, be that sexual, be that cultural or whatever...young people’s services have to be receptive of that...” (Richards & Vostanis, 2004, p. 119).

The young people needed to feel as though they are being treated as a person and not just a file number, age threshold, diagnosis or label (Burnham Riosa *et al.*, 2015, Lindgren *et al.*, 2015). Young people had own unique views and contributions to make to the transition process as such needed to feel empowered to advocate for themselves. This may have contributed to their sense of moving forward and becoming a young adult where they can start “to feel I’m taking charge of whatever I need to do in life” (Burnham Riosa *et al.*, 2015, p. 465).

3.3.1.2 Becoming a “young adult”

However moving from being an ‘adolescent’ to a ‘young adult’ evoked mixed feelings. Some young people felt daunted by the prospect of having more responsibility and feeling “grown up” whereas others felt excited by the same prospects (Lindgren *et al.*, 2015). Therefore it was essential for professionals and those involved in transition

to recognise young people as a “person first, patient second” (Burnham Riosa *et al.*, 2015, p. 464). In doing so, young people could be supported in ways that fitted their unique individual needs such as differing levels of maturity. Professionals recognised the need to adjust their interactions with a young person not according to their age but their level of maturity (Lindgren *et al.*, 2013).

“She talks to me neither as a child nor as an adult, but she talks to me in a way she notices I want to be spoken to” (Lindgren *et al.*, 2015, p. 185).

3.3.1.3 Service expectations

The service age cut-offs were experienced as unhelpful (Hovish *et al.*, 2012; Richards & Vostanis, 2004). The expectation that a young person is an ‘adult’ and therefore should be treated within adult services at age 18 years did not always fit with the young person’s view of themselves. Many young people did not feel like a child, yet would not call themselves an “adult”. One young person described “its sort of like 50/50, on the fence, you know?” (Burnham Riosa *et al.*, 2015, p.462). This sense of feeling in-between was further exacerbated when a young person reached an adult mental health environment as was placed amongst those older than themselves. Burnham Riosa *et al.* (2015) reported that one young person could not imagine “sitting in the same room” as “40 year olds who [sic] suffering from severe depression” (p.463). Richards and Vostanis (2004) also highlighted that adult mental health services need to offer “user friendly and age appropriate” interventions (p.120). This would ensure young people feel their needs have been fully considered during their transition.

3.3.2 Needing containment and trusting relationships

3.3.2.1 The therapeutic alliance

The concepts of containment and trust refer to the descriptions of young people needing to feel that key adults will be present, offering support, before during and after transition. The most significant “key adults” were mainly described and referred to in terms of professional relationships within mental health services (Burnham Riosa *et al.*, 2015; Lindgren *et al.*, 2015; Lindgren *et al.*, 2013; Swift *et al.*, 2013). Young people

needed to experience a good therapeutic relationship with professionals. This facilitated a positive transition experience and increased motivation to continue adult care (Lindgren *et al.*, 2015).

Relationships to key professionals were considered as critical in helping young people to be able to express themselves and share their feelings (Lindgren *et al.*, 2015). In order to “go the extra mile”, professionals needed to understand that young people may struggle to articulate their feelings. They may express their feelings in other ways such as behaviourally through self-harm (Lindgren *et al.*, 2015; Richards & Vostanis, 2004). Professionals interviewed by Richards and Vostanis (2004) highlighted how “getting over young people’s apathy or not wanting to work with us...we’ve got to get across the internal barriers” (p. 121). The transition to adult services may have evoked further difficult feelings that are hard to put into words. Nevertheless these feelings needed attending to.

“It’s not like I don’t want to tell. I’ve no idea what I feel. I can’t put words on it because I don’t know what it is. You haven’t learned so much about emotional life” (Lindgren *et al.*, 2015, p. 186).

3.3.2.2 The importance of trust

Even if professionals were able to provide security in relationships and support during transition, young people anticipated the inevitable loss of key attachments when they left CAMHS (Burnham Riosa *et al.*, 2015). If transitions were not well planned or discussed, young people experienced this loss as being “kicked out” by their clinician (Burnham Riosa *et al.*, 2015, p. 462) and pushed out of CAMHS services as though suddenly “now you gotta go” (Hovish *et al.*, 2012). To avoid feelings of abandonment, professionals felt that follow-up contact with former therapists and joint working for a period of time was beneficial for young people (Hovish *et al.*, 2012; Lindgren *et al.*, 2013). Further, building new attachments was of key importance. Therefore adult clinicians needed to instil confidence in young people. This could be achieved through contact and opportunities to meet new professionals (Lindgren *et al.*, 2013). This was particularly important since young people anticipated “adult” clinicians to be different to their therapists in CAMHS. They envisioned them to be stricter and firmer, acting like a “cold wall” (Burnham Riosa *et al.*, 2015, p. 463). Clinician characteristics were

consequently perceived as important. Young people needed professionals who could be “supportive and informative, non-judgemental and good listeners” (Swift *et al.*, 2013, p. 5).

3.3.2.3 Systemic factors

Relationships with family and peers were also described as being important but perhaps less pivotal than relationships with professionals. The changing relationship with parents in terms of their level of involvement after transitioning to adult services was a significant factor in the transition process (Hovish *et al.*, 2012). Parental and young person perspectives differed in terms of how they perceived parental involvement to be helpful. Parents experienced a sense of being cut-off from their child’s care post transition. It was possibly dependent on the young person and their individual needs as to whether parental involvement assisted in the transition process. Mixed findings showed that some young people viewed family relationships negatively (Burnham Riosa *et al.*, 2015) and relished the opportunity to become more independent from parents in adult services (Hovish *et al.*, 2012). However some young people placed value on the support and involvement in their care from parents (Hovish *et al.*, 2012, Swift *et al.*, 2013). Professionals also viewed their relationship with family members as important for a successful transition (Lindgren *et al.*, 2012).

3.3.3 Changing responsibility

3.3.3.1 Who’s responsible?

The transition from child to adult oriented mental health care was a critical time period for emotional, professional and strategic changes in accountability and responsibility of care. If transitions were well planned they were experienced as positive and successful (Hovish *et al.*, 2012; Swift *et al.* 2013). Many young people relied on professionals involved in their care to take responsibility for ensuring continuity of care at the point of transition (Swift *et al.*, 2013). However this could be difficult for professionals to manage at times due to the “I think they’re doing that syndrome” (Richards & Vostanis, 2004, p.124) where services were unclear about whose responsible for the young person and their case requirements. Young people needed clear care coordination (McLaren *et al.*, 2013) which could be facilitated through joint meetings and good communication

between child and adult mental health service representatives (McLaren *et al.*, 2013; Richards & Vostanis, 2004). Periods of parallel care were difficult for professionals in terms of clinical governance and taking responsibility for potential failures. Services may even argue about boundaries and responsibility (Richards & Vostanis, 2004).

“...if something goes wrong with that client whose responsibility is it?
And for CAMHS I imagine they’re quite keen to just get people transferred, they’re no longer responsible for the care, the new team is...” (Hovish *et al.*, 2012, p. 255).

Given that professionals experienced the changes in responsibility as difficult to manage, it was not surprising that young people were also impacted by these changes. Young people felt that periods of joint care (e.g. transition planning meetings) and good communication between CAMHS and AMHS were important. Young people experienced transitions positively if these factors were in place (Hovish *et al.*, 2012). However a “shared professional identity” (McLaren *et al.*, 2013, p. 5) where professionals are aware of each other’s roles and responsibilities was difficult. This was explained through poor communication channels between CAMHS and AMHS and a lack of knowledge on CAMHS part about the type of support that AMHS were able to offer (Kaehne, 2011).

Taking ownership of care

The pathway to adult mental health care was further complicated by young people’s experiences of multiple transitions simultaneously. Not only did young people need to navigate mental health care transitions, but education and social care transitions in some cases. This was confusing for young people when different services presented with different age cut-offs (Hovish *et al.*, 2012; Kaehne, 2011). It was generally accepted in most “adult” service provision that service users were more self-motivated. “Becoming an adult means own responsibility” (Lindgren *et al.*, 2013, p. 105) meaning that professionals and families no longer had the influence they previously had in child services. The legal cut-off at 18 years meant that young people needed to take more responsibility for attending their appointments and managing their own mental health. In line with the sub-theme “facing identity dilemmas” this prospect was viewed as

either favourable or frightening, depending on the young person and other systemic factors. Where relatives had previously initiated care, lack of family involvement in adult services caused some young people to suddenly become very vulnerable (Lindgren *et al.*, 2013). However some young people viewed the transition as a “fresh start filled with ‘new responsibilities’” (Burnham Riosa *et al.*, 2015, p. 462).

3.3.4 Talking a different language

“Talking a different language” was a term coined by McLaren *et al.* (2013) who reported a significant cultural divide between CAMHS and AMHS from the perspective of professionals. However this term was used as the fourth sub theme since it encapsulated a strong theme existent in much of the data.

3.3.4.1 Different working models

The perceived differences in working practice between CAMHS and AMHS posed many challenges during transition. It was widely recognised that CAMHS offer a more family oriented, holistic model of care whereas AMHS focus more on individual need and pathology (Kaehne, 2011; Lindgren *et al.*, 2013; McLaren *et al.*, 2013). The sudden lack of emphasis on the developmental perspective of mental health difficulties was a difficult adjustment for young people (Kaehne, 2011). AMHS were often viewed as a “long and enduring mental illness service” (Kaehne, 2011, p. 14). Additionally parents suddenly felt cut-off from their child’s treatment which often had a negative impact on the young person themselves (Hovish *et al.*, 2013; Swift *et al.*, 2013).

“One can imagine that it’s difficult when you’re quite cherished at CAP [child services] and all relatives are involved and then you suddenly stand all alone...alone can be quite difficult” (Lindgren *et al.*, 2013, p. 105).

Further, AMHS professionals often received less training in youth mental health resulting in less awareness of the needs of young people (McLaren *et al.*, 2013). This inexperience resulted in greater levels of difficulty in adapting their work for older

adolescents (Richards & Vostanis, 2004). Young people also anticipated the differences between “child” and “adult” oriented therapies and anticipated that they would feel out of place in adult-oriented treatment (Lindgren *et al.*, 2015). However professionals felt that periods of joint care and shared professional training may help with these issues.

“More joint working or more understanding between CAMHS and AMHS. I’m thinking about how different things are... We come at it from a different perspective. Maybe we need to be looking more at joint training and looking at the issues within the context of the family.” (McLaren *et al.*, 2013, supplementary information, p.3).

3.3.4.2 Practical differences

Differences in working practice extended to the practical aspects of transition such as sharing confidential information. CAMHS and AMHS had different approaches to record keeping such as different electronic systems (McLaren *et al.*, 2013). This resulted in AMHS receiving inadequate information about a young person which then further exacerbated discontinuity of care. Further, a lack of knowledge about eligibility criteria (Lindgren *et al.*, 2013; Kaehne, 2011) for AMHS also made it difficult for CAMHS workers to know when a referral was considered appropriate.

“It’s hard to prepare the patient for a transfer when neither we nor the patient know if they will be received at GenP [adult services]” (Lindgren *et al.*, 2013, p. 105).

Eligibility criteria was also an issue in terms of differing thresholds. AMHS were perceived as having higher thresholds for service need, with a greater emphasis on pathology and more enduring mental health labels (Kaehne, 2011; McLaren *et al.*, 2013). Therefore some young people discontinued care even though there is ongoing clinical need.

4 DISCUSSION

4.1 Discussion of findings

This meta-synthesis aimed to integrate qualitative findings on the process of transition from CAMHS to AMHS. The aim was to expand on the current knowledge base of the needs of youth in transition and how services can meet these needs. By conducting an in depth analysis of qualitative primary studies, the meta-synthesis aimed to provide a rich and detailed interpretation that may offer further insights into what is already established in the literature.

4.1.1 Current findings, links to existing research and clinical implications

The current review demonstrated how young people within mental health services have a range of complex needs. These must be addressed in a holistic and person-centred manner during transition. This was captured within the four superordinate themes. Each theme incorporates different aspects of young people's needs from differing perspectives. Appendix G incorporates the four themes but also offers a perspective in how they may influence each other. This conceptualisation is drawn from the meta-synthesis findings but also from the researcher's own third order interpretation of the findings. This third order interpretation (i.e. "Line of Argument") offers a series of hypothesised relationships between the four superordinate themes, as demonstrated through the use of arrows within the model. This offers a way to conceptualise how each theme may directly impact one another in both positive and negative ways. For example, by considering ways to enhance therapeutic relationships at the point of transitions ("trusting and positive therapeutic relationships" theme), then the "cultural divide" between CAMHS and AMHS may become less significant. Hence the model demonstrates a direct relationship between these two themes.

The findings suggested young people place high value in trustful and positive therapeutic relationships with professionals. Existing literature supports this view, that established and trusting relationships with help providers is needed for young people to feel they can access mental health services (Rickwood *et al.*, 2007). Further, when these qualities are present, transitions are experienced more positively. However such relationships can only be achieved if young people also feel understood as unique

individuals. The current review highlighted how professionals need to appreciate the complexity of this population in terms of the identity dilemmas they may face. Young people need to feel treated not as a label or file number, nor as a “child” or “adult”. This may include adapting to their communication style or their level of social and emotional understanding. In turn, young people are more likely to place trust in such professionals.

Strong therapeutic relationships and a sense of personal identity may in turn influence the “cultural divide” between CAMHS and AMHS. The findings of the current review suggested that the sense of “talking a different language” in adult services may only become a barrier to transition if other factors are not in place. This aligns with previous findings, that organisational variation is not necessarily a barrier to establishing transition protocols and subsequent positive transition experiences (Singh *et al.*, 2008). Therefore trusting therapeutic relationships and an appreciation of the “emerging adulthood” developmental stage must be incorporated into transition planning. This awareness may serve as a protective factor against adult services that are perceived as less “child-friendly”. However adult clinicians may feel restrained in being able to respond to this phase. There are stark differences in training between CAMHS and AMHS, alongside differences in commissioning and links to other healthcare policies (Lamb & Murphy, 2013). However it is widely documented that regardless of the therapeutic approach, the most important factor for young people to engage with services is trusting and positive therapeutic relationships (Grossoehme & Gerbetz, 2004; Rickwood *et al.*, 2007).

The current review demonstrated a lack of in depth qualitative findings on the views and experiences of families with only one paper specifically examining such views (Hovish *et al.*, 2012). However previous research confirms that families hold similar views surrounding mental health transitions aligning with the themes within current review. For example, Jivanjee *et al.* (2009) reported that parents felt their children were not prepared for adult life. They also feared that their child would struggle in AMHS without parental involvement and the subsequent increased responsibilities (Jivanjee *et al.*, 2009). In terms of positive relationships, the limited data within the current review

indicates that similar to professionals, young people can benefit from trusting familial relationships during transition.

The change in responsibility can also pose challenges to the transition process. Young people need to feel that their transition is well planned with joint meetings and shared communication. Professionals also need to understand their role in the transition process. This will avoid false assumptions that “someone else” will be taking on certain tasks. As Meleis (2007) outlined in the Middle Range Theory of Transition, “Roles are not dictated; they emerge through interaction and they are shaped by other’s responses and interpretations” (Meleis, 2007, p.217). Therefore good communication between professionals, families and young people is essential in defining roles and responsibilities.

Clear plans and communication will also impact a young person’s sense of identity. Knowing who is responsible for their care and opportunities to discuss transition plans will increase a sense of empowerment and autonomy. A sense of responsibility for oneself and making independent decisions have been identified as the most critical factors in transitioning to an “adult” identity (Arnett, 1998). If young people have lacked meaningful practice of these competencies in child services, they may feel underprepared to use these opportunities as they arise in AMHS.

4.1.2 How the current findings add to the research base

The current meta-synthesis supports previous research (Singh *et al.*, 2010; Young *et al.*, 2011) and mirrors findings of previous reviews (Embrett *et al.*, 2014; Paul *et al.*, 2015). The current results add further support to previous findings, that age-appropriate services, the need for clear plans and communication (Paul *et al.*, 2015) and organisational barriers (Embrett *et al.*, 2014) are all pertinent issues at the point of transition. However, the current findings also add a greater and more in depth insight into the lived experience of transition. This greater insight has allowed the researcher to hypothesise how the different third order constructs may interact and influence each other in the form of a line of argument (Appendix G). This conceptualisation offers a

way of explaining the “story” of transition and offers a greater level of meaning than objective, quantitative outcome data within previous reviews. Based on this hypothesis, this review also offers a practical and solution-focused way for those involved in transitions to consider how relatively small changes in one area of transitional care may have a significant impact on other areas.

The studies used in the review are noted to be varied in methodologies, perspectives and types of mental health service/problems. However the analysis revealed a significant thematic overlap between all papers. This suggests that universal issues in mental health transitions may exist regardless of diagnosis or type of service. The findings also align with similar research in other fields. Cultural divides between paediatric and adult care (Van Staa *et al.*, 2011) complex changes in responsibility and roles (Moons *et al.*, 2009) and personal identity issues (Björquist *et al.*, 2014) have all been linked to difficulties during transition to adult physical healthcare settings. Additionally, having consistent and committed adult support and feeling listened to and understood are important facilitators of transition for young people ageing out of foster care into adulthood (Del Quest *et al.*, 2012; Geenen & Powers, 2007).

4.2 Limitations of the current review

It should be noted that there are limitations to the current review. Firstly the papers selected for this review varied in terms of the methodologies used. Two papers adopted a mixed methods design and the remaining used a range of qualitative analyses. Noblit and Hare’s (1988) prerequisite for the synthesis of qualitative research is that all included studies should have the same epistemological standpoint. This is therefore questionable in the current review. However due to the limited amount of qualitative literature in this field, it was necessary to attempt this synthesis. Further, more recent guidelines for the synthesis of qualitative data suggest that it is not an issue to mix different epistemologies (Sandelowski & Barosso, 2007). It is perhaps more important to focus on the influence of contextual factors within the primary data, such as socioeconomic status of the study populations and how these may influence the synthesis (Atkins *et al.*, 2008). However the studies in the current review demonstrated poor reporting of contextual information which should be noted as further limitation.

It is also noted that the author as sole researcher independently completed all stages of the review. Therefore second opinions on the inclusion and exclusion of papers and the analysis process were not sought. This leads to the possibility for researcher bias.

4.3 Overall conclusions and implications for current policy and practice

The current review highlights the complex needs of adolescents in mental health services and suggests that services do not always meet these needs at the point of transition. It is known that the onset of recurring mental health problems typically begins before the age of 25 years (Birchwood & Singh, 2013). However in the UK, the health and social care system is “letting down many desperately ill youngsters at a critical time in their lives” (Care Quality Commission Report, 2014, p.2). This is despite a significant array of policy guidance and governmental legislation (NHS Act 2006, the Children Act 1989, Children Act 2004) that provides clear, relevant information for optimal transitions and ways to support young people. The Department of Health’s (2011) report ‘No Health Without Mental Health’ also highlights how CAMHS to AMHS transitions should be improved through good planning, good communication with young people and joint commissioning. The current legislation aligns with the evidence base (Embrett *et al.*, 2014; Paul *et al.*, 2015) and the current review findings. Young people, professionals and families support the guidance, yet it is not always experienced at the ground level (Singh *et al.*, 2010; Young *et al.*, 2011).

There are therefore clear implementation barriers in supporting young people’s mental health during a time when they are potentially at their most vulnerable. One way forward in addressing this widespread issue is the conceptualisation of a youth mental health model of working. McGorry (2013) advocates for youth-specific services that recognise youth mental health as a discrete targeted program area for those aged 12-24 years. In Australia such services have been implemented with reported success. Such an approach would incorporate the strengths of CAMHS with their developmental focus and specialist knowledge of young people’s difficulties. It is apparent that this type of approach is lacking in UK services. However some mental health specialities have demonstrated a benefit in providing youth-specific services. Early Intervention Psychosis (EIP) services recognise the need to consider the emerging adult stage and

consider young people typically aged between 14-35 years. The use of early intervention has had significant positive outcomes in reducing the likelihood of enduring mental health problems continuing into later adult life (Bird *et al.*, 2010).

In conclusion, there appears to be a large evidence base that supports the need for collaborative, well planned and flexible transitions for young people in mental health services. A top-down approach is required to re-direct funding to evidenced preventative treatments for young people. Engagement between commissioners and local clinicians, young people and their families alongside an emphasis on key outcome data is needed. Outcome data will be essential in providing clinical and financial evidence for the cost-effectiveness of such approaches. Large-scale evaluations of the existing attempts to bridge the gap between CAMHS and AMHS will also further this progress in the youth mental health field.

5 REFERENCE LIST

* Denotes studies used within the current review

- Arnett, J. J. (1998). Learning to stand alone: The contemporary American transition to adulthood in cultural and historical context. *Human Development*, 41(5-6), 295-315.
- Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55, 469-480.
- Arnett, J. J. (2004). *Emerging adulthood: The winding road from the late teens through the twenties*. Oxford University Press.
- Arnett, J. J. (2007). Emerging adulthood: What is it, and what is it good for?. *Child Development Perspectives*, 1(2), 68-73.
- Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, 8(1), 21.
- Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology*, 9(1), 1.
- Birchwood, M., & Singh, S. P. (2013). Mental health services for young people: Matching the service to the need. *The British Journal of Psychiatry*, 202(s54), s1-s2.
- Bird, V., Premkumar, P., Kendall, T., Whittington, C., Mitchell, J., & Kuipers, E. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: Systematic review. *The British Journal of Psychiatry*, 197(5), 350-356.
- Björquist, E., Nordmark, E., & Hallström, I. (2014). Living in transition—experiences of health and well-being and the needs of adolescents with cerebral palsy. *Child: Care, Health and Development*. Retrieved 30 January 2015 from <http://www.ncbi.nlm.nih.gov/pubmed/24798111>.
- Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy*, 7(4), 209-215.
- Buston, K. (2002). Adolescents with mental health problems: what do they say about health services?. *Journal of Adolescence*, 25(2), 231-242.

- Care Quality Commission. (2014). *From the sea to the pond. Children's transitions to adult health services*. Retrieved from: https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf.
- Critical Appraisal Skills Programme (CASP). 10 questions developed by the National CASP Collaboration for qualitative methodologies. Public Health Resource Unit, Milton Keynes Primary Care Trust 2002. Retrieved from: www.phru.nhs.uk/casp/casp.htm.
- Davis, M. (2003). Addressing the needs of youth in transition to adulthood. *Administration and Policy in Mental Health and Mental Health Services Research*, 30(6), 495-509.
- Del Quest, A., Fullerton, A., Geenen, S., & Powers, L. (2012). Voices of youth in foster care and special education regarding their educational experiences and transition to adulthood. *Children and Youth Services Review*, 34(9), 1604-1615.
- Department for Children, Schools and Families and Department of Health (2008) *National CAMHS Review. Children and Young People in Mind: The Final Report of the National CAMHS Review*. London: Department for Children, Schools and Families and Department of Health.
- Department of Health (DH) (2011) 'No health without mental health: A cross-government mental health outcomes strategy for people of all ages', London: Department of Health.
- Embrett, M. G., Randall, G. E., Longo, C. J., Nguyen, T., & Mulvale, G. (2015). Effectiveness of Health System Services and Programs for Youth to Adult Transitions in Mental Health Care: A Systematic Review of Academic Literature. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-11.
- Erikson, E. H. (1950). *Childhood and society*. New York: Norton.
- Fegran, L., Hall, E. O., Uhrenfeldt, L., Aagaard, H., & Ludvigsen, M. S. (2014). Adolescents' and young adults' transition experiences when transferring from paediatric to adult care: A qualitative meta-synthesis. *International Journal of Nursing Studies*, 51(1), 123-135.
- Geenen, S., & Powers, L. E. (2007). "Tomorrow is another problem": The experiences of youth in foster care during their transition into adulthood. *Children and Youth Services Review*, 29(8), 1085-1101.

- Gilmer, T. P., Ojeda, V. D., Fawley-King, K., Larson, B., & Garcia, P. (2012). Change in mental health service use after offering youth-specific versus adult programs to transition-age youths. *Psychiatric Services*, 63(6), 592-596.
- Grossoehme, D. H., & Gerbetz, L. (2004). Adolescent perceptions of meaningfulness of psychiatric hospitalization. *Clinical Child Psychology and Psychiatry*, 9(4), 589-596.
- Hiles, D., Moss, D., Thorne, L., Wright, J., & Dallos, R. (2014). "So what am I?"—Multiple perspectives on young people's experience of leaving care. *Children and Youth Services Review*, 41, 1-15.
- *Hovish, K., Weaver, T., Islam, Z., Paul, M., & Singh, S. P. (2012). Transition experiences of mental health service users, parents, and professionals in the United Kingdom: A qualitative study. *Psychiatric Rehabilitation Journal*, 35(3), 251.
- Jivanjee, P., Kruzich, J. M., & Gordon, L. J. (2009). The age of uncertainty: Parent perspectives on the transitions of young people with mental health difficulties to adulthood. *Journal of Child and Family Studies*, 18(4), 435-446.
- *Kaehne, A. (2010) Transition from children and adolescent to adult mental health services for young people with intellectual disabilities: A scoping study of service organisation problems. *Advances in Mental Health and Intellectual Disabilities*, 5(1), 9-16.
- Lamb, C., & Murphy, M. (2013). The divide between child and adult mental health services: Points for debate. *The British Journal of Psychiatry*, 202(s54), s41-s44.
- *Lindgren, E., Söderberg, S., & Skär, L. (2015). Swedish young adult's experiences of psychiatric care during transition to adulthood. *Issues in Mental Health Nursing*, 36(3), 182-189.
- *Lindgren, E., Söderberg, S., & Skär, L. (2013). The gap in transition between child and adolescent psychiatry and general adult psychiatry. *Journal of Child and Adolescent Psychiatric Nursing*, 26(2), 103-109.
- Mallory, B. L. (1996). The role of social policy in life-cycle transitions. *Exceptional Children*, 62(3), 213-23.
- Marcia, J. E. (1980). Identity in adolescence. *Handbook of Adolescent Psychology*, 9(11), 159-187.
- *McLaren, S., Belling, R., Paul, M., Ford, T., Kramer, T., Weaver, T., ... & Singh, S. P. (2013). 'Talking a different language': An exploration of the influence of

- organizational cultures and working practices on transition from child to adult mental health services. *BMC Health Services Research*, 13(1), 254.
- McGorry, P. D. (2007). The specialist youth mental health model: Strengthening the weakest link in the public mental health system. *Medical Journal of Australia*, 187(7), s53-s56.
- McNamara, N., McNicholas, F., Ford, T., Paul, M., Gavin, B., Coyne, I., ... & Singh, S. P. (2014). Transition from child and adolescent to adult mental health services in the Republic of Ireland: An investigation of process and operational practice. *Early Intervention in Psychiatry*, 8(3), 291-297.
- Meleis, A. (2007). Developing middle range and situation-specific theories: Exemplars. *Theoretical Nursing–Development & Progress*, 212-237.
- Moons, P., Pinxten, S., Dedroog, D., Van Deyk, K., Gewillig, M., Hilderson, D., & Budts, W. (2009). Expectations and experiences of adolescents with congenital heart disease on being transferred from pediatric cardiology to an adult congenital heart disease program. *Journal of Adolescent Health*, 44(4), 316-322.
- Noblit, G.W., & Hare, R.D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, CA: Sage.
- Paul, M., Ford, T., Kramer, T., Islam, Z., Harley, K., & Singh, S. P. (2013). Transfers and transitions between child and adult mental health services. *The British Journal of Psychiatry*, 202(54), 36-40.
- Paul, M., Street, C., Wheeler, N., & Singh, S. P. (2014). Transition to adult services for young people with mental health needs: A systematic review. *Clinical Child Psychology and Psychiatry*, 20(3), 436-457.
- Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: Analysing qualitative data. *British Medical Journal*, 320(7227), 114.
- *Richards, M., & Vostanis, P. (2004). Interprofessional perspectives on transitional mental health services for young people aged 16-19 years. *Journal of Interprofessional Care*, 18(2), 115-128.
- Rickwood, D. J., Deane, F. P. Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems?. *The Medical Journal of Australia*, 187(s7), s35-s39.
- *Riosa, P. B., Preyde, M., & Porto, M. L. (2015). Transitioning to adult mental health services: Perceptions of adolescents with emotional and behavioral problems. *Journal of Adolescent Research*, 30(4), 446-476.

- Sandelowski, M., & Barroso, J. (2007). *Handbook for synthesizing qualitative research*. New York, NY: Springer Publishing Company.
- Singh, S. P., Paul, M., Ford, T., Kramer, T., Weaver, T., McLaren, S., ... & White, S. (2010). Process, outcome and experience of transition from child to adult mental healthcare: Multiperspective study. *The British Journal of Psychiatry*, 197(4), 305-312.
- Singh, S. P., Paul, M., Ford, T., Kramer, T., & Weaver, T. (2008). Transitions of care from child and adolescent mental health services to adult mental health services (TRACK study): A study of protocols in Greater London. *BMC Health Services Research*, 8(1), 135.
- Singh, S. P. (2009). Transition of care from child to adult mental health services: The great divide. *Current Opinion in Psychiatry*, 22(4), 386-390.
- *Swift, K. D., Hall, C. L., Marimuttu, V., Redstone, L., Sayal, K., & Hollis, C. (2013). Transition to adult mental health services for young people with Attention Deficit/Hyperactivity Disorder (ADHD): A qualitative analysis of their experiences. *BMC Psychiatry*, 13(1), 1-11.
- Tyrer, P. (1999). The national service framework: a scaffold for mental health. *British Medical Journal*, 319(7216), 1017.
- Van Staa, A., Jedeloo, S., van Meeteren, J., & Latour, J. M. (2011). Crossing the transition chasm: Experiences and recommendations for improving transitional care of young adults, parents and providers. *Child: Care, Health and Development*, 37(6), 821-832.
- Vostanis, P. (2005). Patients as parents and young people approaching adulthood: How should we manage the interface between mental health services for young people and adults?. *Current Opinion in Psychiatry*, 18(4), 449-454.
- Young, S., Murphy, C. M., & Coghill, D. (2011). Avoiding the 'twilight zone': recommendations for the transition of services from adolescence to adulthood for young people with ADHD. *British Medical Journal of Psychiatry*, 11(1), 174.

PART TWO: RESEARCH REPORT

The transition to adult mental health services from a secure inpatient environment: An Interpretative Phenomenological Analysis of the experiences of nursing staff.

ABSTRACT

Introduction

The transition to Adult Mental Health Services (AMHS) is a significant time in a young person's life. Existing research suggests it can be a time marked by inconsistencies, increased anxieties and unmet needs (Paul *et al.*, 2013). Secure inpatient Child and Adolescent Services (CAMHS) may incorporate additional challenges for both young people and staff, in navigating the way out of secure environments to the "outside" world (Kane, 2008). Nursing staff working in such settings play a vital role in providing daily support, care and containment (Dogra & Leighton, 2009) for the most complex young people at the Tier 4 level of care (McDougall *et al.*, 2008). The current study aimed to explore nurse's experiences of young people's transition out of a secure inpatient CAMH setting to AMHS.

Method

Semi-structured interviews were conducted with six members of the inpatient nursing team in a CAMH service to explore their lived experience of transitions. Interview data were transcribed verbatim and analysed according to Interpretative Phenomenological Analysis (IPA).

Results

The analysis produced four main themes: "Feeling Powerless", "Having a Privileged Perspective", "The Impact of Unsafe Uncertainty" and "De-institutionalising Young People". Each of these themes were broken down further into three sub-themes. The relationships between themes and convergence and divergence within the individual accounts were explored.

Conclusions

The findings were discussed in relation to existing psychological theory and research literature. Links were also made to existing policy and guidance surrounding the CAMHS to AMHS interface and a number of clinical implications for the secure CAMH service with regard to transitions are presented. These included increasing the power of nursing staff, considering an attachment perspective and defining the nursing role.

1 INTRODUCTION

Transitioning from child to adult mental health services (AMHS) is a complex and challenging experience for both service users and professionals involved (Richards & Vostanis, 2004). The implications of poor transition are significant for both the individual and the wider society (Department of Health (DoH), 2015). Before considering the issues and research around these transitions, it is useful to consider the developmental context of this experience and the importance of late adolescence.

1.1 Developmental Context

1.1.1 *The significance of late adolescence*

Adolescence and young adulthood is a significant and complex time frame in any adult's lifespan. In Western societies, it is a period marked by change and transition. The term "transition", in relation to young people, can be thought of from three differing perspectives; i) a crucial stage of biopsychosocial development ii) healthcare changes and moving to adult services and iii) situational changes, such as changing environments (Singh *et al.*, 2010). During this time, young people are expected to acquire new skills and competencies in a variety of areas including social, emotional and vocational development (Eccles *et al.*, 2003). Becoming an "adult" is marked by the acquisition of such skills alongside reaching the legal threshold of age 18 years.

Arnett (2000) developed a way of conceptualising the complex changes that arise between adolescence to adulthood. Using the term "emerging adulthood", he suggested that the period between 18 to 25 years is a developmentally distinct time frame. This time frame is marked by change, complexity and "feeling in between" (Arnett, 2007, p.69). The significance of emerging adulthood has been recognised for many decades; Erikson's (1950) psychosocial stages of development and Keniston's (1970) distinction of the "youth" stage both encompass ideas of identity, role confusion and tensions and struggles with societal expectations and personal abilities.

1.1.2 Mental health during emerging adulthood

Given the complexity of this time frame, it is often viewed as a critical turning point for future success as a well-functioning adult (Tanner, 2006). However many individuals struggle to manage well. This is particularly apparent for young people who are pre-disposed to face greater challenges in life. Certain vulnerable groups include those with mental health problems (Osgood *et al.*, 2005) who may possess fewer skills to manage the complexity of transitions alongside limited resources such as reduced income, or familial support (Collins, 2001).

Mental health difficulties amongst late teens to early twenties is a striking problem for individuals and society. It is estimated that one in 10 children between the ages of five to 16 in the UK suffer from a diagnosable mental health problem (Green *et al.*, 2005). These individuals may then be at greater risk of developing a wide range of difficulties that continue into their adult lives (Davis, 2003). Indeed, it is estimated that around 50% of most adult mental health problems start by the age of 14 years and 75% by the age of 18 years (DoH, 2015). Therefore it is essential that services cater to the needs of this vulnerable group, since a failure to do so has huge implications for their future lives and the cost of future service use.

1.2 Mental health transitions research

1.2.1 Developmental versus institutional transitions

Young people with mental health difficulties are often in receipt of Child and Adolescent Mental Health Services (CAMHS). CAMHS provide specialist, targeted treatment for young people, typically up until the age of 18 years (DoH, 2015). When these young people reach the upper age threshold within CAMHS, they often require continuing clinical support so may transition to AMHS. They are therefore required to navigate the developmental demands of emerging adulthood alongside the institutional demands of changing healthcare systems. These demands do not always align. Young people within CAMHS are often developmentally delayed for their age yet institutional systems label them as an “adult” at age 18 with the expectation of adult functioning (Davis, 2003). This results in young people moving to AMHS who are developmentally

immature and not get ready to manage the societal and institutional expectations of the adult world (Gilmer *et al.*, 2012; Vostanis, 2005).

Clear guidelines exist that recommend the need for gradual, well-planned and person-centred transitions to AMHS (e.g. NHS Act 2006, the Children Act 1989, Children Act 2004). However implementation of policy and government guidance appears to be lacking at the ground level. Many transitions within UK mental health services are not viewed positively and “optimal” transition conditions are reported to be rare (Paul *et al.*, 2015). The National CAMHS Review (Department for Children Schools and Families and Department of Health, 2008) highlighted concerns regarding the culture differences between CAMHS and AMHS. More recent government guidance documents the ongoing issues in managing transitions effectively (DoH, 2015) and continues to recommend a more person-centred, individualised approach to the transition to AMHS. In reality, there often appears to be a clear lack of coordination, collaboration and an absence of transition planning (Embrett *et al.*, 2015). The effect of poor transition is that young people may disengage from services (Singh *et al.*, 2010) or fail to be adequately supported in the future (Islam *et al.*, 2015). Poor transitions may also contribute to the increase in mental illness and poorer psychosocial outcomes later in life (Memarzia *et al.*, 2015).

1.2.2 Inpatient CAMHS transitions

Despite a wealth of literature stemming from community CAMHS transitions, the transition out of inpatient CAMHS facilities has received relatively little attention. Young people within Tier 4 inpatient CAMHS have often experienced multiple losses and traumas and present with the most complex, severe or persistent mental health problems (McDougall *et al.*, 2008).

Within this already niche sector of CAMHS, secure inpatient CAMHS provide care for young people whom present with a high risk to themselves or other people, requiring intensive support and monitoring (Wheatley *et al.*, 2004). This particularly vulnerable sector within CAMHS has been identified as requiring a particularly robust transition

process (NHS England, 2015). Transitioning out of an inpatient secure facility may have additional challenges due to the nature of the environment. Indeed, adolescents have reported feeling disconnected from the outside world, describing their experiences as “living in an alternative reality”, (Haynes *et al.*, 2011). This "alternative reality" can become very containing and stabilising for those whose lives have previously been very chaotic. The National Children’s Bureau project (Kane, 2008) reported how secure settings provide adolescents with enhanced boundaries and security that is needed for their recovery. This may include strong relational boundaries and close therapeutic relationships with ward staff. Therefore moving back into the community or to AMHS can be a frightening prospect for some young people. Additionally it may be particularly difficult for staff to "let go" of young service users in secure settings or understand how to support them during the transition period (Kane, 2008).

1.2.3 The role of professionals

The emphasis on professional support during transitions has been well documented. Both staff and service users have reported that the therapeutic relationship can be central to positive transition experiences (Lindgren *et al.*, 2015; Lindgren *et al.*, 2013; Burnham Riosa *et al.*, 2015; Swift *et al.*, 2013). In various reports, young people frequently reported the need to trust clinicians (Burnham Riosa *et al.*, 2015) and feel supported and listened to (Swift *et al.*, 2013). Often young people within CAMHS have particular difficulties stemming from trauma and abuse (Murcott, 2014) and it may therefore be difficult for them to build therapeutic alliances and potentially quite traumatic for them to lose relationships when transitioning to AMHS. Indeed, young people have reported feeling “abandoned” by the professionals whom they have learned to trust within CAMHS (Burnham Riosa *et al.*, 2015; Hovish *et al.*, 2012).

The insights and experiences of professionals working within CAMHS and AMHS may be pivotal to understanding how transitions take place. For example, staff have described their experience of poor communication between CAMHS and AMHS (McLaren *et al.*, 2013). This is despite an apparent willingness and need to be able to communicate between old and new care teams (Kaehne, 2011; Hovish *et al.*, 2012; McLaren *et al.*, 2013; Richards and Vostanis, 2004). Staff who support young people

during their transition from CAMHS have also reported their own frustration, uncertainty and feelings of insecurity (Lindgren *et al.*, 2013).

Further, many barriers to successful transitions to general adult services have been linked to staff variables, such as the training of professionals, professional's discomfort surrounding transitions and poor communication and coordination between staff within different agencies (McDonagh, 2006).

1.3 Rationale and aims of the current study

It is clear that the transition from CAMHS to AMHS is a significant time in the trajectory of mental health difficulties yet is an area where continuing problems are being identified. (Singh *et al.*, 2010, DoH, 2015). Efforts have been made to explore the current issues and provide insight into how transitions could be improved (e.g. Hovish *et al.*, 2012; McLaren *et al.*, 2013; Singh *et al.*, 2010). However limited research exists in the context of inpatient secure CAMHS. The only known study, conducted post-discharge, used content analysis and lacked in-depth qualitative information (Wheatley *et al.*, 2013). This particular type of transition may involve greater levels of complexity. Young people who transition from inpatient settings will experience a change in service provision whilst also managing a change in living environment and peer group, i.e. both a healthcare and a "situational" transition (Singh *et al.*, 2010).

Additionally, the role of professionals in maintaining close therapeutic relationships with young people in secure CAMHS has been identified as important in the transition to AMHS (Kane, 2008). This is not surprising given the significant role nursing staff play in such environments. Nursing staff play a key role in many areas including safety, support, structure, containment and validation of the service users (Dogra & Leighton, 2009). All of these factors are of key importance during the transition out of CAMHS. One could argue that they are most at risk during this time when difficult changes are inevitable.

It is therefore likely that nursing staff in a secure inpatient ward environment will play a critical role in the transition process. They may be able to offer a unique insight into the transition from specialised inpatient CAMHS to AMHS. Since this is an area not known to have been previously researched, the main aim of the current study was to examine the experience of transition² from a secure inpatient CAMHS service to AMHS from the perspective of ward-based nursing staff. The following research question was therefore considered:

- How do nursing staff experience the transition of young people from the inpatient CAMHS service to AMHS?

Subsidiary questions that were considered included:

- How do nursing staff perceive the current transition practices?
- How do nursing staff perceive how adolescents in their care experience the transition process?

² The term "transition" has been used to describe the transfer of mental health care from the inpatient secure CAMHS service to an AMHS. The AMHS may be secure or non-secure and community or inpatient based. The key feature of the study was aimed at the experience of the move to adult-oriented mental health care.

2 METHOD

2.1 Design

The aim of the current study was to explore the unique experiences and perceptions of nursing staff on the transition of young CAMHS patients to AMHS. A qualitative interpretative methodology was selected as this aligns with this aim and with the researchers own epistemological standpoint (Appendix H). The researcher felt that an idiographic approach was most suited to this research topic since this situates participants within their particular context and explores individual, personal perspectives and meaning making (Smith *et al.*, 2009). Interpretative Phenomenological Analysis (IPA) was selected as it adopts a bottom-up approach where detailed analysis is permitted of the lived experience of individuals. IPA considers both experiences, perceptions and views of the individual. The topic of life transitions is considered a central topic area within IPA (Smith *et al.*, 2009). IPA has been used in previous transition research both in the mental health domain (Burnham Riosa *et al.*, 2015) and other transitional contexts such as physical health (Miles *et al.*, 2004) and foster care (Mitchell & Kuczynski., 2010).

2.2 Epistemological position of the researcher

The research was conducted from the epistemological standpoint of a critical realist approach (Appendix H).

2.3 Research context

The research was undertaken within a Tier 4 secure CAMH service. Tier 4 services offer the highest level of care for the most complex difficulties within the child and adolescent population. The current service offers care for male and female service users for those aged 13 to 18 years. Specific details of the service have been withdrawn to maintain anonymity.

2.4 Recruitment

Recruitment took place between September 2015 and February 2016. It was intended that six nursing staff members would be recruited, consistent with IPA, that small samples focusing on the depth of data are prioritised over breadth and larger sample sizes (Smith *et al.*, 2009). Smith *et al.*, (2009) also recommended that between four to 10 interviews were most appropriate for professional doctorate research. Given that IPA focuses on the detailed analysis of individual cases, a homogenous sample was important (Smith *et al.*, 2009). Given the nature of the inpatient secure CAMHS setting, the nursing staff team was deemed to reflect a niche group of staff whom work in a very specialised setting and therefore share a lot of unique commonalities in their everyday work experiences. Given the relative lack of research within this type of setting, the researcher did not have any grounds to assume that individual differences within the nursing team would risk homogeneity within the context of the current study, e.g. gender or status within the nursing team.

2.4.1 Inclusion/Exclusion criteria

To participate, respondents had to be any member of the nursing team (healthcare assistant or qualified nurse) who regularly worked within the adolescent service, who had experience of or involvement in the transition process to AMHS. Respondents could be male or female staff who were verbally able and proficient in spoken English. In order to ensure that an in-depth exploration of their experiences and perceptions was possible, a minimum of 12 months experience in the adolescent service was required to ensure multiple experiences of transitions to inform a well-rounded account. Non-regular or inexperienced members of staff (e.g. students on placement, bank staff) or relatively new members of staff were therefore excluded.

2.4.2 Recruitment procedure

Participants were selected through purposive sampling. Initial conversations with team leaders and the field supervisor facilitated the identification of regular staff members. Additionally, informal verbal consent was sought to agree for their staff team to be approached and potentially interviewed. Staff were initially contacted via secure email to invite them to speak with the researcher about the purposes of the study. If staff

members responded favourably to the invite, the researcher then approached the individual staff member whilst on shift and met with them in a private office area. The purposes and aims of the study were explained verbally alongside the provision of a Participant Information Sheet (PIS) (Appendix I).

Ethical considerations of confidentiality and their right to withdraw or refuse participation were explained both verbally and via the PIS. If unsure of their participation, each participant was offered additional time to consider their decision (maximum of one week). If participants agreed to take part, the researcher arranged a suitable time to meet and conduct the interview, outside of working hours or during staff break times to avoid impacting their ability to fulfil their working roles. A consent form was shared and signed (Appendix J) and the principles of confidentiality and their right to withdraw at any stage were reiterated at the start of the interview.

2.4.3 *Final sample*

Six respondents were recruited. Sample contextual and demographic information are detailed in Table 2 below³. To ensure confidentiality, each participant was given a pseudonym and any reference to specific names, places or services that may compromise anonymity were removed from the transcripts.

Table 2- Respondent details

Participant pseudonym	Job title
Craig	Healthcare Assistant
Amy	Qualified Nurse
Andy	Senior Healthcare Assistant
Greg	Qualified Nurse
Claire	Qualified Nurse
Tina	Qualified Nurse

³ Limited information has been provided to ensure anonymity of the respondents and the research site.

2.5 Materials

The research materials used in the current study included a PIS (Appendix I), consent form (Appendix J), a semi-structured topic guide (Appendix K) and a small audio recording device.

2.6 Procedure

2.6.1 Ethical considerations

Prior to recruitment, the research proposal was reviewed by staff at The University of Leicester and a service-user reference group. Ethical approval was sought and obtained through the Northampton Research Ethics Committee. Approval was also granted by the research site's own Research and Developmental department. Research Sponsorship was also obtained via Leicestershire Partnership NHS Trust. All relevant correspondence is provided in (Appendix L).

The principles of confidentiality and the right to withdraw at any stage were communicated to respondents both verbally and within the participant information sheet. The interview data were stored in an encrypted file and any data sent for professional transcription were also encrypted and followed ethical guidelines. Respondents were informed that should they disclose any risk-related information regarding their safety, the safety of service users or anyone else, then the researcher would need to communicate this information to the relevant professional. The researcher also checked for any concerns after each interview and invited the respondent to contact the researcher should any arise.

2.6.2 Interviews/data collection

The research aimed to collate a rich first-person account of staff member's experiences, therefore a semi-structured interview was deemed the most appropriate method for data collection. A topic guide (Appendix K) was devised to guide what Smith *et al* (2009) termed a "conversation with a purpose" (p. 57). Details concerning how this developed over time can be found within the Critical Appraisal (p.86).

Interviews were conducted in a quiet and private staff room booked by the researcher. Interviews were conducted in one sitting (with the exception of one; the interview was split into two parts), ranging from 47 to 56 minutes in length. Interviews were recorded using a discrete audio-recording device for later analysis. Respondents consented to the recording of interviews.

Recordings of each interview were transcribed verbatim by the researcher and through a professional transcription service, approved by the University of Leicester and the research site's own research department (following ethical guidelines). Appendix M provides the corresponding consent form for external transcription. The transcripts were stored on an encrypted laptop for later analysis.

2.6.3 Analysis

Analysis was performed using the IPA framework as outlined by Smith *et al.*, (2009). Appendix N offers an outline of the stages of analysis.

2.7 Quality Issues

2.7.1 Quality

Quality issues pertinent to this type of research involve sensitivity to context, commitment to rigour, coherence and transparency and impact and importance (Yardley, 2000). The credibility of qualitative research is also a key consideration to promote trustworthiness of the findings (Shenton, 2004). The quality of the current study was considered from the outset. In order to enhance credibility, the researcher adopted a well-established research method (IPA), engaged in peer scrutiny of the project (peer review processes) and engaged in a lengthy process of considering previous research and theoretical knowledge in the field (literature searching).

The researcher attended a comprehensive two-day training course in IPA to ensure commitment and rigour within the data collection and analysis. Data transcription was conducted and then checked for each participant to ensure accurate portrayals of the

interviews. During the analysis the researcher kept detailed records of any decisions made to ensure transparency and maintain an audit trail. The researcher also engaged in a two-weekly peer supervision group alongside regular research supervision to ensure credibility and consider issues of impact and importance throughout the research process.

In terms of impact and importance, the current study is the first known attempt to explore the experiences and perceptions of nursing staff in the context of inpatient CAMHS transitions. There is therefore great potential to consider the findings within the context of inpatient secure services and inpatient nursing more generally. By considering the results within a theoretical framework, the current study was able to offer suggestions for how the results may be theoretically and/or clinically transferable to different settings.

2.7.2 Researcher Reflexivity

In designing the method for this study and collating the data, the researcher reflected on their own influence on the process and any potential biases in the method. As a Trainee Clinical Psychologist, the researcher acknowledged that they had prior experience of working in CAMHS services and therefore prior experience of working with young people who had then transitioned to adult services. This impact of this experience and prior knowledge was considered throughout. This has been discussed in more detail within the Critical Appraisal (p.84).

3 RESULTS

Following a detailed case by case analysis of individual interview transcripts, a cross-case analysis of the entire data set revealed four over-arching super ordinate themes. Each super-ordinate theme was broken down into three corresponding sub-themes. To enhance transparency, Appendix O offers an excerpt from the initial coding stages of one example interview, through to the final four super-ordinate themes. A visual representation of the final themes and the suggested relationship between them can be found in Figure 3. The two themes at the top of the diagram (“feeling powerless” (FP)) and “having a privileged perspective” (PP)) are on opposing sides and indicative that they directly contradict one another. They both link into the theme of “unsafe uncertainty” which has been conceptualised as the internal conflict arising from both FP and PP. “De-institutionalising young people” has been placed at the centre of the model, indicative that it was an underlying theme throughout and links to all other themes in different ways. A frequency of themes table can also be found in Appendix P.

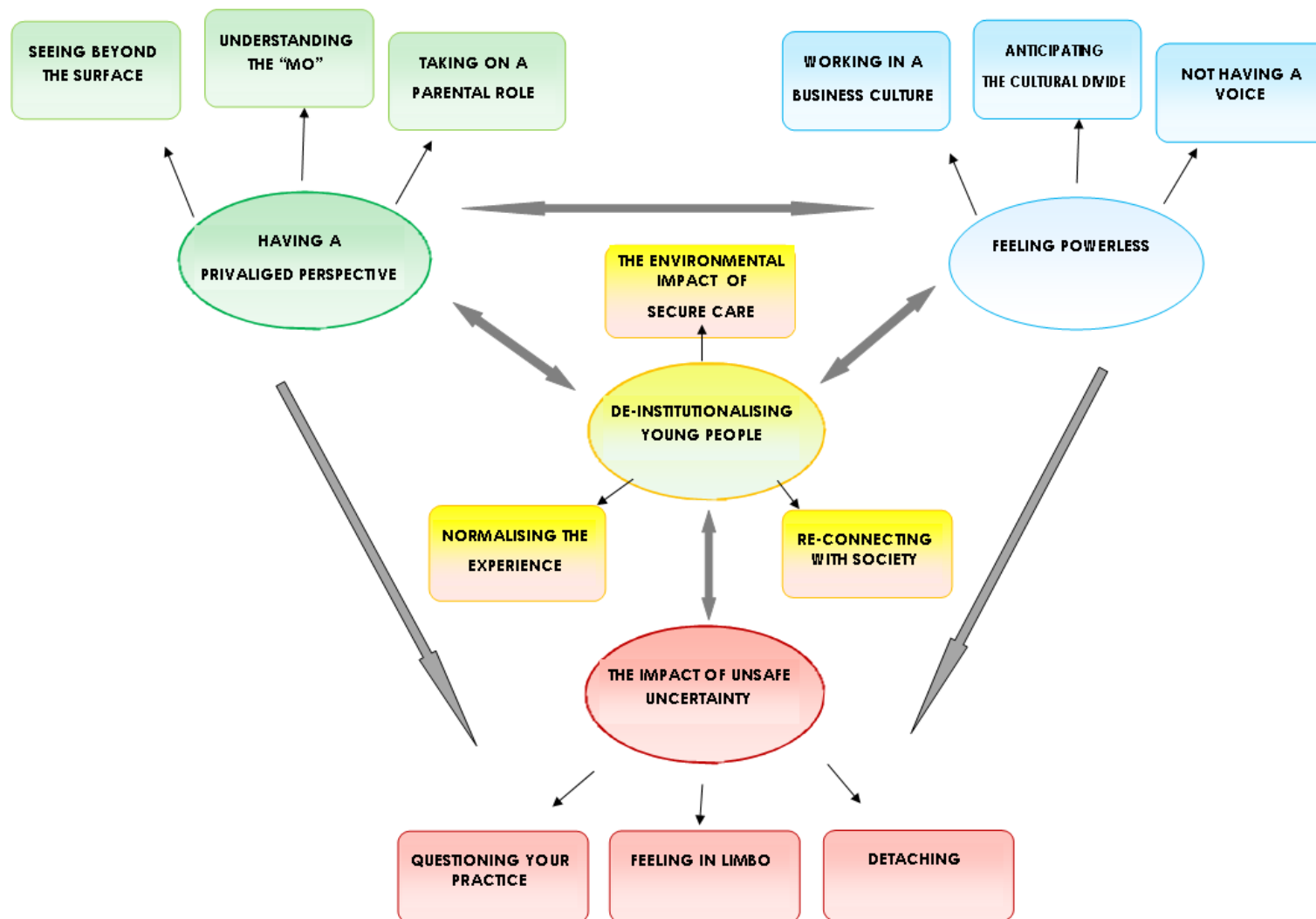


Figure 3- Visual representation of the interaction between the four superordinate themes and corresponding sub-themes

3.1 Feeling Powerless

This super-ordinate theme aimed to capture the sense of powerlessness, communicated by all respondents. This included both external and internal factors that led to feeling powerless.

3.1.1 Working in a business culture

This sub-theme aimed to encapsulate the respondent's sense of working in a culture that dis-connects from the human aspects at the point of transition, in favour of a business, risk-aware model of care. The majority of participants referred to the way in which transitions are dominated by a business lens, resulting in a sense of powerlessness for those at the ground level.

I think it is money and I think that's everywhere now, it's not just in this environment, I think it's in all. I think the moment you start treating healthcare and mental health and anything like that like a business, then you're going to have that as the overall deciding factor (Craig).

Andy also described the business nature of transitions, frequently referring to "they" and "them" to describe outside authorities who manage the processes. This may serve as a way to communicate how he feels disconnected from those who hold more power and authority.

I manage the service users in the environment I work in... the requirements that the funding authorities... they flag up and they have a gatekeeper in there looking at adult services straight away due to.. I think they're not looking at the person, they're looking at the funding and I think that's quite sad really (Andy).

Claire also described the financial nature of the transition process and how this can cause a point of conflict between the funding authorities and the CAMHS care team.

Sometimes the health authority who has the purse strings have a different idea about what would be suitable and appropriate (Claire) .

Claire frequently referred to the "purse strings" suggestive that she feels in a powerless position due to finances taking precedent. Greg also alluded to financial pressures and suggested that the "business culture" has limited his self-efficacy in being able to perform his role due to "budget cuts". Within this business culture, respondents also referred to their sense that risk concerns can become the forefront of transition decisions. Amy discussed how she has to consider risks when a young person reaches the age of transition.

Well just in general, by like funders and everything and just the fact that this is an adolescent service and it's very much focused on the safeguarding concerns like I said, that if anything was to happen ... I suppose it's just the way it's perceived by people... (Amy).

Amy refers to the "the way it's perceived" suggestive that she may not always hold this view but has no choice but to accept it. Similar to Amy, Tina also described transitions in a business-like tone, frequently referring to the "rules" within the secure environment. However, in contrast, Tina appeared to acknowledge that this business culture, i.e. the use of stringent rules and cut-offs, is often needed, particularly when risk issues are involved.

Sometimes they're ready to go, you could have an 18 year old and you've got 13 years olds on a ward, when they're 18 it can be a younger setting, obviously their histories or what they've done, if they disclose all of that then obviously the younger ones could be influenced (Tina, p.15).

3.1.2 Anticipating the cultural divide

Alongside the apparent systemic factors that result in feeling powerless, the respondent's awareness of the stark differences within AMHS also emerged from the data. The majority of respondents referred to their awareness of the potential cultural

divide between CAMHS and AMHS, and the ways in which this can impact the transition process.

It's always kind of like "adult" services and "children's" services, it's really separate isn't it, and in the UK this always comes up... I think it's just a big divide, there's a big sort of gap, and it's actually quite spoken about (Amy).

This “divide” was also referred to by Craig, who described the “jump” to AMHS, suggestive that he perceives there to also be a lack of consistency or continuity of care. Alongside the “gap” between CAMHS and AMHS, the perceived lack of appropriate adult services was frequently conceptualised as a difficulty in the transition process. Claire referred to the “lack of placements” and described her sense of inevitability in that there will be difficulties to come.

It feels like perhaps adult services can't match what we're offering. That's not to say we're all so wonderful...but sometimes it feels like the kids get a bit of a raw deal (Claire)

Claire’s tendency to anticipate problems that are beyond her control was also implicit in her description of services trying to “magic things out of thin air”. Andy also suggested he anticipates difficulties. His description of young people deteriorating after transition suggested he holds quite strong pre-conceived views of what AMHS may be able to offer.

(...) obviously they hit the adult service and then they are left to their own devices. So you look after them well within the adolescent service, set them up and like I say, they go to that and all the other work you’ve done is unpicked, just because they’re in adult services (Andy).

3.1.3 Not Having a Voice

The sense of feeling powerless was further highlighted through the respondent’s sense of not feeling listened to, or considered as someone who may be able to facilitate the

transition process. Tina spoke quite passionately about the role of nursing and identified her profession as being “not really involved in much”. Tina frequently referred to “the team” as having the most powerful voice suggestive that she herself does not feel listened to.

No matter what you say to the team, they don’t seem to stop doing it. I think it’s a form of “you will be leaving so that’s a positive” but for nursing that’s not a positive to give them because you’ve got the repercussion of their behaviour (Tina).

The sense of not feeling part of the planning process was also highlighted by Andy, when he discussed how “they don’t involve you, well they don’t involve the nursing team”. Craig also spoke of the powerless voice of his profession during the transition process and described feeling “disempowered” by this, not only as a nurse but as “a human being”. This emotive description evoked a strong sense that Craig feels his basic human instincts or human rights to act and speak up are absent in some way.

(...)I feel kind of left out of that process with part of them coming in and their transition here and their sort of rehabilitation if you can call it that but then, we’re sort of shut out of the next stage of their life (Craig).

The disempowered voice of the service user was also a strong theme throughout. The sense that transitions are “done to” rather than “with” young people was explicit in Andy’s description of their involvement.

I think their involvement is vital, which I think sometimes it’s, it’s not or it just moves so quick that it just happens in a way” (Andy).

Claire also aligned with this view and described the service user’s input as “a bit of a fallacy”. She emphasised her perception, that person-centred planning is lacking at the point of transition.

They're like the last ones to know things. I don't think they feel that they're at the forefront of their care. Which is what the CPA process is supposed to be about, putting them at the front, do you know what I mean? (Claire).

Conversely when a young person is able to have a voice, the transition experience was perceived more positively. Amy spoke of a positive transition experience for both her and the service user, describing how "the plans were in place and it went really well. I think she felt really involved... I think she just felt really involved" (Amy).

3.2 Having a privileged perspective

This super-ordinate theme aimed to capture the sense of respondent's feeling that they are conversely in a position of personal power, which contradicted the previous theme of feeling powerless from an organisational perspective. This theme encapsulates the sense that respondents felt they hold a unique perspective and privileged access to young people's inner worlds.

3.2.1 Seeing beyond the surface

The apparent discrepancy between a young person's chronological age and their level of maturity and emotional development was referred to by all participants. This resulted in perceived difficulties at transition. Greg discussed how a service user's appearance can be deceptive in terms of their level of functioning.

Although they, chronologically they're looking eighteen, cognitively they're far from, from that threshold... they're functioning like sixteen year olds or maybe younger (Greg).

Claire also recognised the tension between being labelled an "adult" at eighteen, but feeling able to see past this label. She described being eighteen as "just an age" and how service users can function at a much lower level in their mind set.

Yes he's supposed to be a man at eighteen but he's still a twelve, thirteen year old boy in his head and his thought processes (Claire).

Craig also referred to his unique insight as a member of the nursing team when describing how young people may benefit from a longer transition period due to their level of functioning.

(...) to us sometimes they might behave like perhaps a nine/ ten-year-old you know or sometimes even less you know- that in itself means they could do with more time here just to transition (Craig).

This discrepancy was then linked to how young people may experience the transition to AMHS. Andy described his role as "looking after children". Use of the descriptor "children" suggested he sees them as vulnerable despite their apparent "adult" age.

We're not looking at uh, uh, um the individuality of people like, yeah, he's eighteen, but his mind-set might be of a ten-year-old... you'd feel pretty vulnerable I'd imagine (Andy).

Vulnerability was a strong theme that was linked to experiencing services users as younger than their chronological age. Claire linked this back to their histories and described some young people as having "emotional stunts of growth" and suggested that some may not "develop any further". Amy's account differed slightly in that she also referred to those who are at the appropriate level of maturity at transition. However she still referred to the vulnerabilities in others.

(...) and a lot of patients are quite young for their age, we do have some who are fairly mature ... but some of them, it's almost like they're about fifteen, so I think they just find it really intimidating, scary (Amy).

Vulnerabilities were referred to more broadly in terms of everyone having "diverse and distinct needs" (Craig) and everyone being "individualised" (Tina). Craig questioned

whether those organising the transition process consider these needs, suggesting that he feels one of few that observe them.

(...)I don't think organisations kind of ascertain that and it's, you know, that's going to affect their mental health and wellbeing (Claire).

3.2.2 *Understanding "the MO"*

Use of the term, the "modus operandi" or the "MO" (Greg), by definition refers to a "method of operation". This term captures the powerful sense of respondent's perceiving young people to routinely manage transitions in a characteristic way. Most respondent's discussed the behaviours they observe in young people at the point of transition, which included "problematic behaviours" (Craig), "self-harming" (Greg) and physical changes such as being "really emaciated" (Amy).

Rather than taking these behaviours at face value, the respondent's tendency to link the behaviours to underlying feelings suggested a high level of insight and understanding of the young people they work with.

The stresses, the anxieties will manifest in so many ways, you know, aggression, anxieties, you know, they will reject, they, they'll try to reject you before they move on. So they're cutting ties, you have to work with them to support them (Greg).

Greg's description suggested he has formulated how young people may try to reject staff due to feeling "abandoned" by them. Greg gave a powerful sense of young people projecting their feelings onto staff because they're "way ahead of you they're thinking it will be time to move on now", (Greg). Greg acknowledged that you may get "different behaviours" and some young people may respond differently.

Some will be happy...shake your hand give you a hug and say thanks for the help, and leave with a smile (Greg).

However, Craig's account differed slightly. He described universal anxieties regardless of whether the transition is seen as positive or negative. However similarly, he described behaviours he would observe that would be suggestive of underlying difficulties.

I can't actually think of a patient whose gone and not been um anxious or upset...usually I find the ones who are giving it the big-un about going, the ones who are most confident about going tend to then be the ones who don't want to go at the last minute (Craig).

Again, this portrayed a strong sense of not accepting behaviours at face value and alluded to the respondent's position of insight. Craig described the "I don't care attitude" and linked this to young people trying to conceal their fears and anxieties about moving on. Claire also described how she understands the function of behaviours and the way young people may manage their emotions.

His behaviours would tell me, would make me believe that he is more anxious, more distressed and more troubled...his presentation and risk behaviours have increased and the severity of the risks have (Claire).

3.2.3 Taking on a parental role

The sense of identifying with a parental role was a strong theme throughout. Respondent's use of language and description of the therapeutic relationship suggested a strong attachment to young people. The previous themes of seeing beyond the surface and understanding the "MO" also aligns with the qualities that a parent figure may possess. The strength of the therapeutic relationship was apparent in Craig's description of his job role.

(...) to be a positive role model umm in every aspect really, I think you know the way you present and engage with people. Umm, some of our young people have never had sort of a parent kind of umm things to look up to, we are kind of there to fill that gap a little bit I suppose and teach new skills is a big one (Craig).

Craig often referred to the service users with whom he works in a personalised manner, referring to "our boys" and also referred to it being "like children and parents" when the relationship faces difficulties. This suggested ownership of them akin to a parental figure. Claire's tendency to emphasise the child-like and vulnerable nature of the service users was also suggestive that she may possess maternal instincts towards them.

It's just sad because you think god, if that was your child. I know they're not my- they're not our children but they are classed as kids at the end of the day and to now know, for any of us, as an adult, not knowing where we're going to be going. That's a big stress (Claire).

Tina also acknowledged the attachment she has experienced towards young people, describing herself as feeling "overly protective" in the past. Greg also described the bond, and spoke of "termination being difficult" for both staff and young people, indicative of the strength of the relationship.

However Amy and Andy were less suggestive of this relationship and bond, possibly emphasising the fact that individual differences and different nursing styles will impact the experience of transition. Of note, Andy explicitly stated that "I have never felt anything from a service user going". Implicit within this statement is a sense of feeling less like a parental figure or possibly feeling more detached as a way of coping with change and loss of relationships. This aligns with the later theme of "detaching".

3.3 The Impact of unsafe uncertainty

This super-ordinate theme aimed to link the previous two themes by focusing on the impact of having insight whilst conversely feeling powerless. The term "unsafe uncertainty", coined by Mason (1993) within the context of therapy (not knowing the outcome and this resulting in negative affect), has been used to describe this tension and is subsequently divided into three sub-themes.

3.3.1 Questioning your practice

This sub-theme aimed to capture the respondent's tendency to critique their work based on the success rate of transitions. It was apparent that most respondents tended to use the transition experience as a frame for evaluating how "well" they had performed their job role. Greg alluded to this using a visual representation of a "barometer". Generally, given that negative experiences were often discussed by respondents, the resulting evaluation tended to be negative also.

(...) limited like I feel that I don't, I don't give them the best start into their next stage of their care. I feel that there, there's still a lot of skills that they should be picking up and learning within this environment... they go off still quite damaged (Andy).

Andy drew on his experiences where he had perceived young people to leave his care without having all the skills he feels he should be giving them. This resulted in him "questioning" his "own practice". He went on to describe this as "disheartening" suggestive that it is something he feels negatively impacted by. Tina also suggested that she does not feel comfortable with the fact that young people may deteriorate, resulting in her also questioning her own practice.

Knowing they've deteriorated is upsetting because obviously staff have worked really well to get the relationships and watch them move forward and progress and to hear that they've just deteriorated is- you wonder if you're doing your job properly (Tina).

Claire also questioned whether the service she and her colleagues give in fact fully prepare a young person for the next stage in their care.

Maybe we're setting them up to fail, we're saying "oh yeah, we'll give you all of this"" but then when you're eighteen you'll go to an environment where you'll perhaps only get one or two staff available and certainly won't be on tap" (Claire).

3.3.2 *Feeling in limbo*

This sub-theme aimed to capture the respondent's sense of feeling in an uncertain, intermediate situation in terms of progress being halted and in some instances progress being reversed. This was often linked to the fact that the transition process could be drawn out and changeable.

She waited for months and months to go to adult placement...she was just on the ward waiting and she knew she was going to leave and then it would be "oh no that's not happening anymore"... it went round in circles for so, so long, (Amy).

Amy's emphasis on the amount of time it took and her description of the process being circular gives the impression of something that feels never-ending with no end in sight. She went on to describe this as "frustrating" for both her and the young person.

It's frustrating really- you kind of just feel sorry for the individual because it's just a bit of a barrier in the way of their treatment and makes them feel unmotivated. And I wonder if it makes them feel like they don't really matter, like people just leave them here for months and months...feel a bit forgotten almost (Amy).

The prolonged process appeared to result in a sense of limbo, for both the respondent who witnesses the impact this has and the service user themselves, who does not feel like they belong to either CAMHS or AMHS due to feeling "forgotten". This was also reflected in Claire's description of the service user being "up in the air" and "in no man's land" and Tina's perception that "people are just left". Claire went on to describe her sense of how young people must feel when it is difficult to identify a suitable adult placement.

Well we're looking for low secure, or well we're looking for medium secure. They're not even, they're literally, the lad I care coordinate for, feels I think really in limbo. Has no clue which is obviously very unsettling for him (Claire).

Claire and Tina's sense of limbo was captured most in their meaning making of the young person's experience, whereas Craig gave a more personal account.

(...) then all of a sudden it's fallen through, they're gonna be here for another few months and then it's almost like re-building again, you're kind of back to square one (Craig).

Craig described feeling like he is "back to square one" in terms of needing to re-build trust and a therapeutic relationship with young people. Again this suggested a circular process and a position of going back and forth rather than in a linear progressive direction, i.e. a position of limbo.

3.3.3 Detaching

There were apparent contradictions made between respondent's sense of being personally impacted by transitions whilst also describing their job role in a de-personalised manner. This suggested that detaching may be a way respondents manage unsafe uncertainty. For example, Craig previously described feeling akin to a parental figure, there to "fill that gap" yet later described his role in a much more matter-of-fact tone.

These are essentially people you work with so it's about- there's a boundary there and rightly so, you know... you can't sort of overstep that mark and sort of you know, be anything more than someone within your job role (Craig).

This contradiction was also implicit within Amy's description of feeling saddened when a previous service user rang back to the ward, whom described how she disliked her new placement. Amy suggested this impacted her yet went on to justify why this may be the case, possibly as way of detaching from the painful reality of the situation.

But you always have to think she might just be having a bad day... part of their diagnosis as well isn't it... um so things can be quite negative so you don't always know the full picture (Amy).

Some respondents appeared to detach greater than others. For example, Claire did not appear to contradict herself or make justifications for saddening or "disheartening" situations. She described her personal distress, allowing herself to stay connected to the topic. Greg and Andy on the other hand appeared to detach more than most, often talking about reality in a more matter-of-fact tone. Greg's detachment was implicit in his use of the word "blank" which perhaps give the image of blanking out difficult emotions.

I guess a little, that it is what it is. You know, as blank, as blank as it sounds. It's time to move on, you're eighteen, this is where you fit. This is where you're going to go, that's how it's going to be (Greg).

Andy was more explicit in acknowledging his detachment. This also links to the previous theme of "taking on a parental role" where Andy did not appear to identify himself in this role, possibly as a result of feeling more emotionally removed from his work at times.

It makes you feel really disconnected from your, from your practice. It's like you don't have, you start to withdraw from building up these therapeutic relationships because they're not with you for very long (Andy).

3.4 De-institutionalising young people

The final super ordinate theme aimed to capture the sense that at the centre of all transitions is a fundamental aim to "de-institutionalise" young people, away from secure care and back into the community. This super-ordinate theme has been divided into three sub-themes that incorporate the respondent's perceived difficulties in moving out of secure care and ways in which the transition process is objectively and subjectively defined.

3.4.1 The environmental impact of secure care

The reality of working and "rehabilitating" young people within a secure, locked environment was frequently referred to by respondents as a restricting factor. For

example, Andy discussed the ways in which the restrictions of medium security impact how he feels able to “rehabilitate” young people and give them “life skills”.

How you do that within a medium secure setting I don't know, because you have the boundaries of the power of your own environment (Andy).

Interestingly, Andy often referred to “the environment we live in” and then corrected himself to “work in”. This verbal slip suggested that Andy feels defined by his environment. His tendency to describe “living” rather than “working” in the environment was indicative of the powerful impact of medium secure care.

Similar to Andy, Craig's description of his job being a "double edged sword" indicated he feels compromised within his role in terms of wanting to rehabilitate young people but knowing that the secure environment will impact future decisions.

The patient that needs (our) level of care or medium secure environment, err is limited to where they can go (Craig).

The impact of secure care was also implicit within the way respondent's alluded to there being a stigma associated with low or medium secure environments. This was implicit within Amy's definition of what a “successful” transition would look like.

(...) it's a good thing that we're not having people go from here to um women's wards in (anonymised) because they're all wither low secure or medium secure (Amy).

This suggested that a young person moving to another secure environment would be seen as a negative transition, due to the fact that secure care does not have positive connotations. Andy also suggested that he feels secure care cannot offer “normalisation” for a young person. He described one transition to adult secure care as “the wrong path”, again indicative of the stigma associated with being labelled “medium secure”.

Another key way in which the environment appeared to restrict future progress was described in the context of young people becoming institutionalised by the environment. This resulted in the sense of young people feeling scared to “let go” of the restrictions and boundaries that go alongside secure care.

He's scared of the outside world. He says that, he doesn't want to go out. He doesn't want to go home. He wants to be in hospital, he feels safe in hospital (Claire).

3.4.2 Normalising the experience

This sub-theme aimed to relate to the way in which some respondent's appeared to normalise the stresses and anxieties associated with the transition experience. This may be reflective of respondent's own prior experiences of transition in their personal lives. This also reflects the tendency for respondents to relate to young people in a humanistic manner rather than pathologise their reactions to the transition process.

For example, Craig likened the transition experience to moving house, possibly suggestive that he himself can relate to the anxieties that he perceives in young people.

I think it's a natural instinct isn't it to react like that when you're unsure of something... so I think it's just a mixture of all kinds of doubts, anxieties and worries and stresses of like moving house I suppose as well, you know this is what you and then you're going to somewhere you don't know, you know? (Craig).

Craig continued to emphasise the normality of the experience by then justifying the increase in “problematic behaviours” as being “a natural reaction to feeling rejected”. Similarly, Amy suggested that she is able to take an empathic position with respect to young people's anxieties and stress. She gave the sense that she perhaps uses this position to understand why it is difficult for young people to move out of secure care.

None of us like the fear of the unknown, the not knowing what's going on and so it must be even more difficult for the patients who we've got here who've got a lot going on already (Amy).

Another way in which the experience was normalised was implicit within Greg's description of how he views transitions.

(...) but life being what it is, we move on, we have to tackle problems sometimes. So you're preparing for that (Greg).

Greg's use of the preposition "we" suggested a sense that transitioning is an experience shared by everyone. His description also implies that transitioning is a life skill that he has to instil in young people, possibly as part of the rehabilitation process. Within this context, coping with the transition may be seen as part of the process of de-institutionalising young people.

3.4.3 Re-connecting with society

The final sub-theme aimed to capture the respondent's sense that the overall aim for transitions is for young people to re-connect with society and become part of a community that promotes independence and greater opportunities.

The terms "community", "rehabilitation" and "recovery" were often used by respondents in a positive way to describe their hopes for young people and their perception of what their job role should be aiming to achieve. For example, Craig described his job role, to "rehabilitate these young people into the community". Greg also described the aim of his work as being rehabilitative and to work towards "more community work to prevent them from coming back into hospital". Similarly, Andy was very explicit in communicating his sense of what transitions should incorporate.

Positive for me would be recovery, rehabilitation and setting them up for life skills permanently. Um obviously some service users move on, they go to college and so on and they become very independent, that's where I'd be looking at setting the service users up from this environment to going to that type of environment (Andy).

Implicit within Andy's description of his hopes is the sense that westernised values of being independent and engaging with education are influencing his aims for young

people. This appears to factor into his framework for defining what might constitute a “positive” transition.

Craig also suggested that a transition into a community placement is seen as favourable and linked this to feeling more positive himself.

I think that knowing perhaps a patient is going to a community place, um, yea you feel happier for them, definitely, I mean it's a better move (Craig).

Tina also described her hope for young people as “getting them back into the community”. However her hopes were also confounded by her apparent acknowledgement that not all young people will be able to achieve this goal.

You concentrate on the here and now, you don't give them massive goals like "in three months you need to go on unescorted community leave", because it's too much pressure- to say to the young person "when you're 18 you're going to be in adult services, you're going to be in the community in supported accommodation", that would just blow their brains (Tina).

Tina’s sense of not wanting to look to far ahead suggested that she holds hope for young people to be able to re-connect with society but perhaps feels less positive that this can be achieved. Tina was generally more resistant when discussing future-oriented topics, for example stating “this is a hard topic to think about”. It is therefore clear that individual differences influenced the way in which participants made sense of their experience of transition, with some being more grounded in the “here and now” and others anticipating the future more so.

4 DISCUSSION

4.1 Summary of research findings

The current study aimed to explore the lived experience of transition of nursing staff working within a Tier 4 inpatient CAMH service. All six respondents were motivated to share their experiences. Four superordinate themes were identified; feeling powerless, having a privileged perspective, the impact of unsafe uncertainty and de-institutionalising young people. These themes captured the nurse's lived experience of transitions alongside other interrelated topic areas such as the experience of being an inpatient mental health nurse more generally.

4.2 Links to existing theory and literature

The resulting themes embodied concepts that relate to both psychological and social processes and are now discussed and understood in relation to psychological theory, existing research literature and current policy and legislation.

4.2.1 Understanding transitions from an attachment perspective

Respondent's sense of "having a privileged perspective" to the inner worlds of young service users was indicative of the strength of the therapeutic relationship and the strong bonds between the nurse and the adolescent. The experience of transition was shaped by the need to break these relationships, which was suggested to be a difficult process for both nursing staff and young people- "To break those ties is so difficult" (Greg).

It has been long recognised that psychiatric staff may become key attachment figures for inpatient service users (Adshead, 1998). Indeed, nursing staff have reported that the development of a working relationship is a key aspect of their role in an inpatient ward environment (Berg & Hallberg, 2000). This was reflected in the respondent's sense of the young people they work with being "damaged" and the fact that they feel there to "fill that gap". Therefore the sense of respondents "taking on a parental role" suggested a role of providing care and containment of anxiety at the point of transition.

It was clear that respondents experienced the consequence of young people anticipating threats to these therapeutic relationships. The sense that “they reject you” through aggressive or maladaptive behaviours was reflected in the sub-theme of “understanding the MO”. In the context of attachment theory, the identified “problematic behaviours” that were experienced by all respondents may be conceptualised as “attachment behaviours”. These may arise in response to increased anxiety associated with having to break bonds with staff (Adshead, 1998).

These “attachment behaviours” observed as aggression or self-harming behaviour have been recognised in previous research and similarly conceptualised as ways adolescents may express their underlying feelings (Richards & Vostanis, 2004). The ability to look beyond these behaviours and understand their function has also been linked to a key skill of inpatient mental health nursing staff (Delaney & Johnson, 2006).

The significance of the therapeutic relationship has been identified as a key factor in much previous research focusing on the CAMHS to AMHS transition (Hovish *et al.*, 2012; Lindgren *et al.*, 2015; Swift *et al.*, 2013). Transitions have been viewed positively when good working relationships are established (Lindgren *et al.*, 2015) and young people feel cared for a listened to (Burnham Riosa *et al.*, 2015). This is not a finding unique to mental health transitions. Changing relationships with key professionals has been reported as a central challenge in various studies looking at physical health transitions (Fegran *et al.*, 2014).

Kane (2008) suggested that consideration of attachment issues should be a fundamental part of transition planning. However it has also been recognised that AMHS may be less able to relate to and engage with developmental approaches (Kane, 2008; Kaehne, 2011). This aligns with the respondent’s sense of “anticipating the cultural divide”, in that adult services may not be able to “match” the perceived level of care that CAMHS provide. This is reflective of previous research where different working practices within AMHS has been reported (Hall *et al.*, 2013; Kaehne, 2011; Lindgren *et al.*, 2013;

McLaren *et al.*, 2013) with more emphasis on individual pathology at the expense of attachment and developmental needs.

4.2.2 The experience of powerlessness

The respondent's experience of transition was characterised by a sense of feeling in opposing positions of power. The sense of having personal power in the form of a "privileged perspective", whilst "feeling powerless" within the organisational structures were two strong themes throughout. Respondents perceived themselves to "not have a voice" paralleling with their perception of young people also lacking power and a say in how their transition is planned and managed.

The view that nurses may experience differences in terms of their personal and organisational power has been suggested in previous research. Inpatient psychiatric nursing has been identified as a role requiring high levels of skill and expertise whilst understanding the frustration of the mental health system (Benson & Briscoe, 2003). The inpatient nurse's ability to make skilled, "intimate" and "empathic" observations of a ward environment (Hamilton & Manias, 2007, p.340) has been linked to their enhanced knowledge and understanding of patients (i.e. "a privileged perspective"). However, this knowledge, described by Hamilton and Manias (2007) as being "silent" (p.341), has also been linked to nurses having a diminished status amongst colleagues. This may be due to it not being noticed or recognised within the system (i.e. "not having a voice"). Power struggles were also reported by Berg and Hallberg (2000) in their exploration of nursing staff's lived experience of inpatient care. Nurses reported feeling limited to influence the overall care planning whilst feeling that they held a number of responsibilities.

4.2.3 Transitions and psychological burnout

The superordinate theme of "unsafe uncertainty" aimed to capture the perceived consequences of feeling in conflicting positions of power. These included the respondent's feelings of frustration associated with "feeling in limbo" and their subsequent actions which included "questioning your practice" and

“detaching”. Consideration of the concept “psychological burnout” may be one way to further understand these findings. Burnout has been described as a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment (Burke & Richardson, 2000) and has been frequently linked to inpatient mental health work (Bowers *et al.*, 2009; Jenkins & Elliott, 2004). Nursing staff within inpatient secure environments are known to experience higher levels of burnout than non-nursing staff (Caldwell *et al.*, 2006).

The “emotional exhaustion” concept of burnout was not necessarily apparent within the current findings. However respondents did indicate they experienced transitions as “frustrating” and linked this to a sense of “feeling in limbo” themselves alongside witnessing young people experience this limbo. “Going round in circles” and a sense of undoing progress was linked to the emotional demands of the nursing role. Indeed, Andy was the most explicit in giving a sense of emotional exhaustion when he described the “toll on my emotional wellbeing”.

This sense of limbo and emotional distress has been indicated in previous CAMHS to AMHS transitions research, although predominantly concerning young people’s experience. Burnham Riosa *et al.* (2015) reported how many young people did not feel like an “adult” nor did they feel like a “child”, creating a sense of “feeling in-between” and subsequent anxiety, reflective of the phases associated with “emerging adulthood” (Arnett, 2000). Young people not being “ill” enough for AMHS but “too old” for CAMHS has also been frequently identified (Singh *et al.*, 2010). The sense of limbo has been implicated in other types of youth transition within foster care transitions (Hiles *et al.*, 2014) and physical health transitions (Fegran *et al.*, 2014).

The process of managing and supporting the transition of young people into AMHS generated a period of self-reflection and an evaluation of self-efficacy, reflected within the sub-theme “questioning your practice”. Within a “psychological burnout” frame, this may reflect the idea of “reduced personal accomplishment”, i.e. a sense of not feeling satisfied within one’s job role. Previous research has linked this to the idea of a

“troubled conscience” (Dahlqvist *et al.*, 2009). This has been reported where conflict arises between a patient’s needs, staff’s personal views and/or organisational resources. A “troubled conscience” has been linked to feeling powerless and self-blame, therefore paralleling with the current findings of “questioning your practice”.

Finally, the “depersonalisation” aspect of burnout may be linked to the sub-theme of “detaching”. The need to maintain personal boundaries within children’s institutions has been long recognised as a characteristic of nursing staff (Menzies-Lyth, 1979) due to complex transference and countertransference processes. Under this psychodynamic frame, the process of detaching may relate to respondent’s defensive mechanisms. This aligns with much existing research into the impact of institutional health and mental health care (Menzies, 1990). At an individual and organisational level, complex defence mechanisms have been identified as a way to manage underlying anxieties (Hinshelwood & Skogstad, 2002). Indeed, Stokes (1994) suggested that staff’s focus upon powerlessness in itself may be a defensive shift away from the “real” powerlessness of the psychiatric system, i.e. the inability of the system to “cure” the patient.

4.2.4 De-institutionalisation within the UK

The final superordinate theme of "de-institutionalising young people" captured the undertone within all respondent's experience, being that they fundamentally want to support young people to re-integrate with society. Nursing staff therefore experienced themselves to be part of a young person's recovery and rehabilitation process, whilst recognising that several barriers may impede that process within a secure inpatient environment.

Respondent’s negative feelings towards transitions to another secure or inpatient environment were implicit within the way they were described and the terminology used. Young people were often described as being "institutionalised further" rather than “rehabilitated” and further secure care was deemed to be the “wrong path”. The need to

de-institutionalise young people was also reflected in the respondent's sense that young people need to "re-connect with society".

This super-ordinate theme reflects existing legislation and guidance that discharge planning should be an integral and focal part of inpatient Tier 4 CAMH services (Richardson & Partridge 2003) in order to ensure a minimal length of stay in the inpatient/secure environment. Service users within inpatient CAMHS have themselves reported a fundamental need to be a part of society again and to have access to mainstream opportunities such as education and employment (Kane, 2008). This reflects more generally the widespread recognition and move towards community-based care within the UK. Several decades of policy and legislation has seen the closure of many inpatient mental health facilities with an emphasis on de-institutionalising mental health care across the lifespan (Kings Fund report, 2014). However, existing research also recognises that young people leaving inpatient CAMHS are not often prioritised by community-based professionals (Svanberg & Street, 2003) often leaving them without adequate provision, i.e. suggestive that inpatient care, by its very definition, can be a restricting factor for future progress.

4.3 Clinical implications for secure inpatient CAMH services

The current findings offer a unique insight into the experience of transition from a relatively neglected population. The identified themes highlight a range of external and internal conflicts that arise when a young person reaches the point of transition to AMHS.

4.3.1 Empower nursing staff

The current findings suggest that nursing staff may hold their own needs for empowerment and validation of emotional distress when young people leave their care. The importance of staff feeling empowered has significant implications for positive outcomes within mental health organisations. Lynch *et al.* (2005) reported that inpatient staff who felt more listened to and valued within their job role experienced higher job satisfaction. This had a positive impact on their wellbeing and the wellbeing

of young service users. Previous research has also indicated that “feeling powerless” and having a poorly defined job role is closely linked to poorer staff team morale in inpatient environments (Totman *et al.*, 2010). Therefore it is important for nursing staff to feel they have a voice and that their “privileged perspective” is valued during transition planning. Initiatives to increase a sense of empowerment may include speak-up mechanisms, increased opportunities to communicate with higher management (Totman *et al.*, 2010) and improved staff support networks (Gilbody *et al.*, 2006).

4.3.2 Consider attachment

The findings also emphasised the therapeutic relationship and highlighted how young people may leave CAMHS still “damaged” without the positive experience of ending attachments, possibly re-enacting previous attachment difficulties in their lives (DoH, 2015).

Although some recognition has been given to the importance of attachment within inpatient CAMHS transitions (Kane, 2008), current legislation and guidance does not necessarily reflect its significance (e.g. Healthcare Standards for Children and Young People in Secure Settings, 2013). However, the concept of “relational security” has been recognised within secure mental health settings (DoH, 2010), emphasising the importance of consistent and safe staff-patient relationships. More widely, attachment theory has been emphasised as a universal evidence-based theory that should inform all mental health policy (Seager *et al.*, 2007). It is recognised that planning endings and transitions may be especially difficult for those with previous attachment difficulties (Goodwin *et al.*, 2003). Subsequently, through processes of transference and countertransference, it may therefore be especially difficult for front-line staff during discharge planning, given they are most implicated in ending therapeutic relationships (Bucci *et al.*, 2015). Inpatient secure CAMHS therefore need to consider how transitions could be managed in light of attachment theory. This may include consideration of how both front-line staff and service users can be effectively supported to enable “healthy” relationship endings. There may therefore be potential for this to become part of policy or protocol and incorporated into the service philosophy within secure inpatient CAMHS care.

4.3.3 Look at individual values

Despite a high degree of overlap between the individual experiences of nursing staff within the current study, within each theme some divergence was evident. This highlights the personalised nature of the experience of transition and the importance in considering individual needs and values of both service users and staff alike. Dalzell and Sawyer (2011) suggested that CAMHS should adopt the use of "cultural review" tools that consider a practitioner's individual values, hidden influences and unconscious processes that may influence how they engage with young service users. The "Productive Ward" initiative within the NHS (Wilson, 2009) has been one large scale attempt within mainstream health services to incorporate these types of ideas. This has been through empowering front line staff and considering the fit between a staff member's "ideal" role and the reality of what they feel able to achieve. Such initiatives may be highly applicable to mental health services and appear to be lacking within the context of the current findings.

4.3.4 Define the role

The findings also highlight the knowledge base of nursing staff. Respondent's collective sense of how transitions could be improved indicated a level of insight that could be utilised within transition planning. Indeed it has been suggested within the physical health field that nurses are in fact best placed to promote optimal care at the point of transition. This is due to their multi-faceted job role and skill set (Baines, 2009). However it is recognised that the nurse's role within mental health settings may be less well-defined (Baldwin, 2002) thus making it more difficult for them to have a voice and a positive impact during transitions. It has been argued that the CAMHS nursing role requires greater definition (Bonham, 2011) due to the limited visibility of their specialist skill set (Leishmann, 2003). Formalising their role at transition may be one way forward to ensure that their voice is heard and young people remain at the centre of the transition process.

4.4 Strengths and Limitations

The current study is the first known attempt to explore the experiences of nursing staff in a secure CAMHS environment with respect to the transition from CAMHS to

AMHS. Both inpatient services and the nursing staff experience are two under-researched areas. The majority of CAMHS research is focused on community services and no known research has examined the experience of transition within a CAMHS inpatient service. Further, the literature on the experiences of nursing staff within mental health service is scarce, with the majority stemming from general healthcare services. The use of IPA allowed for an in depth exploration of this niche area, whilst allowing connections to be made to existing theory and research.

The researcher's role and influence on the research process has been discussed and reflected upon throughout this paper. A central aspect of IPA research involves a reflective stance and use of the researchers own interpretations, when moving through the "hermeneutic cycle". However, it should be noted that the researcher was the sole and lead analyst throughout this project. Pragmatically it was not possible to utilise a second researcher when coding and analysing interview transcripts. To enhance credibility of the results, it may have been preferable to gain access to a second analyst in order to ensure triangulation of the results (Shenton, 2004). This may have enhanced the researcher's ability to reflect on the given themes by allowing additional space to discuss and explore differing perspectives. In line with a critical realist perspective, the results offer one interpretation of the given phenomena, through the lens of the researcher and the participant's own interpretations of their experience. An additional researcher would have therefore added another "lens" through which the results may be interpreted and applied to clinical settings.

4.5 Recommendations for Future research

The current findings add further support and evidence for the discrepancies between policy and practice. Despite a large number of efforts to legislate and formalise the needs of young people (e.g. DoH, 2011; National Youth Agency, 2006; Health and Social Care Advisory Service, 2008), these needs are often lost or de-emphasised at the point of transition. The current findings therefore add further support to the lack of implementation of policy (Young *et al.*, 2011) and possibly the lack of awareness of existing policy at the ground level (McNamara *et al.*, 2014). This suggests a need for

future research to consider the barriers that may impact policy being translated into practice, from a wider organisational perspective.

It is also recognised that most qualitative CAMHS to AMHS research has focused on the perspectives and insights of CAMHS staff, with a tendency to negatively view the capacity and effectiveness of adult services (Burnam Riosa *et al.*, 2015; Kaehne, 2011). There is a lack of research focusing on the human narratives within AMHS. A similar study focusing on the experience of nursing staff within AMHS who receive transitions from CAMHS may offer further insight and offer an alternative perspective.

Given the under-researched nature of inpatient secure CAMHS, there are many possible avenues for future research within these types of settings. The views of young people post-transition has been previously considered (Wheatley *et al.*, 2013) although this lacked depth of qualitative information. Future research focusing on the views of young people in secure and inpatient CAMHS may offer further insight into the experience of transition. Longitudinal research on young people who undergo mental health service transitions is also extremely scarce (Burnham Riosa *et al.*, 2015) and essential in understanding the long term impact of successful or unsuccessful transitions.

5 REFERENCES

- Adshead, G. (1998). Psychiatric staff as attachment figures. Understanding management problems in psychiatric services in the light of attachment theory. *The British Journal of Psychiatry*, 172(1), 64-69.
- Anderson, B. J. (2006). Families and chronic illness research: Targeting transitions and tools. *Families, Systems and Health*, 24(3), 332-335.
- Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55, 469-480.
- Arnett, J. J. (2007). Emerging adulthood: What is it, and what is it good for?. *Child Development Perspectives*, 1(2), 68-73.
- Baines, J. M. (2009). Promoting better care: Transition from child to adult services. *Nursing Standard*, 23(19), 35-40.
- Baldwin, L. (2002). The nursing role in out-patient child and adolescent mental health services. *Journal of Clinical Nursing*, 11(4), 520-525.
- Benson, W. D., & Briscoe, L. (2003). Jumping the hurdles of mental health care wearing cement shoes: Where does the inpatient psychiatric nurse fit in?. *Journal of the American Psychiatric Nurses Association*, 9(4), 123-128.
- Berg, A., & Hallberg, I. R. (2000). Psychiatric nurses' lived experiences of working with inpatient care on a general team psychiatric ward. *Journal of Psychiatric and Mental Health Nursing*, 7(4), 323-333.
- Bonham, E. (2011). Appreciative inquiry in youthful offender psychiatric nursing research. *Journal of Child and Adolescent Psychiatric Nursing*, 24(2), 122-129.
- Bowers, L., Allan, T., Simpson, A., Jones, J., Van Der Merwe, M., & Jeffery, D. (2009). Identifying key factors associated with aggression on acute inpatient psychiatric wards. *Issues in Mental Health Nursing*, 30(4), 260-271.
- Bucci, S., Roberts, N. H., Danquah, A. N., & Berry, K. (2015). Using attachment theory to inform the design and delivery of mental health services: A systematic

review of the literature. *Psychology and Psychotherapy: Theory, Research and Practice*, 88(1), 1-20.

Burke, R. J., & Richardson, A. M. (2000). Psychological burnout in organizations. In R.T. Golembiewski (Ed.), *Handbook of Organizational Behavior*, (pp. 327-368).

Caldwell, B. A., Gill, K. J., Fitzgerald, E., Sclafani, M., & Grandison, P. (2006). The association of ward atmosphere with burnout and attitudes of treatment team members in a state psychiatric hospital. *American Journal of Psychiatric Rehabilitation*, 9(2), 111-129.

Collins, M. E. (2001). Transition to adulthood for vulnerable youths: A review of research and implications for policy. *Social Service Review*, 75(2), 271-291.

Dahlqvist, V., Söderberg, A., & Norberg, A. (2009). Facing inadequacy and being good enough: psychiatric care providers' narratives about experiencing and coping with troubled conscience. *Journal of Psychiatric and Mental Health Nursing*, 16(3), 242-247.

Davis, M. (2003). Addressing the needs of youth in transition to adulthood. *Administration and Policy in Mental Health and Mental Health Services Research*, 30(6), 495-509.

Delaney, K. R., & Johnson, M. E. (2006). Keeping the unit safe: Mapping psychiatric nursing skills. *Journal of the American Psychiatric Nurses Association*, 12(4), 198-207.

Department of Health (2015). Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. Accessed 3 April 2015, from: <https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people> .

Dogra, N., & Leighton, S. (2009). Nursing in child and adolescent mental health. New York, US: McGraw-Hill Education.

Eccles, J., Templeton, J., Barber, B., & Stone, M. (2003). Adolescence and emerging adulthood: The critical passage ways to adulthood. In M. H. Bornstein, L. Davidson, C. L. M. Keyes, K. A. Moore (Eds.), *Well-being: Positive*

development across the life course. Crosscurrents in contemporary psychology (pp. 383-406). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.

- Embrett, M. G., Randall, G. E., Longo, C. J., Nguyen, T., & Mulvale, G. (2015). Effectiveness of Health System Services and Programs for Youth to Adult Transitions in Mental Health Care: A Systematic Review of Academic Literature. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-11.
- Erikson, E. H. (1950). *Childhood and society*. New York: Norton.
- Fegran, L., Hall, E. O., Uhrenfeldt, L., Aagaard, H., & Ludvigsen, M. S. (2014). Adolescents' and young adults' transition experiences when transferring from paediatric to adult care: A qualitative meta-synthesis. *International Journal of Nursing Studies*, 51(1), 123-135.
- Gilbody, S., Cahill, J., Barkham, M., Richards, D., Bee, P., & Glanville, J. (2006). Can we improve the morale of staff working in psychiatric units? A systematic review. *Journal of Mental Health*, 15(1), 7-17.
- Gilmer, T. P., Ojeda, V. D., Fawley-King, K., Larson, B., & Garcia, P. (2012). Change in mental health service use after offering youth-specific versus adult programs to transition-age youths. *Psychiatric Services*, 63(6), 592-596.
- Goodwin, I., Holmes, G., Cochrane, R., & Mason, O. (2003). The ability of adult mental health services to meet clients' attachment needs: The development and implementation of the service attachment questionnaire. *Psychology and Psychotherapy: Theory, Research and Practice*, 76, 145-161.
- Green, H. McGinnity, A. Meltzer, H. Ford, T. Goodman, R. (2005). Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.
- Hall, C. L., Newell, K., Taylor, J., Sayal, K., Swift, K. D., & Hollis, C. (2013). 'Mind the gap'-mapping services for young people with ADHD transitioning from child to adult mental health services. *BioMed Central Psychiatry*, 13(1), 186.

- Hamilton, B. E., & Manias, E. (2007). Rethinking nurses' observations: Psychiatric nursing skills and invisibility in an acute inpatient setting. *Social Science & Medicine*, 65(2), 331-343.
- Haynes, C., Eivors, A., & Crossley, J. (2011). 'Living in an alternative reality': Adolescents' experiences of psychiatric inpatient care. *Child and Adolescent Mental Health*, 16(3), 150-157.
- Hinshelwood, R. D., & Skogstad, W. (Eds.). (2002). Observing organisations: Anxiety, defence and culture in health care. London: Routledge
- Hovish, K., Weaver, T., Islam, Z., Paul, M., & Singh, S. P. (2012). Transition experiences of mental health service users, parents, and professionals in the United Kingdom: A qualitative study. *Psychiatric Rehabilitation Journal*, 35(3), 251.
- Islam, Z., Ford, T., Kramer, T., Paul, M., Parsons, H., Harley, K., ... & Singh, S. P. (2015). Mind how you cross the gap! Outcomes for young people who failed to make the transition from child to adult services: The TRACK study. *British Journal of Psychology Bulletin*, 40(3), 142-148.
- Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: Nurses in acute mental health settings. *Journal of Advanced Nursing*, 48(6), 622-631.
- Kaehne, A. (2011) Transition from children and adolescent to adult mental health services for young people with intellectual disabilities: A scoping study of service organisation problems. *Advances in Mental Health and Intellectual Disabilities*, 5(1), 9-16.
- Kane, S. (2008). Managing the transitions from adolescent psychiatric in-patient care. London: The National Children's Bureau.
- Keniston, K. (1970). Youth: A "new" stage of life. *The American Scholar*, 39(4), 631-654.
- Leishman, J. L. (2003). Social constructionism, discourse analysis and mental health nursing: A natural synergy. *The International Journal of Psychiatric Nursing Research*, 9(1), 1004-1013.

- Lindgren, E., Söderberg, S., & Skär, L. (2015). Swedish young adult's experiences of psychiatric care during transition to adulthood. *Issues in Mental Health Nursing, 36*(3), 182-189.
- Lindgren, E., Söderberg, S., & Skär, L. (2013). The gap in transition between child and adolescent psychiatry and general adult psychiatry. *Journal of Child and Adolescent Psychiatric Nursing, 26*(2), 103-109.
- Lynch Jr, M. F., Plant, R. W., & Ryan, R. M. (2005). Psychological needs and threat to safety: Implications for staff and patients in a psychiatric hospital for youth. *Professional Psychology: Research and Practice, 36*(4), 415.
- Lyth, I. M. (1990). A Psychoanalytical Perspective on institutions. In E. Trist & H. Murray (Eds) *The Social Engagement of Social Science* (pp 463-465). Philadelphia, US: The University of Pennsylvania Press.
- McDonagh, J. E., & Viner, R. M. (2006). Lost in transition? Between paediatric and adult services: It's time to improve the transition of adolescents from paediatric to adult services. *British Medical Journal, 332*, 435.
- McDougall, T., Worrall-Davies, A., Hewson, L., Richardson, G., & Cotgrove, A. (2008). Tier 4 Child and Adolescent Mental Health Services (CAMHS)-Inpatient Care, Day Services and Alternatives: An Overview of Tier 4 CAMHS Provision in the UK. *Child and Adolescent Mental Health, 13*(4), 173-180.
- McLaren, S., Belling, R., Paul, M., Ford, T., Kramer, T., Weaver, T., ... & Singh, S. P. (2013). 'Talking a different language': An exploration of the influence of organizational cultures and working practices on transition from child to adult mental health services. *BioMed Central Health Services Research, 13*(1), 254.
- McNamara, N., McNicholas, F., Ford, T., Paul, M., Gavin, B., Coyne, I., ... & Singh, S. P. (2014). Transition from child and adolescent to adult mental health services in the Republic of Ireland: An investigation of process and operational practice. *Early Intervention in Psychiatry, 8*(3), 291-297.
- Memarzia, J., St Clair, M. C., Owens, M., Goodyer, I. M., & Dunn, V. J. (2015). Adolescents leaving mental health or social care services: Predictors of mental

- health and psychosocial outcomes one year later. *BioMed Central Health Services Research*, 15(1), 185.
- Miles, K., Edwards, S., & Clapson, M. (2004). Transition from paediatric to adult services: Experiences of HIV-positive adolescents. *Aids Care*, 16(3), 305-314.
- Mitchell, M. B., & Kuczynski, L. (2010). Does anyone know what is going on? Examining children's lived experience of the transition into foster care. *Children and Youth Services Review*, 32(3), 437-444.
- NHS England (2015). Model Specification for Transitions from Child and Adolescent Mental Health Services. Accessed 1 February 2016, from: <https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-transt-camhs-spec.pdf>.
- Osgood, D. W. (2005). *On your own without a net: The transition to adulthood for vulnerable populations*. Chicago, US: University of Chicago Press.
- Paul, M., Ford, T., Kramer, T., Islam, Z., Harley, K., & Singh, S. P. (2013). Transfers and transitions between child and adult mental health services. *The British Journal of Psychiatry*, 202(54), 36-40.
- Richardson, G. J., & Partridge, I. (2000). Child and adolescent mental health services liaison with Tier 1 services. *The Psychiatrist*, 24(12), 462-463.
- Richards, M., & Vostanis, P. (2004). Interprofessional perspectives on transitional mental health services for young people aged 16-19 years. *Journal of Interprofessional Care*, 18(2), 115-128.
- Royal College of Paediatrics and Child Health (2013). *Healthcare Standards for Children and Young People in Secure Settings*. London.
- Riosa, P. B., Preyde, M., & Porto, M. L. (2015). Transitioning to adult mental health services: Perceptions of adolescents with emotional and behavioral problems. *Journal of Adolescent Research*, 30(4), 446-476.
- Sawyer, E., & Dalzell, R. (2011). *Putting analysis into assessment: Undertaking assessments of need-a toolkit for practitioners*. London, UK: Jessica Kingsley Publishers.

- Seager, M., Orbach, S., Samuels, A., Sinason, V., Johnstone, L., Fredman, G., & Kinderman, P. (2007). *National Advisory group on mental health, safety & well-being: Towards proactive policy: Five universal psychological principles*. London: Department of Health.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63-75.
- Singh, S. P., Paul, M., Ford, T., Kramer, T., Weaver, T., McLaren, S., ... & White, S. (2010). Process, outcome and experience of transition from child to adult mental healthcare: Multiperspective study. *The British Journal of Psychiatry*, 197(4), 305-312.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: Sage.
- Stokes, J. (1994) Institutional chaos and personal stress. In A. Obholzer & V.Z. Roberts (Eds). *The unconscious at work: Individual and organisational stress in the human sciences*. London: Routledge.
- Street, C., & Svanberg, J. (2003). *Where next? New directions in in-patient health services for young people: Report 1: Different models of provision for young people: facts and figures*. London: YoungMinds.
- Swift, K. D., Hall, C. L., Marimuttu, V., Redstone, L., Sayal, K., & Hollis, C. (2013). Transition to adult mental health services for young people with Attention Deficit/Hyperactivity Disorder (ADHD): A qualitative analysis of their experiences. *BioMed Central Psychiatry*, 13(1), 1-11.
- Tanner, J. L. (2006). Recentering during emerging adulthood: A critical turning point in life span human development. In J. L. Tanner, & J. J. Arnett (Eds) *Emerging adults in America: Coming of age in the 21st century* (pp 21-55). Washington, DC: American Psychological Association.
- Totman, J., Hundt, G. L., Wearn, E., Paul, M., & Johnson, S. (2011). Factors affecting staff morale on inpatient mental health wards in England: A qualitative investigation. *BioMed Central Psychiatry*, 11(1), 68.

- Vostanis, P. (2005). Patients as parents and young people approaching adulthood: How should we manage the interface between mental health services for young people and adults?. *Current Opinion in Psychiatry*, 18(4), 449-454.
- West, M. Eckert, R., Steward, K., & Pasmore, B. (2014). *Developing collective leadership for health care*. London: The Kings Fund.
- Wheatley, M. D., Long, C. G. L., & Dolley, O. (2013). Transitions of females from adolescent secure to adult secure services: A qualitative pilot project. *Journal of Mental Health*, 22(3), 207-217.
- Wheatley, M., Waine, J., Spence, K., & Hollin, C. R. (2004). Characteristics of 80 adolescents referred for secure inpatient care. *Clinical Psychology & Psychotherapy*, 11(2), 83-89.
- Wilson, G. (2009). Implementation of releasing time to care—the productive ward. *Journal of Nursing Management*, 17(5), 647-654.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.
- Young, S., Murphy, C. M., & Coghill, D. (2011). Avoiding the 'twilight zone': recommendations for the transition of services from adolescence to adulthood for young people with ADHD. *British Medical Journal of Psychiatry*, 11(1), 174.

CRITICAL APPRAISAL

5.1 Introduction

Within this critical appraisal I will reflect on my research journey and consider how I initially chose the topic through to the process of collating data and writing up my results. Use of my reflective diary, maintained throughout the research, will assist this process. I will consider the strengths and weaknesses of the research using Yardley's (2000) evaluative criteria for qualitative research as a framework. I will also explore how the process of conducting research has shaped both my personal and professional development.

5.2 Choosing a research topic

From the outset of my study, I acknowledged my interest and passion for working with young people. My lived experience as a practitioner within secure and community-based CAMH services led to my interest in the topic area of transition. I also hold my own personal experiences of transition, throughout childhood, education and employment. It was therefore important to acknowledge this vested interest and this prior knowledge. My prior assumptions about how transitions can be experienced by young people and more specifically within CAMHS were likely to influence the research process, so were held in mind throughout.

The process of conducting a systematic literature review highlighted the apparent gaps in the research base around the lived experience of both staff and young people within inpatient and/or secure CAMH services, with very few studies conducted within this context (Haynes *et al.*, 2011; Wheatley *et al.*, 2013). This is not surprising given the relatively fewer inpatient settings for young people (McDougall *et al.*, 2008). Given the fact that Tier 4 services care for the most severe and enduring mental health problems in young people, I felt particularly motivated to add to the research base for this population.

5.2.1 *Young person study*

My initial aims were to explore both the experiences of nursing staff and young people, with two separate analyses. Challenges with the recruitment process hindered the young person part of the study being completed in full, in line with the submission deadline for the doctoral thesis. Appendix Q offers an overview of this aspect of the study and describes the data that were collated within the time frame. Despite IPA not prescribing to set sample sizes (Smith *et al.*, 2009) I felt that the data collated from these interviews lacked sufficient breadth to conduct an in depth and rich analysis. My experience of interviewing young people corresponded to my clinical experience, being that engagement can be challenging. The young people I did interview were motivated to tell me their stories, yet struggled to expand at times. I therefore felt that a slightly larger sample size (N= 6) would be required to allow for a sufficient and valid analysis of their experience. After discussion with field and academic supervisors, an application has been submitted and subsequently approved by the Northampton Research Ethics Committee (Appendix R) for an extension for this part of the study. The aims and rationale for this part of the study will remain unchanged and are detailed in my original research proposal.

5.3 **Deciding upon a methodological approach**

Given the nature of the research topic, from the outset I felt that a qualitative research approach would align with my research aims. A qualitative methodology also aligns with my personal views of how we can make sense of social phenomena. As a Trainee Clinical Psychologist, I am trained to formulate complexity from multiple perspectives, which also aligns with my epistemological position of a Critical Realist. Within my clinical work, I often align myself to systemic and narrative therapeutic approaches. They often require the therapist to take a step back from the immediate context and consider deeper, underlying meanings (Barker & Chang, 2013), aligning well with qualitative approaches and more specifically with IPA.

When considering the type of analysis to use I considered various options and found myself very quickly drawn to IPA. Given the under-researched nature of the research setting and the relatively niche sector of CAMHS that it represents, I felt that an in

depth, idiographic approach was required. Given that Grounded Theory focuses on the construction of theory and generalisability of results (Glaser, 2002), I felt that this would not align with my aims or the context of the research. Thematic Analysis was also considered (Clarke & Braun, 2006). However it was anticipated that recruitment may pose various challenges and a smaller sample size would be expected. IPA lends itself to smaller sample sizes, prioritising depth over breadth of information (Smith *et al.*, 2009), which again aligned with my initial aims.

5.3.1 *Developing a topic guide*

The topic guide was informed by examination of examples within previous qualitative research on the experience of transition (e.g. Burnham-Riosa *et al.*, 2015) and through continued reflection, assisted by conversations with peers and supervisors. This enabled various “versions” of the topic guide to be created before the final version was created. Minor edits included some re-wording to avoid the possibility of leading participants and creating researcher bias.

I tried to engage with the concept of allowing a “one-way conversation” (Smith *et al.*, 2009) so therefore tried to minimise the number of questions asked. Prompts were indicated within the guide to remind me to ask for expansion and to encourage reflection on particulars of certain experiences in order to gain an in depth understanding. The questions were designed to be appropriate to the target population with appropriate language for adult participants. My initial questions were designed to build rapport between the researcher and respondent and ease into the interview process (e.g. “Can you tell me about your job role?”). Further questions regarding the experience of transition were designed to be exploratory and open-ended without use of leading questions that could bias the responses (e.g. “Can you tell me about your experience of transitions in the adolescent service?”). My questions covered both how transitions are experienced and perceived by staff personally and how staff perceive transitions to be experienced by the adolescents themselves. The topic guide was used as a way to facilitate an open and exploratory interview. It was important that I remained focused in the research topic whilst allowing divergence at times should the respondent led the conversation into unexpected directions. This aligned with the

position of IPA, that the participant is the “expert” in his or her own experience (Smith *et al.*, 2009).

5.4 Collating data

5.4.1 Recruitment

Recruitment took place within a Tier 4 secure CAMH service, through links with a previous clinical supervisor. My prior experience of working as an Assistant Psychologist within the service both helped and hindered the research process at times. From a personal perspective, gaining access to secure inpatient services could be an intimidating and lengthy process. I undertook induction and safety training and had to ensure I complied with secure standards at all times. My previous experience therefore made this process an easier and less overwhelming one. However from a professional perspective, I encountered a lot of interest towards my presence and my role as a researcher. Being previously known as a clinician by some staff members, it was important that I remained in a “researcher” role and reiterated this throughout. Half of the respondents were familiar with the fact that I used to work within the organisation. I felt it important to emphasise my role at the start of these interviews and remind respondents that I was present in a research capacity and not a clinical capacity. Given there were no apparent differences between these interviews and interviews with staff unknown to me, I do not believe this had an influence on the interview process. However it is something I would consider in future research, particularly if I engaged with research within my own clinical workplace.

5.4.2 The interview process

In line with IPA, it was important for the interview process and topic guide to avoid researcher bias and the potential for participants to be “led” according to the researchers own pre-conceived ideas. Given my previous experience as a clinician in different CAMH services, I was aware that I held pre-conceived ideas and experiences around transitions. In order to “bracket” these whilst collating data, I tried to remain open and curious during the interviews, in line with my own personal style as a therapist. I was aware that I had potential to make assumptions without “digging deeper” for meaning if I had previous experience in a certain topic area.

This awareness influenced my interviewing style. Whilst conducting the interviews I experienced challenges in “putting aside” my therapeutic skills as a reflective practitioner. An important aspect of the interviews involved the refraining from of my natural instinct to reflect and summarise spoken words in order to convey empathy and guide meaning making. Instead I held back from this natural stance, in order to minimise bias. This style was developed through practice with colleagues prior to the interviews taking place.

A further challenge laid in gaining access to nursing staff and organising protected time for them to engage with the interview process. All respondents were keen to share their experiences, however all acknowledged the difficulty in arranging a suitable time to meet that did not impact the ward and service users. Despite a quiet and private room being used, the nature of the environment meant that noise and interruptions also occurred, which at times impacted the rapport and flow of the interviews. The impact of this was reflected upon and noted after each interview.

5.4.3 The context of the institutional setting

Within the early stages of the research process, I acknowledged the potential for certain topic areas to evoke difficult feelings for respondents which may influence the nature of their responses. Although not explicitly stated, I felt that in certain parts of the interviews, respondents were cautious about the language used or how they worded certain parts of their experience. This was partly reflected in the sub-theme “Detaching”. However the difficulty in openly discussing the experience of transition was apparent at times. In one interview, the respondent told me "it's a really hard subject to base a thesis on". From this I sensed a reluctance or inability to articulate certain aspects of the experience. Further, the sense of saying the “right” things to an outside professional was also apparent within another interview. Discussing the relationship he had with young people, it was clear he wanted to emphasise it was “professional” and therefore ethical and boundaried.

Within the context of recent institutional abuse scandals in the UK (E.g. Winterbourne View, Medway Secure Training Centre) there is a growing focus on inpatient and secure care. For example there was an increased focus on inpatient acute care services via inspections from the Care Quality Commission (CQC) after the Winterbourne View institutional abuse cases. I therefore considered this context before commencing my research and throughout. I accounted for this within ethical considerations; respondents were made aware that if they reported anything to me that made me concerned for anyone's safety or wellbeing then I would have a duty of care to respond to this. I also ensured they understood my role as a researcher and someone external to the service. I reiterated I was not there to make personal judgements and all data held would be completely confidential.

5.5 Data Analysis

5.5.1 Homogeneity of the sample

After each interview, I reflected on each experience and noted my thoughts and feelings within a reflective diary. It was clear that individual differences played a role in how the interviews took shape. For example, I noted differences between qualified members of the nursing team and healthcare assistants in the style and content of their responses. On reflection, the differing roles taken within the nursing team may have required greater consideration given the different contexts within which they may work. For example, "feeling powerless" was a strong theme throughout, although more strongly felt from participants who naturally had less power within their job title. However to a certain extent this is felt to be unavoidable in any IPA research, as each individual will always have their own unique stories and background to their experience. As a critical realist, I am also able to acknowledge the multiple layers of reality and the extent to which a qualitative researcher can access these differing levels.

5.5.2 Developing emerging themes

Being a novice to IPA, I took time before starting my research to get to know the methodology and consider the gaps in my knowledge and how these may be managed. I attended a two-day training course which provided a comprehensive introduction to the approach and started a reflective diary from the outset of the research.

I was very aware throughout the analysis process that my prior assumptions and clinical experience within CAMHS may influence how I interpreted the results. I therefore ensured I initially stayed very "close" to the data by focusing mainly on descriptive coding. I built this up to linguistic and conceptual coding and made additional notes throughout of any potential biases I may be experiencing.

Creating a balance of emergent themes that were grounded within the data whilst ensuring I moved beyond the surface meaning was a further challenge as a novice IPA researcher. Some emergent themes appeared to be apparent in the words spoken by participants without the need for developing the interpretation much further. For example the use of the word "power" was used in all interviews and struck me as being indicative of a key part of their experience, i.e. "Feeling powerless". However other emergent themes were more instinctual in nature, reflecting what I interpreted as "hidden" meaning within the text. The use of a reflective diary and re-listening to audio tapes also helped me to develop this deeper sense of the data, for example within the theme "Detaching".

Consideration of Smith's (2011) "spectrum of gems" (gems being the core aspects of the experience) aided this process. The concept of some gems being "shining" and some more hidden and "secret" (p.13) helped me when moving around the "hermeneutic circle" (Smith *et al.*, 2009). I became overwhelmed at times by the interpretative process, when moving from the individual cases to wider contexts, whilst considering my own pre-conceived ideas and the collective voice of the respondents. The point at which I felt this process was exhausted appeared unclear. Use of peer supervision to discuss my emerging themes also added further dimensions when other peer researchers added their own thoughts and views. The finalising of my final themes took a longer process than I anticipated. However I felt that this process was necessary and indicative of the iterative nature of IPA.

5.6 Strengths and weaknesses

Using Yardley's (2000) criteria for evaluating qualitative research, I have considered the strengths and weaknesses of the current study.

5.6.1 Sensitivity to context

My role and influence within the research process has been reflected upon and considered throughout. I was aware of my prior experiences and vested interest in the research topic and the potential for this to bias certain aspects of the process. I was also aware of my own therapeutic style during the interview process and the need to refrain from "leading" the respondent's in any way. There were times where I struggled to remain completely neutral, e.g. reflecting or summarising parts of what the respondent told me, or emotionally reacting to something said during the interview. This may have influenced the nature of the responses. However I considered this to be an important aspect of rapport building and ensuring that respondents felt comfortable and at ease during the interviews. Therefore the benefits of this were deemed to outweigh the potential biases.

5.6.2 Completeness of data collection, analysis and interpretation

Recruiting six respondents aligned with recommendations posed by Smith *et al.*, (2009) and ensured a small sample, to focus my attention of depth of insight and discovering underlying meanings. Recruitment was open to all nursing staff who met the inclusion criteria. In order to maintain transparency throughout, I ensured that every aspect of the data analysis was recorded, using word documents and through taking photographs of any hand written or more creative analysis methods (e.g. use of a whiteboard). The limited word count has meant that my results are limited to selective quotes and explanations of themes. However these were chosen to most reflect the themes for which they align with.

5.6.3 Reflexivity

The current critical appraisal considers issues surrounding reflexivity and the clinical implications of the research are considered within the main write-up (p.71). These

include recommendations for practice within the context of the CAMH service but also for mental health nursing practice more widely.

5.7 Personal and professional development

Although I have been part of various research projects and audit work previously, this was my first experience in applying for ethical approval and completing a major project as the sole and lead researcher. My undergraduate dissertation provided me with my initial experience of recruiting from a student population. However this was my first experience in recruiting within a clinical setting. This process has taught me the importance in planning ahead and anticipating difficulties before they arise. With the support of my academic supervisor, my research proposal was detailed and sufficiently pre-emptive to enable me to manage difficulties in recruitment as they arose.

I have also appreciated the importance in being present as much as possible at the research site and making connections with those who are able to support with recruitment and participant identification. I found that my prior experience within the service as a clinician gave me the confidence to approach staff members and use their professional connections within the service to support my communication with ward managers and nursing staff. Through this process I feel I have developed skills in being able to manage my time and manage differing demands of the research process. Appendix S shows the timescales for this research process.

The research journey has enabled me to develop both existing and new skills in planning, conducting and evaluating research. Given that research skills are a core competency as a Clinical Psychologist, I have therefore developed transferable skills for my future career. The current study has also provided me an opportunity to extend these research skills beyond the remit of the Doctoral Thesis, with regard to the young person's study. My intention to continue this aspect of the study whilst still in training will ensure that I continue to develop skills as a researcher and will have further opportunities to consider publication.

Finally, the experience of conducting in depth interviews with nursing staff has encouraged me to reflect upon my own role within a multi-disciplinary team and consider my own personal values, position of power and role definition. Listening to the experiences of staff who may perceive themselves to hold little influence in decision making has made me reflect on my own feelings of power/powerlessness throughout my training journey. I have been able to reflect on ways I may be able to facilitate a shared voice within team working using the skills of communication and formulation that are inherent to the role of a clinical psychologist. This reflective process has been facilitated through use of a reflective journal throughout the research. A small excerpt from this can be found in Appendix T.

5.8 References:

- Barker, P., & Chang, J. (2013). *Basic family therapy*. Oxford, UK: John Wiley & Sons.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Glaser, B. G. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, 1(2), 23-38.
- Haynes, C., Eivors, A., & Crossley, J. (2011). 'Living in an alternative reality': Adolescents' experiences of psychiatric inpatient care. *Child and Adolescent Mental Health*, 16(3), 150-157.
- McDougall, T., Worrall-Davies, A., Hewson, L., Richardson, G., & Cotgrove, A. (2008). Tier 4 Child and Adolescent Mental Health Services (CAMHS)- Inpatient Care, Day Services and Alternatives: An Overview of Tier 4 CAMHS Provision in the UK. *Child and Adolescent Mental Health*, 13(4), 173-180.
- Smith, J. A. (2011). "We could be diving for pearls": The value of the gem in experiential qualitative psychology. *Qualitative Methods in Psychology Bulletin*, (12), 6-15.
- Wheatley, M. D., Long, C. G. L., & Dolley, O. (2013). Transitions of females from adolescent secure to adult secure services: A qualitative pilot project. *Journal of Mental Health*, 22(3), 207-217.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.

APPENDICES

Appendix A*- Intended journal guidelines

Author Guidelines

Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Ranked in ISI: 2014: 73/119 (Psychology Clinical); 93/140 (Psychiatry (Social Science)); 63/119 (Pediatrics); 75/133 (Psychiatry)
- 4000+ institutions with access to current content, and a further 5000+ plus institutions in the developing world
- High international readership - accessed by institutions globally, including North America (36%), Europe (41%) and Asia-Pacific (15%)
- Excellent service provided by editorial and production offices
- Opportunities to communicate your research directly to practitioners
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; rejection rate is around 84%
- Acceptance to Early View publication averages 45 days
- Simple and efficient online submission – visit http://mc.manuscriptcentral.com/camh_journal
- Early View – articles appear online before the paper version is published. [Click here](#) to see the articles currently available
- Authors receive access to their article once published as well as a 25% discount on virtually all Wiley books
- All articles published in CAMH are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF)

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice.

Original Articles: These papers should consist of original research findings.

Review Articles: These papers are usually commissioned; they should survey an important area of interest within the general field.

Measurement Issues: These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services.

Innovations in Practice: Submission to this section should conform to the specific guidelines, given in full below.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original article, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: http://mc.manuscriptcentral.com/camh_journal and *check for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal *create a new account*. Help with submitting online can be obtained from Piers Allen at ACAMH (e-mail Piers.Allen@acamh.org.uk)

4. Authors' professional and ethical responsibilities

Disclosure of interest form

All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the [Ethical principles of psychologists and code of conduct](#) (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

Informed consent and ethics approval

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study country. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Note to NIH Grantees

Pursuant to NIH mandate, Wiley-Blackwell will post the accepted version of contributions authored by NIH grant-holders to PubMed Central upon acceptance. This accepted version will be made publicly available 12 months after publication. For further information, see www.wiley.com/go/nihmandate.

Recommended guidelines and standards

The Journal requires authors to conform to CONSORT 2010 (see [CONSORT Statement](#)) in relation to the reporting of randomised controlled clinical trials; also recommended is the [Extensions of the CONSORT Statement](#) with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials should be registered in one of the ICJME-recognised trial registries:

[Australian New Zealand Clinical Trials Registry](#)

[Clinical Trials](#)

[Nederlands Trial Register](#)

Manuscripts reporting systematic reviews or meta-analyses should conform to the [PRISMA Statement](#).

The [Equator Network](#) is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work <http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields> and on quasi-experimental <http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research> and mixed method designs <http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond>

CrossCheck

An initiative started by CrossRef to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Keywords: Please provide 4-6 keywords (use [MeSH Browser](#) for suggestions).

Key Practitioner Message: (in the form of 3-6 bullet points) should be given below the Abstract, highlighting what's known, what's new and the direct relevance of the reported work to clinical practice in child and adolescent mental health.

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are

unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributions differ between the author group. (All authors must share responsibility for the final version of the work submitted and published; if the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

10. For referencing, *CAMH* follows a slightly adapted version of APA Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See <http://authorservices.wiley.com/bauthor/illustration.asp> for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

Review Articles

These papers are usually commissioned; they should survey an important area of interest within the general field of child and adolescent mental health disorders and services. Suggestions for topics and proposals (outline and/or draft abstract) may be sent to the CAMH Editorial Office camh@acamh.org

Measurement Issues

These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services: if you have a suggestion for a measurement-based overview article, please contact the CAMH Editorial Office camh@acamh.org with an outline proposal.

Manuscripts for Review Articles are Measurement Issues should follow the standard format for Original Articles but to a word limit agreed at the point of the proposal being agreed.

Innovations in Practice

Child and Adolescent Mental Health (CAMH) promotes evidence-based practice, intervention and service models. Innovations in practice, intervention and service provision may arise through careful and systematic planning, while others are responsive to need, evolution of existing services, or simply arise because of changing circumstances or technology. In this rapidly evolving field, the Editors of *CAMH* warmly welcome short *Innovations in Practice* papers which aim to allow authors to share with our wide international multidisciplinary readership knowledge and initial impact of new and interesting developments.

Manuscripts submitted as *Innovations in Practice* submissions should follow the standard format for *Original Articles* but be no more than 2500 words, including references and tables. They should briefly set out the aims and detail of the innovation, including relevant mental health, service, social and cultural contextual factors; the evaluation methods used; relevant supporting evidence and data; and conclusions and implications. Submissions may describe formal pilot and feasibility studies or present findings based on other evaluative methods. Contributions outlining important innovations with potential significant impact may be considered even in the absence of evaluative data. Close attention should be paid in all submissions to a critical analysis of the innovation.

Manuscript Processing

Peer Review Process: All material submitted to CAMH is only accepted for publication after being subjected to external scholarly peer review, following initial evaluation by one of the Editors. Both original and review-type articles will usually be single-blind reviewed by a minimum of two external referees and only accepted by the decision Editor after satisfactory revision. Any appeal of an editorial decision will first be considered by the initial decision Editor, in consultation with other Editors. Editorials and commissioned editorial opinion articles will usually be subject to internal review only, but this will be clarified in the published Acknowledgement section. Editorial practices and decision making will conform to COPE <http://publicationethics.org/resources/guidelines> and ICMJE <http://icmje.org/> best practice.

Proofs: Proofs will be sent to the designated author only. These will be sent via e-mail as a PDF file and therefore a current e-mail address must always be given to the journal office. Only typographical or factual

errors may be changed at proof stage, and the publisher reserves the right to charge authors for correction of non-typographical errors.

Offprints: The designated author of a published paper will receive a PDF file of their final published article. The designated author should undertake to forward copies of the PDF file to their co-authors.

Copyright: If your paper is accepted, the author identified as the corresponding author for the paper will receive an email prompting them to log into Author Services where, via the Wiley Author Licensing Service (WALS), they will be able to complete a license agreement on behalf of all co-authors of the paper.

For authors who do not chose OnlineOpen

If the OnlineOpen option is not selected, the corresponding author will be presented with the Copyright transfer Agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the Copyright FAQs [here](#).

For authors choosing OnlineOpen

If the OnlineOpen option is selected, the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

Creative Commons Attribution License OAA

Creative Commons Attribution Non-Commercial License OAA

Creative Commons Attribution Non-Commercial-NoDerivs License OAA

To preview the terms and conditions of these Open Access Agreements please visit the Copyright FAQs [here](#) and click [here](#) for more information.

If you select the OnlineOpen option and your research is funded by certain Funders [e.g. The Wellcome Trust and members of the Research Councils UK (RCUK) or the Austrian Science Fund (FWF)] you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with your Funders requirements.

For more information on this policy and the journal's compliant self-archiving policy please click [here](#).

Liability

Whilst every effort is made by the publishers and editorial board to see that no inaccurate or misleading data, opinion or statement appears in this journal, they wish to make it clear that the data and opinions appearing in the articles and advertisements herein are the sole responsibility of the contributor or advertiser concerned. Accordingly, the publishers, the editorial board and editors, and their respective employees, officers and agents accept no responsibility or liability whatsoever for the consequences of any such inaccurate or misleading data, opinion or statement.

Appendix B- Systematic literature review search terms

Terms for young people
young person
young people
youth
emerging adult*
<u>adolesce</u> *
teen*
transition age* youth
youth
young adult*
young female*
young male*
young men
young women

Terms for transition
move to adult*
transition*
transfer*
continuity
to AMHS

Terms for services
mental health service*
CAMHS
youth service

- Terms combined using “AND”.
- Variations of the search terms were applied according to each databases’ specified search syntaxes

Appendix C- Process of developing first, second and third order constructs.

1. Data extraction and first order constructs

The papers were read and re-read initially to determine “first order constructs” which were the main themes identified by the authors, staying close to the original data and using direct quotes and language used by the original researchers. Alongside these, key characteristics of each included study were extracted.

2. Second order constructs

The studies were read again to determine “second order constructs” which were additional concepts and themes reflected in the papers that link to and build on first order constructs. These were formed by staying close to the original data again and by focusing more on the author’s interpretations of the original data (i.e. focusing on the studies’ own conclusions and author’s own insights).

3. Third order constructs

The final step involved the development of “third order constructs” which Noblit and Hare (1988) viewed as “interpretations of interpretations of interpretations”. Since the accounts emerging from each paper were consistent with each other the researcher applied their own interpretation of the first and second order constructs and this interpretation was expressed using conceptual themes. The conceptual themes were then synthesised into a “line-of-argument”, which provided a hypothesised framework for understanding how the third order constructs interact and influence each other.

Reference list:

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy*, 7(4), 209-215.

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies* (Vol. 11). Sage.

Appendix D- Table of first and second order constructs

Study	Key Concepts: (First order)	(Second order)
<u>Burnham Riosa et al. (2015)</u> (10 young people)	<p>Importance of feeling listened to and understood; positive professional relationships crucial</p> <p>Treated like a “real” person; “person first, patient second”</p> <p>Expectations of “adult” therapy/clinicians as being different to CAMHS</p> <p>Mixed feelings about what it means to become and “adult”</p>	<p><i>Institutional and developmental fears about moving on are present</i></p> <p><i>Self-efficacy important during transition</i></p> <p><i>Need for an honest, well planned and gradual transition</i></p>
<u>Hovish et al. (2012)</u> (11 young people 6 parents 10 professionals)	<p>Confusion at transition due to having to liaise with multiple agencies</p> <p>Good transitions are well informed and well planned</p> <p>Feeling out of the loop if communication is poor... “feeling like you’re just being passed on...now you gotta go”</p> <p>Parents feeling cut-off</p>	<p><i>Transitions are a vulnerable and unpredictable time for young people due to multiple changes</i></p> <p><i>One fixed approach will not suit all; transitions must be tailored to individual needs</i></p> <p><i>False assumption that all young people want autonomy; some will continue to want parental involvement</i></p>
<u>Kaehne (2011)</u> (CAMHS workers= 4 AMHS workers= 3 Manager of a mental health unit for adolescents= 1)	<p>Service coordination between CAMHS and AMHS is poor, e.g. no transition protocols</p> <p>Service gaps result in young people not getting their needs met or “missing out” on services</p> <p>Difference in service model can be problematic; CAMHS are more family/focused and holistic</p>	<p><i>Professionals feel “cut-off” from the wider transition context in social care and education so feel disempowered to support young people</i></p> <p><i>Increased awareness of eligibility criteria is needed to reduce ambiguity and enable professionals to communicate a realistic view of AMHS</i></p>
<u>Lindgren et al. (2015)</u> (11 young people)	<p>Support is critical so young people are motivated to continue care.</p> <p>Young people need to feel involved in decisions</p> <p>Treating young people “at their level”</p> <p>Meaning of being an “adult” unique to the individual</p> <p>Transition viewed as a “turning point”</p> <p>Emotional support and trust facilitates recovery</p>	<p><i>The process of becoming an “adult” is complicated and institutional transitions do not match developmental transitions</i></p> <p><i>Social and environmental factors will increase intrinsic motivation to continue care and will lead to more trust in clinicians</i></p> <p><i>Allowing young people to express themselves = increased self-awareness and better engagement in transitions</i></p> <p><i>How professionals relate to young people most important rather than <u>what they do</u></i></p>

Study (continued)	Key Concepts (continued): (First order)	(Second order)
Lindgren et al (2013) (33 professionals)	<p>Greater responsibility in adult care so motivation is critical</p> <p>Level of responsibility dependent on maturity level rather than chronological age</p> <p>CAMHS and AMHS differ in care cultures resulting in therapeutic ruptures</p> <p>“Co operation as a condition for safe and secure transition”</p> <p>Adult services need to be available emotionally and practically during transition</p>	<p><i>The gap at the point of transition between CAMHS and AMHS becomes a challenge and an obstacle</i></p> <p><i>Professionals are unable to support young people due to limitations in knowledge and skills set.</i></p> <p><i>Transitions are as much about professionals as they are the young people</i></p>
McLaren et al. (2013) (34 professionals)	<p>“Talking a different language” between CAMHS and AMHS</p> <p>Differing professional backgrounds impact how staff work with young people</p> <p>Communication between CAMHS and AMHS poor so young people struggle more to adjust to changes</p> <p>Young people can feel “cut out” of the system if transitions aren’t well organised</p>	<p><i>The evidence of a cultural divide means that differing practices could impact continuity of care and therefore influence transition experiences</i></p> <p><i>AMHS may not always be able to meet the needs of young people</i></p> <p><i>Need to invest in better transitional care and improved staff training</i></p>
Richards & Vostanis (2004) (39 professionals)	<p>Complex needs of older adolescents cannot be met by statutory mental health services</p> <p>Adult services lack age appropriate facilities</p> <p>Lack of joint working and shared responsibility</p> <p>Practical aspects of transition that enhance effectiveness not always in place, e.g. 3 way meetings</p>	<p><i>Older adolescents in transition is one of the most neglected age groups in mental health</i></p> <p><i>Working with older adolescents requires a unique perspective, different to child and adult work</i></p> <p><i>Child and adult services need to coordinate resources so that care provided can meet the needs of older adolescents</i></p>
Swift et al (2013) (10 young people)	<p>Clinician qualities pivotal during transition</p> <p>Need to know who is responsible to minimise sense of being “dumped” by CAMHS</p> <p>High expectations of adult services</p>	<p><i>Patient’s experiences of services impacted by the clinician qualities and the professional relationships</i></p> <p><i>Feeling listened to is important for young people... “respected as young adults”</i></p> <p><i>Differing AMHS thresholds can cause problems during transition</i></p>

Appendix E- Key characteristics table

Author	Burnham Riosa et al. (2015)	Hovish et al. (2012)	Kaehne (2011)	Lindgren et al. (2015)	Lindgren et al. (2013)	McLaren et al. (2013)	Richards & Vostanis (2004)	Swift et al (2013)
Aim	To determine the lived experiences of late adolescents who may be transitioning to adult mental health services	To describe the experiences of transition between CAMHS and AMHS	To explore service organisation issues that impact mental health transitions for those with ID.	To explore young adult's experiences of psychiatric care during the transition to adulthood	To describe professionals' experiences and views of the transition process between child to adult psychiatry services	To facilitate the organisational factors which facilitate or impede transitions	To establish the MH service needs of young people from the perspective of professionals	To explore the experiences of young people with ADHD* during transition from CAMHS to AMHS
Country/ setting	Canada: community outpatient mental health team for children and youth	UK: Part of a wider TRACK study (Singh et al, 2010) focused within CAMHS and AMHS community services	UK: CAMHS and AMHS in 4 local authorities in Wales	Sweden: Outpatient psychiatric services	Sweden: inpatient and outpatient psychiatric units	UK: Part of the organisations strand of the London TRACK study. NHS and voluntary sector sites.	UK: 22 statutory and non-statutory CAMHS services across a region	UK: Community CAMHS service
Sampling strategy	Purposive	Opportunistic	Purposive	Purposive	Purposive	Purposive	Opportunistic	Opportunistic
Inclusion/ exclusion criteria	Undergoing a transition to adult MH services of based on clinical judgement, are likely to be transferred to adult MH services	All young people included in a case note review of transition outcomes, who had reached the transition boundary during a 12 month study period (ending September 2007)	Practitioners who had experience within mental health services for young people with ID	Young people aged 18-25 years, experience of care in child and adolescent psychiatry and general adult psychiatry	Multi-disciplinary professionals working in CAP* or GenP*	Professionals working in CAMHS, AMHS or the voluntary sector from 2 geographical areas, recruited from Feb 2007 to April 2008.	Professionals who worked directly with or planned services for young people aged 16-19 years	Young people aged 17 years or over, diagnosed with either ADHD or a psychotic illness. Pre-transition to AMHS.

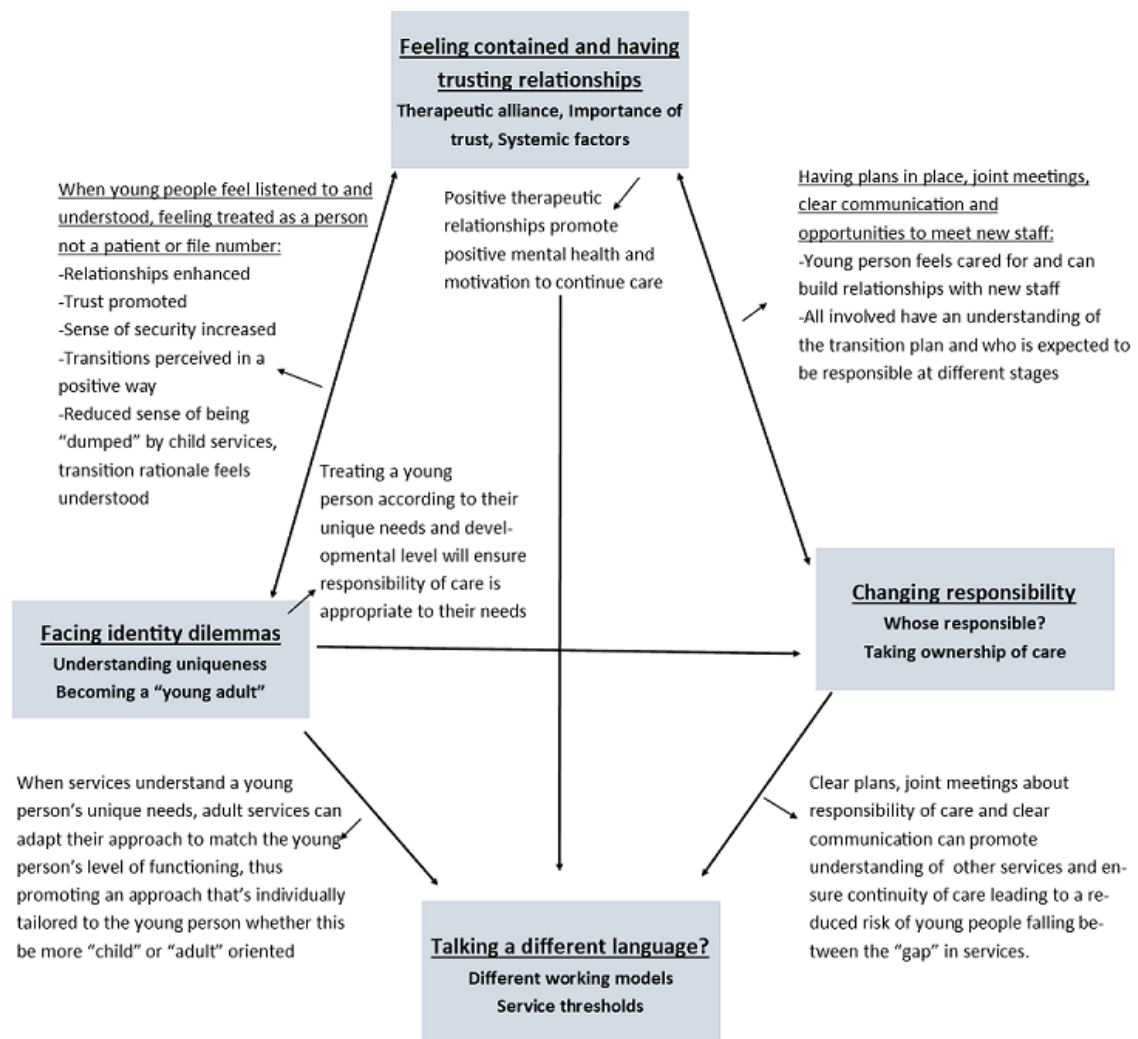
Author (continued)	Burnham Riosa et al. (2015)	Hovish et al. (2012)	Kaehne (2011)	Lindgren et al. (2015)	Lindgren et al (2013)	Mclaren et al. (2013)	Richards & Vostanis (2004)	Swift et al (2013)
N recruited	10	11 young people 6 parents 3 CAMHS clinicians 7 AMHS clinicians	CAMHS workers= 4 AMHS workers= 3 Manager of a mental health unit for adolescents= 1	11	33 professionals Nurse = 12 Psychotherapist = 1 Psychiatrist = 1 Heads of unit = 2 OT= 1 Psychologist= 1 Welfare officers= 3 Social educators= 2	34 professionals: CAMHS= 16 AMHS = 11 CAMHS & AMHS= 3 Voluntary Sector = 4	39 professionals Managers = 18 Practitioners = 21	10
Age range/ mean age	Not stated	Not stated	N/A	19-26 years, mean age 21 years	N/A	N/A	Considered services for those aged 16- 19 years	17-18 years, mean age 17.8 years
Sex	Not stated	5 Female, 6 Male (young people)	Not stated	7 Female, 4 Males	Not stated	Not stated	Not stated	2 Female, 8 Male
Study design	Mixed methods	Qualitative	Qualitative	Qualitative	Qualitative	Qualitative	Qualitative	Mixed methods
Data collection method	Semi-structured interviews	Semi structured interviews	Semi structured interviews	Semi- structured interviews	Focus groups (x3)	Semi structured interviews	Semi structured interviews	Semi structured interviews
Analysis Procedures	IPA	Thematic Analysis	Thematic Analysis	Grounded Theory	Content Analysis	Structured Thematic Approach	Thematic Content Analysis based on Grounded Theory	Thematic Analysis
Reflexivity*	None	None	None	None	None	None	None	None

* For example, naming epistemological standpoint/ discussing the researcher's influence on the findings

Appendix F- CASP quality assessment results

CASP Items	Burnham Riosa et al. (2015)	Hovish et al. (2012)	Kaehne (2011)	Lindgren et al. (2015)	Lindgren et al. (2013)	McLaren et al. (2013)	Richards & Vostanis (2004)	Swift et al. (2013)
Was there a clear statement of the aims of the research?	YES	YES	YES	YES	YES	YES	YES	YES
Is a qualitative methodology appropriate?	YES	YES	YES	YES	YES	YES	YES	YES
Was the research design appropriate to address the aims of the research?	YES	YES	YES	YES	YES	YES	CAN'T TELL	YES
Was the recruitment strategy appropriate to the aims of the research?	YES	YES	YES	YES	YES	YES	YES	YES
Was the data collected in a way that addressed the research issue?	YES	YES	YES	YES	YES	YES	YES	YES
Has the relationship between researcher and participants been adequately considered?	NO	NO	NO	NO	NO	NO	NO	NO
Have ethical issues been taken into consideration?	CAN'T TELL	CAN'T TELL	CAN'T TELL	YES	YES	YES	CAN'T TELL	YES
Was the data analysis sufficiently rigorous?	YES	CAN'T TELL	CAN'T TELL	YES	YES	YES	YES	YES
Is there a clear statement of findings?	YES	YES	YES	YES	YES	YES	YES	YES
How valuable is the research?	YES	YES	YES	YES	YES	YES	YES	YES

Appendix G- Third order interpretation of themes; “Line of argument”



Appendix H*- Epistemological standpoint

The researcher adopted a critical realist standpoint which integrates realist ontology with relativist epistemology. This stance acknowledges that there is a reality and that some entities can exist independently of our observation of them, therefore rejecting radical constructionist ideas that all reality is constructed from discourse. However this stance also rejects the naive realist standpoint, that all reality is universal and quantifiable. Critical realism posits that reality is stratified and certain layers of reality may be more directly observable than others. Critical Realism therefore acknowledges that we, as researchers, do not have immediate access to reality nor are we able to observe every aspect of it (Fade, 2004). As researchers we attempt to understand the "transitive" aspects of reality (the changing knowledge of things) in order to give insight into the "intratransitive" (the relatively unchanging things that we attempt to know) (Bhaskar, 1978).

A critical realist framework is particularly applicable to social sciences and the study of human behaviour since it acknowledges the impact of underlying forces that may not be directly observable. Critical realism also accepts that ideas and discourses are real (alongside the physical world) and can have causal effects. However unlike positivist ideas, causality is a complex process at many different levels that is both contextual and emergent (Alvesson & Sköldberg, 2009). Individual differences in meaning-making are deemed possible because everyone will experience different parts of reality (Fade, 2004). This aligns well with qualitative research and the methodological framework of IPA. IPA is rooted in a social cognitive paradigm which assumes that human speech and behaviour is a reflection of these differences in meaning (Fade, 2004). Within IPA, it is

assumed that the data provided within a rich and detailed personal account can tell us something about the personal experience of an individual within the world and how they make sense of their involvement (Smith *et al.*, 2009). The researcher is therefore able to make assumptions that go beyond the spoken words of the participant and make certain ontological claims about pre-existing material practices (Harper, 2011). However, similar to a interpretivist paradigm, the researcher also acknowledges that their own personal beliefs, prior experiences and the very language we use will limit the extent to which ontological claims can be made. Understanding requires interpretation that can only offer one version of reality at any given time, in any given context (Harper, 2011).

Within the current study, a relativist epistemology is indicated in that the researcher acknowledges that her own prior beliefs, experiences and the current cultural and political mental health context will influence and shape the research findings. Additionally, realities associated with each participant including their own background, culture, gender and job role will also influence how the findings emerge. These influencing factors reflect a multitude of realities that are very real and can be considered causal explanatory factors in a variety of phenomena associated with transitions. However this realist ontological position accepts that our knowledge and understanding of the real world is limited within the current context. This study examined an "open system" (Bhaskar, 1978) that is complex and multi-layered. In order to explore this system and affect change in the real world of mental health service provision, one must accept that we cannot have certain or definite knowledge. However we can accept that this research provides a valid interpretation of the topic area and may be considered an integral part of our understanding of the world of mental health transitions.

References:

- Alvesson, M., & Sköldberg, K. (2009). *Reflexive Methodology: New Vistas for Qualitative Research*. Sage.
- Bhaskar, R. (1978). On the possibility of social scientific knowledge and the limits of naturalism. *Journal for the Theory of Social Behaviour*, 8(1), 1-28.
- Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: A practical guide. *Proceedings of the Nutrition Society*, 63(4), 647-653.
- Harper, D. (2011) Choosing a qualitative research method. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp.83-98). Oxford, UK: Wiley-Blackwell.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: UK: Sage.

Appendix I- Participant information sheet (PIS)



Mental health service transitions: understandings and experiences in a secure forensic psychiatric setting

Information sheet for staff **(Version 2: 12.04.15)**

Introduction to the research

This research is being carried out by a trainee clinical psychologist called Laura at the University of Leicester. It is part of Laura's training to complete a research project.

This research project is focusing on the experience of transition from a secure adolescent service to adult services. The research aims to understand the experiences of nursing staff who support young people during such transitions. The research aims to explore the experience of supporting young people during their transition and how it feels when young people move on to adult services.

You have therefore been invited to take part in this research because you have experience in supporting young people on a daily basis and supporting them during transition periods. It is your decision whether you choose to take part and the following information will help you decide.

Purpose and background of the research

A lot of existing research has focused on the experience of transition. It is known that this can be a very difficult time for both young people and staff supporting them. A lot of research has focused on healthcare settings. However there is a lack of research focusing on mental health transitions. We therefore lack insight into the experiences of both young people and staff *during* the transition period itself, particularly in a specialist setting like (anonymised).

What will happen if I choose to take part?

If you choose to take part in this research, you will take part in a verbal interview, expected to last between 45 to 60 minutes. You will be asked a series of open-ended questions aimed at gaining information on your views, thoughts, feelings and insights into the transition experience of young people within the service. The information discussed will be recorded on a small audio-recording device for later analysis of key themes.

Other staff members (both qualified nurses and healthcare assistants) who have experience in supporting young people on a regular basis will be asked the same questions.

What are the benefits of taking part?

It is hoped that this research will provide insight into how staff perceive and feel about transitions in the service. Using this information, it is hoped that we can understand how

transitions may be improved which would in the longer-term support the well-being of both young people and staff.

What are the risks of taking part?

Everything you say in the interviews will be kept completely confidential. Additionally your participation will in no way affect your job role or impact on your ability to perform your job. However if you shared risk-related information during the interviews, for example about the treatment or safety of young people, then this information would need to be reported to the relevant professional to consider further. However this would be discussed with you first should this situation arise.

What if I change my mind about taking part?

Your participation in this study is completely voluntary and you will have the right to withdraw from the study at any stage without explanation required. You have the right to request that any information you have provided is withdrawn/destroyed. Your participation in this study will in no way affect your job role or position within the service. If you are happy to take part, you will be asked to read and sign a consent form.

You have the right to omit or refuse to answer any question that you may be asked, again without explanation.

If you have any questions during or after the study there will be the opportunity to ask these.

What will happen with what I say?

If you agree to take part in the research then your personal details will never be used at any stage. No personal identifiable information will be used at any point in the research. The interviews will be typed up onto a private and secure computer and the original recordings will then be destroyed. Once the research is complete, the transcribed interviews will be stored securely in locked storage at the University of Leicester for a maximum of 6 years.

All information which is collected during the research will be stored in a secure and locked office, and on a password protected database. Any information about them which leaves the hospital/organisation will have your name and other personal information removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

What happens when the research is finished?

If you wish to know the results of the research then this can be facilitated. The consent form has a tick box which tells the researcher you wish to receive a copy of the results. You can provide contact details for this to take place.

Who is organising and funding this research?

The research is being organised by the University of Leicester and is being sponsored by Leicester Partnership NHS Trust.

Who has approved this research?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Northampton Research Ethics Committee.

What happens if I have a problem?

If you have any concerns about anything related to the research, then you can contact the research team at any point through the contact details below. However if you wish to speak to someone separate to the research team then you can use the following contact details:

(Anonymised) Employee Assistance Service
([Anonymised website](#))
Tel: 0800 019 3453

For further information

If you have any further questions then please find my contact details below. Further if you wish to find out the results of this study once it is completed, then please tick the appropriate box on the attached consent form.

What happens next?

If you decide to take part in the research, then please read and sign the attached consent form.

Thank you for taking the time to read this information sheet.

Chief Investigator contact details

Laura Chance
Clinical Psychology department, School of Psychology
University of Leicester
104 Regent Road,
Leicester,
LE1 7LT

lc315@le.ac.uk
0116 223 1639

Appendix J- Participant consent form



Mental health service transitions: understandings and experiences in a secure forensic

psychiatric setting: Staff Consent Form.

(Version 2, 12.04.15)

Please read this and initial each box if you agree with what is being said. Please sign and date at the bottom of the form.

I have read and understood the participant information sheet (Version 2, 12.04.15).

☐

I have had the chance to ask further questions.

☐

I understand that the interview will be audio recorded and kept in a secure place. I understand that no personal information will ever be shared to identify me as being part of the research.

☐

I understand that direct quotes from interviews may be used in the write-up of the research. However I understand that these will be anonymized and my confidentiality will be maintained.

☐

I understand that all information provided during the interview will be confidential

☐

I understand that I have the right to withdraw from the study at any stage without explanation.

☐

I would like to know the results of this study (optional).

YES

☐

NO

☐

If the answer to the above question is "yes", please provide appropriate contact details below. For example an address or email which may be used to provide you with information on the study results.

Contact Details:

I AGREE TO TAKE PART IN THIS PROJECT.

Name of participant [printed] Signature Date

Researcher [printed] Signature Date

Appendix K- Topic guide



University of
Leicester

Staff Topic guide

Introduce self and go through information sheet/ consent form.
Ask if participant has any questions.

(Questions in bold= main questions. Prompt questions underneath)

1. Could you start by telling me a bit about your job role and the young people you work with?

Personal experience of ward staff

2. Can you tell me about your experience of transitions in the adolescent service?

- *How did you feel/ what did you think at the time?*
- *Is that usual?*
- *What sense did you make of the experience of transition at the time, personally or as you role of ward staff?*

3. Can you tell me your experience of the management of transitions in the adolescent service?

- *How do you feel about the rationale for moving young people on?*
- *How do you feel about the way transitions are planned/ conducted?*
- *Is that usual?*
- *How do you feel about the support young people receive?*

Meaning making of the experience for young people

4. I wonder if you have any thoughts or feelings about how transitions might be experienced by the young people themselves?

- *Any sense of what they might be thinking or feeling at the time?*
- *Do you think they impact young people (if so in what ways, positively/ negatively)?*

5. What do you think makes a positive transition?

- *Are there any factors that are important to consider?*
- *Is there anything that improve transitions in this service?*

The interviewer may need to seek elaboration by using prompts such as:

- *Why?*
- *How?*
- *Can you tell me more about that?*
- *How was that for you?*
- *How did you feel?*
- *Could you maybe think of an example of what you've just described?*

Debrief

- Thank them for taking part and ask how they feel
- Ask if they have any further questions
- Remind that if they do, they are able to contact the researcher to ask these

Appendix L* - Ethics correspondence


Health Research Authority
NRES Committee East Midlands - Northampton
Royal Standard Place
Nottingham
NG1 6FS
Telephone: 0115 8839 440

23 April 2015

Miss Laura Chance
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Miss Chance,

Study title:	Mental Health Service Transitions: understandings and experiences in a secure forensic psychiatric setting
REC reference:	15/EM/0110
IRAS project ID:	165440

Thank you for your letter of 22 March 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Rebecca Morledge, NRESCommittee.EastMidlands-Northampton@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
GP/consultant information sheets or letters [RC info sheet]	Version 2	12 April 2015
Interview schedules or topic guides for participants [Adolescent topic guide]	1	02 February 2015
Interview schedules or topic guides for participants [Staff topic guide]	1	02 February 2015
IRAS Checklist XML [Checklist_21042015]		21 April 2015
Other [Service user review summary]	1	02 February 2015
Other [Field supervisor CV]	1	02 February 2015
Other [GCP certificate]	1	02 February 2015
Participant consent form [Adolescent consent form]	Version 2	12 April 2015
Participant consent form [RC agreement form]	Version 2	12 April 2015
Participant consent form [Staff consent form]	Version 2	12 April 2015
Participant information sheet (PIS) [Adolescent info sheet]	Version 2	12 April 2015
Participant information sheet (PIS) [Staff info sheet]	Version 2	12 April 2015
REC Application Form [REC_Form_16022015]		16 February 2015
Research protocol or project proposal [Research Proposal]	1	02 February 2015
Research protocol or project proposal [Research Proposal]	Version 2	19 April 2015
Response to Request for Further Information		
Summary CV for Chief Investigator (CI) [L.Chance CV]		02 February 2015
Summary CV for supervisor (student research) [Academic supervisor CV]	1	02 February 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/EM/0110

Please quote this number on all correspondence

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

Yours sincerely,



Mr John Aldridge
Chair

Email: NRESCcommittee.EastMidlands-Northampton@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Dave Clarke, Leicestershire Partnership NHS Trust

Appendix M- Transcription consent form



University of
Leicester

School of Psychology – Doctorate in Clinical Psychology

Confidentiality Statement for Transcribers

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the Doctorate in Clinical Psychology Research Committee requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

- I understand that the material I am transcribing is confidential.
- The material transcribed will be discussed with no-one.
- The identity of research participants will not be divulged.

Transcription Procedure

- Transcription will be conducted in such a way that the confidentiality of the material is maintained.
- I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access.
- All materials relating to transcription will be returned to the researcher.

Signed

Jo Welch

Date 14-2-16

Print Name

Jo Welch

Researcher

Laura Chance L Chance

Project Title

Mental Health Service Transcripts: understandings and experiences in a secure forensic psychiatric setting.

Appendix N- Outline of IPA analysis

The analysis process followed recommendations by Smith *et al.*, (2009). This process has several defined stages although acknowledges a level of flexibility and use of personal intuition within these stages. They are therefore not prescribed, but there to guide and facilitate the in-depth analysis process (Smith *et al.*, 2009).

Reading and re-reading

After transcribing each data set in full, the researcher read and re-read each transcript to familiarise with the data. This involved simultaneously listening to the interviews via the audio recording (before deletion) in order to immerse in the data.

Initial coding and developing emergent themes

Following this, each transcript was analysed line-by-line for initial coding. This was divided into three types of code; descriptive, linguistic and conceptual. The researcher engaged with this process in a free-flowing way and noted down any thoughts or responses to the data that arose, considering both the surface meaning of the text alongside the deeper, underlying implications. The initial codes were then grouped into “emergent themes”.

During this process, the researcher also noted down any thoughts or ideas about potential assumptions or influencing factors that were guiding the analysis, for example, the researcher’s own knowledge about transitions. This formed part of the interpretative process of IPA and engaged with the “double hermeneutic” aspect of IPA where “the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world” (Smith & Osborn, 2003, p. 51).

Looking for patterns across emergent themes

Once this process had been completed, the researcher began to look for patterns between the emergent themes. Through a process of abstraction (Smith *et al.*, 2009) the researcher looked for patterns between emergent themes and developed a sense of “super ordinate” themes. In order to stay close the original data, this process involved noting down quotes from respondents and reflecting back on the initial codes. The process was facilitated by compiling extracts and themes on a computer file and visually moving themes around to discover how they may correspond to or contrast one another.

Looking for patterns across cases

Once this process had been completed for each respondent, the researcher then started to look for patterns across all cases. This involved an iterative process whereby previous stages of the analysis were re-visited so that the themes changed and developed over time. To facilitate this task, creative methods were employed, where all the themes were printed onto paper and cut out so that the researcher could visually manipulate the themes to aid with the iterative process. Use of a whiteboard to note down thoughts or ideas, whilst re-visiting the original transcripts ensured that the process moved within the hermeneutic circle (Smith & Osborn, 2003) moving from particulars of an experience, to the wider context and from the researcher’s meaning-making to the participant’s attempts to make sense of their experience. Themes that appeared to attract one another were clustered together and given a descriptive label to capture their conceptual characteristics. The use of a frequency table enabled the researcher to note whether certain themes captured the collective experience within the data and also facilitated the process of looking for divergence and differences between participants.

Translating themes into a narrative account

After a lengthy process of comparing and contrasting clusters of themes and moving back to the original data, the final organisation of themes resulted in four super ordinate themes with three sub-themes within each. These were then organised into a narrative account, a process that facilitated further interpretation by the researcher (Smith *et al.*, 2009).

References:

- Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory. *Method and Research* London: Sage.
- Smith, J. A., Osborn, J. M. (2003). Interpretative Phenomenological Analysis.

Appendix O- Example of coding (Greg's interview)

THEMES – Greg's Interview		
Superordinate/ sub-themes	PAGE/LINE	KEY WORDS
Adapting to a changing culture		
Limited to care within changing policies <i>Context that he has worked in the service for a long time and seen many changes- loss of previous policies/practices that allowed greater flexibility, sense that the changes are to "blame" for his own limitations to care?</i>	3/74 10/303 12/362 13/395 39/1262 48/1564 52/1694	Threshold for admissions has slightly changed Look you can't stay here Budget cuts that's gone Non-existent anymore Pressing matters to deal with We have to justify Wish there was a better way
Detaching from the human element <i>Business-type language used, reflective of his role and/or a way to cope in the pressurised environment, seeing people as numbers and having to manage those numbers- a way of detaching from some difficult feelings surrounding transitions?</i>	2/57 7/217 17/527 24/748 29/831 32/1038 46/1487 51/1667	Our cut off point Fitting the bill Bid sort of for that person Try to transfer to another problem Take it like you take any other issues Developed those skills now to understand that A strategy meeting for that As blank as it sounds
The therapeutic bond		
Projecting feelings <i>Clear message that he feels young people struggle at the point of transition, but cannot openly communicate this so reject staff/display behaviours as a way of rejecting him before he rejects them.</i>	9/261-262 10/305 55/1794 56/1810 57/1837	Aggression, anxieties Try to reject you Withdrawn... resort to self-harming They're way ahead of you, they're thinking They've managed to wean you off That's the MO
Making and breaking bonds <i>Difficulties for both staff and young people- acknowledgement of the close bond between nursing and young people, and the difficulty breaking that when transitions occur</i>	8/239 10/295 11/326 32/1031 40/1285 45/1447	To break those ties is so difficult They get to know you Developed a bond Termination is difficult for some people Would be nice to just give them support I remember that face
Re-connecting with society		
Following social norms <i>The sense that social norms in western society (individualistic culture?) determines "success" and the whole treatment pathway is geared to move people back into society.</i>	23/741 25/796 26/827 28/877 50/1621	On straight and narrow Don't want to be part of community How society functions Prevent them from coming back into hospital You're an adult, you can move on
Transitioning as a life skill <i>Conceptualising transition as a life skill, that young people need to develop. Acknowledgement that we all have to manage change so it's part of his job to make sure that young people have these skills in their "toolbox".</i>	27/8559 37/1198 46/1478	Into your toolbox and dig deep Have to learn to pick themselves up Life being what it is
Evaluating your role		
Wanting validation <i>The need for validation in his job role, knowing he has done a good job. Transitions a way for his to self-reflect on his skills/abilities to fulfil what he feels is a role to help people progress back into society?</i>	14/432 14/440 16/489 22/710 23/717-733	For us to gauge... bit pf progress Valuing your opinion Very sort of satisfying Barometer for the work you've done Did we get it right It's satisfying
Accepting loss <i>Accepting loss of the therapeutic bond, loss of his work, loss of any progress made.</i>	9/277 34/1089 39/1260	Two year's work can just vanish Probably be lost Don't really want to shut them down
Anticipated struggles		
Fear of the unknown <i>Recognition that young people have fears about the unknown, and his own bias that the world isn't all positive- context of his own experiences, his biases about the world?</i>	9/268-269 20/643 35/1131 36/1148 41/1332 42/1347 58/1874	Scary, scary world for them New routines So many dangers out there World is not as safe as it looks A buffer, a safety zone Going to be with some very old people Got this image in their head Let them know what's going on
A "child" lost in adult services <i>He sees the young people as children despite their age and therefore anticipates they will struggle to cope in adult services.</i>	11/339 19/588 19/607 21/654 35/1131 41/1317	Cognitively their far from that threshold Professional in you kicks in Trying to act the grown up Out there on their own Drowned in adult services Going to get lost in the system

Appendix P- Frequency of themes table

Themes	Respondents					
	Craig	Amy	Andy	Greg	Claire	Tina
Feeling Powerless	✓	✓	✓	✓	✓	✓
Working in a business culture	✓	✓	✓	✓	✓	✓
Anticipating the cultural divide	X	✓	✓	✓	✓	X
Not having a voice	✓	✓	✓	X	✓	✓
Having a privileged perspective	✓	✓	✓	✓	✓	✓
Seeing beyond the surface	✓	✓	✓	✓	X	✓
Understanding the “MO”	✓	✓	✓	✓	✓	X
Taking on a parental role	✓	X	X	✓	✓	✓
The impact of unsafe uncertainty	✓	✓	✓	✓	✓	✓
Questioning your practice	X	X	✓	✓	✓	X
Feeling in limbo	✓	✓	X	X	✓	✓
Detaching	✓	✓	✓	✓	X	✓
De-institutionalising young people	✓	✓	✓	✓	✓	✓
The environmental impact of secure care	✓	✓	✓	X	✓	✓
Normalising the experience	✓	✓	X	✓	X	X
Re-connecting with society	✓	X	✓	✓	X	✓

Appendix Q- Young person study

Introduction

An initial aim of the current study was to explore the experiences of transition from the perspective of young people *alongside* those of nursing staff. However due to difficulties in recruitment (i.e. gaining the desired sample size of six to allow a full and valid analysis) the young person aspect of the study could not be completed in full in time for the deadline of the doctoral research thesis.

However, three young person interviews were conducted within the time frame. Given the relative lack of research into the experiences of young people in inpatient secure services, it was deemed important to pursue this aspect of the study and gain further data to fulfil the requirements for a complete and in depth analysis of their experiences. Ethical approval had since been sought and gained for an extension of this aspect to the study (Appendix R).The following outlines the results collated so far.

Aim

The study aimed to explore the experiences of adolescent service users who were in the process of transitioning from a secure adolescent inpatient setting to an adult service. Using qualitative methodology the study aimed to understand what the experience is of being in a secure setting with young people, in the knowledge that a move to a different adult setting is imminent.

The main aims included:

- To explore the experiences of young people in an inpatient adolescent unit during transition to adult services.
- To explore young people's experiences of their prior transitions to a secure psychiatric unit.
- To establish how young people feel about their knowledge, understanding and support received during transitions.

Methodology

In line with current study, the service user study adopted a qualitative research design, using the methodological approach of IPA. An idiographic approach was again considered most appropriate to align with the research aims of gaining an in depth insight into the lived experience of transition. The method of collating data mirrored that of the staff study. The identification and recruitment of participants involved several additional considerations that were unique to adolescent service users. These were discussed in depth within the research proposal which was submitted as part of the ethical approval process. Ethical approval was sought and obtained through the Northampton Research Ethics Committee. Approval was also granted by the research site's own Research and Developmental department. Research Sponsorship was also obtained via Leicestershire Partnership NHS Trust.

Partial Results

Within the time frame of the doctoral research thesis, three participants were recruited. All were male service users, aged 17 years. Although IPA involves the in depth exploration of a lived experience, and has no specific or rigid guidance for sample size

(Smith et al., 2009), a judgement was made that three participants would not ensure an in depth analysis. In brief, the researcher acknowledged the difficulties in building rapport and gaining an in depth insight with participants who were less able and/or willing to expand on their experience at times. The interview data highlighted important emerging themes and can be used to partially begin to answer the research questions. However to ensure quality of analysis and avoid over-interpretation of the results due to limited data (to date), a decision was made that further recruitment would be necessary for a full IPA analysis, with the aim of between six to eight participants.

Emerging themes have been identified within the data already collated. The following offers a very brief descriptive summary of these themes. A full IPA analysis would take place, following further recruitment.

Emerging themes

- **The importance of family-** Young people described the importance of their families and the support from family and how this impacts their views of transition.
- **Anxieties-** Young people have described mixed feelings about their transition, but all describe an element of anxiety. Anxiety may relate to fears of the unknown and what their new placement or peer group may be like. Some viewed the move as a positive step and a sign of progress, others emphasised the need for ongoing care as they still view themselves as "ill".
- **Becoming an "adult"-** Young people referred to their own ideas and concepts around what it means to be an adult. All suggested that they understood they

needed to move on to adult services because they had reached an age threshold. Some viewed this as a positive step others had concerns that their skills were not yet developed to enter the adult world.

- **Having freedom-** Young people have referred to the restrictions of medium security in terms of physical boundaries and restrictions. The move to another placement has been linked to having more freedom and being able to re-integrate into society, e.g. to "*feel a bit more normal*" (Interview Two). The data suggests that young people want to be able to feel like a "normal" teenager and place high value on typical everyday activities that they have lost touch with in medium security.

Discussion

The themes emerging so far within the data indicate that a number of factors may influence the experience of transition to adult services. It is hoped that further recruitment and the collation of further interview data will enlighten these factors further and provide a rich and detailed account of how transitions are experienced by this particular group of young people.

References:

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory. *Method and Research* London: Sage.

Appendix R- Ethics correspondence for extension of young person's study



Health Research Authority

East Midlands - Leicester South Research Ethics Committee

Royal Standard Place
Nottingham
NG1 6FS

11 March 2016

Miss Laura Chance
Trainee Clinical Psychologist
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Miss Chance

Study title:	Mental Health Service Transitions: understandings and experiences in a secure forensic psychiatric setting
REC reference:	15/EM/0110
Amendment number:	
Amendment date:	01 March 2016
IRAS project ID:	165440

The above amendment was reviewed at the meeting of the Sub-Committee held in correspondence on 16 March 2016.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Notice of Substantial Amendment (non-CTIMP)		01 March 2016

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/EM/0110:	Please quote this number on all correspondence
--------------------	---

Yours sincerely



Mr John Aldridge
Chair

E-mail: NRESCommittee.EastMidlands-LeicesterSouth@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Sponsor - Dr Dave Clarke, Leicestershire Partnership NHS Trust*

Appendix S*- Chronology of research process

October - December 2013

- Consultation with academic supervisor
- Initial research proposal

December- May 2014

- Developing research proposal
- Liaison with field supervisor

June- December 2014

- Finalised research proposal
- Internal peer review at the University of Leicester
- Service User Reference Group (SURG) review
- IRAS electronic preparation and submission
- NRES application
- R&D application

January- August 2015

- NRES Committee East Midlands (Northampton) meeting 19th March 2015
- Re-submission of application following minor amendments, 21st April 2015
- Favourable opinion received from NRES, 23rd April 2015
- Approval from the research site's Research and Development team, 20th July 2015

September- January 2016

- Local induction at research site
- Recruitment and interviewing participants
- Interview transcription

February- April 2016

- Analysis
- Write-up period
- Submission of thesis to University of Leicester (deadline 29th April 2016)

May- July 2016

- Viva preparation and viva

August- September 2016

- Dissemination of findings
- Preparation for poster presentation

Appendix T- Excerpt from reflective diary

