



Exploring the ability of child and adolescent mental health services (CAMHS) to respond to new valuable knowledge: the influence of professionals and internal organisational processes

Journal:	<i>Mental Health Review Journal</i>
Manuscript ID	MHRJ-11-2021-0083.R1
Manuscript Type:	Research Paper
Keywords:	Youth mental health services, Community mental healthcare, Absorptive capacity

SCHOLARONE™
Manuscripts

Title

Exploring the ability of child and adolescent mental health services (CAMHS) to respond to new valuable knowledge: the influence of professionals and internal organisational processes

Abstract*Purpose*

Health policies in England highlight the need for CAMHS to embed new knowledge in practice, yet evidence remains scarce about the services' ability to learn from the external environment. The paper presents a critical analysis of the child and adolescent mental health services (CAMHS)' ability to implement new knowledge through the lens of absorptive capacity, an organisation's ability to identify, assimilate and utilise new valuable knowledge.

Design

16 semi-structured interviews were conducted with staff from the CAMHS department of a mental health organisation in England to explore the services' absorptive capacity.

Findings

Professionals were identified having an impact on the main absorptive capacity components in the following ways: professional background and perceived reliability of knowledge sources appeared to affect knowledge identification; informal communication was found to facilitate knowledge assimilation and exploitation; trust was found to enable knowledge

1
2
3 exploitation, particularly between senior management and frontline professionals. At an
4
5 organisational level, team meetings and internal reporting were identified as enablers to
6
7 knowledge assimilation and exploitation, while organisational hierarchy and patient data
8
9 management systems were identified as barriers to knowledge assimilation. No
10
11 organisational processes were found regarding knowledge identification, indicating an
12
13 imbalanced investment in the main components of absorptive capacity.
14
15
16
17
18

19 *Originality*

20
21
22 The study offers novel insights into the learning ability of CAMHS through the lens of
23
24 absorptive capacity.
25
26
27

28 *Practical Implications*

29
30
31 Investing in these underpinning factors of absorptive capacity can assist CAMHS with
32
33 capitalising on new knowledge that is valuable to service provision.
34
35
36

37 *Keywords*

38
39
40 Youth mental health services, community mental healthcare, absorptive capacity
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Introduction

Many ~~Several~~ mental health conditions, ~~such as anxiety and mood disorders~~ can ~~appear for~~ ~~the first time during adolescence~~ ~~before individuals reach adulthood~~ or at the beginning of adulthood, ~~for instance several anxiety disorders~~ (Kessler et al., 2007, ~~McGorry et al., 2011~~). Improving ~~health service systems to enable~~ ~~the quality and~~ access to ~~effective~~ mental health services ~~for children and young people has become~~ ~~is~~, therefore, imperative to address ~~their~~ ~~the~~ mental health needs ~~of children and young people~~ in a timely manner (McGorry et al., 2007). ~~However, children and young people's mental health has yet to become a national healthcare priority in many countries. An evaluation conducted by the World Health Organisation (WHO) showed that only around 25% of 109 countries have national guidance on mental health planning for adolescents, demonstrating the inability of countries to address persistent gaps in mental health service provision (World Health Organisation, 2014).~~

In England, ~~progress has been made in developing policies that explicitly target the improvement of public child and adolescent mental health services (CAMHS) and bring about parity of esteem with adult mental health and health services (Cottrell and Kraam, 2005).~~ recent ~~mental health~~ policies highlighted the need ~~for~~ ~~to improve the quality of services by investing in the development of system-wide service provision and bringing together public child and adolescent mental health services (CAMHS) and other sectors to enable access to care (NHS England, 2015; Tavistock and Portman NHS Foundation Trust et al., 2017).~~ A key priority is the adoption of evidence-based practices and monitoring of care ~~effectiveness by using routine outcome measures (ROMs) (Department of Health, 2011).~~ a ~~system-wide service transformation by bringing together public CAMHS and other sectors~~

1
2
3 contributing to children and young people's mental health enable access to care and
4 address organisational barriers (NHS England, 2015). Latest policies reaffirmed a
5
6 commitment to strengthening service provision by enhancing collaboration across all levels
7
8 from early intervention in schools to crisis care (National Health Service, 2019a). The value
9
10 of using various forms of knowledge was re-emphasised, including evidence-based
11
12 practices, information from lived experiences, and local intelligence (National Health
13
14 Service, 2019a; 2019b).
15
16 Despite efforts to improve services Yet, service evaluations on children and young people's
17
18 mental health services underscore the persistent difficulties services face in meeting
19
20 increasing demand, indicating the failure of national policies to advance the quality of local
21
22 service provision (NHS Digital, 2018; Care Quality Commission, 2018). In England, About
23
24 60% of children and young people with a mental health condition sought professional
25
26 support from education, primary care, or mental health services; about 20% were required
27
28 to wait more than 6 months to access services (NHS Digital, 2018). Two thirds of children
29
30 and adolescents referred to specialist healthcare (CAMHS) did not receive timely access to
31
32 services, either because they had to wait for a prolonged period of time or were discharged
33
34 after not meeting high threshold levels (Children's Commissioner, 2018). Inconsistent
35
36 recording of service activity appears to limit in-depth understanding of access to care and
37
38 signposting pathways to other services (Children's Commissioner, 2018; Crenna-Jennings
39
40 and Hutchinson, 2018). Local service providers continue facing barriers to communication
41
42 due to diverse organisational cultures, restraining the development of a joined-up care
43
44 system (Care Quality Commission, 2018). Lastly, efforts of embedding evidence-based
45
46 practices and ROMs in practice have encountered challenges due to limited implementation
47
48 guidance (Burn et al., 2021).
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 National policy makers and the research communities acknowledge that adopting and
4
5 utilising new forms of information and knowledge can contribute to addressing the
6
7 persistent problems in CAMHS (~~NHS England, 2015,~~ (Fonagy and Pugh, 2017, NHS England
8
9 2019a). Proposed ~~practices-strategies to improve service provision~~ include adopting
10
11 evidence-based practices (EBPs) to enable access to therapies for children and young people
12
13 and their families (Department of Health, 2011, Mitchell, 2011~~Cottrell and Kraam, 2005~~);
14
15 utilising information sourced by service users' experiences to optimise service provision
16
17 (Plaistow et al., 2014); using digital technology to help overcome access barriers to service
18
19 provision (Hollis et al., 2017); and using practices that enable the development of
20
21 collaborations among service providers ~~and facilitate the creation of a joined system of care~~
22
23 (NHS England, 2015). ~~As a result~~Hence, CAMHS' ability to responsdiveness to new
24
25 information and knowledge emerges as a critical n-essential capability for optimising service
26
27 provision and meeting the needs of young service users.

28
29
30
31
32
33
34
35 Research in the field of knowledge mobilisation (KM) increased insight into processes
36
37 through which knowledge can be embedded in practice and contribute to advancing public
38
39 healthcare services (Crilly et al., 2010). Cross-sectoral approaches have been developed
40
41 bringing together healthcare research, management, and learning theories and creating
42
43 new perspectives for healthcare research (Crilly et al., 2010). Recent studies have
44
45 highlighted that organisational learning theories can offer useful insights into the way public
46
47 healthcare organisations adopt and utilise new valuable knowledge (Oborn et al., 2013).The
48
49 construct of 'absorptive capacity' ~~was initially developed in the private sector and has~~
50
51 recently been identified as an approach that can offer novel insights about systemising
52
53 learning in health services ~~and can~~ contribute to increasing learning skills levels of public
54
55 healthcare organisations (Harvey et al., 2010; Ferlie et al., 2015; Croft and Currie, 2016).

1
2
3 Absorptive capacity is defined as the ability of an organisation to (i) identify, (ii) assimilate
4
5 and (iii) use new knowledge from its external environment valuable to improving
6
7 organisational outcomes (Cohen and Levinthal, 1990):
8
9

10
11 (i) The identification of new knowledge refers to an organisation's ability to evaluate
12
13 external knowledge that is most valuable to meet its objectives (Cohen and Levinthal, 1990).
14

15
16 ~~Pre-existing knowledge within an organisation can influence the direction from which new~~
17
18 ~~knowledge is sought, creating a form of "path-dependence" (Cohen and Levinthal, 1990;~~
19
20 ~~p135).~~
21
22

23
24 (ii) Knowledge assimilation is an organisation's ability to interpret and internalise new
25
26 knowledge (Cohen and Levinthal, 1990). ~~Knowledge assimilation can be enabled by internal~~
27
28 ~~policies, learning from successful or unsuccessful examples of practice, utilising IT~~
29
30 ~~management systems, and knowledge sharing from central management towards the rest~~
31
32 ~~of the organisation (Cohen and Levinthal, 1990, Szulanski, 1996, Lewin et al., 2011).~~
33
34

35
36 (iii) The use of new knowledge refers to an organisation's ability to implement the
37
38 assimilated knowledge and modify existing processes (Cohen and Levinthal, 1990). ~~New~~
39
40 ~~knowledge is utilised to transform practice and improve organisational outcomes. While an~~
41
42 ~~organisation can sporadically exploit knowledge, absorptive capacity theory emphasises the~~
43
44 ~~development of regular processes of knowledge exploitation (Zahra and George, 2002).~~
45
46

47
48 "Knowledge" can be defined as a finalised form of information collated to serve a particular
49
50 purpose and "information" as a data summary that may require processing before defined
51
52 as knowledge; the terms, however, have been used synonymously in literature (Richards
53
54 and Duxbury, 2014). In this study, "knowledge" is not limited to research knowledge rather
55
56
57
58
59
60

1
2
3 takes a broader perspective including other knowledge forms, namely professional
4
5
6 knowledge, or service users' lived experiences.
7

8
9 Absorptive capacity has been explored in public healthcare organisations, but we believe
10
11 this is the first study exploring absorptive capacity specifically in child and adolescent
12
13 mental health services (Harvey et al., 2010; Croft and Currie, 2016). Existing evidence has
14
15 shown that although public healthcare organisations may have learning processes in place
16
17 that enable some aspects of absorptive capacity, these tend to be applied unevenly,
18
19 perhaps sporadically to address organisational problems, as opposed to a routine process
20
21 (Harvey et al., 2010). The potential for service improvement led to this current study of
22
23 absorptive capacity in the CAMHS of a mental health organisation (NHS Foundation Trust) in
24
25 England. The aim of theThe present study is aims to explore the absorptive capacity of the
26
27 CAMHS of a mental health organisation (NHS Foundation Trust) in England and to identify
28
29 factors that can enable or hinder the services' learning ability.
30
31
32
33
34

35 36 **Methods**

37 38 39 *Research Design*

40
41
42 The findings presented in this paper form part of an embedded case study set in the CAMHS
43
44 department of a public mental healthcare organisation of the National Health Service (NHS)
45
46 in England, also called Mental Health NHS Foundation Trust. A case study research design is
47
48 suitable for developing a comprehensive understanding about a selected "contemporary
49
50 phenomenon" and exploring the ways it unfolds within its wider social environment (Yin,
51
52 2018; p2). Two research methods were adopted in this study: semi-structured interviews
53
54 and document analysis. Interviews were conducted with staff members of the CAMHS
55
56 department to explore the department's absorptive capacity, and publicly available
57
58
59
60

1
2
3 documents were analysed to investigate organisational learning processes within the Trust.
4
5 In addition, interviews with staff members of local service providers were conducted to
6
7 evaluate their role as knowledge sources utilised by the CAMHS department. The paper
8
9 focuses on the main findings generated from qualitative interviews with staff members of
10
11 the CAMHS department. Reporting of findings in this paper was based on the Standards for
12
13 Reporting Qualitative Research (SRQR) Reporting Guidance (O'Brien et al., 2014). The study
14
15 received ethics approval from the Health Research Authority (HRA) in the UK (IRAS ID:
16
17 230225).

22 23 *Study Setting*

24
25 The selected public mental healthcare organisation employs approximately 3,600 staff and
26
27 addresses the needs of around 900,000 residents including children and young people,
28
29 adults, and older people. The CAMHS department has 29 teams; during the period 2018-
30
31 2019, the department reported approximately 110,000 patient contacts.

32 33 *Research Method*

34
35 Qualitative interviewing was adopted to explore the absorptive capacity of the case study.
36
37 Interviews are often used to explore selected concepts within organisational settings
38
39 through the lens of interviewees (Cassell, 2009). Interviews in this study were semi-
40
41 structured, conducted as an open dialogue between the researcher and the participant,
42
43 allowing for participants to express their perceptions about the interview themes (Warren,
44
45 2001). Weak social constructionism informed the study's epistemological and ontological
46
47 stance on data analysis and interpretation (Searle, 1995). Weak social constructivism
48
49 suggests that social events are interpreted through the meanings individuals collectively
50
51 assign to them within a certain context, thus, knowledge is socially constructed. Yet, it
52
53
54
55
56
57
58
59
60

accepts that there is also an objective reality that exists beyond the social context and objective perception (Searle, 1995). The paradigm assisted with unfolding absorptive capacity within a new organisational context, interpreting individuals' role, and understanding how organisational structure influences its development.

Participants

Participants were selected for the interviews using purposeful sampling, a sampling approach based on including individuals with a good understanding of the examined phenomenon (Patton, 2002). Staff members across the CAMH service were invited to participate in the interview processes. Inclusion criteria for inviting staff members to participate were that their job role included responsibilities of identifying, assimilating or using new knowledge. All seniority levels were considered as elements of learning processes apply across all organisational levels. For example, CAMHS Managers can facilitate the assimilation and implementation of new practices in service provision, while psychologists may identify and share new knowledge about psychological interventions with colleagues. Staff members from other departments were also included in the invitation process where relevant, such as staff from the information & performance department where service data from the CAMHS department are collected and managed. Interviews were conducted with 16 staff members (n=16). Thirteen participants were employed within the CAMHS department, and three participants worked in cross-organisational teams (Table I).

Participants had a diverse professional background including management, nursing, social care and psychology.

[Add here Table I]

1
2
3 Participants were identified with the help of a CAMHS staff member who acted as a
4
5 gatekeeper and who had direct access to staff in the CAMHS department and made initial
6
7 contact with potential participants based on the inclusion criteria. Staff members who
8
9 expressed interest in participating received a participant information sheet and a consent
10
11 form via email. Appointments were arranged at times and locations convenient to
12
13 participants. A total of 40 staff members were contacted, of which 16 agreed to participate
14
15 in the study. Of the 24 staff members who did not participate in the study, twenty staff
16
17 members did not respond and four explained that they were not available due to workload.
18
19 All interview participants signed a written informed consent form.
20
21
22
23
24

25 *Data Collection*

26
27
28 An interview guide was used to direct the interview and keep the discussion relevant to the
29
30 areas of interest, while allowing participants to expand on new topics (Stuckey, 2013). The
31
32 main interview topics focused on the three main components of absorptive capacity and
33
34 explored processes of identification, assimilation and exploitation of new knowledge. The
35
36 guide also included a section about the department's relationships with the inter-
37
38 organisational environment. Interview questions included "What information do you use in
39
40 your daily work?", "How do you evaluate what information is important to prioritise in using
41
42 in practice?" and "What is the relationship of your service with other local service
43
44 providers?" Both terms "knowledge" and "information" was also used during the data
45
46 collection process to discuss processes of absorptive capacity and to facilitate understanding
47
48 of questions. –Data were collected between February 2018 and June 2018. Interviews were
49
50 audio recorded, transcribed verbatim and transcripts were anonymised before analysis.
51
52
53
54
55
56
57
58
59
60

1
2
3 Nine interviews lasted from 50 mins to 1 hour 10 mins. The other 6 interviews lasted from
4
5 20 mins to 49 mins. One interviewee refused to be recorded but did allow note taking.
6
7

8 9 *Thematic Analysis*

10
11 Braun and Clarke's approach to thematic analysis was used to interrogate the data and to
12
13 ensure rigour (Braun and Clarke, 2006). Thematic analysis was chosen as it allows for the
14
15 systematic examination of qualitative data to interpret a selected phenomenon (Braun and
16
17 Clarke, 2006). The aim of thematic analysis is to analyse qualitative data by gradually
18
19 creating codes and then key themes generated from textual data that can offer explanations
20
21 about the examined said phenomenon (Braun and Clarke, 2006). The analysis was based on
22
23 the following steps: the lead author read the transcripts to gain deeper understanding of
24
25 the qualitative data and possible meanings that could be generated from data analysis
26
27 (Braun and Clarke, 2006). Secondly, transcripts were imported into QSR NVivo 12 data
28
29 management software (QSR International, 2018), and were coded into relevant groups and
30
31 sub-groups (i.e., nodes and sub-nodes). Textual data were allocated to new nodes and sub-
32
33 nodes, leading to the development of an initial codebook. Three anonymised interview
34
35 transcripts were discussed among the authors to reflect on the coding process. The lead
36
37 author explained the rationale of coding textual data by giving examples across the
38
39 anonymised transcripts. The remaining authors provided feedback on the final codebook,
40
41 whether there was agreement in the coding process and the team discussed any
42
43 discrepancies. Table II shows an example of nodes and sub-nodes generated from textual
44
45 data.
46
47
48
49
50
51
52
53
54
55

56 [Add here Table II]
57
58
59
60

1
2
3 To ensure credibility, nodes and sub-nodes were reviewed one by one and refined to
4
5 confirm that coded data have been allocated to relevant nodes before finalising the
6
7 generated codebook. This also allowed editing of nodes that overlapped and identifying
8
9 nodes that were more relevant to the research questions (Braun and Clarke, 2006). Key
10
11 findings from the final codebook are presented below.
12
13
14

15 16 **Findings**

17
18 Findings are presented in this section based on their association with each of the main
19
20 components of absorptive capacity (i.e., identification, assimilation and exploitation of new
21
22 knowledge). Specifically, we found that staff's professional background and perceptions
23
24 about the reliability of knowledge sources can influence the identification of new
25
26 knowledge. Analysis also demonstrated that formal organisational processes and informal
27
28 communications can enable knowledge assimilation and exploitation. Organisational
29
30 hierarchy and technical limitations in patient data management systems can become
31
32 barriers to knowledge assimilation. Trust among staff members emerged as an enabler of
33
34 knowledge utilisation. Finally, supervision meetings were identified as good practice for
35
36 embedding new knowledge into service provision. The next sections present findings in
37
38 details:
39
40
41
42
43
44
45

46 47 *Identification of new valuable knowledge: The role of professional background and* 48 49 *knowledge sources*

50
51
52 Analysis indicated that individuals' professional background and knowledge guide their
53
54 judgment in evaluating and selecting new knowledge imported within the CAMHS
55
56 department. Study participants explained that:
57
58
59
60

1
2
3 *We are trained as doctors in assessing the quality of information, things like*
4
5 *quantitative and qualitative study [...]. And I am using my own experience of being*
6
7 *involved in generating this kind of evidence and being involved in the [...] information*
8
9 *over a lot of period of time so I can search what is good, what is not. [CAMHS Senior*
10
11 *Clinician]*
12
13
14

15
16 Professional knowledge can be a facilitator when it comes to collaboration among
17
18 professionals. For instance, multi-disciplinary teams that operate within the CAMHS
19
20 department require professionals with diverse professional backgrounds (e.g., family
21
22 therapist, psychologist, or consultant) to reach consensus about the treatment provided to
23
24 young service users. In such cases, interviewees acknowledged the contribution of
25
26 professional diversity in reaching effective decisions around service provision. A senior
27
28 clinical manager argued that:
29
30
31

32
33 *[...] you get a rich consensus of information about how different disciplines would*
34
35 *consider a topic and what's relevant. So, that can be a whole load of informal*
36
37 *conversations and it can come up through clinical discussions. [CAMHS Senior Clinical*
38
39 *Manager (2)]*
40
41
42
43

44
45 Yet, professional background could also be a barrier to recognising the value of new
46
47 knowledge. This appears to be the case particularly between staff members working in
48
49 management and their clinical colleagues. ~~Here, professional background can be a barrier to~~
50
51 ~~recognising valuable knowledge~~, as managers and clinicians can have different criteria for
52
53 defining what knowledge is most valuable. Diversity among professionals can be often
54
55 expressed via the language staff members use when interacting with colleagues and
56
57
58
59
60

1
2
3 discussing service provision. As a result, professional diversity can have a negative impact on
4
5 agreeing upon the value of new knowledge. A CAMHS consultant argued that:
6
7

8
9 *Where I connect is with the clinicians. [...] it is around clinical care and best practice*
10
11 *for patients and for the community. Sometimes I talk to one of the senior managers*
12
13 *in one of the organisations [...] And it is a bit like being in another country where you*
14
15 *don't speak the language. [CAMHS Consultant (3)]*
16
17

18
19
20 In addition to individuals' professional background, the sources from which new knowledge
21
22 originates can influence the value staff members place on it. The public character of sources
23
24 appeared to add value to new knowledge and, as an outcome, it is more likely to be
25
26 adopted and used in the CAMHS department, for instance healthcare policies, guidance, or
27
28 evaluation reports. Regulatory, advisory, and policy-making organisations in (mental)
29
30 healthcare, including NHS England or the Care Quality Commission (CQ), and local
31
32 authorities are examples of organisations that were seen as sources of valuable knowledge.
33
34
35

36
37
38 *The Prime Minister has brought together a number of these organisations, the expert*
39
40 *groups together, to look at the CQC inspection, and then produced lessons learned*
41
42 *from the Care Quality Commission. [...] So I would see that as a good quality report.*
43
44

45 [CAMHS Senior Clinician]
46
47

48
49 While public organisations were identified as trusted sources of knowledge, other
50
51 organisations were perceived as less reliable, primarily due to the lack of clarity
52
53 demonstrated by the latter in collecting and analysing information. For example, a report
54
55 from a governmental body may be considered more reliable in comparison to a report
56
57 published by a small-size third sector organisation. As a result, the value attributed to new
58
59
60

1
2
3 knowledge appeared to be lower when published by non-public organisations and the
4
5 quality of published knowledge was questioned. A Senior Clinical Manager stated:
6
7

8
9 *Obviously, if you've got something that's been produced by a statutory organisation,*
10
11 *you would hope that it's been through a governance process and has been through a*
12
13 *fairly rigorous checking mechanism, whereas if you have something from a source*
14
15 *that might be non-statutory, you might not know what that source could be.*
16
17

18
19 [CAMHS Senior Clinical Manager (2)]
20
21

22 Thus, the professional background of staff and perceptions about the reliability of
23
24 knowledge sources appeared to play a key role in the value attributed to new knowledge
25
26 assimilated and utilised within the CAMHS department.
27
28

29
30 *Assimilation of new valuable knowledge: The influence of organisational processes and the*
31
32 *role of informal communication*
33
34

35
36 Findings offer insight on the ways internal processes influence the assimilation of knowledge
37
38 within the CAMHS department. As might be expected, formal organisational processes, for
39
40 example team meetings, and informal communication, such as casual discussions and email,
41
42 were identified as factors enabling the assimilation of new knowledge in the department.
43
44 Specifically, departmental, and inter-departmental meetings were identified as “formal
45
46 ways” (CAMHS Senior Clinical Manager (2)), during which new valuable knowledge is shared,
47
48 discussed to be eventually used in service provision.
49
50
51
52

53
54 *Then we have more formal ways of distributing information. So, we have a business*
55
56 *meeting for our team, we have a senior management for our team, which has, kind*
57
58 *of, got clinical governance aspects to it. We have a meeting with our colleagues who*
59
60

1
2
3 *work in different inpatient units. So, we all meet together and talk about possible*
4
5 *challenges and solutions. [CAMHS Senior Clinical Manager (2)]*
6
7

8
9 In addition, staff interest in reaching consensus and sharing accountability about the next
10 stages of embedding new knowledge in practice were reported to further facilitate the joint
11 processing of new knowledge during meetings. Staff members explained that sharing new
12 valuable knowledge with colleagues creates opportunities to discuss and comprehend new
13 knowledge, as well as to apportion responsibility, define new actions and resolve issues that
14 may arise regarding the ways new knowledge can be used.
15
16
17
18
19
20
21
22

23
24
25 *I think it is about sharing consensus and sharing accountability, so no one person is*
26 *taking something forward without colleagues agreeing to it. [CAMHS Consultant (3)]*
27
28
29

30 Data management systems generating data summaries on service activity were identified as
31 often becoming a barrier to knowledge assimilation. Existing limitations in generating
32 tailored information (e.g., number of patients referred from schools), as well as
33 compatibility among different IT systems were identified as key technical barriers restricting
34 the generation of knowledge necessary for clinical practice and decision making around
35 service provision.
36
37
38
39
40
41
42
43
44

45
46 *We don't have any software to pull out what schools have referred. We can tell you*
47 *which schools the children belong to that have been referred, but we don't have a*
48 *way of pulling out which school send the most referrals in, or which GP sends the*
49 *most referrals in. [CAMHS Senior Manager (2)]*
50
51
52
53

54
55
56
57 *We don't have the right data. We don't know who's in our services. We can't say for*
58 *sure, without huge manual trawling, for example, I can't very easily identify [...] what*
59
60

1
2
3 *number of open cases, where those children and young people live. [CAMHS Manager*
4
5 *(3)]*

6
7
8
9 The organisation's hierarchy was also perceived as a potential barrier to knowledge
10 assimilation. Knowledge shared from senior levels of management with practitioners is
11 often only partially communicated, so frontline workers have only a limited understanding
12 of the aims and consequences of, for example, how new knowledge might be driving
13 organisational change. Staff members argued that receiving partial or delayed information
14 regarding the organisation or re-design of services, limits the opportunity for new
15 information to be absorbed in practice, as they cannot fully interpret the purposes of
16 embedding new knowledge in their practice.
17
18
19
20
21
22
23
24
25
26
27
28
29

30 *I think that information does happen to the service managers and things like that. I*
31 *don't think it gets fed down, necessarily, to the clinicians yet. I'm sure there are*
32 *things in progress with that. It will hopefully happen better (CAMHS Psychologist).*
33
34
35
36
37

38 *I suppose, if every day you're told you have to do a new thing, well, for me at least, I*
39 *want to know, "Why am I doing that? What purpose does it serve?". So, "How has*
40 *this information come about in the first place? How is it applicable to this area?"*
41
42
43
44

45 [CAMHS Manager (1)]
46
47

48
49 Next to formal organisational processes, the study found that it is often preferred to share,
50 discuss, and process new knowledge through informal practices to expedite the assimilation
51 of valuable knowledge. Informal gatherings and discussions provided an obvious
52 opportunity to share and converse about information relevant to the team.
53
54
55
56
57
58
59
60

1
2
3 *We have team huddles, so in the morning at 9:00am with a cup of tea or coffee, the*
4
5 *team, we just gather in the staff room for 15 minutes to share how everybody is.*
6
7 *Anything exciting been happening, anything we need to share for that day's*
8
9 *information. [CAMHS Manager (2)]*
10
11

12
13
14 As an outcome, knowledge assimilation appeared to be mediated by formal organisational
15
16 processes set to facilitate sharing and discussions among staff members. Data management
17
18 systems often restricted the assimilation of new knowledge. The tendency of the
19
20 organisation to share knowledge in a top-down manner was identified as a barrier for staff
21
22 members in assimilating new knowledge. Informal communication pathways allowed
23
24 conversations about the potential of new knowledge emerging as an enabler to knowledge
25
26 assimilation.
27
28
29

30
31
32 *Exploitation of new valuable knowledge: The usefulness of organisational processes,*
33
34 *informal communication, and trust*
35
36

37
38 Like knowledge assimilation, formal organisational processes and informal communication
39
40 were identified as factors that enable exploitation of new knowledge. Knowledge
41
42 exploitation was found to be monitored and reviewed by internal reporting processes. Here,
43
44 reporting was used to collect evidence about the implementation of new policies,
45
46 guidelines, and or to provide information on performance management, such as the
47
48 implementation of new services or the mitigation of risks. This appears to be a useful tool
49
50 particularly for senior management staff members who wish to review the implementation
51
52 of new knowledge. A member of the organisation's senior management maintained that
53
54 reporting is a means to oversee the progress of implementation, particularly in areas of
55
56 knowledge that they see as essential for the organisation:
57
58
59
60

1
2
3 *Sometimes I will ask for, particularly if it is something new, new policy or something*
4 *that we need to address I will ask the ... there is a report that comes through to our*
5 *[senior management] so that we can see how that information has become seeded*
6 *and what will change as a result of this information. Now I want to see it reflected*
7 *there (Member of Senior Management (1)).*

8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Congruent with the component of knowledge assimilation, evidence indicated that informal communication is also used to oversee the exploitation of new knowledge within the CAMHS department. Staff members engaged in informal conversations asking other staff members whether specific knowledge is being used in practice or whether a specific task had been completed.

Sometimes I would ask individual colleagues, lots of different colleagues “do you think people are using outcome measures? What do you think?” (CAMHS Consultant (3)).

So those conversations, while they are friendly, also have an element of what’s called holding to account. Which is, “Tell me if this can’t be done, cool. But if we’ve said it can be done, let’s just check that it is being done” (Member of Senior Management (2)).

While monitoring the exploitation of new knowledge is often embedded in organisational processes, it was acknowledged that it remains difficult to have a complete picture of the degree to which new knowledge is integrated into service provision. Consequently, interviewees, particularly senior staff members, explained that individuals were often

1
2
3 trusted and relied upon to implement new knowledge as an integral part of their job
4
5 responsibilities.
6
7

8
9 *I mean that would [be overwhelming] if I wanted feedback from everything. Often, I*
10
11 *trust people to consider themselves whether that information is necessary for the*
12
13 *objectives that they need to achieve (Member of the Senior Management (1)).*
14
15

16
17 Thus, organisational processes, such as internal reporting, and informal pathways of
18
19 communication regarding knowledge use are utilised to monitor the exploitation of new
20
21 knowledge in service provision. Trust towards staff members appeared to be an important
22
23 element contributing to the implementation of new knowledge.
24
25

26
27
28 *Supervision meetings: an example of good practice for embedding new knowledge into*
29
30 *service provision*
31
32

33
34 In this context, “supervision” refers to the routine meetings between an employee and their
35
36 line manager or other staff member with a mentoring role and oversees the employee’s
37
38 progress in their post. Two types of supervision were identified: clinical supervision and
39
40 operational supervision. Both clinical and operational supervision meetings emerged as
41
42 examples of formal organisational processes that enable sharing and discussing of new
43
44 knowledge, monitoring the use of that knowledge, and embedding it in practice. Supervision
45
46 meetings are an opportunity for supervisors and supervisees to discuss and process
47
48 information about patients and treatment, professional training, and operational issues.
49
50

51
52
53 Supervisors may share professional expertise or knowledge from training they have received
54
55 to guide supervisees. Supervisees may share knowledge gained from training, for instance
56
57 new therapy approaches, as well as information from patients and queries for routine
58
59
60

1
2
3 practice. Supervisors can also review the ways knowledge discussed in previous sessions is
4
5
6 implemented in practice. Examples of knowledge discussed relate to clinical practice, the
7
8 use of Routine Outcome Measures (ROMs) by clinicians, feedback from children and young
9
10 people regarding the quality of services or completion, and staff members' mandatory
11
12 training.
13

14
15
16 *I think [clinical and operational supervision] are the structures that are in place, that*
17
18 *determine, that help us keep a tab on what we are practising – everything that is*
19
20 *being discussed in terms of knowledge (CAMHS Consultant (2)).*
21
22

23
24
25 As an outcome, supervision meetings appeared to assist the assimilation of new knowledge
26
27 and keep track of whether such knowledge is being embedded in practice over time.
28
29

30 **Discussion**

31
32
33
34 Study findings highlight the role individuals play in the three main components of absorptive
35
36 capacity and their impact on the CAMHS' learning ability. Individuals' diverse professional
37
38 backgrounds appeared to inform the value they attribute to new knowledge. In cases where
39
40 interdisciplinary collaboration is required, professional background may have a negative
41
42 impact on deciding upon the type of knowledge most valuable, mainly due to individuals'
43
44 inability to recognise the value of knowledge beyond their own professional knowledge.
45
46 Although existing literature in public healthcare organisations has indicated that diversity of
47
48 professional groups can inhibit the use of valuable knowledge and become a barrier to
49
50 knowledge dissemination among those groups (Ferlie et al., 2005), relatively few studies
51
52 have examined the effect of professional groups on a public organisation's absorptive
53
54 capacity (for example see Croft and Currie, 2016). We found that professional background
55
56
57
58
59
60

1
2
3 can impact the CAMHS department' absorptive capacity and even operate as a barrier to
4
5 the service's ability to seek for new knowledge valuable to service provision.
6
7

8
9 Professionals' views on the reliability of knowledge sources were also identified as a factor
10
11 determining the value attributed to new knowledge, further highlighting individuals' impact
12
13 on the service's ability to identify new knowledge. As stated above by a CAMHS Senior
14
15 Clinical Manager, the degree of trust placed in knowledge sources can determine the
16
17 disposition of staff to recognise valuable knowledge. Interestingly, trust in knowledge
18
19 produced from non-statutory organisations, such as third sector organisations, was lower
20
21 than statutory organisations, for instance the Care Quality Commission. Notwithstanding
22
23 this finding, latest mental healthcare policies in England encourage the utilisation of
24
25 knowledge from different sources, namely the third sector, academia, or technology
26
27 resources to improve mental health service provision (NHS England, 2015, National Health
28
29 Service, 2019a). Thus, a limited perception of sources' reliability could inhibit the array of
30
31 knowledge introduced to the CAMHS department, while becoming a barrier to adopting a
32
33 system-wide approach in service provision and engaging with diverse knowledge sources in
34
35 mental healthcare, as recommended by the Long Term Plan and Future in Mind policies
36
37 (NHS England, 2015, National Health Service, 2019a).

38
39
40
41
42
43
44
45
46 Communication among staff members appears to influence the assimilation of new valuable
47
48 knowledge. Informal communication among individuals was identified as having a key role
49
50 in facilitating the internal dissemination and use of new knowledge. Indeed, we know that
51
52 such processes can enhance the department's "coordination capabilities", i.e., an
53
54 organisation's ability to incorporate new knowledge into organisational practice (Van Den
55
56 Bosch et al., 1999; p556). Regarding knowledge exploitation, findings indicated that trust is
57
58
59
60

1
2
3 a key element of knowledge exploitation, which is based on an underlying understanding
4
5 among staff members that utilising new valuable knowledge is part of staff's job
6
7 responsibilities. This was particularly emphasised by senior management staff members
8
9 (e.g., a member of the Senior Management (1)), who explained that they would trust staff
10
11 members in implementing new knowledge. Existing research suggests that trust can
12
13 strengthen an organisation's "socialisation capability" and facilitate knowledge exploitation
14
15 (Jansen et al., 2005; p1003). Findings of this study propose that trust can facilitate the
16
17 utilisation of new knowledge when part of the organisational culture of mental health
18
19 services.
20
21
22
23
24
25

26 In addition to the role of individuals, the study identified organisational processes within the
27
28 CAMHS department that impact different parts of absorptive capacity. It was found that
29
30 sharing and discussing knowledge in the context of organised processes, such as team
31
32 meetings, can enable communication and accelerate consensus on the adoption of new
33
34 knowledge and Such processes can also create accountability about staff members' role in
35
36 assimilation and use of new knowledge. Similarly, internal reporting was identified as a
37
38 formalised process that facilitates knowledge exploitation. Supervision meetings emerged
39
40 as examples of good practice that accelerate the incorporation of new knowledge in service
41
42 provision. Here, the study identifies an existing level of learning capability where
43
44 organisational processes, facilitate communication and knowledge sharing among staff
45
46 members. -which assists the CAMHS department with the assimilation and exploitation of
47
48 new valuable knowledge in clinical practice.
49
50
51
52
53
54
55

56 We also found organisational processes can be a barrier to embedding knowledge in
57
58 practice. The assimilation of new valuable knowledge can be jeopardised by the technical
59
60

1
2
3 limitations of patient data management systems that generate outcomes tailored to the
4 needs of staff. We know that an organisation's Information Technology (IT) capabilities can
5 facilitate the assimilation of new valuable knowledge (Van Den Bosch et al., 1999, Iyengar et
6 al., 2015). Thus, addressing technical compatibility limitations of data management systems
7 could improve the assimilation of knowledge within the CAMH service, while enabling the
8 generation of data useful to service reconfiguration.
9

10
11
12
13
14
15
16
17
18 The study also demonstrated that the assimilation of new valuable knowledge can be
19 inhibited if top-down distribution of knowledge is limited or not fully shared with frontline
20 workers. A CAMHS Psychologist argued that knowledge from senior management is not
21 shared with clinicians as effectively as it should be. This can limit understanding of the
22 purpose of new knowledge, referred to as "causal ambiguity" by Szulanski (Szulanski, 1996;
23 p27), constraining the assimilation of new valuable knowledge. Hence, the organisation's
24 hierarchy appears to limit internal communication and knowledge dissemination. Improving
25 communication and sharing of new knowledge across organisational levels around the
26 purposes of sharing new knowledge can enhance its assimilation in clinical practice.
27
28
29
30
31
32
33
34
35
36
37
38
39
40

41 It is of note that organisational processes supporting the first component of absorptive
42 capacity - knowledge identification - were not found in this study, indicating that not all
43 components of absorptive capacity have been considered when investment in developing
44 organisational learning processes ~~does not address all components of absorptive capacity.~~
45 Imbalanced investment across in the absorptive capacity components can limit an
46 organisation's ability to best utilise new knowledge and improve outcomes (Zahra and
47 George, 2002). Within the CAMH service CAMHS, lack of organisational processes facilitating
48 knowledge identification can operate as a barrier to recognising knowledge that would be
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 most valuable to improving service provision, such as identifying new treatment
4
5 interventions or exploring local intelligence to understand service demand.
6
7

8
9 ~~St~~Study outcomes increase our understanding on the organisational learning ability of
10
11 CAMHS and the contribution absorptive capacity can make to improving CAMHS'
12
13 responsiveness to new knowledge. At a national policy level, recent healthcare policies in
14
15 England ~~have~~ encouraged CAMHS to engage with new areas of knowledge and information
16
17 around service provision, treatment, service users' experiences, quality improvement or
18
19 technological advancements to advance the quality of care (NHS England, 2015, National
20
21 Health Service, 2019a). ~~However, it~~ Less clarity is provided on the organisational changes
22
23 required to achieve this goal. Outcomes of this study ~~could~~ can inform national policies and
24
25 accompanying guidance on the organisational learning ability of CAMHS.
26
27
28
29

30
31 ~~Finally, a~~At a practice level, our findings ~~can inform the quality improvement strategy of the~~
32
33 ~~case study CAMHS, and other CAMHS with similar structure across England and abroad can~~
34
35 ~~be used by senior management to understand factors that limit or accelerate absorptive~~
36
37 ~~capacity and inform the department's quality improvement (QI) strategy. Key findings can~~
38
39 ~~be also used by managers and clinicians to explore their role in CAMHS' absorptive capacity~~
40
41 ~~and the impact of formal and informal processes on communication and knowledge sharing.~~
42
43
44

45
46 A limitation of the study is that data collection did not include service users. Future studies
47
48 could include services users particularly for assessing the impact of absorptive capacity on
49
50 service provision. The study included was undertaken in one CAMHS department, hence,
51
52
53 ~~v~~Variations in the organisational structure of mental health services across England, the
54
55 United Kingdom and internationally should be taken into account when considering the
56
57 transferability of the findings of the present study to other organisational settings. The
58
59
60

1
2
3 study was conducted prior to the COVID-19 pandemic; thus, informal communication
4
5 processes may have been impacted in cases where professionals work in an online setting.
6
7

8 **Conclusion**

9
10
11 The study evaluated the ability of a CAMHS department to respond to new valuable
12
13 knowledge through the lens of absorptive capacity theory. We concluded that the main
14
15 components of absorptive capacity – the ability to identify, assimilate and exploit new
16
17 knowledge – can be impacted by professionals' perceptions on the value of new knowledge.
18
19 We also found that internal organisational processes, i.e., formal meetings, internal
20
21 reporting and supervision meetings, can enable absorptive capacity, while others, including
22
23 organisational hierarchy and the functionality of patient data management systems, can
24
25 restrict absorptive capacity. Lastly, we did not identify organisational processes that enable
26
27 the identification of new knowledge, indicating an imbalanced investment in the main
28
29 components of absorptive capacity.
30
31
32
33
34
35

36
37 Health policy in England has to date provided advice on embedding various forms of new
38
39 valuable knowledge in clinical practice. We propose that future policy should also provide
40
41 guidance on the way CAMHS can improve their ability to *respond* to valuable new
42
43 knowledge more generally. Absorptive capacity is an approach through which such
44
45 organisations could improve their ability to learn and ultimately enhance provision for
46
47 service users.
48
49
50
51
52
53
54
55
56
57
58
59
60

Reference List

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), pp.77-101. <https://doi.org/10.1191/1478088706qp063oa>

[Burn, A. M., Vainre, M., Humphrey, A., & Howarth, E. \(2020\). Evaluating the CYP-IAPT transformation of child and adolescent mental health services in Cambridgeshire, UK: a qualitative implementation study. *Implementation science communications*, 1\(1\), 1-13. <https://doi.org/10.1186/s43058-020-00078-6>](#)

Cassell, C. (2009). Interviews in Organisational Research. In D. A. Buchanan and A. Bryman, eds. *The Sage Handbook of Organisational Research Methods*. Sage. pp. 500-515.

Children's Commissioner. (2018). *Children's mental health briefing*. Children's Commissioner for England. <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/02/childrens-mental-health-briefing-nov-2018.pdf>

Cohen, W. M. and Levinthal D. A. (1990). Absorptive capacity: a new perspective on learning and innovation. *Administrative Science Quarterly*, 35(1), pp.128-152. <https://doi.org/10.2307/2393553>

~~Cottrell, D. and Kraam, A. (2005). Growing up? A history of CAMHS (1987–2005). *Child and Adolescent Mental Health*, 10(3), pp.111-117. Error! Hyperlink reference not valid.~~

[Crenna-Jennings, W. and Hutchinson, J. \(2018\). *Access to children and young people's mental health services: 2018*. Education Policy Institute. \[https://epi.org.uk/wp-content/uploads/2018/10/EPI_Access-to-CAMHS-2018.pdf\]\(https://epi.org.uk/wp-content/uploads/2018/10/EPI_Access-to-CAMHS-2018.pdf\)](#)

[Crilly, T., Jashapara, A. and Ferlie, E. \(2010\). *Research utilisation and knowledge mobilisation: a scoping review of the literature*. National Institute for Health Research Service Delivery and Organisation programme.](#)

Croft, C., and Currie, G. (2016). Enhancing absorptive capacity of healthcare organizations: the case of commissioning service intentions. In: J. Swam, S. Newell and D. Nicolini, eds. *Mobilising knowledge in healthcare: Challenges for management and organization*. Oxford University Press. pp. p. 65-81

1
2
3 Department of Health (2011). *Talking therapies: a four-year plan of action. A supporting*
4 *document to No health without mental health: a cross government mental health outcomes*
5 *strategy for people of all ages.* Department of Health.

6
7
8 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213765/dh_123985.pdf)
9 [data/file/213765/dh_123985.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213765/dh_123985.pdf)

10
11
12
13 Ferlie, E, Fitzgerald, L, Wood, M and Hawkins, C. (2005). The nonspread of innovations: the
14 mediating role of professionals. *Academy of Management Journal*, 2005; 48(1): 117-134.

15
16
17 Ferlie, E., Crilly, T., Jashapara, A., Trenholm, S., Peckham, A. and Currie, G. (2015).

18 *Knowledge mobilization in healthcare organizations: a view from the resource-based view of*
19 *the firm.* *International Journal of Health Policy and Management*, 4(3), p.127.

20
21
22
23
24 Fonagy, P. and Pugh, K. (2017). CAMHS goes mainstream. *Child and Adolescent Mental*
25 *Health*, 22(1), pp.1-3. <https://doi.org/10.1111/camh.12209>

26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
Harvey, G., Jas, P, Walshe, K. and Skelcher, C. (2010). Absorptive capacity: how organisations
assimilate and apply knowledge to improve performance. In K. Walshe, G. Harvey, and P.
Jas, eds. *Connecting knowledge and performance in public services: from knowing to doing*.
Cambridge University Press. pp. 226-250.

Hollis, C., Falconer, C.J., Martin, J.L., Whittington, C., Stockton, S., Glazebrook, C., and
Davies, E.B. (2017). Annual Research Review: Digital health interventions for children and
young people with mental health problems—a systematic and meta-review. *Journal of Child*
Psychology and Psychiatry, 58(4), pp.474-503. <https://doi.org/10.1111/jcpp.12663>

Iyengar, K., Sweeney, J.R. and Montealegre, R. (2015). Information technology use as a
learning mechanism: The impact of IT use on knowledge transfer effectiveness, absorptive
capacity, and franchisee performance. *MIS Quarterly*, 39(3), pp. 615-641.

<https://doi.org/10.25300/MISQ/2015/39.3.05>

Jansen, J. J., Van Den Bosch, F. A. and Volberda, H. W. (2005). Managing potential and
realized absorptive capacity: how do organizational antecedents matter?. *Academy of*
Management Journal, 48(6), pp.999-1015. <https://doi.org/10.5465/amj.2005.19573106>

1
2
3 Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S. and Ustun, T. B. (2007).
4 Age of onset of mental disorders: a review of recent literature. *Current Opinion in*
5 *Psychiatry*, 20(4), p.359-364. <https://doi.org/10.1097/yco.0b013e32816ebc8c>
6
7

8
9 ~~Lewin, A.Y., Massini, S. and Peeters, C. (2011). Microfoundations of internal and external~~
10 ~~absorptive capacity routines. *Organization Science*, 22(1), pp.81-98. Error! Hyperlink reference~~
11 ~~not valid.~~
12
13

14
15
16 McGorry, P. D., Purcell, R., Hickie, I. B. and Jorm, A. F.; (2007). Investing in youth mental
17 health is a best buy. *Medical Journal of Australia*, 187(7), pp.S5-S7.
18
19 <https://doi.org/10.5694/j.1326-5377.2007.tb01326.x>
20
21

22 ~~McGorry, P.D., Purcell, R., Goldstone, S. and Amminger, G.P. (2011). Age of onset and timing~~
23 ~~of treatment for mental and substance use disorders: implications for preventive~~
24 ~~intervention strategies and models of care. *Current opinion in psychiatry*, 24(4), pp.301-306.~~
25 ~~<https://doi.org/10.1097/YCO.0b013e3283477a09>~~
26
27

28
29 ~~Mitchell, P. F. (2011). Evidence-based practice in real-world services for young people with~~
30 ~~complex needs: New opportunities suggested by recent implementation science. *Children*~~
31 ~~*and Youth Services Review*, 33(2), 207-216.~~
32 ~~<https://doi.org/10.1016/j.chilyouth.2010.10.003>~~
33
34
35

36
37
38 National Health Service (2019a). *The NHS Long Term Plan*. National Health Service.
39
40 [https://www.longtermplan.nhs.uk/wpcontent/uploads/2019/01/nhs-long-term-plan-june-](https://www.longtermplan.nhs.uk/wpcontent/uploads/2019/01/nhs-long-term-plan-june-2019.pdf)
41 [2019.pdf](https://www.longtermplan.nhs.uk/wpcontent/uploads/2019/01/nhs-long-term-plan-june-2019.pdf) >
42
43

44
45 ~~National Health Service (2019b). *NHS Mental Health Implementation Plan 2019/20 –*~~
46 ~~*2023/24*. National Health Service. [https://www.longtermplan.nhs.uk/wp-](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf)~~
47 ~~[content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf)~~
48
49

50
51 NHS Digital (2018). *Mental Health of Children and Young People in England*. NHS Digital.
52
53 <https://files.digital.nhs.uk/F6/A5706C/MHCYP%202017%20Summary.pdf>
54

55
56 NHS England (2015). *Future in mind: promoting, protecting and improving our children and*
57 *young people's mental health and wellbeing*. Department of Health.
58
59
60

1
2
3 [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/C](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf)
4 [hildrens_Mental_Health.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf)
5
6

7 ~~Oborn, E., Barrett, M. and Racko, G. (2013). Knowledge translation in healthcare:
8 incorporating theories of learning and knowledge from the management literature. *Journal*
9 *of Health Organization and Management*, 27(4), pp.412-431. Error! Hyperlink reference not
10 valid.
11
12
13
14~~

15 O'Brien B.C., Harris I.B., Beckman T.J., Reed D.A. and Cook D.A. (2014). Standards for
16 reporting qualitative research: a synthesis of recommendations. *Academic Medicine*.
17 2014;89(9):1245-51.
18
19
20
21

22 Patton, M.Q. (2002). Two decades of developments in qualitative inquiry: A personal,
23 experiential perspective. *Qualitative Social Work*, 1(3), pp.261-283.
24
25 <https://doi.org/10.1177%2F1473325002001003636>
26
27

28 Plaistow, J., Masson, K., Koch, D., Wilson, J., Stark, R.M., Jones, P.B. and Lennox, B.R. (2014).
29 Young people's views of UK mental health services. *Early intervention in psychiatry*, 8(1),
30 pp.12-23. <https://doi.org/10.1111/eip.12060>
31
32
33
34

35 QSR International Pty Ltd. (2015) NVivo (Version 11),
36 <https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home>
37
38

39 Searle, J. R. (1995). *The construction of social reality*. Penguin Press.
40
41

42 Stuckey, HL. (2013). Three types of interviews: Qualitative research methods in social
43 health. *Journal of Social Health and Diabetes*, 1(2): 56.
44
45
46

47 Szulanski, G. (1996). Exploring internal stickiness: Impediments to the transfer of best
48 practice within the firm. *Strategic Management Journal*, 17(S2), pp.27-43.
49
50 <https://doi.org/10.1002/smj.4250171105>
51
52

53 ~~[Tavistock and Portman NHS Foundation Trust, Anna Freud National Centre for Children and](#)
54 [Families, The Dartmouth Institute for Health Policy and Clinical Practice and UCL Partners](#)
55 [\(2017\). *i-Thrive: Year One of Implementation – Annual Report May 2017*. Anna Freud Centre](#)
56
57
58
59
60~~

1
2
3 for Children and Families. [http://www.implementingthrive.org/wp-](http://www.implementingthrive.org/wp-content/uploads/2017/05/i-THRIVE-Annual-Report-2017.pdf)
4 [content/uploads/2017/05/i-THRIVE-Annual-Report-2017.pdf](http://www.implementingthrive.org/wp-content/uploads/2017/05/i-THRIVE-Annual-Report-2017.pdf)
5
6

7
8 Van Den Bosch, F. A., Volberda, H. W., and De Boer, M. (1999). Coevolution of firm
9 absorptive capacity and knowledge environment: Organizational forms and combinative
10 capabilities. *Organization Science*, 10(5), pp.551-568. <https://doi.org/10.1287/orsc.10.5.551>
11
12

13
14 Warren, C. A. B. (2001). Qualitative Interviewing. In J. F. Gubrium and J. A. Holstein, eds.
15 *Handbook of Interview Research*. Sage. pp. 83-102.
16
17

18 ~~World Health Organisation (2014). *Health for the world's adolescents: a second chance in*~~
19 ~~*the second decade: summary*. World Health Organisation.~~ **Error! Hyperlink reference not valid.**
20
21
22

23 Yin, R. K. (2018). *Case study research: Design and methods*. Sage publications.
24
25

26 Zahra, S. A. and George G. (2002). Absorptive capacity: A review, reconceptualization, and
27 extension. *Academy of Management Review* 27.2 pp.185-203.
28

29 <https://doi.org/10.5465/amr.2002.6587995>
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Department	Job Position
<i>CAMHS Department</i>	CAMHS Senior Clinical Manager (2 staff members)
	CAMHS Consultant (3 staff members)
	CAMHS Senior Clinician
	CAMHS Senior Manager
	CAMHS Manager (4 staff members)
	CAMHS Psychologist
	CAMHS Team Leader
<i>Information & Performance Department</i>	Information and Performance Manager
<i>Senior Management</i>	Member of Senior Management (2 staff members)

Table I: List of study participants

Mental Health Review Journal

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Interview Question	Original Text	Sub-nodes	Nodes
<p>“In order to do your job on a daily level, what kind of information do you use?”</p>	<p>“And about the information we gather. We tend to be very focused on what we do as... What our profession is, as to the information we gather.”</p>	<p>Role of professional background in value of new knowledge</p>	<p>Knowledge identification</p>
<p>“And from the pool of information that you mentioned, how would you judge what is important for you?”</p>	<p>“I mean, clearly the scientific information – we’re trained as doctors in assessing the quality of information, things like quantitative study and qualitative study using the criteria and the hierarchy of evidence found.”</p>	<p>Role of professional background in value of new knowledge</p>	<p>Knowledge identification</p>
<p>“I was wondering if you could explain how you ensure that information is being used.”</p>	<p>“I mean that would [be overwhelming] if I wanted feedback from everything. Often, I trust people to consider themselves whether that information is necessary about the objectives that they need to achieve.”</p>	<p>Trust to staff members</p>	<p>Knowledge exploitation</p>

Table II: Example of the development of sub-nodes and nodes