

Service User Engagement by Assertive Outreach Staff

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ABSTRACT

Study Aim: Despite 'Assertive Outreach' being a widely researched model of mental health delivery, previous research has mainly focused on how features of the service model encourage service users to engage with the service. Little is known about how the staff working in such services promote service user engagement, especially with service users who are particularly difficult to engage. This qualitative study explores how assertive outreach staff engage and maintain engagement with their service users.

Design, Setting and Participants: Eight care co-ordinators were recruited from three assertive outreach teams in South East Wales. Participants were interviewed about how they engage and maintain engagement with service users. Transcribed interviews were analysed using Grounded Theory. Four of the participants also attended a subsequent focus group and discussed the preliminary analysis of the interview data.

Findings: Three themes appeared to conceptualise the engagement process, 'Building the therapeutic relationship', 'Maintaining the therapeutic relationship', and 'Service factors enabling engagement'. The first two conceptualise the personal factors (i.e. approaches, strategies and personal attributes) that staff use on a daily basis to engage and maintain engagement with service users. The final theme, 'Service factors enabling engagement work', focuses on the service related factors staff identify as being important in enabling them to engage with the people who use their service.

Conclusion: Results from the current study provide a number of useful insights into the specific approaches, techniques and strategies used by assertive outreach staff to engage and maintain engagement with 'hard to engage' service users. The study also identified service elements and personal staff qualities that appear to facilitate the effective engaging of clients. Clinical implications are discussed and suggestions made regarding clinical practice and future research.

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CHAPTER ONE: INTRODUCTION

1.1 OVERVIEW OF CHAPTER

The principal aim of the research reported in this thesis is to explore engagement in assertive outreach (AO) from the perspective of Local Mental Health Teams' Assertive Outreach staff. Specifically the researcher is interested in understanding the approach, techniques and strategies that AO staff use in their day-to-day work to build effective relationships with service users. This chapter will begin by introducing AO development and its current evidence base, with consideration of important service structures, psychological processes and approaches that contribute to its success in engaging 'hard to engage' service users. The general engagement literature will be presented, followed by a systematic review of current research exploring engagement in assertive outreach services. Finally, the rationale for this current study will be presented.

1.2. DEFINITION OF KEY TERMS

1.2.1 Assertive Outreach

Assertive Outreach (AO) is an evidenced based model of community mental health service delivery, underpinned by the Assertive Community Treatment (ACT) model (Bond *et al.*, 2001). Assertive outreach services use a flexible and creative multi-disciplinary team-based approach to working with the complex needs and wishes of a clearly defined group of service users. The approach differs conceptually and empirically from traditional case management approaches (Bond *et al.*, 2001). Assertive outreach services are designed specifically for service users with severe and enduring mental health problems who are not able to use or do not engage with traditional mental health services and who are also often at high risk of frequent psychiatric hospitalisation.

1.2.2 Severe and Enduring Mental Illness

In the UK the Department of Health use the following working definition for people with 'severe mental illness' (SMI). Severe mental illness refers to individuals who:

- are diagnosed as suffering from mental illness (typically schizophrenia or a severe affective disorder, and including dementia);
- are substantially disabled because of their illness, e.g. they have difficulty caring for themselves independently or sustaining relationships or work;
- are currently displaying florid symptoms or are suffering from a chronic, enduring condition;
- have suffered recurring crises leading to frequent admission/interventions; and;
- may at times present significant risk to their own safety or that of others.

(Definition taken from: Sainsbury Centre of Mental Health, 2001; p. 5)

1.2.3 Engagement

The term 'engagement' has been used in various situations to mean different things. There are also various other terms that are used synonymously with 'engagement' including 'therapeutic relationship/alliance', 'compliance' (though this is usually in regard to medication) and 'participation'. However, Gillespie *et al.* (2004) define engagement as 'the client and therapist working collaboratively on treatment tasks, towards mutually endorsed and valued goals. There is also an emotional bond between the client and therapist that includes issues such as mutual trust, acceptance and confidence' (p. 440). Engagement, in this sense, does not refer to increased contact with the service user or compliance with medication, but to the specific relationship that develops between the service user and clinician (AO staff member) that enables the service user to accept input from the AO service. Thus, for the purpose of this study, the terms 'engagement' and 'therapeutic relationship' will be used interchangeably.

1. 3 WHO IS ASSERTIVE OUTREACH FOR?

1.3.1 The Service User Group

Assertive outreach is a specific service model designed for working with a specific service user group. This specific service user group consists of those with 'severe and enduring mental illness' (SMI) who cannot, or will not, work with traditional mental health services such as Community Mental Health Teams (CMHTs). This service model has been identified as the most suitable model of community care for this group of service users (Sainsbury Centre for Mental Health, 1998). Service users within this group often experience major and constant personal distress and disability as a consequence of their illness, and some also present significant challenges to services and to society in general (Sainsbury Centre for Mental Health, 1998).

1.3.2 Prevalence of Service Users with Severe and Enduring Mental Health Problems

There is a small but significant group of people with SMI who have difficulty in engaging with traditional mental health services (Sainsbury Centre for Mental Health, 1998). This is a diverse service user group who are spread unequally across the UK (Sainsbury Centre for Mental Health, 1998). As a result it has been difficult to establish clear prevalence figures for this service user group in the UK but the Sainsbury Centre for Mental Health give estimated figures to be between 14 to 200 people per 100,000 adult population (Sainsbury Centre for Mental Health, 1998). However, caution in interpreting prevalence figures is necessary since the methodology in various prevalence studies is rarely comparable and is also variable in quality. Most prevalence studies also report that a disproportionate number of people with severe and enduring mental illness come from an ethnic minority background (Gath & Higginson, 1995).

1.3.3 Characteristics of Service Users with Severe and Enduring Mental Health Problems

This service user group are also often referred to as “revolving door” patients due to their pattern of repeated brief admissions to psychiatric hospital wards (Sainsbury Centre for Mental Health, 1998). Individuals within this service user group generally have very poor social functioning which means that those who live in the community are vulnerable to experiencing isolation and stigmatisation (Sainsbury Centre for Mental Health, 1998). Wider society also often reacts to this group in a way that may be excluding and rejecting (Rose, 1996). Other problems commonly experienced by this service user group include: repeated offending, substance misuse, homelessness, unemployment, lack of benefits, history of violent behaviour, increased risk of self-harm and suicide, severe self-neglect, and repeated changes of address.

Despite overwhelming evidence over the past 50 years that violent crimes due to mental disorders are low (Taylor & Gunn, 1999; Large *et al*, 2008), the public still hold perceptions that people with SMI are dangerous and unpredictable (Crisp *et al.*, 2000). Negative media representations of community care can reinforce public perceptions that this form of care is not working and that people with mental illness receiving care in the community are unpredictable and dangerous (Rose, 1998). Such stereotypes serve to further alienate people with SMI who can experience discrimination and oppression from their community, and also from the caring professions (Wharne & Williams, 2011). In the UK, the policy to develop AO services was precipitated, at least in part, by government concerns over highly publicised homicides involving service users with SMI who had disengaged from, or been excluded from, services (Firn & Molodynski, 2011).

The cost of providing care for those with SMI who find it difficult to engage with services is disproportionately high. The direct cost of caring for this service user group in the UK has been estimated to be £397 million, and the indirect cost to be £1.76 billion (Davies & Drummond, 1994). In addition, it has been estimated

that ten per cent of people who are treated for schizophrenia require long term care in intensive community programmes or in 24 hour care settings, and that this ten per cent accounts for nearly 80 per cent of the direct cost of mental hospital treatment and care for people with SMI (Davies & Drummond, 1994). The cost-effectiveness of care for this group will therefore have major consequences for the cost of mental health care as a whole (Sainsbury Centre for Mental Health, 1998).

1.4 INTRODUCTION TO ASSERTIVE OUTREACH

1.4.1 The Origin of Assertive Outreach: The Evolution of the Assertive Community Treatment (ACT) Model

The origin of AO is rooted in America in the midst of the deinstitutionalisation movement. By the 1970s, it became evident that there were a significant number of service users with SMI who were either unwilling or unable to access traditional community mental health services (Mueser, 2011). Stein, Test and their colleagues (1980) proposed a potential solution for this problem, originally called the Training in Community Living (TCL) Programme, later changed to the Programme for Assertive Community Treatment (PACT) and then finally shortened to Assertive Community Treatment (ACT) (Stein & Test, 1980:1985; Test, 1992).

Stein and Test's service model for this service user group included a specific team structure, operating principles and responsibilities that were characterised by the following core features:

- low staff to service user ratio (1:10);
- the majority of services being provided in the community as opposed to in the clinic;
- shared caseloads between clinicians;
- direct provision of services;
- team coverage provided 24 hours per day, seven days per week;

- combined focus on providing both traditional psychiatric services (e.g. medication evaluations and case management) and practical assistance in meeting daily living needs (e.g. finances, shopping, transportation)

(Mueser, 2011).

Stein and Test wanted TCL to have a psychosocial orientation that prioritised behaviour change, the formation of community relationships and vocational opportunity (Cupitt, 2010). They further emphasised that a strong therapeutic approach should be embedded in the team's overall philosophy (Cupitt, 2010).

The TCL programme was evaluated by randomised control trials comparing service users who received TCL services to those treated with 'care as usual' (Stein & Test, 1980; Test & Stein, 1980; Weisbrod *et al.*, 1980). Results showed that rates of psychiatric readmission were 58 per cent in the control group and six per cent in the TCL group, with average time spent in hospital being 20 and nine days respectively. The TCL group also spent less time unemployed and more time in independent accommodation, and rated higher on measures of self esteem and activities (Molodynski & Burns, 2011). Also, the TCL programme was found to result in net savings of total mental healthcare costs (Mueser, 2011). However, most gains were lost when participants were followed up some months after the end of the programme, indicating a need for ongoing or indefinite intervention in some of the cases (Molodynski & Burns, 2011).

In 1983, these impressive results were replicated in a further RCT in Australia (Hoult *et al.*, 1983) where highly statistically and clinically significant reductions in hospital use were again reported. In addition, service users reported positively about their experience of this intensive community intervention compared to standard care. There were no significant differences in measures of community burden such as police involvement (Hoult *et al.*, 1983). These two influential studies lead to projects based on the ACT model and its principles being widely

replicated and researched in several countries across the world (Molodynski & Burns, 2011).

1.4.2 UK Policy and Implementation

A UK review of 'needs' and 'care experiences' of service users with SMI who are also difficult to engage with services was carried out by the Sainsbury Centre for Mental Health (1998). Although it is widely acknowledged that many members of this service user group are genuinely very difficult to work with, this review showed that hard-pressed mental health services sometimes respond to this challenging service user group by labelling them as 'needy' individuals and rejecting or excluding them from services (Sainsbury Centre for Mental Health, 1998). This review highlighted the fact that the fit between mental health services and the people in greatest need of care was poor. It concluded that this 'hard-to-engage' service user group could not be catered for within existing service structures and that distinct strategic changes in both policy and practice were required (Sainsbury Centre for Mental Health, 1998). It proposed a model for the way that services should operate with this service user group and recommended that future policy development should pay more attention to developing such services within each Health Authority area.

Around the same time as this Review, two Cochrane Collaboration Systematic Reviews (Marshall *et al.*, 1998 and Marshall & Lockwood, 1998) were published. These systematic reviews concluded that traditional case management was not effective for service users with SMI who experienced frequent hospital admissions. Instead, these reviews showed the ACT model was superior in maintaining service users' contact with services and in reducing hospital use. The ACT model was also shown to improve service users' reported satisfaction with mental health services. The authors of one of the systematic reviews concluded that ACT was 'a clinically effective approach to managing the care of severely mentally ill people in the community' (Marshall & Lockwood, 1998: p. 2).

These two systematic reviews taken together with the report published by the Sainsbury Centre for Mental Health (1998) had an important influence on policy makers. Less than a year later AO teams were specifically prescribed as an essential element of mental health services in The National Service Framework for England (DOH, 1999). Following this, AO teams became widespread across the UK (Cupitt, 2010). However, it was not until 2001 that the UK government provided a clear definition for what they meant by AO when it was included in The Mental Health Policy Implementation Guide (DOH, 2001a). In this guide, ACT service models were described in detail providing a blueprint for service commissioners to provide standardised services across the UK (Williams *et al.*, 2011). However, variations in local budgets and local need have resulted in the emergence of differing formats to AO teams across the UK (Williams *et al.*, 2011). For example, a review of AO services across England by Chrisholm and Ford (2004) found that rural teams modified AO criteria, such as MDT components, 24hour/7 days a week working patterns, caseloads of 1:10, and a range of *in vivo* treatment.

In the UK, the development of AO has been one component, alongside crisis teams and early intervention teams, of a range of mental health service reforms that have radically changed the face of UK community care since 1999 (Williams *et al.*, 2011). In Wales, the revised Welsh National Service Framework for Mental Health (WAG, 2005) highlighted AO as a way of reducing mental health bed days, delivering comprehensive services (including out-of-hours care), and providing effective treatment in community settings. Guidance to assist commissioners and service providers in providing clarity on the application of AO in Wales was published in the Assertive Outreach in Mental Health document (Caffel, 2007). At the time of the study reported here (2011-2012), seven AO teams were operating in South East Wales.

1.4.3 Important Core Elements of Assertive Outreach Services

Assertive outreach teams were developed to provide a flexible approach to engaging and maintaining contact with individuals estranged from mental health services (Williams *et al*, 2011). Assertive outreach teams have a holistic approach to supporting their service users, helping with medications, housing, finances, and everyday problems in living. Most contacts between AO staff and service users occur in community settings. Recovery and social inclusion are the primary task of AO, but staff must first achieve a form of engagement with the service user (Wharne *et al.*, 2011). Killaspy *et al.* (2006) proposed that AO service users were better engaged and more satisfied with services than those in CMHTs. Such evidence suggests that there are core characteristics of the AO model which enable good engagement.

A number of themes emerging from recent meta-analyses and qualitative research (e.g. Gillespie & Meaden, 2010; Gillespie *et al.*, 2004; Priebe *et al.*, 2005; Lukeman, 2003) indicate that the following service features are significantly associated with high quality community mental health care. These are:

- multi disciplinary team (MDT) working;
- smaller caseloads (generally a ratio of 1:10);
- responsibility for both health and social care;
- a dedicated psychiatrist in the team; and
- high rates of home visiting as opposed to office contacts;

(Taken from Molodynski & Burns, 2011, p. 9).

These factors exist within AO teams but are not exclusive to them. They allow staff to provide intensive social and practical support to service users, along with the ability to respond quickly and flexibly in the event of a crisis. These core elements will now be discussed in turn.

- **1.4.3.1 Multi Disciplinary Team Working**

Multi disciplinary team (MDT) working is now widely accepted to be the most effective way to provide support to service users with SMI. Assertive outreach service users present with a diverse and complex range of health and social care needs that require the very best that effective team working can deliver (Steer & Onyett, 2011). Fully staffed AO teams include community psychiatric nurses, psychiatrists, social workers, occupational therapists, clinical psychologists and support workers. Professionals within AO teams are required to deliver a comprehensive range of intensive evidence-based services to service users with SMI, in order to help them achieve a life that is not driven by their mental illness (Stein & Santos, 1998; Burns, 2004). Typical interventions may focus on: treatment issues (medication, physical healthcare and symptom control); rehabilitation issues (employment, activities of living, interpersonal relationships and housing); substance abuse issues; practical assistance and crisis resolution; social issues; and family issues (Steer & Onyett, 2011). In AO services, the range of core staff enables the team to attend to a service user's varying needs in a co-ordinated way (Priebe *et al.*, 2005).

- **1.4.3.2 Smaller Caseloads**

A recent study (Wright *et al.*, 2004) found good evidence that small caseloads (at least one clinician per 20 service users) are an important feature of good quality community mental health care. Defined caseloads allow a more individualised approach that is valued by both service users and their families (Molodynski & Burns, 2011). Small caseloads also allow for the development of a relationship which is not crisis driven and may in turn lead to greater engagement and retention in treatment (Molodynski & Burns, 2011). Currently three types of services that utilise an ACT approach with reduced caseloads have been prescribed by the National Service Framework (DOH, 1999). These are AO, Early Intervention, and Home Treatment Teams. Within UK AO services, caseloads vary between 10 and 20 for each care co-ordinator (Molodynski & Burns, 2011).

- **1.4.3.3 Responsibility for Both Health and Social Care**

Recently, there has been increased recognition that there needs to be a reduction in the number of times that people are passed between health and social service teams. Passing service users between these services causes delays in their receiving of appropriate care and generates unnecessary repeated assessments, which are often frustrating for both staff and service users (Molodynski & Burns, 2011). Research evidence supports a reduction in bed use and greater engagement and compliance with treatment when teams are able to provide both health and social care 'in house' (Molodynski & Burns, 2011). The UK government focus has recently shifted to increase partnership working between health and social services (e.g. DOH, 2000; WAG, 2004; 2007). As a result, most generic mental health teams now attempt to provide support 'in house' first, including social support, occupational therapy, or psychological support (Molodynski & Burns, 2011). However, further progress is required in removing the strategic barricades between health and social care service delivery.

- **1.4.3.4 Dedicated Psychiatric Input**

Having a dedicated psychiatrist within an AO team is deemed to be important for a variety of reasons. Psychiatrists are able to easily keep track of service user progress through attending regular team meetings and discussing service users with other members of the team. This, in turn, enables them to take a more personalised and knowledgeable approach when they see service users, which is often necessary at times of crisis or difficulty (Molodynski & Burns, 2011). Also, having a dedicated psychiatrist in the AO team, with up-to-date information of the service users, means that AO staff are able to respond quickly to service users in crises. At an organisational level, a consultant psychiatrist can give the service a powerful voice which can have a strong impact on decision making (Molodynski & Burns, 2011).

- **1.4.3.5 High Rates of Home Visiting**

Home visiting is an important aspect of the ACT model that makes a positive impact on engagement (Molodynski & Burns, 2011). The AO approach is characterised by work with service users in their own environment, wherever that may be. In contrast, mental health services have traditionally been delivered in office or hospital-based settings where the service user is required to come to the mental health professional at a pre-arranged time (Sainsbury Centre for Mental Health, 2001). Community mental health teams rarely provide any flexibility around appointments and appointments are often offered to service users without any prior discussion of their availability or commitments. Visiting people in their own homes, along with some flexibility around appointment time, can reduce the frequency of non-attended appointments and can allow for more effective interventions (Molodynski & Burns, 2011).

Assertive outreach staff are also able to visit or accompany clients when they use other services. This encourages a two-way therapeutic relationship that helps to develop trust and rapport and to establish links with other agencies (Sainsbury Centre for Mental Health, 2001).

1.4.4 Psychological Approaches in Assertive Outreach

Along with the core features of AO teams discussed above, the AO service model utilises a number of psychological approaches in everyday practice. These approaches are designed to create the optimum environment needed to enable staff to focus on engagement and offer hope to service users who have been alienated from traditional mental health services, sometimes for years. Some of these psychological approaches will now be discussed in more detail.

- **1.4.4.1 The Team Approach**

Assertive outreach services utilise a team approach in their work, whereby staff from different professional backgrounds work together to provide a fully integrated service. The specification for AO services in the UK (DOH, 2001a)

states that there should be a team approach within AO; but it fails to define what this might mean in practice. This has resulted in variations in exactly how team working is achieved across UK AO services (Cupitt *et al.*, 2010). This means that either the team operates as a 'whole' with one shared caseload (the whole team approach), or that individual staff are allocated as the care co-ordinator and act as the primary contact point for a caseload of between 10-20 service users, with care being jointly provided by other members of the team (Cupitt *et al.*, 2010). In Wales, the latter model is used in AO services as it is compatible with the UK's Care Programme Approach (CPA) (DOH, 1990), and also because the provision of a named care co-ordinator has now become a legal obligation for mental health services under the recent Mental Health (Wales) Measure (WAG, 2010b). Although the care co-ordinator takes the lead role in overseeing the care, service users still have access to all professionals within AO teams who can offer a range of specialist skills and knowledge. This model of team working is also widely used in ACT (e.g. Stein & Santos, 1998).

Advantages for the team approach include: reliable weekly contacts, a better response to crisis that is not dependant on one member of staff's availability, reduced staff stress, greater containment of staff's emotional responses to this challenging type of work, better peer support and consultation, and avoidance of 'pathological dependency' (Steer & Onyett, 2011). There are a number of published examples of AO team working approaches in the UK (e.g. Firn, 2007; Gregory & MacPherson, 2006; Jones, 2002; Wharne, 2005; and Williams, 2005). Effective team working requires a clear management hierarchy and frequent team meetings (Steer & Onyett, 2011). There is evidence that the team approach can increase staff morale and improve service user engagement (Gauntlett *et al.* 1996). Stein and Santos (1998) argue that a team approach can facilitate staff to make difficult decisions regarding complex problems.

Despite the advantages, there can also be some disadvantages of the team approach. Some research has found that the team approach may make it more difficult for service users to build effective working relationships with clinicians

(Spindel & Nugent, 1999) or for teams to engage service users in treatment (Williams, 2005), particularly service users who are mistrustful (Burns & Firth, 2002). In a pure AO model, value is placed on an approach where all service users are expected to have contact with all members of the team (Steer & Onyett, 2011). Burns and Firth (2002) claim that, in reality, many teams utilise the team approach flexibly in response to individual service users. Thus the philosophy around AO teams is to consider the individual needs of the service user and then to build the required supports and relationships around each service user's preference. Burns and Firth (2002) further advocate first building a single relationship through invested time, commitment and consistency and only then expanding the network of other staff supporting the individual.

- **1.4.4.2 Team Formulation**

In recent years clinical psychology has increasingly emphasised the use of psychological formulations as a basis for any intervention with people experiencing mental health problems, particularly for those with complex, long standing problems (Whomsley, 2010). Team formulation in AO is a process where 'insights are gained which enable empathy to develop and opportunities are found to improve the service user's quality of life' (Wharne & Spilsted, 2011). In AO services, it can be useful to develop shared formulations, to which every member of the team contributes (Whomsley, 2010). Many AO services have now adapted Lake's (2008) approach to team formulation which draws on cognitive, behavioural, systemic and psychoanalytic ideas in order to promote understanding, foster empathy and enable staff to use interventions appropriately with service users (Wane *et al.*, 2009). Team formulations enable AO staff to understand and respond flexibly to service users, enabling a trusting relationship in which the AO team and the service user both feel empowered and more able to take positive risk (Wharne & Spilsted, 2011). 'Positive risk taking' refers to the ability of staff to support service users to make and carry out their own choices, even when staff do not agree with these choices or fear they may lead to problems (Steer & Onyett, 2011). This is an important part of facilitating

service users to increase their level of confidence and independence in managing their own mental health (Steer & Onyett, 2011).

Whomsley (2010) discusses several approaches to team case formulation and advocates using different formats at various stages in the service user's journey:

- An engagement formulation - learning from the service user's past and current relationships and their understanding of their difficulties.
- A resources formulation - focusing on the service user's power in the environment, including the strengths and difficulties of their relationships with family and friends.
- A risk formulation - to keep the service user, staff team, and community as safe as possible.
- A moving on formulation - for when a service user is discharged from the team or leaves for other reasons (e.g. moving to a different area).

The engagement formulation is used to explore connections between the service user's past and present, in relation to psychological factors that include engagement, attachment, self-esteem and recovery style (Whomsley, 2010).

Engagement formulations can be developed using a template proposed by Cupitt in the 2005 National Assertive Outreach Forum Conference (Cupitt, 2010):

- Past: What is/are the most significant event/s in the person's past and how have these affected them? (e.g. childhood in care, loss of intimate relationships, adult trauma).
- Present: What is/are the most pressing issue/s in the person's present life? (e.g. no trusting and open relationships, chaotic lifestyle, low self-esteem).
- Future: How are we working on these issues? What are we working towards? (e.g. having a trusting, open relationship, less chaotic lifestyle, self-management of symptoms, gaining self-esteem).

Engagement formulations enable teams to develop a better understanding of the reasons why service users pose challenges to traditional mental health services and how they might work to address these. Considering the 'future' element of the formulation enables the team to set goals to work towards and draws upon positive strengths of service users to develop ideas for specific interventions (Whomsley, 2010).

Service users referred to AO teams sometimes engage in risky behaviours which is necessary for the team to address. The Risk Team Case Formulation may initially be conducted at a time of relative stability, but can then act as a guide for the team to consider risk in an ongoing manner (Whomsley, 2010). Risk formulations can increase a team's confidence in working with service users as AO staff are able to plan individualised ways to manage crises (Whomsley, 2010). Further details of Risk Team Formulation is discussed and outlined in Whomsley (2010).

- **1.4.4.3 Staff Characteristics**

Research has shown that service users place the 'values' and 'attitudes' of staff before 'skills and knowledge' as necessary attributes of services and staff (Institute for Healthcare Development, 1995). The quality of the values and attitudes of the individual staff members and the team as a whole are important characteristics to building effective relationships with service users (Bleach & Ryan, 1995; Repper, 2000; DOH, 2001a; Williamson, 2003). Key staff values that are likely to promote effective working relationships include warmth, empathy, genuineness and respect, as well as having an approach that is friendly, non-judgemental, persistent and creative (Steer & Onyett, 2011). A study examining how the characteristics of therapists and style of intervention affected therapeutic relationship found that staff who were perceived as experienced, understanding, supportive, warm and friendly, respectful and interested, flexible and active in their work were more likely to have a stronger therapeutic relationships with their service users (Ackerman & Hilsenroth, 2003). Energy, reliability and commitment

are also important qualities required for developing constructive and effective relationships over longer time frames (Steer & Onyett, 2011).

There is usually a relatively high level of risk associated with many of the service users referred to AO services (e.g. self-harm, self-neglect, alcohol or substance misuse, and sometimes a risk to others) (Gray & Mulligan, 2010). The long-term nature of the relationship between the service user and team suggests that a high degree of staff retention is desirable to minimise disruptions to engagement (Gray & Mulligan, 2010). It is also widely agreed that the health and wellbeing of staff in the NHS is a priority (DOH, 1999; Secretary of State for Health, 1992). Being able to manage ethical and professional issues is an important aspect of working in AO teams. However, competing demands such as engaging 'hard to reach' service users and ensuring the continued safety of the service user and the public can impose high levels of stress on AO staff (Steer & Onyett, 2011).

There is some evidence to suggest that staff burnout in AO teams is directly associated with particular traits of service users (Gray & Mulligan, 2010). The service users referred to AO often possess characteristics that may impact upon staff stress and burnout (Gray & Mulligan, 2010). Research suggests that reduced job satisfaction is associated with high levels of contact with service users with ongoing mental health difficulties (Oberlander, 1990). Priebe *et al.* (2004) examined staff characteristics which were associated with favourable outcomes in AO and found levels of staff burnout correlated with hospitalisation rates of service users. This study found that low levels of staff burnout were associated with reduced hospitalisation and fewer compulsory admissions for service users at nine months (Priebe *et al.*, 2004). This indicates that staff who viewed themselves more positively, in terms of their work, had lower numbers of their service users admitted to hospital. It is also proposed that a greater sense of work-related satisfaction is experienced when a closer therapeutic alliance is achieved between staff and service users (Addis & Gamble, 2004).

1.4.4.4 Managing Staff Stress and Burnout

Gray and Lavender (2001) found three aspects, suggested by staff, to be vital for a sense of emotional containment in their work. These were:

- Structural arrangements - having the same work base as managers, effective management and supervision.
- Practical team processes - efficient documentation, team meetings, team approach and debriefing.
- Informal processes - agreement, advice and discussion, support from colleagues, a non-judgemental environment, equality and available external support.

Assertive outreach staff need to commit to training, supervision and support in order to help sustain effective practice in the long term (Steer & Onyett, 2011). Working to achieve engagement can be a very difficult and demanding experience for workers and there is a high need for supervision and reflection (Gray & Johanson, 2010). Both clinical and managerial supervision is a vital aspect of staff support (Gray & Mulligan, 2010) and also has a role in supporting staff to deliver individualised support to service users (Burns & Firn, 2002). Studies have found that support from supervisors will protect nurses from burnout (Bakket *et al.*, 2000; Leiter & Lashinger, 2006). Low levels of burnout are found in work settings where staff experience good support and feedback (Melchior *et al.*, 1997).

Supervision and regular team meetings can also be used to help promote reflective practice, 'a process by which practitioners stop and think about their practice, consciously analyse their decision making processes, and relate theory to what they do in practice' (Kennard & Hartley, 2009, p.14). It is especially important that AO staff use supervision to explore their relationship with clients since the service users they work with most intensively are likely to have lots of interrelated and complex problems (e.g. anxiety, depression, psychotic symptoms, and substance misuse) (Griffiths *et al.*, 2011). Therapists working

with 'complex' service users can, without appropriate supervision, feel overwhelmed and frustrated by their work. This can lead to staff demoralisation and de-motivation (Griffiths *et al.*, 2011).

Supervision structures vary considerably across teams and will inevitably influence the experiences of staff working within AO (Gray & Mulligan, 2010). Within AO, teams meet regularly, often daily, to discuss their work and formulation plans so as to improve engagement with their service users (Wharne & Spilsted, 2011). Working within a team has been shown to contribute to improved mental health for team members (Sonnentag, 1996); enhanced performance (Kallerberg & Moody, 1994); and more efficient use of staff (Ovretveit, 1988). Research suggests that at present AO staff do not suffer from high levels of burnout (e.g. Meddings *et al.*, 2007). However, these conclusions need to be viewed with caution due to the relatively small number of studies examining staff burnout in AO services (Gray & Mulligan, 2010).

- **1.4.4.5 Risk Management**

One particular dilemma for AO staff is how to engage service users whilst ensuring safety and risk minimisation (McAdam & Wright, 2005). In the current risk adverse climate, AO staff are frequently in a position where they have to decide between respecting the service user's wishes and accepting a course that may lead to relapse (positive risk-taking), or alternatively following established evidence which can entail conflict with such wishes (Molodynski & Burns, 2011). In AO teams it is common for positive risks to be undertaken in many areas of a service user's care (e.g. supporting someone in independent accommodation for the first time or supporting someone to be in charge of collecting and taking their own medications when compliance has been a problem in the past) (Steer & Onyett, 2011). Risk taking is an important part of enabling service users to make informed choices about their own lives, with safe support for their intended actions. (Steer & Onyett, 2011). The team approach, where shared assessments and collective decision making are standard practice, can help manage risk and

reduce staff anxiety about working with their service users (Bowes & Jones, 2005).

1.5 THE RECOVERY MODEL

The Recovery model (Perkins & Repper, 2003) is a model of mental health service delivery which is based on ideas that have been formulated by service users to describe their own life experiences (Shepherd *et al.*, 2008). The model is not a form of mental health intervention in itself but an approach to rebuilding a service user's life. The Recovery model acknowledges that many people with mental health problems are still able to lead satisfying and successful lives and can work and contribute to their communities in many different ways (Perkins, 2007). Therefore, at the heart of the Recovery model are values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms (Shepherd *et al.*, 2008). Recovery has been defined as:

'A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness...'

(Anthony, 1993)

The three important concepts underpinning the Recovery model are hope, control, and opportunity. The recovery process is fuelled by hope and mental health professionals play a crucial role in supporting service users to maintain optimism for their future (Perkins, 2007). Without hope, recovery is unlikely (Repper & Perkins, 2003). The relationship between the professional and the service user is therefore considered important in the Recovery model.

In terms of control, service users have often described mental health problems as being beyond their control with many service users reporting experiences where control over treatment and intervention remained entirely with the mental health professionals (Perkins, 2007). The recovery model maintains that service users are experts in their own self-care and that professionals should work to empower service users to make their own decisions and implement their own solutions with regards to mental health recovery. Within the Recovery model professionals are therefore encouraged to shift from a position of expertise and 'authority' to a role a personal coach (Roberts & Wolfson, 2004).

Finally, the concept of 'opportunity' refers to the need for mental health services to support service users to engage in activities that they themselves value and find rewarding as opposed to what professionals judge to be so (Perkins, 2007). Such activities may include social and leisure activities, work, education, and religious or political possibilities. Within the Recovery model, rehabilitation must therefore focus on social, as opposed to medical, outcomes with an increasing emphasis on self-management and a 'strengths' approach to service users (Rapp & Goscha, 2006).

Although relatively new, the ideas underpinning the Recovery model are now supported by various Department of Health policies which aim to promote choice and self-management of severe and enduring mental health problems (DOH, 2001b: 2006a: 2007b). The use of the Recovery model in mental health service delivery is also supported by the British Psychological Society Division of Clinical Psychology (2000). It is an approach that is being utilised by the three AO teams utilised in this study.

1.6 CRITICISMS OF ASSERTIVE OUTREACH

Some authors (e.g. Macmillan, 2005; Graham, 2006) have compared AO to a form of 'therapeutic stalking'. Assertive outreach has also been criticised as a

vehicle for delivering social control to an already marginalised group (Firn & Molodynski, 2011). It has been argued that some AO interventions, such as more frequent contacts and an interest in all aspects of the service user's life, are oppressive (Smith, 1999).

Assertive outreach staff have been accused of engaging in surveillance, repeated and unsolicited letter writing and calling at the home, which may cause the service user distress (Firn & Molodynski, 2011). However, further research has shown that intense contact is often valued by service users, but only when it is delivered within a positive therapeutic relationship (Wharne & Spilsted, 2011). The main criticisms of AO, however, focus on its use of coercive strategies and the degree of service dependence that the model may create in service users.

1.6.1 Coercion

A study exploring service user experiences of AO support (Krupa *et al.*, 2005) indicates that there is a fine line between collaboration and control. Although participants generally experienced input from AO staff as supportive and engaging, some felt that staff had occasionally 'stepped over the line' and had become authoritative and intrusive (Krupa *et al.*, 2005). Such coercive experiences generally involve choices regarding medication and finances. In addition, supportive elements of the therapeutic relationship were at times inhibited by staff who maintained strict professional-service-user boundaries (Steer & Onyett, 2011). Increasing attention is being placed upon service users' perception of coercion in AO and the impact this may have upon the therapeutic relationship (Firn & Molodynski, 2011). Some studies have found that a good therapeutic relationship will minimise service users' perception of coercion (Thogersen *et al.*, 2010).

The use of care management systems such as the Care Programme Approach (CPA) (DOH, 1990) has been effective both in gaining knowledge through structured assessment and in achieving agreement in care plans (Wharne &

Spilsted, 2011). However, such plans need to be collaboratively developed with the service user and reviewed and updated frequently in order for their use not to be viewed as coercive and to have a negative impact on engagement (Wharne & Spilsted, 2011).

The introduction of the Mental Health Act (DOH, 2007a) which includes the provision of Compulsory Treatment Orders (CTOs) further highlights the dilemma of coercions/collaboration within AO by increasing pressure for staff to become potential agents of social control (Steer & Onyett, 2011). The CTO is an enabling power (used at the discretion of the clinical team) which allows enforced community treatment of service users by members of the community team. These service users can then be recalled to hospital if they refuse medication (Macpherson & Edwards, 2011). The CTO is an explicitly coercive means to try to address patterns of non-compliance and the 'revolving door' cycles (Macpherson & Edwards, 2011). However, there is some variation in how CTOs are used across the UK (Firn & Molodynski, 2011). Although many believe that CTOs will prove effective in improving outcomes in particular cases, there is fear among some clinicians that the widespread use of CTOs will adversely affect the therapeutic relationship (Firn & Molodynski, 2011).

1.6.2 Dependency

Stein and Test (1980) argued that the AO model should work against creating dependency yet ACT has been criticised by some as being paternalistic (Thogersen *et al*, 2010). By virtue of its team approach and because team members share responsibility for service users between them, this goes some way to avoiding service user dependency on any individual AO staff. However, the strong emphasis on engaging people through creative and persistent social and practical support may lead some service users to view AO staff as friends as opposed to health professionals (Gillespie & Meaden, 2010). It is important for AO staff to be aware of the difference between friendships, therapeutic relationships and being a carer (Steer & Onyett, 2011). Ethics (the

theory of moral conduct), NICE guidelines, professional codes of conduct and operational policies all provide guidance for workers and teams in providing appropriate AO interventions (Steer & Onyett, 2011).

Two participants in a study by Priebe *et al.* (2005) reported that AO support promoted dependency. Interestingly, when service users were asked how their AO team could be improved, they asked for more frequent visits, longer visits, weekend and evening work (Minghella *et al.*, 2002). Assertive outreach teams should avoid creating dependency and disempowerment by assisting service users to develop skills which promote empowerment and personal growth (Lukeman, 2003).

1.7 THE CURRENT UK EVIDENCE BASE OF ASSERTIVE OUTREACH

Assertive outreach is probably the most researched form of mental health service delivery (Molodynski & Burns, 2011). Over 90 randomised and non-randomised trials have been published throughout the world in the past 30 years (Marshall & Lockwood; Burns, 2007). However, the positive findings from America and Australia have not been replicated in research that has looked at evaluating the outcome of AO in the UK (Killaspy *et al.*, 2006; Burns *et al.*, 2007). The validity of the AO model in the UK has been widely debated in the literature and it has often been argued that fidelity to the ACT model is important in recreating the outcomes seen in the Stein and Test (1980) paper (Lachance & Santos, 1995; Teague *et al.*, 1998; Bond *et al.*, 2001). The Index of Fidelity of Assertive Community Treatment (IFACT) (McGrew *et al.*, 1994) and the Dartmouth ACT Scale (DACTS) (Teague *et al.*, 1998) have been designed to help services measure fidelity against a list of criteria for ACT services. This DACTS scale is now widely utilised in AO service planning (Molodynski & Burns, 2011). Fidelity scales are useful in measuring the extent to which evidence based interventions are being fully implemented (Drake *et al.*, 2001).

However, despite there now being a general consensus on the core elements of a successful AO service, wide variation still exists in the way in which such services are provided in the UK (Molodynski & Burns, 2011). A study examining the characteristics of AO teams across London, The Pan-London Assertive Outreach (PLAO) study (Wright *et al.*, 2003) found wide variation in service practice across London services. Out of 24 AO teams, only four were rated as having high fidelity to the ACT model when measured by the DACTS (Wright *et al.*, 2003). Such variations are not always a reflection of a deliberate deviation from the theoretical model but a result of variations in team sizes, the use of a team approach and working practices such as availability of out of core office hours (Molodynski & Burns, 2011). It appears, if anything, that variability in the UK is actually increasing over time, although the reasons for this remain unclear (Molodynski & Burns, 2011).

The current evidence base for AO in the UK will now be presented by considering the following as outcome measures:

- reduction in hospital bed use; and
- increased engagement with services.

1.7.1 Assertive Outreach and Reduction in Hospital Bed Use

Many UK studies have focused on the reduction in hospital days as the outcome measure for evaluating AO. The PRISM study in London (Thorncroft *et al.*, 1998) found that AO reduced hospital bed use compared with standard care. However, this was at a much lower magnitude than that reported in the previous randomised control trials (RCTs). The authors' explanation for this was the dilution of research effects in real world settings (Molodynski & Burns, 2011). A smaller RCT conducted by Hollwaway and Carson (1998) found no significant differences between standard care and intensive case management. However, the number of participants in each group (n=35) may have been too small to show an effect. The UK700 study (Burns *et al.*, 1999), a large multi-centre RCT involving 708 service users in London and Manchester followed up over two

years, found hospital use to be equal in both the standard case management and intensive case management group (as used in AO).

These disappointing findings have continued to be replicated in the UK. The REACT study (Killaspy *et al.*, 2006) randomly assigned 251 service users with a history of frequent inpatient care to continuation of CMHT or ACT services and followed participants over an 18 month period. This study found no reduction in bed use with ACT in standard UK settings. Glover *et al.* (2006) compared hospital admission rates across the UK where Crisis Resolution Teams (CRTs) and ACT teams were in operation. They concluded that CRTs reduced hospital admissions but that ACT did not. Thus recent UK research findings appear to indicate that AO does not reduce hospital bed use.

However, there are some exceptions to this general trend. A study of an AO team in a rural setting was found to be associated with significant reductions in hospital admissions, occupied bed days, improved engagement with services and improvement in some aspects of health and social functioning (Wane *et al.*, 2007).

Many researchers question whether these more recent research findings reflect the variation in ACT fidelity in AO services across the UK. In particular, there was great variability in the way the UK teams were commissioned and set up (Molodynski & Burns, 2011). McGrew *et al.* (1994) noted that both research into the effectiveness of ACT services and the implementation of new services were being significantly hampered by the poor fidelity to the model proposed in the initial successful studies by Stein and Test (1980). McGrew *et al.* (1994) suggested that the variation in ACT fidelity impacted on services' ability to deliver effective treatment to the service user group that ACT was intended for.

1.7.2 Assertive Outreach and Increased Engagement with Services

While many studies were reporting that AO did not significantly affect outcome in terms of measuring hospital bed use, other studies were reporting that AO did help to increase engagement and service user satisfaction in individuals who had previously not engaged with traditional mental health services (Wane *et al.*, 2007; Killaspy *et al.*, 2006). When considering engagement as an outcome, the success of AO in this area is rarely disputed (Wharne & Spilsted, 2011). A systematic review for home treatment as a whole (Catty *et al.*, 2002) demonstrated a significant association between the practice of visiting patients at home and having joint responsibility for health and social care, and reduced hospitalisation. Such findings indicate that spending more time with service users and attending to the needs that cause them particular distress (e.g. financial or housing problems) will help increase engagement and service user satisfaction (Molodynski & Burns, 2011).

A simplistic analysis might assume that, because AO teams have smaller caseloads, the more effective engagement that they are able to achieve is a result of a more intensive approach (Wharne & Spilsted, 2011). However, this position implies that AO staff are imposing onto them more of something that has not previously worked for those particular service users (Gray & Johanson, 2010). It is therefore important to consider whether AO teams are pushing standard care and treatment more effectively, or offering something different (Wharne & Spilsted, 2011). The engagement literature will now be considered in more detail.

1. 8 INTRODUCTION TO ENGAGEMENT: A REVIEW OF THE LITERATURE

1.8.1 The Importance of the Therapeutic Relationship

Engagement can be seen as a stand alone intervention and also a central vehicle for the delivery of other interventions (McCabe & Priebe, 2004; Sainsbury Centre for Mental Health, 1998). One of the strongest predictors of successful

outcomes in psychological treatment is the quality of the therapeutic relationship that exists between the therapist and service user (Hovarth & Symonds, 1991; Katzow & Safran, 2007). Research indicates that a positive therapeutic relationship between a clinician and service user has an effect on outcome regardless of the type of therapy administered, including medication (Hovarth & Greenburg, 1994). The National Service Framework for Mental Health (1999) cites Roth and Fonagy (1996), Hovarth and Symonds (1991) and Safran and Muran (1996) as providing evidence that 'The quality of the relationship between the patient and professional in psychological therapies can make as much as 25 per cent difference in outcome' (DOH, 1999, p. 43).

1.8.2 Developing a Therapeutic Relationship

- **1.8.2.1 A model of Engagement**

Hardy and colleagues (2007) propose a three stage model to explain how the therapeutic relationship evolves in therapy with the initial focus on establishing a relationship and engaging the service user in the process of therapy. According to this model, the aim of the initial sessions should be: to develop an understanding of the service user's expectations; to instil a sense of hopefulness about the potential benefits of the intervention; and to develop their motivation to engage in treatment. At this stage in therapy it is important to focus on the humanistic conditions of empathy, warmth and genuineness (Rogers, 1957), negotiating shared goals and establishing a collaborative framework (Griffiths *et al.*, 2011). Instilling hope in service users is important because research has demonstrated that individuals with low hope are less likely to achieve their goals compared to individuals with high levels of hope (Snyder, 2002). Increasing a service user's level of hope improves the chances of a service user remaining in therapy and is associated with positive outcomes (Hardy *et al.*, 2007).

Establishing a good therapeutic relationship early on has been shown to increase the chances of people remaining in treatment (Martin *et al.*, 2000). The service users that AO teams target generally have lower levels of hope than the general population (Griffiths *et al.*, 2011).

The second stage of Hardy *et al.*'s. (2007) model begins once the early relationship has been established. The objective for this stage is to develop the service user's trust in the therapist, as well as engendering the service user to becoming open to the intervention and maintaining a degree of commitment to working with the therapist. In order to do this, the therapist must consider the processes occurring within the relationship referred to as 'schematic mismatch' (Leahy, 2008). These may cause difficulties for the therapeutic relationship if they are ignored. Schemas are specific learned rules that govern a person's behaviour and help them to make sense of the world (Beck, 1964). Both the therapist's and the service user's behaviour within a relationship will be influenced by the schemas they have. Leahy (2008) provides some examples to illustrate how schematic mismatch can cause problems in therapy, for example a therapist with high standards becoming impatient with a service user whose progress is slower than expected. In this example, the therapist may unintentionally express this frustration which then confirms the service user's belief that it is unsafe to trust the therapist, damaging the therapeutic relationship as a consequence (Leahy, 2008). It is recommended that therapists use clinical supervision to explore their personal and interpersonal schemas, in order to minimise their impact on the therapeutic relationship (Leahy, 2008).

The third stage of the model is 'maintaining the therapeutic relationship' (Hardy *et al.* 2007). The aims of this stage are to maintain the service user's satisfaction with the intervention, to strengthen the relationship so that the service user is able to openly express their emotions, and to enable them to begin to explore their view of themselves. This is achieved by strengthening the collaborative nature of the relationship, identifying and repairing possible ruptures to the therapeutic relationship, and dealing with any dissatisfaction the service user may have with the intervention or the relationship (Griffiths *et al.*, 2011). This part of the process appears to be about enabling the service user to realise that they hold the power over their recovery as opposed to them viewing the therapist to hold it.

- **1.8.2.2 The Long-term Nature of the Therapeutic Relationship**

In addition to the three stages suggested by Hardy *et al.* (2007), therapists should be prepared to invest time in building the therapeutic relationship and to work with service users for longer periods than usual to allow adequate time to establish this (Griffiths *et al.*, 2011). When preparing a service user for therapy, it is helpful to first establish a trusting relationship in a non-therapy context, for example by assisting with practical difficulties that are causing the service user high levels of stress (Griffiths *et al.*, 2011).

It is proposed that it would take about a year for an effective therapeutic relationship to become established and that 18 months is a key point by which positive changes should be expected (Sainsbury Centre for Mental Health, 2001b). Taking time to really get to know someone enables the formation of a more effective therapeutic alliance (Wharne & Spilsted, 2011). The importance of time is recognised in both qualitative (Addis & Gamble, 2004) and quantitative research (Frank & Gunderson, 1990). The time it takes to establish an effective therapeutic relationship can be problematic within a healthcare climate where there are continual financial pressures. In such a climate workers can sometimes find themselves unsupported in trying to commit to long-term work when current management and policy focus is on budget cuts and short-term goals (Wharne & Spilsted, 2011).

- **1.8.2.3 Collaboration**

When service users have a long history of contact with services, such as in the case of AO, it is likely that they will have pre-conceived ideas regarding the approaches and methods of staff which have led to their disengagement. It is therefore important that any new therapy/intervention is commenced by asking questions around elements of previous interventions that were helpful/unhelpful, as well as establishing the goals that they would like to focus the intervention on (Griffiths *et al.*, 2011). This approach can facilitate the development of the

therapeutic relationship by emphasising the collaborative nature of therapy and the therapist's commitment to helping the service user (Griffiths *et al.*, 2011).

Treating the service user as an individual is another important aspect of the engagement process. Bradley *et al.* (2006) ran a focus group with five AO service users to examine their experiences, thoughts and feelings with regards to engaging with services. Results showed that service users were more likely to engage with AO teams if they felt treated as individuals in a respectful and equal way. They were less likely to engage if they felt they were being controlled, manipulated, or that staff were judgmental of them.

1.8.3 Attachment Theory and Engagement

Berry *et al.* (2007) reviewed the role of adult attachment style in psychosis and found attachment style to be important in understanding why many service users with psychosis find it difficult to engage with services. Research has found significantly higher levels of insecure attachment in service users with a diagnosis of schizophrenia compared with those diagnosed with an affective disorder such as depression (Dozier, 1990; Dozier *et al.*, 1991). Dozier (1990) also found that service users with avoidant attachment strategies were more likely to reject services than those with secure attachments.

According to attachment theory, an individual's capacity to establish collaborative relationships with others is mediated by their attachment history and their internal working models of self and others (Cupitt *et al.*, 2010). When working therapeutically with people with insecure attachments it is important to provide a secure base whilst at the same time working to disconfirm problematic working models of relationships (Cupitt *et al.*, 2010). This may be an area where traditional mental health services are lacking. Seager (2006) found that, in many cases, mental health services fail to provide a secure base and actually repeat problematic relationship patterns when working with service users with insecure attachment styles. Assertive outreach services, in contrast to CMHTs, have many

features that facilitate the therapeutic nature of the service for people with a history of insecure attachment (e.g. offering of practical help, persistent contact etc.) (Witheridge, 1989).

1.8.4 Measuring Engagement with Services

Since engagement is a core function of AO, teams sometimes use formal engagement measures to monitor progress. Engagement measures are also used by some AO teams as part of the assessment process to decide whether or not a service user is accepted into the service. A variety of formal engagement measures are available (e.g. Hall *et al.*, 2001a; Gillespie *et al.*, 2004; Tait *et al.*, 2002; Wolfson & Cupitt, 2001). One AO team included in this study routinely completes the Hall *et al.* (2001a) measure with referrers as part of the referral process. If referrals score 33 and above on this measure, this is taken to indicate good engagement with CMHT and the appropriateness of the referral is questioned further.

1.9 ASSERTIVE OUTREACH AND ENGAGEMENT

One of the long-term aims of AO is to build an effective relationship between the service user and mental health services to enable the service user's recovery. The therapeutic relationship between the service user and AO staff is key for delivering effective interventions and for promoting recovery in AO services (Frank & Gunderson, 1990; Gold *et al.*, 2003; Meaden *et al.*, 2004; Sainsbury Centre for Mental Health, 2001). The role of strong therapeutic relationships has been found to be associated with good outcomes in terms of fewer days in hospital (Fakhoury *et al.*, 2007), an increased ability to work (Priebe & Gruyters, 1993) and rehabilitation (Gehrs & Goering, 1994). Research has demonstrated that AO service users are more likely to have experienced a history of difficult or traumatic personal relationships which hinder their ability to develop effective therapeutic relationships with AO staff (Beutler *et al.*, 2002). However, recent studies have consistently found that AO services are more successful than

CMHTs at engaging 'hard to engage' service users (Wane *et al.*, 2007; Killaspy *et al.*, 2006).

Despite its obvious importance, little is known about the process of engagement in AO services. Recently, some research has attempted to explore the personal experiences of service users, AO staff, and service users' families in an attempt to understand what it is about AO that helps to engage service users (Molodynski & Burns, 2011). A systematic review of the literature exploring the engagement process in AO services from the perspectives of staff, service users and family members will now be presented.

1.9.1 Systematic Review of the Literature: Assertive Outreach and Engagement from the Perspectives of Staff, Service Users and Carers

Articles for this review were identified by conducting searches on the EMBASE, Ovid Medline, and PsycINFO databases using following search terms and combinations of Boolean operators: Engage* OR therapeutic relationship OR therapeutic alliance, AND assertive outreach OR assertive community treatment. These terms were related to the current study. The search was limited to articles published after 1980. A total of 88 articles were identified. The articles generated were reviewed manually and screened so that inappropriate information was discarded (for information regarding exclusion criteria see diagram of review process in Appendix 2). Forty four studies remained after applying the limitation criteria. A manual search of the references in key books, articles, policy documents and the Cochrane database was conducted. A further five studies were identified through this. The abstracts of the remaining 49 studies were reviewed manually and those not directly relevant to the research question or those that were unpublished were excluded. A total of five articles were retained for the review. A summary of the review process is presented in Appendix 2. A summary of these studies is presented in table format (Table 1.1) below followed by a narrative account of each study.

Table 1.1: Summary of studies used in systematic review

| Article | Aim | Method (design, data collection & analysis) | Quality | Findings | Discussion |
|--------------------------------------|---|---|---|---|---|
| Gillespie <i>et al.</i> (2004) UK | To develop a reliable self-report measure of engagement based on Hall <i>et al.</i> 's. (2001) observer-rated measure of engagement. To investigate whether a self report measure predicted service users' engagement with assertive outreach 6 months later. To compare service user and staff perceptions | Quantitative study. Correlational design. Total of 50 participants (25 service users and their key-workers) from three assertive outreach teams interviewed. Observer-rated measure (completed by key-worker) and self-report measure (completed by service user) of engagement completed at time 1 (beginning of study) and time 2 (six months later). Quantitative analysis | Independent rater asked to provide clinical judgment regarding service users' level of engagement at time 1 and 2. Test-retest reliability, internal reliability, and concurrent reliability assessed. | Self report measure of engagement found to have good test-retest and internal reliability. Staff ratings at time 1 were predictive of ratings at time 2. Client ratings at time 1 were not predictive of ratings at time 2. Lack of correlation between staff and service users at time 2. | Clinical and research implications discussed. Limitations acknowledged. Areas for further research highlighted |
| Addis & Gamble (2004) UK | To understand from the perspective of assertive outreach nurses, the process of engagement and what could be learned from it. | Qualitative study. Five participants from one assertive outreach team. Rural setting Semi structured interviews. | Comprehensive exploration of the nurses interviewed | Seven major themes: Having time; Anticipatory and tired dejection; Pressure, relief and satisfaction; Being the human professional confluence; Accepting anxiety and fear; | First study to explore the process of engagement in assertive outreach from a nurses' perspective. Clinical implications discussed. Limitations acknowledged. |

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|-----------------------------------|--|---|---|--|--|
| | | Analysed using hermeneutic phenomenological thematic method. | | Working and learning together; and Bringing the caring attitude | Areas for further research highlighted |
| Priebe <i>et al.</i> (2005) UK | To explore the views of disengagement and engagement held by service users of assertive outreach | Qualitative study 40 participants recruited from nine assertive outreach teams. Inner-city and suburban settings Semi structured interviews Analysed using components of thematic analysis and grounded theory | Comprehensive exploration of service users interviewed. Interviews conducted by a trained researcher Purposive sampling used to select each participant for interview Participants recruited until saturation was achieved. Interviews reanalysed to check validity | Factors related to disengagement: desire to be independent; poor therapeutic relationship; and loss of control due to medication. Factors important for engagement: time and commitment of staff; social support and engagement without a focus on medication; and a partnership model of the therapeutic relationship. | Clinical and research implications discussed. Limitations acknowledged. Areas for further research highlighted |
| Hughes <i>et al.</i> (2011) UK | To explore the experiences of carers of individuals receiving an assertive outreach service | Qualitative study. Ten participants recruited from asking service users in two assertive outreach teams to identify a relative, partner or friend who supported them on a regular basis. Semi structured interviews Interviews transcribed and analysed using interpretative phenomenological analysis | Comprehensive exploration of the experiences of the carers interviewed | Participants were positive about the service they and their relatives received from assertive outreach teams. The unique way in which assertive outreach teams engage and worked alongside service users and their families is greatly valued by carers | Clinical implications discussed. Limitations acknowledged. Areas for further research highlighted |

| | | | | | |
|---|--|--|---|---|--|
| <p>Wright <i>et al.</i> (2011) UK</p> | <p>To explore the nature and meaning of engagement for assertive outreach staff and service users.</p> <p>Inner city setting</p> | <p>Qualitative study. 27 participants (14 assertive outreach staff and 13 service user).</p> <p>Recruited from one assertive outreach team.</p> <p>In-depth interviews</p> <p>Interviews analysed using Turner's (2003) method</p> | <p>Comprehensive exploration of the views of the staff and service users interviewed.</p> <p>Trustworthiness and reflexivity discussed.</p> | <p>Four themes: contact, dialogue, transformation, and shared understanding.</p> <p>Experiences such as providing and receiving practical assistance, having a genuine two-way conversation, and valuing the experiences and personal attributes of the other person assisted engagement.</p> | <p>Clinical implications discussed.</p> <p>Strengths and Limitations acknowledged.</p> <p>Areas for further research highlighted</p> |
|---|--|--|---|---|--|

Gillespie *et al.* (2004) recruited 23 participants from three AO teams. Care coordinators for the service users included were asked to complete Hall *et al.*'s. (2001) observer rated engagement measure at two time points; the beginning of the study and six months later. Service users were asked to complete an observer rated version that was developed by the researchers and was based on Hall *et al.*'s. (2001) measure. An independent rater (Team Manager or Psychiatrist) was also asked to make a clinical judgement regarding each service user's level of engagement at both time points. Results were analysed using quantitative measures to assess correlations between the two engagement measures. Results found good correlation between staff and service user ratings at time one but a lack of correlation at time two. The self report measure of engagement was found to have good test-retest and internal reliability but was not able to predict which service users were at risk of drop out (Gillespie *et al.*, 2004).

This study highlights the importance of considering both staff's and service users' perceptions of engagement, and that asking service users about what aspects of their care are most important for them is important for increasing engagement. Engagement measures can also highlight areas where service users are less well engaged (Gillespie *et al.*, 2004). The researchers acknowledge the small sample size as a limitation of the study and call for studies with larger sample sizes to be conducted. Further qualitative research is also needed to further investigate the individual factors influencing engagement (Gillespie *et al.*, 2004).

Addis and Gamble (2004) published the first qualitative study to explore the engagement process solely from the perspective of nurses working in AO. The aims of the study were to understand how AO nurses experienced engagement and what could be learned from it (Addis & Gamble, 2004). Five AO nurses, of both genders, working within a rural AO service were recruited by post and interviewed in-depth about their experience of engaging service users and their approach to engagement. Interviews were analysed using the hermeneutic

phenomenological thematic method. Emerging themes were checked with participants in order to validate the interpretation of their interviews. Seven major themes emerged to construct the nurses' experience of AO engagement: having time; anticipatory persistence and tired dejection; pressure, relief and satisfaction; being the human professional confluence; accepting anxiety and fear; working and learning together; and bringing the caring attitude (Addis & Gamble, 2004).

This study was the first to provide important insight into nurses' 'lived experiences' of the process of developing trusting and effective relationships with service users who had not previously engaged with mental health services. It also provided some insight into the techniques and strategies that nurses within AO services utilise to engage service users. The researchers note that due to the small sample that was recruited from a single AO team, it was not possible to generalise findings to the wider population of AO staff. However, they maintain that the purpose of their study was to locate the lived experience of the nurses within their setting at a particular time (Addis & Gamble, 2004). The researchers suggest that replication of the study, with a larger sample, across teams with varying structures and locations would further increase understanding of the engagement process.

Priebe *et al.* (2005) interviewed 40 AO service users in-depth about their views of engagement and disengagement with mental health services. Participants were recruited from nine AO teams across London. Service users were interviewed by a trained researcher and interviews were transcribed using components of thematic analysis and grounded theory. The most common reasons for disengagement with traditional mental health services were: a desire to be independent, a poor therapeutic relationship, and loss of control due to medication and its effects (Priebe *et al.*, 2005). The most common reasons stated for engaging with AO services were: time and commitment of staff, social support and engagement without a focus on medication, and partnership model

of therapeutic relationship (Priebe *et al.*, 2005). The sample used in this study included a disproportionate number from African-Caribbean backgrounds, known to be over-represented amongst this service user group who find it difficult to engage with traditional mental health services (Molodynski & Burns, 2011). This study used purposive sampling to select participants for interviews and to test out emerging themes. Once the type of service user needed for the next interview was identified, the interviewee was randomly selected from a sub-group of participants with the desired characteristics.

Priebe *et al.* (2005) acknowledge that the sample recruited for the study may not be representative of all those referred to AO services as only those who agreed to participate were included in the study. In addition, those who failed to engage with AO services were not approached to participate. Also, the study did not explore the views of AO staff, which may differ from those of the service users. Nevertheless, the results resonate with Stein and Tests' initial proposal that service users value being treated as individuals with a depth of character and some personal worth, without a focus on medication (Molodynski & Burns, 2011). Priebe *et al.* (2005) suggested that future research explore the views of AO staff in order to relate them to those of service users.

Hughes *et al.* (2011) responded to the lack of published studies exploring carers' experience of assertive outreach services. They conducted a qualitative study, interviewing ten carers of service users receiving input from two different AO services. The researchers argued that investigating the experiences of AO carers, and understanding how best to support them in their role, leads to the potential to improve outcomes for both carers and the service users themselves. Participants of this study generally reported a positive experience of AO. In particular they felt that the flexibility and responsive nature of the service were particular strengths that enabled AO staff to build effective relationships with, and meet the needs of, the service user group. The time and effort that AO staff invested in building effective relationships with the service users and their carers,

without a focus on mental health, enabled a more holistic understanding of service user needs. These findings suggest that the success of AO lies in the way in which AO staff engage the service users and their families (Hughes *et al.*, 2011).

However, the researchers acknowledge the limitations of the study in that the small sample size and the inclusion of only the carers whose relatives agreed for them to participate may hinder the transferability of the research findings (Hughes *et al.*, 2011). They suggest the future research could focus on exploring the specific approaches and attitudes of AO staff that make a difference to how the service is experienced.

Wright *et al.* (2011) explored the nature of the relationships between AO staff and service users from the perspective of those who receive the service and those who provide the service. They conducted a qualitative study interviewing 14 staff and 13 service users from one AO team. Participants were asked in detail about their experiences of engagement. Interviews were transcribed and analysed using Turner's (2003) method. The analysis identified four overarching themes: contact, dialogue, transformation, and shared understanding. AO staff and service users suggested that for engagement to occur, contact needed to take place between both parties and that dialogue, or the process of talking and listening, was crucial to developing relationships (Wright *et al.*, 2011). In addition, both AO staff and service users must be aware of the various transformations that have already taken place over the course of care provision and need to attempt to transform together as part of the therapeutic relationship. Finally, both AO staff and service users identified the importance of feeling and being understood in order for engagement to occur. To achieve this, staff need to move beyond diagnosis to view the individual within the context of their life story (Wright *et al.*, 2003). Experiences such as providing and receiving practical assistance, having a genuine two-way conversation, and valuing the experiences

and personal attributes of the other person were also found to assist the engagement process.

The authors of the above study acknowledge that the ability to incorporate the views of 'difficult to engage' service users within research is a strength of the study. They also identify that as the study only focused on a single AO team, findings may not be transferable to other teams across the UK. The findings are congruent with the existing body of research in this area but further research is needed to support these (Wright *et al.*, 2011). Nevertheless, the research findings are clinically relevant to those who work in AO services and have the role as care co-ordinators (Wright *et al.*, 2011).

1.10 RATIONALE FOR THE CURRENT STUDY

Chapter one has provided the background to the current study. It has introduced AO development and its evidence base with consideration of important service structures, psychological processes and approaches that contribute to its success in engaging 'hard to engage' service users. The current existing literature regarding engagement has also been reviewed. Finally, a systematic review of the existing research exploring the process of engagement in AO has been presented.

Understanding the process of engagement in AO services is thought to be vital as it is fundamental in achieving the outcomes that have been celebrated in the AO literature (Addis & Gamble, 2004). Much of the existing research into the success of AO services has focused on the service elements of AO that allow for therapeutic relationships to develop between staff and service users (e.g. MDT working, team approach, team formulation, small caseloads). Until recently, research has seemingly ignored the approach that AO staff take in their day-to-day work that helps to engage service users. Developing a better understanding of the process of engagement, including the specific techniques and strategies

used by AO staff to build an effective working relationship, would have important implications in terms of increasing awareness of how to build effective relationships with 'hard to engage' service users and may help improve clinical practice in both AO services and CMHTs. It will also help make transparent the successful elements of the approach of AO staff which has been referred to previously by others in the field as 'magical skills' (Addis & Gamble, 2004).

Some of the most recent studies have now attempted to explore the process of engaging 'hard to reach' service users in more detail (e.g. Addis & Gamble, 2004; Gillespie *et al.*, 2004; Hughes *et al.*, 2011; Priebe *et al.*, 2005; Wright *et al.*, 2011). Two of these studies were published after the current study was commenced (i.e. Hughes *et al.*, 2011; Wright *et al.*, 2011). There are also further unpublished studies in this area (Bradley *et al.*, 2006; Gray *et al.*, 2001; Lukeman, 2003, Rose *et al.*, 2010).

The purpose of this study is to expand on previous research in this area in order to improve understanding of the specific techniques and skills that AO staff utilise in their approach to engaging service users. It responds to some of the recommendations made by the studies included in the systematic review. This study focuses on exploring the views and experiences of AO staff and is particularly interested in the specific approaches of AO staff that make a difference to how the service is experienced by service users. It also uses a sample that is drawn from different AO teams with varying structures and locations. With a growing number of AO teams across the UK in recent years, there is a need to develop a greater understanding of the engagement process. It is hoped that this study will positively contribute to the existing research in this area by further increasing understanding of the engagement process.

CHAPTER TWO: METHODOLOGY

2.1 OVERVIEW

A qualitative methodological approach, Grounded Theory (Glaser & Strauss, 1967), was adopted for this study to explore in detail how individual staff members working in the Mental Health Services Assertive Outreach Teams engaged service users. 'Engagement' refers to the development of a therapeutic relationship between the service user and clinician (staff member) that enables the service user to accept input from the Assertive Outreach (AO) Service. This researcher is particularly interested in how Assertive Outreach Staff (AO staff) engage (i.e. build effective relationships) with 'hard to engage' service users (i.e. those that have not engaged with traditional mental health services) and, how they maintain the service user's engagement with services. The principal aim is to attempt to understand the strategies, techniques and psychological processes that AO staff have developed to engage and maintain engagement with service users.

This chapter describes the methodological techniques utilised in this study and is structured around the key aspects of research: design, participants, data collection, procedure and data analysis.

2.2 DESIGN

2.2.1 Rationale for Using a Qualitative Methodology

Willig (2001) states that qualitative research is concerned with 'meaning' and how people experience events and make sense of their world. Researchers who adopt the qualitative approach are concerned with the quality and texture of experience, rather than with the identification of cause-effect relationships (Willig,

2001). Qualitative researchers exemplify a common belief that they can provide a 'deeper' understanding of social phenomena than would be obtained from quantitative data and they are not constrained by pre-existing hypotheses (Barker *et al.*, 2002). Qualitative research therefore allows the researcher to explore participants' perspectives and to follow up viewpoints which the researcher may not have anticipated (Fielding, 1994).

Thus a qualitative methodology was selected for this study in order to allow the researcher to explore participants' beliefs, attitudes and perception in greater depth than would have been possible if a quantitative approach had been used (Glaser & Strauss, 1967). The primary aim of this study was to explore and attempt to understand the strategies/techniques and psychological processes that AO staff have developed to engage and maintain engagement with service users. Hence the researcher was not attempting to simply *measure* or quantify this, but to describe, understand and elicit a greater, more in-depth, knowledge of how AO staff attain and maintain service user engagement. These aims are, therefore, consistent with the central tenets of phenomenological approaches (Smith *et al.*, 1999; Strauss & Corbin, 1998; Denzin, 1989).

2.2.2 The Grounded Theory Approach

Grounded Theory was initially developed by Glaser and Strauss (1967) as a research method by which qualitative data can be used not just to provide rich descriptions, but also to generate theory. Such theories are specific to the context in which they have been developed (Willig, 2001). Grounded Theory particularly places emphasis and attention on participants' own accounts of social and psychological events and of their social worlds (Pidgeon, 1996). The Grounded Theory method refers to both the systematic collection *and* the analysis of data, together with the outcome of the analysis. The outcome is a specific emerging theory 'grounded' in the data (Barker *et al.*, 2002; Pidgeon & Henwood, 1996). Strauss and Corbin (1998) suggest that a 'grounded theory' should make sense both to participants and to those practicing in the researched

area. Grounded Theory serves as a way for us to learn about the worlds we study and as a method for developing theories to understand them (Charmaz, 2011).

2.2.3 Rationale for Using Grounded Theory

Data collection and analysis for this research is guided by the principles of Grounded Theory (Glaser & Strauss, 1967). The researcher had no preconceptions about the outcome of analysis. It was not the aim of the researcher to test out preconceived ideas. Instead, it was hoped that the theory would emerge from the data and enhance understanding, thus fitting with Grounded Theory (Strauss & Corbin, 1997). It was envisaged that in employing qualitative methodology, from a phenomenological stance, participants would be encouraged to respond in their own words and in their own way, with the hope that valid, reliable data would be provided.

The emphasis in Grounded Theory is on the exploration of how individual and interpersonal processes develop, are maintained, or change (Charmaz, 2003). The researcher is interested in the individual processes that determine and influence the engagement process between AO staff and service users. That is, 'how' AO staff build and maintain effective relationships with their service users. Willig (2001) suggests that these type of 'how' questions are particularly suited to Grounded Theory as they orientate the researcher towards action and process.

As the literature review highlighted, little qualitative research has been carried out in this area. Until recently, research has seemingly ignored the approach that AO staff take in their day-to-day work that helps to engage service users. The present study provides an opportunity use qualitative methods to extend and build upon existing psychological theory in this area. Strauss and Corbin (1998) suggest that it is appropriate to use Grounded Theory to investigate a topic in need of further development.

2.2.4 Grounded Theory Procedure

Researchers can use Grounded Theory strategies with a wide variety of data collection methods (e.g. semi-structured interviews, observation, focus groups and diaries). In learning how participants make sense of their experiences, data is coded to enable researchers begin to make analytic sense of 'meanings' and 'actions' (Charmaz, 2011). Well established principles for guiding Grounded Theory research have been outlined in the literature (e.g. Charmaz, 2011; Strauss & Corbin, 1998; Willig, 2001).

Unlike other research approaches, Grounded Theory merges the process of data collection and analysis to allow the researcher to move between the two until no new information emerges ('theoretical saturation'). This involves the progressive identification and integration of 'categories of meaning' from data through a process of coding (Willig, 2001). In the early stages of analysis descriptive labels, known as 'concepts', are attached to chunks of data. As coding progresses, the researcher is able to integrate a range of 'concepts' sharing central features or characteristics into 'categories'. These 'categories' are coded at increasingly higher levels of abstraction as the analysis progresses and are aimed at interpreting, rather than describing, experiences or phenomena.

There are a number of processes that are fundamental to Grounded Theory: 'constant comparison', 'theoretical sampling', and 'theoretical saturation'. 'Constant comparison' refers to a process of comparing new information with the analysis 'so far'. It allows for the identification of similarities and differences between emerging categories through the undertaking of comparative analyses between or within groups of persons within a particular area of interest (Morse & Field, 1995; Pidgeon & Henwood, 1996). The aim is to link and integrate categories so that all instances of variation are captured by the emerging theory (Willig, 2001).

The concept of 'theoretical sampling' involves the recruitment of new and 'different' participants and the collection of further data to facilitate the elaboration and refinement of categories in the emerging theory (Charmaz, 2011). Sampling occurs for the purpose of developing the emerging theory as opposed to generalising findings and so, ideally, theoretical sampling should continue until 'theoretical saturation' is achieved. Willig (2001) also identifies an abbreviated version of Grounded Theory where the researcher does not engage in theoretical sampling and works only with the original data. Due to time constraints, the abbreviated version of Grounded Theory has been used in this study.

Finally, 'theoretical saturation' refers to the continued process of data collection, coding, refinement of categories and theoretical sampling until no new categories and no new variations of existing categories emerge (Willig, 2001). However, Willig (2001) highlights that theoretical saturation functions as a goal rather than reality of qualitative research as modification of categories or changes in perspective are always possible.

Additionally, memo-writing is an important aspect of the Grounded Theory method. The researcher keeps a written record throughout the research process to document thinking throughout the analytic process including definitions and justification for categories, and thoughts or themes evoked throughout interviews and transcription. This can help provide direction for theoretical sampling and show up changes of direction in the analytic process and emerging perspectives (Willig, 2001).

2.2.5 Quality in Qualitative Research

Elliott *et al.* (1999) proposed a set of guidelines to increase quality and to maintain credibility and validity when conducting qualitative research. These will now be discussed along with a brief description of how the researcher attempted to address these in this current study.

- **2.2.5.1. Consideration of the Researcher's Position**

It is important that qualitative researchers are aware of the role that their own assumptions, values and interests may play in the collection and interpretation of data (Elliott *et al.*, 1999). This is similar to Henwood and Pidgeon's (1995) concept of 'reflexivity'. Reflexivity requires an awareness of the researcher's contribution to the construction of meaning throughout the research process, and the acknowledgement of the impossibility of remaining 'outside of' one's self when conducting research (Willig, 2001). The researcher acknowledges that her background influences may impact upon the research process and so she provides a statement of her position to allow readers to assess the role that the researcher played in the study.

The researcher is writing from the perspective of a married, 30 year old, pregnant, white female who was brought up, lives and works in the South Wales Valleys. The researcher is currently a third year Trainee Clinical Psychologist and is completing this research as part of her Doctorate in Clinical Psychology training. The researcher acknowledges that these factors can influence her interactions with the participants and subsequent data analysis.

The researcher initially became interested in this area of research during her Adult Mental Health placement, where she worked in a service providing psychological input into community mental health services. She noticed that there were service users with severe and enduring mental health problems who frequently missed appointments and were often discharged from psychology and other mental health services for 'non-engagement'. As part of this placement, the researcher spent time with a Clinical Psychologist working in an AO team and became aware of a specific service approach aimed at engaging 'hard to engage' service users within mental health services. Reviewing the literature around the topic of service user engagement within mental health services further increased her interest in this area. This led to her curiosity regarding how staff working in

AO teams attempted to engage service users who had previously disengaged from traditional mental health services.

Throughout the study the researcher kept a research journal (see Appendix 3) describing her thoughts in order to provide a reflexive account of the research process. As indicated by previous research, this assisted in the maintenance of open-mindedness and a critical approach to the research (Huberman & Miles, 1994; Silverman, 2000).

- **2.2.5.2. Situating the Sample**

Qualitative researchers need to describe participants and their life circumstances in order to allow the reader to assess the relevance and applicability of the research findings (Willig, 2001). The researcher used a demographic information sheet to obtain relevant information from participants (see Appendix 5). Relevant participant information is presented in section 2.3.6 (Description of Participants).

- **2.2.5.3. Grounding in Examples**

It is important that qualitative researchers provide examples of the data to illustrate the researcher's analysis and the interpretations drawn from the data. Elliott *et al.* (1999) propose that this will allow the reader to assess the fit between the data and the interpretations made. The researcher has therefore provided examples of data to illustrate the concepts and categories developed from them (see Results Chapter).

- **2.2.5.4. Providing Credibility Checks**

Qualitative researchers should check the credibility of their categories or concepts to ensure their accuracy in relation to the data (Elliott *et al.*, 1999). The researcher held a focus group following the analysis of the individual interviews and all participants were invited to attend. The purpose of this focus group was to present the analysis back to participants to check that it accurately reflected the information provided by them during the interviews.

- **2.2.5.5. Coherence**

Qualitative researchers need to present their data, analysis and findings in a coherent way that is characterised by a narrative account (Elliott *et al.*, 1999). Such accounts are presented diagrammatically and in writing in the Results Chapter (Chapter 3). Both the Clinical and Academic supervisors checked the account for coherence.

- **2.2.5.6. Accomplishing General vs. Specific Research Tasks**

Qualitative researchers should state explicitly whether their intention is to create a general understanding of a phenomenon or a specific instance of that phenomenon (Elliott *et al.*, 1999). This researcher sought to gain an understanding of the experience of engagement from the perspective of AO staff. Although the researcher recognises that the information presented represents the views of the eight participants and is specific to the AO services utilised in this study, it is possible that their experiences may also reflect views that are universal to others. The limitations of the design and data are acknowledged and discussed in the Discussion Chapter (Chapter 4).

- **2.2.5.7. Resonating with the Reader**

Finally, qualitative researchers are encouraged to ensure that material is presented in a way that resonates with the reader (Elliott *et al.*, 1999). This means that readers and participants should be able to judge the analysis as having represented the subject matter accurately or to have clarified or expanded their appreciation and understanding of it. Therefore, diagrammatic representations of the analysis were presented to research participants during the focus group to enable them to comment on and, if necessary, to amend the themes that had emerged from the data. Participants who were not able to attend the focus group were sent diagrammatic representations of the analysis via email to ensure that they also had to opportunity to provide feedback for the analysis.

2.3 PARTICIPANTS

2.3.1 Sample Size and Source

At the time of this research, there were seven AO teams operating across South East Wales. Due to time limitations and practicality issues, participants were recruited from three AO teams located in South East Wales. Prior to seeking ethical approval for the study, Managers of AO services were contacted by the researcher to establish whether the study was feasible and to also obtain initial permission to recruit staff working within their various teams. At this point the Managers were provided with details about the study including: the researcher's aims and objectives, the researcher's intent to recruit AO staff as participants, and an account of what would be required of participants for this study.

Research suggests that when using Grounded Theory, the optimal number of participants is often between eight and twelve (Glaser & Strauss, 1967). Three rounds of recruitment were conducted; each round took place in a different AO team. These were spaced out by a period three weeks each. Eight AO staff from three different AO teams were selected for inclusion as participants in this study.

2.3.2. Inclusion/Exclusion Criteria

- **2.3.2.1. Inclusion/Exclusion Criteria for the Interview**

Invitations to take part in this study were sent to AO staff working for a minimum period of six months as a care co-ordinator. For the purpose of interviews, participants were further required to understand and speak fluent English. Participants were also required to be able to commit to an interview lasting up to an hour and a half. The researcher used clinical judgement at each interview to make decisions regarding capacity to consent. The researcher also monitored participants throughout the interviews for any indications of distress and was prepared to stop the interview should any participant display any significant level of distress.

Any participant who initially provided consent but then later decided to withdraw consent would be excluded from the study. All previous information provided by them would also be removed.

- **2.3.2.2 Inclusion/Exclusion Criteria for the Focus Group**

The focus group was limited to AO staff who had participated in the individual interviews. It was decided that only those who took part in the interviews could accurately decide whether the initial analysis represented the experiences that they had talked about. Information obtained during the interview was used in the analysis regardless of whether or not the staff member later attended the focus group, providing that they did not later withdraw consent. This was explained in the 'Participant Information Sheet' (Appendix 6) and also verbally at the end of the initial interviews.

2.3.3 Contacting and Selecting Participants

The initial approach to participants was made by the AO Team Manager or the Clinical Psychologist working in the AO team. The researcher only had contact with potential participants once she had obtained permission from them to do so. This procedure is described fully in the Procedure section (see section 2.5.1.2).

2.3.4. Response Rate and Selection of Participants

All AO staff members working in the included AO services, who met the inclusion criteria, were invited to participate in this study. Of these, eight granted permission for the researcher to contact them (see section 2.5.1.2 for an explanation of this procedure). All eight participants were selected for participation in the individual interviews. None of these eight participants were later excluded from this study.

All those who participated in the individual interviews were invited to attend the focus group (see Appendix 7). Of those, only four attended the focus group. The remaining four participants were unable to attend on the date arranged due to

prior work commitments. However, these participants were also sent the information presented during the focus group via email in order to allow them the opportunity to provide feedback for the analysis.

2.3.5. Participant Demographics

At the beginning of the interview each participant was asked to complete demographic information sheet (Appendix 5) which collected information regarding gender, age, professional background and number of years experience in AO services. This information about the participant was used to allow the researcher to ‘locate the sample’ (Elliott *et al.*, 1999). This information is summarised in the table below.

Table 2.1 Demographic details of participants

| Name (pseudonym) | Gender | Age | Job title | Time worked in AO | Total time working in MH services |
|------------------|--------|-----|------------------|-------------------|-----------------------------------|
| Suzie | Female | 40 | CPN | 4 years | 16 years |
| Liz | Female | 46 | CPN | 3.5 years | 11.5 years |
| Gaynor | Female | 48 | Nurse Consultant | 5 years | 30 years |
| Paula | Female | 37 | OT | 3 years | 11.5 years |
| Jenny | Female | 51 | CPN | 5 years | 30 years |
| Lucy | Female | 32 | CPN | 9 months | 8 years |
| Ben | Male | 45 | Social worker | 2 years | 15 years |
| Malcolm | Male | 49 | CMH Nurse | 8 years | 11 years |

2.3.6. Description of Participants

Suzie: Suzie is a forty year old white female who has worked as a Community Psychiatric Nurse (CPN) in the AO team for four years. Prior to this post, she worked in various mental health settings, including inpatient wards and community services. In total, she has 16 years’ experience of working in adult mental health services.

Liz: Liz is a white female in her late forties. She has worked as a CPN in AO for three and a half years. Prior to this post, she worked as a CPN in a Community

Mental Health Team (CMHT), in a mental health day unit, and on inpatient wards. In total, she has over 11 years' experience of working in adult mental health services.

Gaynor: Gaynor is a white female in her late forties who has worked in her AO team since it was established five years ago. She is currently a Nurse Consultant and works with the most complex cases in her AO team. Prior to this she worked in rehabilitation services. Gaynor has 30 years' experience working in mental health services.

Paula: Paula is a white female in her late thirties. She has worked as an Occupational Therapist (OT) in an AO team for three years. Prior to this she worked in a number of different mental health services including inpatient rehabilitation, a day hospital, an elderly mental health service, and an acute inpatient service.

Jenny: Jenny is a white female in her early fifties and is a CPN. She has worked in the AO service for five years. Since qualifying in 1983, she has worked in various mental health settings including acute inpatient services and a CMHT. In total, she has 30 years' experience of working with people with mental health problems.

Lucy: Lucy is a white female in her early thirties and works as a CPN. She is relatively new to AO as she had only been working in the AO team for nine months at the time of her interview. Prior to this job she worked for eight years on acute inpatient wards.

Ben: Ben is a white male in his mid forties who works as a Social Worker. He is also a qualified nurse. He has been a member of the AO team for just over two years. Prior to his current post, he worked for a number of years as a Social

Worker in older adult and adult mental health services. In total, he has 15 years' experience of working in mental health services.

Malcolm: Malcolm is a white male in his late forties. He has worked as a Community Mental Health (CMH) Nurse in an AO service for eight years. Prior to this he worked as a staff nurse in a mental health hospital for three years. In total, he has 11 years' experience of working in a mental health setting.

2.4 DATA COLLECTION

There were two stages of data collection in this study: individual semi structured interviews and a focus group.

2.4.1 Semi Structured Interview

Interviews are frequently utilised for data collection in qualitative research. Willig (2001) suggests that interviews can yield in-depth information quickly in a way that enables immediate clarification and follow up of answers to explore and understand 'meanings' of experiences in everyday life.

For this research, interview stem questions were developed in consultation with the Academic and Clinical supervisors. Stem questions were used as an adaptable guide for the interview and were aimed at exploring the key areas identified in the literature review chapter (see Appendix 8 – Interview Schedule). The interview schedule also included probes to enable participants to expand on their statements.

The key areas explored through the stem questions included:

- AO staff's beliefs about their effectiveness in engaging service users.
- AO staff's experiences of working with 'hard to engage' service users.

- Strategies and techniques that AO staff believe are important for engaging service users.
- Key skills and personal qualities required by AO staff for engagement.
- How AO staff identify and interpret early signs of disengagement.
- How AO staff respond to early signs of disengagement.

Stem questions were as follows:

- 1) How effective do you think your team is at getting people to agree to input from assertive outreach once they are referred?
- 2) Do you find from your clinical experience that some people are willing to work with you whereas some people are resistant to working with you? Can you talk me through some clinical examples?
- 3) Do some people start off easy and then turn out to be difficult to work with or vice versa? Can you talk me through an example of this?
- 4) What three factors do you think are most important for influencing whether someone will agree to work with you or not? How much do these factors influence your day to day work?
- 5) What particular skills would your colleagues say that you have that are helpful for working with people who find it difficult to engage with traditional mental health services? How have these skills developed?
- 6) How would you know if someone was starting to disengage from you and what do/would you do if this happened?
- 7) How typical do you think your approach is compared to that of others in your team?
- 8) Is there anything you feel I should ask or that you would like to tell me about your experience of engaging people in AO services?

Although the stem questions provided a basic structure for the interview, in line with Grounded Theory methodology, participants were also encouraged to speak freely about their experiences. This enabled a 'flexibility' to be adopted within the interview in order to explore new ground with participants, which is consistent with Grounded Theory methodology as a 'valuable method of discovery' (Fielding, 1994).

2.4.2 Focus Group

Krueger (1988) describes focus groups as 'organised group discussions which are centred on a single theme'. Focus groups have the potential to add richness to the data by 'allowing interactions between participants to be explored and for joint constructions of meaning to be extracted' (Krueger, 1988). Focus groups can also add validity to a study by providing a credibility check to ensure that the analysis accurately reflects participants' lived experiences (Willig, 2001).

Although not all concepts will apply to every participant, the theory should still be recognisable to each of them (Strauss & Corbin, 1998). Finally, focus groups also allow people to further develop their views through listening to others' understanding and opinions (Marshall & Rossman, 2006).

In this current study, the main aim of the focus group was to elicit participant feedback on the initial analysis of the data collected in the individual interviews. This would provide a means of validating the concepts and categories that had emerged. Through the discussion of themes during the focus group, participants were able to reflect on these and further develop and promote their views and experiences.

2.5. PROCEDURE

2.5.1. Ethical Approval

Ethical approval for this study was sought and granted by Dyfed Powys Local Research Ethics Committee. Permission was also obtained from the Research and Development Offices within the sponsor Health Board together with two other Health Boards where participants were recruited from. Letters of approval are attached in Appendix 1.

2.5.2. Informed Consent and Confidentiality

At the outset, it was presumed that all of the participants had the capacity to make an informed and rational decision as to whether to participate in the study. This was further checked at the individual interviews and at the focus group by the researcher. Prior to agreeing to take part in the study, all participants received a 'Participant Information Sheet' (Appendix 6) which provided them with information regarding the researcher's aims, procedure of the study, requirements of participation, use of data, and information regarding participants' right to withdraw at any time. The Participant Information Sheet also provided telephone numbers and email addresses for contacting the researcher or either of the study supervisors should participants have any further questions or concerns.

Participation in this study was voluntary and consent was sought at every stage of the study so that participants could make a free and informed decision about whether or not to take part. Potential participants were presented with the information sheet by their team manager and were asked to return a reply slip (located at the end of the Participant Information Sheet- Appendix 6) if they were interested in participating in the study. The reply sheet granted permission for the researcher to contact the participant directly. Participants were then provided with a 'consent for interview' form (Appendix 9) which they were asked to read through and consider in their own time before completing and returning it to the researcher. Once the researcher received the completed 'consent for interview' form the researcher contacted the participant to arrange a suitable time, date and venue for the interview. The interview was arranged a minimum of seven days following receipt of the consent form in order to allow for a suitable 'cooling off period' during which participants might wish to change their mind about participating.

At the outset of each interview the researcher confirmed consent for audio recording and reiterated issues of confidentiality and anonymity to ensure that each participant was aware that direct quotes would be used in the write up of the study. In relation to anonymity, the researcher's intent to use direct quotes from participants in the write up of this study was documented in the Participant Information Sheet. The researcher also ensured that she explained to all participants during the individual interviews and the focus group how direct quotes would be used in the write up of this research. Each participant was made aware that although they would be ascribed a pseudonym, demographic information such as age, profession and gender would be used to allow the researcher to 'locate the sample'. Participants were informed that such information may increase the likelihood of them being identified by colleagues and were asked to consider this carefully before continuing with the individual interviews. In addition, during the focus group stage the researcher ensured that participants had the opportunity to view the quotes that were to be included in the write up of this study in order to allow them the option of requesting them to be removed if they had any concerns regarding potential identifiers. No participants raised any concerns about being identified or asked for quotes to be amended or removed.

For reasons of client confidentiality, participants were also asked not to reveal any personal information about their clients, but were reassured that any client information that was accidentally revealed would be anonymised. Participants were reminded that participation was voluntary and that they were free to withdraw at any point in the research process. The researcher also explained conditions that might warrant breach of confidentiality (e.g. disclosure of unprofessional conduct) and explained the procedure she would follow should this happen.

At the end of the interview, the researcher thanked participants for their time and sought permission to contact them again to invite them to attend the focus group. Participants were informed that attendance at the focus group was not compulsory and that, providing they did not later withdraw consent, interview information would still be used in the study if they did not attend the focus group. Prior to the start of the focus group, the researcher asked participants to read and sign a further consent form (Appendix 10). Before commencing the focus group, participants were again reminded about issues of confidentiality and anonymity, that participation was voluntary, and that they were free to withdraw at any point in the research process.

Direct quotes from interviews were presented in the focus groups. Although quotes were anonymised and identifiable information removed as far as practical, it was acknowledged that participants in the focus group might be able to recognise quotes from their colleagues. Participants were therefore asked at the beginning of the focus group to respect the confidentiality of their colleagues.

2.5.3 Interview Procedure

Interviews lasted between one and one-and-a-half hours. Each interview was audio recorded and later transcribed by the researcher (see Appendix 4 for example). The interviews followed the procedure outlined above (see 2.5.2. Informed Consent and Confidentiality). Participants were offered a choice of locations for the interview (e.g. their work base, the researcher's work base in Cardiff, or any other suitable location that was convenient for them). All participants selected to be interviewed at their work base.

Each interview was transcribed as soon as possible following the interview and the coding process began immediately after transcription. Interviews were spaced out as far as possible to allow time between transcription, coding and analysis in accordance with the iterative nature of Grounded Theory.

- **2.5.3.1 Piloting the Semi-Structured Interview**

Ideally, the researcher would have piloted the interview with AO staff. However, the researcher was unable to do this prior to ethical approval and so the researcher asked her clinical supervisor, who has a number of years experience working within AO services, and her academic supervisor to read and comment on the interview questions and prompts. Their feedback provided verification of the feasibility of the questions along with ideas of how to improve questions.

- **2.5.3.2 Researcher's Interview Skills**

The researcher is a Trainee Clinical Psychologist in her final year of training and was able to use her training in conducting clinical interviews to facilitate the collection of data. The researcher also used active listening, empathic reflection and minimal encouragement when necessary to help facilitate the interview.

In the unlikely event that the interview raised issues that evoked distress in the participants, the researcher had considered a number of contingencies to help manage such a situation. These included the researcher talking to participants about postponing the interview or withdrawing from the study altogether. The researcher was also prepared to provide suggestions about the various sources of support available to participants if necessary. For example, if any participant displayed any indication of distress during the interview, the researcher had previously arranged for them to be offered consultation with a Clinical Psychologist outside their team.

2.5.4 Focus Group Procedure

The focus group took place at the researcher's work base in Cardiff as this was deemed to be the most central location for all participants. The focus group lasted one hour and twenty minutes and four of the eight participants attended. These participants represented staff from two of the three AO services included in this study. At the beginning of the focus group, the researcher explained its format and outlined the aim of feeding back the initial analysis of the interviews.

Participants were asked to consider how accurately the initial analysis reflected their experiences of engaging service users. Participants were informed that categories and concepts could be adapted and modified during the focus group if necessary. Participants were warned that direct quotes from the interviews would be presented during the focus group and were asked to respect each other's views at any times when opinions differed within the group. In addition, participants were asked to provide everyone with an equal opportunity to speak and to be honest in sharing their views and opinions.

Participants were presented with a diagram to illustrate each theme (see Appendix 11) and were then provided with a narrative to explain each major category. Direct quotes from the interviews were used to further illustrate the concepts and categories. Participants were then asked to discuss the categories and concepts that had emerged from the initial analysis and to also highlight any areas of the analysis that required further development.

The focus group was audio recorded and the researcher also kept a written record of main feedback regarding the analysis, key quotes and areas of agreement/disagreement. It was deemed unnecessary to fully transcribe the focus group as its main purpose was to validate the initial analysis. The researcher did however use the audio recording to further expand on these notes following the focus group. Key quotes were transcribed verbatim and have been included in the results (see chapter 3).

2.6 DATA ANALYSIS

The researcher adopted the Grounded Theory approach to analysing the data outlined in section 2.2.4 (Grounded Theory Procedure). The researcher allowed herself to become immersed in the data before the initial analysis by reading the transcripts and listening to interview recordings several times. As Barker *et al.* (2002) propose, this process allows the researcher to gain an overall feel for the

scope and meaning of the data. The researcher transcribed all of the interviews herself. Transcription by the researcher, although time consuming, is important for allowing the researcher to be fully in touch with the data. The analysis of the interview data was conducted simultaneously with data collection.

2.6.1 Transcribing the Interview

Each interview was transcribed by the interviewer as soon as possible following the interview. Each interview took between four and six hours to transcribe. Interviews were transcribed verbatim, but pauses and utterances were removed. The process of transcription is considered a form of analysis, because of the many theory-guided decisions that must be made along the way (Riessman, 1993).

2.6.2. Coding

Coding refers to the process whereby the interviewer identifies categories from the data. The coding process began following interviews and continued following each transcription. Initial coding resulted in the generation of a range of descriptive categories which capture the essence of the segment of the interview (Charmaz, 2011). The researcher noted these descriptive labels in the margin of the transcript next to the data segment (see Appendix 4 for an example). As the analysis progressed, these initial codes were organised and integrated into higher-level analytic categories using the most frequent or significant codes (Charmaz, 2011). The process of 'constant comparison' was used to link and integrate categories until all instances of variation were captured by the emerging theory.

2.6.3. Validation of Initial Analysis

The initial explanatory framework that emerged from the coding of interviews was further developed and validated by presenting the initial framework to participants during the focus group. This process has been described above (see 2.5.4. Focus Group Procedure).

CHAPTER THREE: RESULTS

3.3 OVERVIEW OF CHAPTER

Interview transcripts were analysed as described in the previous chapter (see 2.6). The results from the interviews and focus group feedback are presented in this chapter. Pseudonyms have been used in order to protect participants' anonymity. A brief description of each participant has already been presented in the previous chapter (see 2.3.6).

3.4 INTRODUCTION TO RESULTS

To facilitate reading, **THEMES** are presented in bold upper case, **Major categories** are underlined and in bold, **categories** are in bold, and ***subcategories*** are in bold italics.

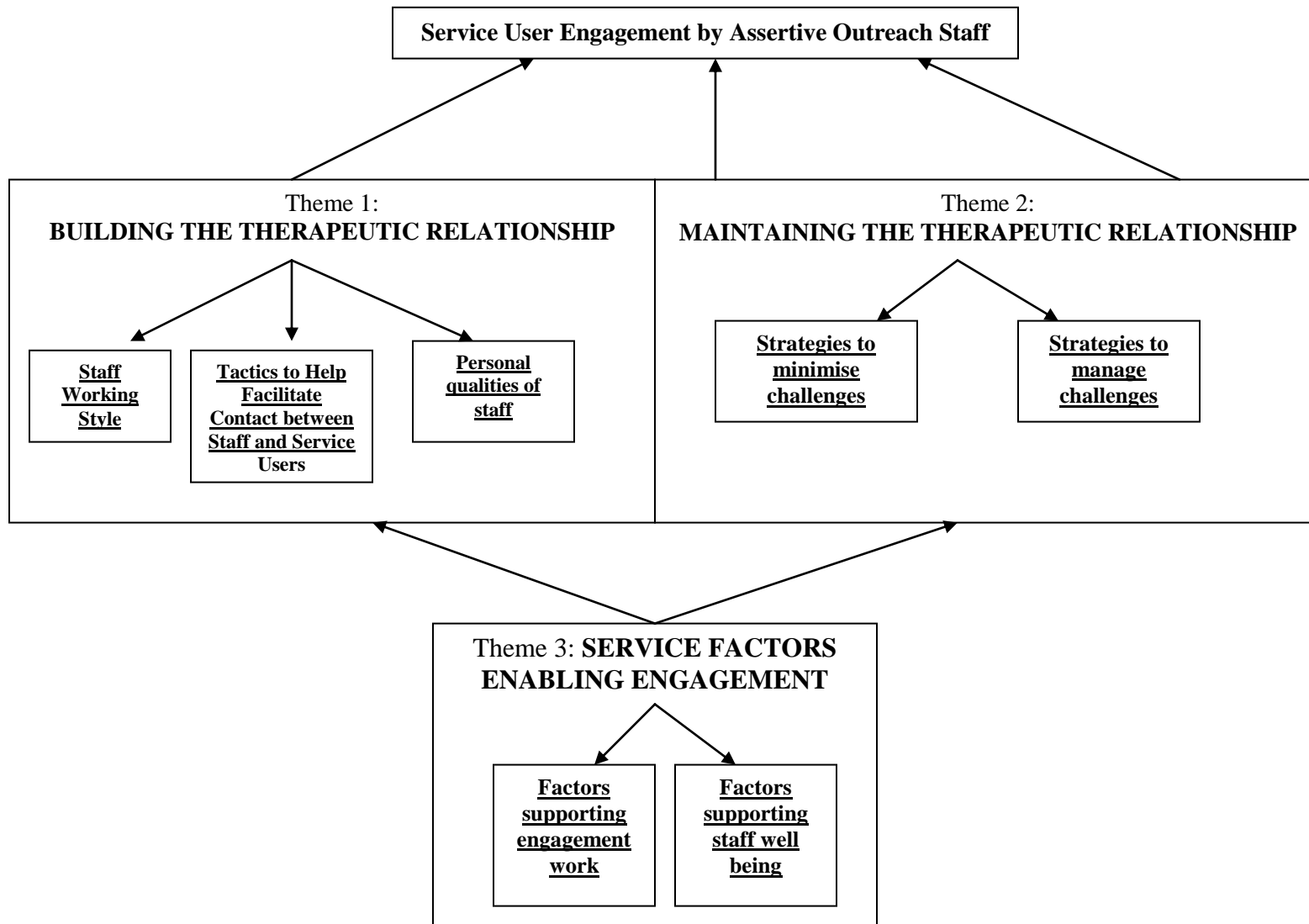
Three themes emerged from the data to conceptualise AO staff's experiences of engaging their client group of 'hard to engage' service users. Two themes, **BUILDING THE THERAPEUTIC RELATIONSHIP** and **MAINTAINING THE THERAPEUTIC RELATIONSHIP** conceptualise the clinical work (i.e. style, tactics and personal attributes) that AO staff use on a daily basis to engage and maintain engagement with service users. A third theme, **SERVICE FACTORS ENABLING ENGAGEMENT**, highlights the service related factors that enable AO staff to undertake the work described in themes one and two. Whereas themes one and two operate at a clinical level, theme three operates at a service level. Within this chapter, the major categories, categories and sub-categories for each theme will be described. An overview of the themes and major categories is presented diagrammatically in Fig 3.1. Full diagrammatic illustration of each of the three themes is provided in Appendix 11.

Theme one, **BUILDING THE THERAPEUTIC RELATIONSHIP**, divides into three major categories to describe the style and tactics that AO staff use to build initial relationships with service users, along with the personal qualities that AO staff possess that assist them with this work.

Theme two, **MAINTAINING THE THERAPEUTIC RELATIONSHIP**, describes how AO staff maintain a therapeutic relationship with service users through the various challenges that can present with this service user group. This theme divides into two major categories to describe the strategies that AO staff utilise in their day-to-day work which help minimise the occurrence of challenges as well as describing how they manage the challenges that present.

Theme three, **SERVICE FACTORS ENABLING ENGAGEMENT**, considers the various service factors that AO staff have identified that enable them to work in the manner described in themes one and two. This theme divides into two major categories which describe factors that enable engagement work to take place and factors which maintain staff wellbeing throughout this intensive work. Assertive Outreach staff suggested that without these factors it would be much more difficult for them to use the approaches and strategies that were identified in themes one and two, hence impacting on their ability to engage service users.

Figure 3.1 Grounded Theory Model of Service User Engagement by Assertive Outreach Staff



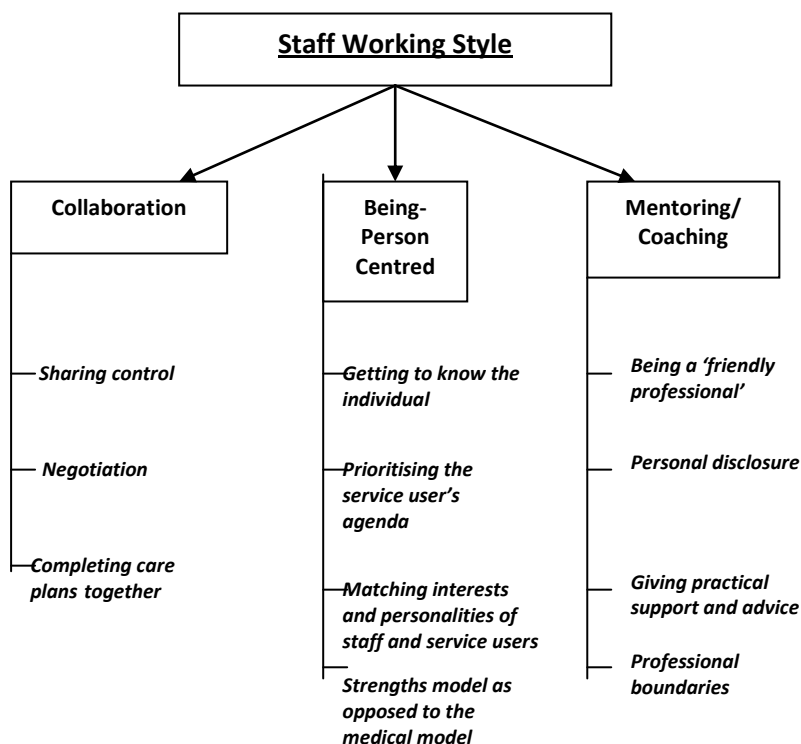
3.5 Theme 1 - BUILDING THE THERAPEUTIC RELATIONSHIP

BUILDING THE THERAPEUTIC RELATIONSHIP was one of the major themes identified in this Grounded Theory account of how AO staff engage 'hard to engage' service users. Within this first theme are three major categories: **Staff Working Style**, **Tactics to Facilitate Contact between Staff and Service Users**, and **Personal Qualities of Staff**. Each of these major categories will now be discussed in turn.

3.5.1 Staff Working Style

Staff Working Style illustrates the main approaches and working styles that AO staff use in their all their work with service users to help them build an effective therapeutic relationships. This major category conceptualises the general style of therapeutic relationships that AO staff seek to develop with AO service users. This major category is represented diagrammatically in Figure 3.2. Three categories emerged from the data: **Collaboration**, **Being Person-Centred**, and **Mentoring/Coaching**.

Figure 3.2 Diagrammatic representation of **Staff Working Style**



- **3.3.1.1 Collaboration**

Collaboration is used to help AO staff build effective therapeutic relationships with service users. This category refers to the process of joint-working with service users and incorporates the sub-categories of '**Sharing control**', '**Negotiation**' and '**Completing care plans together**'.

'Sharing control'

All participants spoke about the importance of sharing control over service input in order to facilitate engagement with the AO service. In particular, participants spoke of the importance of sharing control with regards to setting up appointments and contact with the AO service:

Suzie: 'We let them have some control too. So we might say to them – "what day do you want us to call?" and they can choose and then they have already started to take some responsibility and have some ownership over their contact with AO. They seem to like that element of it too.'

Gaynor: 'He knows that he can ring me anytime. I am not always available but he can leave a message and I'll get back to him as soon as I can ... it's about giving them (the service user) some control too, you know, where the contact doesn't always have to come from you first.'

Jenny: 'We give them some control back. Control is often taken away from them through family and other services. Sharing control is important for engagement.'

'Negotiation'

Participants also highlighted the importance of negotiating with service users regarding various aspects of their care from early on in the relationship:

Ben: 'We do a bit of negotiating early on about the type of contact and input we give people.'

Lucy: 'We negotiate with people over the things they want from us from the very beginning.'

Malcolm: 'I often have to negotiate with some of my service users, especially around appointments. It works'

One participant also spoke about how important negotiation was for all service users, even those under Compulsory Treatment Orders (CTOs):

Suzie: 'We still negotiate as far as possible with service users on CTOs because we discuss and negotiate with them around what needs to go in (to the care plans) and what their individual needs

are. We still do this with service users on CTOs because we believe it's important for them to have input into their plans and the service they receive.'

'Completing care plans together'

Finally, in terms of **Collaboration**, participants also reflected on how important it was for service users to be involved in writing their care plans:

Suzie: 'We sit down with people and do their care plans together so that they have some responsibility for complying with them rather than us just putting paperwork in front of them and saying – this is what you have to do.'

Gaynor: 'Care plans are completed with service users so that the end result is a mutually agreed care plan, not one that we (staff) draw up ourselves.'

One participant also spoke of how important it was to revisit already completed paperwork with service users as other mental health services may not have taken a collaborative approach when writing service users' care plans:

Gaynor: 'It's always nice to go over already completed paperwork again with the service user because it's surprising how much of it can be wrong. Some information can be based on hear say or solely on the point of view of the staff. We are much more interested in the person's view, working together with them and including the things they would like to go into the plans.'

- **3.3.1.2 Being Person-Centred**

The second important style for building effective relationships with service users identified during analysis was **Being Person-Centred**. For AO staff, the idea of organising input around the service user's need is an appealing element of AO work:

Paula: 'I think we use the whole kind of concept of patients fitting into services rather than services fitting around patients and the latter is far better and we tend to do more of that in AO services. I like that part of the work.'

In order to work in a person-centred way, AO staff highlighted the importance of a number of approaches they take when building relationships with service users. The sub-categories of **Being Person-Centred** will now be presented.

'Getting to know the individual'

Participants talked about the importance of first '**Getting to know the individual**' they were working with and how this is one of their early priorities with service users:

Liz: 'In AO you have the opportunity to really get to know the individuals you work with. That's always my first priority.'

Jenny: 'Our aim is basically just to get to know them (service users).'

Lucy: 'You obviously need to get to know that person quite well.'

One participant spoke of receiving feedback from service users regarding this. They identified this as a key difference between the AO approach and that of traditional mental health services, such as CMHTs:

Suzie: 'They (service users) often say that we are able to understand them better as people than others have in the past. I have often been told that this is a big difference between us (AO) and the way that CMHTs work.'

'Prioritising the service user's agenda'

Prioritising the service user's agenda was another approach that enabled staff to work in a person-centred way:

Gaynor: 'Second most important thing is that you work on their (service users') agenda. If you don't do this then you risk losing the person.'

Liz: 'It should be all about what they want and what is important to them.'

Ben: 'Once we know what they need and want, we make sure it happens.'

In prioritising the service user's agenda, participants gave examples of some service user goals and how supporting them to achieve these helped AO staff to build relationships with those service users:

Jenny: 'I take someone horse riding ... You've just got to do things that they want to do, I suppose, more than anything else.'

Gaynor: 'There is one person. She didn't want to talk about medication ... what she needed help with was getting more access to her daughter, so we helped with that. This worked wonders with getting her to engage with us.'

Liz: 'For example, one lady I supported to go to 'Zumba' classes. It doesn't sound big but it is something she had wanted to do for such a long time ... It would never have been my priority but it was hers so it was important for her and really helped our relationship.'

‘Matching interests and personalities of staff and service users’

Interestingly, participants from each of the three AO services in this study spoke about how their AO service attempted to match up the service users with staff who had similar interests or personalities:

Liz: ‘We do try to match people up with who they may have things in common with whenever we can ... We don’t just decide you are going to be care co-coordinator for that person because you are the next person due to take on someone, we look at the bigger picture and think about who they may get on better with.’

Jenny: ‘As I said, we tend to be partnered up with patients where personalities won’t clash as well.’

Ben: ‘We do try to match people up with who we think they will get along better with as far as we possibly can.’

‘Strengths model as opposed to the medical model’

Finally, participants spoke about the importance of working to a strengths model as opposed to the more traditional medical model that exists within many mental health services:

Ben: ‘We look at peoples’ strengths rather than their deficits. We work on building up peoples’ strengths.’

Jenny: ‘... and what we tend not to do is focus on their illness, we tend to focus on the things that they are good at, their strengths.’

Gaynor: ‘Moving away from the medical model is high on the agenda ... You need to be aware of that and trying to get a feel for what the person’s strengths are instead.’

Participants identified that working within the medical model can sometimes act as a barrier to engagement:

Liz: ‘The worst thing you could do would be to go straight in and start talking about medication. That would cause problems straight away.’

Paula: ‘I wouldn’t go in and talk about hallucinations or ask “Have you had any hallucinations?” That straight away puts up a barrier.’

- **3.3.1.3 Mentoring/Coaching**

The third ‘working style’ that AO staff described when building relationships with service users is a **Mentoring/Coaching** approach. Within this category are four sub-

categories: '***Being a friendly professional***', '***Personal disclosure***', '***Giving practical support and advice***', and '***Professional boundaries***'.

'Being a friendly professional'

All participants spoke about the importance of reaching a balance between a professional and a friendly approach with service users:

Gaynor: 'I think you need to use your personality much more in this work as you can't just be a professional or take a professional stance ... It's informal and kind of more of a friend as well as being a professional at the same time.'

Liz: 'You are a professional but you are like a friend too at the same time.'

Paula: 'Service users tend to respond to a far more flexible friendly based approach when you are trying to build a rapport. So you are befriending the person rather than just going in as a worker.'

'Personal disclosure'

To help AO staff achieve the balance between being a professional and being a friend, many participants highlighted the role of personal disclosure in the relationship building stage:

Liz: 'I think that with this lady it was important that I shared with her some of my own personal experiences. For example, she suffered terrible panic attacks and I have experienced panic attacks too. So I told her this ... So she asked me what it was like for me and I told her and tried to explain to her ... That's how our relationship started. She opened up to me a bit more after that.'

Ben: 'I do a bit of self-disclosure, you know, tell people a bit about my background and my interests.'

Malcolm: 'I do disclose to people some of the problems I've had in my life. That's what makes them realise I am human. They relate more to you after that.'

'Giving practical support and advice'

In addition to achieving a balance between being a friend and a professional, participants also reflected on the usefulness of offering practical support to help them build relationships with service users:

Suzie: 'We have a lot of people with very complex needs that have a lot of housing and social problems. If you can help them work through all the very basics in their life, like food, money and shopping, you've got a foot in the door.'

Ben: ‘For example, we’ve helped people paint their houses, taken their dogs for a walk with them. Practical stuff like that, really. They may seem like trivial tasks, but we help out with this kind of stuff.’

Malcolm: ‘I go to medical appointments with service users if they want me to and with their permission I will speak up on their behalf if they find it difficult to explain things. They seem to like that type of support.’

Assertive outreach staff also identified that providing guidance in the form of **‘Offering advice’** as opposed to ‘being prescriptive’ with information, particularly with regards to medication, can also be helpful:

Gaynor: ‘Sometimes, if you give information about medication in the form of advice, people seem to take it on board.’

Lucy: ‘They’ve had those experiences in the past where maybe things have been a bit more prescriptive, especially with medication. Things have been “you’ve got to do this or you must do that because this will happen”. It’s about getting the person to understand, but you do it in more of an advice giving way.’

‘Professional boundaries’

Finally, in relation to taking a **Mentoring/Coaching** approach to building relationships with service users, all participants reflected on the importance of maintaining professional boundaries:

Gaynor: ‘Although you sometimes act like a friend, you’re not a friend, you have to have that professional boundary. You can’t ignore the risk element.’

Liz: ‘We have a situation now where someone is sending abusive texts to members in the team. Really nasty texts and it has gone down the route of the police. As his care co-ordinator I’ve had to remind him that although we are friendly professionals, we have a job to do which is keeping you well and supporting you to live in the community. It’s not nice that we had to get the police involved, I don’t like that, but we had to because it is a form of abuse and the staff don’t deserve that’.

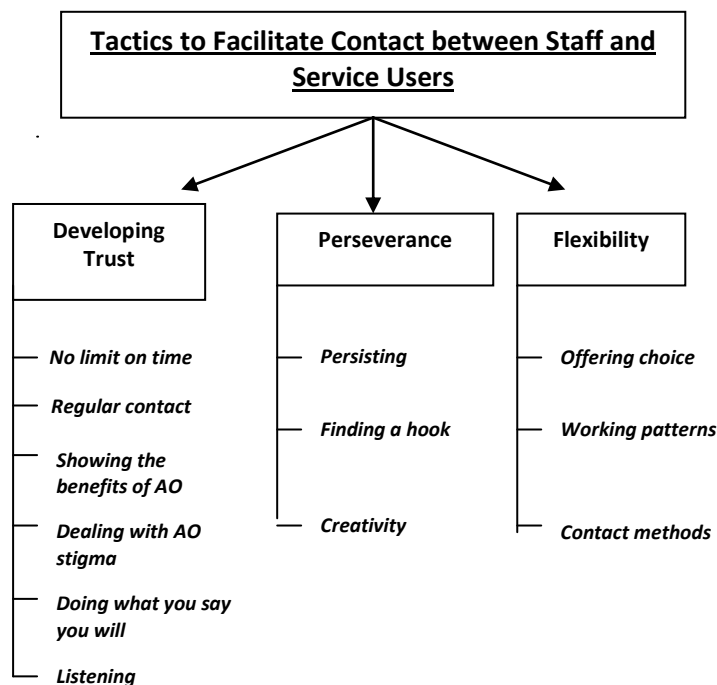
Maintaining professional boundaries therefore appeared to be important to help manage some of the risks associated with this service user group.

3.5.2 Tactics to Facilitate Contact between Staff and Service Users

Tactics to Facilitate Contact between Staff and Service Users illustrates the main activities and tactics used by AO staff to achieve the necessary level of contact for the building effective therapeutic relationships. It differs from **Staff Working Style**

in that the activities and tactics included within **Tactics to Facilitate Contact between Staff and Service Users** are specifically aimed at enabling AO staff to establish a particular frequency of contact between the service user and AO staff. The difference between **Staff Working Style** and **Tactics to Facilitate Contact between Staff and Service Users** was clarified with participants during the focus group. This major category is represented diagrammatically in Figure 3.3. Three categories of ‘tactics’ emerged from the data: **Developing Trust**, **Perseverance**, and **Flexibility**.

Figure 3.3 Diagrammatic representation of **Tactics to Facilitate Contact between Staff and Service Users**



• **3.3.2.1 Developing Trust**

All participants spoke of the importance of gaining the trust of service users when attempting to establish frequent contact between AO services and service users. This appeared to be the most important tactic for building effective relationships with service users:

Paula: ‘It’s about getting that person to kind of start to trust you. That is the most important thing of all.’

Jenny: ‘Trust is a big, big thing. It’s all about the trust.’

Lucy: ‘He didn’t particularly trust me initially. That was my initial step with him, developing trust.’

Assertive outreach staff identified a number of techniques that they use to build service users' trust in them. These sub-categories have been integrated into **Developing Trust** and will now be presented.

'No limit on time'

Participants identified one important aspect of building trust as being not placing any limit on the time it takes to develop a trusting relationship with service users:

Suzie: 'It takes a long period of time to build a trusting relationship- it doesn't happen over a period of a week or overnight. We've got time to spend on this and we are allowed to. For one service user, I've spent two years just working on building a relationship with her.'

Jenny: 'We're able to give them however long it takes, so I think that time is a big factor of the engagement and relationship building.'

'Regular contact'

Another aspect of developing trust for participants was having regular contact with service users:

Liz: 'It's not a case of just turning up to an MDT meeting and introducing yourself and then them never seeing you again for months. You have to keep having chats and meetings with them.'

Lucy: 'It basically took going to visit him several times a week to start to gain his trust.'

'Showing the benefits of AO' and 'Dealing with AO stigma'

Participants also spoke about the importance of showing service users the benefits of engaging with AO, from early on in the relationship, in order to help develop a trusting relationship:

Paula: 'If you show them there are benefits of working with you from the start, it helps them to realise that you care and they open up to you more.'

Ben: 'You help with stuff so that the person can see that they are getting something out of it so you can start to build the relationship.'

In addition to this, AO staff also highlighted the importance of managing some of the stigma surrounding AO services:

Suzie: 'Initial thoughts seem to be that it is going to be too intrusive into their lives. They don't want anything to stop the process of getting back to normal life from happening and their initial thought is

often that input from AO means that they are iller than what they perceived themselves to be or that AO would stop them from going back into work. AO has some stigma attached to it. We have to manage this.'

Jenny: 'He didn't want anything to do with services because he was afraid they would take him into hospital. That's what he thought AO was for.'

'Doing what you say you will'

Another important aspect of trust building that participants spoke about was ***'Doing what you say you will'***:

Suzie: 'So if you say you're going to call on Tuesday at two o'clock then you have to call at that time. They seem to have had some bad experiences where the community nurse or social worker has not turned up to their appointment or has kind of messed them around.'

Malcolm: 'I do my best to be there when I say I will be. That's important.'

Ben: 'If you say you're going to help with something, you need to follow through with that.'

'Listening'

Finally, participants spoke about ***'Listening'*** to service users as being an important technique for developing a trusting relationship:

Ben: 'It's so important to just sit and listen to the person. Our service users frequently identify that we listen to them more than others have.'

Lucy: 'Just listening to what they have to say is really important for trust.'

Paula: 'You need to be prepared to listen to what they have to say. They won't trust you if you don't listen.'

- **3.3.2.2 Perseverance**

Perseverance is the second tactic used by AO staff to establish frequent contact with service users and build effective relationships. Within this category are the sub-categories of ***'Persisting'***, ***'Finding a 'hook''*** and ***'Creativity'***.

'Persisting'

This sub-category related to the notion of AO staff not giving up in their attempt to build relationships with service users. All of the participants spoke about persistence as a strategy to build the initial relationship with service users, particularly in relation to a 'hard to engage' service user group:

Gaynor: 'Other services give three appointments and if they (service users) don't turn up the service closes the books. We have to be persistent because there are lots of cancelled appointments with these service users ... There were some where we had to go back twice a day.'

Liz: 'You constantly need to think of new ways to engage that person if one way doesn't work. Try something else and don't give up. You can't give up.'

Paula: 'For clients who find it very difficult to engage, I think persistence is very important.'

'Finding a hook'

In addition to persistence, three participants spoke of the importance of ***'Finding a hook'*** or an interest that they could build their input around and gain the service users' willingness to work with the AO service:

Liz: 'You do often read the notes before you meet someone and you are often keeping an eye out for something that you may be able to connect with them over while you are reading them. If you can find a niche or way in, then engagement seems to get a lot easier from then on.'

Gaynor: 'From the day you meet someone you are looking for a hook. Something to make you think, "right that is the area I need to work on first".'

One participant gave a specific example of this:

Ben: 'It was the dog for this one service user. That was my way in, offering to go with him to take the dog for a walk together. Persistence had finally paid off.'

'Creativity'

Finally in terms of perseverance, four participants spoke about the need to be creative with attempts to engage service users:

Ben: 'We have to work more creatively with our people to get them to engage. I often have to think outside the box.'

Lucy: 'We have to really think outside the box and be creative'

Malcolm: 'We have to be creative in the work we do.'

- **3.3.2.3 Flexibility**

Flexibility is the third tactic that AO staff use to establish regular contact with service users. Within this category are the sub-categories: ***'Offering choice'***, ***'Working patterns'*** and ***'Contact methods'***.

'Offering choice'

All participants spoke of the importance of being flexible with service users, particularly in relation to offering choices with appointment locations, times and days:

Gaynor: 'People do respond quite positively when in our first approach we are already asking "Well when shall we meet? When is the best time for you?" Rather than just sending an appointment out.'

Paula: 'It's actually about offering the choice of coming to see us at the base here if they prefer that or we can meet somewhere else if they prefer.'

Lucy: 'We let them make decisions about appointment times, locations, etc. '

As part of ***'Offering choice'***, all participants spoke of the importance of being flexible in terms of agreeing to meet service users wherever they were most comfortable meeting:

Gaynor: 'It doesn't have to take place in the CMHT, it can be in their own home, café or anywhere where the person feels most comfortable.'

Paula: 'We arrange to meet them elsewhere if that suits them, wherever is most convenient for them. It's not based on outpatient appointments where they'd have to come here, we go to them.'

Malcolm: 'I go to see them wherever is best for them.'

'Working patterns'

This sub-category relates to the ability of AO staff to be flexible by offering weekend appointments in addition to weekday appointments. Two out of the three AO services that participants were recruited from were able to do this as they were currently providing a service between the hours of nine to five, 365 days a year:

Suzie: 'We are a lot more flexible with them, we work weekends, they like that element of it.'

Jenny: The thing is our patients know that somebody will be available seven days a week, even on Christmas day we cover. They know that if there is a problem one of the nurses or the support workers that are working on the weekend can visit.'

Malcolm: 'People are surprised to hear we work weekends. They like being able to have appointments on weekends.'

With regard to the third participating AO service, at the time of the study it was only operating a nine to five service Monday to Friday. However, there were imminent plans in place to recruit more staff in order to extend the service to cover weekends.

'Contact methods'

There were some differences between the AO services in terms of methods through which service users were able to contact AO staff. In two of the services, AO staff were able to give out their work mobile numbers to service users. All members of staff working in these two services (n= 6) mentioned this as an important factor for engagement:

Liz: 'We give them our mobile number, too, so they can ring us if they are worried about anything. They think it's brilliant that we can text them and that they can text us.'

Ben: 'Our service users contact us by mobile phones. It's quite a refreshing change being able to give your number out. Some (service users) find it easier to text us, see.'

In addition, one of these services also regularly provided service users with their work email addresses. One participant working in this service spoke of the helpfulness of this:

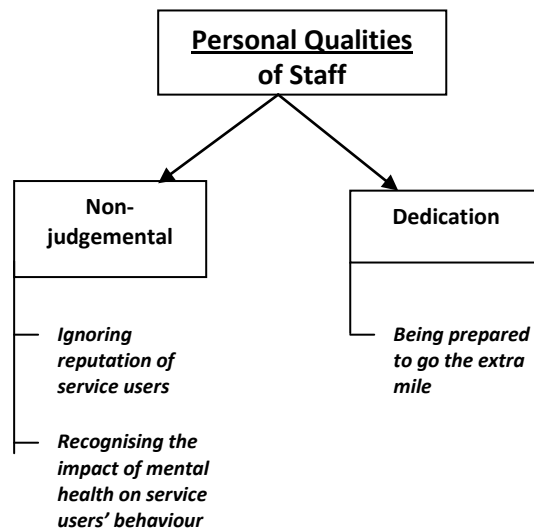
Gaynor: 'Another lady who I work with emails me. Even though we do have quite a good relationship, there are some things that she can't tell me face to face or over the phone. She uses email to bring the subject up with me and will often say in the email, can we talk about this when we next meet? We are even flexible in our communication.'

In the AO service that did not provide its service users with work mobile numbers, participants were not aware that other AO services operated in this way and were unsure as to whether or not giving out mobile numbers and work email addresses would benefit engagement. This service only provided service users with a team contact number through which they could leave messages for staff on the answering machine if no one was available.

3.3.3. Personal Qualities of Staff

Personal Qualities of Staff illustrates the main attributes of AO staff that emerged from the data as being important for enabling the building of effective therapeutic relationships with 'hard to engage' service users. This major category is represented diagrammatically in Figure 3.4. Two categories are included in this: **Non-Judgmental** and **Dedication**.

Figure 3.4 Diagrammatic illustration of Personal Qualities of Staff



- **3.3.3.1 Non-Judgemental**

The ability to not judge service users was one of the desirable personal qualities of AO staff identified through this analysis. Within this category are the sub-categories ***‘Ignoring the reputation of service users’*** and ***‘Recognising the impact of mental health on service users’ behaviour’***.

‘Ignoring the reputation of service users’

AO staff spoke of how service users are often referred to AO services after many years of contact with mental health services. As a result, these service users often have large mental health files containing lots of information regarding previous service input and any difficulties that previous services have experienced when working with the service users. One participant spoke of the negative reputations that service users referred to AO services can have:

Suzie: ‘We’ve had a service user recently that had a horrendous reputation with mental health services and it wasn’t really her fault. She was a mother of two teenage children and had had quite a horrendous life, lots of trauma and drug abuse. She was really happy to come to us because she had such a bad relationship with the CMHT.’

Seven participants told of how they ignore such reputations and attempt to avoid passing judgement on service users when they meet with them.

Lucy: ‘I try not to judge people on the past or things they do. I try to work in a way that they feel comfortable enough to tell me things without feeling judged.’

Jenny: ‘Some people come to us with lots of files/ notes about the problems CMHTs have had. We read these but we start off working with people from a blank slate.’

‘Recognising the impact of mental health on service users’ behaviour’

In addition to this, three participants spoke of the importance of being aware that peoples’ mental health can impact upon their behaviour and how it was helpful to try and view difficult behaviour in the context of their mental health difficulties:

Paula: ‘I think realising that people have an illness is important. That’s really hard to do sometimes and especially sometimes for qualified staff to realise this is not somebody being awkward this is actually an illness, whether it’s personality disorder, schizophrenia, bi-polar, this is actually an illness and it affects how they behave.’

Lucy: ‘People often act as they do because they are unwell. They have an illness which influences their behaviour.’

Gaynor: ‘We work with a lot of people who have substance misuse problems. We don’t make judgments about this as we know they are often just trying to manage their symptoms the best they can.’

Interpreting difficult behaviour as a symptom of mental health difficulties appeared to be used as a strategy to help participants to avoid passing negative judgement on service users.

- **3.3.3.2 Dedication**

Dedication was the second important personal quality of AO staff, identified through analysis. Within this category was the sub-category of ***‘Being prepared to go the extra mile’***.

‘Being prepared to go the extra mile’

All participants spoke of their willingness to do things for service users that would not be possible, or they would be unlikely to do, if they worked in other mental health services:

Suzie: ‘I’ve never worked in a team before where everyone always goes that one step further. Everyone’s the same in that respect. That doesn’t always happen in other places’

Ben: ‘You end up doing a lot more for that person, more than you ordinarily would when working with people in other services’.

Two participants provided examples to illustrate this:

Liz: 'We've actually popped to her parent's house to pick up money and Christmas presents for her. She's like, "What, you would go to my house and get that from my parents?" We are like "Yeah, of course we will". We've been over and met her mam and dad and picked up clothing for her, and brought them to the ward.'

Gaynor: 'He's never ever had someone do the stuff that we have helped with. I've taken him to visit his sister. I've gone to the job centre with him to sort out his benefits. He gets very frustrated easily when people don't understand him and he just storms off which meant that he was never able to get the help he needed'.

'Being prepared to go the extra mile' appeared to be a personal quality shared by all participants and is a quality that reflects their dedication to their work.

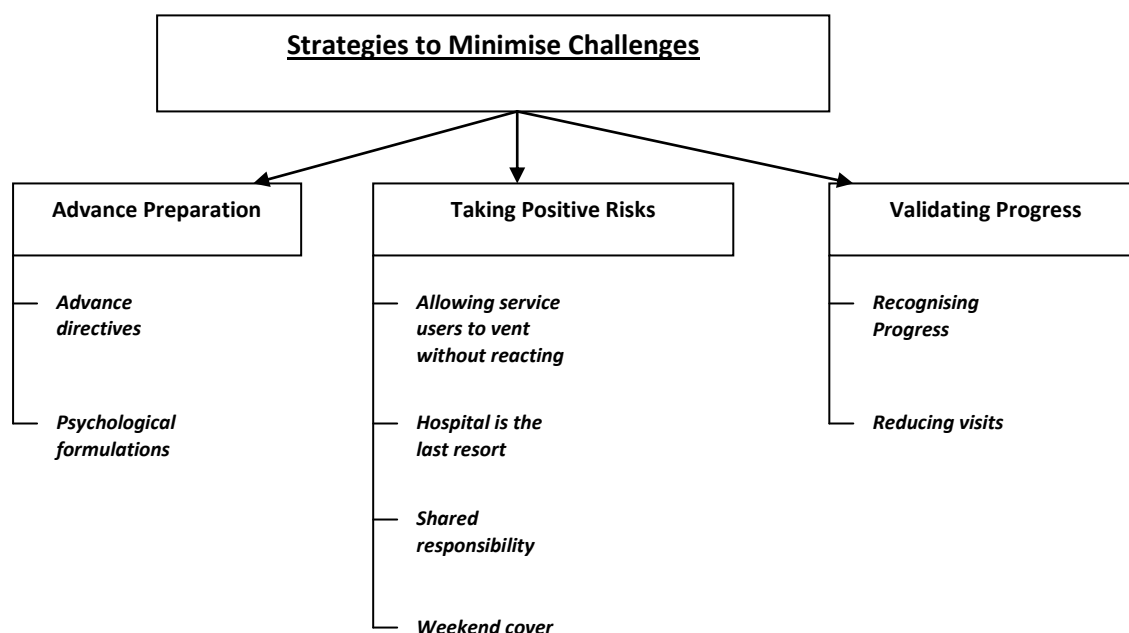
3.6 Theme 2: MAINTAINING THE THERAPEUTIC RELATIONSHIP

MAINTAINING THE THERAPEUTIC RELATIONSHIP is the second theme in this Grounded Theory account of how AO staff engage 'hard to engage' service users. Within this theme are two major categories: **Strategies to Minimise Challenges**, and **Managing Challenges**, both of which will now be discussed.

3.4.1 Strategies to Minimise Challenges

Strategies to Minimise Challenges illustrates the strategies that AO staff use to minimise the impact of, and occurrences of, problems in their relationships with service users. This major category is represented diagrammatically in Figure 3.5. Three categories emerged from the data: **'Advance preparation'**, **'Taking positive risks'**, and **'Validating progress'**.

Figure 3.5 Diagrammatic representation of **Strategies to Minimise Challenges**



- **3.4.1.1 Advance Preparation**

Advance Preparation is one of the strategies that AO staff use to minimise the impact of challenges to their therapeutic relationships with service users. Within this category are the sub-categories of '**Advance directives**' and '**Psychological formulation**'.

'Advance directives'

Three participants spoke of the importance of preparing in advance for problems with engagement, due to the complex nature of the service user group. With advance preparation, participants told of how it was beneficial to have early discussions with service users about how the AO service would respond if the service user's mental health began to deteriorate, or if they began to behave in ways that demonstrated increased risk:

Lucy: 'We discuss risk and problems in advance with service users and this gets incorporated into their care plans. They are aware then, in advance, of what will happen if things start to deteriorate and they can have some input into what goes into the plans too.'

Liz: 'We have contingency plans in place which we can use if things deteriorate. We do this with the service user so they are clear what will happen if things go wrong. This helps when problems occur.'

Participants also highlighted the importance of asking service users in advance what they would like to happen in such circumstances so that they could incorporate the service user's wishes, as far as possible, into these advanced plans:

Gaynor: 'We discuss with them what they would like to happen/not happen, who they want us to contact, what would make us recall them to hospital ... all that stuff in advance.'

These '**Advance directives**' are used to assist AO staff to respond to difficulties in a way that minimises negative impact on the therapeutic relationship.

'Psychological formulation'

Another form of advance preparation that AO staff use is '**Psychological formulation**'. Six participants spoke of using risk formulations to help them identify issues of risk and ways of responding:

Lucy: 'We do risk formulations as a team'

Suzie: 'We do risk formulations here which help us identify potential problems well in advance.'

Ben: 'We do risk formulations and look at relapse signatures early on, so we have all the info we need about people from the start.'

Engagement formulations are also used to help facilitate AO staff's understanding of engagement difficulties with services and to identify alternative ways that AO staff could manage such difficulties:

Suzie: We do team formulations looking at engagement difficulties with the clinical psychologist in the team, we think together about what we can do differently to engage people.

Malcolm: 'When we still had our Psychologist working here, she would help us think through a problem we had with engagement'

Formulations were devised in a team setting and were usually facilitated by the team's Clinical Psychologist. Such formulations were helpful for enabling staff to spot early signs of disengagement along with identifying intervention strategies to help promote engagement and to minimise risk.

- **3.4.1.2 Taking Positive Risks**

This category refers to AO staff's strategy of managing risk by supporting service users to remain in the community for as long as possible without recalling them into hospital. AO services work intensively with service users and participants identified that this was helpful for allowing them to successfully support individuals to remain in the community through occasions where other mental health services may have needed to admit them to hospital:

Ben: 'Because we have the ability to work intensively with people and can visit on a daily basis, or twice daily, we are more prepared, or able, to take the chance with people when they start deteriorating.'

One participant illustrated an example of this:

Paula: 'She had a forensic assessment while she was in hospital (under Mental Health Section) and the forensic assessment basically said that she needed to be in a low secure service ... Other services suggested she be admitted to a low secure unit. Myself and *** (Psychiatrist in the AO team), we basically didn't want this because we think that it would be the end of this person. So basically we worked with her at going to a rehab unit in the community, and myself and the OT techs would be seeing her three to four times a week to try and get her to function in the community ... we've helped her to maintain her mental health and she's actually spent the longest period of time out of hospital in, like, eight years. She's done excellent, brilliant.'

'Allowing service users to vent without reacting'

'Allowing service users to vent without reacting' is a sub-category within **Taking Positive Risks**. Five participants spoke of their ability to allow service users to vent their frustrations without interpreting this as a risk issue:

Gaynor: 'This gentleman has a huge problem sleeping and he is the type of person who has to get his frustrations out. How he does that is he rings and leaves a message, a garbled message on the answer machine here (AO team base) or he'll ring my mobile or text me ... Often the next time I see him he will say "I'm sorry about that message but I left it and then felt better after doing it." so that in itself serves a purpose. It's done and dusted and I don't feel the need to do any more as long as he feels ok.'

Suzie: 'She is quite a volatile person and has quite a bad relationship with her family and some of the stuff she says can be quite paranoid. We just let her vent and then talk things through with her and once she has done this she's fine. She's worried about what she can say to the CMHT and how they will react and if she will be misunderstood and misinterpreted. It's really important not to overreact or react too quickly to some of the things the service users say. We don't panic ... They may have lots of symptoms in terms of emotional distress, but if they are functioning well and are able to talk things through then it may not be having a massive impact on their day to day functioning.'

'Hospital is the last resort'

Most of the participants also spoke of hospital admittance being the last resort in their management of difficulties with service user engagement:

Suzie: 'Even if they become unwell, hospital admission is the last resort. We will offer more regular visits first, daily visits. We'll look at their medication and they can see a consultant ASAP. Once they see that we don't panic and send them to hospital at the first sign of problems, then they start to settle and respect the relationship with us.'

Lucy: 'If there are concerns about someone's mental health that we feel that we can deal with in the community then we carry on. Hospital is the last resort.'

Instead of admitting service users to hospital when their mental health begins to deteriorate, staff spoke of a number of more proactive strategies such as increasing contact with the AO service and arranging an immediate appointment with the Consultant Psychiatrist to review medication.

'Weekend cover'

Finally, three participants highlighted the importance of AO operating as a seven day service in enabling them to take greater risks with service users. This was mainly due to them being able to ensure that service users are provided with support over the weekend when they need it:

Ben: 'It's a seven day service, so you're not clocking off on a Friday and leaving someone without support over the weekend.'

Jenny: 'We work over the weekends too, so people are never left without support if they need it over the weekend.'

AO staff who are not working over the weekend therefore appear reassured by the fact that service users can be monitored/supported over the weekend if they show indications of deterioration on a Friday and are less likely to recall them into hospital as a precaution:

Liz: 'Even if you're off over the weekend then you can pass work to someone else to visit and follow up if you are worried, rather than admitting them.'

- **3.4.1.3 Validating Progress**

Validating the progress of service users emerged as an important strategy for maintaining service user engagement. Within this category are the sub-categories of ***'Recognising achievements'*** and ***'Reducing visits'***.

'Recognising achievements'

This sub-category relates to the importance of recognising the achievements of service users over the course of their input with the AO service. Two participants spoke of this:

Jenny: 'If they've (the service user) achieved something, you have to recognise that, even if it is not a massive achievement for you.'

Liz: 'You need to realise what is something little for you can often be a massive achievement for them. You have to recognise that. Small things mean a lot.'

This highlights the importance of recognising achievements from the service user's point of view as opposed to staff's.

'Reducing visits'

Participants also identified a reduction in the frequency of visits as another way to validate service users when they are making progress with regards to managing their mental health:

Suzie: 'We have some cases where we reduce visits as their mental health is improving. We might drop visits from three times a week to twice as a matter of progression. They like this as it lets them know they are making progress- that's important too, to acknowledge progression.'

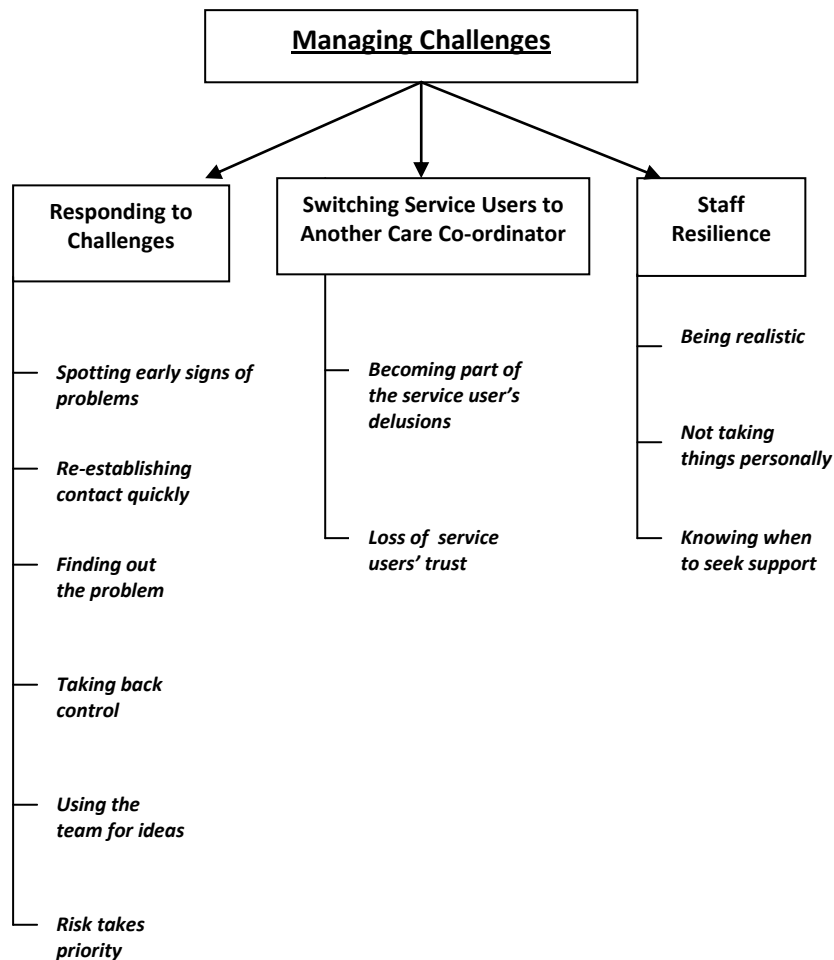
Jenny: 'We've just reduced somebody down to fortnightly visits because she's doing so well. Same input, same thing you're doing, but we just reduce them down to fortnightly visits. She's really happy about this.'

3.4.2 Managing Challenges

Managing Challenges illustrates how AO staff respond to challenges (i.e. indications of disengagement or deterioration in mental health) and how they attempt to re-engage service users at such times. This major category is represented

diagrammatically in Figure 3.6. Three categories emerged from the data: **Responding to Challenges, Switching Service Users to Another Care Co-ordinator** and **Staff Resilience**.

Figure 3.6 Diagrammatic representation of Managing Challenges



- **3.4.2.1 Responding to Challenges**

Participants spoke about how they would respond to indications of problems during interviews. This category contains a number of sub-categories. Each will be presented below.

‘Spotting early signs’

All participants spoke about the importance of spotting the early signs of problems, which are often in relation to ceasing contact with AO staff:

Liz: 'It can vary but if someone suddenly stops answering their phone to you or stops opening the door and is not there when you've arranged to meet.'

Paula: 'She would avoid staff and that's when the problems would start. She'd actually avoid staff. She'd be in the house but she wouldn't actually answer the door to staff.'

'Re-establishing contact quickly and finding out the problem'

Once service users are displaying early signs of problems, participants said that their first response would be to re-establish contact with that service user:

Ben: 'We keep going back on a daily basis until we can get contact.'

Suzie: 'If we went on a Monday as arranged and they weren't there then we would go back everyday until we manage to make contact with them.'

Jenny: 'As a service, we keep on going back and knocking on the door and keep on ringing to try and re-establish contact as quickly as possible.'

Once contact was re-established, AO staff then spoke of the importance of finding out what problems the service user was experiencing:

Suzie: 'Whoever managed to get in to see them would say- "you weren't in for the last arranged appointment, is there anything wrong? What's going on? Is there anything we can help with?" And that might take a couple more visits to try and establish what the problem is.'

Ben: 'Once we have re-established contact we try to find out why they have missed appointments. Is there a problem? What can we help with?'

'Taking back control'

In addition to '***Re-establishing contact***' and '***Finding out the problem***', two participants spoke of the importance of temporarily '***Taking back control***' from service users at this point of the process. This was in the form of suspending negotiation around appointments frequency:

Suzie: 'These visits are not negotiated with the service users, we start to take more control at this point until the problems have settled.'

Lucy: 'If someone is deteriorating we start to take back control a bit. Up the visits, whether they want us to or not. We can review this then later.'

'Using the team for ideas'

Another strategy for responding to disengagement was ***'Using the team for ideas'***.

This sub-category relates to AO staff utilising the team approach and using their colleagues to help generate additional ideas of how to respond to disengagement.

This is normally done in the AO team meetings:

Suzie: 'We do team formulations ... we think together about what we can do differently. We all work together to offer support, ideas and advice.'

Gaynor: 'When this happens I discuss it with the team and we look at other approaches. Is there anything else we could try? In an MDT like this people often have different ideas of what we can try.'

'Risk takes priority'

Finally, all participants spoke of how matters of risk always need to be prioritised when there are indications of problems with engagement. In particular, if there are concerns regarding the safety of the service users or others, participants spoke of how this needs to take priority over the therapeutic relationship:

Lucy: 'Certainly if there is a risk of suicide or self-neglect then that primarily is something we need to concentrate on over anything else.'

Two participants gave specific examples to illustrate this:

Liz: 'Things changed a bit then, because I had to explain to him that while he is using cannabis he isn't able to have his daughter on his own because of the risk ... The health visitor was involved as well and was aware that he had bipolar and was using substances. That caused a bit of conflict between myself and the service user, because he thought "This is great. You were supposed to be here helping and supporting me and now you are referring my daughter into children's services". That was hard, but at the end of the day we have to prioritise the safety of children. I had to be upfront with him and say "this is just the way it is if you continue using drugs".'

Gaynor: 'We went up to the flat but couldn't get an answer and then we noticed that he had bolted himself in and we were concerned about his safety. The only option we had was to get the police to knock the door down, really. Turns out he wasn't actually in the flat anyway but it was a sign that he had become very paranoid. He was coming and going from the flat through a window. He came back to the flat and saw that the door had been smashed in and because I was his care co-ordinator and had called the police, things just deteriorated from there in terms of our relationship.'

- **3.4.2.2 Switching Service Users to Another Care Co-ordinator.**

There are also times when AO staff have made the decision to no longer act as a service user's care co-ordinator. In these situations, service users are passed onto another team member for management of their care. Participants spoke of such

decisions only being made when it was deemed to be in ‘the best interest’ of service users:

Lucy: ‘I know there have been times when people in the team have transferred a case to another care co-ordinator, but this is usually because it is in the best interest for the service user for one reason or another.’

Participants spoke of two situations where they would deem it to be in the best interest for them to stop working with a service user: **‘Becoming part of service users’ delusions’** and **‘Loss of service users’ trust’**.

‘Becoming part of service users’ delusions’

Two participants spoke of occasions when they had become part of service users’ delusions and needed to take the decision to transfer those specific service users to a different care co-ordinator in the AO service.

Liz: ‘It’s horrible as I have become part of her delusional belief system. She won’t work with me now and I’m not sure if that’s because she’s embarrassed or whether she believes that I’m still part of a paedophile ring (delusional belief). She is quite unwell. I have to stay away though, not because I don’t want to work with her but I realised that me being around her made things worse for her.’

Gaynor: ‘He became very paranoid and I became part of his paranoia because of what had happened (Care co-ordinator had telephoned the police to break into service user’s home). He was still getting on well with the support worker, so we were very careful not to involve the support worker in what had happened by making sure that he knew that it was I who had authorised the police to knock down the door. It ruined the relationship with me, unfortunately, so we had to transfer him to another member of the team. It was important to keep him engaged with the service, so it was something we had to do (transfer him to another care co-ordinator). He’s doing really well at the moment.’

‘Loss of service users’ trust’

The second reason given for transferring care to another care co-ordinator was loss of the service users’ trust. Four participants spoke of such experiences:

Jenny: ‘Because I’ve got her taken into hospital, she doesn’t want to be near me now. My relationship with her was excellent before that.’

Malcolm: ‘I’m not involved with him anymore, that’s his choice not mine. He thinks I accused him of lying when I didn’t. I respect his choice and there is no point in me carrying on if he doesn’t trust me as it will just antagonise the situation.’

However, participants did point out that they have never taken the decision to transfer a service user to another care co-ordinator because they no longer wanted to work with someone:

Liz: 'There have never been any times when I stopped working with someone because I decided I didn't want to anymore. I would only do that if it was detrimental to the service user that I continued working with them e.g. I was part of their delusions.'

Malcolm: 'To my knowledge we have never transferred someone to another care co-ordinator because that AO staff member no longer wanted to work with someone.'

- **3.4.2.3 Staff Resilience**

The final category in **Managing Challenges** is **Staff Resilience**. When discussing challenges in their work, participants reflected on some of the strategies used by AO staff to help them remain resilient when working with this challenging service user group. The sub-categories of '***Not taking things personally***', '***Being realistic***', and '***Knowing when to seek support***' were integrated into this category.

'Being realistic'

'Being realistic' refers to the importance of AO staff remaining realistic in their expectations of the service users they work with. Participants explained that it was important to recognise that setbacks are likely to occur when working with this service user group:

Liz: 'You are working with people with the aim of reducing hospital admissions but you have to remember that you are working with the most complex individuals, so at the end of the day they are going to be going back into hospital. You need to try and avoid getting that feeling that you have failed someone when they do have to go back into hospital.'

Jenny: 'I think that a misunderstanding about AO is that we will always be able to keep people out of hospital and that they are never going to become unwell. That's unrealistic; people do become unwell regardless of daily visits. We need to be realistic about this.'

'Not taking things personally'

This sub-category is closely linked with '***Being realistic***' and relates to the ability of staff to appreciate that challenges are inherent when working with a 'hard to engage' and complex service user group. Therefore, it is important that AO staff do not take the development of problems personally:

Gaynor: ‘Don’t take things personally. You’re not going to get on with everyone- that’s life.’

Paula: ‘One minute they are kind of saying they love the input, then the next minute they are saying it’s completely rubbish, that sort of thing. And it’s accepting that the reason you are working with them is because they are complex and not taking lashings to heart.’

‘Knowing when to seek support’

Finally, all participants identified the importance of seeking additional support in order to manage the personal impact of the work. This support may be in the form of supervision or peer support from colleagues in the team:

Liz: ‘You can also have supervision, too, if you want ... It is there if we need it but it’s up to the individual to ask for it now. It’s always there if you need it.’

Paula: ‘I think if you do start to take things hard then you need to realise this and use supervision too because it’s really important and you have to talk about these things.’

Ben: ‘You’re not isolated, you work as a team. You always have the support of your peers.’

Malcolm: ‘We share problems with the team and work through stuff together.’

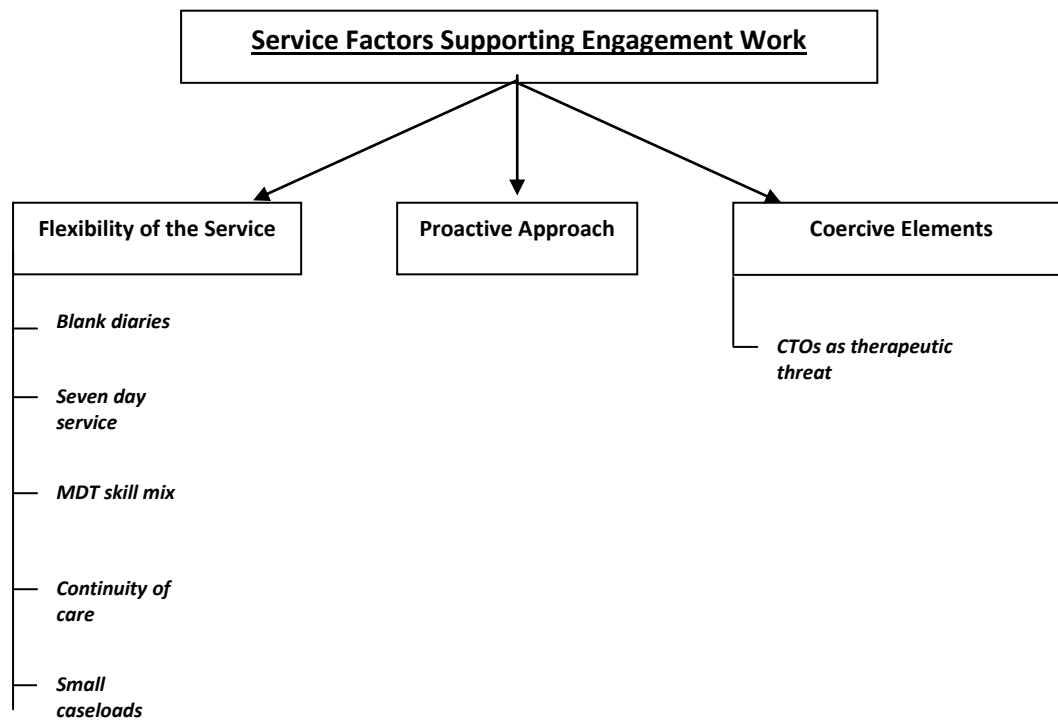
3.7 Theme Three: SERVICE FACTORS ENABLING ENGAGEMENT

SERVICE FACTORS ENABLING ENGAGEMENT is the final theme in this Grounded Theory account of how AO staff engage ‘hard to engage’ service users. This theme does not explain what AO staff do to clinically to engage service users but instead describes the various service factors which support AO staff to carry out the work described in the other two themes. Within this theme are two major categories: **Service Factors Supporting Engagement Work** and **Service Factors Maintaining Staff Wellbeing**. These major categories will now be discussed.

3.5.1 Service Factors Supporting Engagement Work

Service Factors Supporting Engagement Work illustrates the service context surrounding AO staff which supports their engagement work with service users. This major category is represented diagrammatically in Figure 3.9. Three categories emerged from the data: **Flexibility of the Service, Proactive Approach, and Coercive Elements**.

Figure 3.7 Diagrammatic representation of **Service Factors Supporting Engagement Work.**



- **3.5.1.1 Flexibility of the Service**

Flexibility of the Service is one category in **Service Factors Supporting Engagement Work.** This category integrates the various service factors that participants identified as helpful in supporting them to undertake engagement work with service users.

‘Blank diaries’

Many of the participants identified that it was important that the AO service encouraged them to keep their work diaries free of clinical appointments as far as possible. This was important as it enables AO staff to manage appointments on a day-to-day basis with the ability to respond quickly to those service users who most require visits on that particular day:

Suzie: ‘We leave our diaries clear so that we can work appointments on a day-to-day basis which helps to keep appointments flexible. If someone calls then, to say they are feeling unwell, and asks if someone can go see them, we can go out straight away to see them.’

Liz: ‘We can respond to people quickly with regards to visits as our diaries are flexible’

Lucy: 'We have flexibility with appointments because we keep our diaries empty.'

'Seven day service'

In addition to blank diaries, two of the AO services included in this study operated a seven day service. This was identified by participants working in those two services (n=6) as an important service factor, particularly with regard to their ability to be flexible with appointments (see **Tactics to Facilitate Contact between Staff and Service Users**) and to take positive risks with service users (see **Strategies to Minimise Challenges**):

Suzie: 'We are a lot more flexible with them, we work weekends.'

Lucy: 'We work seven days a week so can see service users on the weekend as well.'

Jenny: 'We cover every day in the year.'

'MDT skills mix'

The usefulness of working within a team with a good range of multi-disciplinary skills was also identified as a helpful service factor in enabling services to tailor AO input to the specific needs of each service user:

Lucy: 'Because we have a good MDT, we can organize input around what the individual needs.'

Paula: 'We've got a range of staff in the team, so we can make sure people get input from those that they need, e.g. nurses if they have medication needs, etc.'

'Continuity of care'

Another important service factor for supporting the engagement of service users was related to the team approach that AO operates. In AO services, service users are able to receive visits from AO staff even when their care co-ordinator is on annual leave, sick leave or is unable to visit the service user for any other reason. This was identified by participants as an important service factor as it ensured service users were never left without a service in the absence of their care co-ordinator:

Paula: 'I think they have continuity of care, as everyone working with all service users means they never go without input, say if somebody's off sick or just on leave. It provides them with the continuity of support.'

Jenny: ‘We know them (service users) all practically, so if one of us is off because of the shift pattern ... we can cover each others patents.’

‘Small caseloads’

Finally, the fact that AO services carry small caseloads in order to allow them to work intensively with service users, was identified by participants as an important service factor for engagement work:

Jenny: ‘They wouldn’t get that support in a CMHT, but because we have small caseloads we can do it.’

Lucy: ‘Because our caseloads are small, we can provide a lot more time to people.’

Ben: ‘We have a luxury of a smaller client group, meaning we can spend more time with people.’

‘Small caseloads’ was identified by participants as being a supportive factor for enabling AO staff to work in a person-centred way (**Being Person Centred**) and to work flexibly with service users (**Flexibility**):

Liz: ‘When I worked in community mental health services, we all had really high caseloads and you never had the time to really get to know that person. It was very much led by “Are they meeting their medication?” We needed to keep them well. We just didn’t have the time to explore who that person really was. In AO you have the opportunity to really get to know the individuals you work with.’

Paula: ‘We have the luxury of smaller caseloads, and that means you can be far more flexible with how you see people. I’ve had many times with a number of different clients where they have not been there when I’ve gone to their house. Where teams have large caseloads they wouldn’t be able to try again for a couple of weeks whereas we’d work it where I can kind of try on the next day.’

- **3.5.1.2 Proactive Approach**

Proactive Approach emerged through the analysis as a category on its own. It emerged as an important aspect of AO services for supporting engagement work. Participants identified the proactive approach as a key difference between the way that AO services and CMHTs operate:

Malcolm: ‘We do not have to run around constantly putting out fires like people sometimes have to do in CMHT. We are proactive in our approach. We deal with problems before they really start.’

Paula: 'We're very proactive in our work. Because we know people well, we can recognize early signs of problems. For various reasons, it's harder for CMHTs to work with such a proactive approach.'

Ben: 'Because we work intensively, we can deal with problems early on. This is a difference between AO and CMHT. I'm sure CMHTs would like to be more proactive, but they can't really, because of their caseloads'.

- **3.5.1.3 Coercive Elements**

Surprisingly, another service aspect that was identified as being supportive for engagement was the coercive elements such as Compulsory Treatment Orders (CTOs).

'CTOs as therapeutic threats'

Many participants spoke of the usefulness of CTOs early in the engagement process for persuading some of the more resistant service users to engage with AO:

Suzie: 'We sometimes have service users referred who are on a CTO and as part of their CTO on their care plan they are expected to engage with AO. So there is that element too, sometimes. It can be a powerful motivator, as awful as it sounds, for the people who are quite ill and risky. It's a fabulous tool, really, because they don't tend to disengage with us then. They don't want to come back into hospital.'

Ben: 'CTOs can help with initial engagement, as engaging with us is often part of the conditions. I think once service users begin to work with us this changes and they engage more because they want to, then, not because they have to.'

Participants spoke of CTOs being a 'powerful motivator' for some service users to engage with AO. This was because a consequence of not engaging with AO could mean them being recalled to hospital for breaching the conditions of their CTO. Participants therefore admitted sometimes using the CTO as a form of 'therapeutic threat':

Suzie: 'It helps sometimes when they are on a community treatment order because they are in breach if they are not engaging with us. It's a 'therapeutic threat' as we would have to call them back into hospital if they do not engage with us.'

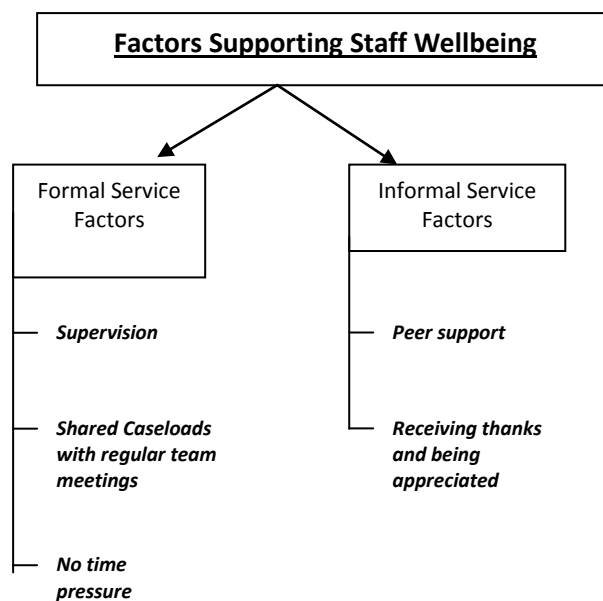
Paula: 'We've used the boundary of the CTO to say "you have to see staff because it could lead to recall if you don't see the team".'

Ben: 'People are very reluctant to go back into hospital, so this is sometimes there in the background as a motivator to engage with us.'

3.5.2 Factors Supporting Staff Wellbeing

Factors Supporting Staff Wellbeing illustrates the service factors which minimise AO staff's stress levels and supports them to maintain their wellbeing when working with a challenging service user group. This major category is represented diagrammatically in Figure 3.10. Two categories emerged from the data: **Formal Service Factors**, and **Informal Service Factors**.

Figure 3.8 Diagrammatic representation of **Factors Supporting Staff Wellbeing**.



- **3.5.2.1 Formal Service Factors**

Formal Service Factors refers to the various aspects of AO services which have been formally specified in AO service documentation. Within this category is a range of sub-categories which were identified by participants as being supportive for staff wellbeing.

'Supervision'

Four of the participants identified supervision as important in helping them to manage the personal impact of their clinical work:

Gaynor: 'It can start to get to me when I think I invest so much in the job... And then it goes wrong. But you just need to have some time out and to take things like that to supervision ... You need to have that avenue to release it.'

Paula: 'Supervision is important to help you talk through things you're finding hard'

Lucy: ‘Supervision is available to help us manage the personal impact of working with these service users.’

However, two participants did not see this value of formal supervision:

Ben: ‘I tend to just go to my manager then and there if I need to discuss something or feel I need support with, so I don’t wait for supervision to do this, anyway. Personally, I don’t really get that much from supervision but I know we have to have it.’

Malcolm: ‘We do all our supervision in the weekly team meetings as far as I’m concerned. If I have a problem I take it to the team meeting.’

In these examples, both participants did however acknowledge that formal systems of support were available for them if needed. In addition, at the time of this study, one of the participating AO services no longer had a dedicated Clinical Psychologist or Consultant Psychiatrist in the team due to the service being in the process of disbanding in that particular area.

‘Shared caseloads with regular team meetings’

Another formal service factor that was identified as being helpful for staff wellbeing was the fact that AO services operated shared caseloads and had regular (at least once weekly) team meetings in which all service users were discussed. In particular, participants spoke of how this supported them to manage the personal impact of the job:

Suzie: ‘We work with a team approach and this really helps stop you from taking things personally e.g. risk assessments are done as a team, moving on formulations are done as a team, as are risk formulations and engagement formulations. You don’t have to hold any responsibility on your own.’

Gaynor: ‘The approach of the AO team means that you are not on your own. When you are a care co-ordinator in the CMHT, you carry the buck on your own and you’re isolated. Here you aren’t. In this team we have weekly meetings to run through everyone we are working with so that we share concerns. We get support from other members of the team. It’s a team approach and that really, really helps.’

Jenny: ‘We usually discuss our whiteboards (with all patients listed on it) on a daily basis ... On a Thursday morning we discuss everyone with the consultant.’

‘No time pressures’

In addition, participants acknowledged that they did not experience any service pressure with regard to the time they invested in working with individuals:

Paula: 'I think it is easier, again, as we have the luxury of having time with this team.'

Jenny: 'I've had somebody started with me 5 years ago and if I was here another 5 years I would probably have that same person. There's no time frame here, really.'

In addition to being a sub-category in **Factors for Maintaining Staff Wellbeing**, the importance of time has also been identified as a sub-category in **Developing Trust**.

- **3.5.2.2 Informal Service Factors**

Informal Service Factors emerged as a category in **Factors for Maintaining Staff Wellbeing**. Within this category are the sub-categories of ***'Peer support'*** and ***'Receiving thanks and being appreciated'***.

'Peer support'

'Peer support' emerged as an important informal service factor for maintaining staff wellbeing. Participants spoke of the support they received from their team colleagues and how this helped them to manage the personal impact of their work:

Liz: 'It is tough to deal with when things don't go to plan but you just have to off load to others in the team. It's ok to discuss things with the team and to let off steam a bit.'

Jenny: 'Most of us tend to try and talk amongst ourselves, anyway, so if there are things up and coming, we discuss it on a daily basis.'

Malcolm: 'I get a lot of support from colleagues in this team, so it doesn't really matter that we are not having regular supervision at the moment.'

'Receiving thanks and being appreciated'

'Receiving thanks and being appreciated' is the second sub-category of **Informal Service Factors**. Two participants spoke of occasions when service users had personally thanked them for their input:

Gaynor: 'He's not a man of many words, but he has often texted to say "thank you for helping me with this" or "I really appreciated you doing this for me".'

Liz: 'People are generally very thankful towards AO whereas, I worked for years in a CMHT and I can't remember anything like that happening there. There was no "thank you for what you have done or what you are doing to help me".'

This highlights that AO staff value the experience of receiving thanks from service users and that this was something they had not experienced when working in a CMHT.

CHAPTER FOUR: DISCUSSION

4.1 OVERVIEW

The purpose of the current study was to add to the existing literature regarding the understanding of the engagement process in Assertive Outreach (AO). To date, much of the existing research into this area has focused on the service elements of AO that allow for therapeutic relationships to develop between AO staff and service users. This current study was designed to develop a better understanding of the engagement process by exploring the specific techniques and strategies that AO staff use to build and maintain their effective therapeutic relationships with 'hard to engage' service users. It is hoped that through this study the successful key elements of the work of AO staff will become more transparent.

Eight AO staff from varying disciplines, and from three different AO Adult Mental Health services in South East Wales, were interviewed about their experiences of engaging 'hard to engage' service users. An analysis of these interviews identified three themes: **BUILDING THE THERAPEUTIC RELATIONSHIP, MAINTAINING THE THERAPEUTIC RELATIONSHIP**, and **SERVICE FACTORS ENABLING ENGAGEMENT**. In this chapter the researcher will discuss each of these themes in turn with reference to existing research and literature. The researcher will then reflect on the strengths and limitations of this study and will consider the implications for clinical practice and services. Suggestions for further research will also be provided.

4.2 DISCUSSION OF RESEARCH RESULTS

4.2.1 Theme One: **BUILDING THE THERAPEUTIC RELATIONSHIP**

This theme conceptualises important approaches, strategies, and personal qualities of AO staff that help them build therapeutic relationships with service users.

- **4.2.1.1 Staff Working Style**

In terms of the approaches that AO staff take in their work, it emerged that a collaborative person-centred approach was most important for engaging 'hard to engage' service users. In addition to this, AO staff attempt to take on more of a role

as personal mentor or coach when working with service users as opposed to being a 'mental health professional'.

Collaboration

Participants spoke of attempting to establish genuine collaborative relationships with their service users by facilitating the process of joint working and by sharing, with the service user, the control and power over decisions regarding service input.

Participants explained that they achieve effective collaborative working through techniques such as negotiating with each service user regarding their contact with services (e.g. appointment times, frequency and locations) and completing paperwork with service users' involvement. Genuinely involving service users in the completion of care plans has been referred to in the engagement literature as a technique to emphasise the collaborative nature of therapy (Griffiths *et al.*, 2011) and to reduce the perception of mental health services as coercive (Wharne & Spilsted, 2011). The provision of Compulsory Treatment Orders (CTOs) is an explicitly coercive means to address problems in engagement with services that is utilised by AO. Participants in this study spoke of the importance of negotiating as far as possible with service users regarding their CTOs to help minimise the perception of such measures as being coercive. Research has suggested that service users are less likely to engage with services if they feel they are being controlled (Bradley *et al.*, 2006).

The importance of collaborative working as a way of improving engagement is not a new concept. Collaboration was identified by Rogers (1957) as an important factor to establish in therapy. Hardy *et al.* (2007) also identify the establishing of a collaborative framework as a key technique for developing and maintaining the therapeutic relationship. Hardy *et al.* (2007) proposes that facilitating service users to hold some power over their recovery process is an important factor in engagement. The importance of collaboration has also been identified in recent studies exploring engagement from the perspectives of both AO staff (Addis & Gamble, 2004; Wright *et al.*, 2011) and AO service users (Priebe *et al.*, 2005; Wright *et al.*, 2011). Collaboration is also an important concept within the Recovery Model (Perkins & Repper, 2003).

Being Person-Centred

Taking a person-centred approach and organising AO service input to meet the specific needs of each service user was another key approach of AO staff identified through analysis. In order to achieve this, participants highlighted the importance of getting to know individual service users well and also working to a strengths model as opposed to the more traditional medical model of mental health services. In addition, AO staff also take time to discover the personal goals of each service user so that these could be prioritised over those of the staff/service. In order to enhance this person-centred process, participants also spoke of how their AO team deliberately attempted to match service users up with AO staff who shared similar interests or who had similar personalities. Adopting a person-centred approach has been recognised as a key factor for AO engagement in recent studies, particularly when service users feel: that they are treated as individuals (Bradley *et al.*, 2006); that they are understood by AO staff (Wright *et al.*, 2011); and also when the focus of input is shifted away from medication (Priebe *et al.*, 2005). This approach is again consistent with the Recovery model of mental health service delivery.

Mentoring/Coaching

The third tactic that emerged from the analysis was a '**Mentoring/Coaching**' approach. Participants said that for this to take place, it was important to achieve a balance between being a 'friend' and being a 'professional' in their relationships with service users (*'being a friendly professional'*). Staff achieved this through techniques such as *'personal disclosure'* of their own lives and personal experiences, and by *'providing practical support and advice'* to help with service users' social and financial problems. This approach is congruent with the idea that mental health professionals should shift from a position of 'expertise' to a role of a 'personal coach' as highlighted in the Recovery model. The '**Mentoring/Coaching**' approach was also identified in this research as a key supportive factor for enabling service users to take on board AO staff's advice with regards to medication compliance. This approach has some similarities to Addis and Gamble's (2004) theme of 'being the human-professional confluence' where AO staff spoke about the importance of 'showing the more human side of myself' and discarding some of their walls of professionalism in order to help service users relate to them. Maintaining strict professional-service-user boundaries at all times is suggested to be an

inhibiting factor for engagement (Steer & Onyett, 2011). Help with practical day-to-day issues such as finances was also identified by service users as being a factor that supported their engagement with mental health services (Priebe *et al.*, 2005). It is also one of the operating principles of the original Assertive Community Treatment (ACT) model (Stein & Test, 1980).

However, participants in the current study also suggested that it was important to remember that they were members of staff and therefore needed to maintain professional boundaries at all times in their work with service users. This helped them to manage some of the risks associated with working with their service user group. Participants were able to give specific examples of when they took decisions that they knew would upset the service users because it was necessary in terms of managing risks. This is an important factor as it indicates that AO staff appear to be fully aware of the important difference between ‘friendships’ and ‘therapeutic relationships’. Assertive outreach staff operate according to their professional codes of conduct and operational policies. The ability to maintain a friendly approach whilst managing professional boundaries has been identified in the literature as one of the qualities AO staff need to possess in order to manage the challenges and dilemmas of working with this service user group (Steer & Onyett, 2011).

- **4.2.1.2 Tactics to Facilitate Contact between Staff and Service Users**

It emerged from the analysis that the three main ‘tactics’ that AO staff use to facilitate contact between staff and service users were: **Developing Trust, Perseverance and Flexibility.**

Developing Trust

In order to help staff develop a trusting relationship with service users, participants spoke of needing to have regular contact with the service user. Showing service users the benefits of engaging with the service while at the same time dealing with some of the stigma that often surrounds AO services (e.g. intrusive input and increasing the likelihood of being recalled into hospital) helps the process of engagement. The concepts of ‘sticking to your word’, listening to what the service user had to say, and being able to invest time were also identified as important techniques for developing trusting relationships between AO staff and service users.

Developing a trusting relationship between a service user and a clinician is the second stage of Hardy *et al.*'s. (2007) model of engagement. Within this model, trust is identified as a factor for facilitating the service user's willingness to work with the therapist. Through addressing the stigma of AO services and showing some of the benefits of working with AO, it is possible that, in addition to gaining the trust of service users, AO staff are also increasing a service user's level of hope in recovery. Increasing a service user's hope in recovery is a key element of Hardy *et al.*'s. (2007) model of engagement. Individuals with high levels of hope are more likely to achieve their recovery goals in comparison to individuals with low hope (Snyder, 2002).

Participants highlighted the fact that building a trusting relationship was an individual process and that there was no fixed time frame allocated to this element of engagement. The importance of investing time in building therapeutic relationships with service users has already been identified in the engagement literature (Griffiths *et al.*, 2011). It has also been recognised in both qualitative (Addis & Gamble, 2004; Hughes *et al.*, 2011; Priebe *et al.*, 2005) and quantitative research (Frank & Gunderson, 1990) exploring the engagement process in AO services. The importance of AO staff 'listening' to service users has also been highlighted by both AO staff and AO service users as an important factor in the engagement process in recent research (Priebe *et al.*, 2005; Wright *et al.*, 2011).

Perseverance

Perseverance emerged as the second major tactic used by participants to engage service users. All participants spoke of the importance of persisting when attempting to build relationships with 'hard to engage' service users. In addition, participants spoke of the importance of being creative with their persistent attempts to engage service users and the helpfulness of finding a specific area which would enable them to connect with that particular service user (e.g. service users' individual interests or hobbies). Perseverance as a strategy for engagement is a similar theme to that of 'Anticipatory persistence and tired dejection' identified in a previous study exploring engagement from the perspective of nurses working within AO (Addis & Gamble, 2004). In Addis and Gamble's (2004) study, AO staff also spoke about the importance of not giving up in their attempts to engage service users. Persistence and creativity have also been identified in the engagement literature as important

staff characteristics for promoting effective working relationships with service users (Steer & Onyett, 2011).

Flexibility

In addition to being persistent, **Flexibility** also emerged as a significant tactic for encouraging engagement. In this sense, flexibility refers to the way in which AO service input is provided for each service user. Participants achieved this flexibility through offering choice in terms of days, times, locations and methods of contact between service users and AO staff. The offering of choice in terms of days, times and locations for appointments is a core feature of AO service provision (Sainsbury Centre for Mental Health, 2001) and has been referred to in the literature as a supportive factor for effective treatment intervention (Molodynski & Burns, 2011).

In addition, professionals from two of the AO services included in this study spoke about the importance of choice with regard to contact methods between service users and AO staff. For example, staff in two of the three AO services in this study provided service users with their work mobile numbers in addition to the main service contact number. This was identified as being a crucial aspect for enabling the service user to have some control over when and how they were able to contact AO staff. Furthermore, in one of the participating AO services, staff were also able to share work email addresses with service users if they felt this would be useful. One participant shared a specific example to show how this enabled a service user to share important case information in an email that they felt unable to speak about during face-to-face contact. Participants in these two particular AO services reflected on how they felt these additional contact methods had a beneficial effect on the engagement process. By allowing for flexibility in contact methods, AO staff may be facilitating service users to remain in regular contact. Regular contact has been identified as a necessary factor for engagement to take place (Wright *et al.*, 2011). In addition, service users have also highlighted the fact that 'AO staff are easy to contact' as a supportive factor for engagement with AO services (Priebe *et al.*, 2005).

- **4.2.1.3 Personal Qualities of Staff**

Through the analysis, being non-judgemental and having a dedication to work emerged as particularly desirable personal qualities of AO staff.

Non-Judgemental

Participants spoke of the importance of recognising how mental health symptoms influence a service user's behaviour and of the need to ignore previous service reputations of service users in order to avoid judging them. This allowed AO staff to begin from 'a blank slate' in their relationship building with service users and to view difficult behaviour in the context of the individual's mental health difficulties as opposed to their 'personality'. 'Passing negative judgement' on service users may impact negatively on the relationship building process. Being non-judgemental has already been suggested in the literature as an important quality for AO staff (Steer & Onyett, 2011). In a recent study, service users suggested that being 'non-judgemental' was an important personal quality for AO staff (Bradley *et al.*, 2006). Being non-judgemental also appears to be an important staff quality given the multiple difficulties that AO service users often experience (e.g. repeated offending, substance misuse, violent behaviour), especially since wider society often reacts to this group of service users in a way that may be rejecting (Rose, 1996).

Dedication

Dedication was also identified as a desirable staff quality for engagement. In particular, all participants spoke of their willingness and ability to go over and above what would normally be expected of them, or possible for them, for example if they worked in a CMHT. In this study, '**Dedication**' may be similar to the quality of 'Commitment' which has been suggested in the AO literature as a significant staff quality for developing effective relationships over longer time frames (Steer & Onyett, 2011). In addition, the commitment of AO staff has been recognised as a quality valued by AO service users (Priebe *et al.*, 2005) and carers of AO service users (Hughes *et al.*, 2011).

4.2.2 Theme two: MAINTAINING THE THERAPEUTIC RELATIONSHIP

This theme illustrates the important strategies that AO staff use to minimise and manage challenges with service users in order to maintain their engagement.

- **4.2.2.1 Strategies to Minimise Challenges**

In order to minimise the occurrence of challenges within their relationships with service users, **Advance Preparation**, **Positive Risk Taking**, and **Validating Progress** of service users over the course of AO input emerged as important strategies used by AO staff.

Advance Preparation

In order to help them prepare in advance for problems, participants spoke of developing advance agreements/plans with service users over what would happen if AO staff became concerned over their wellbeing. Psychological formulation was also identified by participants as a way to help staff understand engagement problems, identify and manage risks, and also to generate ideas for responding to engagement difficulties.

In **Advance Preparation**, participants said that it was important for AO staff to engage in discussions with service users from the beginning of AO input. Discussion over what would cause staff to become concerned and how they were likely to respond on such occasions was imperative. As part of these conversations, service users were encouraged to share their own views of what they would like to happen if their mental health started to deteriorate so that their wishes could be taken into consideration as far as possible. The importance of advance preparation has not previously been identified in AO engagement research. However, such advanced discussions with service users may also be an important method for further enhancing the collaborative nature of the relationship between AO staff and service users. Collaboration is an important part of engagement (Addis & Gamble, 2004; Bradley *et al*, 2006; Priebe *et al.*, 2005; Wright *et al.*, 2011). Strengthening the collaborative nature of the therapeutic relationship is also identified in the third stage of Hardy *et al*'s (2007) model of engagement in order to maintain the service user's satisfaction with the intervention.

Psychological formulation has been increasingly emphasised as an important basis for any intervention with people experiencing mental health problems (Whomsley, 2010). In addition, the development of team formulations can help foster empathy to facilitate staff to use interventions appropriately with service users (Wane *et al.*, 2009) and also to enable staff to respond flexibly, to build trusting relationships, and to empower service users (Wharne & Spilsted, 2011). Risk formulations can be an important factor for increasing a team's confidence in working with 'hard to engage' and complex service users (Bowes & Jones, 2005).

Taking Positive Risks

'Positive risk taking' refers to the ability of AO staff to enable service users to make and carry out their own choices, even when staff do not agree with these choices or fear they may lead to problems (Steer & Onyett, 2011). Many of the participants in this study spoke of their willingness to take risks with AO service users as being beneficial for engagement. In particular, AO staff said that allowing service users to remain in the community and not recalling them to hospital at times when there were early indications of problems was of key importance in maintaining trust. Participants reported that they believed that such risk taking was a key difference between the AO service and CMHTs. Participants recognised that a factor enabling them to take such risks without having to recall individuals unnecessarily to hospital was the AO services' ability to provide intensive seven day support to service users. Risk taking is an important part of facilitating service users to increase their level of confidence and independence in managing their own mental health (Steer & Onyett, 2011). Enabling them to realise that they, rather than services, hold the power over their recovery may be one way of reducing service users' dependency on service input. This is important as 'creating dependency on service input' is a frequent criticism of the AO approach.

Other important elements of positive risk taking were allowing service users the opportunity to openly discuss their mental health symptoms and to 'vent their frustrations' to AO staff without feeling judged and without this being interpreted as a risk issue. The opportunity to speak freely and openly about mental health symptoms to AO staff has been identified by service users in Pirebe *et al.* (2005) as a factor for promoting a partnership model for the therapeutic relationship. Supporting service

users to openly express emotions via the therapeutic relationship is also part of Hardy *et al's.* (2007) model of engagement.

Validating Progress

Validating Progress emerged as a third strategy used by AO staff for minimising challenges to the therapeutic relationship. As part of this strategy, participants spoke of how it was important to recognise all achievements, no matter how small, that AO service users make over the course of their engagement with AO services. As an example of validating service user progress, participants talked about reducing the frequency of AO visits and contact with service users. The importance of validating service users' progress has not been discussed within the AO literature as such, but reducing the frequency of visits has been suggested as a method for reducing service user dependence on AO in preparation for discharge from AO services (Gillespie & Meaden, 2010).

- **4.2.2.2 Managing Challenges**

The ability to respond quickly to difficulties with service users and the possibility of switching the care of service users from one care co-ordinator to another in the AO team, emerged as strategies that could be used to manage various challenges to the therapeutic relationship. In addition, participants also identified the importance of AO staff remaining resilient in order to manage the personal impact of such challenges in their work with service users.

Responding to challenges

Participants spoke of the importance of being able to recognise early indications of problems in their relationships with service users and to respond quickly to such indications by first re-establishing contact and then establishing what the problem is. Alongside this work, participants also spoke about needing to take back some of the control from participants at this point in the engagement process, particularly with regards to ceasing negotiation around appointment decisions. Participants also highlighted the fact that they would often utilise their team colleagues at this point to help them think through problems and generate ideas of how best to respond. Finally, all participants stressed the fact that matters of risk would always take priority at this point in the engagement process, even if this meant risking the

therapeutic relationship. Although these specific techniques have not previously been referred to in AO engagement research, they have some similarities to the notion of identifying and repairing possible ruptures to the therapeutic relationship as mentioned as part of the engagement process in Hardy *et al's* (2007) model.

Switching to another Care Co-ordinator

In addition to responding to challenges, some participants also told of the rare occasion when AO staff took the decision to end their relationship with a particular service user and to transfer their care to another care co-ordinator in the AO team. Such actions were only taken when it was deemed to be in the best interests of the service user, that is, if the AO staff member had become part of a service user's delusions or if a service user had lost trust in that particular care co-ordinator. Research has highlighted the fact that the loss of trust in a therapist is often detrimental to the therapeutic relationship (Lehay, 2008). In the current study, such decisions to transfer service users to another care co-ordinator were taken in order to preserve service users' engagement with the AO service.

Staff Resilience

Finally, in order to manage the challenges of working with their service user group, participants reflected on some of the techniques used by AO staff to reduce the personal impact of such challenges. Participants spoke of the importance of not taking things personally by recognising that challenges are inherent when working with a 'hard to engage' and complex service user group and also the importance of being realistic in their expectations of service users. For example, participants spoke of the need to remember that the characteristics of the service user group meant it was likely that many service users would be recalled into hospital at some point and that this was not a reflection of any failure on the part of AO staff. In addition, participants also highlighted the fact that it was important that they recognised occasions when they were finding their work difficult emotionally so that they could seek additional support from their colleagues in the AO team or via formal supervision.

It is well established in the AO literature that the intensive nature of AO work can impose high levels of stress on staff working in these services (Steer & Onyett,

2011). The ability to appropriately express and contain feelings that may be triggered when working in such challenging situations has therefore been suggested as a desirable staff quality for AO work (Steer & Onyett, 2011). Many of the AO service factors such as supervision, the team approach, and peer support from colleagues have been identified in research as aspects vital to enable staff to contain the emotional impact of their work (Gray & Lavender, 2001) and to protect staff from experiencing burnout (Bakker *et al.*, 2000; Leiter & Lashinger, 2006). The service factors of AO that are supportive for staff well-being will be discussed in greater detail in the third theme.

4.2.3 Theme three: SERVICE FACTORS ENABLING ENGAGEMENT.

This theme illustrates the service context surrounding AO staff which supports their engagement work with service users. This is the area where most of the existing research exploring engagement in AO services has focused to date.

- **4.2.3.1 Service Factors Supporting Engagement Work.**

The main service factors supporting the engagement work of AO staff that emerged through analysis were: **Flexibility of the Service**, **Proactive Approach**, and the **Coercive Elements** of the service.

Flexibility of the Service

One important service element of AO that emerged through analysis is its ability to provide a flexible service by operating as a seven day service, having a good mix of professionals working within the team, and having small caseloads. Participants also identified the fact that the flexibility of the service is further enhanced by staff keeping their work diaries free of set appointments thereby enabling them to arrange appointments on a daily basis, based on whichever service users needed to be visited on that particular day. In addition, the team approach of AO also enables the service to maintain a continuity of care for all service users by ensuring that service users are able to receive input from the service regardless of whether a particular staff member is present on that specific day.

Proactive Approach

In addition to its flexibility, the AO service also takes a proactive approach to the care it provides for service users. Participants believed that this was another key difference between AO services and the way that CMHTs operate. For example, participants spoke of their ability to identify and respond to problems in their very early stages as opposed to having to focus on 'crisis management'. Participants believed this was due to the intensive support that the AO service is able to provide for service users and also the fact that AO staff are managing smaller caseloads in comparison to their colleagues in CMHTs. Small caseloads has been identified in the literature as important for allowing the development of a relationship which is not crisis driven and may in turn lead to greater engagement and retention in treatment (Molodynski & Burns, 2011).

Coercive Elements

Surprisingly, the coercive elements of AO services, specifically the use of Compulsory Treatment Orders (CTOs), were identified by participants as a supportive factor for engagement in the initial stages of the therapeutic relationship. Participants explained that 'engaging with the AO service' can often be specified as a condition of a service user's CTO. This can then be used as a form of 'therapeutic threat' to persuade resistant service users to meet with AO staff when they are attempting to build a relationship with them. Service users will be aware at this point that they will be recalled into hospital for breaching their CTO if they continue to refuse to meet with AO staff. However, participants who spoke of this element of AO services further elaborated that this strategy would only be used in the very early stages of the engagement work in order to encourage resistant service users to agree to meet with AO staff initially. Participants explained that once they were able to meet with the service users, they would then rely on the techniques and strategies outlined in '**BUILDING THE THERAPEUTIC RELATIONSHIP**' to further engage service users. This finding is interesting as there are some concerns that the use of CTOs may have a negative impact upon the therapeutic relationship (Firn & Molodynski, 2011).

Many of the service factors discussed above (small caseloads, multi disciplinary team (MDT) working , and high rates of home visiting) are consistent with the original

ACT model (Stein & Test, 1980) and have already been widely reported in the AO literature and research as important service characteristics for engaging 'hard to engage service users' (Gillespie & Meaden, 2010; Gillespie *et al.*, 2004; Lukeman, 2003; McGrew *et al.*, 1994; Priebe *et al.*, 2005; Sainsbury Centre for Mental Health, 1998). Such findings have now led to a general consensus regarding the core elements of a successful AO service, as discussed in Chapter One of this thesis. However, this study has attempted to add a further dimension to the existing knowledge in this area by providing a suggested framework/model to demonstrate why these service factors are supportive for engagement and how they enable AO staff to engage service users in their day-to-day working practice.

- **4.2.3.2 Factors Supporting Staff Wellbeing**

It has already been identified that the reality of working with a complex and 'hard to engage' service user group can have an adverse impact on AO staff wellbeing. However, a range of formal and informal AO service factors emerged through analysis as being protective for AO staff wellbeing.

Formal Service Factors

In terms of **Formal Service Factors**, participants reflected that the way in which AO services operate, i.e. a team approach with shared caseloads, regular team meetings to discuss all service users, and the lack of time pressures, were all helpful for enabling staff to manage their work-stress levels. In addition, some participants also spoke of the importance of formal supervision as a further service element that was supportive for staff wellbeing, although there was some disagreement amongst participants in relation to this. Despite all participants agreeing that formal supervision was a necessary service factor, some felt that they were able to achieve the support necessary to manage the personal impact of their AO work through the team meetings alone. These participants believed that they did not really benefit from individual supervision in the same way that they did from the regular team meetings. It is worth bearing in mind, however, that these participants also reflected that formal one-to-one supervision was not regularly provided as standard in their service and that it was up to individual AO staff to seek supervision if they felt they required it. Also, one of the AO services utilised in this study no longer had a dedicated Consultant Psychiatrist or Clinical Psychologist in the team at the time this

study was undertaken as the team was in the process of being disbanded, possibly as a result of funding decisions and service re-organisation. It is possible that this is likely to have an impact on the provision of and availability of clinical supervision in this service and may in turn have influenced participants' views of supervision.

Formal supervision is well documented within AO and engagement literature as an important factor for: improving clinical practice (Steer & Onyett, 2011), supporting engagement work with service users (Gray & Johanson, 2010; Kennard & Hartley, 2009; Leahy, 2008), and for supporting staff well-being (Gray & Lavender, 2001; Gray & Mulligan, 2010; Griffiths *et al.*, 2011; Melchior *et al.*, 1997).

Informal Service Factors

Informal AO service elements that appeared protective for staff wellbeing were the availability of peer support from their team colleagues through the team approach, and the occasions when AO staff received messages of thanks from their service users. Participants spoke of many occasions where they had turned to their colleagues in the AO service for support to manage the personal impact of their work with service users. The fact that AO services operate a 'whole team' approach with regular team meetings, daily handovers, and team formulations is likely to mean that participants have regular opportunities to discuss challenges with their colleagues and to have their emotions contained by the team. The team approach, where there are shared assessments and decision-making, can also help to reduce staff anxiety regarding risk management in the context of working with service users with complex needs (Bowes & Jones, 2005). Working within a team has also been shown to contribute towards the improved mental health of staff (Gray & Lavender, 2001; Sonnentag, 1996) and enhanced staff performance (Kallerberg & Moody, 1994).

Some participants also told of occasions when they had received personal messages of thanks from service users for the input and support they had provided. These participants spoke of how such messages had had a positive impact upon the way in which they viewed their work in the AO service. One participant also disclosed that she had never received any thanks from service users when working in a CMHT. Receiving thanks from service users may result in a greater sense of

work-related satisfaction. Greater work satisfaction may lead to a closer therapeutic alliance with service users (Addis & Gamble, 2004).

4.3 STRENGTHS OF THE STUDY

This research reflects the experiences of the eight members of AO staff interviewed and has used a well-established qualitative methodology to provide further insight into an under-researched area. Although this currently remains an under-researched area of AO, some recent published studies have attempted to further explore the engagement process from the perspectives of: AO service users (Priebe *et al.*, 2005; Wright *et al.*, 2011), AO staff (Addis & Gamble, 2004; Wright *et al.*, 2011), and carers (Hughes *et al.*, 2011). This research supports some of the findings in these studies including the importance of collaboration, adopting a mentoring approach, perseverance, flexibility, and the commitment/dedication of AO staff.

Addis and Gamble's (2004) study previously attempted to capture AO nurses' lived experiences of AO engagement through in-depth interviews with five nurses working within one rural AO service. Although the current study also explores the engagement process from the perspective of AO staff, its sample is larger (n=8) and has been drawn from three different AO teams of varying location and structure. In addition, the participant sample for the current study also includes AO staff of varying professional backgrounds (e.g. nurses, a social worker, and an occupational therapist). Such factors may enhance the validity and reliability of the findings of this current research.

The findings of this research support those of the existing research looking at the important service elements of AO that allow for the development of effective therapeutic relationships between AO staff and service users. They also provide some new insights into the specific approaches, techniques and strategies used by AO staff to build and maintain engagement with service users. The findings of this research have also identified some of the personal qualities that are said to be desirable for staff working in AO services to help support engagement work and also to reduce the personal impact of such work on AO staff. The current study has

therefore attempted to create a transparent framework of the key ingredients required for the engagement of 'hard to engage' service users in a way that has not previously been attempted in existing research exploring the engagement process in AO services (e.g. Addis & Gamble, 2004). The current study has, however, used the conclusions from existing research to help contextualise new findings.

These findings are relevant to service commissioners and service managers for thinking about how services can be organised to improve the engagement of 'hard to engage' service users within mental health services. Findings may also be helpful for mental health staff working with such service users, who wish to improve their clinical practice of engaging with 'hard to engage' service users.

Finally, an additional strength of this study is the provision of service and clinical recommendations, as discussed in the next section, which could lead to further improvements in the understanding, and clinical practice, of working with 'hard to engage' service users.

4.4 LIMITATIONS OF THE STUDY

A number of methodological considerations need to be taken into account when interpreting the results of the present study.

Care co-ordinators from three AO teams were invited to participate in this study. However, following an invitation to partake, participants were required to complete and return a 'consent to be contacted' form if they wanted to take part. It may therefore be possible that this method of selection resulted in the inclusion of AO staff who had positive work experiences and/or strong views in this area and not those who felt less confident or less positive about engaging service users. This method of recruiting participants may therefore have resulted in a biased sample. However, this is an unavoidable consequence of the need to utilise self-determining and consenting participation.

Another methodological consideration is the departure from the normal Grounded Theory methodology in relation to utilising 'theoretical sampling'. Due to time constraints of completing this study, interviews were often completed with only a short time period between interviews. As a result, the same questions and prompts were often used for participants as opposed to the refining of categories and a continued sampling based on themes identified during previous stages of analysis. This may have limited the researcher's ability to seek negative cases and opposite views. In addition, the application of the recommended 'abbreviated version' of Grounded Theory (Willig, 2001) meant that the researcher was not able to leave the original data set and broaden and refine the analysis. However, no new categories emerged during the seventh or eighth interview and so this was taken as an indication that theoretical saturation was established for this data set.

Although a focus group was arranged to check that the analysis and emerging theory accurately reflected participants' understanding and comments, only four of the original participants attended. Although these represented two of the AO teams utilised in this study, no participants from a third service attended. Through the process of conducting this research, the researcher noted some key differences between each of the three AO services (e.g. working patterns, provisions of supervision, range of professionals within the team, and contact methods between AO staff and service users). It is therefore possible that the results may have been biased towards two of the AO teams included in this study. Although it was not possible to arrange a further focus group for the remaining participants due to time constraints, the researcher did email diagrammatic illustrations of each emerging theme along with a brief summary to those participants who had not attended the focus group. This ensured that all participants had the opportunity to examine the results and provide feedback before they were written up.

Finally, the findings of the current study may be limited by the small sample size. Although the total number of participants in this study (n=8) is generally reported to be a sufficient sample size for Grounded Theory, future research in this area involving a larger sample may provide more representative and generalisable findings.

4.5 CLINICAL AND SERVICE IMPLICATIONS

The findings of the current study highlight a number of service and clinical implications with regards to engaging 'hard to engage' service users within mental health services. The implications from this study fall into three broad areas: service delivery and clinical skills, staff qualities and support systems, and risk management.

4.5.1 Service Delivery and Clinical Skills

This research has identified some specific service features that may be important for supporting the engagement of 'hard to engage' service users within mental health services. These are: a good MDT mix of professional skills, the operation of a seven day service, a team approach to case management, small caseloads, and no formal time pressures in relation to engagement work. Within the results of this study, these service factors appeared important as they support staff to work intensively with service users in a flexible and proactive manner. In addition, these particular service factors were also identified in this study as being supportive for maintaining staff wellbeing. Many of these service factors are in keeping with those in the original ACT model (Stein and Test, 1980) and also already have a strong evidence base within AO research.

There is some disagreement within the literature as to whether fidelity to the original ACT model is important or whether services should be able to apply the ACT principles flexibly to suit the local needs of their service user group (see Chapter One for discussion). Some examples of deviations from the ACT model were discovered in this research in terms of working days/hours and the presence of a dedicated psychiatrist within the team. Although the current research is not able to answer the question of whether fidelity to the ACT model is an essential requirement of AO services, the findings of this research suggest that the core features of the ACT model are important for engagement. It may therefore be worth AO services considering regularly assessing their fidelity to the original ACT model through use of tools such as The Index of Fidelity of Assertive Community Treatment (IFACT) (McGrew *et al.*, 1994) and the Dartmouth ACT Scale (DACTS) (Teague *et al.*, 1998) (see Chapter One for more details). The researcher is aware that at least one of the

services utilised in this study was regularly using the DACTS as part of their service audit process.

In terms of clinical practice, this research highlights the importance of using a collaborative, person-centred and mentoring approach that is delivered flexibly and persistently to service users. These features enabled staff to provide practical support to service users and facilitated the building of effective trusting relationships with 'hard to engage' service users. Such approaches and strategies are consistent with the government's current vision of developing patient-lead mental health services which empower service users and promote a recovery approach within a partnership model of service delivery (DOH, 2001b:2006a: 2007b; Shepherd *et al.*, 2008; WAG, 2010). Such approaches are in line with the Recovery model (Perkins & Repper, 2003); a service user driven model of mental health service delivery (Appleby, 2007; DOH 2006b; Shepherd *et al.*, 2008). Many of the identified processes also share similarities with those in Hardy *et al.*'s. (2007) model of engagement. In addition, given that attachment difficulties may be higher amongst the AO service user population (Beutler *et al.*, 2002), these strategies may help to provide a stable base necessary for building effective relationships with service users with a history of attachment difficulties in a way that CMHTs may not be able to.

The results of this study suggest that a genuine collaborative approach can be best achieved by effectively involving service users in most aspects of their care, particularly with regards to the completion of care plans, advanced directives regarding how services will respond to problems, risk management and the provision of a range of contact methods through which service users are able to contact staff. Assertive outreach staff appear to effectively facilitate a process of sharing more control at times when service users are functioning well and temporarily taking back some of that control at times when service users are experiencing greater difficulties. Assertive outreach staff also appear to take an approach to risk management that follows many of the principles outlined in the 'Best Practice in Managing Risk' (DOH, 2007c) document.

Although the process of engagement remains an under researched area of AO, the approaches and strategies identified as part of the engagement process are consistent with the findings of the few published studies exploring engagement from the perspectives of service users (Priebe *et al.*, 2005; Wright *et al.*, 2011), carers (Hughes *et al.*, 2011) and AO staff (Addis & Gamble, 2004; Wright *et al.*, 2011). The fact that these approaches and strategies emerged naturally and consistently from AO staff working in various AO services implies that the collaborative, person-centred and mentoring philosophy has successfully been embedded within AO service as an approach to engaging 'hard to engage' service users.

In addition, the researcher proposes that the AO model of service delivery, along with the clinical skills of AO staff, meets the agenda of Psychological Therapies in Wales (WAG, 2012) as it is a psychologically-minded service which supports the psychological needs of service users and focuses upon the quality of the relationship between practitioners and service users in the delivery of all treatment and interventions.

4.5.2 Staff Qualities and Support Systems

The personal qualities that appear desirable for staff working with 'hard to engage' service users include 'being non-judgemental' and 'dedication to their work'. These qualities were identified by participants as qualities that they shared with all their colleagues in their AO teams. These qualities have also been suggested as desirable staff qualities in the AO literature and so this research provides some evidence to reinforce this. The researcher therefore proposes that these personal staff qualities be promoted and supported in services working with 'hard to engage' service users. The values and attitudes of teams as a whole have also been identified as important characteristics for building effective relationships with service users (Bleach & Ryan, 1995; Repper, 2000; DOH, 2001a; Williamson, 2003). It is suggested that the use of a team approach may help promote and reinforce desirable staff values. In addition to the team approach, the peer support of colleagues and a lack of time pressure were identified as being supportive factors for helping staff to manage the personal impact of their intensive work with a challenging and complex service user group.

Furthermore, the team approach was also identified as being helpful for managing the personal impact of AO work and for facilitating engagement work with service users as it enables the AO service to: develop team formulations which enhanced staff's understanding of difficulties with service users; manage risk; and ensure that service users were provided with a continuity of care at times when certain members of the team were not available to visit service users. The team approach therefore appears to be a particularly useful model of service delivery for 'hard to engage service users'.

Although there were some mixed findings in terms of the helpfulness of one to one clinical supervision, existing research has consistently found supervision to be important for improving clinical practice (Steer & Onyett, 2011), supporting engagement work (Gray & Johanson, 2010; Kennard & Hartley, 2009; Leahy, 2008), and for supporting staff wellbeing (Gray & Mulligan, 2010; Griffiths *et al.*, 2011; Gray & Lavender, 2001; Melchior *et al.*, 1997). Regular clinical supervision is therefore recommended as an important factor for maintaining staff wellbeing when working with 'hard to engage' service users. However, the researcher acknowledges that some individuals may have been receiving a form of group supervision during their team meetings that stood in place for one-to-one clinical supervision.

4.5.3 Risk Management

Having a team approach also emerged in this study as being important for supporting AO staff to manage the various risks associated with their service user group. Elements of risk management were present within each of the three themes identified in this current study. The team approach means that issues of risk and risk decisions are made and held jointly by the team as opposed to individuals holding this responsibility. This in turn appears to enable AO staff to engage in positive risk taking in order to empower service users to manage their own mental health difficulties and reduce their dependency on mental health service input. Positive risk taking may be an important difference between AO and CMHT. Participants felt that traditional mental health services operated in a 'risk adverse' manner in which they sought to avoid and minimise risk issues as opposed to supporting service users to develop the skills to manage their risks. This may be one factor preventing traditional mental health services from operating with a proactive approach and is likely to be

influenced by the fact that care co-ordinators in CMHTs are managing high caseloads. The notion of risk taking is in keeping with the Recovery Model as it promotes the empowerment and recovery of service users and facilitates them in the process of increasing their independence from mental health services.

4.6 RECOMMENDATIONS FOR FUTURE RESEARCH

This research has attempted to address a lack of research into the specific approaches and strategies used in AO to promote engagement with 'hard to engage' service users. This study has provided some insight into the approaches and strategies that AO staff use in their clinical work in order to engage and maintain engagement with service users. It would now be useful to explore AO service users' views and experiences of the strategies and approaches identified in this research to help broaden the research literature in this area. In addition, it may also be interesting to conduct some observational research to access the lived experience of AO staff in working with 'hard to engage' service users.

It would also be useful to examine what clinical psychology can offer AO. For example: providing clinical supervision and/or consultation to AO staff, facilitating team case formulations, supporting and developing the promotion of a psychological approach to AO service delivery, plus staff training in enhanced engagement work. Clinical psychologists may also be able to take an indirect approach to their work with key stakeholders to influence service delivery policy in AO.

Additionally, further research could be conducted to further explore the concept of 'positive risk taking' in AO to further investigate its role in empowering service users to manage their own mental health difficulties and reduce dependence on mental health services.

Finally, as previously mentioned in this report, one of the AO services utilised in this research was in the process of being disbanded (possibly for financial budgetary reasons or as part of local service re-organisation) at the time data collection took place. At this point, a plan was in place to transfer all the service users currently

being supported by that particular AO service back into the CMHT. It would be interesting to follow up those service users to monitor the impact that this had on their engagement with services and to explore those service users' experiences of engaging with AO and CMHT and also the AO staff's experience of returning to the CMHT.

4.7 CONCLUSION

This study has reviewed the existing AO and engagement literature and attempted to address some of the gaps in the research base. The results of the current study provide some insight into the specific approaches, techniques and strategies used by AO staff to engage and maintain engagement with 'hard to engage' service users. In addition, the results of this study also identify important service elements and personal staff qualities that may be desirable for this engagement work to take place effectively. Themes regarding the building of therapeutic relationships with service users, the maintenance of those relationships through the various challenges that may present, and the service elements that enable the engagement work to take place, have been identified. In particular, it appears that it is imperative that staff use a collaborative, person-centred, and mentoring approach in their work to enable them to develop trusting therapeutic relationships with service users. The process of building effective relationships between AO staff and service users was further enhanced by the provision of practical support to service users. When provided in a flexible, persistent, dedicated and non-judgemental manner, this work enables AO services to engage service users who have previously disengaged with mental health services. The strategies and approaches that have been identified need to be delivered within a team approach model in a service that is able to provide intensive flexible input to service users. In addition, staff need to be supported within such services by operating with protected caseloads, minimal time pressures, shared decision making and risk management, and regular access to peer support and clinical supervision. The current study has also identified some clinical and service recommendations which have been generated from the findings of this research. Finally, some suggestions for future research have been proposed.

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APPENDICES

Appendix 1

Ethics approval- Dyfed Powys Research Ethics Committee

R&D approval- Cardiff and Vale UHB

R&D approval- Cwm Taf HB

R&D approval- ABM UHB



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30 August 2011

Dear Mrs Connor

Study title: Service User Engagement by Assertive Outreach Staff
REC reference: 11/WA/0212

The Research Ethics Committee reviewed the above application at the meeting held on 24 August 2011. Thank you for attending to discuss the study.

Ethical opinion

Mrs Connor confirmed she had not piloted the schedule but had discussed the content with her clinical supervisor who had experience in the field and who had attempted to answer the questions

The Committee were concerned that the service could be over-burdened as the interviews would be taking place during the working day and queried whether team managers had agreed to this. Mrs Connor explained that the outreach staff worked in shift patterns and it would be possible therefore to arrange the interview outside work time but still within the working day if participants were willing to do so.

The Committee were concerned that team managers could feel coerced into inviting staff to take part in the research as the researcher had used terminology such as "illicit" support. The Committee suggested an alternative method of recruiting participants directly could be more appropriate. Mrs Connor explained that she was trying to avoid direct contact with potential participants until they had agreed to take part in the study. Her clinical supervisor had discussed the project with team managers and felt they would not feel pressurised into issuing the invitations to staff.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Personal details
Academic Supervisor
Clinical Supervisor
Participant Consent

24 April 2011
24 April 2011
24 April 2011



Cynhelir Cydweithrediad Gwyddor Iechyd Academaidd y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd gan Fwrdd Addysgu Iechyd Powys

The National Institute for Social Care and Health Research Academic Health Science
Collaboration is hosted by Powys Teaching Health Board



Ariennir gan
Llywodraeth
Cynulliad Cymru
Funded by
Welsh Assembly
Government

Ethical review of research sites

NHS Sites

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

Conditions of the favourable opinion

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

The Committee queried whether it was possible to maintain "strict confidentiality" given that direct quotations were being used and suggested the Information Sheet and Consent Form should make participants aware that direct quotations may be used which could be identifiable.

The Committee queried why the Personal Details Form was required given that the details would not be included in any report of the study. Mrs Connor explained that the details would give her a picture of the participants as a sample of the group rather than being interested in the specifics. It was agreed it was not necessary to ask for the name of the participant and this form should be amended.

The Participant Information Sheet should be amended under the heading 'Who has reviewed the study?' the correct Research Ethics Committee should be inserted.

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

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

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

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

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

Approved documents

The documents reviewed and approved at the meeting were:

| Document | Version | Date |
|---|---------|-----------------|
| Covering Letter | | 19 July 2011 |
| Interview Schedules/Topic Guides | 1.3 | 24 April 2011 |
| Investigator CV | | |
| Letter of invitation to participant | 1.2 | 24 April 2011 |
| Personal details form | 1.2 | 24 April 2011 |
| Academic Supervisor CV | | 23 January 2011 |
| Clinical Supervisor CV | | |
| Participant Consent Form: Consent to be contacted by the researcher | 1.2 | 24 April 2011 |

| | | |
|--|-----|---------------|
| Participant Consent Form: - Interviews | 1.3 | 25 May 2011 |
| Participant Consent Form: - Focus Groups | 1.3 | 24 April 2011 |
| Participant Information Sheet | 1.2 | 22 April 2011 |
| Protocol | 3 | 25 April 2011 |
| REC application | 3.1 | 19 July 2011 |

Membership of the Committee

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

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

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

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

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

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/WA/0212

Please quote this number on all correspondence

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

Yours sincerely


Mrs Sarah Jones
Vice-Chair

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
"After ethical review – guidance for researchers"

Copy to: Professor Nick Craddock, Cardiff and Vale UHB R&D office
Professor Neil Frude



Uned
Cyllynol
Canolfad | **PCU** | Permisïons
Co-ordinaating
Unit

Dyfed Powys Research Ethics Committee
PO Box 108
Building 1
St David's Park
Carmarthen SA31 3WY

Telephone : 01267 225045

Fax : 01267 225226

E-mail : sue.byng@wales.nhs.uk

Website : www.nres.nhs.uk

Mrs Caroline Connor
Trainee Clinical Psychologist
Cardiff and Vale UHB
South Wales Doctoral Programme in Clinical Psychology
Archway House, 77 Ty Glas Avenue
Llanishen, Cardiff
CF14 5DX

8 September 2011

Dear Mrs Connor

Full title of study: **Service User Engagement by Assertive Outreach Staff**
REC reference number: **11/WA/0212**

Thank you for your email of 6 and 7 September 2011. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 30 August 2011. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

| Document | Version | Date |
|---------------------------------------|---------|-------------------|
| Personal Details Form | 1.3 | 01 September 2011 |
| Participant Consent Form: Focus Group | 1.4 | 01 September 2011 |
| Participant Consent Form: Interviews | 1.4 | 01 September 2011 |
| Participant Information Sheet | 1.3 | 01 September 2011 |

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

11/WA/0212 Please quote this number on all correspondence

Yours sincerely

Mrs Sue Byng
Committee Co-ordinator

Copy to: Professor Nick Craddock, Cardiff and Vale UHB R&D Office



Cynhelir Cydweithrediad Gwyddor Iechyd Academaidd y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd gan Fwrdd Addysgu Iechyd Powys

The National Institute for Social Care and Health Research Academic Health Science
Collaboration is hosted by Powys Teaching Health Board



Please accept this letter as confirmation of sponsorship by Cardiff and Vale UHB and permission for the project to begin.



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Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Ysbyty Athrofaol Cymru
University Hospital of Wales

Heath Park,
Cardiff, CF14 4XW
Phone 029 2074 7747
Fax 029 2074 3838
Minicom 029 2074 3632

Parc Y Mynydd Bychan,
Caerdydd, CF14 4XW
Ffôn 029 2074 7747
Ffacs 029 2074 3838
Minicom 029 2074 3632

Eich cyf/Your ref
Ein cyf/Our ref
Welsh Health Telephone Network 1872
Direct line/Llinell uniongyrchol

Tel: 029 20746986
Fax: 029 20745311
CAV_Research.Development@wales.nhs.uk

From: Professor JI Bisson
R&D Director
R&D Office, 2nd Floor TB2
University Hospital of Wales
Cardiff
CF14 4XW

22 September 2011

Miss Caroline Connor
Trainee Clinical Psychologist
South East Wales Doctoral Programme in Clinical Psychology
Archway House
77 Ty Glas Avenue
Llanishen
Cardiff
CF14 5DX

Dear Miss Connor

Project ID : 11/MEH/5147 : Service User Engagement By Assertive Outreach Staff

Further to recent correspondence regarding the above project, I am now happy to confirm receipt of:

- Evidence of favourable opinion from the relevant NHS Research Ethics Committee
- Revised documentation as required by the REC in order to obtain favourable opinion
- Evidence of appropriate informed consent training for the PI

The following amended documentation is approved for use with this study:

| Document | Version | Date |
|---------------------------|---------|------------------|
| Patient Information Sheet | 1.2 | 22 April 2011 |
| Consent Form: Focus Group | 1.4 | 1 September 2011 |
| Consent Form: Interviews | 1.4 | 1 September 2011 |
| Personal Details Form | 1.3 | 1 September 2011 |

Please accept this letter as confirmation of sponsorship by Cardiff and Vale UHB and permission for the project to begin.



May I take this opportunity to wish you success with the project, and to remind you that as Principal Investigator you are required to:

- Ensure that all members of the research team undertake the project in accordance with ICH-GCP and adhere to the protocol as approved by the Research Ethics Committee
- Inform the R&D Office if any external or additional funding is awarded for this project in the future
- Inform the R&D Office of any amendments relating to the protocol, including personnel changes and amendments to the actual or anticipated start and end dates
- Complete any documentation sent to you by the R&D Office or University Research and Commercial Division regarding this project
- Ensure that adverse event reporting is in accordance with the UHB adopted Cardiff and Vale NHS Trust Policy and Procedure for Reporting Research-Related Adverse Events (refs 164 & 174) and Incident Reporting and Investigation (ref 108)
- Ensure that the research complies with the Data Protection Act 1998
- Ensure that arrangements for continued storage or use of human tissue samples at the end of the approved research project comply with the Human Tissue Act, 2004 (for further information please contact Sharon Orton, HTA Coordinator OrtonS@cf.ac.uk).

If you require any further information or assistance, please do not hesitate to contact staff in the R&D Office.

Yours sincerely,



Professor Jonathan I Bisson
Cardiff and Vale University Local Health Board R&D Director

CC R&D Lead Prof Nick Craddock
Professor Neil Frude, Clinical Psychology, Archway House, Llanishen



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Bwrdd Iechyd
Cwm Taf
Health Board

Your ref/ein cyf:
Our ref/ein cyf: JG/RG
Date/dyddiad: 05/08/2011
Tel/ffôn: 01443 443421
Fax/ffacs: 01443 443420
Email/ebost: Susan.kedward@wales.nhs.uk
Dept/adran: Research & Development Dept

Ms Caroline Connor
Clinical Psychology Training
1st Floor Archway House
77 Ty Glas Avenue
Llanishen
Cardiff
CF14 5DX

Dear Ms Connor

**Re: CT/167/11 - Service User Engagement by
Assertive Outreach Staff**

The above project was reviewed at the RRRG on 23rd June, 2011 and I have pleasure in confirming that this project has full approval to commence in the Cwm Taf Health Board. However, commencement of the project should be upon the receipt of ethical approval if required. If the project is a multi site study it is advised that you also obtain approval from all other Health Boards before commencing the project at individual sites.

The Group reserve the right to notification of the project start date information on the progress of the project at any time and should receive a progress report six monthly and a written report on completion.

Random audits will be carried out to ensure that projects comply with the clinical guidelines for research. Any serious adverse incidents relating to the project should be reported to the R&D office and a Clinical Incident Form filled in.

Return Address:

Research & Development Department, Royal Glamorgan Hospital, Ynysmaerdy,
Llantrisant, RCT, CF72 8XR

If your project includes participants or resources from other Health Board it is your responsibility to contact the relevant R&D Office(s) in order to gain R&D approval to commence. Without individual R&D approval from all Health Boards involved in the study, Welsh Risk Pool indemnity will not be afforded to the researcher.

On completion of the project it is important that you inform the Health Board R&D office.

It is a requirement of approval that a synopsis of your project and its findings (if not commercially too sensitive) be submitted to the R&D department upon completion. This synopsis can then be placed on the R&D departments web page to provide useful R&D resource for other research active professionals across the Health Board.

It is also a requirement that an abstract is submitted for review and possible inclusion in the Health Boards annual R&D conference. This facilitates the distribution of all research findings and any resultant changes in clinical practice.

I would like to take this opportunity to wish you well with your research and look forward to the presentation of your findings.

If you require any further assistance please do not hesitate to contact the office

Yours sincerely



Dr John Geen MSc, PhD, FRCPath
Associate Medical Director – Research & Development

Enc. Notification of Start Form, Interim Progress Report Form,
Notification of End Form

Cc: Dr Huw Griffiths, Clinical Director of Mental Health, Royal
Glamorgan Hospital.
Mrs Diane Stacey, Directorate Manager of Mental Health, Royal
Glamorgan Hospital.
Professor Neil Frude, Academic Supervisor, Clinical Psychology
Training.

Yours sincerely

Please reply to: Research & Development Department
Clinical Research Unit
Abertawe Bro Morgannwg University
Health Board
Morriston Hospital
SWANSEA
SA6 6NL

Telephone: 01792 704056

Fax:

E-mail: jemma.hughes@wales.nhs.uk

Mrs Caroline Connor,
Trainee Clinical Psychologist
Cardiff and Vale NHS Trust
South Wales Doctoral Programme in Clinical Psychology
Archway House, 77 Ty Glas Avenue
Llanishen, CARDIFF
CF14 5DX

05 August 2011

Dear Mrs Connor,

ID: B11Psyc333 Service User Engagement by Assertive Outreach Staff, v1

I am pleased to inform you that the above research study, which you recently submitted for review, has been approved by Abertawe Bro Morgannwg University Health Board.

Approval has been granted on condition of a favourable ethical opinion being received from Dyfed Powys REC. A copy of the ethics approval letter is required by the R&D Office.

Cardiff University is Sponsor for this study, as required under the Research Governance Framework.

As a requirement of the Research Governance Framework, all research studies registered as active within ABM University Health Board will be subject to a randomised audit procedure to ensure appropriate standards of Research Governance (RG) and Good Clinical Practice (GCP) are being applied throughout the conduct of the research. Research Active Personnel must therefore ensure they familiarise themselves with the standards of RG and GCP. For clinical trials of investigational medicinal products, please ensure all members of the research team are up to date or have attended recent training in GCP. Details of GCP training are available from the R&D Office.

Researchers employed by ABM University Health Board, including those holding Honorary Contract status are indemnified against actions for negligent harm via standard arrangements with Welsh Risk Pool (WRP). Provision for 'no-fault' compensation is limited under the scheme and is only available on an ex gratia, discretionary basis where the Sponsor is a NHS Organisation.

ABM University Health Board reserves the right to suspend approval of any research study where deviation from appropriate RG & GCP standards is uncovered.

Please ensure that any changes made to the study are submitted to the R&D Department for review and approval, including:

- Notification of Amendment (copy of all documentation sent to Ethics is also required by R&D)
- Adding new Sites and Investigators (CV's to be included)
- Progress and Safety Reports
- Notifying of the End of study

May I take this opportunity to wish you well in undertaking the research. We will write to you in the future to request updates on the progress of the research and look forward to receiving outcomes of the study.

Yours sincerely

S. Hughes
① Professor Stephen Bain

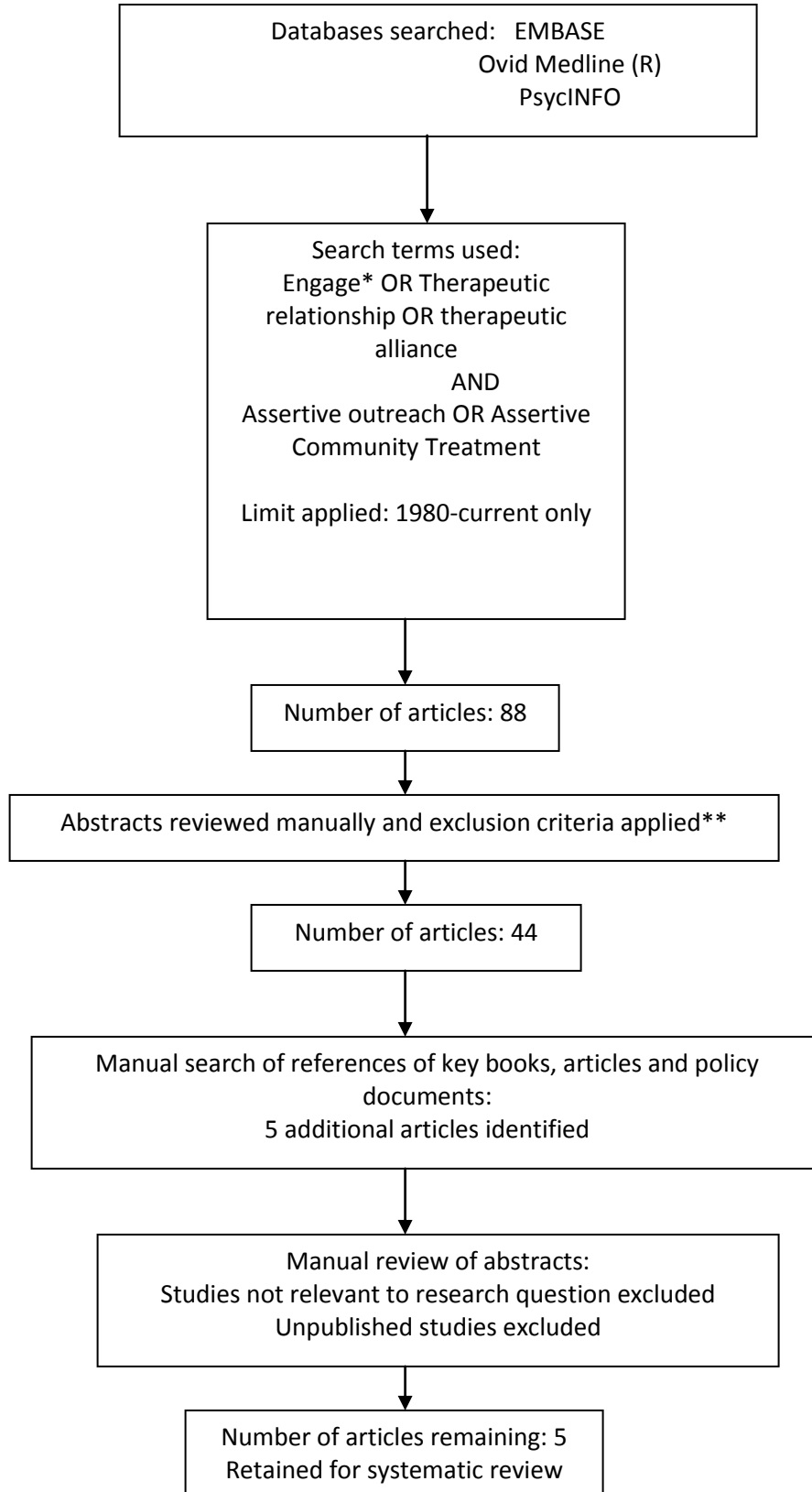
Assistant Medical Director (R&D)
Abertawe Bro Morgannwg University Health Board

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Appendix 2

Diagram of literature review process

Summary of Systematic Literature Review Process



** Exclusion criteria: studies not considered to have a strong research methodology, not assertive outreach focused, non-UK service, article not published in English language, duplicate paper, drug/alcohol addiction focused, child (not adult) focused

Appendix 3

Excerpts from research diary

9/12/11- Did my first interview today. Listening to the participant talk about engaging service users was very interesting and the interview seemed to flow well. I think I managed to get the information I wanted from my interview questions and prompts.

20/1/12- Second participant said very similar things to the first participant. This is interesting. Both participants work in the same AO team. I wonder whether they have undergone some specific training about engaging service users. Once I have finished analysis, I will ask the clinical psychologist working in this team about staff training etc.

Also, both members of staff have spoken very positively about the service users they work with. I caught myself feeling surprised by this. I wonder why this is? Is it that because I have worked in services that have discharges this service user group for non-engagement and have heard a lot of people complaining about these service users being very demanding and difficult to work with. I need to think some more about any preconceived ideas/ prejudices that I may have about this service user group and the impact this may have on my research.

3/2/12- I have now completed four interviews. The concepts that are coming out of them are all very similar even though I have now interviewed staff from three different services. Risk taking and risk management seems to be an important concept that keeps coming up in the interviews. I will include some more questions about this in future interviews. Staff seem to be talking about two different things- strategies and approaches that they use for engagement is the main content of the interviews but staff are also speaking about some service factors that they need to be in place in order for them to be able to carry out engagement work.

Also, there are some differences between the ways that each of the AO services operate. For example, one service is only operating Monday to Friday (although they are in the process of recruiting more staff so that they can cover 7 days). There is also differences in the way that service users can contact staff (e.g. mobile numbers and emails). Staff in the AO service that provides this think that this has a beneficial impact on engagement. I wonder what staff in the AO team that only gives out the team number thinks of this? I will ask.

17/2/12- Have been on placement all week this week and am feeling quite tired in the evenings (pregnancy related I suspect). I have another interview coming up this week so need to make sure I have finished analysing my last interview in order to think about any avenues that I may need to explore in more detail. I think I will have to make sure that I am particularly organised with regards to how I plan and use my research time as I need to ensure that I invest an appropriate amount of energy into this research.

Appendix 4

Extract of interview transcript and analysis

Initial thoughts seem to be that it is going to be too intrusive into their lives. They don't want anything to stop the process of getting back to normal life from happening and their initial thought is often that input from AO means that they are iller than what they perceived themselves to be or that AO would stop them from going back into work. AO has some stigma attached to it. We have to manage this.

-reception
AO stigma

We sometimes have service users referred who are on a CTO and as part of their CTO on their care plan they are expected to engage with AO. So there is that element too, sometimes. It can be a powerful motivator, as awful as it sounds, for the people who are quite ill and risky. It's a fabulous tool, really, because they don't tend to disengage with us then. They don't want to come back into hospital. We still negotiate as far as possible with service users on CTOs because we discuss and negotiate with them around what needs to go in and what their individual needs are. We still do this with service users on CTOs because we believe it's important for them to have input into their plans and the service they receive.

use of
loose means for
engagement

Negotiation
is important

engage with
no aspect of
CTO

many people

Negotiate with
all service users

Q2

We have a number of sus that have had a very poor experience with CMHTs they've disengaged for various other reasons- CMHTs have disengaged with them, they haven't been flexible enough, they are the ones who are usually back and forth in hospital and they really want to stop that process from happening to them.. They are happy to engage with a different service. We are a lot more flexible with them, we work weekends, they like that element of it and just building it up slowly doing the very very basic things and building a relationship with them from the very basics. They like that.

flexibility
reengagement

flexible
working has
flexible appointments

working
time

Q4

Trust, negotiation and control. It takes a long period of time to build a trusting relationship- it doesn't happen over a period of a week or overnight. We've got time to spend on this and we are allowed to. For one service user, I've spent two years just working on building a relationship with her. It takes us being persistent and taking a consistent approach. So if you say your gonna call on Tuesday at 2 o'clock then you have to call at that time. They seem to have had some bad experiences where the CPN or social worker has dnd their appointment or has kind of messed them around. So they like you to be consistent and it's very important to turn up when u say you will. Consistency and

-> no limit on
time in relationship
building

other services
let them down
not kept words

consistent
approach
think what you
say you will

persistence are important. They also like you to help with finances. We have a lot of people with very complex needs that have a lot of housing and social problems. If you can help them work through all the very basics in their life, like food, money and shopping, you've got a foot in the door. It's useful if they can see some benefits of engaging with us from the very beginning.

giving practical support

knowing the benefits of the start

We let them have some control too. So we might say to them - "what day do you want us to call?" and they can choose and then they have already started to take some responsibility and have some ownership over their contact with AO. They seem to like that element of it too. Collaboration is important and that a little different their previous experience of MH services based on what I have heard them say. I.e. they might be just given an app. for 3pm on Wednesday and that might not be convenient so they are not there when they call and then may have DNAd a couple of appointments so perhaps have no contact with services for a month or 2 and may have even have relapsed in that time. They may also have had a letter to say you have not engaged with us so you're being discharged from the service.

Strong control / give + take

Collaboration is important

Control not flexible / chaos with apps

Negotiation is something that we do right from the beginning; everything we do is completely flexible to SUs need. If they say we only want to see you once a fortnight and we think they are quite unwell, and need to be seen more often. We will discuss this with them and give our reasons and then often negotiate with them about this then. Having them take ownership of our contact with them helps with engagement.

negotiate from the beginning

Strong control they then have ownership

We have some cases where we reduce visits as their mental health is improving. We might drop visits from three times a week to twice as a matter of progression. They like this as it lets them know they are making progress - that's important too. to acknowledge progression. With others we continue with our process or we say, ok is you can't meet us twice a week would you meet us once a week our policy is that a qualified nurse or a qualified member of the team will see them at least once a week, even if it's only for 20mins. We will always offer this and we will meet as a team to discuss the case, negotiate with them. We do team formulations looking at engagement difficulties with the clinical psychologist in the team, we think together about what we can do differently to engage people. We do everything as a team really, even when only one person might be meeting the SU we will all work together to offer support, ideas and advice, thinking about things that have worked for us in the past with other SUS. We will always be persistent. It also depends on someone's mental health as well, if they are disengaged with you and are not taking their meds we need to recognise the impact that has on someone's mental health.

Recognising progress by reducing visits

negotiate

Strong decisions with team

Team formulations engagement formulations

Recognising impact on behavior

Appendix 5

Participants demographic information sheet (Personal Details Form)



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 1.3 : 01/09/11

Personal Details Form

These questions are just to give me (Caroline Connor) some background information about you. They will only be used to give an overall picture of the participant sample.

Professional background.....

Current place of work.....

Number of years working in an Assertive Outreach Team.....

Do you have any previous experience of working in adult mental health services?

Yes No

If yes, please provide a brief description

.....

Gender: Male Female

Age 18-30 31-45

46-60 61+

Thank you very much



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost deborah.robinson2@wales.nhs.uk



Appendix 6

Participant Information Sheet



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 1.3: 01/09/11

Participant Information Sheet

Service User Engagement by Assertive Outreach Staff

Thank you for agreeing to receive some information about my research. My name is Caroline Connor and I am a Trainee Clinical Psychologist employed by Cardiff and Vale University Health Board. I would like to invite you to take part in a research study which I am conducting under the supervision of Prof. Neil Frude (Consultant Clinical Psychologist and Research Director, South Wales Doctoral Programme in Clinical Psychology) and Dr. Julian Pitt (Consultant Clinical Psychologist, Cwm Taf Health Board). The results of the research will be written up as a dissertation and submitted as part of my examinations towards a Doctorate in Clinical Psychology.

To help you decide whether or not you would like to take part in this research I have written this information sheet to tell you what my project is about and how you might become involved.

Please take time to read the following information carefully.

If you are not clear about anything in this information sheet or you would like more information, please feel free to contact me using the contact details at the end of this form.

What is the purpose of the study?

Assertive Outreach Teams (AOTs) have been successful in engaging service users within services and in reducing inpatient days and increasing levels of functioning for those with severe and enduring mental health problems. This group of service users are often termed 'hard to reach' and have not engaged with traditional mental health services.

Part of the Assertive Outreach model that has received increased attention is that of engagement. In this sense, engagement refers to the relationship between the assertive outreach staff member and the service user that enables the service user to accept input from the Assertive Outreach Team. Although engagement is a 2 way process between the service user and clinician (staff member), very little research literature has explored the engagement process from the perspective of Assertive Outreach (AO) staff. Therefore, not enough is currently known

about how AO staff are able to engage and maintain engagement with service users who have previously disengaged from other services.

This study aims to explore the engagement process from an AO staff perspective to develop an understanding of how AO staff build relationships with service users and maintain their engagement in AO services. If we are able to better understand the psychological processes involved in engagement then this knowledge may contribute to the development of a shared understanding of how to engage 'hard to reach' service users within mental health services. This has implications for the development of service models, future research agendas, training and practice.

Why have I been invited?

You have been invited to take part because you have worked within an AOT for at least 6 months and have the role of a care co-ordinator.

Do I have to take part?

It is up to you to decide whether or not to take part, as taking part in this research study is entirely voluntary. If you decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason. If you decide to withdraw at a later date, all the data provided up to the point of withdrawal will also be withdrawn from the study.

What will happen if I agree to take part?

If you decide to take part you will be invited to attend an individual interview, followed by a focus group. These will be facilitated by the researcher, Caroline Connor (Trainee Clinical Psychologist). You will also be asked to complete a brief personal details questionnaire. It is anticipated that the interview and focus group will last between 60 – 90 minutes each, and will take place during the working week. Arrangements will be made for interviews to take place at a time and place convenient to you.

The individual interview and focus group discussion will be audio recorded so that the researcher can transcribe the information in order to analyse it. All data received in the interview will be anonymised before being presented in the focus group or written up in the final report.

What are the possible advantages of taking part?

I hope that you will welcome the opportunity to talk about your experiences and, in light of the limited available literature on the process of engagement from a staff perspective, it is hoped that the information provided will shape future service development.

What are the possible disadvantages of taking part?

This study is a psychological study and there are no known risks involved in taking part. However, if at any point during the interview or focus group you feel that you would like to withdraw from the study you will be free to do so without giving any reason or explanation.

A clinical psychologist who does not work in your team will be able to offer you a consultation session should you feel the need for additional support.

Will my taking part in this study be confidential?

Direct quotes will be used in the write up of this research. This means that some of the things you say during interviews may be quoted in the focus groups and final report. Although direct quotes will be used, these will be anonymised and all information that the researcher considers to be identifiable information will also be removed. The data will be stored in a locked cabinet within the host University Health Board and the researcher alone will have access to the data. When the data is transcribed all names will be changed so that you will not be identifiable from the transcripts. Following transcription, the audio recordings will be destroyed.

However, if you were to disclose a risk to yourself or another person or if you disclosed unethical practice in your professional work, this information would need to be communicated to your manager. I will always tell you first if I need to break confidentiality.

What will happen to the results of the study?

The results of the research will be written up as a dissertation and submitted as part of my Doctorate in Clinical Psychology. Transcribed interview data will be anonymised as will the identity of the participants. If you would like a summary of the final report you can ask for this by ticking the relevant part on the consent form.

What if I have a problem with the study?

If you have concerns about any aspect of this study, please contact the researcher (contact details below) – I will do my best to answer your questions. If you remain unhappy and wish to complain formally I will give you details of how you may do this.

Who has reviewed the study?

All research in the NHS is looked at by an independent group, a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Dyfed Powys Research Ethics Committee.

What do I do if I want to take part in the study?

If you decide that you would like to take part in this study please complete the 'consent to be contacted by the researcher' form attached to the end of this document and return it to me (Caroline Connor) using the details below. I will then arrange to send you a consent form to complete.

Further information

If you have any further questions about taking part in the study or require any more information please do not hesitate to contact me (Caroline Connor) or either of the study supervisors (Prof. Neil Frude or Dr. Julian Pitt) using the following contact details:

Caroline Connor (Researcher):

Archway House, 77 Ty Glas Avenue, Llanishen, Cardiff, CF14 5DX.

Telephone: 02920 206464.

Email: caroline.connor@wales.nhs.uk

Professor Neil Frude (Academic supervisor):

Archway House, 77 Ty Glas Avenue, Llanishen, Cardiff, CF14 5DX.

Telephone: 02920 206464.

Dr. Julian Pitt (Clinical supervisor):

Assertive Outreach Team, St Tydfil's Hospital, Merthyr Tydfil CF47 OSJ Telephone: 01685 726555

Thank you very much for taking the time to read this. Your help is greatly appreciated



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Email/Ebost deborah.robinson2@wales.nhs.uk





SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 1.2 : 24/04/11

CONSENT TO BE CONTACTED BY THE RESEARCHER

I am interested in participating in this study and consent to the researcher (Caroline Connor) contacting me to discuss this further. My contact details are:

Name.....

Job Title.....

Current place of work.....

Email address.....

Contact phone number.....

Please can you return this completed form to:

Caroline Connor
Trainee Clinical Psychologist

Archway House
77 Ty Glas Avenue
Llanishen
Cardiff
CF14 5DX.

Or e-mail it to: parnellck@cardiff.ac.uk

Thank you very much



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Appendix 7

Focus group invitation letter



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Version 1.2 – 24/04/11

INVITATION LETTER TO FOCUS GROUP

Date: 14th March 2012

Dear

I am writing to inform you about my progress with the research study that you participated in regarding service user engagement by assertive outreach staff. I am pleased to tell you that all of the interviews have now been completed and analysed. Everyone's contribution was very valuable and has provided interesting insights into the engagement process.

You may remember that at the interview I informed you that I would contact you with an invitation to take part in a focus group with the other participants who took part in the study. The purpose of this group is to feed back the main themes that emerged during the interviews and to discuss how these findings fit with your experiences of engaging service users. This is to ensure that the findings are accurate and that I have not missed anything important. Anything you said during the interview will be anonymised and therefore any quotes used will not identify you.

The focus group will be held on Wednesday 28th March at 10am at Archway House, 77 Ty Glas Avenue, Llanishen, Cardiff CF14 5DX.

Please could you complete the attached slip to indicate whether you willing and able to attend the focus group and if you are available on the suggested date. Please confirm whether you are likely to attend by emailing me at: parnellck@cardiff.ac.uk

Please do not hesitate to contact me if you have any queries about the group: **02920 206464**.

I look forward to hearing from you.

Kind regards

Caroline Connor
Trainee Clinical Psychologist



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Email/Ebost deborah.robinson2@wales.nhs.uk



RETURN SLIP

Name: _____

- a) I would like to attend the focus group on [DATE]
- b) I would like to attend the focus group but am unable to make [DATE].
- c) I do not wish to attend the focus group.

Thank you

Appendix 8

Interview Schedule

Interview schedule

Service User engagement by Assertive Outreach staff

Tasks for the interviewer

1. Introduce self and project
 2. Check if there are any outstanding questions from the information sheet and consent form.
 3. Check that the consent form has been completed, and make sure that the participant has agreed to the interview being recorded.
 4. Remind participant that everything discussed will remain confidential, and that client confidentiality should be maintained throughout the discussion (i.e. the names of clients should not be used). Also remind participants of the limits to confidentiality when discussing professional issues.
 5. Intervene to keep the discussion focused on the broad topic.
 6. Keep the overall interview length to between one and one and a half hours.
-

Questions for the interviewer to ask

Stem questions are in bold, and prompts are in italics.

- 9) **How effective do you think your team is at getting people to agree to input from assertive outreach once they are referred?**
- 10) **Do you find from your clinical experience that some people are willing to work with you whereas some people are resistant to working with you? Can you talk me through some clinical examples?**
(Why do you think they were willing/ resistant to working with you? Was there anything in particular that you did that helped make it easy for them to work with you? For those that were resistant, what did you do to help get them to work with you? Is there anything that you would have done differently if you had the opportunity to start again?)
- 11) **Do some people start off easy and then turn out to be difficult to work with or vice versa?**
Can you talk me through an example of this?
What do you think caused the change? Is there anything you could have done differently?
- 12) **What three factors do you think are most important for influencing whether someone will agree to work with you or not? How much do these factors influence your day to day work?**

What do you think would make it more likely that someone would agree to work with you? What do you think would make it more likely that someone would not want to work with you?

13) What particular skills do you have that are helpful for working with people who find it difficult to work with traditional mental health services and how have these skills developed?

14) How would you know if someone was starting to disengage from you and what do/would you do if this happens?

What are the key signs that someone is starting to disengage? What do you interpret these signs to mean? How do you respond to these signs?

15) How typical do you think your approach is compared to that of others in your team?

How similar is your way of working to your colleagues in the AOT? What do you know about the way others in your team work? Is there anything that you do that is particularly different to your colleagues in the team?

16) Is there anything you feel I should ask?

Thank you very much

Appendix 9

Participant Consent Form: Interview



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Consent form – Interviews Version 1.4

Research title: Service User Engagement by Assertive Outreach Staff

Researcher: Caroline Connor

1. I confirm that I have read and understand the information sheet (Version 1.3) for the above study. I have had the opportunity to consider the information, ask questions and have them answered satisfactorily.

Please
initial box

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I understand that the interviews are confidential unless I disclose information suggesting that I or someone else may be at risk or harm. Direct quotes from the interviews will be presented during the focus groups and used in the write up of the research but these will be anonymised.

4. I understand that the interviews will be tape recorded, and the tapes will be kept securely.

5. I agree to take part in the above study.

I wish to be sent a summary of the research findings on completion of the study

Please circle
YES NO

If you have indicated 'yes' to the above question please provide details of where you would like the summary sent (i.e. email or address). Contact details: _____

Participant name

Date

Signature

Researcher name

Date

Signature



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Appendix 10

Participant Consent Form: Focus Group



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Consent form – Focus groups Version 1.4

Research title: Service User Engagement by Assertive Outreach Staff

Researcher: Caroline Connor

Please
initial
box

6. I confirm that I have read and understand the information sheet (Version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have them answered satisfactorily.

7. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my standard of healthcare or legal rights being affected.

8. I understand that the focus groups are confidential within the group, unless I disclose information suggesting that I or someone else may be at risk or harm. Direct quotes from the interviews will be presented during the focus groups but these will be anonymised.

9. I understand that the focus groups will be tape recorded, and the tapes will be kept securely.

10. I agree to take part in the above study.

Participant name

Date

Signature

Researcher name

Date

Signature



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
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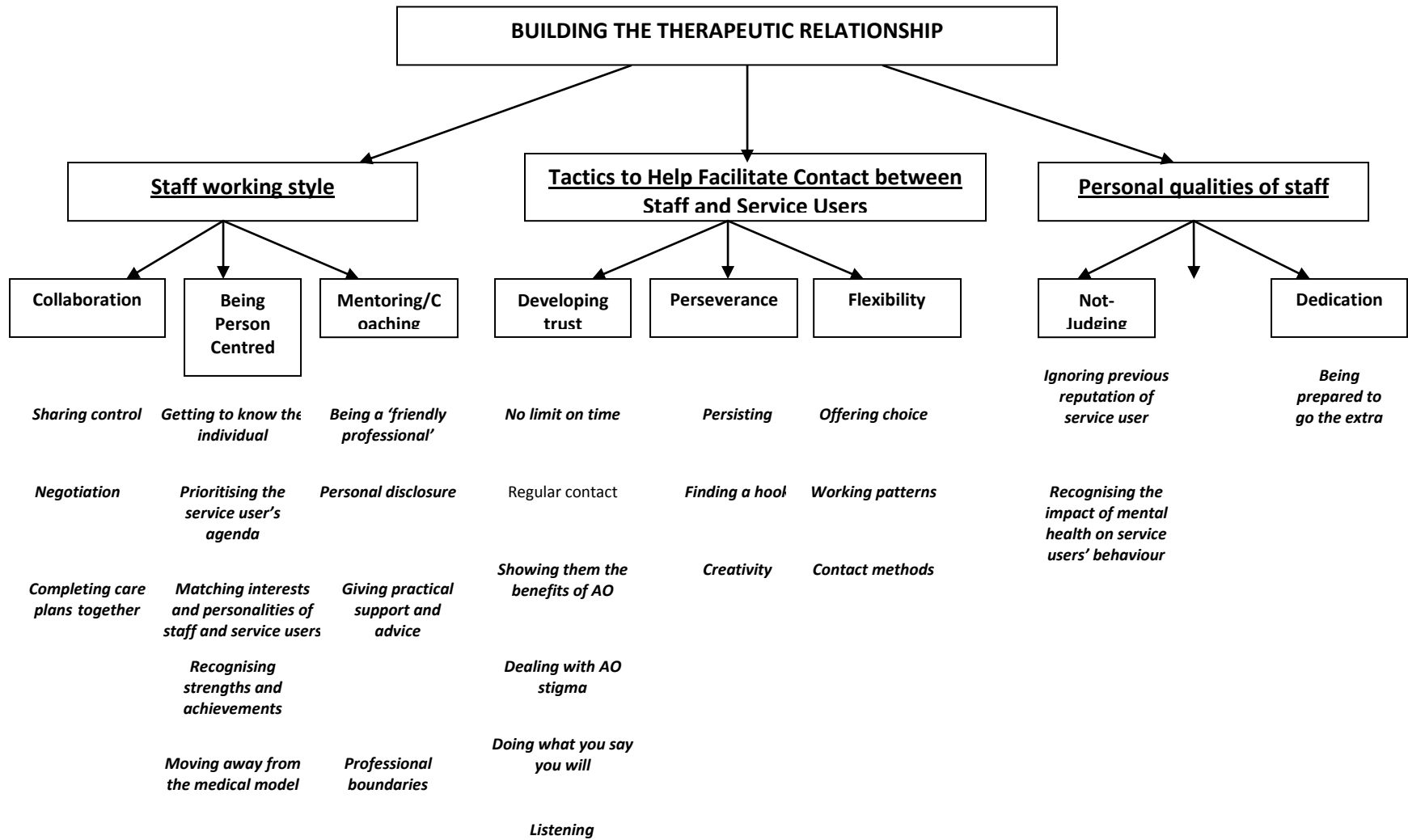
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Appendix 11

Diagram to illustrate themes

Theme 1. BUILDING THE THERAPEUTIC RELATIONSHIP



Theme 2. MAINTAINING THE THERAPEUTIC RELATIONSHIP

MAINTAINING THE THERAPEUTIC RELATIONSHIP

Managing Challenges

Strategies to minimise challenges

Responding to Challenges

Switching service users to another care co-ordinator

Staff resilience

Advance preparation

Taking positive risks

Validating progress

Spotting the early signs

Becoming part of the service user's delusions

Not taking things personally

Re-establishing contact quickly

Loss of service users' trust

Being realistic

Finding out the problem

Knowing when to seek support

Taking back control

Using the team for ideas

Risk takes priority

Advance directives

Allowing service users to vent without reacting

Recognising Progress

Psychological formulations

Hospital is the last resort

Reducing visits

Shared responsibility

Weekend cover

THEME 3. SERVICE FACTORS ENABLING ENGAGEMENT

