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A SNAPSHOT OF THE ROLE OF SOCIAL WORKERS IN  
MULTIDISCIPLINARY CHILD AND ADOLESCENT MENTAL HEALTH  
TEAMS IN THE REPUBLIC OF IRELAND

BY

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## *Declaration*

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Margaret Lisa Brennan



## *Summary*

This study sought to describe and explore the role and practice of social work in multidisciplinary child and adolescent mental health teams in the republic of Ireland (CAMHS). There was little existing literature in the area and the issue of role definition was of interest to social workers in practice in CAMHS. The area of role definition in CAMHS generally is also of interest to health service managers as there is concern about long waiting lists in some parts of the country. The literature review pointed to social work as a socially constructed profession often defined externally to the profession and determined by agency context.

A qualitative approach was adopted to gain an in -depth insight into the social work description and perception of role and contribution to the multi disciplinary team. The impact, if any, of individual social workers further training on the development of social work roles in child and adolescent mental health teams was also explored.

Semi structured interviews were held with ten social workers currently in practice in specialist child and adolescent mental health teams. The participants represented all grades of social workers and a variety of employing agencies and geographical areas. The interviews were audio taped with the permission of the participants and transcribed by the researcher. The data collected was analysed using thematic analysis to identify significant themes and to compare the experiences of the participants. The findings were drawn from this analysis.

The study found that there is not a universal, discrete social work role in child and adolescent mental health teams in the republic of Ireland; the development of the social work role is impacted upon by factors external to the teams, the further training undertaken by individual social workers and the particular skills and interests of social workers and other team members. Considerable overlap in roles among the various disciplines involved in the multidisciplinary teams was noted. Social workers are involved in direct intervention with children and families and indirect intervention with schools and local community initiatives. Participant social workers are also very involved in education offering practice placements to social work students and teaching on third level courses in social work and related fields.

The main focus of social work intervention is with parents but not to the exclusion of direct work with young people. Social workers reported changes in the social work role to a primarily therapeutic activity with practice being determined by skills, competencies and individual interests than by discipline training. Social workers in child and adolescent mental health services have tended to pursue further training in particular therapeutic modalities such as family therapy which has varying impacts on their practice of social work. The study found some differences in practice in relation to the use of social worker as a title with some participants using the title of therapist. While individual casework was the most common intervention, social workers in child and adolescent mental health also report significant involvement in providing group work interventions to children and parents.

Social workers view their particular contribution to the multi disciplinary child and adolescent mental health team as offering a social perspective to compliment the medical understanding of mental health issues in childhood and adolescence. Social workers also see themselves as becoming involved with the more complex and difficult presentations. The area of involvement in cases where there are child protection and welfare concerns varies widely from team to team.

A key finding was the impact of external factors such as the availability of resources within the team and in the local community on the practice of social work in CAMHS. The current focus on reducing waiting lists and increasing the number of clinical contacts is causing concern for participant social workers who fear that the capacity to engage in long term complex work with children and families will be reduced.

The study points to the need for further research in the area of role definition in CAMHS and to the need for further development of continuing professional development opportunities for social workers.

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## ***Glossary of Terms and Abbreviations***

**Definition of social work:** *“The primary focus of social work is working with individuals, families and groups within their social context. Through the training, knowledge and skills which support a high standard of professionalism, the social work task is to facilitate and enable clients identify options and make decisions for themselves so that they may develop strategies to effect improvement in the quality of their lives. Social work also focuses on issues of social policy, social administration and social justice and the betterment of society as a whole.”* IASW code of ethics (1995)

*“The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the point where peoples interact with their environments. Principles of human rights and social justice are fundamental to social work”* (Social Work At Its Best, General Social Care Council, 2008)

**Multidisciplinary team:** a team employed to work together, within a single agency, to provide a service to a common client group with co-ordinated input from each discipline as required (Byrne, 2005).

**CAMHS** Child and Adolescent Mental Health Services

**D.o.H:** Department of Health

**D.o.H.C.** Department of Health and Children

**H.S.E.** Health Services Executive

**I.A.S.W.** Irish Association of Social Workers, social work professional organisation.



# Chapter 1 Introduction

## 1.1 Research Context

Irish mental health policy promotes the delivery of community mental health services to children and adolescents through a network of community based multi disciplinary child and adolescent mental health teams (CAMHS) (*A Vision for Change*, Department of Health and Children, 2006). This thesis reports on a study of the practice of social workers in such teams in the republic of Ireland (ROI) and their perceptions of their particular contribution to the service. This research topic was chosen for investigation due to interest in the area at a local professional level, national level and in the literature.

The area of roles, skills and competencies of all disciplines in CAMHS in the ROI is of interest to the Health Service Executive (HSE) as part of the current key objective of maximizing capacity in CAMHS to meet demand ([www.hse.ie](http://www.hse.ie)).

As a principal social worker in a large child and adolescent mental health service, the issue of clearly defined roles for social workers in CAMHS is of considerable interest to the author. The author has involvement in planning for the creation of new teams within CAMHS and the creation of job descriptions for CAMHS social workers. As a line manager offering support and supervision to CAMHS social workers experiencing multidisciplinary team work as stressful, the author is acutely aware of confusion in relation to roles in practice.

This area is also of interest to CAMHS social workers. The social work professional body, the Irish Association of Social Workers (IASW) have a special interest group whose membership is open to all social workers in specialist CAMHS in the republic of Ireland. The issue of social work practice and role definition is increasingly a discussion topic at meetings of the group and recent efforts have been made to create an agreed description of the role ([www.iasw.ie](http://www.iasw.ie)).

While the roles of social workers on multi disciplinary CAMHS teams have not attracted significant interest in the academic literature, Asquith et al

(2005:4) concluded that role definition is an area of particular concern to social workers in general asserting that there is a crisis in social work as a profession in terms of professional identity and an urgent need for social work to clarify its identity and distinctiveness compared with other disciplines.

As there is no clearly accepted definition of the particular role of social workers in CAMHS it was decided to conduct this study to begin a process of definition by describing current practice.

## 1.2 Mental Health Needs of Children and Adolescents

Mental health problems in childhood and adolescence are considered to be an international public health issue affecting up to 20% of children (Bayer et al, 2008; Belfour, 2008). There is some disagreement about whether the incidence of mental health difficulties in childhood is increasing. Walker (2003) reports growing concern about an increasing incidence of child and adolescent mental health problems internationally although Sourander et al (2008) studied Finish 8 year olds and found an increased use of services rather than a general increase in symptoms of mental health difficulties although girls were self reporting more depressive symptoms.

However, the accepted international prevalence of severe and enduring mental health needs in children and adolescents that require specialist intervention is 2% of the population (*A Vision for Change*, DoHC, 2006). The 2006 census of population recorded 1,036,029 young people less than 18 years in Ireland, this age group make up 24.46% of the population (Waiting list survey, CAMHS, 2007, unpublished). Of this group, children and adolescents from socially deprived areas have been found to be more likely to need specialist CAMHS intervention (Davis et al, 2000; McKeown, K., Haase, T., 2006).

To meet this need, the *A Vision for Change* (DoHC, 2006) policy recommended that there be 72 CAMHS teams for the country of which there are 47 in place at present. There is a commitment to developing further CAMHS teams, particularly for adolescents, over the next four years and it will be important to establish the optimum skill mix for these teams. As part

of the action plan to address capacity issues, there is a plan to develop a standard skill set for multi disciplinary team members in CAMHS which will require detailed knowledge of the existing skills and competencies of team members. This study could contribute to this process for social workers.

### 1.3 Mental Health Service Delivery

The concept of multi-disciplinary service provision in mental health has long been accepted at policy level although the implementation of multidisciplinary teams in adult services has been slow (Mental Health Commission, 2006, A Vision for Change Monitoring Group, DoHC, 2007). The policy document *Planning for the Future* (DoH, 1984) recommended the establishment of multidisciplinary teams made up of psychiatrists, psychologists, social workers and occupational therapists to deliver adult services as that model of service delivery was deemed most appropriate. The need to recognise the importance of the social and economic determinants of mental health in addition to the individual level determinants has been stressed (DoHC, Slan 2007), a multidisciplinary approach lends itself to this broader understanding.

The Mental Health Act (2001) changed the definition of a child from a person under sixteen years to a person under eighteen years (unless married) which created a need for changes in service delivery. *A Vision for Change* (DoHC, 2006) outlined a comprehensive policy for the delivery of mental health services across the lifespan. This policy clarified the role of CAMHS as responding to the needs of the children and adolescents with severe and enduring mental health disorders. This represents a change the position of CAMHS in the service network as CAMHS services had tended to respond to a broader range of less severe mental health needs in the past (Fitzgerald, 2003). Maximizing capacity in CAMHS is a key objective of the HSE due to concern about long waiting lists in some parts of the country ([www.hse.ie](http://www.hse.ie)).

The development of primary care services and early childhood intervention teams may also impact on the demands for CAMHS services as the demand for assessment and intervention in younger children and less severe

presentation may now be responded to by the new teams (*Primary Care, A New Direction*, DoHC, 2001). The changing demands on CAMHS teams and the development of new teams in an economic climate of increased focus on effectiveness and efficiency in service delivery make it timely to begin to explore the roles of the different disciplines within CAMHS.

#### 1.4 Current Model of Service Delivery in Child and Adolescent Mental Health

Specialist CAMHS have been provided in the Republic of Ireland since the 1950's. While services for adult mental health had tended to be provided around large psychiatric hospitals, services for children and adolescents developed on a community based, multidisciplinary team model. Services are provided directly by the H.S.E. and by voluntary agencies funded by the H.S.E. with each team offering service to a geographically defined catchment area. The multi disciplinary team has included psychiatrists, psychologists and social workers from the early days of service development (Fitzgerald, 2003) and in recent years has been expanded to include speech and language therapists, nurses, child care workers, occupational therapists and other therapists (The Second Report of the Working Group on Child and Adolescent Psychiatry; DoHC, 2003). In a recent press release the Minister of State at the department of health and children described multidisciplinary team working as "vital" to the delivery of a modern mental health service (John Moloney, press release, DOHC, 29.05.08). This policy is supported by evidence of the short and long term effectiveness of multidisciplinary service and service user experience of multidisciplinary intervention has been found to be positive (Walker, 2003). Consultation with service users in Ireland suggests a desire to have multidisciplinary service provision (The Mental Health Commission, 2006). However, the rationale for the composition of teams is rarely thought out and there is a view that research in this area is needed (Byrne, 2005).

There is no clear definition as to the differing roles and contributions of each discipline within CAMHS. CAMHS services are facing significant challenges meeting existing demand and the issue of waiting lists for services is causing

concern (Waiting List Survey, unpublished). There has been development of a new model of service in some parts of England. The collaboration and partnership model (CAPA) seeks to enable access to service for all referred children within six weeks of referral ([www.camhsnetwork.co.uk](http://www.camhsnetwork.co.uk)). The model adopts a flexible, partnership approach with parents and the roles of team members are defined in terms of individual competencies, skills and capacity rather than initial discipline training (York and Lamb, 2005). Skills and competencies are described as core and specialist and each team member contributes both core and specialist skills to the team. Each team member has a clearly defined set of tasks. The adoption of the CAPA model has led to significant reduction in waiting lists in England and is currently being discussed as a possible alternative model of service delivery within the CAMHS service where the author works.

The identified need to maximize capacity has also led to the introduction of audits of clinical activity, performance targets of clinical activity per clinician and a focus on speedy discharge of service users to minimize waiting lists.

## 1.5 Social Work in CAMHS

Social workers have been part of child and adolescent mental health services since services began to develop in the U.S.A. in the early 1900's driven by a concern that juvenile delinquency was a serious threat to society and a belief that the social and cultural factors impacting on children and adolescents were an important factor in the assessment and treatment of juveniles with challenging behaviour (McCabe, 2003). The social control element of the social work task was evident in this development. With the creation of the health boards and community social work services following the 1970 Health Act, social workers in CAMHS were employed and managed by the community team and seconded to CAMHS. During the health spending cutbacks of the 1980's many of these social work posts were returned to the community services and a separate CAMHS social work team structure developed.

With the introduction of Children First Guidelines (Department of Health, 1999), there was a clear separation of the child protection assessment role. There is, at present, no statutory role for social workers in CAMHS in Ireland. In England social workers continue to be employed by generic social services and seconded to specialist CAMHS teams. However, there has been a significant reduction in social work posts in CAMHS as social services departments withdrew the posts in the late 1980's to focus on child protection investigations (Messent, 2000). The development of social work in CAMHS as a separate structure was not mirrored in England. This difference in the employing agency structure makes comparisons to England problematic and must be taken into account when reviewing the literature. Much of the literature from England is concerned with exploring the integration and collaboration of CAMHS and social services (social work) departments. There is little written about the role and tasks of social workers in modern CAMHS in any jurisdiction. In my experience the lack of literature reflects the lack of a clearly defined role and function for social workers in CAMHS. This lack of clearly defined role is not unique to the Irish context, as social work is "*forced to define and refine unique role on basis of ever present direct comparisons to other professions*" (Marriot et al 1994)

## 1.6 Research Objective

Given the concern about role clarity in the literature and among social workers as evident in the special interest group of the IASW and the author's own experience, this research sought to establish a description of the current practice of social work in specialist CAMHS in the ROI. The objective was to describe the current practice from a social work perspective and explore some of the factors that may be impacting on the role externally in terms of changes in overall service orientation and internally in terms of social workers further training and professional development. The expected output was a clear description of the current roles, tasks and particular contribution of social workers in CAMHS to contribute to the understanding of the practice of social work in CAMHS the creation of job descriptions and planning for new service developments.

## 1.7 Outline of Thesis

This chapter introduced the area of study and the rationale for the project. Chapter two reviews the literature in relation to social work roles and the social work contribution to multi disciplinary teams. Chapter three outlines the chosen methodology, a qualitative study using semi structured interviews. Chapter four presents the findings interpreted using template analysis and chapter five presents a discussion of the findings. Chapter six draws conclusions and recommendations from the study.



## Chapter 2 Literature review

### 2.1 Introduction

This chapter will review the literature in relation to social work as a profession, training, grading structure and continuing professional development (CPD). The roles and tasks of social workers as described in the literature will be reported. As all CAMHS teams are multi disciplinary teams led by a consultant psychiatrist, particular reference will be made to the factors impacting on the social work role on medically led multidisciplinary teams.

### 2.2 Literature Search Strategy

Using the key words “social work”, “child and adolescent mental health” (or child guidance, or child psychiatry), “multidisciplinary team work” (or multi agency or inter-professional), “social work” and “role” and “career development” a search was conducted using three main databases; Ovid (including psycINFO and psycArticles), Swetwise and Ebsco host which includes CINAHL Plus, socINDEX, Nursing and Allied Health Collection comprehensive and the psychology and behavioural sciences collection. The search returned two articles in relation to child and adolescent mental health and the search combining “social work role” and “multidisciplinary team” returned 8 articles of interest mainly in relation to social work in adult mental health services.

Backward and forward searches were undertaken which generated some articles of interest around multidisciplinary teamwork that was not specific to social work. A search of specific social work journals such as the British Journal of Social Work, Community Care and the International Journal of Social Work in addition to a search of academic textbooks generated some theoretical discussions around social work in child and adolescent mental health.

There was limited literature on the specific roles of social workers in CAMHS although there was some relevant research in relation to the social work experience of consultant led multidisciplinary team working, particularly in adult mental health services. This literature review draws on the available literature to identify and explore some common themes and factors which impact on social work role development within such teams. These themes include the social construction of social work as a profession, the impact of agency context on the development of social work roles, issues around role blurring, continued professional development, the perceived lack of social work generated research activity and the positioning of social work understanding of mental health in a social and environmental context. This chapter will present the findings of the literature review thematically following a brief overview of social work grading and training and CPD opportunities.

### 2.3 Social Work Training

Professional training in social work in the ROI is accredited by the National Social Work Qualification Board (NSWQB) and there are clear guidelines for colleges seeking to award the National Qualification in Social Work (NQS) which is the basic qualification for employment as a professionally qualified social worker ([www.nswqb.ie](http://www.nswqb.ie)).

The professional training includes both theoretical and practical elements. Students spend half of the course time on placement under the supervision of a qualified social worker. Training is generic and expected to enable graduates to offer a social work service in a wide range of agency contexts. It is expected that agency specific further training will be undertaken ([www.nswqb.ie](http://www.nswqb.ie)).

At present there are no social work specific further training/career development opportunities for social workers in CAMHS in the R.o.I. There has been significant developments in post qualifying training for social workers in England with awards at specialist, higher specialist and advanced specialist social work levels ([www.gscc.org.uk](http://www.gscc.org.uk)) although the systems are not

directly comparable as the basic social work qualification in the UK is to diploma level. Mitchell (2001) reports an increase in confidence and understanding of professional roles among social workers who have gained post qualifying awards while Smith et al (2006) investigated self perceived change in knowledge, attitude and behaviour in licensed social workers in the USA following continuing professional education and found that change related to motivation and increased expectation to apply the learning.

Traditionally, the options for further training for social workers in CAMHS have been around specialism in particular therapeutic modalities although there have been recent developments in post graduate training courses in mental health with a child mental health option. These courses are delivered to multidisciplinary groups of students and are not social work specific.

The entry level grade for social workers in CAMHS is at professionally qualified grade (PQSW). Social workers can apply for promotion to senior medical grade with three years experience. This grade reflects social workers who can work with more complex cases. In CAMHS services the grade of principal social worker is a clinical and managerial post which can be applied for with five years experience.

## 2.4 Social Work and Social Control

A review of the development of professional social work suggests that there is evidence of social work in most western democracies for over one hundred years but it has developed differently in different countries depending on the broad political and social context (Skehill, 1999, Barnes and Hugman 2002). By the latter part of the twentieth century there was evidence of professional social work on all continents (Barnes and Hugman, 2002).

Social work has been described as having emerged in western Europe and north America as a response to a societal need to act in response to the characteristics of all human society which are “*compassion, benevolence, love, disaster, war and oppression*” (Payne, 2005: 1). It has been argued that social work was seen as “*women’s work and a natural extension of appropriate feminine domestic duties into the public sphere*” (McCabe, 2003: 1) However social work cannot be seen as a straightforward response to self

evident human need, the development of social work services has also had a social control element (Harris, 2008). Asquith et al (2005) reported on a comprehensive international literature review on the role social workers and points to a social work function of social integration and dealing with policy failures in areas such as crime, health and education. McCabe (2003) points to the clear social control element in the social work involvement in early child psychiatry services.

Thus social work has developed as a contextual profession concerned with social justice, social control and social policy.

## 2.5 Impact of Agency Context on Role Development

There is interest in the academic literature in the social construction of social work. This social construction starts with the areas of activity that social workers are involved in. Payne (2005) argues that for an issue to be seen as requiring a social work response it must firstly be characterised as a social issue requiring some political response and for which social work has developed an appropriate response. This social construction has led to the development of a contextual profession which varies with the cultural context in which it operates although there are universal elements of helping others, preventing harm and social justice with a unifying principle of empowerment (Taylor, 1999). There has also been conflict between the agency contexts of social control and the social justice / empowerment remit of social work (Taylor, 1999).

While there is an international commonality to the emergence of social work as a profession, the particular development of social work services in different countries has depended on the prevailing political and social contexts. The development of social work services in England, and how the role of social work has been seen, have been closely linked with the dominant political views over the last hundred years (Harris, 2008). Developments in Scotland have also been seen as intrinsically linked to the political context there (Brodie, Nottingham and Plunkett, 2008). Professional social work in Ireland is seen as having grown out of charity and philanthropy (McCabe, 2003) with

the development of professional social work having parallels with developments in England but significant differences due to the influence of the religious organisations in Ireland (Skehill, 1999; Kearney and Skehill, 2005).

There are reports of a move towards social workers as case managers (Payne, 2005). The changing construction of social work from case work to case management in England has led to the mission of social work becoming “*confused with organisational and institutional contexts*” (Walker,2001:32). Case management implies an agency led intervention with clearly defined limits to resources which can cause an inherent conflict with the social justice and empowerment role of social workers. This change in the focus of social work is also seen internationally; Carey (2008) argues that despite historical differences in the organisation of services in Canada and England for example, both countries are converging towards a purchase model of service leading to a loss of understanding of role and purpose for social workers.

Social workers work in a wide variety of health, justice and social service areas internationally. The developmental history of each specialist area has varied and this varied development impacts on the current roles and tasks in each type of agency (Kearney and Skehill 2005). There is concern that the development of social work in Ireland has been reactive and piecemeal which has led to a dominance of child protection discourses within the profession (Walsh, 1999:35). A review of the academic debate in Ireland in 2001 revealed an absence of debate in areas other than children at risk of abuse which was understood to be a reaction to the very public child protection scandals of recent years (Christie, 2001). Social work in CAMHS services has not attracted academic attention in Ireland.

This brief overview of the history of the development of social work suggests that social work is a socially constructed profession, reactive to prevailing political and cultural factors with inherent conflict between social justice and social order.

## 2.6 Social Work Definitions of Social Work Roles

Social work has been seen as a socially constructed profession which has had two main areas of activity, that of helping individuals to find their own solutions to their problems often within an agency context of social control and of seeking societal change from a social justice perspective (Payne, 2005). This is evident in the definitions of social work. The IASW (code of ethics 1995) definition of social work primarily reflects the view of social work as intervening at the level of the individual while the international federation of social work definition puts more emphasis on the underlying social justice principle (Social Work At Its Best, General Social Care Council, 2008).

Social work as an activity can intervene at either or both levels depending on agency context. This can create a conflict for social workers intervening at the level of the individual in the context of clear structural disadvantage and underpins the need for role clarity for social workers in practice.

## 2.7 Role Clarity for Social Workers

Distinction needs to be drawn between social work roles and tasks; social work roles are based on the broad purposes of social work and the outcomes it enables people to achieve. The social construction of social work has led to an interest in the clear definition of social work as a professional activity and the roles and tasks of social workers in a variety of settings. It has been suggested that the many definitions of social work that have been offered lead to confusion (Thompson, 2000). The tasks of social work are the activities required to deliver those purposes and outcomes (General Social Care Council, 2008)

There is a concern within social work that there is a lack of a clear, accepted understanding of social work and that the

*“understanding of social work is “up for grabs” in the sense that what constitutes social work depends on the outcome of attempts by powerful groups and institutions to shape social work policy and practice”.*

(Thompson, 2000:24)

There have been efforts to establish clarity. The generic roles and tasks of social workers in England have been described in detail (General Social Care Council, 2008). The role of social workers in adult mental health has also been described (National Institute of Mental Health, 2005, Ray et al, 2008). However, social work is described as struggling to define and redefine social work practice as social workers seek the certainty, clarity and effectiveness of definitive models of practice (Walker, 2001; Marriot et al 1994). Harker (2004) points to the lack of strong professional identity for all social care workers. The lack of a clear evidence base for social work intervention has been identified as a significant issue in the struggle to establish clarity (Walker, 2001) and the issue of social work generated research has been suggested as relevant.

### 2.7.1 Research Activity

It has been suggested that the lack of role clarity for social workers arises from the lack of an evidence base for social work practice pointing to the difficulty of assessing treatment effectiveness of psychosocial treatment (Thyer and Wodarski, 1998). There have been concerns raised about the lack of social work generated research and that

*“until social work can assert the value of its unique contribution, its impact on policy and practice will remain weak, and the prospects for a more socially based model in integrated services may be undermined”* (McCrae et al 2005)

This appears to be an international issue, in the USA social workers are the largest occupational group of mental health professionals but produce very little research (Joe and Niedermeir, 2008). While social work has played a significant role in mental health care in Britain the social work contribution to the knowledge base is meagre in comparison to other disciplines (McCrae et al 2005). Social work seems to lack a research tradition and to become involved in research less than other disciplines (Lask, 1994, Walker 2001)

While Giles et al (2007) found growing evidence of social work literature on evidence underpinning social work practice, a comprehensive review of UK

research studies evaluating social work contribution to mental health practice found research to be patchy and many areas of practice under-researched (Ray et al, 2008). Evidence based practice may improve collaboration and communication but can present problems for social workers who do not have a tradition of research (Ramchandani, Joughin and Zwi 2001).

### 2.7.2 Social Work Roles: Generic and Specialist

Six key conceptions of generic social work roles were identified by Asquith et al (2005) as counsellor (or caseworker), advocate, partner, assessor of risk or need, care manager and agent of social control. The role adopted tends to be agency dependent. It has been suggested that the role of social work in family centred multi disciplinary teams is to carry out an ethnographic assessment, provide support and enhance service user empowerment (Deweese, 2004). It has also been suggested that social workers must assist the service user in change, work with the service user in his/her community context and promote prevention while allowing the service user to be a partner in the work (Jordan, 2004). In some agencies there is a more statutory focus to the role. In England and Northern Ireland many social workers in adult mental health are “approved” social workers with a statutory role in the process of involuntary admission to in-patient care. The approved social worker’s role is to “*ensure that service users right are safeguarded and the general public protected*” (Wilson et al 2005) again reflecting the conflict than can occur with social control elements of the social work role.

The role of social workers on CAMHS teams initially was data collection and liaison with school and community (Lask, 1994). McCabe (2003) gives a comprehensive outline of the tasks of one social worker on a child guidance team in the 1970’s. The role of social work at that time was to provide an holistic vision of mental health with an awareness of not only the individual child but their family, community and wider environment. Social work intervention included casework and group work. The tasks included pre assessment home visiting and social history taking, working with parents, liaising with schools and community services and contributing to case discussions (McCabe, 2003). Walker (2002) outlined the traditional roles within the CAMHS as follows

*“Traditionally the psychiatrist would lead the team and be responsible for clinical diagnosis. Social workers would support parents, psychotherapists worked with children individually, while education staff would focus on learning ability and liaise with teachers” (p49)*

The use of the word “traditional” suggests that the social work role has changed. Lask (1994) suggests that social work in CAMHS has become an increasingly therapeutic activity. While there is a view that social work has lost its way and needs to reorient towards a focus on equality and justice (Jacobson, 2001; Lymbery, 2001) there appears to be a move toward a reflexive-therapeutic model of practice in CAMHS in Ireland (Brennan, 2002) and England (Allen 2007). It is possible that the move towards a more therapeutic model of social work has blurred the boundaries with other members of the multidisciplinary team leading to less clarity as to the unique contribution of social work to the team. This move towards increasingly therapeutic activity seems to have echoes in other countries. The role of “senior therapist” in child psychiatry was developed in an inpatient setting in Canada by nurses and social workers to respond to user needs for holistic experience of the in patient service before during and after admission (Leung, 1984).

### 2.7.3 Role Blurring on Multi Disciplinary Teams (MDT) in Mental Health

There is an acceptance that role blurring occurs on MDT’s (Byrne, 2005). The issue of role conflict has been found to cause stress and to lower job satisfaction among social workers and nurses in community mental health teams (Parry-Jones at al, 1998; Baldwin 2002). There is a view that integration on MDT’s can feel like submersion (National Institute for Mental Health in England, 2005).

Professional’s confidence in their own role is associated with less professional jealousies and enhanced communication in MDT’s (Molyneux 2001). Clearly defined professional roles and responsibilities for each discipline have been

described as a key factor to overcoming the barriers to effective multidisciplinary teamwork in adult mental health (Hannigan, 1999). Clarity of role has also been found to be significant in other studies, while some stretching of professional role is encouraged to provide seamless service to service users, the experience of role blurring on interdisciplinary teams has been found to encourage professionals to preserve their own professional boundaries (Brown, Crawford and Darongkamas, 2000; Rees et al, 2004).

Social work shares commonalities with other disciplines within multidisciplinary teams and key differences in terms of working towards social justice (Thompson, 2000). There is some evidence that social workers have poorer perceptions of team functioning and to have experienced higher levels of role conflict than other members of multidisciplinary teams (Frost, 2005). Social workers can perceive themselves as having a marginal position; have concerns about role blurring as well as a clash of values between medical and social models of mental health (Carpenter, 2003; Evans, 2006). Status and power within teams were also found to be important. Community based services do not imply a greater level of equality or shared power than traditional hospital based services and social workers may be more aware of status more than other professionals (Carpenter, 2003).

Job satisfaction of psychiatric social workers in Canada has been linked to professional respect and the quality of team interactions (Marriot, Sexton and Staley, 1994). High levels of burnout and role confusion were found to be improved by conjoint assessment which is described as “*two workers from different disciplines interviewing the client at the same time and sharing responsibility for completing a single multidisciplinary assessment*” (Mitchell and Patience, 2002:607). However, there is some evidence that the flexibility offered by role blurring can be perceived positively and in a qualitative study of Australian social workers, Graham and Shier (2009) found that having a variety of roles in practice contributed to the subjective well being of participant social workers.

## 2.8 Social Work Contribution to MDT's

Social workers have been seen as having skills appropriate to multidisciplinary team work (Frost, 2005). In a United Kingdom qualitative study of social work on multidisciplinary teams argues that social work as a profession is well placed to negotiate between professionals and between professionals and families (Frost 2005:195). Asquith et al (2005) in a review of the literature, concludes that social workers can and do work well in multidisciplinary contexts. Barnes and Hugman (2002) describe social work as "*unique in the breath of its mission*" concerned with enhancing the well being of people while placing emphasis on the social contexts of their lives.

However a number of studies have found that multidisciplinary team working creates particular stress for social workers (Frost, 2005; Yip, 2004, Carpenter et al 2003). There is evidence that models of professional practice vary, there are differing explanatory models of practice, the "social" model which is described as subservient and the "medical" dominant model. It is important that there is an "*acceptance of difference*" to enable workers to "*embrace diversity while not sacrificing those beliefs which underpin their commitment*" (Frost 2005:191). The issue of clashing values between social and medical models was also noted as a feature in other studies of social workers on MDT's (Carpenter et al, 2003; Yip, 2004). The medicalisation of social work in the context of dominant medical discourses in some multidisciplinary settings has been described.(Yip, 2004)

However there seems to be an acceptance that there is a value to having social workers on specialist CAMHS teams (Messent, 2000; Walker, 2003a). The medical model has been found to have limits in the area of child and family mental health (Child, 2000) and the presence of a social worker on a multidisciplinary team may provide a social balance. Messent (2000) argues that social workers are in ideal position to spearhead preventative work and in an audit of a CAMHS team that had no social work post he identified areas where the multidisciplinary team felt the lack of social work contribution as child protection; children in need; cases where there was the possibility of court involvement and working with children in care. The value of social

work has been described as having an alternative viewpoint to the prevailing medical model (Messent, 2000; 107). Lask (1994) defined that difference as the continued concern for the interplay of individual, family and community factors.

Ray et al (2008) in a comprehensive review of the research literature see the social work role in adult community mental health teams as providing critical perspectives drawn from a range of social sciences and supporting social models of understanding mental health needs underpinned by a commitment to promote social justice. They see this contribution as crucial at the present time when there is concern for user involvement in service planning and an awareness of the inequity in access to services. Valios (2008) concurs arguing that social workers need to maintain a broad social view of mental health problems especially with regard to concerns about civil rights.

These descriptions of role are broad and it is not clear how providing critical perspectives and supporting social models of understanding mental health are reflected in practice. Evans et al 2006 in a multi method study of mental health social workers in England and Wales assessed burnout and job satisfaction and found very high levels of stress and emotional exhaustion among social workers. This was higher than reported for other professions, social workers perceived their contribution to be undervalued had limited latitude in decision making and were dissatisfied about the place of mental health social work in modern services.

## 2.9 Social Work Values

Although the work of social workers tends to become linked to agency function, there remains a constant commitment to the basic values of social work across different societies; these values include a respect for the inherent worth of all people and a belief in the right to self determination and participation in society (Asquith et al, 2005). Dewees (2004) suggests that the social work commitment to a strengths perspective, social justice, human rights and social construction create a unique contribution to MDT's.

This value base can present challenges for social workers in relation to confidentiality and information sharing as there are differences between social workers and other health workers (Frost, 2005). Walker (2005:247) argues that social workers unique psycho-social perspective rooted in principles of social justice, culturally competent, anti-discriminatory practice and holistic understanding of the interplay between the environment and internal factors affecting young people, is valuable to CAMHS services.

## 2.10 Conclusion

The review of the available literature describes social work as a socially constructed profession, with roles and expectations often constructed outside of the profession itself. There is an inherent conflict between the belief in social justice and the agency functions which may include social control. While offering a socially informed perspective is seen as a valuable contribution to multidisciplinary mental health teams it is not clear how this applies in practice. Social workers have been found experience MDT working as stressful and the lack of role clarity and professional respect seem to be a factor in this. This may relate to changes in the social work role towards a more therapeutic model of practice perhaps increasingly overlapping with other disciplines. There is a lack of a clear role definition for social workers in CAMHS in the literature and a perceived lack of a definition in practice. The lack of social work generated research has been suggested as a factor in this lack of clarity. It has been suggested that social work does not have a research tradition and the lack of a clear evidence base for practice is seen as problematic.

This research project sought to contribute to the literature by beginning to describe the current practice of social workers in CAMHS from the perspectives of social workers currently in practice on specialist CAMHS teams. Chapter three will describe the chosen methodology for the study.



## **Chapter 3 Methodology**

### **3.1 Introduction**

This chapter will describe the rationale for the research methodology and the process of the research. The literature review pointed to the social construction of social work as a profession and the perceived difficulty for social workers of having their role defined externally to the profession in response to contextual factors. This was found to have particular relevance for social workers in medically led multi disciplinary teams. The objective of this study was to describe and explore the perception and experience of the role of social work in multi disciplinary CAMHS from the perspective of social workers currently in practice on such teams.

The literature also suggested that the social work contribution to multidisciplinary teams can be around offering a different more holistic perspective and a concern for social justice. Consideration of the research strategy reflected the desire to enable broad range of in-depth data to be collected that would allow participants fully describe their perception of their contribution to the CAMHS service users.

### **3.2 Research Objectives and Questions**

This research project sought to investigate whether there is a specific social work role in multidisciplinary CAMHS teams in the ROI by describing the current practice of social work in CAMHS and exploring the perceptions/experiences of social workers currently working on CAMHS teams of their role. The research also sought to ascertain what, if any, additional training had been undertaken by the participant social workers and to explore to what extent this impacts on their role on the team. The study sought to explore the extent to which social workers in CAMHS saw research activity as an element of their role and sought their perception of the particular contribution of social work to the multidisciplinary team.

The study asked

- What is the social work perception of the current practice of social work in CAMHS including their views about social work generated research activity?
- What, if any, further training has been undertaken by the participants and the impact of this training on their role?
- What do social workers see as their particular contribution to the service offered to CAMHS service users?

### 3.3 Research model/design

There are two distinctive clusters of research strategy, quantitative and qualitative (Bryman 2008). The quantitative strategy employs measurement, using a deductive approach to the relationship between theory and research and embodying a view of social reality as objective. A positivist paradigm underpins this research strategy and the intention is to seek “*explanation, verification and prediction of human behaviour*” (Ulin, Robinson, Tolley, 2005) A quantitative approach was considered initially for this study. The author had explored the possibility of using a questionnaire to survey the total population of social workers in CAMHS. The data collected could be descriptive of numbers of cases, types of intervention undertaken and other quantifiable data. It was felt that while this could produce a description of workload and work practices, it would not reflect the experience of the role or answer the research question in depth.

Qualitative research strategies are described as emphasising words rather than quantification, using an inductive approach to the relationship of theory and research and concentrating on the individual’s interpretation of the social world which is constantly shifting (Bryman, 2008). Qualitative research is interested in meanings, concepts and descriptions of things (Berg, 1989). An interpretivist paradigm underpins such research;

qualitative research seeks to discover, understand and gain insight into the circumstances of human behaviour. (Ulin, Robinson, Tolley, 2005).

While there are many debates in the literature as to which research strategy is best, Sackett and Wennberg (1997) argue that a focus on whether qualitative or quantitative research methods are “best” is unhelpful and the question should be which research strategy will best answer the research question. The consideration of research design and methodology was informed by the literature and research questions.

As described in the literature review, social work is seen as a socially constructed profession which is carried out in relationship with the service user and does not lend itself to quantification. Professional role tends to be experiential and difficult to define in objective terms and a qualitative approach seemed to present the more appropriate strategy to explore the social work perception of role. The literature search has shown that there is very little written about the role of social workers in CAMHS internationally or the current practice of social work in CAMHS in the ROI. The author chose a descriptive model of research to obtain a base description of the current practice. Descriptive research describes the phenomenon of interest and can provide valuable information about the characteristics of the population (Bowling: 2005). It is the “*method of choice*” when straight descriptions of phenomena are desired (Sandelowski, 2000:334). Mark (1996:25) recommends descriptive research when we have limited theory to work from or when we are beginning to explore a new area that has not been researched before. This study was seeking to describe and explore a new area.

There were also exploratory elements to the study seeking to explore social workers views of research and their perception of the particular contribution of social work to the MDT. A descriptive qualitative design was chosen to gain in-depth data as to the participant social workers’ perception and experience of the practice of social work in CAMHS using a semi-structured interview.

### 3.4 Sampling

There are 47 CAMHS teams in the ROI. Services are provided directly by the HSE in some parts of the country and by voluntary providers in others. Not all teams have a social worker in post. Some teams have more than one. There appear to be significant regional variations. The IASW is the social work professional organisation and has a special interest group, of social workers in CAMHS. This group's most recent directory suggests that there are 69 social workers employed in CAMHS. Participants were contacted using this directory and although the directory is the public domain gatekeeper permission was sought to use the directory from the chairperson of the special interest group.

To ensure protection of the participants, the chairperson of the IASW special interest group was approached and agreed to act as gatekeeper (see letter to gatekeeper appendix 5 and letter from gatekeeper appendix 6). To avoid any risk of coercion, the social workers to whom the researcher is line manager were excluded from the study. All other current social workers in CAMHS were contacted through the gatekeeper and invited to express an interest in the project. (Invitation letter, appendix 2; participant information leaflet appendix 3). 60 potential participants were contacted.

Morse (2001) outlines five factors to consider in designing sample size; the scope of the study, the nature of the topic, the quality of the data, the study design and the use of shadowed data. Shadowed data refers to data generated when participants speak of others' experience as well as their own experience. Interviews generate in depth data and very large samples are not necessarily needed and for phenomenological studies the typical sample size is one to ten people (Starks and Brown Trinidad, 2007). The target sample for this study was ten participants. This study also generated a considerable amount of shadowed data.

As there were 17 expressions of interest, purposive sampling was used to select participants from each HSE region and the non HSE service providers. There were 10 participants representing three employing agencies and four HSE regions. Where more than one social worker from

the same team/area expressed an interest in participating, the person who made contact first was chosen.

### 3.5 Data collection

The two data collection methods considered for this study were focus groups and semi structured interviews. While focus groups are a useful way of exploring non-sensitive, non controversial topics there is risk of less depth in the data collected. For this study, the geographical considerations were also felt to be important as convening a group representative of the regional variations was likely to prove difficult.

It was felt that semi structured interviews would offer the best method to answer the research question and be most convenient for participants. Semi structured interviews are interviews where the interviewer has a series of questions in the general form of an interview schedule but the sequence of the questions can be varied. The questions are open ended and general in their frame of reference and the interviewer can ask further questions in response to significant replies (Bryman, 2008). The semi structured interview is felt to be most useful when the researcher and participant “*speak the same language*” (Stier-Adler, Clarke 2003, 283) which was the case in this study.

A semi structured interview allows freedom to digress and reflects an awareness that individuals understand the world in varying ways (Berg, 1989). It was felt that semi structured interviews would allow a broad exploration of the questions in keeping with a qualitative research strategy. Mark (1996) points out that semi structured interviews allow the researcher to probe for understanding and enable the participants to expound on their answers and to raise other points of relevance. However, researcher values and perception can colour the data and interpretations (Mark, 1996) and the data collected is substantially influenced by the nature of the interaction between interviewer and interviewee (Tutty et al, 1996).

Brett Davies (2007) points out that “*at its best, the method can lead to significant advances in our theoretical understanding of social reality*”

and “*is particularly good at enabling the researcher to learn at first hand about people’s perspectives on the subject chosen as the project focus*” (2007, 29).

The interview, (approx 40 minutes) sought information about the caseload and types of intervention that participants are engaged in. Information about what, if any, further training participants have undertaken and their perception of the impact of this training on their role within their team was also sought. The participant’s view of the particular contribution of social work to CAMHS teams and of research was also sought.

### 3.6 Interview schedule

The interview schedule (appendix 1) was created to provide a guide and prompts for the researcher to ensure all participants were asked about all areas of interest. The schedule was tested on two quasi participants (social workers in CAMHS who were not participants in the study) to ensure common understanding of the questions and assess whether the schedule gathered the data to answer the research questions. The schedule was altered slightly to include an open question asking participants what else they saw as part of their social work role that had not been already discussed. This question gleaned interesting data about a variety of additional roles that were unique to individual participants that would otherwise not have been discussed.

10 participants were interviewed and each interview lasted 35-45 minutes. Four interviews were conducted by telephone with geographically distant participants. The face to face interviews took place in a public place of convenience to the participants at a time of their choosing. All interviews were audio recorded with participant permission. The telephone interviews were audio taped using the loudspeaker function on the telephone.

The taped interviews were transcribed by the researcher. All identifying information was removed and the transcripts identified by codes. The codes were stored separately to the transcripts. The computer used is encrypted and password protected to the highest available standards to protect participant information. The study data was saved in a password protected file. The retention of data adhered to best practice in accordance

with the Data Protection Act (2005, amended). Data was held in secure storage in the investigator’s workplace. Audio records were destroyed when the analysis was complete and only anonymised data retained.

### 3.7 Data Analysis

The transcribed data was analysed using thematic analysis. Qualitative data analysis is an ongoing process which commences as the data is generated and shapes the ongoing data collection (Pope, 2000) Formal analysis involves moving from the raw data to meaningful understanding and requires rich engagement with the raw data (O’Leary, 2004). Systematic, rigorous analysis allows qualitative research “*to document its claim to reflect some of the truth of a phenomenon by reference to systematically gathered data*” (Fielding, 1993; 155).The method used in this study was template analysis.

Template analysis, as described by King (2007) is a seven step analytic process which involves the development of a template which summarises themes identified by the researcher as important in a data set and then organises them in a meaningful manner. Initially themes likely to be relevant were derived from the literature which formed the basis for the interview schedule. These broad themes were used to generate *a priori* codes. These codes were then applied iteratively to the data *in vivo* to produce the final template which was then applied to the data. A detailed description of the application of template analysis to the study data is given in chapter four.

The seven steps of template analysis are described in Table 3.1

**Table 0.1 Steps of template analysis process**

Step 1	Definition of “a priori” codes likely to be relevant from the literature and researchers own experience
Step 2	Transcription and familiarisation with the data
Step 3	Initial coding of data

Step 4	Development of initial template
Step 5	Application of initial template to data set generating in vivo codes
Step 6	Development of final template
Step 7	Quality check

### 3.8 Ethical considerations

Ethical approval was sought and granted from the ethics committee in Trinity College Dublin (TCD) (Appendix 7). The IASW does not have a separate ethics process and accepted the TCD approval. Due to the risk of any sense of coercion, social workers to whom the researcher is line manager were excluded from the study.

Confidentiality was one of the key ethical considerations for this project. As described above, the project was conducted with a high level of regard for the protection of participants’ confidentiality with the use of identifying codes and significant attention to computer security.

Informed consent was another area requiring attention. Potential participants were contacted by letter from the gatekeeper with the full participant information and asked to contact the researcher directly if interested in participating in the project. On contacting the researcher, potential participants were offered the opportunity to clarify any aspect of the study. Those participants that continued to express an interest were then contacted again two weeks later to arrange a time to conduct the interview. All participants signed a consent form prior to interview (Appendix 4). A consent form was sent to those participants who were interviewed by telephone and the telephone interview was arranged on receipt of the signed consent form.

It was felt that there were unlikely to be significant risks attached to participating in the study. As this study sought to describe the participant’s role within the multidisciplinary CAMHS team it was not expected that distress would be caused. In the unlikely event of distress, it was planned that the interview would be stopped and the support of the occupational

health department would be offered. There was no distress caused during the study. There were no sensitive issues discussed.

In the event of any disclosure indicative of bad practice during the interview it was planned to make a report to the appropriate authority. No such report was necessary as no such disclosure was made.

There were no direct benefits to individual participants. Dissemination of the findings could possibly lead to improved clarity around the social work role in CAMHS and thus have a positive influence on the experience of all social workers in the field.

### 3.9 Rigor and Robustness

There are differing views about the criteria for evaluating qualitative research. There has been a view that qualitative research requires a different set of criteria from quantitative studies. Yardley (2000) proposes sensitivity to context, commitment and rigor, transparency and coherence and impact and importance as the criteria by which qualitative studies should be judged. D'Cruz and Jones (2004) describe reliability, internal validity, generalisability and objectivity as key criteria. These criteria are paralleled by the trustworthiness criteria described by Guba and Lincoln (1994) who also describe authenticity as important.

Trustworthiness has four elements credibility, transferability, dependability and confirmability. Bryman (2008) argues that credibility parallels internal validity which refers to the extent to which the interview measures what it is supposed to measure. In this study the interviews generated data which answered the research question and so can claim credibility.

Transferability parallels generalisability which refers to the extent to which the data gathered can be said to be representative of the wider group of social workers in CAMHS. This study cannot claim generalisability but as pointed out by Tully et al (1996) this is less important in qualitative studies which provide a rich, in depth understanding of the phenomena being studied.

Dependability parallels reliability which refers to the extent to which the data collection method is stable and consistent and could be repeated. Qualitative interviews are of their nature a subjective experience between the researcher and the participant however in this research the interviews generated a marked commonality of themes among the participants which suggests the interview schedule as used in practice was reliable.

Confirmability parallels objectivity and is concerned with ensuring that while recognising that complete objectivity is not possible in social research that the researcher has not overtly allowed personal bias to impact on the conduct of the study or the findings.

The authenticity criteria (fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity) suggested by Guba and Lincoln (1994) refer to the wider political impact of the research and its contribution to change and are thought to be somewhat controversial and of more relevance to action research projects (Bryman, 2008).

### 3.10 Limitations

As this research sought only the views and perceptions of social workers it reflects only that view. The view of other stakeholders such as service users, other members of the multidisciplinary team, referral agents and employers was not sought.

The practice of CAMHS teams varies depending on the team composition and skill mix, availability of other services in the community and historic service development issues. This study did not have the scope to explore any potential impact of these factors.

Chapter four describes the data analysis and findings of the study.

## Chapter 4 Data Analysis

### 4.1 Introduction

This chapter describes the findings of this qualitative study which aimed to describe and explore the current practice of social work in specialist CAMHS teams in the ROI. A brief description of the participants will be given. Geographical locations and service providers will not be named with regard to the need to maintain participant anonymity. The application of template analysis to the data in this study will be described and the findings outlined thematically.

### 4.2 Participant Profile

This study sought to recruit participants from CAMHS teams in the ROI. Letters were sent to all social workers currently working in CAMHS teams, who were listed in the directory produced by the special interest group of the IASW, inviting expressions of interest in the project. The letters were sent by the chairperson of the IASW who acted as gatekeeper. Social workers to whom the researcher is line manager were excluded from the study. In total sixty social workers were invited to take part in the study.

There were seventeen expressions of interest from which ten participants were purposively selected. Selection was based on a desire to include participants from a range of service providers and regions. When there were multiple expressions of interest from an area or agency, the first participant who expressed an interest in taking part was selected. Broad geographical and agency representation was achieved.

The participants represented three grades of social workers. There were four male and six female participants. The participants had many years experience. Table 4.1 outlines the grades and experience of the ten participants; gender, employing agency and geographical area are not included to avoid risk of identifying participants.

**Table 4.1 Participant Profile**

Code	Grade	Years of experience in CAMHS	No. of SW colleagues on team (shadowed information)
P01	Senior	10	+1
P02	Senior	1.5	+2
P03	Senior	10	+5
P04	Senior	11	+1
P05	Professionally Qualified Grade (PQSW)	3	+1
P06	Senior	3	+1
P07	Principal	10	+1
P08	Principal	14	+5
P10	PQSW	4	+5
P16	Principal	5	.5

None of the participants works as a single handed social worker.

Shadowed data was also gathered. The composition of the teams differed.

The presence of psychologists, nurses, child care leaders, speech and language therapists and occupational therapists on the teams varied across the sample. There were regional variations in the position of the CAMHS team in the overall network of services which was dependant on the

availability of community psychology teams, family support services and specialist autism services in each region. The researcher was not in a position to analyse these regional variations.

Five interviews took place in the participants' place of work, one in the researchers place of work and four were conducted by telephone. There was good rapport with the participants.

### 4.3 Analysis Methodology

When choosing a methodology to inform the data analysis, consideration was given to framework analysis, grounded theory and template analysis. Template analysis was felt to be most appropriate as the researcher's experience and the literature review had suggested a priori themes as likely to be relevant and there was a desire to also generate themes in vivo from the data. The analysis was done manually using colour coded matrices.

#### 4.3.1 Template Analysis

Template analysis as described by King (2007) has seven elements which were applied in this study as follows;

#### 4.3.2 Definition of "a priori" or top down codes

Themes likely to be relevant to the research question were identified from the researchers experience and the literature. These codes had also informed the interview schedule (appendix 1). The a priori codes were identified as outlined in table 4.2

**Table 4.2 A priori codes**

THEMES (RELATING TO RQ1)	<ul style="list-style-type: none"> <li>• Team process, referral routes etc (generic/specialist)</li> <li>• Intervention models/focus</li> <li>• Child protection</li> <li>• Values/theories/worldview</li> <li>• Non direct work social policy/education/research</li> </ul>
THEMES (RELATING TO RQ2)	<ul style="list-style-type: none"> <li>• Therapy or social work/ social work as therapy</li> <li>• Lack of clarity as to “generic” SW role in CAMHS</li> </ul>
THEMES (RELATING TO RQ3)	<ul style="list-style-type: none"> <li>• Social model/ critical perspectives/ alternative view social work values</li> <li>• Role blurring on multi disciplinary teams</li> </ul>

### **4.3.3 Transcription and Familiarisation with Data**

The researcher listened to all taped interviews twice before transcription. The researcher then transcribed all interviews to enhance familiarity with the data. Once transcribed, all transcripts were read in depth and segmented to identify what was being talked about in each sentence. A sample transcript is attached (Appendix 9).

#### **4.3.4 Initial Coding of Data**

The segmented data was examined to identify those parts of the transcripts relevant to the research questions. Segments relevant to one of the a priori themes were coded as such. Data that was not relevant to the existing a priori codes was used to modify existing themes or devise new ones (in vivo or bottom up coding); new themes were identified as necessary. In vivo themes generated included external factors, title of social worker and involvement in education as part of the social work role.

#### **4.3.5 Production of Initial Template**

Three transcripts were used to produce an initial template. The many themes identified were grouped into a smaller number of higher-order codes to describe broader themes in the data. These were identified as description of workload, further training in therapy and a social/systemic understanding of children and the problems they present with. Within each broad code there were sub themes identified.

#### **4.3.6 Development of Template**

The template was developed by applying it to the full data set. The template was continually revised and modified to absorb the data from each new transcript. A colour coded matrix was used to apply the template to the data.

#### **4.3.7 Interpretation of Data Using Final Template**

The final template was used to interpret the findings of the study looking at similarities and differences in participants' responses to each theme. An example of participant responses to the theme of child protection is available in appendix 8.

The final template is outlined in table 4.3. The findings will be presented using the identified themes as headings.

**Table 4.3 Final Template**

Question	Theme	Sub-theme
<p><b>Research question 1</b></p> <p>What is the current practice of social work in CAMHS in the ROI?</p>	<p>Description of workload</p> <p>External factors</p>	<ul style="list-style-type: none"> <li>• Team process/referral route/reason for referral</li> <li>• Child protection</li> <li>• Direct-Intervention</li> <li>• Theoretical underpinning</li> <li>• Case work/Group work</li> <li>• Indirect intervention research</li> <li>• Economic factors/ service gaps</li> </ul>
<p><b>Research Question 2</b></p> <p>What, if any, further training has been undertaken? Why? Perceived impact on role?</p>	<p>Further training</p>	<ul style="list-style-type: none"> <li>• Social work as therapy</li> <li>• Title of “social Worker”</li> <li>• Clarity of SW role in CAMHS</li> </ul>
<p><b>Research Question 3</b></p>	<p>Contribution of SW to team</p>	<ul style="list-style-type: none"> <li>• Psycho social world view</li> <li>• Child protection</li> <li>• Social work values</li> </ul>

		<ul style="list-style-type: none"> <li>• Confusion specialist/generic skills</li> </ul>
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#### 4.3.8 Quality Check

King (2007) stresses the need to ensure that the analysis is not being systematically distorted by researcher preconceptions and assumptions. As a social worker in CAMHS, the researcher needed to be aware of potential bias in the data collection and analysis. The researcher assumptions were taken into account by being specified as a priori codes. There was significant attention paid to both confirming and non confirming data to ensure that the a priori codes were valid. The in vivo codes were generated from the data. The systematic coding and logical inductive approach to generating themes also provided protection against bias. Reflexive questions and discussion with the research supervisor were employed to ensure quality.

#### 4.4 Findings

The study findings will be presented thematically with reference to the research questions and as interpreted using the template analysis as described. The practice of social work in CAMHS, the further training undertaken by participant social workers and the social workers' perception of their contribution to the service will be reported.

#### 4.5 Description of Workload

The description of the workload of the participant social workers will be presented in terms of referral routes, presenting issues and direct and indirect intervention. The impact of economic and other external factors on the workload will be described.

#### 4.5.1 Referral Routes to Social Work

There are two referral routes to social work within specialist CAMHS teams with some variation in relation to emergency referrals. All of the participants report taking on routine cases for assessment at the point of referral. This is, in most cases, from the team/referral meeting and on one team directly from the consultant,

*“most of the referrals would come through a referrals meeting, we have an allocations meeting once a month and cases would be allocated” (P03; SSW).*

The frequency of allocation varies from weekly to monthly and in all but one team new referrals are discussed by the MDT and allocated as deemed appropriate with reference to the team’s priorities. The team meeting discussion enables all newly referred cases to benefit from indirect input by all disciplines. One team is described as *“very consultant led” (P10; PQSW)* and referrals are decided upon by the consultant alone.

The team meeting is also used to ensure multi disciplinary discussion of all new cases after initial assessment.

Social workers on CAMHS teams also get referrals from within their teams when a colleague has done the initial assessment and feels further intervention is necessary as described

*“there would also be cases where I would be drafted in at a later point, for example, we have a rotating registrar post here and sometimes I might be drafted in to co-work with a registrar or to take over a case after a registrar has left” (P08;PSW)*

The involvement of social workers in the assessment of children and young people presenting in an emergency varies. On some teams it is primarily a role for the psychiatrists

*“if it’s questions around suicide and self harm, psychiatry tend to mop those up” (P01;SSW)*

whereas on others

*“we have emergency slots that are set aside and ring fenced and two team members deal with emergencies then...it could be psychology and social work.... psychology, social work, psychiatry- two of those three-and not necessarily involving psychiatry” (P02; PQSW).*

#### 4.5.2 Presenting Issues

The reasons for referral to social work within CAMHS are varied across the teams studied. The participant social workers offered service to a broad range of presenting issues. There were reports of initial allocation being more dependent on capacity than discipline

*“the way that the service operates here is there wouldn’t be a massive demarcation at the point of referral in terms of your discipline so everybody at the team meeting, depending on who has capacity, would take on cases. “(P07;PSW).*

Participant social workers found it difficult to define the rationale or criteria for social work involvement in cases although psycho social and family issues were seen as an important factor

*“Social work does take maybe a lot of the traditional psycho social type cases if it’s unclear about the school issues if they are around psycho social issues- if they felt there was a big family issue involved I think if they felt there was a big family piece or the parents needed support”. (P06; SSW)*

However, there were many reports of complex family situation, longer term intervention and the involvement of child protection services being a factor in the referral of cases to the social workers in CAMHS.

*“ well it’s interesting that like there isn’t really ah criteria around when people would ask social work to become involved ahm I suppose what would happen is in the situations where there are maybe complex family issues” (P07:PSW) –*

#### 4.5.3 Child Protection

The involvement in cases of child protection is reported to vary across teams and individual workers. There were ten interviews conducted and a

large amount of data gathered. It was no feasible to report all of the participant responses within the word limit. Appendix 8 outlines the broad range of responses in relation to the theme of child protection. The main findings will be reported without the supporting quotations.

Some participants reported a change in practice in relation to child protection concerns with other disciplines becoming increasingly comfortable with dealing with child protection concern in their cases.

Many participants described a consultative role with their colleagues but this consultative role was not universal. On some teams the direct involvement of social workers continues to be sought

Individual social workers had differing views on whether CAMHS social workers had a role in this area with some participants valuing child protection as an area of clear social work expertise and others seeing it as an area of responsibility for all clinicians.

#### 4.6 Direct Intervention

Direct intervention refers to face to face contact with children and their families. Social workers in CAMHS work jointly with other professionals and work independently with children and families, this seems to depend individual team process and on demand for service and individual skills and interest. On many teams there is an effort to provide some multi disciplinary input at the assessment stage.

*“initial assessments here are nearly always done with one psychiatrist and one member of the broader multidisciplinary team” (P05;SSW)*

However, the need to get children and families seen and off the waiting list seems to have created some changes in practice.

*“Ideally in the past we would have tried to take on – you know that two different professionals would take on a new assessment but because of now- the urgency- we are trying to get people seen -anyone who has space and time” (P04;SSW)*

All social workers reported a mix of individual and joint working,

*“my work would break up into cases that I would be doing an independent piece of work on. I suppose ahm where I might be doing a piece of work with a family and at the same time there may or may not be another clinician working with that child or family kind of independently of each other. Then there would be cases that it would be co-working with someone, like most of the sessions we would be both involved in and then there are also cases where I would be more peripherally involved”*  
(P10; PQSW)

While social workers in CAMHS report working with parents, children and external agencies, the main focus of intervention reported by participants in this study is with parents and families

*“I..probably predominantly see families; I would also see young people individually, I would see parents by themselves”* (P02:SSW)

There was some suggestion that this focus is an historic one

*“I’d moved from adult because I kind of wanted to work more with children and found when I got here I was working less with children because it didn’t seem to be at that time what social workers did in the service-social workers were seen to work with parents and that kind of idea and that’s has changed a fair bit now- even since I’ve been here”*  
(P10: PQSW).

One participant described how social workers are perceived to have particular skills in working with parents

*“well we would have a role with young people and other professional would have a role with parents but we would be generally considered to be the ones most qualified and the ones most skilled at working with parents”* (P05: PQSW)

There were also reports of a desire to intervene at the parental/family level due to a belief that the child’s social context is of significant importance in understanding the mental health needs of children and in effecting change for children.

*“often the difficulties described turn out to be difficulties that the parents have rather than difficulties that the child has and often the child is either acting out or proving difficult because of other issues or difficulties in the family either because of inconsistent parenting or ahm the fact that parents are going through difficulties and the children are acting out but the parent sometimes prefer to see the child as having the problem”*  
(P16:PSW)

This focus on parents is not to the exclusion of direct work with children and young people. The broadening of role to include direct work with young people was described by one participant as something that had to be established although it is now accepted on all teams that were part of this study.

*“when I came to this service first I was very I was very aware through my role with the CAMHS subgroup of the IASW that in some agencies, social workers have the role of seeing the parents only and I was very clear that I would not be stuck into that pigeon hole so what I have been able to do here and in fact it has spread to the whole department of social work within this agency is that we all get to see a mixture of the child or the parents or the family or to work with schools and to do school observation”* (P 03: SSW)

There was a report from one service that resource availability was a factor in determining the focus of intervention.

*“the service at the moment and the lack of resources that we have means that we don’t have the same capacity in terms of individual longer term work with children than we would have if we had more resources”*  
(P07:SSW).

The two primary methods of intervention reported were casework as reported above and group work. In some teams the organisation of groups is seen as a social work responsibility.

*“I would have taken a lead role, as I say, in the setting up of groups and getting things running and maybe that’s part of who I am but I think my skills like organisation skills, co-ordinating, you know leadership skills -*

*all of those- mean I would have taken on a lot of responsibility's in the service d' you know (P04: SSW).*

The participant social workers were involved in group work with children and young people around a range of issues primarily in relation to social skills development and emotional regulation.

*“I run groups for adolescents and groups for younger children in relation to social skills” (P16:PSW)*

There is also significant involvement in running parenting skills programmes

*“the role would also be then in helping to run parents groups” (P01: SSW)*

#### 4.6.1 Theoretical Underpinning

Social workers on CAMHS teams report working from a broad theoretical base related to their social work training, further training and reading around particular presenting issues.

*“theories of human behaviour and social systems theory ahm and just where social work comes in, you know, where people to interact with their environments we would have studied that in our social work training there also psychological theories you know I would end up reading books a fair few psychology books” (P06: SSW)*

The two most commonly reported theoretical stances were systemic theory and attachment theory influenced by social constructionism, anti-oppressive practice and the strengths perspective.

*“I suppose I would be very influenced by attachment theory, by systemic family therapy” (P07: PSW)*

*“ I work from a strengths perspective and brief solution focused work” (P06: SSW)*

#### 4.7 Indirect Intervention

Indirect intervention refers to contact on behalf of service users and intervention at a community wide level. Indirect work also includes involvement in education, research and policy development. The main indirect interventions on behalf of service users reported were involvement with schools and other agencies both on behalf of individual service users and at a whole school level.

*“contact with the schools in the past would have been constructive, I mean, I would have gone out and spoke on say mental health promotion programmes and I was giving talks in local secondary schools maybe on eating disorders or dealing with depression as part of their mental health module” (P04: SSW)*

At a community level there were also reports of joint working with other agencies around particular projects.

*“I would be the link person here I meet regularly with community care social work services and family support services-I am becoming involved to in the leadership forum which is around looking at the development of community resources” (P07: PSW)*

Involvement in education and social policy areas were also reported.

All participant social workers have had social work students on placement at some time although not all in their current post and all see practice teaching as an important part of the role.

*“the practice teaching bit -because that’s something that’s an important role on the team it increases your number of social workers on the team and other team members see the quality of social work students coming through so that kind of an area that ahm I would see as an important part of my social work role” (P10: PQSW)*

Issues of lack of space and perceived lack of value by the multi disciplinary team were cited as barriers to offering placements by some participants

*“I couldn’t do it when I wasn’t able to get office space for a student” “it depends on the consultant whether practice teaching in social work is allowed you know, in a subtle way- because sometimes I think- I’ve noticed that consultants expect a certain amount of students which they get from a psychology student which is at a very different level and has different needs and they get from a registrar and they then want value for money from a social work student – they are not willing to let a social work student be a student, they expect a level of expertise from day one” (P16: PSW)*

Four of the participant social workers reported lecturing on third level courses on child care and social work courses around a range of child mental health related topics and see this broader educative focus as an important element of the role.

Participant social workers also report involvement in policy development at a local and national level. One participant is also a member of the national forum working towards the implementation of the Vision for Change (DoHC, 2006) policy

*“I would have been part of writing the strategy for the development of mental health in this part of the world which went into the national document for the country and I was part of that for a couple of years ahm so I would have an interest in the looking outside of the team and being part of groups” (P04:SSW)*

#### 4.7.1 Research Activity

Research activity is not seen as an integral part of the social work role by social workers in CAMHS although it is an acknowledged area of interest to other disciplines within the services. There is a common sense that social work training does not equip social workers with the necessary skills to conduct research in practice.

*“we don’t have that kind of tradition or conditioning in social work I think is no reason why we couldn’t do it” (P08:PSW)*

There were also reports of a perception that social work as an activity does not lend itself to research in the accepted randomised control trial methodology.

*“I’m not sure for me how well traditional notions of research fit with the kind of work that I see myself doing -or fit for me really-and I mean the traditional notions of research I guess. And I suppose I think differently about evidence base which is obviously the big buzz word at the minute and I would probably have a wider idea about what evidence is than what I would hear other disciplines having” (P10:PQSW).*

Three participants reported having been involved in direct practice based research and while no participant reported an agency expectation of research as part of the social work role there were no reports of agency resistance social work driven research.

#### 4.8 External Factors

There were reports of a significant impact on the development of social work practice reported in relation to factors external to the team. The presence or absence of community psychology teams, the availability of local community resources and the development of primary care/early intervention teams were reported to impact on the work of the CAMHS team and that of social work within the team.

This was evident in working with preschoolers on one team

*“for starters we don’t get a lot of referrals of that age group and there is an early intervention service which has been set up within the past year or so -separately and with their own multi disciplinary team” (P08:PSW)*

Relationships with other service providers in the network also seemed to have an impact particularly relationships with adult mental health and child protection services.

*“In relation to the age at which a child gets seen by adult services there are huge issues and huge conflict between adult psychiatry and child psychiatry in this particular region” (P05:PQSW)*

*“there could be a messy family situation and I could turn around and say yes I’ll give that one a lash someone else might saying well you know looks like we’re going to need to be making a referral to the community care social worker on that one so if there is a social worker involved from here they are less inclined to pick it up so maybe we hold off on a social worker on that one” (P05:PQSW).*

The current economic climate, the emphasis on managing waiting lists/counting contacts was reported to be impacting on social work practice. Restrictions on travel expenses in some parts of the country have led to less school and home based work.

*“there used to be in the past you would go to schools and it would be very hands on it used to go out to you know even with the school refusals go to the house and model how to speak to a child but get them motivated and out of bed to go to school to get them ready ahm those kind of roles are harder to implement now - for the last year you were not allowed to travel” (P16: PSW)*

The focus on reducing waiting lists by increasing throughput was described by many participants.

*“so, you know, we have a long waiting list. We are under a load of pressure in terms of getting people seen so that does influence in terms of the nature of the work. We would be a lot more focused on specific pieces of work and emm sometimes having to say well we can’t offer anymore at the moment -trying to get the balance between those on the waiting list waiting for service and those who are getting a service (P08:PSW).*

However, there was concern expressed as to the impact of this change in practice for social workers

*“well, over time, if it is changing more towards a quick turnover of cases, social work may have to think about what is the unique contribution to the team” (P01: SSW)*

## 4.9 Continuing Professional Development (CPD)

### 4.9.1 Social Work as Therapy

All of the participants had some form of further specialist training some had more than one form of further training. Participants had pursued further training in a range of therapeutic modalities including systemic family therapy, cognitive behaviour therapy, Marte Meo therapy, reality therapy and play therapy. The reasons reported for pursuing further training included agency expectation, lack of confidence in role, desire to enhance therapeutic skills and a desire for role clarity.

There was a common experience of social workers in CAMHS feeling that a therapeutic qualification in addition to the original social work training was necessary within the agency.

*“It’s not good enough to be professionally qualified to you need to be doubly qualified and it’s not good enough just to base yourself on being a social worker you have to be a social worker with an edge” (P16: PSW)*

There were also reports of a desire to enhance confidence and sense of having a valuable skill to offer

*“I suppose that there is a confidence thing if you know that you have a certain training under your belt that then you can work with the greater sense of all of authority about what you do” (P08 PSW)*

Participant social workers also reported being unsure as to their role and contribution and looking to further training to establish a clear role.

*“to be honest actually you know when I came here first I felt really unskilled I didn’t know what my role was” (P10:PQSW)*

There was also a common description of a desire to develop therapeutic skills to enhance the service available to service users. Participant social workers also described a desire to specialise in *“therapeutic social work”* by further training in therapeutic modalities.

*“to get some therapeutic skills to decide if I wanted to stay in therapeutic social work” “there is a difference between being a social worker and*

*being a therapist. Being a social worker we have therapeutic skills but I don't think we are really full blown therapists" (P05: PQSW)*

Systemic family therapy was the most common form of further training undertaken; six participant social workers had training in this intervention. The choice of family therapy was reported to reflect both a belief that the mental health needs of children and adolescents are closely linked to their families and a sense that family therapy fit well with social work training.

*"maybe it's common sense to me in some ways you can't but see a child with in the family context if you want to achieve change I suppose"*  
(P16:SSW)

*"that's what social work is kind of about it seemed to fit and felt very social work. And it felt like that's what I was doing a lot of the time anyway was unqualified family therapy or therapeutic family work or whatever (P10:PQSW)"*

Cognitive behavioural therapy (C.B.T.) was the choice of three participants and seemed to reflect a desire to work therapeutically directly with service users.

*"So I thought the CBT made a lot of sense in terms of my own outlook and how I work- solution focused work and ahm I wanted to do further training so this course came up" (P06:SSW)*

The impact of the further training on the social work role was variable. Some participants reported minimal impact on their role

*"in some ways I suspect that a lot of what you might end up doing might not be hugely different than what you would have been doing originally"*  
(P08:PSW)

while others reported that the training had a significant impact of the work they did.

*"I would be asked to get involved maybe later on because of my family therapy training -there would be a difference made there I would get a case sometimes where someone is seeing them for CBT and feel that*

*family issues have arisen I would see them because I'm a family therapist not because I'm a social worker" (P05:SSW).*

On some teams, family therapy trained social workers offer family therapy in conjunction with other colleagues who are also systemically family therapy trained as a major part of the role.

The current pressure to increase throughput was described by one participant as impacting negatively on the capacity to offer specialist intervention

*"sometimes I would do some play therapy sessions with children but the type of course I did was more non directive or client centred therapy so that's often long term play therapy and the dilemma is that you see a boy or girl for the equivalent of two sessions by the time you get the room ready and tidy up you could fit two others in- so there is that pressure around seeing people".. " there is always that dilemma about using your specialist training to its full advantage"(P01: SSW)*

#### 4.9.2 Title of Social Worker

One significant impact of further training was reported as the use of the title of social worker and the sense of professional identity as a social worker. While some social workers reported a desire to maintain the title of social worker

*"I am mindful that I don't want to go off and be a therapist and not a social worker "(P05:SSW)*

others reported the use of a dual title

*"I use both terms social worker and family therapist "P03: SSW*

Some participants raised questions as to the identity of social work as a profession within CAMHS in the context of further training in family therapy.

*"I think that I see myself – I seem to have to spend as much time training in family therapy as I did in social work. I think in terms of what I do when I meet client I am probably more influenced by my family therapy*

*training than my social work training although my social work training is indelibly enmeshed in that ahm..but I think sometimes it can create a bit of -a kind of multiple identities are floating around when we consider ourselves” P02: SSW*

The issue of the public perception of social work was also raised

*“But I think often it’s ( use of title as therapist) used to get round the uncomfortableness of how do we explain to a family that we are bringing in a social worker but isn’t a social worker in the way people think of social workers if that makes sense” (P16: PSW)*

#### 4.10 Particular Contribution of Social Work to CAMHS

The participants had clear views about the particular contribution of social work to CAMHS in relation to offering a psycho social viewpoint to compliment the dominant medical view. Many described offering a different voice. Social work values and skills around collaborative work with parents were also seen as offering a valuable contribution. There were frequent reports of skill blurring between disciplines and at times, participants struggled to identify that which is uniquely a social work contribution. It was acknowledged that many of the social work contributions are not unique to one discipline. The views around contribution were also coloured by the participant’s further training and interests.

##### 4.10.1 Psycho social Viewpoint/ Alternative Voice

All participants report offering a psycho social viewpoint as central to their work. This viewpoint is described as

*“I think maybe a wider more systemic understanding maybe of not only the individual internally and externally – how they are influenced by and are influencing things but also the family, community issues like poverty issues, like ill health. In some ways it’s like the opposite of but complementary to a purely medical model which is quite reductionist because you are trying to reduce it to the lowest common denominator to make a diagnosis” P07: PSW*

The fact that social workers on CAMHS teams do not tend to use a diagnostic framework such as the International Classification of Diseases (ICD 10) was seen as a benefit

*“it means we are not distracted by it so when we are sitting down with a client, with a mom, with a dad, with a kid, with a stroppy teenager with whoever it is ah we don’t get tied up in diagnostic questions but can explore the totality of the experience of attending for the child and parents and getting into the nitty gritty emotional world of the client and we can do that – I’m not saying other people can’t do it – but I think it’s very much drummed into us in our training and that’s what we’re about”*  
(P05:PQSW)

Participant social workers also describe having a different voice or perspective as important

*“our job is to identify the perspective that is not being articulated and articulate that perspective and that would be common when people are giving out about dad’s or the young person to come in and say God it must be hard for that family, we can see splitting and see where it’s coming from”* P05:PQSW.

Participant social workers understand child mental health difficulties in the context of a child’s family and community life and perceive this as a crucial contribution to the assessment and intervention process for children and families.

*“ I think it’s like go back to the start of what I said, a lot of the problems come from the context of being in a family, in a community, deprivation ah family break up and all those things – a lot of child psychiatric problems don’t come because of some sort of organic problem they come from the hard work of being a kid in a community so I think if you look at it from a very medical model and lose social work that would be a shame”*  
(P16:PSW).

#### 4.10.2 Child Protection

As already described there is a wide variation of social work practice in relation to direct involvement in cases where there are child protection and

welfare concerns. The majority of CAMHS social workers are involved in consultation with colleagues and some become more directly involved in working with families when child protection and welfare concerns arise. For some participants, child protection expertise is the particular contribution to the team (see appendix 8).

#### 4.10.3 Collaborative Work with Parents

Participant social workers describe a particular contribution to the team around a skill and competence in engaging with parents and children and building relationships with service users and other agencies.

*“We bring collaboration with service users -their voice is very very important in their engagement with the service. I also think our approach lends itself very well to interagency work to liaising with people ahm and generally seeing people within their context -seeing a social justice agenda which I think is attached to that contextual piece which is not necessarily part of other people’s approach” (P02:SSW)*

*“also what we are quite good at, it has become clear lately, is keeping parents informed about who is talking to who and ensuring that parents consent to information sharing and working in collaboration with parents. And recently, social work brought a process to the team that before any report is sent out in relation to a child it is copied to the parents without question” (P03: SSW)*

#### 4.10.4 Social Work Values

The value base of social work demands that practice demonstrates respect of the individual and the individuals’ right to self-determination. The adoption of a non-judgmental attitude and attention to confidentiality is also crucial. The participants in this study described social work values as underpinning all of their work and as a particular focus of social work.

*“the respect for people and you know kind of empowering parents and the client self determination and all of those core values -. Social work is also*

*into, maybe you know, advocating for people in terms of equality and anti-discriminatory practice and that does surface for me” (P04:SSW)*

*“it’s an ethic of social justice and human rights (pause)and a holistic view and a systemic view” (P10: PQSW)*

There was an acknowledgement that social work was not the only discipline to work from a value base of respect for individuals, but social workers perceive the value base as central to all of their work.

#### 4.10.5 Generic/Specialist Skills

The participant social workers expressed some confusion in defining the particular role of social work as a discipline on their teams. They described significant similarities in the work of different disciplines on CAMHS teams.

*“ to students on the team it’s hard to distinguish between disciplines- social work and psychology can look very similar” (P01: SSW)*

One participant described a commonality of roles within the CAMHS teams that was very different to social work as practiced in other agencies

*“So there could be more similarities between me and other members of the multidisciplinary teams then there are between me and other social workers” (P 02: SSW)*

Within the areas that social workers see as their particular skill base there is an acknowledgement that many of these skills are shared by other disciplines

*“for me it is a clear role but I do think it merges very much with what other people see as their role within the team which is probably fine you know, but I would find it sometimes hard to differentiate between what it is that we do like for example having a client centred approach, working collaboratively with parents, with the child and other people on the team everybody on this team would say that the same thing- that they do this- you know respect for clients you know empowering the client -all of those*

*that I would have said were part of my role so would anybody else on this team” P04: SSW*

This was a source of potential difficulty for one participant

*“I think that, you know, when you see that people are all on different salary scales and then you have different titles and coming from different experiences were and different managements styles and different ways of line management within a team it can bring up a lot of difficulties when everybody is doing a similar job on the face of it” (P16: PSW)*

Within CAMHS social work there has been a move to differentiate in terms of discipline strengths rather than seeking unique contribution.

*“ I think for some reason, certainly in Ireland we haven't had, throughout the country, a clear sense of what it is we do that's different. In defining social work role in discussions we have had in CAMHS over the last two years we haven't been saying we only do this or only us do this but we are saying this is something we are particularly good at it's a particular strength of ours” (P03: SSW)*

The current practice on CAMHS teams is reported to be determined by factors other than original discipline training. Individual skills, interests and further training directly impact on the each individual's workload. The working relationships on teams was also deemed an important factor.

*“It's more about- on my team -I think it's more about what you've got- what is your area of interest and training is” (P10:PQSW)*

*“I suppose if people see you as a competent worker and able to relate well to families that's what matters on the ground” (P08: PSW)*

The other major influence on the distribution of work on the teams represented in this study is reported as capacity rather than discipline training.

*“Issues like who is available, how busy are you, what do you want to do you have any slots” P05: PQSW*

## 4.11 Conclusion

The ten participants in this study described social work practice on their teams as influenced by capacity consideration and individual skills, interest and further training. Team process differs in relation to whether initial assessments are seen by one or more disciplines and the extent to which work is carried out by one or more professional. Social workers are involved in discussing initial referrals, assessment, intervention and case discussion at team meetings. The primary focus of intervention are parents and families but not to the exclusion of direct work with children. Case work and group work are the two main methods of intervention with social workers adopting primary responsibility for group work on some teams. Social workers are also involved with a variety of community projects as representatives of the MDT. The participant social workers reported that while other disciplines also become involved with community projects at times it is often seen as an area of particular strength for social workers.

All social workers report working with a broad range of service users although some social workers do not take on initial assessments where there is a question around autism. There are reports of social workers becoming involved in the more complex family situations.

Social workers describe significant commonality of skills with other disciplines on the CAMHS team and describe their work in terms of individual skills and interests rather than as discipline specific. The role in relation to child protection varies from direct involvement in cases to a consultative role with colleagues.

There are descriptions of the impact of external factors on the practice the lack of resources and pressure to increase throughput are seen as impacting negatively on work with complex cases.

Social work in CAMHS is described as a therapeutic activity; all participant social workers reported some level of further training in therapeutic modalities. There were reports of some ambivalence around

the use of the title of social worker both by participant and other team members. Participants described a degree of role blurring and commonality of skills within disciplines in CAMHS and acknowledged that identifying a particular contribution based on discipline can be difficult. The psycho social, systemic viewpoint, adopting the alternative voice, collaboration with parents was among the strengths of social work identified by the participants.

Chapter five will discuss these findings in detail in relation to the literature review.



## Chapter Five Discussion of Findings

### 5.1 Introduction

In this chapter, the findings described in chapter four will be discussed and comparison drawn to the literature review findings reported in chapter two. The discussion will be presented in relation to the themes identified in the data analysis (Table 4.3). The main broad themes discussed will be the practice of social work in multidisciplinary CAMHS in relation to both direct and indirect intervention and external influences, further training and the social work perception of the particular contribution of social work to such teams.

### 5.2 Practice of Social Work

Participant social workers in this study describe many commonalities of practice across the country and across employing agencies in relation to involvement in case discussion, casework and group work interventions and liaison with schools and other agencies. In many ways this description of practice reflects that described by McCabe (2003) of one social worker on a child guidance team in the 1970's. The role of social work at that time was to provide an holistic vision of mental health with an awareness of not only the individual child but their family, community and wider environment. The primary methods of intervention were casework and group work. The tasks included pre assessment home visiting and social history taking, working with parents, liaising with schools and community services and contributing to case discussions. There are no reports of pre assessment home visiting by participants in this study but many of the other tasks continue to be described in current practice. However, there appears to be more direct involvement in the initial assessments with social workers carrying out initial assessments both alone and jointly with colleagues.

Walker (2002) outlined the traditional social work role within the CAMHS as working with parents while psychiatrists conducted the psychiatric assessment with the child or young person. In Walker's

description and that of McCabe (2003), individual children and families routinely had the input of more than one discipline. This study found that social workers continue to have a significant role in working with parents but not to the exclusion of direct work with children and young people individually and in groups. Some participants described this change as something that had to be “*fought for*”. It was also reported in the findings that other disciplines also work with parents. Not all children and families have input from a variety of multidisciplinary team members.

McCabe (2003) and Walker (2002) describe a discrete area of work for social workers in traditional CAMHS that was understood to be common to all social workers in CAMHS and only undertaken by social workers. The findings of this study would suggest that while social workers in multi disciplinary CAMHS continue to have many areas of common practice there are reports that workload is determined more by individual skills and interests than by discipline. External factors also have a significant impact on practice; this will be discussed further later.

Social workers in CAMHS are working with children and families presenting with a broad range of issues and of all ages. The area of assessment of children and young people where there is a question about autism was one area that many social workers in CAMHS teams do not see themselves as having a role. All participants reported being requested by colleagues to become involved in the more complex and “messy” cases.

Asquith et al (2005) identified six key conceptions of generic social work roles as counsellor (or caseworker), advocate, partner, assessor of risk or need, care manager and agent of social control. The findings of this study suggest that participant social workers adopt roles of case worker, advocate, partner and in some cases assessor of risk with little evidence of the other roles. This may in part reflect the literature review findings of a move within social work in CAMHS to a more therapeutic focus. The participants in this study report a primarily therapeutic focus to their activity with many of the participants working primarily as therapists. The social work as therapy/therapeutic social work issues will be discussed

later. The other key role reported by participant social workers is group work co-ordination and facilitation. Social workers in CAMHS are involved in facilitating parenting groups, parent support groups and direct intervention groups with children and young people.

Much of the literature describes significant involvement in the area of child protection and welfare as central to the social work role (Messent, 2000; Walker, 2003). This study found that social workers in CAMHS in the ROI have developed some differing practice in relation to this area. The Children First guidelines (DoHC, 1999) clearly place the responsibility for the investigation of child protection and welfare concerns on the community social work teams. Participants in this study describe a range of responses to child protection concerns arising within their teams. All describe having a role in consultation with colleagues and on some teams there is an expectation of direct involvement in the referral to child protection services and attendance at case conferences. Child protection and welfare issues are seen as a clear area of expertise by most participants.

The literature review raised questions about social work involvement in research activity particularly in the context of the need for evidence based practice (McCrae et al 2005) with an acknowledgement that the effectiveness of psycho social intervention is difficult to assess (Thyer and Wodarski, 1998). This study found that while some participants had been involved in research activity, the majority did not feel that social work training equipped them to conduct research. There were also concerns expressed that the current construction of research does not meet the needs of social workers practicing in CAMHS. Social workers questioned the reliance on randomised control trials as the key form of evidence and described a desire for a broader definition of what constitutes evidence including service users' perception of treatment.

There were reports of a significant focus on contributing to education as part of the social work role in CAMHS which had not been identified in the literature. All participant social workers had current or previous involvement in offering practice placement to social work students. There

were issues raised about the availability of space to facilitate student placements and some reports that the value of trainee social workers on CAMHS teams was questioned. Some participants were also involved in lecturing on third level courses.

The participant social workers also showed evidence of commitment to continuing professional development all having pursued some form of further training. This will be discussed under continuing professional development.

### 5.2.1 External factors

A significant finding of this study is that social work practice in CAMHS is directly determined by external factors. The availability of other services in the local network can influence the referrals to CAMHS, relationships between service providers were also reported as significant. There are not universal criteria for acceptance of referrals by teams. Intervention was also reported to depend on resources and this was not just in relation to the specific resourcing of the team in terms of skill mix. One participant described significant impact on home and school based work as a consequence of travel restrictions in some areas. While the *Vision for Change* policy (DoHC, 2006) envisages a clear role for CAMHS teams, this study found that in practice external factors can determine practice.

Of particular concern to participant social workers is the introduction of performance targets and a fear that an emphasis on the number of clinical contacts will lead to less in depth work. This area of concern was not identified in the literature and is a new finding of this study. A related finding is that on many teams the initial assessment is done by a single discipline as a response to waiting list demands.

## 5.3 Further Training/CPD

All of the participants had undertaken some training a therapeutic modality, seven to masters' level. Participants reported that their social work colleagues had also undertaken further training. Lask (1994) suggested that social work has become an increasingly therapeutic activity

over time. The findings of this study suggest that social work in CAMHS in the ROI is primarily a therapeutic activity. While participants reported their perspective as informed by social justice and human rights, the primary focus of intervention was therapeutic. There was no evidence of significant conflict between the agency contexts and the social justice / empowerment remit of social work for this group of social workers.

Many of the participant social workers reported feeling unclear as to their role and lacking in confidence when joining CAMHS teams and this was a significant motivating factor in the decision to pursue further training. One participant referred to the need to distinguish her skill base from that of other team members as the reason for further training. Role blurring has previously been found to create stress for social workers in multidisciplinary team work (Evans, 2006).

Other motivating factors included a desire to specialise in therapeutic social work and a desire to enhance skills in intervening with children and their families. Many participants reported that there was some degree of agency expectation that social workers would have additional training. Walker (2001) argued that the mission of social work has become confused with the agency context and this argument was echoed by participants in this study by participants who reported having more in common with other disciplines in CAMHS than with social workers in other agencies. This would seem to support the views of Kearney and Skehill (2005) who argue that the developmental history of each specialist area of social work has varied and this varied development impacts on the current roles and tasks of social workers in each type of agency.

The most common choice of additional training was systemic family therapy. Participant social workers also reported training in cognitive behaviour therapy, reality therapy, play therapy and Marte Meo therapy. CPD is an expected part of professional social work internationally (Smith et al, 2006; Mitchell, 2001). In Ireland, the availability of formal additional training has been limited to therapeutic modalities or management skills. The availability of further training in the area of

mental health is too recent to assess its impact for social workers in CAMHS.

Systemic family therapy training was described as “close” to social work and as making sense for participants given their focus on parent/family work. The impact of therapeutic training on the development of role within CAMHS teams seemed to vary. Some participants reported that the training informed their work and offered a family focused perspective to understanding the needs of the child and family. Other participants reported working, at least some of the time, as family therapists offering formal family therapy to service users.

The other trainings pursued impacted to varying degrees on the participants involved. Despite the significant involvement in group work, participants had not pursued further training in group work and felt the social work training had provided the necessary skills and competencies for this work.

One finding of the study was that there can be concerns on some teams and for some social workers around the title of social worker. Some participants reported using the title of therapist while others are clearly seen as social workers with additional skills. Participants also reported some discomfort among colleagues in trying to explain to families why a social worker was being asked to become involved in their assessment/treatment. There were suggestions of some sense of stigma around the title and some sense that families would assume there was a child protection concern if social work became involved. This issue was not noted in the literature review although Asquith (2005) did raise concern around a crisis in professional identity for social workers.

#### 5.4 Contribution to Multi disciplinary CAMHS

The literature review reported in chapter two suggested that social work intervention could be described as “unique in the breath of its mission” concerned with enhancing the well being of people while placing emphasis on the social contexts of their lives (Barnes and Hugman 2002). The participants in this study describe their particular contribution as

offering a psycho social perspective to the understanding and formulation of presenting issues. This was described by participants as understanding the inner world of the service user while also understanding the external world and the interplay between them.

Participant social workers describe themselves as offering an alternate understanding of the presenting issues and describe looking at the broad context rather than a narrow diagnostic focus. This is reflected in the literature. Child (2000) found that the medical model has limits in the area of child and family mental health and the presence of a social worker on a MDT may provide a social balance. Messent (2000) described the value of social work as having an alternative viewpoint to the prevailing medical model while Lask (1994) defined the particular contribution of social work as the continued concern for the interplay of individual, family and community factors. This study confirms these observations.

Participant social workers described one of the strengths of social work as being the capacity to develop collaborative working relationships with parents and other agencies. Frost (2005) argues that this is a key area for social workers in multi disciplinary work.

There was also significant commonality between different MDT members reported by participant social workers. Roles on teams have become blurred and tend to develop with reference to individual skills and interests rather than initial discipline training. The majority of participants had some degree of difficulty in identifying what element of their work was uniquely social work. The value of social work was perceived to be around the value base and contextual perspective rather than the actual intervention. The exception to this was that on some teams, group work was seen as a particular area of expertise for social workers. This finding has relevance for service managers in considering a move from discipline training to skill mix in the structuring of new CAMHS teams.

Chapter six will draw conclusion from this study and make recommendations for further research.



## Chapter Six Conclusions and Recommendations

### 6.1 Contribution to Literature

This study set out to describe the current practice of social work in multidisciplinary CAMHS in the ROI from the perspective of social workers currently working in such teams. There has been little written to date about social work in CAMHS and this study contributes to the existing knowledge in this area. The primary finding is that while there are commonalities in role among the participant social workers, there is not a universal social work role in modern CAMHS. The position of CAMHS in the network of services, resource deficits and individual skills and interests shape the specific social work role on each team. All participant social workers perceived their contribution to be in relation to offering a perspective on cases grounded in social work values and an understanding of the interplay between the child, family and broader community.

The study also found considerable concern among participant social workers as to the impact of performance targets on their capacity to offer longer term, in depth and multidisciplinary assessment and intervention to families.

### 6.2 Generic/ Specialist roles

The study found that social workers are involved in assessment and intervention with children and families presenting to CAMHS with a broad range of mental health problems. The main focus of social work intervention remains with parents and families but not to the exclusion of direct work with children and young people. Participant social workers in this study have a significant role in relation to group work. All participant social workers reported that their role had developed in relation to the demands of the service and their particular skills and interests rather than their initial training. This finding suggests that the model of service delivery in CAMHS has been changing from a model where each discipline has a discrete area of operation to one where skills and

competencies determine role. With the current interest in the CAPA model (as described in the introduction to this study) social workers on CAMHS teams may be well placed to transition to a skills and competency based service delivery. This finding will be of relevance to service managers in future service planning.

### 6.3 Social Work as Therapy

This study also found that social work in CAMHS is primarily a therapeutic activity. All participant social workers had pursued some form of training in a therapeutic modality, many to masters' level. It was difficult for some participants to identify which elements of their work was social work although all felt their worldview and value system was strongly influenced by their social work background. While participants were motivated to pursue further training to enhance and develop their skills, many also reported seeking a further qualification to clarify their role and contribution to the team.

The study also identified some issues in relation to the use of the title of social worker with some perceived stigma attached to the title. There were reports of concern that families would interpret social work involvement in their care as indicative of concern about child protection or welfare issues. On some teams this has led to the increased use of the title of therapist.

The lack of post graduate training opportunities for social workers in social work related areas may also contribute to the move towards therapy training. The recent development of post graduate training in mental health may impact on the further training choices of social workers in CAMHS.

### 6.4 Education / Research Activity

Participant social workers report significant interest in the area of education: all reported having current or previous involvement in offering practice placements to social work students. Many were also involved in teaching on third level courses in social work and related areas. Despite this interest in education and in continuing professional development,

participant social workers had very limited involvement in research activity. This study found that the two primary barriers to involvement in research activity are a perceived gap in social work training and a belief that social work as a professional activity does not lend itself to the existing research frameworks like randomised control trials.

## 6.5 Limitations of the Study

The author acknowledges that there are limitations to this study.

The study was conducted as part of an academic programme and was limited in scope by time considerations.

This study was also limited in that it was conducted solely from the perspective of social workers in CAMHS. The research methodology generated rich data which was subjective. The views of other team members, service users, referral agents or other stakeholders were not sought.

The study sample was a small one. As a nationwide study, broad representation of each region was achieved. This was at the cost of an in-depth exploration of any single area. This may have an impact on the generalisability of the findings; however, the author is confident that the commonalities of the participant descriptions indicate a reasonably representative sample. The study excluded those social workers to whom the author is line manager and so excluded one of the longer established CAMHS services.

## 6.6 Recommendations for CAMHS Management

□ This study began an exploration of social work roles in CAMHS from a social work perspective. It found a social work perception of role blurring on CAMHS teams and descriptions of overlap with the roles of other disciplines. This may indicate that CAMHS teams are well positioned to adopt a different model of service delivery such as CAPA. Further research is needed to explore the roles of all disciplines in CAMHS to ensure that CAMHS teams have the mix and balance of skills and competencies needed to deliver a quality service to the population

identified in *A Vision for Change* (DoHC, 2006). Future research should reflect the views of a broad range of stakeholders.

□ The study also identified a concern in relation to the impact of performance targets measuring clinical contacts on the practice of social work in CAMHS. The impact of these targets on outcomes for service users should be carefully monitored by service managers.

## 6.7 Recommendations for Social Work Training, Management and Practice

□ Perceived discomfort among other members of the MDT with the use of the title of social worker was noted. This is felt to reflect an association in service users' perception between social workers and child welfare concerns. Social work managers should ensure that service users have a clear understanding of the differing roles of social workers in different agencies.

□ Social workers in CAMHS are active in pursuing further training and professional development. The available options for further training to date have been in therapeutic modalities. The range of CPD provision should be explored in relation to the needs of clinicians in CAMHS. The impact of the recently developed multidisciplinary post graduate training in mental health on the needs of clinicians in CAMHS should be assessed.

□ Social work training in relation to research activity should be explored by the providers of social work training courses. This study also identified a need for research frameworks that can accommodate social work interventions and perspectives as different to those interventions that can be assessed using randomised control testing.

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# Appendix 1 Interview Schedule

## Workload

What types of clients are you working with?

- children directly (age range)
- parents
- schools
- other agencies

Where do you get referrals from?

- within the team (already seen by other professional)
- directly from the referral meeting

What are the main presenting issues for the children/families you are working with?

- Why attending CAMHS
- Why referred to social work

What are the main interventions you use?

- Individual casework
- Groupwork
- Community work

What are the main theories underpinning your work?

What in your opinion has been the impact of the Mental Health Act, Vision for Change and the development of enhanced community health services such as the primary care teams on the work of social workers in Camhs?

## Further study

Have you undertaken further study?

What type?

How has this impacted on your role?

## Contribution

What do you consider is the particular contribution of social work to the CAMHS team?

## **Appendix 2**

### **Invitation letter to potential participants**

**To all Social Workers**

**Child and Adolescent Mental Health Services**

*Request for research participants*

My name is Lisa Brennan and I am currently completing a MSc in Health Services Management in TCD. I am a principal social worker on a CAMHS team and am interested in researching the current practice of social work in specialist CAMHS in the republic of Ireland from a social work perspective. This is currently an important topic in the context of the changing legislation and health policy. It is likely that the Mental Health Act (2001) and *Vision for Change* (DoHC, 2006) will alter the demands on CAMHS services and the role of social work within the team is likely to be questioned and redefined.

I am interesting in describing the social work role as part of existing multi disciplinary CAMHS teams in terms of caseload, client profile, methods of intervention and what social workers see as their particular contribution to their teams. I am also interested in whether individual social workers have undertaken further training and what, if any, the impact of this training is on the profile of the workload.

I believe this research will generate valuable information which will help us to further explore our role within CAMHS. The possible benefits of this exploration include an improved understanding of our role, enhanced job satisfaction and an empowerment of social work within the multi-disciplinary team.

The research may also be of relevance in the planning and development of social work services in CAMHS and to the colleges offering social work training courses and continuing professional development.

*Where do you come in?*

**I am seeking volunteer participants.**

*What is involved?*

I hope to conduct the research by interviewing eight to ten social workers currently working in specialist CAMHS teams about the practice of Social Work on their team. The interview will be approximately 30 minutes duration and take place at a venue convenient to you. I hope with your permission to tape the interviews to ensure accuracy.

If you are interested in volunteering to participate please contact me within the next two weeks

[lisa.brennan@hse.ie](mailto:lisa.brennan@hse.ie)

**Tel: 016265676**

**Child and Family Centre**

**Ballyfermot Road**

**Dublin 10**

Thank you for considering my request,

Lisa Brennan

## **Appendix 3**

### **Participant information leaflet**

Research study: *“A snapshot of the role of social workers in multidisciplinary CAMHS teams in the republic of Ireland”*

Thank you for expressing an interest in taking part in this research project.

As you know I am undertaking this research as part of the MSc in Health Services Management.

I am interesting in describing the social workers role as part of CAMHS multi disciplinary teams in terms of caseload, client profile, methods of intervention and what social workers see as their particular contributions to their teams. I am also interested in whether individual social workers have undertaken further training and what, if any, the impact of this training is on the profile of the workload.

I hope to conduct the research by interviewing eight to ten social workers currently working in specialist CAMHS teams. Interviews will take place in a neutral location that is most convenient for participants.

Interviews will be semi structured and last approximately 30 minutes duration.

#### Confidentiality

Participant confidentiality will be maintained at all times unless there is a disclosure indicative of bad practice in which case it will be reported to the appropriate authorities.

With your permission, I hope to record the interviews and analyze the data thematically. Participants will be assigned a code to protect their identity. The code will be known only to me and kept securely locked in a location separate to the transcripts.

Audio tapes will be destroyed and anonymous data held in a securely locked cabinet for five years in keeping with recommended best practice. The transcripts will not be used for any further research project without the prior consent of the participants.

I am seeking ethical approval from the TCD ethics committee and hope to begin interviews in Feb/March 2009. I hope to present the findings at the national special interest group meeting in Spring 2010 and will disseminate the findings as widely as possible.

Participation is totally voluntary and participants are free to withdraw at any time. Transcripts of the interview will be available to participants if desired. While there is no direct payment or benefit to individual participants, the research hopes to contribute to role clarity for all Social Workers in CAMHS and to inform provision of continuing professional development.

If you are still interested in taking part, please contact me at [lisa.brennan@hse.ie](mailto:lisa.brennan@hse.ie),

Or, Child and Family Centre, Ballyfermot Road, Dublin 10

Tel: 016265676

I am available at the above address/phone number if you have any queries about the project.

Lisa Brennan

## Appendix 4 Consent Form

### Consent Form

**Study Title;** *A snapshot of the role of social workers in multi disciplinary CAMHS teams in the republic of Ireland*

**Principal Investigator:** Lisa Brennan

**Background:** Participants will take part in a semi structured interview of about 40 minutes duration exploring their experience and perception of the role of social work on multi-disciplinary CAMHS teams. The interview will be tape recorded and transcribed. The transcribed data will include no identifying data and be stored in a secure filing cabinet in the investigators workplace.

**Declaration:** I have read, or have had read to me, the participant's information leaflet for this project and understand the contents. I have had the opportunity to ask questions and have had any questions answered to my satisfaction. I freely and voluntarily consent to take part in this research study and understand that I may withdraw at any time. I understand that I can check the transcript of the tape recording of the interview for accuracy.

**Participants Name** \_\_\_\_\_ **Contact**

**Details** \_\_\_\_\_

**Participants Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### Statement of Investigator's Responsibility

I have explained the nature and purpose of this study, the interview procedure and any potential risks to the participant. I have fully answered any questions asked. I believe the participant understands what is involved and has freely given informed consent.

**Investigator's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

## **Appendix 5 Letter to gatekeeper**

Ms Sinead Freeley

Chairperson

IASW, Special Interest Group, CAMHS

St., James' Hospital,

Dublin 8

05.11.08

Dear Ms Freeley,

I am writing to you in your position as chair of the IASW special interest group in CAMHS. I am currently a student on a two year Masters programme in Health Services Management in TCD. As part of the course I will be undertaking a piece of research and am interested in describing and exploring the social work role in CAMHS.

I enclose the participant information leaflet, consent form and letter of invitation for your information. I am requesting permission to access currently practicing social workers through the special interest group directory. I am also requesting that you act as gatekeeper for the study by sending out the research information and letter of invitation on my behalf.

I will be seeking ethical approval from the TCD ethics committee for the study. I would be grateful for your advice on any IASW ethics process.

Yours sincerely

Lisa Brennan

Principal Social Worker

## Appendix 6 Letter from gatekeeper

20<sup>th</sup> November 2008

Ms Lisa Brennan  
Principal Social Worker in CAMHS  
Ballyfermot Child & Family Centre  
Ballyfermot  
Dublin 10

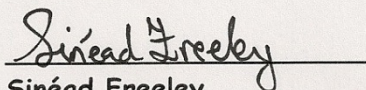
Dear Lisa,

Many thanks for your letter regarding your research project.  
The IASW does not have a separate ethics process therefore you do not need to seek approval from the IASW.

As chairperson of the special interest group of Social Worker's in CAMHS, I hereby give you permission through this special interest group to interview Social Worker's in CAMHS as part of your research. I have sent the relevant letter and your participant information leaflet to all Social Worker's in this SIG.

Please do not hesitate to contact me at anytime regarding the above.  
Wishing you all the best with your research project.

Kind regards



Sinéad Freeley  
Chairperson of SIG, SW's in CAMHS

## Appendix 7 Ethical approval



THE UNIVERSITY OF DUBLIN

TRINITY COLLEGE

SCHOOL OF MEDICINE

FACULTY OF HEALTH SCIENCES

**Professor Dermot Kelleher, MD, FRCPI, FRCP, F Med Sci**  
Head of School of Medicine  
Vice Provost for Medical Affairs

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Tel: +353 1 896 1476  
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email: [medicine@tcd.ie](mailto:medicine@tcd.ie)  
email: [medschadmin@tcd.ie](mailto:medschadmin@tcd.ie)

Monday, 23 February 2009

Study: A snapshot of the role of social workers in specialist child and adolescent mental health services (CAMHS) in the republic of Ireland

Dear Applicant (s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee – December 2008, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely

Dr. Orla Sheils  
Chairperson  
*Faculty of Health Sciences Ethics Committee*

cc Mr Michael Brennan, School of Nursing and Midwifery, 24 D'Olier Street, Dublin 2

## Appendix 8 Responses in relation to child protection

<p>Involvement in child protection cases</p>	<p>I might say I really think that kid needs a social worker involved. And that would often be to do with ah.. there may be -there may be child protection issues involved and social work services may be involved in the case and the case going to require the input of both services (P06)</p> <p>Child protection -ahm is another thing that I would still be asked to come in on a lot. But again not always (P10)</p> <p>I think if there is the involvement of child protection social work, often other team members perceive a need for social work in CAMHS to become involved. I'm not saying I believe that but that's sometimes what happens. (P02)</p> <p>I think they would be the ones that would have lots and lots of layers to them may be multiple services more than likely there would be an element of concern about the child welfare at some level and often referral to me would happen because there is confusion amongst other team members about what is available in the community or what is the responsibility legally of community care teams(P16)</p> <p>P:sometimes if other disciplines become involved my experience has been sometimes that child protection is can be seen as purely a</p>
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	<p>social work role so off you go  R: and is that a perception on this team?  P: I would fight that (P01)</p> <p>it might also be where cases have already got a link or would be likely to have a link with the area child protection teams (P08)</p> <p>I also would be involved with a couple of families where there would be child protection concerns, case conferences happening-where the community services social work department would be involved also (P06)</p> <p>if it was part of a referral they might think of me you know if there was child protection services are already involved with the family they might think it would be useful for me to be involved(P06)</p> <p>maybe we could be asked to see cases where there was particularly complex social work case or cases that are referred by the social work department that are particularly difficult (P04)</p>
<p>Interagency work with child protection team</p>	<p>I'm on the child protection notification committee representing our team so every second Wednesday we meet and that is around looking at all child protection notifications there are representatives from all the disciplines with in community services so that would involve looking at children who have been notified into the child protection notification system and making decisions as to whether they go to case conferences or whether they come off the notification system are not (P06)</p> <p>ahm and so when colleagues lack confidence in looking at how</p>

	<p>services should be split and how services can be delivered in partnership with other services they tend to hand it over in the social workers direction so normally the cases would involve lots of services complex families (P16)</p> <p>it also works the other way because if sometimes it looks like there could be a messy family situation and I could turn around and say yes I'll give that one a lash someone else might saying well you know looks like we're going to need to be making a referral to the community care social worker on that one so if there is a social worker involved from here they are less inclined to pick it up so maybe we hold off on a social worker on that one and you know maybe the nurse or the psychologist and so there would be a bit of an attraction to put us on ones where there is more clearly a family situation for new assessments but that can work the other way and be the reason for us not to take us on if we think it's going to go to the social work department (P05).</p> <p>the types of cases where we would refer to community care – community care then say we want them to come to a service like yourselves –that's the answer -so it's about how to keep that going because the risk is that you refer to community care and damage the relationship with the family and possibly nothing happens with community care from the family's point of view and the family are then turned against the service (P01)</p>
<p>Consultation role with colleagues</p>	<p>Certainly when I started here and Children First was a little bit younger there would have been a lot</p>

	<p>of discussion involving the social worker on the team about when to make a notification and ask things like what does professional judgment mean, you know, and that kind of thing, we are a bit more used to children first now and people have a better idea (P10) we can advise- if you send that into child protection this is the way it's likely to go. Try this angle. Not that we need to take on all the child protection referrals but that we can offer a supportive consultative service to our colleagues on those types of issues (P05)</p> <p>if someone comes to me I'm inclined to say thank you for coming to me but I think you are also able to make that judgment around whether to make a report to child protection services but I wouldn't take the case on (P01) I'm not consulted that often no I'm not consulted (P01)</p> <p>in the child protection area anything that smacks of child protection people come to consult with me. : in terms of possible referrals to the social work department of what to look out for or when to refer or what information to share P(06) if there were issues or if someone was worried about ah that there were signs or symptoms or some worries they would often come to me to consult on that R: mnn hmn P:ahm..or if they had to attend a case conference because it's something they don't do that often and you know they would look to me for that (P06). we would advise people in doing that so if somebody came to me and said listen I'm worried about this case I would advise and offer consultation around the child protection issues (P03)</p>
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<p>Other disciplines taking on child protection work</p>	<p>But even when there are like child protection issues and people are going to community care it would not always be me (P10)</p> <p>I think they do read the guidelines and would work with the families and make the onward referral to CC as needed so I do think that other disciplines do take that on (P01)</p> <p>I think all of the disciplines do it to varying degrees (P08)</p> <p>in the past it are used to be that if child abuse concerns emerged in someone else's work with the family they would think oh let's get to the social worker involved to and they can make the contact with community care but we have been a very clear for and it has been accepted to do quite a while now ah that are no you do it if you come across a the issue it's your issue to process. We will help you with that, we will tell you who you need to call and what you need to do but it's your job to do it and otherwise it's almost irrelevant in terms of how the HSE investigations are concerned and also it's irrelevant really in terms of therapeutic work to bring in somebody from the outside team to deal with that (P03)</p> <p>even cases where there would be social work issues and difficulties like child protection- someone might bring it up at team and look for our opinion but they wouldn't..ah. we wouldn't get involved in the case no (P04)</p>
<p>Child protection as an area of particular social work expertise/skill</p>	<p>I would sometimes promote myself in that way because I do think that I have obviously a knowledge of SW and that it makes sense for me to be involved and normally if I know that CP are involved I might say look do you want me to become</p>

	<p>involved or is there anything you want me to do          But the CP stuff, we have specialised training around the area and it is a specialist area and a particular skill that SW has (P10).</p> <p>On the administrative level we do have a degree of expertise in child protection (P05)          ahm well I'd think the responsibility of doing it rests with social worker when it comes to child protection and welfare but (P08)          very particular bit but I can see there's been act in a consultative capacity in cases of a child protection and welfare nature and having a knowledge of the different services that are available with in the local county areas so if these cases come up for discussion in a team meeting that my antennae need to be out sharply to pick up on possible child protection and welfare issues that may not have been identified previously or if a colleague is identifying them and asking for guidance about how to proceed with them so I suppose that be our baby          (P08)</p> <p>I worked for many years as a team leader in the child protection area so I see that as an area of expertise whereas other social workers in our services who haven't had that experience ahm wouldn't see that they particularly have a role in that area any more than any other person and on the multi-disciplinary team          P(08)</p> <p>the particular thing that we bring it been expertise in asking difficult questions around child abuse and neglect if it needs to be explored we can explore it, but we can do it tactfully and we can follow through to the end (P03)</p>
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## Appendix 9          Sample of a section of a transcript

A04/04

Length of tape 49:37

Interview with P05 on the 25<sup>th</sup> of March 2009

R: Okay (name) if you wouldn't mind just describing for me the types of clients that you work with on your caseload. I mean, do you tend to work primarily with parents? with families? with children? or with schools and other agencies?

P: ah.. Primarily I work with- I would think 60% of my work would be with parents ahm-60 per cent or more would either be parents or parents and children-then that 40 per cent would be you know dealing directly with or doing direct work with young people. So we tend to be -I mean the social workers here, we tend to specialise in parenting work

R: so parenting would be part of what would be seen as the social work

{P=role}

P: Role yes. Or it may be more accurate to say the social work area of expertise more so than the social work role. Ah.. ah..

R: how do you define those as different (name)?

P: well, we would have a role with young people and other professional would have a role with parents but we would be generally considered to be the ones most qualified and the ones most skilled at working with parents whereas the nurses and psychologists are very good with parents but we would generally be perceived to be better with parents. So the bulk of that work would come in our direction.

R: OK, and do you have much work with schools or other agencies or inter agency projects-that kind of thing?

P: we would yes, we would have good bit of work with that. Just about every case throws up something -whether it's just a few telephone calls to the school or whether it's intensive interagency work -could be with community care social work, community care psychology, adult psychiatry and then schools, NEPS- that type of stuff.

R: Would that tend to be on an individual case by case basis or are there any service driven interactions

P: ahm.. service driven ones that I am involved with would be psychology I would have formal meetings with psychology and we would have a subcommittee looking at doing some joint group work together and I would be involved in that

R and when you say psychology do you mean the community based psychology team?

P: yes- not just with our psychologist here. And in addition to that ahm I do a lot of linking in and my social work colleague does a lot of linking in with community agencies -youth agencies to bounce a few ideas around and then there are some broader initiatives that we are involved in so there is an initiative in (name of county) where we are trying to pool all of our resources to try to run parenting groups so I have been involved in that

R: OK so members of a number of different agencies in the area are pooling resources to run joint parenting programmes?

P: yes that's a right, so an example of that would be I have gone to have few of the meetings on that so now myself and a worker from the community family centre, community support agency -herself and myself are going to run a group- a parenting group for dads that type of thing.

R: and would that be something that other members of the multi-disciplinary team do as well or would that be something that is also seen as an area of expertise for social work

P: What the parenting group?

R: the whole area of interagency interventions, co-working

P: I think everyone would consider themselves as doing a bit of that. But maybe social work would be more focused on it. We would try to do that a good bit of it. I think the others would do it but I think we probably do more. And there is another initiative, its setting up a project in relation to domestic violence and I have been sitting on the steering committee, for the last six months with a view to trying to set up this new project so that would be another interagency collaboration

R: and that's exactly what I was asking about in your own workload ahm (name)- where do you get your referrals ? Do you get them directly from the team meetings for initial assessments or do you tend to get them more from within the team where somebody else has already done an initial assessment?

P: Both. I do initial assessments – initial assessments here are nearly always done with one psychiatrist and one member of the broader multidisciplinary team so I could get one of those and myself and the psychiatrist would do it. But once you are involved in the initial assessment you usually end up staying on it ahm unless it was really are thought to be way out of your expertise and then it'll go into someone else's hands. And then at team meetings somebody could say that they have a case that they are looking for a little bit of help with and so it could be allocated to me. And I suppose what happens as well somewhat informally would be, let's see, one of the nurses or one of the child care workers could have a case that there are little bit stuck on come up and ask me to have a look at it and maybe to join them for a family meeting and so I could take it on for a bit of something and very often that would go back to the team meeting just to sort of validate it but sometimes we forget to do that.

R OK what would be the types- you know if I was at the referral meeting and if the cases are going to be seen by a psychiatrist plus one other is

there anything that would indicate why it would come to social work rather than to one of the other disciplines you know what I mean

P: ahm.. Let's see.... There is and there isn't. Eating disorders tend to go to the nurses because they just have the degree of expertise in eating disorders they have just sort of build up degree of expertise pretty much no one else does eating disorders except the nurses. The dietician does too-we have access to a dietician now from the hospital and she tends to get involved in all of the eating disorders so we tend not to get eating disorders. Ah.. But a lot of it then comes down to availability whose available on such and such a day to do something with a psychiatrist that would take up a fair chunk of it- a good 50%. And then if the case looks like it might be well if there are some messy family issues then somebody might say we could do with social worker on that one

R: OK so

{P: is also works the other way} sorry Lisa to cut across you there- it also works the other way because if sometimes it looks like there could be a messy family situation and I could turn around and say yes I'll give that one a lash someone else might saying well you know looks like we're going to need to be making a referral to the community care social worker on that one so if there is a social worker involved from here they are less inclined to pick it up so maybe we hold off on a social worker on that one and you know maybe the nurse or the psychologist and so there would be a bit of an attraction to put us on ones where there is more clearly a family situation for new assessments but that can work the other way and be the reason for us not to take us on if we think it's going to go to the social work department.

R: and that's not because of any sense of deficits in the skill base but a local issue in terms of getting child protection services involved?

P yes exactly

