Getting ready to move on: Considering attachment within young peoples' experiences of preparing to transition out of CAMHS.

Thesis submitted by

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DECLARATION I, Emma Rich, confirm that the research contained within this thesis is my own work and has not been submitted for any other academic award.

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Thesis Abstract

Literature Review

Transitions between CAMHS and AMHS services have been identified as problematic and in need of improvement, due in part to the different philosophical underpinnings of CAMHS and AMHS services. The review section of this thesis synthesises evidence of the lived experience of adolescent service users', parents' and clinicians' of the CAMHS to AMHS transition. The review reveals that individuals experience a sense of abandonment at this point in the care journey, expressing feelings of insecurity, anxiety and a belief that they are unable to affect change. It highlights the need to explore further individuals experiences of CAMHS to AMHS transitions, giving voice not only to service users and parents but also to clinicians involved in the transition process. It demonstrates the on-going need for further improvements regarding service transitions as recommended by government policy.

Research Project

The transition out of CAMHS is a significant event for adolescence reaching the upper age limited of CAMHS services. Through the process of accessing CAMHS support and building relationships within CAMHS it is possible that young people come to feel attached to the service and/or clinicians. The current study used Interpretative Phenomenological Analysis (IPA) to explore the lived experiences of young people who were preparing to transition out of CAMHS, viewed through the lens of attachment theory. Four overarching themes emerged: 'navigating the journey to find help', 'endings', 'transition to adulthood: A deadline on my 18$^{th'}$ and 'feeling connected'. Implications for clinical practice and future research are discussed.

Critical Appraisal

The final section of the thesis is the author's reflective account of the research journey, considering the challenges, opportunities and lessons learned from the experience.

Acknowledgements

I would like to express my most heartfelt thanks to all those who have supported me on this unbelievable journey: My friends who have stuck with me through the ups and the downs and kept me smiling. My research supervisors; Dr Noelle Robertson, Dr Gareth Morgan and Dr Shelia Bonas, who have inspired and guide this research and my learning. The young people who so bravely and generously agreed to share their stories and without whom this research would not exist.

To my mum and dad, Linsey, Jack, Daisy, Lucy, India and Monti for loving me and supporting me unconditionally, this is for you!

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Contents

SECTION A: LITERATURE REVIEW

Going it alone: A systematic review of Young people's, parents' and clinicians' lived experiences of the CAMHS to AMHS transition.

(Guidelines to authors of journal targeted for Literature Review available in Appendix A)

Literature Review Abstract

Objectives

To explore experiences of young people, parents and clinicians regarding CAMHS to AMHS transition, to enrich understanding of this key event through a critical interpretative thematic synthesis.

Method

A comprehensive search of four data bases (PsychINFO, PubMed, Scopus and Web of Science) was conducted using specified search terms. Inclusion criteria; peer reviewed, English language articles, published, 2013 to 2016, utilising a qualitative methodology to explore experience of the CAMHS to AMHS transition. Quality appraisal was completed using the CASP. Data extraction and synthesis; ten articles were identified, data and themes were extracted by two researchers.

Findings

Two superordinate themes emerged from the data; 'Relationships', encompassing autonomy, trust and relationship dyads, and 'Resources' encompassing structural, fiscal, and intellectual.

Discussion

The transition from CAMHS to AMHS was experienced as challenging by the majority of young people, parents and clinicians: both young people and parents described feelings of abandonment and distress. Clinicians also appeared adversely affected by the experience of transition, notably in respect of relationships with partner families; clinicians expressed a sense that they were letting families down. Young people and parents who described positive transition cited feeling prepared, provided with information and involved in the process. Clinicians framed more positive experiences as being related to effective inter-service communication, such as information sharing and joint planning.

Introduction

Background

Within the UK, approximately 20% of adolescents experience a mental health problem in any given year (WHO, 2003). A significant number (4 in every 1000) will be referred to CAMHS for support, with 79% of those referred receiving a service (Children's commissioner, 2016). Furthermore, NHS England has reported that "50% of lifetime mental illness begins by the age of 14…and that 75% of adults requiring secondary care mental health services developed problems prior to the age of 18." A significant number of young people accessing CAMHS will therefore be likely to experience transition to AMHS.

In the U.K., transitions between CAMHS and AMHS typically occur at the age of 18 years. For many young people in the UK, the age of 18 represents a culturally embedded psychosocial transition from childhood into adulthood. However, adolescence is a developmental stage, rather than a phase that is demarcated by age (Arnett, 2007) and for many young people the transition into adulthood is a challenging journey of gradual development.

The challenge of adolescent to adult transition may be further exacerbated by its coincidence with other transitional experiences; notably leaving home, moving into higher education, or finding employment (Osgood, et al 2005). Young people being treated in CAMHS services face the added challenge of coping with mental health issues throughout these transitions, as well as negotiating the additional move from CAMHS to AMHS. (Arnett, 2007) Mindful of such tasks, services should be sensitive to facilitating transition, not least to minimise potential adverse impacts on young people (Joint commissioning panel for mental health, 2012).

Current commissioning situates CAMHS and AMHS within different structural frameworks of service delivery, which has led to the development of significantly different mental health service provisions for children/adolescents and adults (McLauren, 2013). This has created a substantial difficulty for young people transitioning between CAMHS and AMHS, as they face a not only the challenge of

transferring to a new service, but also one that operates a significantly different culture of care (Hall, 2013).

In recognition of the challenge presented by the transition from CAMHS to AMHS, NICE guidance recommends that young people be given the opportunity to be involved in all aspects of the transition process from service design and delivery, through to the transition itself (NICE, 2016). NICE emphasises tailoring to the individual's capabilities and aspirations and suggests that transfer occurs at a point of developmental stability rather than chronological age (NICE, 2016). Additional recommendations by NHS England (2015) suggest that Care Programme Approach guidance is adopted and a referral is made at least six months prior to the point of transition in order to respond to an individual's needs and ensure care continuity.

Previous investigation such as the four stage multi-centre, multi-method research project known as the TRACK study (Singh et al, 2010) has explored policy, protocol, and process as well as the lived experience of the CAMHS to AMHS transition. Transitions research has been conducted in a variety of care settings, utilising various methodological approaches, with consistent allusion to numerous problems hampering the transition process, such as failures in the preparation of young people and their families and ineffective management of communication and referrals, which have negatively impacted upon the transition experience (Hovish, et al. 2012).

Circumscribed literature reviews have drawn together research on CAMHS to AMHS transitions, which appear to resonate with TRACK study findings, notably Munoz-Solomando, Townly and Williams (2010) summarising transition findings from diverse service structures, but expressing a clear need to enhance patient experience. A scoping review (Reale & Bonati, 2015) and a more recent systematic review (Paul, Street, Wheeler & Singh, 2015) have also argued that seamless service transitions are desirable but currently lacking. The latter study synthesised the findings of 19 quantitative, qualitative and mixed methods studies published before May 2012, but in its focus on the barriers to and gaps in services failed to give voice to experiences of young people, parents and clinicians and consequently the lived experience.

Justification of current review

The aim of the current review is thus to focus on the lived experiences' of CAMHS to AMHS transitions of service users, parents and clinicians, previously little considered in the literature base. Qualitative research provides a valuable means by which to access and assess how people experience life events and situations such as therapy and the provision of care. This can highlight strengths and weaknesses of services and provides an opportunity to develop a greater understanding of the gap between provision by services and outcome for service users. However, a significant criticism levelled at qualitative research is a lack of generalisability, notably when studies are examined in isolation. With the advent of rigorous met-synthesis, data from multiple studies can be synthesised to reveal new, integrative interpretations of lived experiences.

Current understanding of how CAMHS to AMHS transitions are perceived is limited. Previous reviews have tended to take a broad perspective resulting in minimal attention being directed towards the elements of lived experience and sense making of those affected. This review seeks an enriched understanding of how transitions are experienced by searching published qualitative research studies that focus on how children, parents and therapists perceive, appraise and understand the experience of mental health care transitions. Published qualitative evidence has hoped to offer a context in which to understand families' adaptation, coping and emotions as they proceed through care.

Aims and Objectives

The CAMHS to AMHS transition has received growing attention in recent years, however lived experience of transition remains under-represented within the review literature. The synthesis of the current data is therefore important to give voice to all those involved in the CAMHS to AMHS transition process, helping identify continuing gaps in service provision and inform the future direction of research and clinical practice.

The focus on research from four different first world countries further expands the knowledge base by identifying convergence and divergence of transition experiences

between these nations. Research from the UK, USA, Sweden, and Canada was utilised and deemed comparable due to significant similarities in cultural conceptualisations of mental health and services provision. Although obvious differences were recognised to exist between the different nations, especially in respect of service commissioning, it was felt that there was enough similarity of lived experience to warrant qualitative exploration. Whilst research from more culturally diverse nations was not found, it would not have been included due to the recognised differences in conceptualisation and treatment of mental health, and transitions more broadly.

Methodology

Thematic synthesis was used to apply a rigorous approach to integrate findings from multiple studies using diverse methodologies, and offer a novel understanding of transition experiences. (Thomas & Harden, 2008).

Search Strategy

A comprehensive search was carried out of four major online databases. PsychINFO, PubMed, Scopus and Web of Science. A search term strategy informed the search of the identified databases and focused on the areas of transition, service provision and age, using the terms (Transition* OR transfer* OR "continu* of care" AND Child* OR "young people" OR adolescen* OR Youth OR TAY AND CAMHS OR AMHS OR "mental health service* OR Psych* OR Therap*). Ancestral searches were carried out based on the references of review articles found exploring a similar theme.

Inclusion/Exclusion Criteria

A number of limits informed the search: All articles explored the subject of the transition between child/adolescent and adult mental health services and employed a qualitative methodology, utilised a content-based analysis (nine inductive and one deductive), and were published in the English Language, although were not limited to research conducted only within the UK. Secondly, the timeframe for publication of the articles was limited to 2013-date, respecting publication of previous review.

The initial search was carried out between June and September 2016, and again in March 2017. Titles and abstracts were checked against the inclusion/exclusion criteria and all duplicates were removed. Where the relevance of an article was unclear, the

article was retrieved and read in full. Once all potential articles were identified they were retrieved and read in full. The quality of each article was checked using the CASP quality assessment tool (Appendix B).

A total of 1337 records were retrieved from the first search, with 561 records remaining after duplicates were removed. The researcher screened the titles and abstracts of all 561 references; 547 were excluded because they failed to meet the inclusion/exclusion criteria. 14 full-text records were read; of these, four were excluded. Ten reports were included in the analysis (See PRISMA flow chart figure 1).

Characteristics of Included Studies

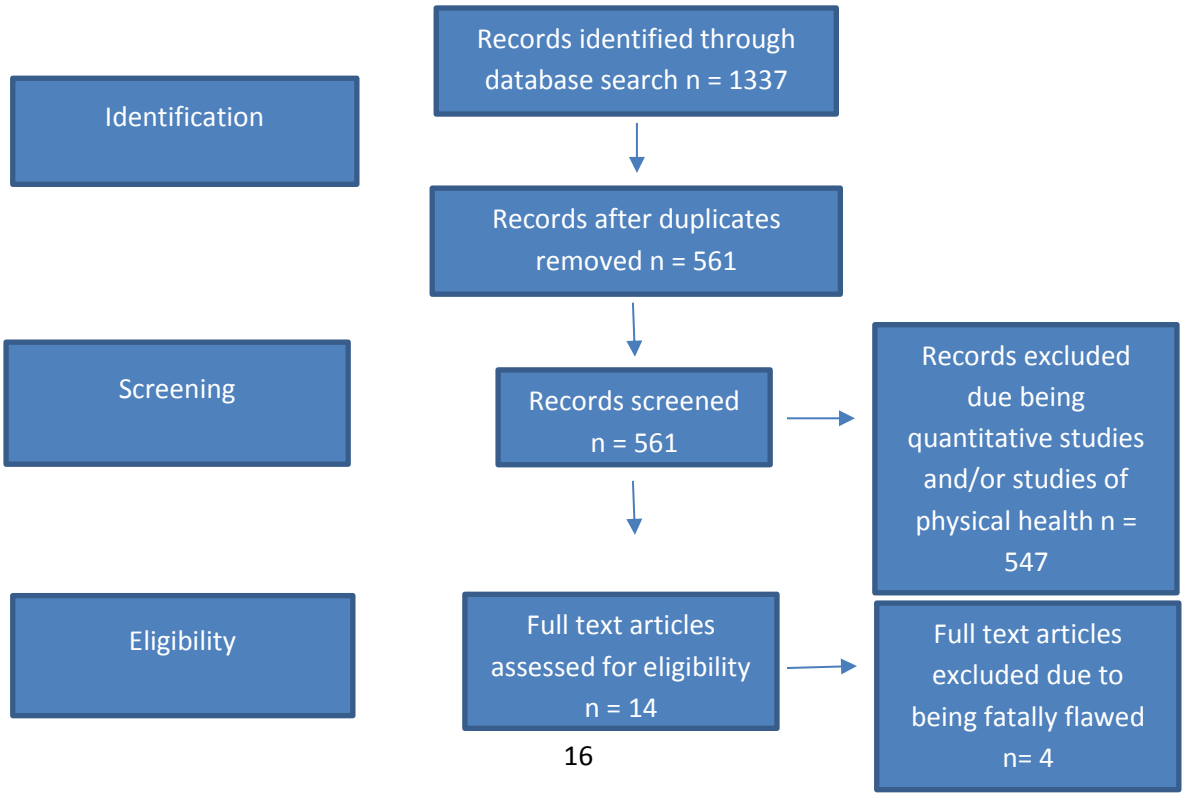
All studies were conducted in the U.K, USA, Canada, or Sweden. Five papers were diagnostically driven, with three exploring the transition experiences of individuals diagnosed with an eating disorder, one focusing on individuals with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and one on individuals diagnosed with Autism Spectrum Disorder (ASD). One study explored the experiences of transitions of young people within a secure environment, whereas all others were non-secure environments, or community settings. The age range of the service user participants was 16-24 years. Ethnicity was recorded for only four studies, two of which used the same participants (Dimitropoulos et al, 2014; 2015) and recorded a 46.7% Caucasian sample, with the remaining two studies recruiting only Caucasian participants. Gender was recorded within seven studies, but not within those that recruited professional participants. Where gender was recorded it was predominantly female, with three studies using only female participants and a further two studies using 66.7% female participants. Of the remaining two studies, one recorded 59.4% female participants and the other provided a contrast with 80% male participants (Appendix C).

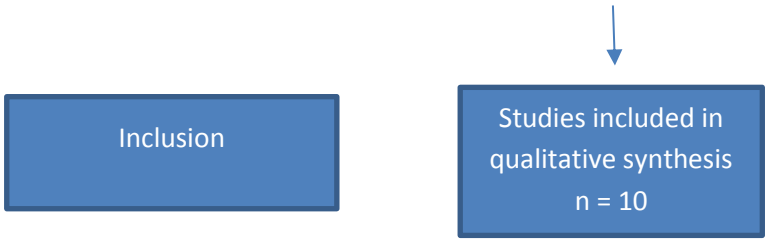
The studies used diverse methodologies including thematic analysis (3) IPA (1) grounded theory (4) and deductive content analysis (2). The aims of the studies also varied with six studies directly exploring lived experience, two examining barriers and facilitators to transition and one targeting participants' desire for family support based on their previous experiences. All the studies shared a realist epistemological position.

Quality Assessment

The CASP (Critical Appraisal Skills Program, 2013) was used as a measure of quality for each article. The CASP was chosen due to its relevance to health related research and utility in evaluating methodological rigour of qualitative research (see table 1) Each study was scored across ten items (0=not present, 1= partially present 2= present) accruing an overall score, with a potential range of 0-20, which was used to rank the studies by order of quality. Four studies were excluded on this basis; three because of poor qualitative methodological quality, one because focus was not on the transition experience. Two papers authored by Dimitropoulos et al (2015, 2016), used the same population of patients. The studies included in the review attained CASP scores ranging from 16-19/20 thus suggesting an adequate to good level of quality within the studies. It is acknowledged that some studies attracted greater scores than others, nevertheless the triangulation provided by the replication of each themes across several studies, offers a measure of reassurance of validity. Four studies were excluded from the analysis after being deemed fatally flawed due to achieving low scores on the CASP.

PRISMA flow chart (figure 1)





Meta-synthesis

This review utilised Sandelowski and Barroso's inductive and interpretative approach to thematic synthesis (Sandelowski & Barroso, 2003). This comprised; a) a thorough and repeated reading of each article, b) extraction of the findings across articles relating to the lived experiences of CAMHS to AMHS transitions, c) visual mapping of key findings, d) clustering and translating the findings into themes, e) rereading each article using constant comparison to further synthesise key findings and concepts into themes and f) final description and naming of the themes. Table 2 presents the main findings of each study and table 3 demonstrates the transition of the original study findings across each theme identified through the thematic synthesis. (Appendix E)

Findings

The thematic analysis identified two main themes were in which three sub-themes were subsumed in each; Relationships; Autonomy, Trust and Dyads, and Resources; Structural, Fiscal, and Intellectual were subsumed. (Appendix D).

Quotes are from author's commentaries or are direct patient quotations, taken from the articles under review.

Relationships

Autonomy

The question regarding locus of responsibility for the young person's mental health difficulties during and after transition was discussed in eight papers (Burnham-Riosa et al, 2015; Cheak-Zamora & Teti 2014; Dimitropoulos et al 2016, 2015; Lindgren et al, 2014, 2013; Swift et al, 2013; Wheatley et al, 2013). Young people appeared ambivalent about independently managing their mental health difficulties, expressing a desire for both autonomy yet ongoing support. A majority of respondents expressed a wish for greater independence as they transitioned from CAMHS to AMHS, but acknowledged feeling unprepared to take full responsibility for their mental healthcare and desired their parents to exercise tapering involvement. "She should be involved as much as possible I think, but later on I can go there by myself…I want to decide if she should follow me to the meeting or not." (Lindgren, et al, 2014, p.3).

Parents acknowledged the dilemma their children faced "…a desire to fend for themselves and the frightening prospect of taking responsibility." (Lindgren, et al 2013, p.4). They expressed a clear wish to remain involved in their adult children's mental healthcare, worrying that their children would struggle without their ongoing support and intervention. Consequently, they had difficulty relinquishing their role as the decision-making, accountable adult and allowing their children to take responsibility for themselves reporting feelings of terror and panic at the idea of being excluded (Cheak-Zamora, 2015, p.996). Young people expressed an awareness of their parents' concerns, but wanted their families to support them to take control of their situation. "I tell them this is my recovery, you can't do it for me. Like, I want your

support, but that's not the same as you doing it for me." (Dimitropoulos et al, 2016, p.263).

Professionals empathised with both young people's ambivalence towards autonomy and parents desire to remain involved acknowledging parents' difficulty "accepting that they could not participate in the same way as before…" (Lindgren et al, 2013, p.105) and highlighting the importance of a young person's self-motivation once they transitioned into adult care. However, clinicians also emphasised the importance of preparing young people to become more autonomous prior to the transition. "…interventions need to be established to assist with fostering greater independence and autonomy in young people…Young people have been robbed of the opportunity to become autonomous due to developing illness at a young age and the long illness course" (Dimitropolous et al, 2013, p.7). Professionals within adult services also suggested that transition itself could progress maturity encouraging autonomy and self-motivation. "…confirming the diagnosis strengthened the awareness of their difficulties, and that contributed to increased maturity." (Lindgren et al, 2013, p.105).

Trust

Young people and parents in seven studies highlighted the importance of trust within their relationships with clinicians and services. (Burnham-Riosa et al, 2015; Cheak-Zamora & Teti 2014; Dimitropoulos et al 2016; Lindgren et al 2013; 2014; Swift et al, 2013; Wheatley et al, 2013). Young people and parents described having worked hard to establish trusting relationships with CAMHS, in which they felt understood and respected.

Young people and parents expressed difficulty trusting that adult services would be able to cater for their specific needs. "I think like…the way they're going to be talking to you is probably different" Young people identified themselves as needing a different treatment approach to that of "older" adults however, worried that their developmental stage would not be respected in AMHS. "…participants expected adult clinicians to be cold, distant and firm…in contrast to the nurturing relationships that participants described with their current clinicians." (Burnham-Riosa et al, 2015, p. 463).

Parents described lacking confidence in the ability of adult services to be able to support their children's needs, based on previous experiences of clinicians who had inadequate knowledge and understanding of the implication of their child's diagnosis. "Every time we do have to switch doctors, we have to re-educate the doctor [about] our child." (Cheak-Zamora and Teti, 2015, p. 5). They reflected that although they had been able to intervene in such situations whilst their child was under the care of CAMHS, once transitioned to AMHS they would no longer be included by services and would be unable to support their children, which left them feeling anxious and afraid. (Swift et al, 2013). Parents' emotional reactions were potentially linked to an assumption that the homogeneity of adult services would render them less sensitive to the nuance of their child, a possible residual effect of struggling to obtain an initial diagnosis/access to services.

Professionals on either side of the CAMHS/AMHS interface described difficulty trusting professionals in the 'other' service to adequately manage the transition of young people. They acknowledged limited knowledge and understanding of each other's services which "led to opinions about each other instead of knowledge based on reality." (Lindgren et al, 2013, p. 105). AMHS staff worried that young people and parents were exposed to unrealistic expectations of provision and that the affirmative strength of the relationships between some CAMHS professionals and the families they supported was so strong as to make it difficult for them to feel confident referring the young people to adult services, (Lindgren, 2013).

Relationship dyads

Young people, parents and clinicians were required to negotiate and renegotiate their relationships with one another throughout the process of transition – a topic that was discussed in all the papers.

- *Child/Parent*

Young people in six studies (Burnham-Riosa et al, 2015; Cheak-Zamora et al, 2014; Dimitripoulos et al, 2016; Lindgren et al, 2014; 2013; and Swift et al, 2013) indicated that they experienced their parents as both helpful and unhelpful in the support that

they offered. Many adolescents commented that they preferred emotional support, and support to foster independence rather than active management of their mental healthcare by family members. Some young people experienced their parents as controlling, "…our respondents reported frequent conflicts with family members after the transfer to adult services, as families seemed reluctant to relinquish responsibility for managing the eating disorder to patients." (Dimitropoulos et al, 2015, p. 153). However, others relied on their parents' active involvement in their care, "some cases even suggested that they would not be willing to attend services without their parents present." (Swift et al, 2013, p. 8). Several young people suggested that their parents would also benefit from receiving support and education to help them adjust to the transition of their child into adult care (Dimitropoulos et al, 2016; 2015; Cheak-Zamora & Teti 2014).

Parents described difficulty relinquishing control of managing of their child's mental healthcare, despite recognising the strain that this could put on their relationship "I called [counselling] to make an appointment for him and they said he had to be the one to call. Well my 18-1/2year old son doesn't think he needs counselling." (Cheak-Zamora and Teti, 2015, p. 18). Parents lacked trust in mental health services acting in the best interests of their children and indicated that they believed that their children were unable to advocate for themselves.

- *Parent/Professional*

Parents in four studies (Cheak-Zamora & Teti 2014; Lindgren et al 2014; 2013; and Swift et al, 2013) commented on their experience of the transition from CAMHS to AMHS, framing it as disjunctive and fracturing. All described the sudden shift in care culture from one in which they were actively engaged with responsibility for their children's care, to one in which they were marginalised and actively excluded. Parents seemed unprepared for this precipitate change, leaving them feeling powerless and worried about the welfare of their children. Thus parent found themselves in a difficult position, from which there appeared no obvious solution. Parents alluded to a feeling of being forced to abandon their children at a time when their children needed them, which led to feelings of anger and frustration towards clinicians and services. Parents also described feeling let down by services that failed to involve them in, or

provide information about the transition process, adversely affecting relationships with clinicians.

Correspondingly, CAMHS professionals reported struggling to inform parents about the transition and likely future care as they themselves lacked information. Clinicians expressed feelings of anxiety and a lack of confidence in future care, which they were concerned might harm their relationship with parents. “You really try that your feeing of insecurity shall not be mirrored and you try to convey a positive image. But I have not much to say and no information to give and that sounds uncertain, when I can’t tell what will happen (CAP).” (Lindgren et al, 2013 p.104).

The majority of clinicians from both CAMHS and AMHS services advocated family interventions should be offered during transition to enable families to renegotiate their relationships regarding management of the young person’s mental healthcare needs. “Participants…unanimously supported the establishment of family interventions incorporating information about the changing roles of parents in care and supporting their loved one…” (Dimitropoulos et al, 2014, p. 6).

- Child/Professional

The relationship between adolescent service users and clinicians was discussed in eight articles. (Burnham-Riosa et al, 2015; Cheak-Zamora & Teti 2014; Dimitropoulos et al 2015, 2014; Lindgren et al, 2014; 2013; Swift et al, 2013, Wheatley et al, 2013). Young people placed their relationship with their clinician as central to their transition experience (Wheatley et al 2014) and those reporting a positive relationship with their clinician were more likely to view the service and their transition positively.

Young people voiced feelings of distress and abandonment at having to terminate their relationship with their CAMHS clinician and worried about forming a new relationship within a new unknown adult. “I don’t feel like I’m moving at a good enough rate to be able to stand out by myself. So it’s like, okay, my legs are still wobbling and yet you’ve abandoned me, it almost feels like? So I’m afraid, I’m terrified actually.” (Burnham-Riosa et al, 2015. p. 463). These feelings were particularly prominent for those who had not had an adult service identified for them.

Adolescent participants debated how adult clinicians would need to adapt to the young person's specific developmental stage in order to engage with them. "I'm just thinking [at an adult clinic], they're always dealing with adults and that they're just more like, 'Hi how are you . . . okay bye.' [firm tone]." (Burnham-Riosa et al, 2015. p.463). Young people described wanting the opportunity to meet their new clinician prior to the transfer of care, in order to initiate this relationship before having to relinquishing their relationship with their CAMHS clinician.

Professionals working in CAMHS often felt worried about the transition to adult services struggling to "let go" of their young people. Child clinicians indicated that the lack of relationship between child and adult services left them with limited knowledge of how adult services operated and a sense of adult services as being unable to meet the needs of their young service users. . "…the inability to answer their questions gave the professionals a feeling of insecurity. This feeling also made it more difficult to realise a good ending with the young adults. Professionals at CAP [Child and Adolescent Psychiatry] described that they tried to convey a feeling of security even though they themselves were uncertain and could not provide information about what would happen." (Lindgren et al 2013, p. 105-106).

Professionals working in AMHS worried that young people transitioning into adult services were likely to have high expectations that they would be unable to meet. "It's quite a big difference between child and adult psychiatry in how you think, it can be a big gap between. . . what can I say, in CAP it's more family-oriented" (GenP). (Lindgren et al, 2013 p. 105). They also questioned the motivation of some of the referred young people and their ability to cope in the adult environment. "Someone has not understood why they should come over here, they have felt their care completed. "(GenP) (Lindgren et al, 2013 p. 106).

- *Professional/Professional*

The operational relationship between CAMHS and AMHS professionals at the point of transition between their respective services was explored in two studies (Belling et al, 2014; and Lindgren et al, 2013) with notable emphasis on gaps and absences, with clinicians in both services identifying that they had little relationship with each other.

They indicated that this was associated with the introduction by clinicians of unhelpful assumptions. “Professionals at both CAP and GenP described that if they got to know each other and increased cooperation, the imaginations and assumptions about each other could be eliminated and the professionals would feel more secure during the transition.” (Lindgren et al 2013, p. 107).

Professionals from both CAMHS and AMHS seemed to experience a level of frustration that characterised their experiences of one another and was born out of a lack of mutual understanding. Professionals in AMHS expressed concern about the expectations held by CAMHS of their role within the transition process. “Clarity over what’s expected of adult services would be helpful. There is a great deal of ignorance on the part of CAMHS as to what adult services do or might do…” (Belling et al 2014, p.19). Whilst CAMHS professionals similarly indicated a desire for greater clarity. “It does seem a bit vague to me what’s available.” (Belling et al, 2014. p.172).

Resources

Structural Resources

Structural resources were widely discussed, being mentioned in nine of the ten articles (Belling et al, 2014; Cheak-Zamora & Teti 2014; Dimitropoulos et al 2016; 2015, 2014; Lindgren et al, 2014; 2013; Swift et al, 2013; and Wheatley et al, 2013). Services did not seemed to utilise a formalised transition protocol resulting in a lack of planning and organisation of transition, often meaning young people and parents received no formalised transition information. (Belling et al, 2014; Burnham-Riosa et al 2015; Cheak-Zamora et al 2014; Dimitropoulos et al, 2016; 2015; 2013; Lindgren et al, 2014; 2013; Swift et al, 2013). Young people and parents indicated that information about transition would prepare them for what to expect, relieving uncertainty and potentially reducing distress.

The narrow referral criteria employed by AMHS meant that not all young people leaving CAMHS were eligible to transition into an adult service. “They said, ‘Well you’re not sick enough to be in [adult] inpatient, then I guess there’s really nowhere else to go.’ And I turned 18, so I couldn’t be at [paediatric hospital] anymore.”

(Dimitripoulos et al, 2015 p. 10). Those most likely to be affected were found to be young people with emotional/neurotic, emerging personality and neurodevelopmental disorders. Thus highlighting a clinical need for the commissioning of a greater number of services designed to support the mental health of young adults who fall short of the current AMHS referral criteria.

Young people and parents argued for greater flexibility within the mental health resources available to them. "The whole point of still having the flip over,…it should be more catered to you and what you want?...Just because [professionals] have put a limited on something, doesn't mean it's always right for you." (Burnham-Riosa et al, 2015). Young people also wanted to be informed and involved at all stages of transition.

Fiscal resources

Young people, parent and clinicians highlighted the impact of financial limitations upon their experience of transition. High service demand and limited staffing were perceived to be precursors to long waiting lists and gaps in care, in which it was easy for young people to be deemed ineligible or to get lost from the system resulting in failure to transition. "AMHS staff perceived high case-loads, due to inadequate staffing as a major transition barrier…Efforts to cope with staff shortages led to rigid interpretation of eligibility criteria…" (Belling et al, 2014, pp172). Professionals implied that when they felt overstretch and under-pressure transitions became less of a priority.

AMHS were thought to operate strict referral criteria due to the financial constraints place upon them. Such strict referral criteria affected transition experience by creating uncertainty for both CAMHS clinicians and service users about whether a referral would be accepted by adult services. "It's hard to prepare a patient for transfer when neither we nor the patient know if they will be received at GenP" (General Psychiatry). (Lindgren et al, 2013, pp105). Young people voiced experiencing this as rejection by AMHS, feeling 'dumped' by services. Preparing young people for the possibility that adult services would not accept them was deemed essential to

“reduce the potential for patients to feel let down by services, or that services are not ‘responsible for them.” (Swift et al, 2013, p.7).

Service limitations and financial constraints impeded the ability of services to work collaboratively. Professionals in both CAMHS and AMHS highlighted the need for greater shared understanding and the opportunity for more collaboration between services, however struggled to action any changes. “All professionals agreed there were shortcomings in the cooperation between CAP and GenP. They had tried to cooperate in some cases during transition, but failed. The main reasons it failed were lack of availability to psychiatrist and difficulties deciding who should be medically responsible.” (Lindgren et al 2013, pp106). Thus, highlighting the potential reluctance of either service to carry the clinical responsibility and associated risk during the transition process, which could be linked to the perception of low staffing levels and high caseloads.

Intellectual Resources

Professionals expressed a lack of knowledge and understanding about the other service, which left them feeling unable to adequately equip their transitioning service users with the information they needed. “…their inability to answer their *[service users’]* questions gave professionals a feeling of insecurity.” (Lindgren et al, 2013, p.105). Similarly, service users and parents disclosed they were not given enough information about the transition process, leaving them to feel anxious and fearful about future care. Professionals highlighted the need for better communication and a desire for collaboration between themselves and greater willingness to share information about their services and service users. (Lindgren et al, 2013).

Young people and parents highlighted the importance for them of being included in all aspects of the transition process through the provision of information and being involved in any decision making processes. They described that this was not always the case and highlighted the impact upon them when it wasn’t, alluding to feelings of anxiety and insecurity. “I didn’t like that I was told on the day of moving, just one hour before” (Wheatley et al, 2013, p.214).

Young people and AMHS clinicians requested that precise information about the young person's history and treatment to date be shared by CAMHS with the new service prior to the transition. Young people indicated that they wanted to feel known by their new clinician before starting work together. AMHS clinicians also thought that prior information about the transitioning young person would help them to make informed decisions about how best to approach and support the young person in question. "Professionals at CAP described the importance to hand over information about the young adults and receive information from GenP about their possibilities of continuing care. As a complement to the referral, the professionals' at CAP wanted to give verbal information about the young adult. In some cases, GenP had been invited to a network meeting before a decision was made to refer the young adults." (Lindgren et al, 2013, pp106).

Parents and young people with specific conditions such as Autism, ADHA and eating disorders described being referred to professionals who lacked specialist knowledge about their particular condition. A finding highlighted by four studies (Burham-Riosa et al; 2015; Cheak-Zamora & Teti; 2015, Dimitropoulos el, 2015; Swift et al, 2014). "The other doctor, she didn't seem that knowledgeable about eating disorders. She kind of asked me, 'What do you want me to do? Do you want me to refer you somewhere?' It just didn't seem that helpful." (Dimitropoulos et al, 2015 p.150).

Discussion

A comprehensive thematic-synthesis of nine research articles was conducted, exploring adolescents', parents' and clinicians' experiences of the CAMHS to AMHS transition. Dominant findings included perception of the transition experience as an abandonment, not only by service users but also parents and clinicians. Other findings were linked to uncertainty about independence and autonomy and who should take responsibility for a young persons' mental healthcare at the point of transition, as well as highlighting the importance of positive relationships, good communication and information sharing. Results suggested that although some young people experienced a positive transition, this appeared capricious; the intervention of individual clinicians, rather than the enactment of a service specific transition protocol. Review findings echoed earlier studies, notably the Track Study (Singh et al 2010) indicating generally poor transition experiences with significant negative consequences, despite interim guidance issued by governing bodies such as NICE and NHS England focused on enhancing the CAMHS to AMHS transition. Where positive transitions were reported they were characterised by good preparation, communication and information sharing between CAMHS and AMHS, young people and their families.

The transition experience for most young people, parents and clinicians was characterised by a sense of abandonment. Parents appeared particularly afraid for their children at this time, feeling powerless to protect them, forced to abandon their children to fend for themselves, due to the individual approach upheld by AMHS services. Parents worried and felt angry about the emotional impact of transition on their children and questioned the support offered by services to help them manage the transition, whilst they themselves were excluded.

Young people described feeling abandoned by mental health services, but especially by their CAMHS clinicians' at the point of transition (Lindgren et al 2014). This was particularly pertinent for those whose relationship with CAMHS had been longstanding. These findings can be informed by attachment theory (Bowlby 1969) implying that young people may have established attachment relationships with their CAMHS clinician's. Adshead, (1998) argued that clinicians could come to represent attachment figures for patients. If so, an abrupt or unplanned termination of this

relationship would cause distress and adversely affect perception of the transition experience. For young people who transition into adult services emotionally safety may be regained through AMHS support, however those ineligible for AMHS services are at risk of being left unsupported to deal with their feelings of loss and abandonment. Swift et al (2013) supported this assertion finding that those who failed to transition were at increased risk of re-presenting to adult mental health services at a later date, in crisis. Thus, emphasising the importance of services getting the CAMHS to AMHS transition right, taking into consideration the potential influence of individuals' relational attachment patterns and seeking to facilitate positive endings to longstanding relationships and the gentle formation of new attachments.

Young people supported the potential role of attachment relationships within transition experience highlighting their desire for emotional containment from clinicians throughout the transition period. They suggested keeping their CAMHS relationship going until they were established with AMHS, potentially allowing for a gradual transfer of their relationships, which could minimise the distress associated with transition through providing a sense of containment.

Age as a trigger for transition received significant criticism from parents, young people and clinicians. Young people and parents appeared angry and frustrated by the rigid transition age and expressed incomprehension as to the logic of a transition dictated by age and argued instead for flexible transitions organised around need, maturity and readiness. Clinicians also recognised the need for greater subjectivity when it came to transition age boundaries. (Burnham-Riosa et al, 2015; Cheak-Zamora et al, 2015; Dimitropoulos et al 2015; Lindgren et al, 2014; Swift et al, 2013). Building services that consider transition in light of the concept of 'emerging adulthood' Arnett (2007), would be more likely to result in flexible services that are able to respond to considerable individual variability and are not tided to rigid age limits. Emerging adulthood conceptualises transition from adolescent to adulthood being a gradual move from one position to another with considerable individual variability.

Young peoples' desire for autonomy and independence varied considerably between individuals, with young people and their parents entering into an ongoing process of

negotiating responsibility for management of their mental healthcare during the transition process. These negotiations appeared reflective of other parent-child negotiations that are inherent within adolescence and could be linked to changing relational attachment patterns associated with normal adolescent development, which typical manifests a desire for greater independence (Laible, 2000). However, despite seeking greater autonomy majority of young people desired the option of continued parental involvement during and after transition to AMHS highlighting the importance of parental attachments and support in late adolescence. Clinicians also recognised the importance of family support for young people during and after transition to adult services. A willingness on the part of adult services to include parents' with the permission of the young person concerned would provide a measure of security and consistency, potentially improving transition experiences and engagement with services. (Dimitropoulos et al, 2015, 2016; Swift et al, 2013).

The findings demonstrated that respondents engaged in blaming and failing to understand one another's position. Applying systemic theory to understand CAMHS to AMHS transition experiences gives a means of helping to account for both the apparent lack of empathy displayed by respondents and also the 'stuckness' they seem to convey. Systemic theory places individuals' within their context, exploring relationships, communication and interaction between individuals and the systems in which they are involved. Systemic theory could be used to suggest that respondents blamed one another because they were unable to effect change individually due to the problems stemming from the relationships that exist between them within a set of systems. As stated by Bateson (1972) "Pathology is not in each individual person but it is in the pattern of relationships between them."

Finally, results highlighted the difficulty clinicians faced attempting to facilitate positive transitions when they felt insecure and uncertain themselves, again highlighting the potential role of attachment theory within understanding transition experience.

Strengths and Limitations

The benefits of systematic review lie in its conceptualisation as a rigorous, structured and replicable process through, which to explore and synthesise the findings of multiple research studies. Historically, the emphasis has been place on the systematic reviewing of quantitative studies and RCTS with qualitative data being rather overlooked and judged to stem to methodologies too far apart in their epistemological stance to allow their findings to be satisfactorily synthesised.

Systematic review of qualitative literature, offers the opportunity draw together evidence of experiences, which is important as it is known to have significant impact upon outcomes and should, therefore, contribute to the creation of best practice guidelines and service development. The structured approach of a systematic review also benefits from increasing generalisability; a common criticism of qualitative research. (Dixon-Woods et al, 2006)

The validity of this review was increased through the use of an appropriate search strategy and the use of a second reviewer to verify the themes developed out of the interpretations made by the first reviewer. Further weight was added by the exploration of the views of clinicians' and unique findings; the sense of abandonment, the 'stuckness' in the system and the tendency towards the denigration of 'other' highlighted by the respondents. However, the review was limited by factors that affected the generalisability of the results including; the gender disparity of study participants and the lack of ethnicity reporting by many studies. Furthermore, there were significant differences in the healthcare systems operated within those countries from which the studies were drawn, which would have undoubtable impact upon service users lived experience of utilising those services and by extension service transitions.

Exploration of lived experience requires interpretation by the original researchers, which is then re-interpreted within the current review, leading to the potential for bias. However, the potential for bias was minimised by situating interpretation firmly in the original data of participants through the use of quotes and conducting quality appraisal checks of the articles included in the review, which elicited the attempts the

researchers made to minimise bias in their results through techniques such as triangulation.

Conclusion

In conclusion, despite current best practice guidance young people, parents and clinicians continue to experience CAMHS to AMHS transitions as emotionally distressing and difficult, characterised by high levels of anxiety, feelings of abandonment and a sense of 'stuckness' within the system. The synthesised research evidence presented in this review demonstrates the negative impact upon young people, parents, and clinicians of uninformed, unplanned, hasty CAMHS to AMHS transitions. However, this review also sought to highlight those elements needed to create a positive transition experience, as identified by those with lived experience of the CAMHS to AMHS transition.

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SECTION B: RESEARCH REPORT

Getting ready to move on: Considering attachment within young peoples' experiences of preparing to transition out of CAMHS.

Abstract

Aims: The aim of this study was to qualitatively explore, from an attachment theory perspective the lived experience of young people as they prepared to transition out of CAMHS services.

Method: Five participants were recruited from a local CAMHS service and engaged in in-depth interviews exploring their experiences of engaging with CAMHS and preparing to leave the service. Interpretive Phenomenological Analysis (IPA) was used to consider how participants created meaning from their experiences. An extra layer of analysis was added in which the initial interpretations were viewed through the lens of attachment theory in order to create the results. This process was validated using the interview data.

Results: Four superordinate themes were identified: Navigating the journey to find help, Endings, Transition to adulthood: A deadline on my 18th, Feeling connected.

Conclusions: Themes demonstrated the complex journey young people embark upon as they move through CAMHS toward a final transition out of the service. The results reflected the possibility of attachment patterns playing a part in the mean making of young people preparing to transition. It is recognised that whilst services are aware of the need to focus on the lived experience of transition, prioritising endings is a difficult task given time constraints and resource limitations. Clinical and research implications are discussed.

Introduction

This study reports the results of an attachment theory focused, phenomenologically informed study of the experiences of five young people preparing to leave Child and Adolescent Mental Health Services (CAMHS).

Background and context

In 2015 almost a quarter of a million children were referred to CAMHS services with approximately 72% receiving a service. (Children's Commissioner, 2016). Given the not insignificant numbers of young people undergoing transition out of CAMHS it seems important to develop a fully comprehensive knowledge and understanding of CAMHS transitions, especially the lived experience of service users.

CAMHS to AMHS transitions research

Mental health transitions research has served to demonstrate significant room for improvement of the CAMHS to AMHS transition. The TRACK Study (Singh et al, 2010) comprised of a comprehensive exploration of the transition process and was conducted in response to recognition that young people were at risk of being 'lost' into a care gap during the transition between CAMHS and AMHS. Its aims centred on identifying organisational factors affecting transitions and making recommendations about service organisation, delivery and continuity of care. Lived experience was also looked at with only 5% of transitions perceived to be positive (Singh et al, 2010, Pp22). Track study findings have been echoed by more recent research, reporting transitions marred by a lack of information, poor communication and failures in the preparation of young people and their families. (Belling, et al 2014; Swift, et al, 2013; Wheatley et al, 2013). Literature reviews have drawn together research on CAMHS to AMHS transitions with similar results. Munoz-Solomando, Townly & Williams (2010) identified a clear need to enhance patient experience and more recently a scoping review (Reale & Bonati ,2015) and a systematic review (Paul, Street, Wheeler & Singh, 2015) argued that what was needed, but lacking were smooth service transitions.

Adolescent Transitions

Adolescence is accepted as a time of great flux in which many transitional experiences occur, (Osgood, et al 2005). Adolescence itself is a transition according to Arnett

(2007) who proposed the concept of 'emerging adulthood' to describe the gradual transition journey young people undertake as progress from adolescence towards adulthood. The challenge of transitioning out of CAMHS is therefore an additional transition for CAMHS services users. The lived experience of CAMHS transition may be affected by its coincidence with other transitional experiences.

Transitions and Attachment Theory

Research to date does not appear to have qualitatively explored the potential role of attachment theory (Bowlby, 1969) within the subjective experience of transition out of CAMHS services. Research regarding adolescent transitions and the role of attachment style has been conducted in respect to other life transitions, such as transition to university (Ames et al., 2011; Car et al., 2013), physical healthcare transitions (Nathan et al., 2011) and transition to adulthood (O'Connor et al., 2012). Typically, these studies have indicated that a secure attachment style aids coping and adjustment (Ames et al., 2011; Scharf et al., 2011).

Attachment theory may be helpful in exploring individuals' lived experiences of mental health service transitions, (Bucci, Roberts, Danquah & Berry, 2014; Goodwin, 2003). Transitions between mental health services have been identified as an area in which numerous problems can arise. Mental health service transitions often present a situation with a high level of uncertainty, which can be distressing and anxiety provoking for service users, their families and clinicians (Burnham-Riosa, Preyde and Porto, 2015; Lindgren 2013). Successful transitions could be argued to depend largely on the individual service user's ability to regulate difficult emotions, tolerate uncertainty, adjust and adapt to the changes in service provision. Service users with an autonomous attachment style may therefore, be better equipped to cope with the demands of transitioning than service users with an insecure attachment pattern. Attachment style might therefore impact upon how young people make sense of their experience of preparing to transition out of CAMHS.

Attachment Theory

Attachment theory (Bowlby, 1988) argues that infants seek to form relationships in order to survive and do so through developing and utilising adaptive attachment

behaviours that are designed to ensure that an individual's attachment needs are met. Attachment theory postulates that early relational experiences lead to the formation of internal working models of the self, others and relationships, which support future relationship formation and maintenance. In circumstances in which early interaction is 'good enough' (consistently positive and reliable) a secure attachment style is like to develop. Secure attachments engender trust in the relationship with the caregiver (Ainsworth, 1964), which through consistent availability and positive interaction creates a sense that they are a 'safe haven' which the child can turn to for protection when seeking safety and comfort at times of distress and a 'secure base' from which the child can confidently explore their environment when they are feeling safe (Cooper,et al, 2001).

Alternatively, early interactions and experiences that violate the 'good enough' threshold (i.e. inconsistent, unreliable, abusive) lead to the development of insecure attachments and attachment patterns. Insecure attachment is broken down into three categories; anxious-ambivalent, avoidant and disorganised. Anxious-Ambivalent attachment is a strategy that serves to try and fulfil the attachment needs of an infant through attempting to maintain proximity to and avoid separation from the caregiver. Where Anxious-Avoidant attachment is an attempt by the individual to ensure their attachment needs are met by avoiding proximity to the caregiver and becoming overly independent and self-reliant. Finally, disorganised attachment is thought to occur when a child is fearful of a caregiver, frequently occurring due to instances of abuse, or serious neglect (Cooper, Hoffman, Marvin, and Powell, 2001).

An insecure attachment style can cause an individual to encounter many difficulties as they attempt to negotiate their environment, including problems relating to, or trusting others and forming/maintaining relationships, as well as difficulties with emotional regulation and distress tolerance (Winnicott, 1965).

Infant attachment is known to be predictive of attachment style in adolescence however is not predictive of adult attachment style. When considering attachment in adolescence and adulthood four categories of attachment have been suggested, which loosely map on to the attachment styles of infancy and childhood; autonomous,

preoccupied, dismissive and disorganised. (Main and Goldwyn, 1998). It is noteworthy that research has shown that attachment style can change overtime and through circumstance with previously insecurely attached individuals developing secure attachments and vice versa (Cozzarelli, et al 2003).

Rationale of the current research

The developmental, systemic nature of CAMHS, encourages the formation of positive, meaningful and supportive relationships. Such relationships arguably have the potential to become attachment relationships because they aim to offer proximity, a sense of safety and a meaningful relational connection (Bowlby, 1969). This assertion is supported by Adshead (1998) who found that clinicians could come to represent attachment figures for patients, and this attachment affected the manner in which patients and clinicians interacted. It is entirely possible that attachment patterns influence young people's lived experiences of CAMHS and plays a part in how service users make sense of preparing to move on from CAMHS.

The current research hopes to qualitatively explore, using IPA, young peoples' experiences of preparing to transition out of CAMHS, from an attachment theory perspective. It is hoped that providing an insight into the possible ways in which service users make sense of their experiences, services can become more sensitive to service users' needs as they move through their transition journey. Developing services that positively support the lived experience of service users would arguably lead to better transition outcomes and service user satisfaction.

Aims of the current research

The study aimed to gain a deep and rich understanding of the lived experiences of service users' as they prepared to leave CAMHS. The study aimed to view these experiences through the prism of attachment theory to see if this could illuminate an alternative explanation, or deeper understanding of CAMHS transition experiences.

Methodology

Design

A qualitative methodology was considered appropriate to explore the research question due to the lack of previous research exploring the lived experience of young people preparing to transition out of CAMHS. Interpretative Phenomenological Analysis was employed as its idiographic nature captures "a persons' relatedness to or involvement in, a particular event or process." (Smith, Flowers and Larkin, 2009, p.40). The double hermeneutic embodied in IPA reflects the process of the researcher making sense of the participants' sense making thus giving voice to individuals' lived experiences (Larkin and Thompson, 2011).

In addition the study was also interested in the potential role of attachment theory within the transition experience and the results of the study were interpreted through this lens and discussed with this theoretical perspective in mind.

Researcher's epistemological position

The researcher adopted the epistemological position of a critical realist (Appendix F).

Quality Issues

Yardley (2008) listed four principles for ensuring quality with regard to qualitative research; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Smith (2011) suggest seven key elements possessed by a good IPA study. 1) clear focus, 2) strong data (through conducting good quality interviews), 3) rigor (breadth and depth of themes supported by data extracts), 4) sufficient space for the elaboration of each theme, 5) interpretative not just descriptive analysis, 6) analysis pointing to both convergence and divergence, 7) carefully written. It was the aim of the research to reflect the recommended elements of quality as suggested by both Yardley (2008) and Smith (2011) throughout the research process.

Binocularity which is the examination of data through different prisms such as attachment theory, as seen within the current study and can be seen in Langdridge's (2007) critical narrative analysis, which assimilates aspects of phenomenological and

narrative approaches. The use of binocularity has been advocated by several researchers including Frost and Saville Young (2008) in Willig and Stanton-Rogers (2008) who explored transcripts through the lens of psychoanalysis and Eatough and Smith's (2008) whose approach to IPA "involves moving between different levels of interpretation, starting off with a descriptive phenomenological account which is then followed by a level of analysis that involves critically probing and then theorizing the data, thus offering a deeper hermeneutic reading." (Willig, 2013, p. 516).

Extracts of coding at each stage of the analysis are displayed in appendices H and I to support transparency. The researcher kept a reflective diary throughout the research process and engaged in supervision to discuss themes and prejudices influencing interpretation.

Sampling

"Participant are selected on the basis that they can grant us access to a particular perspective on the phenomena under study." (Smith, et al, 2009, p.49). Sampling was therefore purposive. The sample comprised young adults (n=5) who were nearing the transitional age for CAMHS (18years). A sample size of three participants is deemed sufficient within an IPA framework in order to see convergence and divergence and small homogenous samples maximise validity of phenomenological interpretations for specific groups (Smith et al., 2009) whilst supporting meaningful comparisons across the data (Smith, 1999). Five participants was therefore considered to be an appropriate number to provide sufficient opportunity to explore both the similarities and the differences between individual's experiences

Participants

Participants were recruited from a CAMHS service located in the U.K. They ranged in age from 17year 6months to 18years one month and had been engaged with CAMHS for at least 12months. Suitable participants were identified by their key clinician and invited to take part.

Participants were offered an incentive; a £20 gift card, which was considered to be sufficient to express gratitude to the participant without being coercive.

Participant demographics

Name	Age	Ethnicity	Gender	Transition to AMHS Yes/No
Daisy	17years 6month	Caucasian	Female	No
Molly	17years 11month	Caucasian	Female	Yes
Thomas	17years 7months	Caucasian	Male	No
Adam	18years 1months	Caucasian	Male	Yes
Jack	17years 11months	Caucasian	Male	No

Ethical Consideration

Interested participants were given a patient information leaflet (appendix G) and minimum of 48hours to reflect on their decision before being contacted by the researcher to offer them the opportunity to ask questions and to arrange a time for interview. Prior to an interview a consent form (appendix G) was read with the participant and signed by both the participant and the researcher. Participants were encouraged to ask questions at any time throughout the research process and to contact the researcher if they experienced any distress. Participants were informed and reminded that they could withdraw from the study at any time without explanation.

Procedure

Participant Recruitment

Potential participants were identified as young people who were within 12months of discharge from CAMHS due to reaching the upper age limit for the service. All potential participants were identified by their CAMHS clinician, who then discussed the research project with them within their scheduled CAMHS appointment. Interested parties were provided with a Participant Information Leaflet and Consent Form to read and if interested in taking part they informed their clinician who in turn informed the researcher.

Interview Procedure and Materials

An interview schedule was used by the researcher to help guide the general direction of the interviews. However this was not prescriptive and wherever possible the researcher allowed the interview to be led by the participant.

Participants could choose where they were interviewed: Home, or CAMHS. All participants opted to be interviewed at home. The interviews lasted for approximately 1hour and were recorded using a digital voice recorder and then downloaded onto an encrypted memory stick, which was kept in a locked cabinet.

Transcription Analysis and Procedure

The data was analysed using a method set out by Larkin and Thompson (2011) in Harper and Thompson (2012). However this was modified to include a final layer of analysis in which the researcher viewed the data through the prism of attachment theory in an effort to explore the possible impact of relational attachment patterns on participants' lived experience of preparing to transition.

The audio recordings were transcribed verbatim by the researcher, including verbal and non-verbal nuances, gestures and gesticulations. It was acknowledged by the researcher that the act of transcription was a form of interpretation.

Interview transcripts were read and re-read in order for the researcher to become fully immersed in the data. The researcher then engaged in a process of line-by-line coding of the transcripts (Appendix H) followed by looking for 'objects of concern' (things that seem important to the participant) and 'experimental claims' (linguistic and narrative clues as the meaning of those objects). Each 'object of concern' was then linked to all the relevant experimental claims, which in turn were summarised by the researcher into several all-encompassing points (Appendix I). These themes were then further synthesised and collapsed into each other producing a list of 20-30 themes for each transcript with supporting quotes.

Once each individual transcript had been analysed separately the researcher looked to identity patterns of convergence and divergence across the transcripts. This was followed by an additional layer of analysis, re-examining the results through the lens

of attachment theory. This novel approach was in part justified by Smith et al's, (2009) acknowledgement of the potential value of research expanding IPA's connection to other qualitative methods; "we welcome these developments towards a more mature, synthesized, qualitative psychology" although warned against losing sight of "lived experience, hermeneutic inquiry and idiographic focus". The researcher also looked to Langdridge (2007) who suggested utilising the "imaginative hermeneutic of suspicion" which encourages "alternative ways of reading the text" (p.140) to accommodate and justify the application of the hermeneutics of attachment theory as a final step in the analysis. The researcher first analysed the data using the approach to IPA analysis described by Larking and Thompson (2011) to ensure the initial interpretations made were grounded in the data. The extra layer of analysis was then applied in an attempt to take the interpretations further, moving towards a more hermeneutically suspicious position, questioning the initial interpretations of the data using attachment theory as a prism.

Results

Three superordinate themes were generated from the interview data, each with several subthemes that shall be elaborated upon below.

Where an Attachment Theory perspective is offered, it is denoted in **bold.**

Superordinate themes	**Sub-themes**
Navigating the journey to find help	'Circling, circulating CAMHS
	The availability of help
Endings	Loss/Abandonment: *'The ground from beneath me has sort of been taken away'.*
	Transition/Metamorphosis
Transition to adulthood: A deadline on my 18th	Expectations of Adulthood
	An internal working model of the adult self
Feeling connected	Social connections
	One of the lads

Navigating the journey to find help

'…it was quite difficult because the only thing they could offer me was CAMHS and um it wasn't really there t-at the beginning.' (Daisy)

A topic raised by all participants was their experience of engaging with CAMHS, which appeared to influence their expectations of AMHS and their prospective transition out of child services. The first subtheme illustrates how experiences of obtaining support from CAMHS influenced expectations of both the availability and responsiveness of AMHS. The second subtheme relates to participants understanding of what is required in order to access help in light of their experiences of obtaining help from CAMHS.

– Circling, circulating CAMHS

The theme 'Circling, circulating CAMHS' comes from a quote by Molly and relates to her sense of reaching CAMHS, but then struggling to get a grip on it, to get access into the core of the service where the 'real' help could be found. Adam supported this view commenting that he had only recently been able to reach 'the heart of CAMHS' after years of being part of the system. Other participants also highlighted lengthy journeys and waits, from referral through to finding CAMHS support that they found helpful. Participants found this experience extremely challenging:

'I have had to push through and fight so much' (Molly)

'*A referral was easy but actually getting into it was quite difficult […] Because there was a few times I thought that maybe they* [CAMHS] *had forgotten about me sort of thing.' (Daisy)*

Participants experienced anxiety about if and when help would be provided and struggled with the uncertainty of not knowing. Four participants described having to wait a considerable length of time before they received an intervention from CAMHS that they found helpful. These young people highlighted how the lack of responsiveness to their request for help left them feeling isolated, powerless and struggling to cope.

'I had sort of been circling, circulating CAMHS but I hadn't actually, I had been on their record as it were, but I hadn't actually been sent anywhere.' (Molly)

'It was quite difficult um cuz I had sort of experienced before since I was a kid about like dealing with anxiety and things like that but not too well and it was quite, it was quite difficult because the only thing they could offer me was CAMHS and um it wasn't really there t-at the beginning…and I didn't really have anyone to sort of go to from CAMHS because I was on a waiting list and it was just like…,or if like I had really bad, or if I had a breakdown or anything like that, it was probably the worst because there was like nobody to go to…' (Daisy).

Once accepted into CAMHS, four participants described the challenges of finding the 'right' CAMHS support. Participants described the problems associated with irregular appointments and inconsistent clinicians who did not know them.

'But it was always like with different doctors as well…never something permanent, never something I could go to every so often, every month or something, it was always random.' (Adam)

'…it takes ages for you to get into the system…I remember, um, I went to my doctor and told my doctor all about it and my doctor then sent me somewhere else and I had to tell them all about it…[…]…and there was lots and lots of people there that I had to speak to and tell the same thing to, um so when I got to Dr Naylor and Dr Naylor told me that she thought I was quite ill and that I needed medication, I cried because it was the first time anyone had said to me, 'hey, I think there is something wrong with you and I think there is something I could do to help.' (Molly)

In addition two participants reported being offered support, but finding it unhelpful .

"…I went in with my mum and someone else who is in the healthcare system that's one of our friends…Um, she had to come in to explain everything to us, cuz then, they were still, they were just still talking, well in all the technical terms which was confusing for both me and my mum..." (Thomas).

"Um, I mean with the first lady I had, it sounds really weird…And um I had her for quite a while I think um but that didn't really do much, it was more just sort of, in my mind I was just like this it-it'll help, you know um I then ran out of sessions with her so then she left, well I left the thing um then I had the guy from mindfulness um who I had for maybe about three sessions and I just didn't feel comfortable sort of thing, I just wasn't, I just didn't like it." (Daisy)

Furthermore, the journey into CAMHS appeared to mirror participants' expectations of AMHS, especially availability and responsiveness. Jack, who perceived his CAMHS journey to be smooth and seamless thought AMHS would be easily accessible. Whereas Molly and Daisy who perceived more difficulty in accessing CAMHS questioned whether AMHS support would be available to them.

"Yeah, it's just, it's always been there, it's, yeah, um, it's always been there and um…it's something I have always been there to fall back on. I like just need it there and it's always been…it's just really helped me… […]..So I will definitely keep those in mind so if need to go back to them…" (Jack).

'In-in their minds I'm not like priority, which is fair enough, I am not like threatening my life or anything like that…um so I don't really think I'll be seen at all, I think I'll end up like at the bottom of the list.' (Daisy)

Participants' experience of CAMHS also appeared to influence their expectations of AMHS clinicians and how they might be treated within an adult service.

'And I don't know because it will be adult mental health whether they will be less sort of… caring.' (Molly)

'"I think I feel like it is going to be a bit more like…a little less relaxed I'm feeling because it is not a chat between a teenager and an adult it would be a chat between two adults which is relaxed but not as relaxed as someone who is still quite young. In that kind of sense it almost scares me, I don't know why"' (Thomas)

Using Attachment Theory to consider participants' experiences of 'Navigating the journey to find help', allows for the suggestion that, like an infant whose caregiver is experienced as unavailable, adolescents experienced CAMHS as unavailable leading to increased anxiety and a lack of trust in the availability of services to meet their needs. Feeling anxious and unsafe could result in young people with a more anxious-ambivalent attachment style seeking reassurance from other sources as a means of reducing their emotional distress, whereas those with a more dismissive style may stop seeking support altogether. In the quotes below Daisy refers to seeking medical support and Molly describes the frustration she experienced due to the lack of responsiveness from CAMHS.

"I had like scans, the full works and-and basically nothing came back and they were like it's probably to do with anxiety sort of thing, um, and I didn't really have anyone to sort of go to from CAMHS because I was on a waiting list." (Daisy)

'I did get through there in the end, it just took a while and by the time I got to Dr Naylor I was quite…er…I don't know, um…confrontational about it, cuz I had told my story so many times, and I couldn't really get anywhere.' (Molly)

The availability of help

Participants described a sense that they needed to exaggerate, or demonstrate their distress in order to gain access to consistent help from services.

'I don't think anything will really happen um unless I'm like climbing rooves or something, I don't know.' (Daisy)

'I know how hard it is to get recognition for your mental health and it kinda has to have that you have this massive snap and you break for people to go damn, maybe, maybe we need to support her a bit more.' (Molly)

Participants highlighted that they had an awareness of service limitations and the need to prove that they qualified for the support they were seeking. Daisy in particular demonstrated a clear tension between what she felt she needed and what she believed was available. She described feeling guilty for wanting support from such limited services when she believed that others were in greater need. Daisy implied that she thought she would be seen as attention seeking if she did ask for help again and seemed to have begun to question her own deservedness.

'…like one of the therapists, was that, saying about the waiting list and how it's quite long and she was asking if I was suicidal, self-harm sort of thing and basically saying that if I was that would bump me up the list sort of thing and it's sort of like, you do feel like, cuz obviously there are people out there who do sort of need it more and are having a harder time, but…you do need it as well…' (Daisy)

Molly and Daisy both made a distinction between 'the system' and the people working within 'the system', suggesting that whilst they might have experienced relationships with specific CAMHS clinicians as more containing, their relationships

with 'the system' in which CAMHS operated was experienced as inconsistent and unresponsive. Consequently, both participants expressed difficulty trusting that AMHS would be any different.

'I trust [therapist] and I do trust [therapist], I just don't trust the system.' (Molly)

'It's the people there that all they wanna do is help but there's just not enough people and there's just not enough time for it […] you can see their like schedule is like full to the top of people that they've got to see and they just, it's not the people at CAMHS it's the, yeah it's the system that's just, needs sort of revamping I guess.' (Daisy)

From and Attachment Theory perspective it could be argued that experiencing services as only offering support if they deem risk to be high can result in a person thinking that they have to overemphasise their need in order to secure support. This pattern parallels with a pattern of preoccupied attachment and resultant hyper-activation of the attachment system. Hyper-activation of the attachment system is an adaptive strategy that an infant might learn in order to optimise getting their attachment needs met and occurs when the caregiver isn't consistently available and/or does not do enough to encourage exploration. Hyper-activation is therefore an adaptive strategy to try and maintain proximity to the attachment figure. If, therefore, young people experience mental health services as unavailable this may lead some individuals to adaptive attempts to ensure support is provided, for example through demonstrating their level of need. Conversely, if an individual believes services will continue to remain unavailable to them in spite of their attempts to ensure support they may suppress their attachment seeking behaviours (Adshead, 1998; Vogal and Wei (2005).

Jack provided a contrast to the other participants in that his experience of accessing CAMHS support was smooth and easy suggesting that the tasks of creating a 'secure base' and 'safe haven' might have been enacted through his engagement with CAMHS. He described engaging and disengaging with CAMHS as he chose and being quickly provided with helpful support when he requested it. Jack's experience of

accessing support appeared to have led to a belief that his requests for help now and in the future would be fulfilled.

"Yeah, it's just, it's always been there, it's, yeah, um, it's always been there and um…it's something I have always been there to fall back on. I like just need it there and it's always been…it's just really helped me." (Jack)

"I think sometimes I've gone off it and then sometimes I go back there for a bit but um…yeah they have always been helpful and I have always been able to talk about my issues." (Jack)

Jack further intimated that he returned to CAMHS at times when he felt distressed and alone, leaving again when life was running more smoothly. Perhaps suggesting that he retreated to his perceived 'safe haven' when his attachment system had been activated, leaving from this 'secure base' once he had sought reassurance and his exploration system had come into effect, reducing his sense of needing CAMHS. This fitted with Jack's description of how he thought he might use adult services in the future:

but I think, I feel like I am fine with leaving CAMHS…[…]… it does help a lot, so I will miss it a bit, not knowing that I am going there, but um I think it's also a good thing, I couldn't do it forever I don't think. I think I need some months to face these things alone sort of." (Jack)

Endings:

Participants viewed the ending of their relationship with CAMHS and their CAMHS clinicians in different ways, which appeared to influence how they felt about transitioning out of the service.

Loss/Abandonment: …the ground from beneath me has sort of been taken away.

Some participants expressed feeling a sense of loss at having to move on from CAMHS, indicating that they would have liked to stay longer.

Daisy described the frightening loss of certainty that came with moving on from CAMHS, highlighting the impact upon her emotional state of not knowing what would happen next, or how she would cope.

'I felt like I was finally getting help and then it ju-it just stopped sort of thing and it was just quite, I don't know…it's-it's weird, like I obviously, like I knew it was going to happen but it was just sort of, I don't know, it's difficult to not have, or to know like in the next week or whatever um that I am not going to go back there and get some sort of help it's just sort of, it's weird, I don't know, it's quite scary to be honest, it's just sort of, dunno. I just feel like the ground from beneath me has sort of been taken away and like not yet but when it does, I feel like I am just going to end up falling back to where I was, which is quite a scary thought…' (Daisy)

Daisy expressed her fears about the possible impact of ending her relationship with CAMHS on other supports such as her financial aid, hinting at the ending representing a potential loss of financial security as well as emotional support. The uncertainty of not knowing whether, or not this was the case further exacerbated her sense of losing something significant.

'I am sort of scared, scared of losing sort of PIP because I am not on the CAMHS system, cuz they might see it as "oh, she's not getting mental health support, she might not…" and then I'm, literally I can't pay rent I am not going to be able to, you know, do things and…'(Daisy)

Molly also alluded to leaving CAMHS as a loss, fearing that this would lead to abandonment by mental health services, like Daisy, she highlighted the impact of uncertainty upon her experience of preparing to transition out of CAMHS. She described feeling both anxious and scared as a result.

'Errr, unfortunately I don't really know because [Therapist] has sort of mentioned it and I just sort of go into a blind flurry of panic, cuz I think I just want [Therapist] to wait until after I am 18 and then we have a meeting and then I know that I am not going to be dropped…[…]…You know it is stupid paranoia but after I am 18 we can talk about it because I know the [therapist] isn't just going to be like, right, bye!' (Molly)

Metamorphosis

In contrast, Jack, Adam and to a lesser extent Thomas, gave the impression that they considered ending their work with CAMHS as an opportunity to move forward to something new, conceptualising leaving CAMHS as a being both an ending and a new beginning:

'when I started with [Therapist] I built, I've changed a lot as a person since then, I've just, loads of stuff like handling meeting new people, and my anxiety and stuff like that I have gotten way better at I think CAMHS has definitely helped with that and I hope that, that is going to be enough to get me through the rest of my life. Set me up to be able to face these things better.' (Jack)

"It makes you feel really confident, the fact that there is someone there, that there are people there, like the same as here, the same as the younger care in CAMHS cuz I am not just being chucked under the bus or anything, you not what I mean, it's not going in completely blinded." (Adam)

Jack alluded to conceptualising the ending of his time with CAMHS as something manageable, especially in light of his supportive relationships outside of CAMHS. He suggested that he felt ready to move-on from CAMHS implying that he interpreted it as something of an achievement. However he also highlighted the challenge of not being forewarned of the upcoming ending and the impact of this on his experience, suggesting that he had been left with some sense of regret for not having taken full advantage of the support offered.

"It probably would have made me a bit more acceptant about it and maybe um get some things out the way before it's all over. Like different problems I am having, like I need to fix that, like you know before it all ends and stuff. Maybe think about things a bit more rather than waste the sessions talking about like certain problems that aren't that big, maybe, I don't know maybe talk about what I am going to go on and do later in life and maybe some of my anxieties about that." (Jack)

Adam described feeling that his clinician had prepared him well for the transition, potentially supporting his sense of the ending as a metamorphosis. Although Adam

also reflected on how his sense of connection to CAMHS was limited due to the short amount of time he had been receiving helpful support and the impact this had on his experience of preparing to transition.

'I think the heart of CAMHS at a really late on stage I'm not really sure, it doesn't really bother me kind of thing…[…]…the time I had with her is a very short space of time I've had, but she has done a really good job, in the time that she's had, and she's explained it to me like really well. Like proper done a good job there I think…I feel like she's explained it to me and…I know basically what's going to happen kind of thing, she's let me know to the best of her ability and she's still going to help me with it, yeah.' (Adam)

The ending for Thomas seemed to produce mixed feelings. He indicated a sense that he had used the service to meet his needs and could therefore move on. He expressed relief at finally having completed work with CAMHS and that he did not need to go to adult services. However, he also expressed sadness at the ending of his relationship with his clinician.

'It actually means a lot, the fact that they have finally got everything done, um, I know now that all I have got to do is, um, I am getting everything sorted now.' (Thomas)

The young people interviewed will have experienced their time in CAMHS as addressing their needs to differing degrees and this is also likely to be relevant to their interpretation of the ending of their time with the service.

How participants experienced the approaching ending may have been linked to their attachment styles. Looking through the lens of Attachment Theory it could be suggested that participants working closely with CAMHS for a lengthy period of time came to rely on CAMHS. Leaving CAMHS therefore provoked feelings of sadness and anxiety and was in turn interpreted as a loss. Daisy's and Molly's feelings of fear could be argued to be indicators that their attachment systems' had been activated by the prospect of no longer receiving support from mental health services.

In addition it maybe that those with secure attachments are better equipped to manage endings and therefore they are more able conceptualise endings in a

positive light, confident in their ability cope and adjust, as compare to their less securely attached counterparts.

Transition to adulthood: 'A deadline on my 18th'

"I just feel like everything, there's almost like a deadline on my eighteenth which scares me quite a bit." (Daisy)

Four participants raised issues relating to the transition to adulthood, which signalled various transitions, not just the ending of their contact with CAMHS. The young people highlighted their expectations of adulthood and the expectations that they perceived others to hold for them as adults. Participants' comments also indicated how their internal representations of the self and others had changed over time and how these representations were now influencing their understanding of leaving CAMHS.

- Expectations of adulthood

Four participants indicated that, despite being nearly 18, they did not feel like adults and by extension several indicated that they did not yet feel ready to leave behind all that was associated with adolescence. Participants highlighted the multiple transitions they would be facing, with feelings of being overwhelmed, unprepared and anxious pitted against feelings of hope, excitement and readiness. Leaving CAMHS represented one transition participants associated with turning 18.

Participants talked about how they thought they should be as adults. Jack suggested that, as an adult, decisions and actions had greater consequences and therefore required an individual to take them more seriously. Other participants commented on the importance of gaining employment and taking 'greater responsibility'.

"I am kind of becoming an adult soon and it's kind of all a bit more serious...[…]…I think it's good for me though at the end of the day I am playing, I'm procrastinating less and playing less games and watching less films and doing more work, like this whole week I haven't watched a film, more than anything I have just been working and I think I am getting better at it." (Jack)

'The fact that I am looking for a job as well that's going to help me out a lot.' (Thomas)

Individual understandings of what it meant to be an adult appeared to play a role in participants' sense making of preparing to leave CAMHS. Participants appeared to view becoming more independent as synonymous with becoming an adult and seemed to conceptualise moving on from CAMHS as being part of this process. For some, this was seen as a step forwards, whereas for others it was experienced as an additional pressure that left them questioning their ability to cope with either transition.

'I am just a bit worried about moving on and stuff, becoming more independent. I am also really excited I think, I think it's a good thing as well, sort of, I always wanna be at this point but I get a bit scared before, um thinking about it, but I also get a bit excited about being more independent…' (Jack)

Daisy expressed surprise at how quickly the end had come round, hinting that she thought she would feel different by the time she turned 18, perhaps better able to cope and to cope without the support of mental health services.

"…then it sort of hit me and I was like "oh yeah I am. I am like seventeen; I am going to be like eighteen in like half a year and I was like oh no this has gone quite a lot faster than I thought." (Daisy)

Daisy also highlighted her belief that the expectations others had of her would change once she became an adult and seemed to imply that she was unsure she would be able to meet these expectations.

"I feel like cuz I've h-hit a certain age, 'oh, you can like deal with it now', and I'm like no! (giggles) wait! (giggles) but I don't know." (Daisy)

In the above quote Daisy indicated that she was experiencing a dissonance between her expectations of adulthood, the expectations she believed were held by others and the reality of how she was actually feeling. Daisy appeared to feel that she was not ready to transition into adulthood and meet the demands that she perceived it would place upon her. Similarly, Jack and Molly expressed that they did not feel their age, suggesting that they also expected to somehow feel different upon reaching adulthood.

'Yeah really soon and it's really weird I don't feel like I am eighteen yet I feel still like I'm fifteen (laughs) but um yeah it's going to happen…[…]… (Laughs), yeah, that's how I sort of feel. I just sort of feel far younger than I actually am but um yeah I've got to start becoming more independent now, but I'll still work it (laughs).' (Jack)

'…though you are legally adult you are still very child-like in some aspects.' *(Molly)*

– An internal working model of the adult self

Participants commented on how their mental health difficulties had affected their developing sense of self, particularly in relation to others, alluding to feelings of difference.

'My attendance has always been bad but I just stopped going in because I was so nervous, I didn't talk I was just so like scared of school. Which everyone's like about school but it was almost like a phobia for me, I'd get panic attacks about going in and um I don't have many friends and the things like that.[…] *It's definitely impacted my education and I guess life skills as well, um cuz I-I just couldn't experience it I guess, or do it cuz my brain like stopped me I guess, (quiety) I don't know it's weird.' (Daisy)*

Participants intimated that their engagement with CAMHS, or lack thereof had contributed to their developing sense of self. In Jack's case he described feeling that he had fallen behind his peers because of his childhood problems, but had experienced a sense of catching up through his contact with CAMHS. In contrast Adam, who also struggled with problems during childhood, described how he learned how cope with his difficulties whilst waiting for CAMHS support to be offered, therefore suggesting that it was the absence of support from services that led to him developing a sense of self-reliance.

"CAMHS has just helped me over the years become, like I feel […] primary just put me a bit behind everyone else and I feel like CAMHS […] kind of lately has just kind of helped me get to where I need to be to start making the next step to going to university […] and meeting new people and stuff like that and I think I'm I think I'm more ready now that I was before." (Jack)

Molly described that the therapeutic work that she had recently been engaged in within CAMHS, focused explicitly on deconstructing and developing her sense of self:

"So it was important for [Therapist] to break that and that attachment to values and the fact that I am not a walking grade, that was an important thing to shake apart and really break down and get that you know I am a person not just someone that's at school (Molly)

Participants' internal sense of self appeared reflected in comments made alluding to their confidence in their future goals. Adam and Jack appeared to conceptualise their futures as opportunities to achieve their desired goals they seemed more confident in this assertion than the other participants. Conjuring up such optimistic visualisations of their futures seemed to provide Adam and Jack with a sense of positivity and hopefulness, which in turn supported their feelings towards transition.

"I want to start going back to night-college, learn a new, learn a new skill or something… cuz I am willing to learn if it is something I want to do, I gunna want to learn, I am always willing to learn it and I think it would be…good for me." (Adam)

'…making the next step to going to university and um and meeting new people and- and meeting new people and stuff like that and I think I'm I think I'm more ready now that I was before.' (Jack)

Attachment theory introduces the concept of internal working models to represent the self, others and relationships. It has been suggested that these models are updated throughout the process of adolescent development, which allows for the integration of attachment information and the representation of more complex relationships (Crittenden, 1997a). This seemed especially pertinent to the participants who were all adolescents. Participants' experiences of engaging with CAMHS appeared to play a part in shaping their internal working models of their 'emergent' adult selves.

Furthermore, it is possible that for both Adam and Jack a more secure attachment style allowed them to utilise either the experience of, or thought of having to be without support to activate their 'exploration' systems' (Bowlby, 1969). The

exploration system within attachment theory becomes operational when the attachment system is deactivated and safety seeking is no long a priority. The exploration system encourages and supports learning and engaging with the wider environment. Jack and Adam described feeling ready and able to 'explore' the possible alternatives to CAMHS support, resulting in both participants feeling ready to move on from CAMHS. In contrast those with an insecure attachment style maybe more fearful of losing the support of CAMHS, especially when a transition to adult services is uncertain, as they do not perceive themselves to have the internal resources to be able to cope without the support.

In continuance, participants' ability to be able to visualise achieving future success and to feel reassured by these cognitions was perhaps related to how secure they felt in their relationships with themselves and others and whether these relational experiences reflected the possibility of them achieving future success.

Feeling connected

All of the young people interviewed commented upon their relationships with their clinicians, family and friends. Participants indicated that, in part, they made sense of their experiences through their relationships with others including their experience of preparing to leave CAMHS. Participants highlighted the importance of being in relationships with others and the support that they derived from these relationships.

CAMHS as a secure base

The idea of CAMHS as a secure base came from viewing the data through the prism of attachment theory and considers the relationship of the service user to the service as a whole. This was interpreted from data of several participants, who commented on the helpfulness of having CAMHS there in the background even when they weren't actively being supported.

"…just sort of having it there, in your mind just sort of helps." (Daisy)

"I mean…it does help…going there cuz you know you've support behind you as well, just the fact of oh there is support there, you're being involved in is satisfying. Like it

just helps knowing it's there know you're part of that, knowing there are people who are helping you." (Adam)

It was most strongly represented in Jack's account, in which he highlighted how his need for CAMHS appeared to increase at times he experienced stress, and thus, it could be speculated, his attachment system would have been activated.

'…I went into college for a bit and I didn't, I was in this course and I was like…you know just panicking and I was like don't really, as you do though I just didn't know anyone I guess but everyone was in that position and everyone else seemed to be, all my other friends had gone on different courses, so they were enjoying it and that's when I went back into CAMHS I think.' (Jack)

Jack identified perceiving his relationship with his girlfriend as having worked in conjunction with CAMHS to provide him with support. He suggested that he would like the option to remain in CAMHS for longer, but felt more able to tolerate this ending because he felt able to turn to his girlfriend for similar support.

"Yeah she is really good, and really helps me out when and, and that's why I think CAMHS and the combination of her have been good cuz, like when I am not, like when I use to not be at CAMHS and just at school I was huh, and I would go to CAMHS and be like uh, but now it's constantly more um feeling a bit happier and um yeah, yeah, it's a better combination nowadays being able to talk to her and talk to CAMHS. " (Jack)

Adam thought that adult services would be similar to CAMHS and appeared to feel confident about the idea of transition, contained by the knowledge that an adult service would be available to him.

"…it might be a different person or something but it's the same level of help, they will still help you this,…I'm assuming it would just be very similar, I don't see why it wouldn't be, I don't see why it would be completely different or anything, I am assuming it would be the same kind of thing, same kind of help…" (Adam).

For Adam, the availability of AMHS services appeared to be containing, potentially allowing him to feel safe and therefore more secure with 'exploration'.

"I'm just taking on board what it's, what it's done for me, which I have done and just using it to the best of my ability to what I can do cuz I'm confident in myself with it at the moment. I think just to carry on the best that I can with that, best I'm gunna do, cuz even if it does fall back for whatever reason, I've still got adults CAMHS then, so I'm confident" (Adam).

One of the lads

Adolescence is considered to be a key time for the development and reorganisation of attachment relationships. Attachment theory suggests young people require less physical proximity to their parents and place greater importance on their peer relationships (Laible, 2007). Participants within this study reflected these relational changes when describing the role played by their friends and family in offering them support.

Jack described the importance of being part of a group: 'one of the lads', which for him meant not discussing his emotions, or sharing his mental health difficulties with his peers. Thus, Jack appeared to feel supported by his friends through his sense of fitting in, but conversely was unable to seek direct emotional support with his difficulties from his peer group, which he instead sought from CAMHS and his girlfriend.

"I think it's just because they are lads, you know. They're just sort of lads, that's just the way it works and it's a little bit like we don't want to talk about our feelings." (Jack)

It is possible that Jack felt 'abnormal' in comparison to his peers because of his difficulties and his attendance at CAMHS, leading to feelings of difference and fear that he would be rejected if his difference was revealed. For Jack, leaving CAMHS reflected a sense of having 'caught-up' with his peer group and perhaps represented therefore a chance to be 'normal'.

Adam, like Jack, explained that he chose not to discuss his difficulties with his friends, however he described this in relation to his conceptualisation of his diagnosis being separate from himself implying that he did not want it to intrude unnecessarily on his social life, rather than feeling unable to talk about it. Unlike Jack, Adam reported that his friends were aware of his difficulties and he felt supported by their acceptance, implicitly highlighting their role in helping him to cope with life challenges, such as the transition between CAMHS and AMHS.

"I don't talk about it a lot, I just let it happen and they know that as well, so I'm more free with my ticks around my friends and family, but I won't like discuss it with them, they'll like let it happen." (Adam)

Daisy explained that many of her friends also experienced mental health difficulties and her comments suggested that she perceived her role as that of supporter, rather than supported within her peer relationships. Daisy acknowledged that she felt supported knowing that she was not the only one with mental health difficulties, but worried about seeking support from her friends knowing that they were also struggling. Like Jack, Daisy implied that she may not be willing, or feel able to seek support from her friends.

"I have my mates but they more rely on me than I do on them, so when I do get down I feel bad going to them cuz they've got really bad problems."

Thomas's comments indicated that his experience of a therapeutic relationship helped him develop a framework for building secure attachments with others.

"I am starting to build up that trust with one of my closest friends, cuz he is starting to understand the fact that I need someone to talk to…and he understands that I, that he has got to keep it to himself and not say anything to anyone. But it is not exactly the same as what it is with CAMHS…[…]…the fact that I know that I can build up that trust with a complete stranger, put into my head, that if I can build that trust with a complete stranger, why can't I build it up with somebody that I already know?" (Thomas)

Discussion

The aim of this research was to explore, from an attachment theory perspective the lived experience of young people as they prepared to transition out of CAMHS, having neared, or reached the upper age limit for the service. The results will be explored within the context of the wider evidence base examining adolescent attachment in relation to; accessing support from CAMHS, transitioning to adulthood, and relationships. In addition, consideration will be given to alternative explanations for young people's experiences of preparing to transition, along with a critic of the limitations imposed upon the data by viewing it through the lens of Attachment Theory.

Participants' experiences of CAMHS varied widely, although certain elements of their accounts presented significant similarities. It was possible to explore participants' interpretations of their experiences through the lens of Attachment Theory, considering the potential of the attachment systems to influence how individuals made sense of their CAMHS journey and especially preparing to move-on. However Attachment Theory is only one lens through which interpretations of the data could have been made and alternative hypothesis such as systemic perspectives for example, have been recognised to be equally valid.

Entry into CAMHS

The attachment system is primarily concerned with the management of anxiety and arousal; activated by the perception of threat, its job is to motivate safety seeking through achieving proximity to an attachment figure (Bowlby, 1988). Whilst it is acknowledged that young people seek input from CAMHS for many different reasons, it could be argued that some young people looked to CAMHS for support because they were seeking a 'safe haven' and 'secure base' from which to try to manage their mental health difficulties and subsequently develop an attachment relationship with their clinician. However, it is also acknowledged that young people often reported limited agency in the decision to seek CAMHS intervention, with schools and parents making this judgement on their behalf.

The difficulty and likelihood of long waiting times between referral and the offer of appointments has been widely acknowledged, with 58% of referrals being placed on waiting lists and average waiting times of 200days (Children's Commissioner, 2016). From a systemic perspective young people and their families have little control over the system that they are trying to access and therefore to resolve the problems they face in this regard. It is likely then that young people's lived experiences of engaging with CAMHS are influenced, at least in part, by their inability to resolve organisational level problems, which may account for the difficult emotional experiences they reported.

Many of the young people interviewed highlighted that waiting to receive CAMHS support resulted in increased and anxiety and for some increased personal difficulties. However, individual responses to this anxiety varied, opening up the possibility that differing attachment styles may have influenced sense making of this experience, with those individuals with more secure attachment relationships being better able to cope with the challenge of waiting and managing uncertainty. Vogal and Wei (2005) found that those with an insecure attachment style perceived less available support than those with a secure attachment style.

Service Availability and Responsiveness

Young people in this study linked their experiences of gaining access to CAMHS with preparing to transition out of CAMHS, including their expectations of adult services and the availability of future support.

Overall, services were perceived as unresponsiveness and unavailability, which was experienced as emotionally un-containing. This could be argued to potentially mirror the attachment theory concept of unpredictability of a caregiver. Unpredictability in this sense can lead to attempts by individuals to meet their own attachment needs by either maintaining proximity to the caregiver, avoiding separation whenever possible, or through becoming overly self-reliant perceiving others as unable/willing to help. It is possible therefore that the operationalisation of services triggers the attachment system of service users by failing to be available and responsive to individuals' cries for help at times of distress. If so, the activated attachment system would likely influence individuals' lived experience of those services.

If the lived experiences of some young people were influenced by their attachment systems being triggered by a perception of CAMHS as unavailable/unresponsive, it may account for their difficulty believing that adult services would be available and responsive to them in the future. Furthermore, individuals' willingness and ability to seek help has been found to be influenced by previous experiences of pursuing support (Mitchell *et al.,* 2017). If therefore support is not forthcoming when it is sought it is likely that individuals will come to believe that it will not be available when they request it in the future. In this case some young people may feel that they need to cling to CAMHS for as long as possible, avoiding discussion of moving on, fearing abandonment, or give up all together on the idea of help being available, decreasing the likelihood that they will ask for help in the future, should they need it.

Participants in this study, Daisy in particular, highlighted both an awareness of the limitations and resource constrains of statutory mental health services and service prioritisation of risk. Demonstrating the dilemma service users faced, Daisy described wanting continued mental health support, but knowing that she would not be eligible for AMHS unless she increased her risk level and was 'climbing rooves'.

Daisy's dilemma highlighted the way in which services can inadvertently encourage individuals to escalate, their distress states in order to secure service responsiveness. From an attachment perspective responding only when an individual becomes acutely and demonstrably distressed has the potential to lay the foundations for an internal help seeking blueprint that negatively impacts upon distress tolerance and emotional regulation. Adshead (1998) stated "the institutional environment may stimulate abnormal attachment behaviour, rather than reduce it" (p67). Encouraging abnormal attachment behaviour is clearly not the intention of mental health services, nevertheless it appears that this may be the case.

Whilst attachment theory offers one possible lens through which to understand service users' lived experiences of engaging with services, alternatively, individuals' responses to operational issues may simply be pragmatic attempts at problem solving, which could be explained through the application of other theoretical models such as Social Learning Theory (Bandura, 1977). Systemic theory could also have a role in

helping to develop an understanding of service users' sense of powerlessness within their interactions with services, offering an embodied example of distal and proximal power in action (Smail, 2005). Proximal power is the power individuals possess and can use to create upwards change and problem solve, whereas distal power is the power that is held within systems, such as by governments and within corporations and exerts a downward influence onto smaller groups and individuals. Smail, argued that individuals typically overestimate their proximal power and diminish, or are unaware of the influence upon them of distal power. It is possible therefore that service users felt disempowered by their failed attempts to exert their proximal powers within services, to solve problems created distally and only resolvable therefore at a systems level. Again this may account for some of the frustration and anxiety experienced by service users. In this vein several of the participants referred to the system and distinguished between the system and the people working within it, conceptualising the system as bad and the people with it as good.

Arguably, young people's experiences of accessing help will influence their future decisions to seek support and means of doing so, and may in part account for the results of a study conducted by Salaheddin and Mason (2016) who found that 35% of the young adults with emotional distress, who responded to an online survey, were not currently seeking mental health support.

Endings

In the current study, how young people interpreted the ending of their time with CAMHS influenced how they felt about their journey through CAMHS, moving on from CAMHS and life after CAMHS. Fredman and Dalal (1998) presented a model of endings in therapy that was explicitly used to shape the results of the current study in relation to endings. Fredman and Dalal (1998) identified four different types of therapeutic endings; loss, transformation, metamorphosis and relief. For Daisy and Molly the end appeared to represent a loss, whereas for the others it appeared to present more of a metamorphosis, or transformation. Fredman and Dalal (1998) highlighted the impact different types of ending could have on the therapeutic experience and by applying their model within the context of the present research, it is suggested that participants' experiences of preparing to leave CAMHS were influenced by their

conceptualisation of the ending. The importance of services utilising structured transition protocols and procedures and therapists proactively targeting endings within the therapy, was highlighted.

Ending therapeutic work with their current therapist was commented upon by all participants and how this had been addressed within their therapy was particularly important. Four out of five participants suggested that the 'ending' of therapy and their time with CAMHS was introduced too late and reflected that they would have liked the opportunity to talk about the ending sooner to give them more time adjust to the idea. Again Systemic theory could be useful to help explain the lack of control and power experienced by service users in relation to the ending process. However, from an attachment perspective it could be argued that individuals with dismissive or preoccupied attachment styles might, for different reasons, seek to avoid discussion of endings. In this instance it is likely that what is needed may be at odds with what is requested and service users seeking to avoid facing the ending of therapy may in fact require their therapist to recognise and proactively address this dynamic. As stated by Fedman and Dalal, (1998, p.2) "It is the job of the therapist therefore to recognise that the 'ending discourse' gives meaning to the therapeutic relationship thereby influencing therapists' and clients' actions in the final stages of therapy and their actions in turn involve experiences which might elaborate the contextual discourses or pool of ideas and stories they have about ending." Furthermore, therapist may need to consider and respond to the possibility that individuals with different attachment styles may require different therapeutic approaches to addressing the ending of therapy.

Adolescent development

Many young people accessing CAMHS face the prospect of having to leave just as they enter a new developmental phase, 'Emerging Adulthood' (Arnett, 2007) and at a time when they are simultaneously confronting other significant life transitions. Four of the five young people in the current study suggested that they did not yet feel 'adult' enough to comfortably envisage engaging with adult services. These findings reflected those of Burnham-Riosa, Preyde and Porto (2015) who found that transition aged young people thought adult clinicians would need to treat them differently to their

'older' adult clients, due to their particular developmental stage. The development of a more 'adult' identity appeared to support young peoples' sense of being 'ready' to move on from CAMHS, as suggested by Adam, who was already over 18 and employed, thus enacting a role typically associated with adulthood.

Attachment theory considers adolescence a time when internal working models of the self, others and relationships are redefined and reorganised, with young people typically seeking less proximity to their primary caregivers and investing more heavily in their social relationships, moving towards a more autonomous and independent identity (Bowlby, 1969). It is possible therefore that other supportive relationships besides family and friends, such as CAMHS become more important at this time. CAMHS services may come into their own by potentially offering a 'secure base' and 'safe haven' (Cooper, et al 2001) for young adults to utilise. CAMHS' role for participants of the current study appeared to be about providing them with a sense of containment and nurturing; time and space to safely talk about their difficulties with somebody who cared. This suggested that CAMHS clinicians might represent attachment figures for some of their service users and play a part in the reorganisation of their internal working models of relationships (Bowlby, 1969), thus presenting a potential opportunity for clinicians to intervene and attempt to support the formation of (more) secure attachment patterns. Withdrawal of CAMHS support at this time therefore appears counterintuitive; an assertion that was reflected in the comments of several participants of the current study who argued for the option to stay longer in CAMHS.

Young people emphasised the importance of family and peer support whilst engaging with and preparing to transition out of CAMHS, but distinguished it from the support offered by CAMHS. The availability of social and familial support appeared to influence how the participants envisaged coping without CAMHS. This finding was supported by Laible (2007) who found that adolescent emotional and social competence was significantly related attachment security with both parents and peers. This finding highlights the how clinicians could positively support their service users lived experience of transition through actively supporting them within their familial and peer relationships.

Limitations

Yardley's (2000) principles for assessing the quality of qualitative research and Smith's guidance on what makes a good IPA paper, as described in the methodology section were used in an effort to ensure the quality of the study. However, some methodological limitations warranted further attention.

IPA assumes a homogenous sample and there were significant differences in the socio-economic backgrounds of the participants, which may have impacted upon their access to resources and their perception of availability alternative of support. Furthermore, due to the challenge of recruitment it was not feasible to limit the sample to only those who would be transitioning into AMHS and therefore two of the participants were aware that they would be referred to adult services and three knew that they would not. It is possible that this difference impacted upon their experience of preparing to transition out of CAMHS. However, overall it appeared there was enough overlap in the described experiences and the themes that emerged to accommodate these differences.

The study was potentially limited by the recruitment method, in which clinicians were gatekeepers to participant, thus relying on them to identifying suitable participants. Furthermore, participants' responses may have been influenced by the interviewer's status as a clinical psychology trainee with links to the service providing their treatments.

The results were viewed through a prism of attachment theory, which the researcher acknowledged was only one potential lens through which the data could have been interpreted. Whilst this added to the theoretical richness of the study, it inevitably resulted in the data being interpreted in a manner that fitted with this theory, potentially blinding the researcher to other perspectives. However, the explicit use of an attachment theory lens made overt the researchers bias toward attachment theory and opened a forum for both the implementation of attachment driven exploration of the data, but also a critic of the use of such a lens.

The introduction of other alternative explanations for the data such as systemic theory provided a direct challenge to the researchers stated theoretic position and

encouraged deeper questioning of the interpretations made. Nevertheless, the use of IPA as a methodology in combination with attachment theory as a lens through which to view the data was controversial and was further impeded by the lack of a validated measure of attachment, thus limiting the validity of the results.

Clinical implications

This research has highlighted the clinical importance of considering the lived experiences of young adults as they prepare to transition out of CAMHS. It emphasised the potential role of individuals' attachment styles in this experience. It is therefore the job of the therapist to understand the relational attachment patterns of their adolescent service users and utilise this knowledge to offer attachment informed support during the transition out of CAMHS.

The current study demonstrated the need for CAMHS services to offer considerable pre-transition therapeutic time and space to allow service users to confront the 'ending' and work through what this means for them. Therapeutic time dedicated to transition would also provide the therapist with the opportunity to give service users information about adult services, which they are currently lacking. (Burham-Riosa et al, 2015; Cheak-Zamora & Teti, 2015; Wheatley et al, 2014).

For those transitioning into AMHS they should be enabled to visit the service and have an opportunity to meet their adult clinician prior to finishing work with CAMHS. Furthermore CAMHS clinicians should share information with AMHS clinicians in order to make CAMHS service users 'known' before they arrive. Feeling known may have been important to participants due to their sense that so many transitions and changes were happening all at once. It may therefore be advantageous for young people to be able to maintain supportive relationships with services whilst navigating these stressful life events, especially if services might represent a 'secure base' for some service users.

Participants within this study highlighted the impact of their early experiences of engaging with CAMHS on their perception of transition. It is therefore important for clinician's supporting transitioning service users to be aware of individuals' experiences of entry into CAMHS and the impact this is likely to have on how they

approach the ending. Equally, it is important for services to try and facilitate smooth and seamless access to their services and to provide regular information and updates to those that are placed onto waiting lists.

Finally, research has demonstrated that when experiencing emotional distress only a small proportion of people seek help and typically only as a last resort (Andrews, Issakidis, & Carter, 2001; Hinson, & Swanson, 1993; Lin, 2002). It is important therefore than when young people seek support from mental health services those requests are responded to with information that reduces uncertainty and through the provision of a service that, just like parents who are trying to support a child to develop a secure attachment style, appropriately negotiates the balance of being available to comfort and help organise the feelings of the young person and help the young person to develop skills that will support them to develop their own coping strategies and social networks to avoid them becoming overly dependent upon services.

Future research

This study was explicitly interested in the potential role of attachment theory within young people's lived experience of preparing to transition out of CAMHS, demonstrating possible means by which attachment patterns could exert influence over such experiences. It would be opportune to further explore this potential relationship through more rigorous study, which could be achieved through the use of a validated measure of attachment style such as the Adult Attachment Interview (Maine, 1985/1991) coupled with further qualitative exploration of live experience.

Furthermore, the results of the current study call not only for consideration of ending discourses that might shape how young people experience the transition out of CAMHS, but how this might interact with their attachment style to influence how they try to make sense of preparing to move-on.

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SECTION C: Critical Appraisal

Introduction

This personal reflection of the research journey from conception to fruition is based on a reflective diary kept by the researcher throughout the research period. The purpose of the critical appraisal is to reflect on the research process and what has been learned through the experience.

The Research Journey

Choosing a research topic

The researcher was drawn towards exploration of the possible role of adolescent/adult attachment patterns within the experience of mental health service transitions after working as an assistant psychologist with young parents involved with social services, whose parenting capacity was being assessed. The researcher became interested in their experience of transitioning from a supportive residential environment where they actively received help and support both as individuals and parents, back into the community where the level of support was considerably diminished or withdrawn altogether. The role provided the researcher with insight into the challenges faced by these young parents as they transitioned from on environment to another and led the researcher to question and reflection on why these parents appeared to find this transition so difficult. Parents who had been coping independently, requiring a minimal level of support within the residential setting, began to struggle significantly once back in a community setting, presenting as if they had forgotten most of what they had learned, achieved and demonstrated within the residential environment.

Furthermore, the researcher was privileged to learn of the parents clinical histories within the context of her role as an assistant psychologist and was able to identify that many of the parents' own experiences of being parented appeared less than conducive to the formation of a secure attachment (Bowlby, 1969). Many described early experience of trauma, for example that would have increased their likelihood of developing insecure attachment styles (Ainsworth, 1978). The researcher became curious as to whether there was a potential link between the attachment styles of the

young parents she was working with and their experience of and ability to cope with transition from a supportive residential to a less supportive community environment. The researcher questioned whether there was a possibility that losing the support provided within the residential setting and adapting to the more independent requirements of a community setting was an easier process and experience for those with a secure attachment style.

The researcher's interest in attachment theory and its potential role within different life experiences was further confounded by working in a variety of different settings with children who were from different socio-economic backgrounds and home environments. Again the researcher was drawn to reflect on the different ways in which the children sought to form and maintain relationships and attempted to ensure their needs were met.

Working in a CAMHS service highlighted the CAMHS to AMHS transition as a potential difficult experience for all concerned; service user, parents and clinicians and directed the researcher's interest towards wanting to try to further understand this transition experience.

Choosing a methodology

Having previously only conducted quantitative research, the researcher was interested in the opportunity to conduct a qualitative study. The researcher's interest in exploring young peoples' lived experience of transition lent itself to utilising a qualitative methodology. Discussion of the researcher's ideas for empirical research within supervision led to a decision to use Interpretative Phenomenological Analysis (IPA). IPA was decided upon due to its suitability for exploring the topic of interest because it is phenomenological and therefore is interested in the construction of meaning through language and attempts to give voice to peoples lived experience of different events and occurrences and it is also interpretative and is therefore an attempt by the researcher to interpret how individuals perceive the world (Wilig, 2013). IPA offered the researcher the opportunity to explore the lived experience and

mean making of young people preparing to leave CAMHS through conducting in-depth interviews designed to elicit individuals mean making.

However the researcher not only wished to explore the lived experience of young people preparing to transition out of CAMHS but to explicitly explore their lived experience of this through the lens of attachment theory. The researcher planned to do this by moving away from the traditional IPA analysis by adding in an extra element to the study in the form of two self-report attachment questionnaires, which the researcher planned to use to support/further her interpretations having first analysed the data in the traditional manner. Pluralism in qualitative research is a controversial topic however is supported by various qualitative researchers who argue for the possibility of more comprehensive research through combining different research methodologies through which to explore the same data. (Frost, 2011)

When the researcher conceived of the idea for her study she considered the possibility of utilising the Adult Attachment Interview (AAI) as she was aware that this would provide the most comprehensive insight into young people's attachment styles. However further investigation of this possibility revealed the costs both fiscal and temporal were prohibitive and beyond the scope of a doctoral thesis, therefore alternative possibilities were sought. The researcher decided upon two short self-report attachment questionnaires design specifically for use with adolescents; the Adolescent Attachment Questionnaire and the Unresolved Adolescent Attachment Questionnaire, (West et al 1998; 2000) both of which used a Likert type scale to identify current conscious relational patterns of behaviour and the caregiving experiences of unresolved adolescents (as recipients of care) respectively. West et al (1998; 2000) found that the Adolescent Attachment Questionnaire and the Adolescent Unresolved Attachment Questionnaire exhibited "high convergent validity with the Adult Attachment Interview." However in contrast to the AAI which is believed to "tap into subconscious attachment processes" the AAQ and the AUAQ were thought to "explore conscious current relational patterns of behaviour". The AAQ and the AUAQ were not therefore designed to "identify specific attachment styles in the manner of the AAI. However the AAQ and AUAQ provided an insight into the adolescent's perception of the availability of their attachment figure and their emotional response

to that person" (West et al 1998). The researcher felt that the AAQ and AUAQ therefore would provide an insight into the adolescents' perceptions of the security of their attachments. For the purpose of this study, it was believed that the AAQ and the AUAQ would provide enough information regarding attachment style for qualitative inferences to be made as part of the interpretive aspect of the IPA methodology.

Data Collection

Prior to recruitment or data collection the researcher sought ethical approval from the Regional Ethics Committee (REC). The researcher decided to attend the panel hearing of the committee and was pleasantly surprised by the experience, perceiving the panel as supportive and encouraging and was rewarded with a favourable opinion subject to a couple of minor amendments, which the panel requested the researcher made before going ahead with the study. These included rewording of the participant invitation letter so that it read with a more relax and friendly tone as appropriate to the teenage population the sample was to be taken from. They also requested that one question/answer was removed from the patient information leaflet pertaining to parental consent as this was considered to be superfluous as all participants were going to be over the age of 16years and therefore would not require parental consent and finally they requested submission of a topic guide.

Having decided on a study topic and methodology the researcher required the support of a clinical service through which participants could be accessed. This process was more challenging that the researcher anticipated and involved considerable time, determination and assertiveness in order to make contact with and secure the support of a suitable clinical service. The next challenge the researcher faced was making contact with individual clinicians who would be acting as gatekeepers to their service users and potential participants and informing them of the study and its requirements. The researcher circumnavigated this hurdle by attending two team meetings, several months apart, at the service base, giving a short presentation about the research and offering clinicians the chance to ask any questions. Again this process took more time than the researcher had initially anticipated but produced the desired results over the

course of several months, with six participants being recruited into the study, although one subsequently dropped out resulting in a final total of five.

Arranging interview dates and times directly with participants proved to be easier than expected, with all participants requesting to be interviewed at home. This meant that trying to find a clinic room at a convenient time was not necessary, which was something the researcher had been anxious about due to the very limited availability of suitable clinical space. However, interviewing individuals at home was not without its challenges, including several pets sitting in and at times attempting to join in with the interviews. Being distracted by various dogs and cats was at times a challenge to the researchers focus particularly as a novice interviewer, however they equally appeared to be relaxing and comforting presence for the participants, so were viewed by the researcher overall as being a positive addition to the process.

As a novice interviewer with respect to conducting qualitative research, the researcher found the interviews themselves somewhat challenging to conduct, struggling not to respond and react from the perspective of a clinician. The researcher however enjoyed engaging the young people in interviews and eliciting their stories and reflected on what a privileged position this was to be able to ask people about such intimate details of their lives and to have them trust her with that information.

Transcription and analysis

The researcher was largely unprepared for the lengthy, time consuming process of transcription. The researcher reflected on whether the use of a professional transcription service would have been advantageous however feels that through the process of transcription she came to know the data and was able to fully immerse herself in it, which significantly aided future data analysis.

Analysing the data was more challenging than the researcher had anticipated, partly because the researcher was new to qualitative research and the methodology of IPA, but also because of the lack of a definitive answer and the added complication of incorporating an extra layer of analysis through the inclusion of an “attachment lens”. The researcher was naturally aware of both these facts before embarking on her

research however had not anticipated the extent to which she would be affected by the feeling of uncertainty and the 'messiness' of data analysis within IPA.

Once the researcher had completed the initial coding and drawn out the emergent themes for all participant data, she then turned to the two short, self-report attachment questionnaires intending to use the data to inform her sense making of the participants sense making. However upon exploring the data the researcher realised that the data appeared to give her very little useful addition insight into the experiences of the participants. The researcher discussed this problem within supervision and it was agreed that this element would dropped from study and not used within the analysis of the data. However the researcher remained interested in attachment theory and viewing the data through this lens. Therefore the researcher completed the traditional IPA analysis of her data and then reviewed the resultant themes through the explicit lens of attachment theory using what emerged as the finally results of the study. The researcher reflected that whilst use of an attachment measure within her study had not proved useful, or effective, using a validated standardised measure of attachment such as the AAI could potentially add valuable information and insight to a future research project that wished to explore attachment patterns in relation to live experiences.

Dissemination

The researcher plans to present the findings of the current research at a local research conference and also to produce a poster publishing her research which will be displayed at the conference. The researcher also intends to explore the possibility of future publication of her research in a peer review journal article.

Personal and Professional reflections

The researcher has reflected on her experiences of undertaking the current research project, comparing it to undertaking a long journey, or pilgrimage to reach a longed for destination. In the completion of the current study the researcher has learned about herself both professionally and personally.

The researcher was surprised by the overall time consuming nature and 'messiness' of conducting research and on reflection was interested by the ease with which she managed the 'messiness' of collaborating with a service and various clinicians and organising and conducting interviews, compared to the difficulty she had managing the 'messiness' of data analysis. Collaborating with and recruiting participant from an out of county service entailed considerable effort, in time and travel in order to meet with the service clinicians to inform them of the research and then to interview the recruited participants. This meant that although the researcher had been given permission to go back and interview the young participants for a second time this wasn't feasible within the time constraints of the project, which disappointed the researcher as she felt this would have added to the results of the project.

Collecting qualitative interview data was a powerful experience for the researcher and something she had not anticipated. Switching out of clinician mode whilst conducting interviews was another challenge and highlighted for the researcher in a stark manner what it actual is that we do as clinicians that can be so hard to articulate, that goes beyond simply asking questions and listening to people. The researcher has reflected upon how much she would be interested in doing similar research again in the future.

The research had anticipated that it might be difficult to recruit and then engage young people in interviews surrounding their mental health. However, this was not the case and the participants recruited were keen to articulate their experiences, views and opinions. Interviewing the teenage participants highlighted to the researcher her own bias in thinking teenagers were likely to be reticent in discussing personal issues and especially their mental health. The interviews with the young people recruited also suggested to the researcher that these young service users did not seem to feel that they had any other official forum for expressing and sharing their

thoughts and opinions on the service they were receiving and yet presented as if this was clearly something that they were interested in doing.

The researcher's personal and professional certainty in the value of critical reflection has also been further confirmed by the research process. Reflecting on her own thoughts and feelings as enabled the researcher to remain self-aware and to identify and challenge her own biases and judgements, whilst simultaneously being able to offer herself compassion empathy.

The research process highlighted to the researcher the importance of self-care and being self-aware in this regard. The support of family and friends and the maintenance of hobbies and interests outside of research and clinical practice during the research process has been invaluable and essential.

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Appendices

Appendix A

Guidelines to authors of the target journal for the Literature Review and Research Report

Name of Target Journal for Literature Review and Research Report: Journal of Adolescence (Guidelines retrieved April 2017 from www.elsevier.com/journals/journal-of-adolescence/0140-1971/guide-for-authors)

GUIDE FOR AUTHORS

Introduction

The Journal is an international, broadly based, cross-disciplinary, peer-reviewed journal addressing issues of professional and academic importance to people interested in adolescent development. The Journal aims to enhance theory, research and clinical practice in adolescence through the publication of papers concerned with the nature of adolescence, interventions to promote successful functioning during adolescence, and the management and treatment of disorders occurring during adolescence. We welcome relevant contributions from all disciplinary areas. For the purpose of the Journal, adolescence is considered to be the developmental period between childhood and the attainment of adult status within a person's community and culture. As a practical matter, published articles typically focus on youth between the ages of 10 and 25. However, it is important to note that JoA focuses on adolescence as a developmental period, and this criterion is more important than age per se in determining whether the subject population or article is appropriate for publication. The Journal publishes both qualitative and quantitative research. While the majority of the articles published in the Journal are reports of empirical research studies, the Journal also publishes reviews of the literature, when such reviews are strongly empirically based and provide the basis for extending knowledge in the field. Authors are encouraged to read recent issues of the Journal to get a clear understanding of style and topic range.

Types of contributions

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Full research articles: The majority of the articles carried in the Journal are full research articles of up to 5000 words long. The word count relates to the body of the article. The abstract, references, tables, figures and appendices are not included in the count. These can report the results of research (including evaluations of interventions), or be critical reviews, meta-analyses, etc. Authors are encouraged to consult back issues of the Journal to get a sense of coverage and style, but should not necessarily feel confined by this. Articles should clearly make a new contribution to the existing literature and advance our understanding of adolescent development.

Brief reports: The Editors will consider Brief Reports of between 1000 and 1500 words (three to five typewritten pages). This format should be used for reports of findings from the early stages of a program of research, replications (and failures to replicate) previously reported findings, results of studies with sampling or methodological problems that have yielded

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Appendix B Critical Appraisal Skills Program (CASP)

Study → / CASP Questions ↓	Belling et al 2014	Burnham Riosa et al 2015	Cheak-Zamora and Teti 2015	Dimitropoulos et al 2016	Dimitropoulos et al 2015	Dimitropoulos et al 2013	Lindgren et al 2014	Lindgren 2013	Swift et al 2013	Wheatley et al 2013
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Consideration relationship between researcher and participants	No	No	No	No	No	No	Partially	Partially	Partially	No
Have ethical issues been taken into consideration?	No	Partially	No	Yes	Yes	No	Yes	Yes	Yes	No
Was the data analysis sufficiently rigorous?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
How valuable is the research?	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes	Yes	Partially

Appendix C: Key Characteristics of the studies included in the review

Study	Belling et al 2014 U.K	Burnham Riosa et al 2015 Canada	Cheak-Zamora and Teti 2015 U.S.A.	Dimitropoulos et al 2016 Canada	Dimitropoulos et al 2015 Canada
Research Aims	To investigate the organisational factors that impede or facilitate transition of young people from child and adolescent (CAMHS) to adult mental health services (AMHS).	An investigation of the needs and experiences of late adolescents with emotional and/or behavioural problems who access mental health services at a local child and adolescent clinic.	To explore the health care transition experiences of youth with ASD and their caregivers.	To identify types of family support desired by young adults with eating disorders during the transfer of care from paediatric to adult eating disorder programs.	To identify systemic facilitators and barriers to transferring young adults (17-21years) with eating disorders from paediatric to adult health and mental health services.
Theoretical Framework	Thematic Analysis	Interpretative Phenomenological Analysis (IPA)	Thematic Analysis	Grounded theory	Grounded theory
Sampling & Population	Purposive sampling n=34	Purposive sampling by clinicians of young people (n=10) undergoing transition	Convenience sampling youth n=13, parents, n=19.	Convenience sampling n=15	
Methodology	In-depth semi-structured interviews with health and social care professionals	In-depth interviews	Focus groups (4) with youth with ASD and separate parents groups.	In-depth interviews with young adults, recently transitioned out of paediatric care	
Analysis	Structured Thematic Approach	IPA	Thematic Analysis	Constant comparative analysis, Grounded theory.	Constant comparative analysis, Grounded theory.
Ethical Consideration	Local Research Ethics Committee	Institutional approval (hospital and university)	Informed consent	Informed consent	Informed consent
Reflexivity	No	Yes	No	No	No

Study	Dimitropoulos et al 2014 Canada	Lindgren et al 2014 Sweden	Lindgren 2013 Sweden	Swift et al 2013 U.K.	Wheatley et al 2013 U.K
Research Aims	To increase understanding of the factors that impede or facilitate successful service transition for individuals with Anorexia Nervosa moving from paediatric to adult eating disorder programs.	To explore expectations and experiences of transition from child and adolescent psychiatry to general adult psychiatry as narrated by young adults and relatives.	To describe professionals' experiences and views of the transition process from CAP (Child and Adolescent Psychiatry) to GenP (General (adult) Psychiatry).	To explore the experiences of young people with ADHD during the transition from CAMHS to AMHS	To gain a fuller account of the experience of young people during the transition from adolescent services to adult services and to add to the knowledge around the transitional process.
Theoretical Framework	Grounded theory	Grounded theory	Deductive content analysis	Thematic analysis	Content analysis
Sampling & Population	Purposive sampling	Theoretical sampling	Purposive sampling	Purposive sampling of transition aged young people with ADHD accessing CAMHS (n=10)	Purposive sampling of all females who had completed a transition from the adolescent medium secure service to the adult female secure services with an 18month period (n=8)
Methodology	Two focus groups one with CAMHS clinicians (n=8) and one with AMHS clinicians (n=10) and five in-depth individual interviews (n= 5)	In-depth individual interviews with young adults (n=3) and relatives (n=6)	Six focus group; three group with CAP clinicians (n=12) and three with GenP clinicians (n=11)	In-depth semi structured interviews	In-depth semi structured interviews conducted within three months of transition.
Analysis	Thematic analysis using grounded theory	Grounded theory	Deductive content analysis	Thematic analysis (Braun and Clarke 2006)	Content analysis
Ethical Consideration	Approval from the research ethics board of the university health network in Toronto.	regional Ethical Review Board	regional Ethical Review Board	Local	Local
Reflexivity	No	No	No	No	No

Appendix D: Themes across articles

Superordinate themes	Sub-themes	Belling et al 2014	Burnham Riosa et al 2015	Cheak-Zamora and Teti 2015	Dimitropoulos et al 2016	Dimitropoulos et al 2015	Dimitropoulos et al 2014	Lindgren et al 2014	Lindgren 2013	Swift et al 2013	Wheatley et al 2013
Relationships	Autonomy		X	X	X	X		X	X	X	X
	Trust		X	X	X			X	X	X	X
	Dyads -parent/child -child/clinician -parent/clinician -clinician/clinician		X	X	X			X	X	X	
			X	X		X	X	X	X	X	X
				X				X	X	X	
		X							X		
Resources	Structural	X		X	X	X	X	X	X	X	X
	Fiscal	X								X	
	Intellectual	X		X	X	X	X		X	X	X
	Desired	X				X	X	X	X	X	X

Appendix E: Themes with quotes and comments

	Author	Quotes	Themes	Author comments	Conclusions
1	Belling,R., McLaren, S., Paul, M., et al. (2014).	"Clarity over what's expected of adult services would be helpful. There is a great deal of ignorance on the part of CAMHS as to what adult services do or might do." "It feels sometimes the adult mental health service has a very medical, biological model so of course there is going to be discrepancy between young people who are perhaps 16, self-harming, have low mood, relationship difficulties, poor self-esteem, who don't have problem solving skills that…aren't going to meet the threshold for adult services (Nurse CAMHS)." "There's [named voluntary organisation]…they will take our clients up to 23 I think because they accept that they're vulnerable and therefore the normal age	CLINICIANS 1. Eligibility (core theme) - Lack of clarity on service availability/eligibility - different thresholds CAMHS/AMHS - adult services not accepting patients until their 17th/18th birthday 2. Resources	Professionals desired greater clarity, information and understanding of each other's service structures, roles and responsibilities to facilitate transition. Staff perceived that CAMHS tended to work with a different client group regarding presenting problems. CAMHS staff perceived AMHS as rigid regarding age criteria for transfer. Variable service age limits affecting decisions on where to transfer young people, resulting in need to use shared care. AMHS staff perceived high caseloads due to inadequate staffing as major transition	Differing eligibility criteria, underpinned by a perceived lack of resources impacted negatively on transition and continuity of care. Lack of mutual inter-service knowledge reinforcing concerns about the complexity of the CAMHS/AMHS interface and negatively affecting transition.

		cut-off doesn't apply (Psychologist AMHS)."	- Adult service workloads - Adult services not meeting needs beyond severe and enduring mental health	barrier. Staff shortages led to ridged application of referral criteria. Young people who failed to transfer smoothly were more likely to re-engage with adult services on an unplanned basis. Resource gaps with AMHS providing a narrower service range than CAMHS. Lack of AMHS provision for young people with developmental disorders particularly ADHD and ASD.	

2	Burnham Riosa, P., Preyde, M., and Porto, M.L. (2015).	"You're slowly getting pushed and you're skidding…I'm not ready…I haven't dealt with what I need to here, but deal with it with the next doctor. It's like someone handing over, calling "next," right?" "I don't feel like I'm moving at a good enough rate to be able to stand out by myself. So it's like, okay, my legs are still wobbling and yet you've abandoned me, it almost feels like? So I'm afraid, I'm terrified actually." I woke up and there was all these papers on my wall that said, "You're the best," "Be the change you want to see." [These messages} just kind of said I'm out of school, I'm not telling anybody, people think I have cancer or I'm pregnant, I can't deal with anything or wake up in the morning…and the point of [these messages] is not making me feel much better about myself."	PATIENT - Fears of uncertainty and not knowing - Trusted relationships and the exposed self - Mental illness and a vulnerable, isolated self - A person first a patient second	- Unsettled stressed and fearful of transition to adult services and adulthood. - Ambivalence towards the future. . -Importance of individualised support. - Feeling abandoned at thought of leaving their current clinician – - Loneliness of living with mental health problems - Desire to be involved in transition process and feel empowered 1)individual level and	Positive family relationships were reliable and supportive. Ongoing concerns about continuance of mental health difficulties Self-efficacy likely to affect the transition experience and motivation to continue accessing services. Young adults as a unique group want to be involved, listened to and shown respect.

		"The whole point of still having the flip over,…it should be more catered to you and what you want?...Just because [professionals] have put a limited on something, doesn't mean it's always right for you."	and	2) advocating for other adolescents with mental health needs -Individualised transition process	Transition should be gradual–process.
3	Cheak-Zamora, N.C., and Teti, M. (2015).	"I mean all that matters to me, is just who it is, when it is, where it is…I never care about what their profession is." "I feel as though my parents [should] just keep taking care of the [healthcare] business." "I got to start doing it. 'Cause it's eventually will be my problem." "[They had] a six year relationship. [The doctor] knew him and [asked] questions that she remembered from the last visit…That's a doctor you want to hang on to… I think	PATIENT - Understanding of and interest in providers' role. - Managing medical lives independently PARENT - Loss of relationship with provider and lack of support	Varying levels of understanding existed about youths' medical condition and healthcare providers role within transition to independence. Many identified their caregivers as "in charge" of their medical care. Some preferred this but others aspired for more responsibility. Upset at having to leave an engaged, trusted sensitive provider. Building trust is especially hard for youth with ASD and therefore difficult for	Dependence on parents Ambivalence about autonomy Want more than medication Negotiating the care journey – knowing how, feeling able, being motivated

		that's hard for [our kids], not only for them but for us to trust somebody else." "Every time we do have to switch doctors, we have to re-educate the doctor [about] our child. He may understand the big picture of Autism, what's on the handouts. But when you're talking about Autism, we're talking about complete individuality with our children…All children with ASD are not going to look the same." "She says, "I won't talk to the doctor." I have to make a script out. So, every time that she talks to someone new, we have to write a script. If I don't write a script she won't say anything."	transitioning - Providers lack of knowledge about ASD	parents. Parent felt overwhelmed and that they did not have adequate supported.	Caregivers felt the transition was overwhelming and frustrating. Caregivers need support, information and involvement. Fear that their child will be taken advantage of by adult provider. Providers did not understand ASD and subsequently the needs of their children.
4	Dimitropoulos, G., Herschman., J., Toulany, A., et	"When I left the program I was 17…but I felt like I had to do it on my own."	PATIENTS - Family related challenges	- Conflict arising from Uncertainty regarding control over illness management during transfer of care - Unclear expectations about adult care system of	Uncertainty about who assumes responsibility

	al. (2016).	"I think it was a lot harder to remain motivated [after discharge from paediatric care] because there was that unknown where I could just completely [trails off]. I didn't have to go to [paediatric hospital] anymore I could stop the psychologist if I wanted to. I was an adult, I could make my own decisions." "I tell then this is my recovery, you can't do it for me. Like, I want your support, but that's not the same as you doing it for me." "Being able to have someone listen I guess, and checking in. Maybe even just asking how your day is going, or if they're noticing habits like talking to you about it." "The hardest part for my parents has been when I do experience a blip, they sort of go crazy."	associated with transition - Conceptualisation of family support during transition and on-going recovery	both young adults and family members. - Young adults ambivalent about parental involvement in recovery; desire for both autonomy and ongoing support. Helpful family support included emotional support, assistance with physical and practical aspects of treatment and recovery, as well as external motivation for recovery during initial stages of transition. Unhelpful family support included ongoing parent control over recovery, , as well as a lack of understanding/knowledge about EDs and emotionally volatile responses to relapses and/or setbacks,	Ambivalence re: recovery. This duplicates previous column Dual and contradictory desires for independence and support Abrupt shift in care culture, experienced negatively. Emotional support as opposed to direct involvement in ED treatment Parents struggle to relinquish control of care.

5	Dimitropoulos, G., Toulany, A., Herschman, J., et al. (2015).	"I was really, like, left out in the open…It was a big transition from having so much support at [paediatric hospital] to really having nothing." "The other doctor, she didn't seem that knowledgeable about eating disorders. She kind of asked me, 'What do you want me to do? Do you want me to refer you somewhere? It just didn't seem that helpful." "They said, 'Well you're not sick enough to be in [adult] inpatient, then I guess there's really nowhere else to go.' And I turned 18, so I couldn't be at [paediatric hospital] anymore." "It was very structured and strict, and I didn't feel I had much role in my recovery."	PATIENT - Accounts of inconsistent transfer procedure - Systemic barriers to recovery after transferring out of paediatric EDS	Discussion between patients and health care providers about the transfer were either minimal or could not be recalled. Barriers to accessing support…included; difficulties accessing adult intensive eating disorder programs and/or trained adult care providers, inability to achieve post-secondary education goals due to the structure and intensity of available treatments, limited availability of preferred options such as outpatient therapy, waiting lists, geographic obstacles, ridged admissions criteria and inflexible or limited treatment options. Lack of specialist knowledge held by professionals' i.e. family doctors.	Minimal preparation for transition "An abrupt loss of support" Getting worse to get help Expectation of autonomy after dependence Learning life skills before transition i.e. in paediatric services

		"[Paediatric hospital] did a really good job of taking care of me. Lie, they made sure I was at a stable weight, whatever, but in terms of teaching me how to take care of myself and making recovery sustainable…it was not even close." "I came to a lot of fighting with my Mom about…she wanted to be really involved whereas I was like, well I'm 18 now, I'm not a child, I'm not at [paediatric hospital] anymore, so I should be responsible for myself and doing this by myself." "I know when I was in day-treatment, we had a family therapist that we seam every week. So maybe like, continuing family therapy, or even just having a few sessions before you're completely transitioned out of outpatient."	- Recommendations for improving transition	Desire for more collaborative treatment approaches that help to foster patient independence during paediatric care and help prepare them for the adult system. A distinction should be made between 'discharge' and 'recovery'. After Discharge from paediatric are these adults reinforced the importance of ongoing management, but with an emotional and psychological focus.	Discharge does not equate to recovery
6	Dimitropoulos, G., Tran, A.T.,	"Who defines what adolescence is? The paediatric system has defined the age of 18	CLINICIAN		

	Agarwal, P., et al. (2013).	when in fact, developmentally, some people don't finish their adolescence until they're 30." "So on the one hand I think we need to be looking at what the family doctors know and I think one of the ways that we could be doing that is actually sharing care much more often with the family doctors when we are seeing patients and following them in our clinics…We will share the monitoring with the family doctors so that they can become knowledgeable about what are the things that they need to be monitoring… so that they know what's been happening with the patient and therefore can much more easily transition."	1. The Timing of the Transition—Flexible Service Transition Plan Based on Readiness, as Well as Age 2. Interventions for Patients and Families to Improve Service Transition. Facilitating Seamless Transition to AEDP.	Need for developing a conceptualisation and operationalisation of transition that's not restricted to age but readiness of the patient/family to leave the adolescent treatment setting. Recognition of age group 18-25 as a developmental stage in its own right, "emerging adulthood" (Arnett 2007). Family interventions to prepare young people and their families for life course changes prior to and preceding transition. Interventions that assist young people with psychological and developmental changes and the integration of self-management skills to facilitate seamless transition Coordinated medical follow-up.	Chronological age should not be the primary criterion. Transition should be based on the psychosocial needs. Family interventions that decrease the involvement of parents…while relinquishing more responsibility to the young adult. Psychosocial treatment with a focus on self-management, independence and autonomy. Young people and their

				Paediatricians and family doctors should receive specialist training.	families should be involved in transition planning. Support groups for parents.
7	Lindgren, E., Söderberg, S., and Skär, L. (2014).	"I wanted company (relative) the first times we met because I didn't know the person. I didn't know what I should sit there and say (young adult)." "She should be involved as much as possible I think, but later on I can go there by myself…I want to decide if she should follow me to the meeting or not."	PATIENT AND PARENT KEY THEME managing transition with support Being of age but not mature 1) Still in need of support 2) Being close yet letting go	Balance between providing support and promoting independence.	Young adults in transition have special needs that professionals have to understand and take into account. Young adults are affected by their family and in turn

					they affect their family.
		"It is important that the kids don't feel like they are thrown away…maybe you can meet two or three times depending on the situation (relative)."	Walking out of security and into uncertainty 1) Achieving closure and starting again	Time needed to establish trusting relationships.	It is important to support relatives during the process of transition.
		"I think we hit it off pretty well…she got to know me pretty well better than I knew myself (young adult)."	2) Leaving close relations behind	Need for confidence that professionals have the skills to meet their current needs.	Young adults and their families have to adapt to an individual rather than systemic care culture.
		I didn't like it, it sucks but I have no choice I just have to accept it (young adult)."	Feeling omitted and handling concerns 1) Left to their fate	Young adults and relatives felt excluded and reliant on own personal qualities.	
		"Lack of knowledge about who when or anything, missing the security that disappeared, it has been really tough			

		(relative)."	2) Insecurity that needs to be relieved		
8	Lindgren, E (2013).	"It's quite a big difference between child and adult psychiatry in how you think, it can be a big gap between…what can I say, in CAP it's more family oriented (GenP)." "It's hard to prepare for the patient for a transfer when neither we nor the patient know if they will be received at GenP (CAP)." "You really try that your feeing of insecurity shall not be mirrored and you try to convey a positive image. But I have not much to say and no information to give and that sounds uncertain, when I can't tell what will happen (CAP)."	CLINICIANS <u>Developmental Transitions vs Situational/Organisational Transitions</u> Developmental Transition – becoming an adult means taking responsibility	A gap in transition between CAP and GenP that becomes a challenge and an obstacle in transition CAP and GenP had different care cultures…A gap could occur due to different perspectives, and lack of; knowledge, mutual understanding and cooperation. Professionals at CAP felt insecure and experienced a lack of control. The professionals (from both services) need opportunities to get to know each other and generate a mutual understanding of caring for young adults.	Transition as uncertain and frightening for young people. Triangulated trust between young people, relatives and professionals. Differing care cultures which are not understood by the opposing service associated with feelings of professional insecurity. Need for greater cooperation/information sharing/relationships

		"It's important that the patient is in the process about how we proceed and have the opportunity to meet someone from adult psychiatry who explains how everything works in ahead of time before transfer to reduce anxiety. The fantasies that they have are often much worse. Although difficult, it's better to have a meeting so they get the opportunity to ask their questions about GenP (CAP)."	Situational/Organisational Transition – challenges when different perspectives and care cultures meet. - Cooperation as a condition for safe and secure transition.	Professionals have to learn like parents to let them go. Transition affected the involvement of the relatives in the care. Professionals suggest an individual approach to the transition process. They had a desire for flexibility regarding the age limit and a possibility to work in parallel. Transition process based on achieving the age 18 with little consideration of maturity. Follow-up between former therapist and new therapist could reduce likelihood of feelings of abandonment and allow an evaluation of the transition process from all perspectives.	between child and adult services. Young people should be involved in the transition process. Joint planning and education days for CAP and GenP workers to improve inter-service knowledge/relationships Flexibility regarding transition age needed.

9	Swift, K.D., Hall, C.L., Marimuttu, V., et al. (2013).	"She listened to X and she never judged and she came up with good practical ideas that were achievable and realistic, whereas the one before was just, she didn't listen." "I don't know 'cos I can see where they're coming from 'cos he's an adult, but he's an adult with something wrong with him, and that and they know he won't go out the house and won't do certain things on his own yet he's got to go all the way up there and that's the point he won't do that." "I don't see what age had got to do with who you're seeing and where you see 'em. Right, we're used to coming here, but now we've got to change and go somewhere else, so that's a bit annoying."	PATIENT - Clinician qualities and relationships - Responsibility for care - Nature and severity of	Clinician qualities were very important in how participants viewed the service and their transition experience Those participants whose clinician had appeared to work hard in the transition period reported a less turbulent transition process. The young people did not typically have sole responsibility for their care and were reliant on family members for support. Young people viewed transition as unsettling and did not see it as a logical step and did not feel age is an appropriate indicator of readiness to transition. Difference in care culture…may impede access to services. Adult services require	Trust and feeling listened to were key for young people. Positive experience of CAMHS, more likely to engage with adult services. Young people and parents wanted involvement in transition but felt clinicians were responsible for its ultimate success. Preparation for transition typically resulted in a more positive view of both CAMHS and AMHS.

			problems - Expectations of adult services	more autonomy. Parents desired…a consistent service and for them to be included. Families held high expectation of AMHS, which were unlikely to be met.	Expectation and concerns surrounding adult services need to be managed.
		"When she get to 18 is there gunna be somebody there that can talk to us and talk to her? Is it gonna happen because we don't know. We just don't know. And it worries you."			
10	Wheatley, M.D., Long, C.G.L., & Dolley, O. (2013).	"Some patients were really aggressive." "I was scared of being attacked." "It's good they are friendly."	PATIENTS General Themes 1. Impact of aggressive behaviour of other patients upon the transition experience.	Young people are sensitive to the behaviour of others and are able to articulate the impact upon them. The impact of aggressive behaviour of other patients…as a prominent consideration in the transition process. Young people clearly identified the importance of feeling safe as they moved from one treatment environment to	Other people's behaviour impacts upon a young person's experience of transition. Young people need to feel safe during and after

		"Some patients were not supportive." "They (staff) listened to me which helped." "Staff didn't comfort me." "I didn't know what to expect on the day." "I wasn't given information."	2. The importance of support from fellow SU's and staff during transition. 3. The importance of adequate and timely information re: transition.	another. Importance of staff support during the transition process, reflecting the critical importance of "relational security" in services for women. Many of their (patients) emotional experiences result from the positive aspects of relationships. Participants identified their strong desire to be fully informed and involved in the planning process for transition.	transition. Relationships with staff are important within the transition experience. Preparation and information Transition as a process, gradual adjustment and acceptance .

Appendix F: Statement of Epistemological position

"Qualitative research can be conducted from within different epistemological and ontological frameworks that require different standards of excellence. This is because different methodological approaches are based upon different assumptions about the nature of the world, the meaning of knowledge and the role of the researcher in the research process." (Willig, 213, p. 496).

The researcher adopted in a critical realist position in order to carry out the current research. Critical realism is recognises that knowledge production is a subjective process and therefore fits with the underpinnings of IPA. Critical realists argue that all events are caused by multiple interacting causal powers (Bhaskar, 1975). Critical realism, could be said to exist in the realm between the positivist and interpretivist paradigms. Critical realisms "rejects the rhetoric of neutrality and objectivity associated with positivism, as well as its unfounded presumptions about a priori natural categories. It also rejects the denial of an independent, deep and powerful reality by post-structuralism." (Pilgrim, 2013 p16). The researcher adopted a position of critical realism because it offered the opportunity to explore the meanings participants gave their experiences, whilst accepting that the act of interviewing participants would construct meaning.

Taking a critical realist stance towards mental health research was support by Pilgrim (2013) who argued that "all science is a form of human production like any other and can accordingly be investigated and reflected upon." Furthermore critical realism allowed for the inclusion of both "methodological pluralism and theoretic exploration" (p17). The researcher in wanting to explore the experiences of young people preparing to transition out of CAMHS services from an attachment perspective was not only interested in developing a rich understanding of the lived experience of the participants, but also to acquire some measure of their attachment patterns. A critical realist position was able to support the aim of the researcher in taking a pluralist approach within the confines of an IPA methodology.

IPA was considered to be a suitable methodology to use because its underpinnings are consistent with the critical realist position. Firstly, IPA assumes that interpreting individuals' personal accounts of their experiences can reveal established and persistent cognitive and emotional experiences (Smith, et al,1999). Secondly IPA acknowledges that researchers and therefore research is not neutral. Both of which are consistent with a critical realist position, as assumed by the researcher. As Pilgram (2013) stated "the focus of enquiry is human life and thus the enquirer is part of their object of enquiry."

In conducting the current research the researcher was keenly aware that the interpretations made of the participant accounts were influenced by the researchers own biases and life experience and as such were subjective interpretations rather than factual conclusions. However, it felt important to the researcher to provide a space within research for hearing the voices of the CAMHS service users' experiencing transitions out of CAMHS services, whilst considering the possibility of an underpinning link to attachment theory.

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Appendix G: Patient consent form and Information Leaflet

Version 3 05.05.2016

Study Number: 16/WM/0131

Doctorate in Clinical Psychology

University of Leicester

Centre for Medicine
Lancaster Road
Leicester LE1 7HA

Patient Identification number:

CONSENT FORM

Study Title **"Getting ready to move on: Considering attachment within young peoples' experiences of preparing to transition out of CAMHS."**

Investigators: Emma Rich, Clinical Psychologist in training, University of Leicester.
Please read and initial each box if you agree with what is said. Please then sign and date the bottom of the form

I confirm that I have read and understand the patient information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

I agree to be interviewed and I understand that the interview(s) will be recorded using a digital voice recorder and a transcript of the interview(s) will be created. ☐

I agree to the recording, transcript and questionnaire data being stored in a safe and secure place at the University of Leicester, department of Clinical Psychology and understand that it will be destroyed after five years. I understand the information I give will be used for this project only. ☐

I agree that the information I give will be treated as confidential unless the researcher becomes concerned that somebody is at risk. ☐

I agree that my identity will be protected throughout the study and that what I say in my interview will be anonymised when directly quoted in things written about the research and I understand what this means. ☐

I understand that the information collected during this study may be looked at by individuals from the NHS trust and from Regulatory Authorities where it is deemed relevant to my taking part in this research study. I give permission for people from these organisations to have access to my records. ☐

I understand that the interview(s) will be included as part of a doctoral thesis and that results may be published in academic journals. ☐

I AGREE TO TAKE PART IN THE ABOVE RESEARCH STUDY

Participant (Print)…….(Date)……

Participant (Signed)…….(Date)……

Researcher (Print)…….(Date)…….

Researcher (Sign)…….(Date)…….

Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester LE1 7HA

Version 3 05.05.2016

Study Number: 16/WM/0131

Participant Identification number:

Study Title: "Getting ready to move on: Considering attachment within young peoples' experiences of preparing to transition out of CAMHS."

Investigators: Emma Rich, Clinical Psychologist in training, University of Leicester.

Interested in taking part in research?

Can you help me? I want to hear your story.

What has being in CAMHS been like for you?

How do you feel about moving on?

What support have you received to think about the idea of transitioning out of CAMHS?

What is research and why do we do it?

Research is an attempt to explore a topic area to find answers to questions previously unknown or not understood. Research is carried out in order to develop/increase knowledge of the topic area in question and is done with the aim of using the findings in a helpful/meaningful way.

What is this research study about?

This study aims to explore your experience of preparing to leave CAMHS. Leaving a service that you might have been involved with for a while can result in a variety of different emotions. However little is known about how young people feel about leaving CAMHS. How you feel about moving on is important and is what this study is hoping to find out.

The study is also interested in finding out about your experience of building relationships with the people you have been working with at CAMHS, but also more generally. It is possible that how you form relationships might affect how you feel about moving on out of CAMHS. We don't know, but hope to find out.

Who is carrying it out the research?

The research is being carried out by Emma Rich a Trainee Clinical Psychologist from the University of Leicester and will form part of a Doctorate of Clinical Psychology qualification.

Why is this research important?

Gaining a better understanding of how young people experience the transition out of CAMHS can help us to advise CAMHS services about how they can improve the experience of their service users. Relationships form an important part of the CAMHS experience so it is likely that they play a role in young peoples' experiences of preparing to leave.

How will this be done?

The information will be gathered by way of interview. You will be interviewed about your experience of engaging with CAMHS and how you are feeling about moving on.

The interviews will be carried out by Emma Rich, a Trainee Clinical Psychologist, who is responsible for the research.

The interviews will be recorded on a voice recorder and then typed-up word for word, creating a transcript. Each participant will be allocated a special code and this will be used to identify all your information.

Participants are given codes to distinguish them from each other whilst maintaining their confidentiality. Each person's interview data will then be analysed and written up. Within the write-up direct quotes will be taken from different participants interviews, but only their unique code will be given, thus protecting your identity.

You will also be asked to fill out two short questionnaires that ask about your perception of important relationships in your life. Again this will be identified by your unique code, protecting your confidentiality.

The interviews will be carried out either within your normal CAMHS building, or at your home. You can choose, so hopefully wherever you are interviewed will be comfortable and familiar to you.

The interviews are designed to explore your views, but we want you to feel as comfortable as possible and therefore you can chose to attend the interview(s) alone, or bring a supportive person with you.

What will be expected of you?

You will be asked to attend an initial interview which will last approximately one hour.

The interview will be conducted by Emma Rich, a trainee clinical psychologist.

The interviewer will ask you questions about your experiences of being a CAMHS service user and your thoughts and feelings about moving on.

You will also be asked to fill in two short questionnaires which should take only a few minutes to complete. The results of the questionnaires will be used to help the researcher think about your interview responses.

You may also be asked to attend a follow-up interview at a later date. This would be to ask any additional questions and makes the interview process more flexible.

What if you feel upset?

Feeling upset is a common response to the prospect of leaving something familiar and moving on. Feeling upset is not in itself a problem and if you were to feel, or become upset in the interview you would be encouraged to discuss your feelings and would be supported by the interviewer. However, if you were to feel too distressed the interview would be ended and you would be offered support by one of the CAMHS clinician's.

Confidentiality

The interviews will be carried out by a trainee clinical psychologist for the purpose of research. Your interview recordings and information will not typically be shared with people outside of the research project without your permission. However, if you were to say something which caused the interviewer to become concerned about your safety, or the safety of others then this information would be shared in order to make sure you were offered support. This is unlikely to happen, but it would be discussed with you at the time if concerns were raised.

Interview recordings and questionnaires will be destroyed after five years and in the meantime will be stored securely within the Clinical Psychology Department of the University of Leicester.

What will you get out of participating?

Participating in this study will provide you with an opportunity to express your thoughts and opinions about the service you have received and discuss the prospect of moving on. It will also be an opportunity for you to reflect on how you are feeling about the upcoming transition. It may help you to think about important issues that you want to discuss with your clinician before your transition out of CAMHS.

By taking part in the study you will be helping to increase the knowledge professionals have of service users' experiences and in turn you will be helping to improve services for other young people.

In order to show our appreciation for your time and effort in participating in this study you will be given you a £20 gift voucher on completion of the study.

What is consent?

Before taking part in any research it is important that you fully understand what you are agreeing to do and have chance to ask questions if you want to. It is also important that you understand what will happen to the information you have given and what it will be used for. Therefore, before taking part in this research you will be asked to read and sign a consent form which details the study and what it entails.

What if I change my mind?

Sometimes after agreeing to do something, or even after doing it, we change our minds. You will be able to change your mind at any time up to one month after completing the interview. If you change your mind you simply need to contact the researcher who will destroy all the information you have provided up to that point.

Choosing to participate in this research, or choosing to withdraw from this research will not impact on your on-going care in any way.

Complaints Procedure

We hope that if you choose to take part in this research it will be a pleasant experience. If however, you were to experience any difficulties, or have any concerns you could discuss this with either Emma Rich (the researcher), one of the clinicians within CAMHS, or contact PALS (Patient Advice and Liaison Service).

Patient Advice and Liaison Service is a free and confidential service for people who would like to comment on, any aspect of the services provided by the NHS. The service has been set up to give patients, their families and carers a voice in the way their health service is run.

Your local PALS can be contacted using the information below.

Xxxxxxxxxxxxxxxxx NHS Foundation Trust
xxxxxxxxxx
xxxxxxxxxxxxxx
xxxxxxxxxxxxx
xxxxxxxxxxxx
xxxxxxx

Freephone telephone: xxxxxxxxxxxxxx
e-mail: xxxxxxxxxxxxxxxxxx

Contact

If you have any questions about this study you can contact the researcher Emma Rich at xxxxx@le.ac.uk, and/or speak to you CAMHS clinician.

Appendix H: Example of Coding

Original Transcript - MOLLY Interview	**Exploratory Comments**
MOLLY I can't give you exact dates because my memory is shot and I can't (laughs) but around year nineish time I started having mental health problems and around year ten my teacher was really pushing for me to get through to CAMHS, but it just, it takes ages for you to get into the system. Cuz like first, fucking hell, I remember, um, I went to my doctor and told my doctor all about it and my doctor then sent me somewhere else and I had to tell them all about it and then I had a little bit of therapy with them, which lasted about four weeks and then I had someone else to come and see if I was alright and then I had another person and then I had the school counsellor and there was lots and lots of people there that I had to speak to and tell the same thing to, um so when I got to Dr Naylor and Dr Naylor told me that she thought I was quite ill and that I needed medication, I cried because it was the first time anyone had said to me, "hey, I think there is something wrong with you and I think there is something I could do to help." E Um MOLLY rather than just shove me off onto someone else and that took quite a while. E So was that at the point that you went to CAMHS? MOLLY No I have sort of been circling, circulating CAMHS but I hadn't actually, I had been on their record as it were, but I had actually been sent anywhere. E Right MOLLY I just kept being added to waiting lists seeing someone and then them adding me to another waiting list and I wasn't really…	Emphasising lack of expediency. Pauses suggesting careful consideration of choice of descriptors and also a linguistic re-enactment of her experience. Memory ruined/destroyed rather than always poor. Teacher concerned, not just her, therefore more real/valid? Justification of need. Long journey via many different people to get to CAMHS. One very long sentence; lack of punctuation perhaps indicating the extensive and exhaustive nature of her experience. Telling and retelling her story. Having her story listened to and heard. Being believed? Feeling doubted? Quoting-caricature. "Shoved" Did she feel physically assaulted by those who had heard her story but then passed her on? "The-rapist" Use of metaphor invoking images of being passed around like lost mail. Within sight but out of reach. Sense of time ticking away, passive recipient, no control in the process. Initial use of 'I' then subsequent use of 'we' – taking responsibility then becoming passive?

Appendix I: Example of Objects of Concern and Units of meaning

Objects of concern and units of meaning for Jack

Time in CAMHS

- Growing up within CAMHS
- Coming and going with ease from the service
- CAMHS has always been there when needed

Number of different clinicians

- A general positive attachment to the service rather than individual clinicians
- Difficulty recalling specific clinician's or interventions but overall sense of it being helpful
- Always somebody available to listen and to "vent" to

Helpful CAMHS

- Feeling liked, heard and cared about by clinicians
- Relaxed, informal environment that promotes feelings of security
- Being able to talk especially about emotions without judgement
- Techniques and advice to try out that give a sense of progression and helps to move things forward
- It's grounding promoting feelings of containment
- Collaborative, encouraging and celebratory – confidence building and self-belief
- "It discharges me"
- Different to medical settings which are clinical and school which is authoritarian

West Midlands - Edgbaston Research Ethics Committee

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Nottingham

NG1 6FS

Telephone: 0207 104 8069

Appendix J: HRA Provision Approval

30 March 2016

Miss Emma Frances Rich
Trainee Clinical Psychologist
University of Leicester and Leicester Partnership NHS Trust
Leicester University
104 Regent Road
Leicester
LE1 7LT

Dear Miss Rich

Study Title:	**"Getting ready to move on: Considering attachment within young peoples' experiences of preparing to transition out of**
REC reference:	**16/WM/0131**
IRAS project ID:	**199369**

The Research Ethics Committee reviewed the above application at the meeting held on 16 March 2016. Thank you for attending to discuss the application.

Provisional opinion

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

1. The following changes to the invitation letter are required:

   a) It must be written in the first person, with a friendly tone, to include an introduction from you as Chief Investigator.

   b) The purpose of the second interview must be explained.

   c) Reference to the involvement of parents/guardians in the invitation letter/reply slip must be removed.

2. You are required to review the information sheet and consent form to ensure typographical and punctuation errors are corrected.

3. The following additional changes to the participant information sheet are required:

    a) Reference to the involvement of parents/guardians must be removed.
    b) It must refer to the second questionnaire that will be administered and explain the reason for this.
    c) It must include the research study title, Chief Investigator's name and the address of the sponsoring institution at the start.
    d) Independent contact details for complaints and to seek independent advice must be added e.g. NHS complaints process/PALS.

4. You are required to provide a copy of the finalised topic guide containing the questions that will be asked during the interview.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact the REC Manager, Helen Poole at nrescommittee.westmidlands-edgbaston@nhs.net

When submitting a response to the Committee, the requested information should be electronically submitted from IRAS. A step-by-step guide on submitting your response to the REC provisional opinion is available on the HRA website using the following link: http://www.hra.nhs.uk/nhs-research-ethics-committee-rec-submitting-response-provisional-opinion/

Please submit revised documentation where appropriate underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. You do not have to make any changes to the REC application form unless you have been specifically requested to do so by the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 29 April 2016.

Summary of the discussion at the meeting

Social or scientific value; scientific design and conduct of the study

The Committee commented this was a very good study into an important topic, but it seemed a shame the opportunity had not been taken to involve patients in the design process. *You responded you had submitted the study to a lay service user panel as part of the university process for their feedback.* The Committee were pleased to hear this had been done, although it had not been described in the REC application.

The Committee queried whether gender balance had been accounted for in the recruitment strategy at all. *You explained you did not believe gender should be a factor in this area. You added this was quite an un-researched area generally, so it was not yet known what factors would contribute to handling transition differently.*

The Committee noted you would adhere to a Lone Working Policy in relation to conducting home visits. They queried what process would be followed to ensure individuals were appropriate and safe to visit at home. *You explained the key clinician who had identified the service user as potentially eligible for the study would inform her whether it was safe in each case, prior to a visit being conducted.*

Members commented this was a very important area of research and one that was currently subject to national debate. They queried whether there was the intention to expand the research beyond the initial cohort of 6 participants*. You confirmed the sample size was in line with the recommended guidelines for an IPA study, and was a practical number given the in depth analysis required as part of her doctorate. You confirmed 6 participants would be the end point as far as this study was concerned, however, there would be scope for others to expand on the research beyond this if they wished.* The Committee sought to confirm the numbers were adequate for you to achieve your doctorate. *You confirmed this was the case.*

The Committee noted there had been no primary or secondary outcomes listed in the REC application. They noted qualitative studies sometimes stated they could not list formal outcome measures due to the nature of the study, but added applicants should have an intended outcome. *You confirmed you hoped to evaluate why people felt detached when transitioning to adult services.*

Recruitment arrangements and access to health information, and fair participant selection

Prior to your arrival the Committee commented the invitation letter should be written in a more friendly tone and in the first person. For example, with the Chief Investigator introducing herself and her role in the first person, and changing sentences to the first person such as 'I will conduct the initial interview…'. Members also commented the purpose of the second interview required explaining in this document.

Members commented the invitation letter could be further personalised given it was being sent directly from the Chief Investigator. They added it should be amended in order that it read as though the Chief Investigator was addressing them directly, and in a friendly manner. *You noted this.*

The Committee noted there was reference in the both the invitation letter /reply slip and participant information sheet to discussing the study with parents. Members sought to clarify

that all participants would be older than 16 years of age, given they would be transitioning into adult support services. *You confirmed this was the case.* The Committee commented all references to parents/guardians could therefore be removed, as their involvement would not be required. *You agreed.*

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

Members queried whether you intended to register the study publically. *You confirmed you would register the study with Northamptonshire NHS Trust Research and Development Department.*

The Committee queried how the results of the study would be fed back to participants. *You responded results would be fed back to the CAMHS service, and participants would also be written to directly with a lay summary of the study findings.*

Informed consent process and the adequacy and completeness of participant information

Prior to your arrival the Committee commented the information sheet needed to be amended to ensure it referred to both of the questionnaires that would be administered.

The Committee recommended you reviewed the participant information sheet and consent form in order to correct any typographical and punctuation errors. *You noted this.*

Members commented the information sheet should include the research study title, Chief Investigator's name and the address of the sponsoring institution at the beginning. In addition, independent contact details for any potential complaints and to seek advice should be added. With regard to the latter a service such as the NHS's Patient Advice Liaison Service (PALS) could be used. *You noted this.*

Suitability of supporting information

It was noted the topic guide for interviews had not been provided as yet. *You confirmed this had not yet been finalised.* Members asked that it be submitted for review as part of the response to the Committee in order that it could be approved for use.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
Letter from sponsor [Sponsorship]	1	11 February 2016
Letters of invitation to participant [Invitation]	1	11 February 2016
Other [Response to Validation Queries]		02 March 2016
Participant consent form [Consent Form]	1	11 February 2016

Participant information sheet (PIS) [Patient Information	1	11 February 2016
REC Application Form [REC_Form_05032016]		05 March 2016
Referee's report or other scientific critique report [Peer	1	28 February 2016
Research protocol or project proposal [Research Proposal]	1	11 February 2016
Summary CV for Chief Investigator (CI) [C.V.]	1	11 February 2016
Summary CV for supervisor (student research) [Research	1	11 February 2016
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Lay Summary]	1	11 February 2016
Validated questionnaire [Attachment Measures]	1	28 February 2016

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached

sheet

Statement of compliance

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

16/WM/0131 **Please quote this number on all correspondence**

Yours sincerely

PP

Mr Paul Hamilton

Chair

Email: NRESCommittee.WestMidlands-Edgbaston@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: *Dr David Clarke*

Ms Rose Streeton, Northampton NHS Foundation Trust

West Midlands - Edgbaston Research Ethics Committee

Attendance at Committee meeting on 16 March 2016

Committee Members:

Name	*Profession*	*Present*
Dr Oladipo Babalola	Relief Pharmacy Manager	No
Dr Sheila D'Souza	Dentist	Yes
Dr Hora Ejtehadi	Senior Academic Lecturer	Yes
Mr Chris Foy	Medical Statistician	Yes
Mr Paul Hamilton (Chair)	Retired Local Government Officer	Yes
Dr Adrian Hamlyn	Consultant Physician & Hepatologist	Yes
Dr Sarahjane Jones	Research Fellow	No
Dr Nigel Langford	Consultant Clinical Pharmacologist & General	Yes
Professor John Marriott	Pharmaceutical Chemist/Academic Pharmacist	Yes
Mrs Alison Parsons	Retired Senior Manager	Yes
Mr Philip Russell	Retired Head Teacher	Yes
Dr Eric Silove	Retired Paediatric Cardiologist	No
Dr Michael Wolffe	Optometrist	Yes

Also in attendance:

Name	*Position (or reason for attending)*
Jessica Parfrement	Deputy Regional Manager
Helen Poole	REC Manager

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Appendix K: HRA Favourable Opinion

19 May 2016

Miss Emma Frances Rich
Trainee Clinical Psychologist
University of Leicester and Leicester Partnership NHS Trust
Leicester University
104 Regent Road
Leicester
LE1 7LT

Dear Miss Rich

Study title:	**"Getting ready to move on: Considering attachment within young peoples' experiences of preparing to transition out of**
REC reference:	**16/WM/0131**
IRAS project ID:	**199369**

Thank you for your submission of 12 May 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require

further information, or wish to make a request to postpone publication, please contact the REC Manager, Helen Poole, at NRESCommittee.WestMidlands-Edgbaston@nhs.net

Confirmation of ethical opinion

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

Conditions of the favourable opinion

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

the study.

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

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

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

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

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

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

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

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

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

Ethical review of research sites

NHS sites

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

"Conditions of the favourable opinion" below).

Approved documents

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

Document	*Version*	*Date*
Interview schedules or topic guides for participants [Topic	1	12 April 2016
Letter from sponsor [Sponsorship]	1	11 February 2016
Letter from sponsor [Sponsorship]	1	
Letters of invitation to participant [Contact Letter]	3	05 May 2016
Other [Response to Validation Queries]		02 March 2016
Participant consent form [Consent Form]	3	05 May 2016
Participant information sheet (PIS) [Participant Information	3	05 May 2016
REC Application Form [REC_Form_05032016]		05 March 2016
Referee's report or other scientific critique report [Peer	1	28 February 2016
Referee's report or other scientific critique report [Peer	1	
Research protocol or project proposal [Research Proposal]	1	11 February 2016
Summary CV for Chief Investigator (CI) [C.V.]	1	11 February 2016
Summary CV for supervisor (student research) [Research	1	11 February 2016
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Lay Summary]	1	11 February 2016
Validated questionnaire [Attachment Measures]	1	28 February 2016
Validated questionnaire [Questionnaires]	1	28 February 2016

Statement of compliance

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

After ethical review

Reporting requirements

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

Notifying substantial amendments

Adding new sites and investigators

Notification of serious breaches of the protocol

Progress and safety reports

Notifying the end of the study

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

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

16/WM/0131 **Please quote this number on all correspondence**

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

project. Yours sincerely

Mr Paul Hamilton

Chair

Email:NRESCommittee.WestMidlands-Edgbaston@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr David Clarke*

Ms Rose Streeton, Northampton NHS Foundation Trust

Appendix L: Chronology of the research process

Research stage Timescale

Research proposal (first submission) May 2015

Panel review and internal peer review (feedback and amendments) June 2015 to August 2015

Preparation for ethics application September 2015 to November 2015

Service User Reference Group (lay summary review and feedback) February 2015

NHS Research & Development sponsorship approval 10th February 2016

Final HRA REC approval 19th May 2016

Participant recruitment and data collection September 2016 to November 2016

Preparation for the Literature Review Mid-September 2016 to mid-November 2016

Data transcription and analysis October 2016 to December 2016

Write up of the thesis January 2017 to June 2017

Thesis submission 30th June 2017

Research article preparation for submission in a peer-reviewed journal for publication July 2017 to September 2017

Research viva 17th July 2017

Preparation of a research poster August 2017 to September 201

Trainee research conference and dissemination of findings to relevant people and services September 2017