

# Wellbeing of CAMHS staff and changes in working practices during the COVID-19 pandemic

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## Abstract

**Introduction:** The coronavirus disease 2019 pandemic has necessitated significant changes in working practices across healthcare services. The current study aimed to assess the wellbeing of health professionals and quantify the adaptations to working practices in a Child and Adolescent Mental Health Service (CAMHS) during the pandemic.

**Method:** The study was conducted in a UK CAMH team six weeks into lockdown measures. All clinicians were invited to complete a survey eliciting their experiences of working practices during the pandemic, degree of worry about the virus and mental wellbeing.

**Results:** Clinicians had significantly lower levels of mental wellbeing during the pandemic than population normative data, to the extent that some clinicians were classified as at heightened risk of depression. A significant shift to remote working, reduction in face-to-face appointments, and decrease in clinicians' perceived ability to undertake clinical tasks was observed. Themes emerging from clinicians' experiences of working during the pandemic include being supported within the team, providing a service, working adaptations, and working as a team. A further theme highlights the needs of clinicians to complete their clinical role effectively.

**Conclusion:** CAMHS clinicians require additional support, training, and guidance during a pandemic to promote mental wellbeing and effectiveness in completing clinical tasks.

## KEYWORDS

COVID-19, remote working, wellbeing, working practice, worry

## 1 | INTRODUCTION

On March 11, 2020, the World Health Organisation declared the 2019 novel coronavirus (COVID-19) as a pandemic (World Health Organisation, 2020). On the March 23, the UK government introduced social distancing measures to reduce the spread of the virus, including the closure of schools and universities, implementation of remote working

policies and avoidance of all but essential travel. To reduce the risk of infection many National Health Service (NHS) providers across the UK, including community mental health teams, limited the provision of face-to-face appointments and actively encouraged staff members to work from home, where possible.

The COVID-19 pandemic is likely to place a major strain on community mental health services (Druss, 2020), including child and

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adolescent mental health services (CAMHS) nationwide. Rates of anxiety in the population are predicted to increase as a result of the direct effects of fears of contamination, stress, grief, and depression triggered by exposure to the virus, and as a result of distal social and economic consequences occurring at an individual and societal level (Druss, 2020). Furthermore, a high proportion of children and families accessing CAMHS are classified as "vulnerable" by the UK government, due to special educational needs and disabilities. These young people and families have been found to be at a greater risk of experiencing poor mental health, and under substantially greater pressure than less vulnerable families during the pandemic (Asbury et al., 2020), resulting in families/carers requiring additional CAMHS support (Toseeb et al., 2020). It is predicted that social isolation in children, insecurity in parental employment and increased parental distress may result in a rise in childhood mental health problems and a subsequent upsurge in demand for CAMHS input (Crawley et al., 2020).

As well as increased demand, CAMHS clinicians are required to make significant changes to working practices as a result of the virus. The restrictions on physical contact have demanded a transition to novel formats for facilitating clinical contacts, including telephone and video consultations, to continue service provision. Before the pandemic, a survey of 154 CAMHS clinicians in the UK estimated that only 4.5% were using videoconferencing technology in their clinical role on a weekly basis (Cliffe et al., 2020). Research has highlighted several barriers to the use of technology in health settings, including the limited integration as a part of routine practice (Topooco et al., 2017), resulting from clinicians' uncertainties about the availability of technologies and the technical aspects regarding privacy and security, reliability, and safety of use (Cliffe et al., 2020). It is also noteworthy that the evidence-base for CAMHS intervention is predominantly based upon face-to-face working. Although there are a minority of studies evaluating the effectiveness of telehealth modalities (e.g. Gloff et al., 2015), this is not yet the norm in clinical practice and the majority of clinicians are not trained or familiar with intervention in such a format. In the UK, the pandemic has proven to be a catalyst for managers, information technology (IT) staff, and health professionals to rapidly overcome barriers to telehealth to continue service delivery (Wind et al., 2020).

The transition to remote working has the potential to further influence service delivery and staff wellbeing during the pandemic. In other occupational settings, remote working has been found to have a negative impact on workforce wellbeing, due to the collapsing of boundaries between work and private lives and reduced social interaction and relationships with colleagues (Grant et al., 2013). For instance, in the context of a nationwide lockdown, working from home may mean that many staff members are required to balance the demands of work with caring responsibilities for vulnerable family members or providing education and care for dependents. Similarly, reduced social interactions and more distanced relationships with colleagues can potentially impose challenges in managing clinical risk effectively, providing high quality care, as well as in ensuring staff are adequately supported at times of change.

Finally, research has been conducted investigating factors associated with increased risk of anxiety and depression in frontline hospital workers during emerging virus outbreaks. Factors found to

be associated with increased psychological distress include being female, having fewer years clinical experience, having a chronic health condition, younger age, and living with children (Kisely et al., 2020; Zhu et al., 2020). Furthermore, health workers perceptions of the sufficiency of precautionary measures in the workplace, such as personal protective equipment (PPE), have been associated with an improvement in virus-related concern and psychological outcomes (Kisely et al., 2020). To date, there is a paucity of research investigating risk factors for psychological distress in mental health professionals during a pandemic.

The current study aimed to quantify the impact of the COVID-19 virus on adaptations to CAMHS working practice including workforce perceptions of: (1) the primary method of delivery of clinical contacts, (2) the ability to undertake clinical roles, (3) the supportive structures in the service, and (4) outstanding needs to work effectively. The study also sought to examine levels of staff wellbeing and worry about the virus, as well as to elicit CAMHS clinicians' broader experiences of working during the COVID-19 pandemic.

## 2 | METHODS

### 2.1 | Participants

The study was conducted in a community CAMH service in the UK, comprised of several community and specialist teams providing mental healthcare for children and families experiencing a range of difficulties. The service is made up of multidisciplinary professionals including medical, psychological, therapy, nursing, and social work clinicians.

### 2.2 | Measures and procedure

A questionnaire survey was designed to elicit staff members' views of working during the pandemic. The survey consisted of 40 items, requiring respondents to provide open-ended qualitative reflections and multiple-choice or Likert scale responses. The questionnaire aimed to capture clinicians' attitudes to changes in their working practices and perceived ability to complete core clinical tasks in CAMHS (namely; building rapport, assessing risk, and completing an assessment and intervention) before and during the pandemic. Further items were included that related to staff perceptions of (a) formal and informal support systems within the service, (b) the information and guidance about COVID-19 provided by the organisation, and (c) the adequacy of IT and PPE provision. The questionnaire was developed by senior members of the service informed by ongoing consultation with the staff team, in addition to the available guidance and literature relating to healthcare services during emerging pandemics (e.g. British Psychological Society COVID-19 Staff Wellbeing Group, 2020; Kisely et al., 2020). Two questions relating to the degree and type of worry associated directly with the pandemic were assessed using adapted items developed by Goulia et al. (2010). During the survey development,

questions were iteratively reviewed and modified, before a final review by an independent third party.

The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) was used as a measure of staff wellbeing (Tennant et al., 2007). The WEMWBS is a 14-item, self-report measure. Items on the measure are positively worded and related to the main components of mental wellbeing, capturing both the eudaimonic (e.g., respondents' functioning, social relationships, and sense of purpose) and hedonic (e.g., feelings of happiness) perspectives of wellbeing (Ng Fat et al., 2017). The responses from each of the 14 items on the WEMWBS are summed to create a total scale score (range: 14–70), with a high score indicating a high level of mental wellbeing (Taggart et al., 2015). The measure has robust psychometric properties (Tennant et al., 2007) and sensitivity to change (Maheswaran et al., 2012). Previous research comparing the WEMWBS to the Centre for Epidemiological Studies Depression Scale (CES-D) indicates that individuals with a WEMWBS score of less than 40 can be classified as “at risk” of psychological distress and depression (Bianco & Gremingni, 2012; Taggart et al., 2015). The necessary permissions were granted to use the WEMWBS measure as part of the current study (registration ID: 518453203).

Open-ended questions were also included to elicit (a) staff members' views on aspects of their current working environment and (b) staff perceptions of childrens' and families' service needs during the pandemic. The survey questionnaire is available on request.

All staff members working in a clinical capacity across the service were invited to anonymously complete either a paper or online version of the survey. The online survey was administered using Survey Monkey, with most questions requiring a response for completion. The survey responses were collected between May 4th and 12th, 2020, approximately six weeks after a national lockdown was instigated.

### 2.3 | Ethical considerations

Ethical approval was granted by the NHS Foundation Trust Quality and Standards Department. All participants provided informed consent when taking part in the study.

### 2.4 | Statistical analysis

Quantitative statistical analysis was conducted using Statistical Package for Social Sciences (IBM Corp. SPSS Statistics for Windows, Version 26, 2019). The sample was first characterized using descriptive statistics. Following this, data were analyzed for normality by generating standardized skewness and kurtosis scores. Most of the data were found to be non-normally distributed ( $Z = 1.96$  standard deviations from the mean) and therefore nonparametric statistics were used. Individuals with incomplete responses on survey items were excluded from relevant analyses. To test hypotheses

examining the differences between staff groups, and to compare staff attitudes and working practices before and during the pandemic, Wilcoxon signed-ranks tests were calculated. A one-sample Wilcoxon signed-rank test was used to establish if there were significant differences between the median wellbeing scores in the current sample, when compared to population normative data. Hypotheses exploring the factors associated with wellbeing and COVID-19 worry were examined using Kruskal-Wallis H and Mann-Whitney U-tests. Fisher's exact tests were used to determine if there were nonrandom differences between the proportion of staff endorsing different modes of working and levels of ability to complete clinical tasks before and during the pandemic. To explore hypotheses positing associations with wellbeing and COVID worry, a series of Spearman's rank correlation tests were performed.

Qualitative data collected from the open-ended survey questions were analyzed using thematic analysis using the procedure described by Braun and Clarke (2006). To promote anonymity, researchers were blind to the demographic variables of respondents when completing the qualitative analysis. The primary authors formed a research team, led by the primary author (CB). Each author independently immersed themselves in the data, before collaboratively highlighting key sections of text to develop an initial list of codes. The initial codes were then debated, reviewed and consolidated, with constant reference to the original text, to arrive at a final coding list. A process of searching for themes was then undertaken through examination of these codes and the collated data to identify broader patterns of meaning until a position of consonance was achieved. The final themes were identified and labeled. Authentic anonymous citations were used to illustrate the findings. The thematic analysis process was aided by NVivo qualitative data analysis software (QSR International Pty Ltd. Version 12, 2018).

## 3 | RESULTS

### 3.1 | Sample characteristics

A total of 51 responses were returned from clinicians working in the service invited to participate (total  $n = 99$ ; 51.5% response rate). Table 1 reports the demographic characteristics of the respondents. Years of professional experience ranged from 6 months to 40 years (median = 17 years; interquartile range (IQR): 10–25 years). Thirteen respondents (25.5%) reported an underlying health condition classifying themselves as a vulnerable worker in the pandemic.

### 3.2 | Staff wellbeing and COVID-19 worry

Forty-six of the clinicians responding to the survey completed the WEMWBS measure (90%). A one-sample Wilcoxon signed-rank test was used to compare CAMHS clinicians' wellbeing score to normative data collected as part of the Health Survey for England in 2012 (Bridges, 2012). The wellbeing scores of CAMHS clinicians during the

**TABLE 1** Sample characteristics

	N	%
<b>Gender</b>		
Female	37	72.5
Male	9	17.6
Not disclosed	5	9.8
<b>Age</b>		
25 or less	0	0
35–44	15	29.4
45–54	12	23.5
55–64	8	15.7
65 and over	1	2.0
Not disclosed	5	9.8
<b>Professional background</b>		
Nursing staff	16	31.4
Medical staff	5	9.8
Therapists	24	47.1
Social workers	1	2.0
Not disclosed	5	9.8
<b>Working hours</b>		
Full time	20	39.2
Part time	29	56.9
Not disclosed	2	3.9

pandemic were found to be significantly lower than scores found in the general population before the pandemic (see Table 2). There was no significant difference in wellbeing scores between male and female clinicians ( $U = 179.0$ ;  $p = 0.364$ ). However, relative to general population medians, reported wellbeing scores amongst male clinicians did not differ, whereas female clinicians' median ratings of wellbeing were significantly lower than population normative data collected before the pandemic. However, cautious interpretation of this finding is required given the small sample of male clinicians responding to the survey ( $n = 9$ ). Eight clinicians (17%) completing the WEMWBS reported a wellbeing score of 40 or less, a cut-off posited to indicate an increased risk of depression and psychological distress.

Clinicians were asked to subjectively rate their level of worry about the COVID-19 pandemic. A value of 0 represented no current worry, whereas as a value of 10 represented the highest possible level of worry about the pandemic. Clinicians' median responses indicated a high degree of worry overall (median = 7; IQR: 5–7). Clinicians were then asked to identify the particular source of worry relating to COVID-19. Table 3 displays clinicians' reported concerns relating to the virus.

It was hypothesized that clinicians endorsing high levels of worry related to the COVID-19 pandemic would exhibit lower overall wellbeing scores. However, a Spearman's rank correlation found no significant association between the COVID-19 worry score and wellbeing score ( $r_s = -0.193$ ;  $p = 0.099$ ).

It was also hypothesized that individuals self-classified as “vulnerable” during the pandemic would report higher levels of COVID-19 concern and lower levels of wellbeing. However, no significant differences were found in ratings of COVID-19 worry ( $U = 319.0$ ;  $p = 0.076$ ) or wellbeing ( $U = 241.5$ ;  $p = 0.348$ ) between individuals with or without self-reported underlying health conditions. Similarly, based on extant research in hospital workers, it was proposed that younger clinicians would experience higher levels of COVID-19 worry and lower levels of wellbeing during the pandemic. However, a Kruskal–Wallis H test found no significant differences between individuals' age and levels of COVID-19 worry ( $\chi^2(4) = 2.17$ ;  $p = 0.705$ ) or wellbeing ( $\chi^2(4) = 2.53$ ;  $p = 0.640$ ). Furthermore, based on the existing literature, it was hypothesized that clinicians with more years of professional experience would report less anxiety about the COVID-19 pandemic, however this association was not supported by the data ( $r_s = -0.119$ ;  $p = 0.204$ ).

Overall, the level of wellbeing reported by CAMHS clinicians six weeks into the lockdown period was significantly lower compared with the general population normative data (before the pandemic), with approximately 17% of respondents endorsing answers that would classify them “at risk” for depression. Concordant with this, a high-level of worry was also reported by CAMHS staff. Interestingly however, low-levels of wellbeing and high-levels of worry were not found to be related to one another, or associated with variables such as age, underlying health conditions or years of professional experience.

	CAMHS clinicians	Health survey for England (2012)	
	Median	Median	One-sample Wilcoxon signed-rank
Men	50 (IQR: 41.00–58.50)	53	( $Z = -1.01$ ; $p = 0.313$ )
Women	46 (IQR: 41.50–51.00)	53	( $Z = -4.47$ ; $p < 0.001$ )
Full sample	46.5 (IQR: 41.75–51.25)	53	( $Z = -4.67$ ; $p < 0.001$ )

Note: The results of the WEMWBS range from 0 to 70, with higher scores indicating a higher-level of mental wellbeing.

Abbreviations: IQR, interquartile range; CAMHS, Child and Adolescent Mental Health Service; WEMWBS, Warwick-Edinburgh Mental Well-Being Scale.

**TABLE 2** Comparison of CAMHS clinicians' scores on the WEMWBS questionnaire measure relative to pre-existing normative population data

**TABLE 3** Frequency of concerns endorsed by CAMHS clinicians related to the COVID-19 pandemic

	N	%
Risk of family or friends being infected	41	80
Risk of contracting the infection	32	63
Impact of the virus on the ability to function if infected	24	47
Social isolation due to lockdown	24	47
Financial implications of the pandemic	11	22
None of the above	2	4

Abbreviations: CAMHS, Child and Adolescent Mental Health Service; COVID-19, coronavirus disease 2019.

### 3.3 | Changes in working practice

During the pandemic, seventy percent of clinicians ( $n = 36$ ) worked from home for three-quarters of their working week or more, which was significantly more than reported before the lockdown (Fisher's exact  $< 0.001$ ;  $p < 0.001$ ). It was hypothesized that clinicians working remotely for a greater proportion of their contracted hours would report lower levels of wellbeing and higher levels of worry about COVID-19. An independent samples Kruskal–Wallis H-test showed no statistically significant differences in wellbeing score based on the proportion of hours worked remotely during the pandemic ( $\chi^2(4) = 4.45$ ;  $p = 0.349$ ). However, the proportion of remote working was associated with COVID-19 worry ( $\chi^2(4) = 12.26$ ;  $p = 0.016$ ). Post hoc analysis (Bonferroni-corrected) indicated that clinicians working from home for 100% of contracted hours experienced significantly higher levels of COVID-19 worry (median = 7; IQR: 7–8) than those working from home for only 25% of hours (median = 4; IQR: 2.5–6; adjusted  $p = 0.046$ ). Due to the additional burden of caring responsibilities, it was also proposed that clinicians working from home with children would have lower levels of wellbeing, however, no significant differences were observed between those with and without dependents ( $U = 172.5$ ;  $p = 0.161$ ).

Clinicians were asked to report the change in the format of clinical contacts provided to patients (Table 4). The results of repeated-measures Wilcoxon signed-ranks tests suggest a significant decrease in face-to-face appointments with young people and families, and a significant increase in appointments administered using telephone and video platforms (Table 4).

Clinicians were also asked to rate their perceived level of competence in completing core aspects of their role. There were statistically

significant differences reported in clinicians' ability to undertake core aspects of their role during the pandemic compared with the pre-pandemic period. Clinicians' self-ratings of their ability to build rapport with families ( $Z = -5.80$ ;  $p < 0.001$ ), conduct an assessment ( $Z = -5.77$ ;  $p < 0.001$ ), assess risk ( $Z = -5.53$ ;  $p < 0.001$ ), and provide an intervention ( $Z = -5.70$ ;  $p < 0.001$ ) were all rated as significantly worse during the COVID-19 pandemic. Before the pandemic, none of the staff reported they were unable to perform aspects of their role. However, during the pandemic period, seven respondents reported being unable to build or maintain rapport with families (Fisher's exact = 0.0125,  $p < 0.05$ ), nine respondents reported being unable to conduct an assessment (Fisher's exact = 0.0027,  $p < 0.01$ ), 11 were unable to assess risk, (Fisher's exact = 0.0005,  $p < 0.01$ ) and 12 reported being unable to provide an intervention (Fisher's exact = 0.0002,  $p < 0.01$ ). It was hypothesized that clinicians reporting that they were no longer able to complete clinical tasks during the pandemic would experience lower levels of wellbeing. However, no significant differences in wellbeing scores were observed between those able and not able to complete an assessment ( $U = 184.5$ ;  $p = 0.353$ ), assess clinical risk ( $U = 219.5$ ;  $p = 0.144$ ), provide an intervention ( $U = 237.0$ ;  $p = 0.134$ ), and build rapport ( $U = 171.5$ ;  $p = 0.291$ ).

### 3.4 | Attitudes to changes in working practice

Clinicians were asked to report their perceptions of the adequacy of PPE available to complete their job safely during the pandemic. Table 5 displays clinicians' perceptions of PPE provision, which were largely neutral at the specified timepoint in the pandemic. It was hypothesized that clinicians reporting a lack of adequate PPE would experience greater levels of worry related to COVID-19, however, this was not supported by an independent-samples Kruskal–Wallis H test ( $\chi^2(5) = 9.83$ ;  $p = 0.080$ ).

Daily team meeting and supervision attendance were largely perceived to be more important during the pandemic (Table 5). Furthermore, the majority of respondents indicated they had been negatively impacted by a reduction in informal staff support since the increase in remote working in response to the COVID-19 outbreak (Table 5). Half of clinicians (51%;  $n = 26$ ) agreed that a service offering a reflective space or psychological support regarding concerns about the COVID-19 pandemic would be important, a quarter (25%;  $n = 13$ ) were neutral, and 24% ( $n = 12$ ) felt this was not important. A significant association was observed between clinicians' worry about the pandemic and perceptions of the importance of a reflective space or psychological support ( $r_s = .282$ ;  $p = 0.023$ ).

**TABLE 4** The format of clinical contacts offered by clinicians before and during the COVID-19 pandemic

	Before COVID-19 Median % (IQR)	During COVID-19 Median % (IQR)	Wilcoxon Signed-ranks test
Face-to-face	95% (IQR: 90–100)	0% (IQR: 0–0)	( $Z = -6.18$ ; $p < 0.001$ )
Telephone	5% (IQR: 0–10)	98% (IQR: 67–100)	( $Z = 6.14$ ; $p < 0.001$ )
Video	0% (IQR: 0–0)	0% (IQR: 0–20)	( $Z = 4.03$ ; $p < 0.001$ )

Abbreviations: IQR, interquartile range; COVID-19, coronavirus disease 2019.



**TABLE 5** Clinicians' attitudes to changes in working practices

	N	%
<b>PPE provision</b>		
Adequate PPE provision to complete job safely	10	20
Neutral	36	72
Insufficient PEE provision to complete job safely	4	8
<b>Daily team meeting attendance</b>		
More important during the pandemic	34	67
Unchanged	12	23
Less important during the pandemic	5	10
<b>Supervision attendance</b>		
More important during the pandemic	44	86
Unchanged	6	12
Less important during the pandemic	1	2
<b>Informal staff support</b>		
Negatively impacted by reduction in informal support	35	69
Neutral	12	23
Not negatively impacted by reduction in informal support	4	8

Abbreviation: PPE, personal protective equipment.

Overall, the results identified a substantial move to working from home compared with pre-pandemic levels, with 70% of the CAMHS team working from home for three-quarters of the week or more. It was evident that clinicians relied upon telephone contact with children and families rather than adopting new technologies such as video calls six weeks into the lockdown period of the pandemic. Interestingly, whilst there was no relationship between those with an underlying health condition and the degree of worry/adverse wellbeing experienced, those working from home 100% of the time were found to have higher levels of COVID related worry. One of the most striking findings related to the change in perceived competence of CAMHS clinicians, with the pandemic having a highly significant adverse effect on clinician's self-rated ability to establish rapport, assess risk, undertake an assessment, and provide an intervention remotely. Concordant with this, a substantial proportion of respondents reported being unable to undertake core aspects of their roles. Reports also highlighted the increased need for frequent contact with the team, and more importance placed on supervision and mechanisms of informal staff support.

### 3.5 | Clinicians' experiences of the working environment

Of the 51 staff members who completed the survey, 50 responded to the optional open-ended questions eliciting CAMHS clinicians' experience of working during the pandemic. The analysis identified five major themes which were labeled: (1) providing a service to young people and families, (2) being supported within the team, (3) working as a team, (4) working adaptations, and (5) needs of the team. A pictorial representation of the major themes and subthemes is presented in Figure 1.

#### 3.5.1 | Providing a service to young people and families

Clinicians perceived the provision of a continuing service and regular contact to families as a key subtheme. Another subtheme was the appreciation from families of being "held in mind" by CAMHS clinicians during a time of uncertainty. Flexibility in offering appointments remotely and choice in service provision was also important in the narratives of clinicians. Finally, a subtheme emerged around families' appreciation of the provision of additional resources during the pandemic including signposting to online material.

*"I think [families] appreciate the fact that we're still open for business and looking to support them during a difficult time, even if remotely...we give a message that we care about their mental health needs and haven't abandoned them."*

*"[Families value] our flexibility in working differently e.g. offering phone and video consultations in place of face-to-face appointments."*

*"On the other hand, other families don't seem to want services at present. They seem to be experiencing less difficulties."*

*"[Families value] practical information they can use to understand what they might be experiencing and things that might help...being given information and access to resources, groups and other people."*

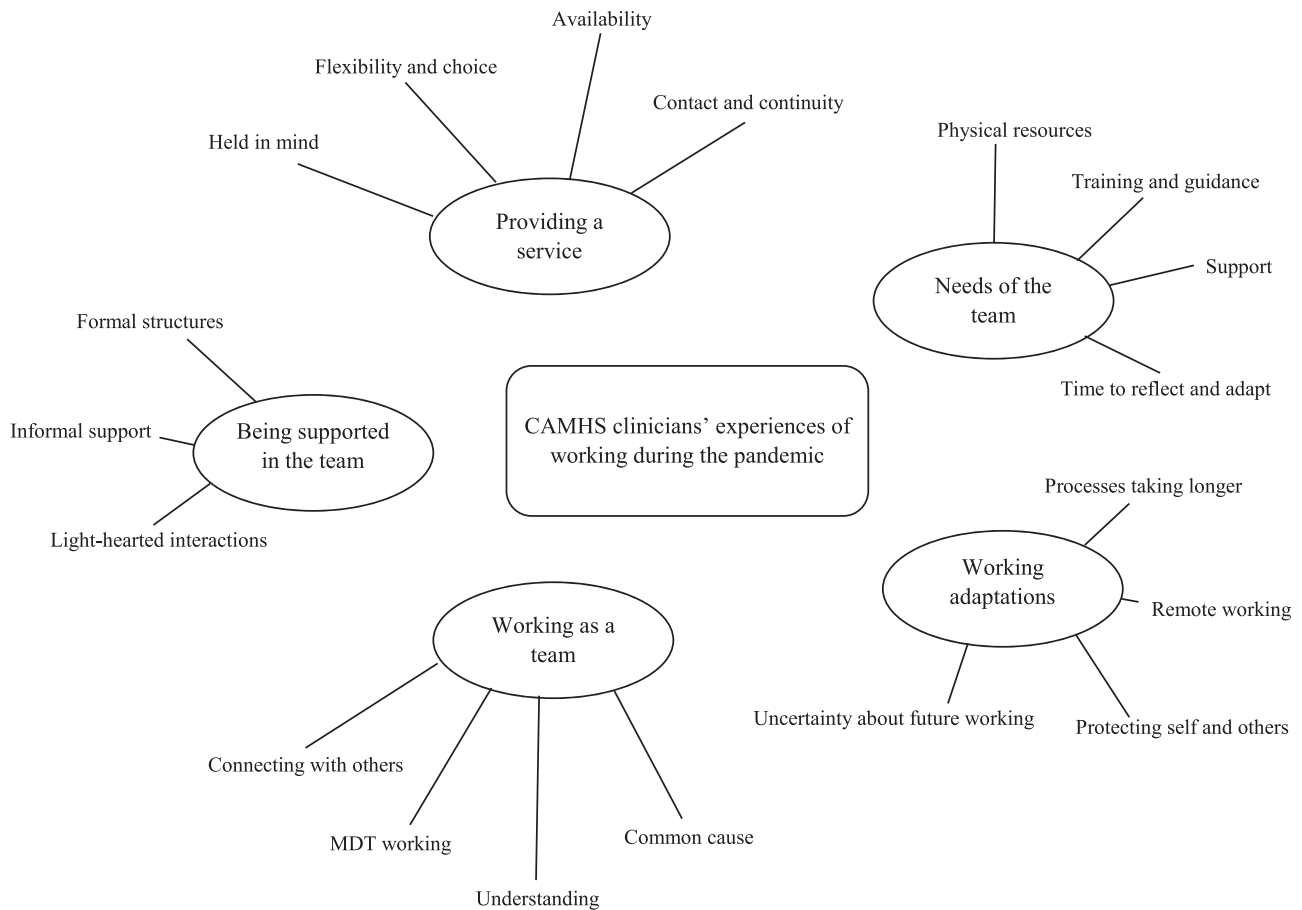
#### 3.5.2 | Being supported within the team

A further pervasive theme across clinicians' narratives was the value of support provided by the team during the pandemic. Respondents frequently highlighted the benefits of informal support, including having a space to "chat" and "check-in," and share "mutual support and feeling for each other" (Clinician 34). The opportunity to share light-hearted moments of interaction, including connecting through "humour" appeared to provide some balance to discussions related to COVID-19. The formal support mechanisms within the service, including line management, clinical supervision and the daily team meeting, were also highly appreciated by clinicians.

*"The humbling experience of the extraordinary support from colleagues...the support I have received has been phenomenal."*

*"Humour in the workplace allows me to still feel connected to people."*

*"[Daily team meeting] attendance seems to have improved since lockdown which means we have a greater*



**FIGURE 1** Pictorial representation of themes and subthemes. CAMHS, Child and Adolescent Mental Health Service

*range of views and ideas about how we can help ourselves and each other at this time."*

*clinical work, at this time where we are working increasingly on an autonomous basis."*

### 3.5.3 | Working as a team

A subtheme emerged highlighting clinicians' perceptions of unified working and commitment of their colleagues in the pandemic, labeled "working towards a common cause." With a shift to remote and autonomous working, daily team meetings were valued to maintain a multidisciplinary focus to share concerns and seek advice on complex cases. The subtheme connecting with colleagues highlighted the importance of virtually maintaining relationships, however, some clinicians valued the physical, albeit socially distanced, contact with their co-workers. The final subtheme related to clinicians feeling understood by their colleagues with regard to the impact of personal circumstances on their ability to work.

*"I appreciate the commitment shown by my colleagues to continue a service."*

*"[The daily team meeting] has been very much appreciated as an opportunity to connect with the wider team, and to retain a shared multi-disciplinary focus to our*

*"[It is] good to see familiar faces whilst the staffing is distant at this time."*

*"I've appreciated the understanding from colleagues and at times management of the impact of this situation on us as human beings."*

### 3.5.4 | Working adaptations in the pandemic

A prominent subtheme of working adaptations in the pandemic was the reflection on the advantages and disadvantages of working remotely. Many clinicians felt that face-to-face appointments are necessary to establish engagement and rapport. However, clinicians stated that for some young people virtual appointments are preferable as they mitigate practical and psychological barriers to engagement and have resulted in a reduction in cancellations.

*"It has been difficult to engage young people who I've not met before or who struggle to relate to people on the phone."*

*"The situation may bring forward new ways of working that have previously been unavailable to us, such as video sessions. This may really help certain clients, such as those with agoraphobia or practical issues limiting their ability to get to CAMHS clinic sessions."*

The next subtheme focused on the protection of staff members, young people and families. Clinicians valued the efforts of colleagues to maintain social distancing procedures and access to PPE when needed.

*"[I appreciate] the opportunity to access PPE if I need it... being able to access spacious offices that allows respect for social distancing."*

There was recognition that the adaptations in working practice were resulting in tasks taking longer to complete especially with regard to IT systems and accessibility of information.

*"Everything takes longer to perform, resources or historical data...are not available. It is not as easy to work creatively which is so important for children, so this requires more thinking and planning time for both the clinician and the family."*

A subtheme emerged highlighting clinicians' uncertainty about future working, including a plan for the reintegration of face-to-face appointments and clarity about the direction of service delivery.

*"Part of what I am worried about is the process of getting back to working at work and having face-to-face therapy sessions with patients. I am hoping that there is very clear guidance for this so that I know exactly how to re-integrate and can manage the transition gradually and with confidence."*

### 3.5.5 | Needs of the Team

A salient subtheme was the provision of equipment, such as a work mobile phone and reliable connectivity through the virtual personal network, to facilitate the transition to remote working. Furthermore, a considerable number of clinicians supported the need for a reliable, user-friendly platform to facilitate video appointments with young people and families.

*"It would be extremely helpful to have a work mobile phone, rather than having to rely on my own personal phones."*

*"The IT system has not kept pace with the quick changing needs of the service. We need a way of video calling families that is not overly complicated."*

Clinicians reported the need for clear guidance relating to the use of virtual platforms, and specialized training for the provision of evidence-based teletherapy.

*"[We need] to be guided to use systems in a uniformed and consistent way."*

*"[We need] whole service training on remote working rather than a DIY approach."*

The subtheme of support highlighted clinicians' need for additional informal support as well as formal supervision. Furthermore, given the reliance on IT platforms, the need for dedicated and timely IT support was often highlighted in clinicians' feedback.

*"[I need] more frequent supervision allowance in my job plan as the changes raise added issues in terms of therapeutic working...some dedicated consultation with an IT expert regarding the new ways I need to work to adapt therapeutic practice to video therapy."*

The final subtheme is the need for time to reflect and adapt to different ways of working. There was a sense from clinicians that a shared space to reflect on the personal and professional implications of the pandemic and space to adapt to the new working "normal" was needed.

*"[We need] a space to think about the challenges of containing clients when clinicians are also facing uncertainty."*

## 4 | DISCUSSION

The global pandemic has been associated with high levels of mortality as well as significant changes in the social and working environment. In addition, a substantial strain on mental health services has been forecast (Druss, 2020). This is the first study to investigate the impact of the COVID-19 pandemic on a UK based CAMHS service. The response rate in the current study (51.5%) was high compared with existing research recruiting mental health professionals (e.g., 35%; Sherring & Knight, 2009), potentially reflecting the emotional salience of the topic and respondents' desire to express their views on the personal and professional impact of the pandemic.

### 4.1 | Staff wellbeing and COVID-19 worry

The main finding of the current study is that clinicians' wellbeing six weeks into the lockdown phase of the pandemic is significantly below normative population levels, to the extent that 17% of clinicians were classified as "at risk" for depression. A correspondingly high rate of COVID-19 related worry was also observed in the CAMHS workforce.



The level of COVID-19 worry and adverse wellbeing are unsurprising given the high mortality rate of the virus, saturation in the global media, and the perceived threat the virus poses to clinicians' health, loved ones, and wider society. The findings are also consistent with recent studies in the general population which have reported an increased rate of psychological distress during the pandemic (McGinty et al., 2020). It was somewhat surprising that no association was observed between the degree of worry related to the COVID-19 pandemic and clinicians' self-reported wellbeing. This association was, however, approaching significance, and may be an artifact of the nonparametric statistics employed in the quantitative analysis.

Contrary to the extant literature investigating correlates of anxiety and stress in hospital workers during emerging virus outbreaks (Kisely et al., 2020), the current study found no associations with COVID-19 worry or wellbeing with relation to gender, age, pre-existing health condition, living with children, years of clinical experience, or perceptions of the adequacy of PPE provision. The reasons for the lack of association between these factors are unclear. However, it does suggest that research investigating the psychological impact of the pandemic on frontline healthcare workers cannot be directly applied to mental health professionals. It is likely that a range of tertiary variables are associated with the high-levels of worry and adverse wellbeing amongst CAMHS workers, which include the possibility of factors external to the working environment.

## 4.2 | Changes in working practice

The second key finding of the current research was the reported decrease in clinicians' ability to undertake clinical aspects of their role, to the extent that a proportion of clinicians (range: 14%–24%) no longer felt able to complete an assessment, provide an intervention, assess risk or build and maintain rapport with patients. The current study was not able to establish the direct causal factors contributing to this for some clinicians. However, some inferences can be made from the qualitative analysis of clinicians' outstanding needs. The qualitative data suggested that, at the specified time-point in the pandemic, clinicians lacked the physical resources, training and guidance, as well as support to maximize their effectiveness in completing their role. As expected, there was a significant shift to remote working and offering clinical contacts to young people and families by telephone or video, with telephone calls being the predominant format of appointments. This could potentially offer a further explanation of perceived inability, as clinicians are less able to examine vital forms of nonverbal communication which are relied upon to form clinical impressions and maintain engagement (Reinhard & Sporer, 2008). Furthermore, frequent or sustained use of videoconferencing platforms has been found to be more cognitively demanding than face-to-face interactions, with a greater potential for miscommunication and misattribution (Schoenberg et al., 2014).

The current study found no association between clinicians' reported ability to complete clinical tasks and wellbeing. It may be that clinicians perceive the change in work competency as a shared experience with their colleagues, transitory and temporary, and outside

of their locus of control, therefore limiting the impact on their self-esteem and wellbeing. It was, however, observed those working remotely for the entirety of their contracted hours reported experiencing significantly higher levels of COVID-19 worry than those working predominantly in the service base. One potential explanation posits that those working entirely remotely may have less exposure to the reality of the world during the pandemic and less connection with familiar routines, exacerbating levels of worry. Alternatively, those individuals reporting greater levels of COVID-19 worry may be more likely to have made the behavioral choice to stay at home, where possible.

## 4.3 | Remote but not distant

A key aspect running throughout the study was the value of human support and connectedness at a time when clinicians are working increasingly in isolation. A high percentage of the workforce indicated they had been negatively impacted by the reduction in informal staff support. However, many reflected on their appreciation of moments of connection and informal support with their colleagues, either remotely or physically at a social distance. Formal support mechanisms, including supervision and daily team meetings, were largely deemed to be more important in the context of the pandemic and continued the sense of working together as a team. Despite this, there was an expressed need to build in additional support structures, such as space for reflection or tailored psychological support, which was observed to be of particular importance to those individuals experiencing higher degrees of COVID-19 worry.

## 5 | LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

The assessment of staff wellbeing was based on comparison to population normative data, rather than baseline data collected from clinicians at a timepoint before the pandemic, therefore limiting the ability of the current study to make substantive inferences about the factors influencing wellbeing in the CAMHS workforce. Similarly, there was no available WEMWBS data collected during a pandemic, limiting the ability of the current study to ascertain if CAMHS clinicians' reportedly low wellbeing was in the normative range given the global context. Although an online survey allows for timely collection of responses from larger numbers of individuals, the questions are static and are not able to evolve, as they can with interview methodologies, to elicit information about new lines of inquiry or encourage individuals to expand on their responses, therefore potentially reducing the richness of the qualitative data collected. Finally, the qualitative strand of the research identified potential protective factors, for example, feeling supported in the team, which were not quantified in the survey and may mitigate a proportion of the negative impact of the pandemic on staff wellbeing. Further research is needed to assess clinicians' wellbeing longitudinally over

the pandemic, examining a range of occupational, and personal factors. Furthermore, future research would benefit from eliciting the views and opinions of young people and families in response to the shift to remote clinical appointments.

### CONSENT TO PARTICIPATE

All participants provided full consent.

### CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

### ETHICS STATEMENT

The study was approved by Sheffield Children's Hospital Foundation Trust Quality and Standards Department (Project No. SE1981).

### DATA AVAILABILITY STATEMENT

The survey questionnaire is available on request from the authors.

The study data is not available due to privacy/ethical reasons.

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