Case managers' experiences of engagement with service users in UK early intervention services

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere

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Abstract

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Background: Early intervention services (EIS) were set up during the 1990s worldwide to provide support and treatment for individuals experiencing first-episode psychosis (FEP) to reduce delay of treatment. Staff engagement with individuals with FEP in EIS settings is important to reduce the longer-term impact of this condition and promote recovery. Further qualitative understanding is required due to a paucity of evidence exploring engagement from the perspectives of staff in these settings.

Aim: To explore and understand case managers’ experiences of engagement with service users in early intervention settings.

Methods: A systematic review of qualitative literature was undertaken and followed by a primary qualitative study. Seven case managers from mental health nursing backgrounds and working in EI services were purposively sampled and interviewed from a single NHS Foundation Trust. Semi-structured interviews were used. Interpretive phenomenological analysis (IPA) of transcripts was undertaken following six stages.

Results: The reviewed literature identified three key themes influencing engagement: 1) Being authentic based on real dialogue and collaboration 2) Pushing against barriers- engaging against all odds 3) The chameleon effect- the skill of being adaptable. Five master themes were identified from the primary qualitative study as key to engagement: (1) Being on the same page; (2) Engagement as an interpersonal relationship; (3) Managing self and emotions; (4) The practicalities of engagement (5) The impact of organisational factors upon engagement.

Discussion: Engagement was experienced as multi-faceted, complex, and changeable. Collaboration, trust, and shared understanding were identified as important elements to effectively engage.

Conclusions: Engagement in the context of EIS can be defined as a mutually beneficial connection that takes place between service users and staff which allows for implementation of treatment. Engagement strategies found helpful were trust, therapeutic dialogue, shared understanding, collaboration, and practical approaches. Further exploratory research should be conducted across multiple UK settings, to further build on and understand engagement within the wider EIS context.

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Chapter One : Introduction and background

1.1: Introduction

A first-episode of psychosis (FEP) typically begins in a person's mid to late teens to early twenties and can be characterised by a range of symptoms that includes hallucinations, paranoia, and other delusional ideas, disorganised speech, or social withdrawal (French et al., 2010; Bromley et al., 2015). Consequently, FEP is a typically highly disruptive and distressing experience not only for the individual but also for their families and friends (Brunet & Birchwood, 2010). To address the impact of FEP, specialist mental health teams such as early intervention services (EIS) were set up during the 1990s to provide intensive support and treatment for individuals experiencing a first episode (Birchwood et al., 2002).

A key guiding principle of EIS is that treatment should begin as soon as possible during the course of FEP to prevent the development of severe symptomatic and functional impairments known to occur in major mental illnesses such as schizophrenia (McGorry, 2000; McGorry et al., 2008). Thus, engagement of individuals with FEP with early intervention and treatment is fundamental to reduce the devastating, longer term impact of this condition upon individuals and their families, and to facilitate a more favourable recovery (Birchwood et al., 2002). However, despite the extensive efforts of mental health professionals to engage with individuals within this critical period of early treatment to optimise recovery, some may begin to partially engage or disengage from such services due to factors that can include poor insight, poorer quality of life, substance misuse, fear, or stigma (Lecomte et al., 2008; Tindall et al., 2019). The core aim of this empirical study was to understand how mental health nurses in their professional roles as case managers within EIS settings experience the process of engagement, what they understand by engagement, how they work with varying levels of participation, and what approaches they used to optimise and maintain contact with people using such services.

1.2. What is psychosis?

Psychosis affects up to 3% of the worldwide population, can occur in a range of psychiatric diagnoses, and is typically characterised by a cluster of symptoms that can include hallucinations, disorganised speech, paranoia, delusional beliefs, or social withdrawal (Bradford et al., 2003; Brunet & Birchwood, 2010; Waldheter & Penn, 2009). FEP affects greater number of males than females and usually begins in the mid to late teens or early twenties (McGrath et al., 2004; Morgan et al., 2006). Furthermore, young males have an earlier onset than females (median 5 years) and for the psychotic disorder to develop more severely (Birchwood et al., 2002). FEP can be a highly distressing experience as it can seriously affect an individual's life opportunities and become a burden for the family, leading to dropping out of education or employment, family breakdown, hospitalisation and in some cases, detention and treatment under the Mental Health Act (Pugh & Lamb, 2010; Brunet & Birchwood, 2010). There is also a significant decline in social contact with a young person's peer group, especially with young men (Birchwood et al., 2002).

1.3 The critical period hypothesis for early intervention for FEP

The early stages of psychosis are regarded as a critical period with major implications for preventing the advancement and chronicity of the illness and social and functional deterioration (Birchwood et al., 2002). It is contended that psychosis ticks all the boxes as a mental illness which requires immediate attention and has the potential to become a lifelong disabling condition (French et al., 2010). However, it may take up to two years for some individuals to access help after experiencing the first symptoms of psychosis (Brunet & Birchwood, 2010). This delay in accessing treatment is commonly referred to as the ‘duration of untreated psychosis’ (DUP) (Marshall et al., 2005). It has been suggested that such delays in receiving help may be due to a young person’s mood state and functional and behavioural changes being misinterpreted as typical adolescent characteristics or mood changes such as depression (Lal & Malla, 2015). Additionally, detecting a clinical picture of FEP can be further blurred by pre-existing problems such as personality traits, use of street drugs or abnormal adolescent behaviours (French et al., 2010). However, it is within this period of delayed help that individuals with FEP may further withdraw from important familial and social relationships or key milestones such as educational or employment opportunities.

In the UK, the Department of Health and Social Care (DHSC) emphasises the reduction of duration of untreated psychosis (DUP) as a national priority by setting a median target of three months to receive help with no delay to extend beyond six months (DHSC, 2002). Similarly, the ‘Early Psychosis Declaration’ (Bertolote & McGorry, 2005) requires treatment to be reached within three months of the first onset of psychotic symptoms. Hence, the rationale for early interventions is based on the premise that the early course of psychosis will be favourably responsive to treatment and support, with major implications for secondary prevention (Birchwood et al., 2002). Evidence suggests that initiation of treatment at the earliest possible opportunity not only leads to better individual outcomes for young people but can lead to substantial health care savings in the medium- and long-term treatment trajectory of the condition (French et al., 2010). However, individuals experiencing negative symptom profiles such as reduced motivation or social withdrawal are less able to recover and also less likely to be identified, or come forward and engage with treatment (Waldheter & Penn, 2009).

1.4 The concept of early intervention provision for FEP

Since the 1990s, there has been increasing confidence that earlier, preventative interventions for psychotic disorders can be a realistic proposition in clinical settings (Birchwood et al., 1997; McGorry, 1998). The TIPS Project in Norway (Early Treatment and Intervention in Psychosis) was an early example of the effectiveness of early interventions through targeting of health care providers, education providers, and the public through educational campaigns, which increased help seeking and reduction of DUP from 1.5 years to 6 months (Larsen et al., 2001). Another study carried out as part of the Early Psychosis Intervention Programme (EPIP) in Singapore found that a combination of public education and networking with primary health care providers reduced DUP from a median of 12 to 4 months in the experimental group (Chong et al., 2005).

In view of the promising evidence-base, there has been an increasing international interest in developing EISs to reduce DUP and improve the prognosis of the first-psychotic episode (Craig et al., 2004; Craig & Power, 2010). EISs are specialist multi-disciplinary community based mental health teams set up to seek, identify and reduce treatment delays and prevent the chances of FEP becoming a lifelong condition (Polari et al., 2009). Timely access to EISs has been shown to have a significant long-term beneficial impact on the lives and livelihood of individuals with FEP and their families (NHS England, 2016). The evidence for the effectiveness of EISs stems mainly from specialist teams that were set up during the late 1990s in Melbourne, Australia followed by Birmingham and Lambeth, London in the United Kingdom (Dodgson & McGowan, 2010). EISs have demonstrated their effectiveness in helping to reduce admission and readmission rates to hospital, prevention of further psychotic relapses and by cutting demands on mental health services in the medium to long term (McCrone et al., 2008). As a result, EISs are now well established in Europe, North America, and Australia providing care across the first two to three years following the onset of FEP (Craig & Power, 2010).

The Department of Health and Social Care recommends that individuals with FEP who are aged between fourteen to sixty-five years should receive three years of treatment and support with EISs to promote recovery (Department of Health and Social Care [DHSC], 2002; 2011; NHS England, 2016). Clinical guidelines on schizophrenia and psychosis first published by the National Institute for Clinical Excellence in December 2002 (NICE, 2002) expect EISs to deliver evidence-based recovery interventions such as low dose antipsychotic medication, cognitive behavioural therapy, psychoeducation, and family interventions. However**,** continuous engagement of individuals with FEP in EISs is regarded to be the single most important factor to reduce the potentially devastating impact of the disorder by reducing hospital admissions, improving mental state, and by enabling individuals to access support for their personal development and recovery (Tait et al., 2010).

1.5 What is engagement?

Although engagement is regarded to be an important concept and increasingly used in many clinical practice settings and research facilities, it is difficult to fully establish and explain what is meant by this term across the broader healthcare context (Bright et al., 2015). Engagement as a concept lacks a clear universal definition (O'Brien et al., 2009). Consequently, engagement as a term is often used interchangeably or inconsistently across broader health care and rehabilitation settings to include *accessing services, retention within services, enthusiasm and self-management, service provisio*n and *the interaction between the patient and healthcare provider* (Bright et al., 2015; Doyle et al., 2014). However, engagement as a term is regularly used in mental health settings to describe a collaborative and person-centred interaction that takes place between service users and service providers (Tait et al., 2010). Burns and Firn (2002) have further suggested that engagement involves a contact between mental health service providers and service users with both parties agreeing that this contact is mutually beneficial. It is further contended that an individual who willingly arranges appointments with his/her mental health worker, and actively participates in managing and co-operating with treatment and seeking help as needed, should be considered more engaged than someone who either passively accepts treatment or refuses it (Tait et al., 2002).

A further definition based on the recovery model in mental health settings regards engagement to be a trusting therapeutic relationship that is developed with individuals to ensure effective support (Tait et al., 2002). It is widely assumed that the interactive nature of engagement is beneficial for developing a trusting, therapeutic relationship and for promoting the necessary conditions for recovery for individuals with major mental health problems (Wright et al., 2011). It is contended that a trusting therapeutic relationship depends upon appropriate communication, developing rapport, demonstrating empathy, and instilling hope (Adam et al., 2003; Shattell et al., 2007; Stanhope et al., 2009). This is consistent with the notion that the relationship between the service user and mental health worker is a central tenet for a service user's engagement in treatment, both as a stand-alone intervention and as a platform for delivering other interventions (McCabe & Priebe, 2004). The importance of the two-way relationship of engagement is further corroborated by Bright et al. (2015, p.651), in which engagement was 'co-constructed through interpersonal connection' and thus challenging the notion that engagement was solely the responsibility of the service user.

A further viable explanation is provided by the 'Tidal Model' in which the patient and the mental health professional are engaged in a therapeutic relationship that is based upon mutual influence (Kusdemir et al., 2022). By employing the concept of therapeutic alliance, the Tidal Model gives emphasis to engaging the individual fully in the process of care to determine and contribute to interventions that may best meet their varying needs (Barker, 2001a). The Tidal Model's emphasis on mutuality to foster effective engagement represents itself as a conceptual framework through which mental health nurses and other professionals adopt a person-centred, empowering approach to human lived experiences (Barker, 2002). Thus, the current literature draws attention to the essential elements of engagement being relationship-centred that focus on service users collaborating, contributing, and actively participating with practitioners around decision-making in care and treatment.

1.6 Principles of engagement in early intervention settings

A range of attitudes, behaviours and skills of mental health professionals have been identified as being optimal to successfully engage with individuals who use EISs. For example, developing a positive personal relationship based on trust, rapport and respect between the individual using EIS and the mental health professional has been identified as a key factor that influences and enhances engagement (Tindall et al., 2019). Furthermore, individuals successfully engage with mental health professionals in EIS settings in instances where they feel valued, listened to, and understood (Stewart, 2012).

Individual preferences are key considerations in successfully engaging with people using EISs. These include the importance of collaboratively working alongside the individual to negotiate the timing of visits, or phoning or texting to remind the individual of the appointment beforehand (Tait et al., 2010). Engagement in EIS settings can thus be viewed as complex, nuanced and multi-dimensional that emphasises the working relationship between service users and mental health professionals to work in agreement and collaboration towards goals as opposed to just physical attendance at appointments (Tait et al., 2002; Tait et al., 2010; Tindall et al., 2015). However, it has also been identified that non-traditional methods of establishing engagement, by using a variety of approaches have been regarded to work just as effectively with some individuals in EIS settings. For example, non-face-to-face electronic methods such as text messages and email communication have been generally considered to be an approach that is useful for some individuals to maintain contact in EIS settings (Tait et al., 2010). Hence, although engagement is largely regarded as placing much importance on the building of trusting, therapeutic and collaborative relationships, there is also an emphasis on engagement being fundamentally based on establishing contact with the service.

As an individual's engagement with mental health services has been previously described as the single most important factor to prevent further psychiatric relapses and hospitalisation, the need to measure and evaluate engagement within community mental health services is vital (Lal & Malla, 2015). Measuring engagement in EISs is mainly achieved by electronically recording face-to-face contacts to provide critical information about the frequency and duration of each service user contact taking place (DHSC, 2001). Although this clearly does not cover the full range of factors that comprise engagement, another commonly used measure of service engagement in EIS settings is the Service Engagement Scale (SES) that enables professionals to report service user availability, collaboration, help seeking and adherence (Tait et al., 2002). However, it is also acknowledged that broader understandings of service user engagement In EIS settings may not be fully captured by using measurement tools in isolation (Tait et al., 2002). Given that SES and electronic recording is not jointly completed by professionals and service users, it is questionable as to how these systems can further enhance engagement. Despite the usefulness of technology-based measurement tools, it could be argued that integrating the service user's access into such processes is more in line with the person-centred and collaborative nature of engagement and may remove some of the practical and perceived barriers to care (Dixon et al., 2016).

1.7 Challenges of engagement

Disengagement rates across mental health services are reported to be significantly higher than for all other health services (Mitchell & Selmes, 2007). Up to 50% of individuals who use mental health services will disengage with this being particularly problematic with adolescents and young people (Lal & Malla, 2015). This may relate to adolescents and young people finding it difficult coming to terms with a psychiatric diagnosis due to the associated stigma and questioning the usefulness of professional help and support (O'Brien et al., 2009; Gulliver et al., 2010). Moreover, research has shown that psychotropic medication side-effects impact upon an individual's willingness to engage with services (Stanhope et al., 2009). Some individuals may disengage from mental health services due to perceiving that medication is being enforced and sustaining their mental ill health (Priebe et al., 2005). Similarly, individuals may avoid contact with mental health services for fear of being compulsorily detained and treated under legislative processes such as the Mental Health Act (Sweeney et al., 2015). However, engagement is reported to be more challenging with individuals who are experiencing FEP and perhaps more so than with any other mental health disorder (Birchwood et al., 2002). Between nineteen to forty percent of individuals diagnosed with FEP will disengage with EISs throughout their three-year period of care (Tait et al., 2003; Tindall et al., 2015). Several factors have been identified that may hinder engagement with individuals with FEP and include interpersonal difficulties, poor insight, limited motivation, and reluctance to engage in frank discussions about psychotic symptoms (Birchwood et al., 2002).

Further FEP studies reveal that poor engagement is associated with being male, being unemployed, substance misuse, or lack of family support or breakdown (Tait et al., 2010; Stowkowy et al., 2012). Similarly, individuals with FEP are less likely to engage if the relationship with EISs is perceived to be coercive, non-collaborative, negative or patronising (Stewart, 2012). Likewise, persuading individuals to comply with treatments or by insensitive use of psychoeducation have been identified as potential triggers for avoidance and subsequent disengagement with EISs (Tait et al., 2010). Notwithstanding, due to a lack of research, such associations do not explain why an individual with FEP may begin to re-engage with EISs after a period of disengagement (Anderson et al., 2010; Doyle et al., 2014).

A further limitation of the FEP evidence-base is being able to capture and understand the perspectives of disengaged service users in contrast to those who are well engaged and have less severity of symptoms (Tindall et al., 2015). However, given the emphasis that has focused on person-centred approaches in influencing engagement, it is important to further understand how collaborative rather than one-way approaches can enhance engagement.

Given that engagement is not solely the responsibility of service users and draws attention to the practitioner's active role in this process, there is limited literature that has explored case manager's views and experiences of engagement with service users within EIS settings internationally (Harris et al., 2011; Tindall et al., 2015; Tindall et al., 2018; Tindall et al., 2019). Case managers typically have the most contact with service users throughout their three-year period of care (Stewart, 2012; Tindall et al., 2015). Therefore, case managers are well placed to provide valuable insights into why engagement may take place or not. In view of this, it is important to understand engagement from the perspectives of staff working in these services. Therefore, the focus of this thesis is to gain greater understanding and insight of a case manager's experiences of engagement with service users within EIS settings.

1.8 The structure of the thesis

The key aim of this thesis was to understand how community mental health nurses in their capacity as case managers within EIS settings experience the process of engagement and the various approaches that they use to establish contact and engagement. This first chapter provides an introduction and background to the research and sets out the rationale for the focus of this research. This chapter also considers the wider perspectives around engagement in EIS teams and begins to describe the challenges faced by mental health professionals in establishing and maintaining contact with individuals who use these services.

Chapter two is a literature review which aims to systematically present and discuss the qualitative literature in relation to mental health professional's engagement with service users in a range of community mental health settings worldwide.

Chapter three presents the methodology and research methods overview which outlines the epistemological approach and methodological framework underpinning the research. Interpretive Phenomenological Analysis (IPA) was used as a qualitative methodological framework to examine how mental health practitioners make meaning of their engagement experiences in EIS settings. The research included the use of semi-structured one-to-one interviews. The IPA analytical method as outlined by Smith and Osborn (2008) was used as a guiding framework, flexibly following six key stages.

Chapter four provides an overview of the study findings. Chapter five further discusses the study findings by interrogating the challenges and opportunities for mental health professionals and their engagement with individuals in EIS settings. Limitations and study choices are also discussed. Key recommendations are made for practice and areas that further warrant more detailed investigation.

Chapter six summarises and concludes by considering the study's implications for practice and its contribution to the knowledge base. This final chapter will also consider my thoughts and reflection of the research process and the topic area.

Chapter Two : Mental health practitioner experiences of engaging with service users in community mental health settings: a systematic review of qualitative evidence.

2.1 Introduction

This chapter presents a systematic review of qualitative studies to further understand mental health practitioners' experiences of engagement with service users across a range of community mental health settings. To begin, there is a discussion and justification for the chosen literature review's methodology and methods. This is followed by a presentation of the review's results and a discussion of the themes identified following a process of thematic synthesis (Thomas & Harden, 2008). Finally, there is further consideration of the implications for research and practice as well as limitations.

Early scoping searches indicated that some qualitative studies had been undertaken to explore mental health practitioners' perspectives of engagement. However, no known qualitative systematic reviews were identified that synthesised the findings from individual studies around this topic. Systematic reviews of qualitative literature are increasingly regarded as important **to summarise research addressing a phenomenon of interest and to contribute to understanding of the topic** (Wood et al., 2015). Moreover, Thomas and Harden (2008) state that qualitative studies provide important perspectives and should be subject to the same rigour as quantitative studies to examine a specific evidence base.

2.2 Aims

This review aimed to synthesise qualitative evidence regarding mental health practitioners' experiences of engagement. The research question was:

> *'What are the experiences of mental health practitioners in relation to engaging with service users in community mental health settings?'*

The SPICE components (**S**etting, **P**erspective, **I**ntervention/interest, **C**omparison, **E**valuation) were used to develop the review question (Booth et al., 2012). A protocol was registered with the PROSPERO systematic review protocol registry (www.crd.york.ac.uk/prospero/; ID CRD42017083976). A search of the PROSPERO database showed no previous or present reviews on this topic.

2.3 Methods/design

2.3.1 Inclusion and exclusion criteria

Studies were included if they were reported in English and published in a peer-reviewed journal. Studies had to examine mental health practitioners' experiences of engaging with service users in community mental health settings by using interviews and/or focus groups and utilise qualitative methods of analysis. Studies which used quantitative methods or mixed-method studies where qualitative data could not be separated were excluded. Conference abstracts, reviews, editorials, opinion pieces and grey literature were also excluded.

2.4 Search strategy

A comprehensive search of Medline, EMBASE, PsychINFO, CINAHL and

AMED was performed in January 2018. The search strategy was developed in consultation with an academic librarian. Given the paucity of qualitative studies focusing on practitioner engagement in community mental health services, the search terms were broad to ensure that no potential studies were missed. Key search terms were based on SPICE components and used symbols such as truncations and wildcards to capture spelling variations across international studies. Boolean operators such as AND, and OR were used to combine key search words. The limits of peer-reviewed journal and English language were applied. The following keywords were used:

(‘Community Mental health team*’ OR ‘Community Mental Health Setting*’ OR ‘Early Intervention Team*’ OR ‘Early Intervention Service*’ OR ‘Early Intervention Setting*’ OR ‘Assertive Outreach team*’ OR ‘Assertive Outreach setting’) AND (‘Mental health practitioner*’ OR ‘Mental health professional*’ OR ‘Mental Health Nurse*’ OR ‘Clinician*’ OR ‘Case Manager*’ OR ‘Care Coordinator*’) AND (‘Engaging’ OR ‘Engagement’ OR ‘Participation’ OR ‘Collaboration’ OR ‘Therapeutic alliance*’) AND (‘Serious mental illness’ OR ‘Severe Mental Illness’ OR ‘Psychos*’ OR ‘Psychotic’ OR ‘Psychotic disorders’ OR ‘Schizophrenia’ OR ‘Bipolar Disorder*’ OR ‘Dual Diagnosis’) AND (‘Experience*’ OR ‘Perspective*’ OR ‘Staff experience*’ OR ‘Lived experience*’ OR ‘View*’ OR ‘Perception*’ OR ‘Understanding*’ OR ‘Standpoint*’ OR ‘Description*’).

Additional manual searches of reference lists of included papers were conducted through a process of pearl diving to identify further studies (Booth et al., 2012). Specific date ranges were not imposed to maximise the identification of potentially relevant literature.

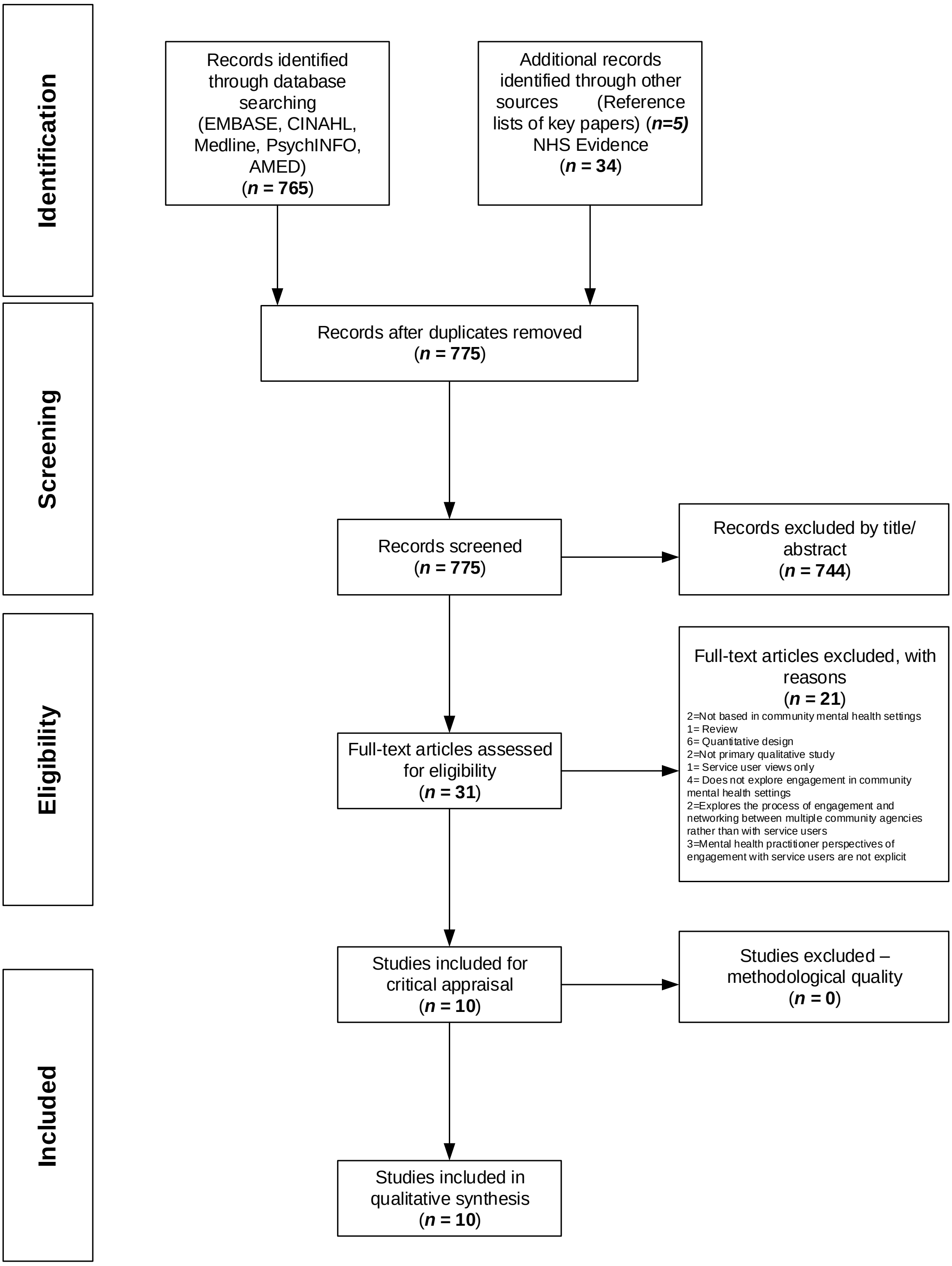
2.5 Selection of studies

The database searches led to the identification of 765 articles. An additional 39 records were identified by searching through NHS evidence (www.evidence.nhs.uk) and reference lists of retrieved papers. After removing duplicates, this resulted in 775 papers from all database and manual searches. Titles and abstracts were screened, and 31 full-text studies were assessed against the review question and inclusion criteria. Ten studies were included and this process is summarised in the PRISMA (preferred reporting items for systematic reviews and meta-analyses – Jakimowicz et al., 2015) flow chart in Figure 2.1. The first reviewer had responsibility for selecting studies for inclusion. The second reviewer independently reviewed five randomly included papers and five excluded papers to confirm eligibility. There was 100% agreement between these raters regarding papers for inclusion.

2.6 Data extraction and quality appraisal

Characteristics of included studies were extracted by the lead reviewer into a qualitative data extraction template provided by the National Institute of Clinical Excellence and the Social Care Institute for Excellence (NICE-SCIE, 2007) (See Appendix 1). The second reviewer reviewed the data extraction process of five randomly selected articles for accuracy.

Figure 2.1: PRISMA flow chart of selection process



There were no disagreements on information extracted. Included papers were quality appraised using the Critical Appraisal Skills Programme (CASP) tool for qualitative studies (Critical Appraisal Skills Programme, 2002) or where appropriate, an adapted CASP tool for mixed methods studies (Critical Appraisal Skills Programme, 2018). A ‘yes’, ‘no’ or ‘can’t tell’ response was given to indicate how clearly points prompted by the CASP checklists were addressed in each paper.

Due to the complexity of assessing the quality of primary qualitative studies, there is no one recommended tool or gold standard (Aveyard et al., 2016). However, as the CASP tool is a user-friendly and generic tool for novice researchers, it is the most commonly used quality checklist tool for qualitative studies (Dixon-Woods et al., 2007). Although the CASP tool is reported to be less robust as a measure of methodological quality, it is reported to be a relatively good measure for transparency of research practice and reporting standards (Booth et al., 2012). Therefore, the CASP tool was used not to exclude studies on the basis of their quality and to weight the information derived in forming the final themes. Weaker studies were not excluded following quality assessment to avoid eliminating potentially valuable insights in the synthesis.

A summary of the outcome of the CASP appraisal process is provided in Table 2.1. The second reviewer independently appraised each included study to ensure greater transparency and rigour of this process with 100% agreement being attained across all studies/categories. Looking across Table 2.1, the quality of included studies varied. All studies except for two provided clear and specific aims for their research. Six studies clearly explained their choice of research design to meet the study aims. Four studies did not explicitly discuss why their selected sample was the most appropriate to participate. It is noteworthy that ethical considerations and the researcher-participant relationship were the areas least discussed. Only two studies openly considered the relationship between researchers and participants. Four studies omitted or only superficially reported the ethical process. Six studies demonstrated a transparent and rigorous approach to analysis. However, all studies clearly presented their findings and were further illuminated by participant quotes. All studies received a positive final rating in terms of the value of the research to further enhance knowledge and understanding of engagement across community mental health settings.

2.7 Study characteristics

Characteristics of included studies are provided in Table 2.2. Published between 2004 and 2016, they had been conducted in three countries: UK (*n*=6), USA (*n*=1) and Australia (*n*=3). Most were purely qualitative (*n*=8), two studies using mixed methods. Four reported from assertive outreach teams (AOTs) (Addis & Gamble, 2004; Hitch, 2009; Wright et al., 2011; George et al., 2016), one study was from an Early Psychosis Prevention Intervention Centre (Gairns et al., 2015) and three were based in community mental health teams (CMHTs); (Coombes & Wratten, 2007; Procter et al., 2015a; Procter et al., 2015b). One study reported from two assertive community treatment teams and thirteen CMHTs (Killaspy et al., 2009). In another study, participants were drawn from one early intervention service (EIS) and three AOTs (Clutterbuck et al., 2009).

Table 2.1: Quality assessment of included studies[1]

Qualitative studies			**CASP quality criteria met**							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Addis & Gamble (2004)	√	√	√	√	√	-	√	√	√	√
Coombes & Wratten (2007)	-	√	√	√	√	X	-	-	√	√
Clutterbuck et al. (2009)	√	√	√	-	√	X	X	√	√	√
George et al. (2016)	√	√	-	-		X	-	-	√	√
Hitch (2009)	√	√	√	√	√	-	√	√	√	√
Procter et al. (2015a)	√	√	-	-	-	X	√	-	√	√
Procter et al. (2015b)	√	√	√	√	√	X	√	√	√	√
Wright et al. (2011)	√	√	√	√	√	√	√	√	√	√
Mixed method studies										
Gairns et al. (2015)	√	√	-	-	√	√	√	-	√	√
Killaspy et al. (2009)	-	-	-	√	√	X	-	√	√	√

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[1] **Key**: Yes (✓) No (x) Can't tell (-)

CASP questions (qualitative & mixed method studies) **1**: Aims clearly stated; **2**: Appropriate methodology; **3**: Appropriate study design; **4:** Appropriate recruitment strategy; **5:** Data collection methods; **6**: Consideration of the relationship between researcher and participants; **7**: Ethical issues & considerations; **8**: Data analysis methods, validity, and reliability; **9**: Clear discussion of findings; **10**: Value of the research and transferability/generalisability of the findings.

Table 2.2: Summary of included studies

Study	Author(s) and year	Study research question/aims	Sample	Data collection methods	Type of analysis
1	Addis & Gamble (2004)	Aim: To provide a constructed view that captures nurses' experiences of assertive engagement.	5 nurses from one AOT setting in the UK.	Semi-structured interviews.	Hermeneutic philosophical thematic analysis.
2	Clutterbuck et al. (2009)	Aim: To explore the attitudes of staff working within mental health services toward cannabis in general and cannabis use in individuals with severe mental health problems.	20 practitioners from 1 Early Intervention Team and 3 AOTs in Birmingham, UK.	Semi-structured interviews.	Grounded theory.
3	Coombes & Wratten (2007)	Aim: To describe the lived experiences of community mental health nurses working with people with a dual diagnosis.	7 community mental health nurses from 2 NHS Trusts in South of England, UK.	Semi-structured interviews.	Colaizzi's (1978) 6 stage method.
4	Gairns et al. (2015)	What treatment barriers are associated with young people with FEP? What supports would be useful to implement PTSD intervention?	16 (of 20) Case Managers from an Early Psychosis Prevention Intervention Centre in Melbourne, Australia.	2 focus groups for the qualitative component of the study (8 participated in focus groups).	Grounded theory.
5	George et al. (2016)	Aim: To explore the perceptions and experiences of clinical staff related to assertive engagement in PACT services.	12 clinicians from one assertive community team in Central Virginia, USA.	Semi-structured focus groups.	Thematic analysis.

List of abbreviations: AOT= Assertive Outreach Team; CMHT= Community Mental Health Team

Table 2.2 continued overleaf

Table 2.2 continued

Study	Author(s) and year	Study research question/aims	Sample	Data collection methods	Type of analysis
6	Hitch (2009)	Aim: To describe the experience and meaning of engagement for staff and clients of assertive outreach teams	5 clinicians and 5 service users from one AOT setting in London, UK.	Semi-structured interviews.	Interpretive Phenomenological Analysis.
7	Killaspy et al. (2009)	Aim: To investigate if there are differences of care delivered to study participants in terms of CMHT interventions and Assertive Community Treatment (ACT) and why ACT may be more acceptable to clients than CMHT care.	37 community mental health practitioners from 13 CMHTs and 2 assertive community treatment teams in London, UK.	Semi-structured interviews for the qualitative component.	Qualitative analysis used coding to generate themes plus specialist software.
8	Procter et al. (2015a)	Aim: To explore the views and experiences of community mental health clinicians with regard to the way that they engage consumers in the emergency context.	16 mental health clinicians from one emergency community mental health service in Adelaide, Australia.	Semi-structured focus groups.	Thematic analysis.
9	Procter et al. (2015b)	Aim: To identify the skills and attributes deployed by rural mental health clinicians when engaging with consumers in the community mental health context.	9 mental health clinicians from one rural community mental health service in South Australia.	Semi-structured focus groups.	Thematic analysis.
10	Wright et al. (2011)	Aim: To explore the participants perceptions of engagement within one assertive outreach setting.	14 mental health practitioners and 13 service users from an AOT Setting in the Midlands, UK.	Semi-structured interviews.	Phenomenology informed thematic analysis.

2.8 Data synthesis

Thematic synthesis (Thomas and Harden, 2008) was used to analyse and synthesise content across included studies. This method has been used in systematic reviews that address questions about lived experiences (Booth et al., 2012). Due to the multi-disciplinary nature of included studies, thematic synthesis was deemed suitable given its ability to translate the findings across disparate literature into common themes for comparison and analysis (Thomas, et al., 2012). In line with guidance set out by Thomas and Harden (2008), this method followed three key steps:

The first stage involved free line-by-line coding of the findings section of each study. Each sentence and paragraph were carefully read with a view to identifying underpinning themes and concepts. Text was highlighted if it was considered to represent mental health practitioner experiences of engagement with service users, with a code being created to summarise its content. A code was represented as a single word (such as 'empathy') or a short phrase ('being person-centred') to summarise and describe a sentence or paragraph of text (see Appendix 2). In total, forty-five initial codes were developed.

In the second stage, conducted by the lead reviewer, codes were juxtaposed and compared across studies with similarities being grouped together to construct descriptive themes. Practitioner quotes were taken from included studies to further support the descriptive themes (see Appendix 3 for list of codes and descriptive themes). The third stage involved the development of analytical themes by grouping descriptive themes together with clear commonalties (see Appendix 4). This stage entailed going beyond the content of the original studies by using the descriptive themes to answer the review question. For example, four of the nine descriptive themes focused on the importance of effective interpersonal relationships and collaboration (*Building rapport so that they can feel safe; And I go with their choices, because they've got rights too; Showing a more human side to myself; You actually have to got to show that person that you are interested in helping them and in what they've got to say*). From these descriptive themes, it was noted that open, honest, respectful, and collaborative relationships were associated with greater levels of trust and rapport. These perspectives were thus captured in the first analytical theme entitled '*Being authentic based on real dialogue and collaboration'*. Altogether, this process resulted in the development of three overarching analytical themes.

2.9 Reflexivity

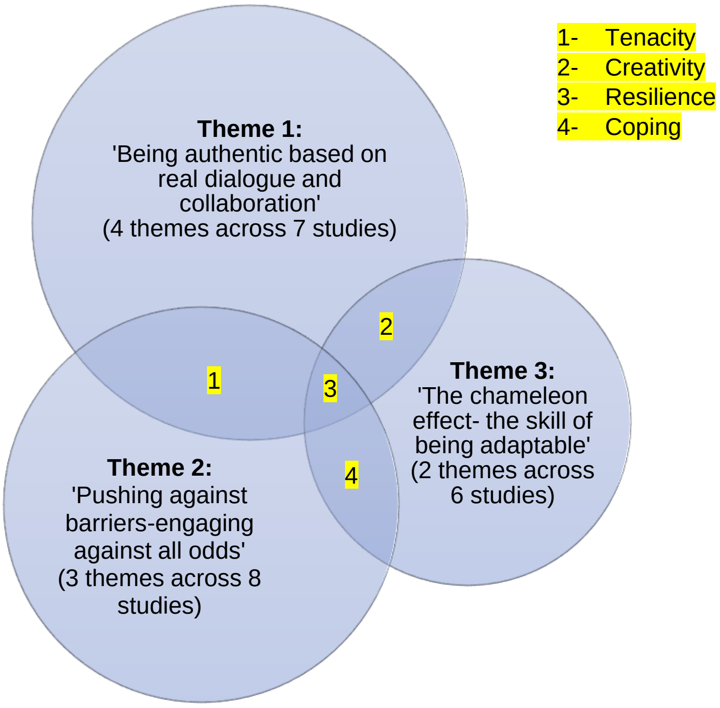
This review was primarily conducted by the lead reviewer (P.H.) who has previously worked as a mental health nurse in several community mental health teams in UK settings. By virtue of this extensive clinical background, a wealth of experience in engagement work has been gained which is a notable strength for the focus of this review. However, to address the potential influence of prior experiences on the data extracted and synthesis, reflexive notes were kept to identify biases and assumptions. Regular supervisory discussions with the research team allowed for assumptions to be scrutinised and facilitated ongoing critical reflection.

2.10 Results

Engagement is experienced by mental health practitioners as a multi-faceted, changeable, and complex phenomenon. Nine descriptive themes were identified: 1) ‘Building rapport so that they can feel safe’; 2) ‘And I go with their choices, because they’ve got rights too’; 3) ‘Showing a more human side to myself’; 4) ‘You actually have to show that person that you are interested in helping them and in what they’ve got to say’ 5) ‘You can’t force someone to like you’ ;6) ‘I have got a time restriction I have got to go and see someone else’; 7) Anxiety and fear about the unknowingness of engagement work; 8) ‘You mustn’t give up on them’; 9) ‘It’s about the things you do alongside them’. Further development generated three analytical themes which are discussed below: 1) Being authentic based on real dialogue and collaboration; 2) Pushing against barriers- engaging against all odds; 3) The chameleon effect- the skill of being adaptable.

The findings are structured overleaf according to the analytical themes, along with the descriptive themes. Although the three analytical themes are identified as distinct categories, some overlap was evident to illustrate the consistent emphasis on use of person-centred, therapeutic skills across all themes. Figure 2.2 indicates the level of overlap between the three themes.

Figure 2.2: Illustration of the relationship between the three analytical themes



Theme 1: Being authentic based on real dialogue and collaboration

The first theme emerged as the largest analytical theme as this was informed from four of the nine descriptive themes ‘Building rapport so that they can feel safe’, ‘And I go with their choices, because they’ve got rights too’, ‘Showing a more human side to myself’ and ‘You actually have to show that person that you are interested in helping them and in what they’ve got to say’.

Practitioners consistently attached a high value to engaging as a person rather than a practitioner to more effectively facilitate this process. An important finding within this theme is that engaging service users is experienced as more successful when relationships are open, honest, and respectful, where collaborative approaches are the norm and where there is mutual trust. Interestingly, concepts of trust and rapport were strong, recurring descriptions throughout all the reviewed studies and perceived as fundamental qualities for increased engagement. Building rapport was also identified as an integral process for engagement. One practitioner stated:

> *‘Building rapport so that they can feel safe, so that you’re a safe person for them to be with, so that they can start telling you more. Because if they don’t feel safe, they’re not going to tell you hardly anything’* (Procter et al. 2015a, p.431).

Some studies demonstrated that when time was invested to build trust and develop rapport, there was evidence of greater help seeking and engagement from service users (Hitch, 2009; Procter et al., 2015a; George et al., 2016). Person-centred qualities such as trust and rapport were highlighted as aiding collaborative approaches to engagement (Addis & Gamble, 2004; Hitch, 2009; Procter et al., 2015a; Wright et al., 2011; George et al., 2016). Practitioners identified that working at a service user’s pace and respecting their choices were essential for successful engagement, as exemplified by the following quote:

> *‘This person that you are working for, you are working for them you are not deciding on what they should be doing’* (Wright et al., 2011, p.828).

Moreover, the latter description ‘working for’ gave emphasis to engagement being a service user-led process rather than necessarily directed by the practitioner.

It was found that respecting choices and pacing work also meant that active engagement could be experienced as a lengthy, and time-consuming process depending on the service user's perception of time and immediate priorities (Addis & Gamble, 2004). Some studies emphasised that displaying human qualities as well as professional ones would further encourage greater rapport and trust and influence future engagement (Addis & Gamble, 2004; Procter et al., 2015b; George et al., 2016). One practitioner described:

> '*There's still professional objectives, but I have to be consciously more human with people and let them see a different side of myself'* (Addis & Gamble, 2004, p.456).

Some practitioners further humanised their interactions by providing normalising explanations for mental health experiences which in turn, instilled greater levels of hope and optimism and encouraged greater levels of engagement (Procter et al., 2015b; George et al., 2016).

Person-centred qualities such as being warm, understanding, sincere and straightforward were emphasised by practitioners as facilitating better levels of engagement (Killaspy et al., 2009; Wright et al., 2011; Procter et al., 2015a; Procter et al., 2015b). One practitioner identified that engagement was also optimised by active listening:

> *'I think you have to show interest. That's the big one. You actually have to show that person that you are interested in helping them and in what they've got to say'* (Procter et al., 2015b, p.355).

Displaying a warm, genuine interest in the service user was also viewed as pivotal to developing a trusting relationship and promoting further engagement.

Theme 2: Pushing against barriers- engaging against all odds

The second theme was the next largest analytical theme being developed from three of the nine descriptive themes 'You can't force someone to like you', 'I have got a time restriction I have got to go and see someone else', 'Anxiety and fear and the unknowingness of engagement work'. This theme illustrated that engagement was influenced by several external pressures. It was noted throughout the reviewed literature that practitioners faced organisational pressures to engage with service users which could be perceived as being an artificial or forced process. Similarly, organisational requirements to engage service users, would suggest that this was at the expense of engendering person-centred approaches such as service user choice and autonomy.

Practitioners experienced hostility, ambivalence, or rejection in engaging some service users (Addis & Gamble, 2004; Killaspy et al., 2009). Furthermore, they described the reluctance of some service users to engage for varied reasons including fear, anger, stigma, or shame (Addis & Gamble, 2004; Hitch, 2009; Killaspy et al., 2009; Clutterbuck et al., 2009; Procter et al., 2015b; Gairns et al., 2015).

It was further emphasised that a service user's engagement was hindered by past negative experiences of mental health services rather than being attributable to the characteristics of practitioners working alongside them (Hitch, 2009; Gairns et al., 2015). However, it was identified how persistent efforts to engage service users placed pressure on staff to form artificial relationships as described in the following quote:

> *'Just because I'm working in assertive outreach…. you can't force someone to like you, and I think sometimes you've got to wrestle with that'* (Hitch, 2009, p.487).

Equally, it was reported how organisational pressures to engage with service users would lead to practitioners experiencing self-criticism or doubt if engagement was unsuccessful (Addis & Gamble, 2004).

Time related pressures were regarded as a major hurdle in terms of the quality of engagement (Addis & Gamble, 2004; Coombes & Wratten, 2007; Killaspy et al., 2009; Wright et al., 2011; Gairns et al., 2015). Various workload demands were perceived to impact upon the frequency of engagement with service users as described by the following statement:

> '*I think that you're seeing people fortnightly, but there are people like xx who need more that, and you're just not able to offer it due to time constraints placed on you by large caseloads, chronic caseloads and all the rest'* (Killaspy et al., 2009, p.537).

Efforts to engage hard-to-reach service users were also experienced as being emotionally demanding. Some studies identified that staff experienced feelings of frustration, despondence, or hopelessness when engagement was unsuccessful (Addis & Gamble, 2004; Killaspy et al., 2009). One practitioner stated:

> *‘It makes me feel pretty useless at times’* (Addis & Gamble, 2004, p.455)

Similarly, engagement with service users with dual diagnoses could be experienced as an almost impossible challenge due to the length of time taken to establish trust and rapport with this client group (Coombes & Wratten, 2007). Furthermore, practitioner fatigue was also experienced after working intensively to engage with service users (Addis & Gamble, 2004).

Possible risk factors in community settings were described as triggering practitioner anxiety which could create barriers to further engagement with some service users (Clutterbuck et al., 2009). Similarly, another study described the management of risk and the impact upon engagement as highlighted by the following quote:

> *‘You don’t often have (police) or other clinicians…so I guess the risk assessment is really important then, to make sure that when you do engage with someone that you do have some kind of backup or…you might have to leave the person just where they are, until that support can come along’* (Procter et al., 2015b, p.354).

Practitioners expressed anxiety about the potential negative consequences of engagement due to a service user's 'past bad experiences' of mental health services (Hitch 2009, p.486). Moreover, some studies described increased risks associated with engagement due to a service user's increased level and severity of mental health symptoms (Gairns et al., 2015; George et al., 2016). Some practitioners identified that constant vigilance was key prior to and during visits to manage potential risks (George et al., 2016). Such descriptions also emphasise the empathy and sensitivity expressed by practitioners in relation to service user tensions and worries.

Theme 3: The chameleon effect- the skill of being adaptable

There was a recurring thread throughout the literature indicating that practitioners had to be creative and flexible in engaging service users as the process could be experienced at times, as being challenging and unpredictable. This theme indicated that engagement with service users was not experienced as a single discrete phenomenon. This theme was the least weighted analytical theme being informed from two of the nine descriptive themes "You mustn't give up on them", "It's about the things you do alongside them.

Use of ordinary human qualities and getting to know the service user as a person were viewed as invaluable in engaging hard-to-reach service users (Addis & Gamble, 2004; Killaspy et al. 2009; Wright et al., 2011; George et al., 2016). Some practitioners described that there was an element of being human but persistent to allow for active connections to be made. For example:

> *‘With a lot of our clients, initially, they don’t want any kind of contact with us whatsoever, and we come out regardless of how many times they slam the door in our face. We do it consistently’* (George et al., 2016, p.884).

Conversely, it was reported how persistent efforts to engage with service users was experienced as “forced” at times due to organisational pressures to maintain contact (Hitch, 2009, p.486). Furthermore, this was perceived to pressure staff to engage with service users who may not want involvement with services (Hitch, 2009).

Practitioners used creative, flexible, and sometimes unconventional methods to establish engagement (Addis & Gamble, 2004; Hitch, 2009; Killaspy et al., 2009; Procter et al., 2015a; George et al., 2016). Working alongside service users to provide practical assistance for their other relevant needs beyond their mental health was emphasised as an important engagement strategy. For example:

> *‘Really, we’ve used a lot of non-nursing and non-medical ways of engaging her. Going to the cinema…. getting a pair of trainers…one of the really good ways of getting to see her is going to cafes’* (Killaspy et al., 2009, p.535).

Practitioners also actively worked alongside family members to engage service users as described in the following quote:

> ‘*He agreed to go to hospital with his sister, she’d pop inside and talk to us. And it was a rather unusual way of engaging…It was much better than getting the ambulance and police of course.’* (Procter et al., 2015a, p.43).

2.11 Discussion

From the outset, the aim of this literature review was to consolidate practitioners’ experiences of engagement in community mental health settings. Ten papers were identified for inclusion and inductively through a process of thematic synthesis, three overarching analytical themes were developed namely, *Being authentic based on real dialogue and collaboration*; *Pushing against barriers- engaging against all odds; The chameleon effect- the skill of being adaptable.*

The review finds that humanistic, person-centred relationships are a key feature of successful engagement. This is in line with the tenets of the ‘Tidal Model’ which was developed to emphasise greater focus on empowering, person-centred approaches such as collaboration, building of genuine trusting relationships and promoting the conditions for personal recovery for people experiencing mental illness and distress (Barker, 2001b). The Tidal Model suggest that to engage with an individual in an empowering and collaborative way rather than *manage*, *treat,* or otherwise *fix* their problem is integral to good recovery outcomes (Barker & Buchanan-Barker, 2005). Within the first analytical theme, a trusting, collaborative relationship was identified as the single most important factor in determining whether engagement between practitioners and service users was positive or negative as illustrated by the descriptive theme ‘And I go with their choices, because they’ve got rights too’. However, although the first theme suggests the emphasis given to the therapeutic alliance, practitioners were also aware that their efforts to maintain contact particularly within AOT contexts could be perceived as coercive or pressuring. This increases the need to further improve understanding of such pressures and how they affect the relationship between service users and services.

A further concept proposed by the Tidal Model is that genuineness is an important feature within engagement strategies (Barker & Buchanan-Barker, 2005). This was paralleled within theme one in which authenticity was central to successful engagement. Genuine human interactions are regarded as key qualities to effectively engage service users in meaningful partnerships (Clarke & Walsh, 2009). For example, three of the ten studies highlighted how practitioners adopted role duality by sharing aspects of their personal self (Addis & Gamble, 2004; Procter et al., 2015b; George et al., 2016). It could be argued that in doing this, they placed more emphasis on the human aspect of their interactions with service users in order to establish common ground and encourage successful engagement. This is consistent with Egan (2014) who argues that practitioners are more effective when they adopt a position of being themselves. Likewise, the emphasis on ordinary conversation taking place between the professional and the service user may re-shape the relationship, enabling engagement to be transformative and generate new trains of thought rather than just exchanging of facts (Zeldin, 2000).

The Tidal Model acknowledges the emotional challenges faced by some practitioners in that they may risk subconsciously addressing their own feelings rather than those of the service user which may lead to distant forms of care and engagement (Barker & Buchanan-Barker, 2005). The Tidal Model further re-iterates the importance of practitioners accessing debriefing to re-evaluate their human qualities rather than their skills to effectively engage with individuals (Barker & Buchanan-Barker, 2005). This is an ongoing consideration for community mental health practices as highlighted within the second analytical theme, where practitioners often felt pressured as illustrated by its descriptive theme "I have a got a time restriction, I have got to go and see someone else". Although practitioners had the skills to engage, they experienced levels of anxiety and worry due to time pressures, larger caseloads, and risk management considerations which could hinder engagement. This is consistent with Kielhofner et al. (2002) in that emotions are important to understanding engagement experiences. However, although 'pushing against barriers' identified varying pressures that practitioners faced in engaging service users, it was also perceived to result in engagement that was more outcome-orientated than collaborative. It is suggested that this approach may place further pressure on service users to engage with services with subsequent loss of autonomy and feelings of powerlessness (Priebe et al., 2005).

Further research has suggested that individuals with mental health problems may disengage if they cannot see benefit from the service or if there is a sense of loss of control over their own lives (Kreyenbuhl et al., 2009). Moreover, although practitioners in the reviewed studies did not explicitly describe mandated community treatment such as Community Treatment Orders, it is claimed that such approaches can create further barriers to contact with services (Sweeney et al., 2015). In contrast, mental health practices that embrace service user autonomy and decision making are suggested to facilitate greater levels of engagement (Priebe et al., 2005).

A further consideration within the Tidal Model is its notion of the ‘helpful helper’ (Barker & Buchanan-Barker, 2005, p.134). It is argued that the practitioner as ‘helpful helper’ is aware that there is not a one-size-fits-all approach and to only do what needs to be done to meet the service user’s immediate and pressing needs. Furthermore, this practical approach recognises human experience as a fluid, dynamic process that acknowledges the importance of critical, short-term needs as well as longer-term developmental care to support recovery (Barker & Buchanan-Barker, 2010). However, there was no explicit discussion of how a practitioner’s role was defined within the reviewed literature. Notwithstanding, a role within mental health teams is regarded to be a multi-dimensional one with practitioners taking on several different roles that overlap with those of other professional groups (Newbigging, 2004). Indeed, in the third theme, engagement was experienced as successful when practitioners were flexible whether it be the social, practical, economic, or clinical needs of the service user. The latter point is supported by Repper and Perkins (2003) in that practitioners are pivotal to linking service users to other services or providing practical help to reduce social exclusion. Practitioners working within AOT contexts would take on multiple positions/roles that appeared to be similar to advocacy, family work and social support depending on the individual needs of service users (Addis & Gamble, 2004; Hitch, 2009; Wright et al., 2011; George et al., 2016).

AOTs have been found to be more successful than CMHTs in engaging service users due to smaller caseloads (Killaspy, 2007; Killaspy et al., 2009). However, some care must be taken in considering the wider organisational impacts of such services. Although AOTs have been mostly welcomed by service users and their families, it could be argued by their ‘assertive’ nature that this leads to different engagement strategies being used including persuasion to compulsion (Molodynski et al., 2010). Within the descriptive theme “You mustn’t give up on them”, practitioners were critical of the assertive outreach model of engagement as this was generally perceived as pressuring staff to make connections with service users who may not want services (Hitch, 2009). Hence, there is a potential tension between building a therapeutic alliance based on mutual trust and the need to manage risk and potentially implement mandated community treatment orders. The latter point needs further explicit acknowledgement to allow realistic expectations for mental health staff and service users.

2.12 Limitations

Although this review specifically sought to explore practitioner perspectives, it acknowledged that engagement may be experienced and understood differently by service users. It is possible that practitioners may experience genuineness, flexibility, and collaboration as effective qualities when service users are agreeable to engagement. However, many widely held assertions about engagement are not based upon consistent evidence (O’ Brien et al., 2009; Doyle et al., 2015). Given that a universal definition of engagement is not fully agreed upon, more detailed investigation is needed to further understand how engagement works for individuals who do not fully accept services.

The potential influence of the author's experiences as a mental health nurse in community mental health services are acknowledged. The analysis and synthesis of the qualitative evidence being conducted by the first author only is acknowledged as a further limitation of the review process and thus may introduce reviewer's bias. However, regular, and frank discussions with the supervisory team, who are from clinical and non-clinical backgrounds, throughout the review process were used to minimise the potential for individual assumptions and biases to influence the review's overall findings.

Another limitation is the low number of studies included in the review for thematic synthesis. Although Thomas and Harden (2008) state that six to eight studies should be adequate for such a review, a larger number of studies supporting the same themes may have added further depth of insight to the analysis. However, this highlights the paucity of qualitative evidence examining mental health practitioner's perspectives of engagement and that the evidence-base needs to be further expanded upon within this topic area. Moreover, although this review used clear inclusion/exclusion criteria and a broad search strategy, services are continuing to change. For example, UK based community mental health services have changed over the last ten years with AOTs being gradually decommissioned or integrated into CMHTs (Gilburt, 2015; Firn et al., 2018). It is thus possible that some published reports around more recent community mental health initiatives may have been missed from the systematic searches.

A final limitation is that the engagement experiences of carers, families, and users of mental health services were not considered. Given the importance of the three-way relationship between staff, service users and families/carers, future reviews could consider integrating findings regarding engagement from these three groups’ perspectives into one review.

2.13 Implications for research and practice

The findings indicate that mental health professionals see engagement with service users as complex, multi-dimensional, person-centred, and involving practical and social approaches as well as clinical interventions. This is in keeping with the increasing emphasis within contemporary nurse education on collaborative, person-centred and relationship building approaches (Nursing and Midwifery Council, 2019), and suggests that registered mental health nurses and other professionals would benefit from further systematic guidance around engagement strategies. There is an invaluable opportunity within pre-registration nursing programmes for such guidance to be shared to further support learning and teaching practices within concepts of person-centred care. Based on the review’s findings, this guidance includes the importance of key facilitators to optimise engagement such as the therapeutic relationship, therapeutic dialogue, working towards shared goals, and working creatively to meet the varying practical and material needs of people using services.

The engagement experiences of mental health practitioners working within specialist settings such as EIS are less well understood as most studies in this review focused on staff engagement in AOT or CMHT settings. Given the paucity of qualitative evidence that focuses on the engagement practices of practitioners in EIS settings (Tindall et al., 2018), there is a need to gain deeper insights of such experiences within this area of service provision. Future research should aim to qualitatively explore EIS practitioner's experiences of engagement in order to add to the knowledge-base about what contributes to successful engagement. In line with the review's findings, this could include a detailed phenomenological inquiry of practitioner views and experiences around the barriers and facilitators to engagement in EIS settings in relation to relationship building, therapeutic dialogue, collaboration, and practical strategies. This would add to the body of knowledge about what contributes towards engagement in EIS settings which could then be published and disseminated.

2.14 Conclusion

This review has aimed to understand mental health practitioners' experiences of engagement with service users with the intention of providing actionable knowledge for successful engagement approaches across a range of community mental health settings. The findings confirm the importance that mental health practitioners place on being person-centred, collaborative, and creative with service users in a range of community mental health settings to enable successful engagement. This is also in line with the tenets of the Tidal Model which emphasises the importance of mental health professionals embracing empowering, interactive and collaborative approaches to enhance engagement with service users in mental health settings (Barker, 2001a). Furthermore, it has been identified how practitioners ensure that engagement is not solely focused on clinical interventions but that also addresses social and practical needs. However, the professional challenge is being able to maintain engagement in a context characterised by issues that include time pressures, larger caseloads and risk management considerations along with the service user’s perception of time and priorities.

Chapter Three : Methodology and Methods

Having identified a gap in knowledge in chapter two, this chapter examines the chosen methodology and methods, providing a justification for the choice of Interpretative Phenomenological Analysis (IPA) as the primary research method for this empirical study. The second section of this chapter will examine the practical elements of the research; recruitment, sampling, data collection and data analysis by detailing the core features and procedures associated with IPA alongside the ethical principles that guided the research.

3.1 Choice of methodology

My choice to undertake qualitative research, was based on a sense that the topic in which I was interested in could be best explored through qualitative approaches. An underlying premise of qualitative research is that individuals can attribute their own unique meanings to their environments and that reality is thus understood from a range of perspectives (Parahoo, 2006; Byrman, 2012). It was important that this research study would gather in-depth accounts of mental health practitioner experiences of engagement and value the unique and personal accounts of each participant.

A metaphor provided by Shank (2005) was useful to further justify my choice of qualitative research. Shank (2005) described qualitative research as adopting a lantern approach. The lantern illuminates the participant’s world, allowing researchers to gain clarity and insight of areas that are usually concealed in the dark. Understanding and meaning are discovered in relation to a phenomenon that has not been previously understood.

In further considering an appropriate qualitative methodology to utilise, I was drawn to the ontological and epistemological commitments of IPA with its focus upon the interpretation, understanding and uniqueness of lived experience (Smith et al., 2009). The exploratory qualities of IPA are said to provide the potential for greater insight into topics of which little is known or understood (Eatough & Smith, 2006; Smith et al., 2009; Tompkins & Eatough, 2012). A further distinctive feature of IPA is based upon the premise to understand not only the subjective meanings held by individuals but also to account for those of the researchers (Pietkiewicz & Smith, 2012). IPA assumes that the researcher's own knowledge, experiences, and perceptions of the topic in question should be taken into account, but not so they form the focus of the research. Hence, the two-stage process of IPA, the 'double hermeneutic' involves the participant attempting to make sense of their experiences, with me as the researcher, attempting to make sense of their sense-making processes (Smith et al., 2009). However, it is also contended that these must be openly acknowledged and integrated within the research findings through a process of reflexivity (Tuohy et al., 2013).

I have a wealth of experience as a former case manager in an EIS team in North- West England, having previously worked in this specialist mental health setting between 2005 and 2011. This experience has motivated my interest to further investigate engagement. However, my case manager experiences have also proved to pose some potential challenges. I am aware that my engagement experiences with service users in EIS settings were unique to me and consequently, that my perceptions of engagement may not be typical, relevant, or identifiable with other practitioners. It was also considered there could be a potential impact upon the research due to my prior working relationship with the service and some participants. It was particularly important to recognise and monitor my impact and influence upon the research process not only having previously worked in an EIS setting, but this setting. Thus, supervisory dialogue encouraged me to tease out the impact of my previous clinical role, expose tacit knowledge and assumptions and ensure that I was making sense of engagement from the perspectives of participants rather than my own.

To demonstrate a transparent and rigorous approach to the research process, my personal characteristics such as age, professional background and social experiences were openly disclosed from the outset of the study (Berger, 2015; Moore, 2012). Additionally, I maintained a reflexive diary which involved examining and consciously acknowledging as to how my previous clinical and professional experiences could impact upon my interpretations (Larkin & Thompson, 2012). The open-mindedness of the reflexive process allowed for any prior or unfounded assumptions and pre-conceptions to be documented and thoroughly scrutinised through frank discussion in supervision (An example of a reflexive diary entry is illustrated in Box 3.1).

Based upon my experiences as a case manager, I also considered that the complexity of the issue under investigation (engagement) would not be amenable to a more generalised focus, as each practitioner's experiences of engagement are uniquely situated, discrete and subjective due to the fluid, dynamic and changeable nature of engagement. Thus, by deciding upon IPA as the primary research method for this study, it was anticipated that this would provide deeper interpretation of personal accounts, leading to potential new insights and understandings.

A further notable feature of IPA research is that it aims to move beyond descriptive accounts and provide a deeper focus upon personal meaning, and sense-making in a particular context, for people who share a particular experience (Larkin et al., 2006). In line with the research question, it was important that this study would gather in-depth descriptions of experiences of engagement and value the unique and personal accounts of each participant during the analysis phase. I therefore felt that IPA with its roots in phenomenology (the study of structures of consciousness as experienced from the first-person point of view) and hermeneutics (the study of interpretation), was an appropriate qualitative approach to provide richness, depth and insight into each practitioners' perceptions and experiences of engagement (Smith et al., 2009). Furthermore, the requirement to facilitate an idiographic approach within IPA to provide a detailed focus on the particularity of each case was seen as an opportunity to make further sense of the phenomenon (engagement).

A social constructionist epistemology was further considered as appropriate for this study due to its ontological assumption that individuals through their social dealings, produce a range of possible social constructions of events to construct their own versions of reality (Crotty, 1998; Burr, 2015). I carefully considered that adopting a social constructionist epistemology would allow me to explore the contrasting views of practitioners with an acknowledgement that there would be no single universal reality that existed independently, and I would be searching for multiple meanings of engagement within rich qualitative descriptions.

IPA principles echo social constructionism in terms of meaning-making of lived experiences (Smith et al., 2009). Thus, IPA resonated as being a ‘good fit’ with my clinical experiences as a mental health nurse and my encounters with health care professionals and service users as I was constantly in a process of reflecting and searching for answers to make sense of engagement. However, a notable characteristic of other practitioners that I worked alongside, is that each professional would attribute different meanings and contexts to their engagement experiences. This premise that multiple realities of engagement can be experienced was considered as consistent with the methodological commitments of IPA, in that each practitioner’s perspective would be afforded its own legitimacy (Cuthbertson et al., 2020).

IPA like other phenomenological inquiries is meritoriously noted for its ability to illuminate understanding of lived experiences (Larkin et al., 2006). However, it has been argued that this can limit further understanding, as in focusing on the meanings given to experiences, IPA fails to address the reasons why they occur (Tuffour, 2017). It is contended that research inquiry seeking to maximise understanding of lived experiences should also explore triggers located in past events, histories and/or social-cultural contexts (Willig, 2008). However, Smith et al. (2009) have argued that IPA uses hermeneutic, idiographic and contextual analysis to understand the social and cultural position of people’s lived experiences. Thus, by using IPA, I was mindful to take extra care and attention to the experiences of each practitioner that were also embedded in their social, historical, and cultural contexts.

IPA has been further described as an approach, rather than a method, that is not intended to be prescriptive (Smith et al., 2009). However, given that there is no one right way to conduct IPA, it has been criticised for lacking such standardisation (Tuffour, 2017). Consequently, two researchers working with the same data may come up with different interpretations (Smith et al., 2009).

Box 3.1: Example of a reflexive diary entry

July 2017: *I am a former employee of the host NHS Trust having worked as a case manager in an EIS setting. I am a registered nurse (mental health) and my own practice history largely relates to the care and treatment of young people with first-episode psychosis. As I develop my research study and methods, I am conscious of the need to critically reflect upon my role as a researcher and the impact that this has on participants especially those who have been known to me in my previous role. I am aware that my previous role as an EIS case manager may have an impact on recruitment strategies- will some staff be comfortable taking part since some will have worked with me previously? During interviews, I will need to reflexively recognise my influence as a former EIS case manager and respond to such issues as interactions take place. Additionally, I will need to fully acknowledge and respond to my prior and unfounded assumptions and pre-conceptions with the analysis of the interview data.*

Following an initial literature search, little qualitative evidence was found for research that explored mental health practitioners' perceptions and experiences of engagement in EIS settings (see Chapter 2). The relative dearth of qualitative research into engagement within EIS settings was counter-balanced by most studies of this area having used quantitative methods (Anderson et al., 2010; Doyle et al., 2014; Lal & Malla, 2015). Certain factors are known to be associated with a service user’s levels of engagement such as substance misuse, impaired insight, or social issues such as family breakdown or unemployment (Doyle et al., 2014). Although quantitative methods can utilise exploratory designs, its reliance on measurement processes and procedures do not allow for more in-depth, detailed probing that is possible with qualitative research in exploring practitioner experiences with individuals who partially engage, disengage, or re-engage with services (Anderson et al., 2010; Doyle et al., 2014; Tindall et al., 2015; Tindall et al., 2018).

In more recent times, one qualitative study that utilised thematic analysis was found that explored case managers perspectives of engagement in EIS settings (Tindall et al., 2019). Although this study provided some valuable insights into case manager experiences of engagement, it also highlighted that no case managers from nursing backgrounds took part. Although no explanation was given as to why nurses did not take part in this EIS study, the researchers stated that nursing experiences may further increase understanding of engagement and to draw useful comparisons to the experiences of other professional groups such as occupational therapy, social work, or clinical psychology (Tindall et al., 2019). For example, most clinical contacts that EIS service users have are with nurses as the majority of team members in EIS teams in North- West England are from mental health nursing backgrounds. Therefore, to understand engagement more fully, I believe that a qualitative lens is required to capture these multiple complexities in more depth and detail (Tindall et al., 2019).

3.2 Research methods

3.2.1 Research questions

The aim of the study was to explore and understand case managers' experiences of engagement in early intervention settings (EIS). The central research question was:

> *What are case managers' experiences of engaging with service users in early intervention services?*

The study was further guided by the following four secondary questions:

1. What do case managers understand by the term 'engagement'?
2. How do case managers foster engagement with service users?
3. What are the facilitators that enhance engagement with service users?
4. What are the barriers that make it harder to engage?

3.2.2 Objectives

The primary objectives of the study were as follows:

1. To interview between 8 and 12 case managers working in EISs
2. To explore case manager's personal experiences of engagement with service users within UK EISs
3. To identify what factors case managers perceive to facilitate or hinder their engagement with service users within EISs
4. To interpret, explain and understand engagement from the case manager perspective

3.2.3 Sampling

In line with IPA methodology, the aim of this study was to find a homogeneous sample for whom the research question was salient (Smith & Osborn, 2008). Initially, I had proposed to invite EIS case managers from both mental health nursing and social work backgrounds to take part. However, supervisory discussions prompted further consideration to focus on one core professional group to ensure homogeneity. Hence, the decision was made to recruit participants from nursing backgrounds as nursing experiences of engagement in EIS settings are not well researched or understood in comparison to other professional groups such as occupational therapy and clinical psychology (Tindall et al., 2019). This was also considered as particularly important in view of mental health nurses being the main case management workforce in UK community mental health settings, providing direct care for individuals with mental health problems (Happell et al., 2012).

Smith et al. (2009) assert that participant groups within IPA research should be as uniform as possible according to social or theoretical factors to allow examination of the psychological variability within the group and analysis of convergence and divergence. Furthermore, IPA studies aim for relatively homogeneous samples as psychological similarities and differences are usually analysed with a group that contains comparable knowledge and experiences (Pietkiewicz & Smith, 2012). The rationale for such sample-specific requirements within IPA is to ensure that broader claims are arrived at cautiously and cumulatively (Smith et al., 2009). Purposive sampling techniques were used to recruit mental health nurses who had similar knowledge, experience, and expertise of engagement with service users in EIS settings.

There is no consistent agreement on an acceptable or optimum sample size in IPA research (Smith et al., 2009). Nonetheless, there is a greater consensus that larger samples are inappropriate for IPA studies and smaller samples allow more attention to be given to generating richer and more in-depth accounts (Smith et al., 2009). Furthermore, in keeping with IPA's idiographic principles, the sample must be small enough to allow for detailed case-by-case analysis of individual accounts (Miller et al., 2018). Pietkiewicz and Smith (2012), recommend small samples averaging five to ten homogeneous participants. Similarly, Turpin et al. (1997), recommended six to eight participants as being appropriate for clinical psychology doctoral programmes in the UK. In the case of a more recent doctoral study conducted by Chan (2018), a total of three individuals participated in that study. The aforementioned study highlights how it is possible to conduct IPA studies with very small samples, as it is likely that participants will provide rich, detailed data if their lived experience is meaningful to them (Miller et al., 2018). The aim of IPA is not to generalise about larger populations, but to arrive at more general claims cautiously, and only after analysis of individual cases based on relatively small samples (Smith & Osborn, 2008; Smith et al., 2009). For this study, individuals were eligible if they met the following criteria:

1. Currently employed as a case manager within an EIS setting.
2. Had more than one year of clinical experience in an EIS setting.

3. Possessed a professional qualification in mental health nursing.

3.2.4 Ethical considerations

Ethical approval was sought from Lancaster University Ethics committee (Reference number: FHMREC19138) and research governance approval sought from the Health Research Authority (HRA) (IRAS project ID: 219135). Furthermore, I contacted the host NHS Trust via the research and development department to seek further agreement. To ensure that true free informed consent was obtained, prospective participants were provided with verbal and written information about the purpose of the research and advised that taking part would be voluntary (Appendix 5). To ensure ethically sound research practice, the issue of consent was also revisited prior to interviews taking place, with written consent being sought at the point of interviewing (Smith et al., 2009).

As IPA studies are concerned with existential issues, it is crucial that the researcher monitors how the interview process affects participants (Pietkiewicz & Smith, 2012). In relation to the topic, it was considered that some case managers may have perceived engagement with service users as a potentially sensitive and anxiety-provoking issue due to factors such as risk management, accountability, or litigation. To reassure potential participants and ensure greater transparency, two interview questions were provided in the participant information sheet to illustrate the types of topics that would be explored (Appendix 5). Furthermore, in considering the potential for distress following interviews, a list of contact numbers to access appropriate support were provided in the participant information sheet (Appendix 5). In the event of interviews being upsetting for some participants, debriefing in the form of a reflective and supportive discussion was offered following each interview with signposting to other services such as counselling as appropriate.

The requirement to ensure that anonymity and confidentiality are maintained for research participants is well documented (DHSC, 2005; Holloway & Wheeler, 2010; Bowling, 2011; Bryman, 2011). However, given that the sample was recruited from three EIS teams working within the same NHS Trust, ensuring the anonymity of participants was challenging. Thus, participants were assured that their identities and data would be safeguarded as far as possible by using pseudonyms and removing any identifying information to ensure that it was not possible to deduce who the participants were. In accordance with the Data Protection Act (1998) and NHS research governance (DHSC, 2005), several data management practices were followed. Participant names and contact details were stored separately from research data such as digital voice recordings and interview transcripts (Ritchie et al., 2014). Raw digital data were transferred, securely stored on a password-protected computer, and backed up on an encrypted external hard drive. Paper-based data such as consent forms and interview transcripts were securely stored in a lockable filing cabinet that only I could access.

3.2.5 Recruitment

Access to prospective participants was initially sought by contacting three EIS team managers based in one NHS Trust within North-West England via an email that also included a recruitment flyer and participant information sheet. Once local consent for recruitment was given, each EIS team manager re-circulated the recruitment flyer and participant information sheet to their team of case managers. The initial email also offered the opportunity for a face-to-face meeting with the three EIS team's case managers to further outline the purpose of the study and encourage additional questions about the research. As a result, I visited each EIS team to conduct a short presentation about the research and to invite case managers to take part.

Following my presentations, eleven case managers from across the three teams expressed a preliminary interest in taking part. However, prior to the scheduled interviews, two case managers declined to participate due to workload constraints with a further two not attending for their interview, resulting in a final sample of seven case managers. I subsequently re-visited all three EIS teams to recruit more potential participants, however, no further interest was expressed. However, I was aware of the complexities and finite time demands on practitioner workloads and did not wish to exert any further pressure to participate. As seven practitioners took part, PhD supervision prompted an exploration around 'data saturation' to ascertain if there were enough detailed data to assure that data collection may cease (Bryman, 2012, p.426). However, in contrast to another widely used qualitative approach of Grounded Theory, data saturation is not advocated in IPA research as its aim is to micro-analyse rich, phenomenological data that focuses on actual slices of human life (Smith et al., 2009; Cuthbertson et al., 2020). Hence, in view of such theoretical considerations, the final sample size was deemed appropriate in line with IPA commitments to focus on smaller samples, to generate richness, depth, and quality of data rather than breadth.

3.2.6 Data collection

In IPA research, semi-structured, one-to-one interviews are suggested as the preferred means for collecting data (Smith et al., 2009). Hence, each case manager took part in a semi-structured, one-to-one interview that averaged forty minutes. Utilising a one-to-one interview allowed for developing rapport and trust with each case manager and engaging in a dialogue to facilitate rich, in-depth, personalised discussions. Due to the in-depth and enquiring nature of qualitative interviewing, the site of the interview was of paramount importance to allow space to think, speak and be heard without interruptions (Smith & Osborn, 2008). Hence, participants were asked their preferences for where the interview would take place. All participants agreed to be interviewed in a suitable, private office space at their place of work during normal office hours. This allowed for interviews to take place in a comfortable and familiar setting that was reasonably quiet and free from interruptions. Each interview was audio recorded before being transferred to a password protected computer (Pietkiewicz & Smith, 2012; Smith et al., 2009). Once all interviews had been completed, all the recordings were transcribed verbatim.

I began each interview with an interview topic guide that was flexible enough to allow for novel and unexpected issues to arise. Ten open-ended core questions along with possible probes and prompts were developed for the interview topic guide to allow for up to ninety minutes of conversation (Appendix 6) (Smith et al., 2009). As I was a novice IPA researcher, the interview topic guide was discussed, refined, and rehearsed with PhD supervisors to develop the process for thinking qualitatively and to address any anxieties prior to the real interviews. In keeping with IPA sensibilities, a ‘warm-up’ scene-setting discussion was initiated to build rapport and trust and allay participant anxieties prior to discussing more complex and sensitive issues (Pietkiewicz & Smith, 2012). The following warm-up question was used: ‘*To start with, I would like to know a little more about you and how you came to work in early intervention services’.* Additionally, an initial core question was asked: ‘*In your own words, can you tell me what the term ‘engagement’ means to you in your role in early intervention?’* As previously mentioned, I adopted an open-ended questioning approach to interviewing to enable all participants to develop and elaborate upon their own perceptions of engagement.

To ensure a consistent interviewing approach, all participants were asked the same core questions in varying order, with extra prompts and further questions when necessary, depending on responses. The interviews allowed scope for participants to raise issues that were relevant to them. Some similar topics were raised such as using creative and flexible strategies to engage, along with some unique topics such as use of self-disclosure to build rapport. Examples of open-ended core interview questions included: *‘Can you tell me what you do to engage with service users?* and ‘*What makes it hard to engage with service users?’* However, interviews in the context of qualitative research are not neutral tools of data gathering; but active interactions between two or more people, leading to negotiated, contextually bound results (Fontana & Frey, 2005).

Consequently, factors such as the researcher’s background can influence the subsequent findings obtained (Bonner & Tolhurst, 2002).

I had acknowledged my professional background during the recruitment phase. However, it was apparent that my background as a registered mental health nurse in an EIS setting aided rapport and credibility with participants throughout the interviewing process. The risk of social desirability bias was considered. Social desirability bias involves participants providing the researcher with answers that they feel are more socially acceptable (Bryman, 2012). Additionally, I was concerned that in my dual role as a mental health nurse and researcher, and with my knowledge and interest in the topic, that I could inadvertently impose my knowledge, experiences, and views within this process. The further possibility of co-creating narratives that confirmed or reflected my views and biases by showing my recognition of experiences or responses could have impacted upon this process. In view of this, carefully monitoring the impact of my prior professional experiences was central to recognising this unconscious process. As suggested by Bryman (2012), no research can claim to be value-free, and thus, exhibiting self-reflection and reflexivity can increase the confirmability of research. A reflexive account of the data collection was thus kept allowing for my biases and assumptions to be documented and scrutinised (see an example of a reflexive diary entry in box 3.2 overleaf).

Box 3.2: An example of a reflexive diary entry

November 2017: *Throughout the first interview, I was aware that my previous experiences as a Case Manager in an early intervention service inevitably influenced my rapport with the participant as I felt that I could readily identify with her engagement experiences as a fellow mental health nurse. These experiences have helped me to further understand how other mental health practitioners can perceive engagement with service users and families. However, I also felt that my own engagement experiences could unintentionally influence my focus, judgement, and interpretation to the participant's interview responses. Consequently, I was acutely aware to not allow my own personal experiences to overshadow the participant's engagement perspectives and ensure that her voiced experiences were the central focus to the topic. It also appeared that this was the first opportunity for the participant to openly talk about her engagement experiences in an EIS setting. At times, I felt as though this was a cathartic experience for the participant, and I was concerned that the interview did not become a talking therapy session, to ensure that the interview retained its primary focus and to take care that I did not drift into a dual role of both researcher and therapist.*

3.2.7 Data analysis

IPA uses an idiographic approach in that the meanings that each individual attaches to their experiences are explored (Smith & Osborn, 2008). During this stage of IPA, researchers engage in a double hermeneutic, trying to make sense of the participants trying to make sense of their own experiences (Smith & Osborn, 2008). This double hermeneutic approach captures the dual role of the researcher in that he/she is employing the same mental and personal skills and capacities as the participant to assist in the meaning-making process (Peat et al., 2019). Although IPA analytical processes are not intended to be wholly prescriptive, all IPA studies share the same analytic focus in paying close attention to patterns in participants' experiences, considering the ways in which meaning is made of those experiences, and interpreting such experiences within social and theoretical contexts (Larkin & Thompson, 2012).

As I was conducting IPA for the first time, the IPA method as outlined by Smith and Osborn (2008) was utilised as a guide to analysis, flexibly following six key stages to make the process manageable and minimise the risk of feeling overwhelmed. I waited for all interview transcripts to be transcribed before starting analysis. For the first stage of analysis, each interview transcript was read separately several times in order to immerse and familiarise myself in the participant's account before going through it line-by-line. In addition, the digital recordings for each interview were listened to several times to recall the atmosphere, the nature of the setting and to highlight any distinctive phrases and emotional responses (Pietkiewicz & Smith, 2012). I closely read each transcript one-by-one before moving on to the next one and listened to each interview to facilitate an appreciation of how rapport and trust were developing. Additionally, this process enabled me to reflect on my broader interview approach and consider how the general flow or rhythm may have contributed to the overall interview process to further develop and refine my skills for future interviews for this study.

For the second stage, the left-hand margin of each transcript was used to make initial notes and comments on anything relevant to the focus of the research i.e., participants' perceptions of and experiences of engagement (Smith & Osborn, 2008). This was the most detailed and time-consuming aspect of analysis what to comment upon. It is recommended that researchers stay as close as possible to the participant’s explicit meanings around their experiences (Smith et al., 2009). This can include issues that matter to individuals such as relationships, places, events, values, and principles (Pietkiewicz & Smith, 2012). I thus remained open-minded and exploratory in my approach and underlined anything that was significant to the participant so that I could begin to identify and understand how each participant perceived engagement. For each piece of underlined text, I wrote an accompanying summarising note in the left-hand margin of the transcript to capture its relevance for the participant, staying as close as possible to the participant’s own meanings. In doing this, I took care to avoid making my own interpretations, or value-based judgements. These initial notes included commentary on issues that all participants discussed as important to their engagement experiences such as therapeutic relationships, work-related schedules, professional values, personal feelings, and significant events. However, approaching each transcript individually, enabled me to observe how each participant made sense of those experiences. Initial noting sensitised me to the preliminary ideas coming from the data and to construct possible meanings and conceptualise what was happening in the data.

Following completion of step two, for the next stage of analysis, I began to focus on my initial notes rather than rely on the content of each transcript itself as suggested by Smith (2004). For the third IPA stage, the main task was to turn initial notes into emergent themes to produce a succinct statement of what was important based on the annotations written in the left-hand margin. According to Smith et al. (2009), emergent themes should reflect researcher interpretations to capture and convey a higher level of understanding. For this, the right-hand margin of each transcript was used to reduce the initial annotations into succinct summary statements that captured how the participant made sense of the aspect of their experience they were describing in the relevant segment of text. This was still grounded in the participant’s account, however, I found myself becoming more central to the organising and interpreting of the analysis. In keeping with the IPA framework, the interpretation and analysis within this stage highlighted the meanings that participants gave to various aspects of their engagement experiences with service users such as dealing with challenging behaviours or encountering feelings of frustration. I aimed to ensure that the emergent themes reflected the essence of each reported experience by focusing on the need to capture what was crucial, not only to each specific part of the text, but in relation to the whole testimony.

I found the process of developing emergent themes to be less overwhelming than the previous stage of initial noting due to the requirement to reduce the volume of data generated by the annotations within the transcripts (Appendix 7). Nonetheless, I felt uncomfortable about re-organising the initial text notes into more concise phrases as this initially appeared to reduce and fragment the meanings and perspectives of participants represented in the notes. However, it is acknowledged that the researcher plays an inescapable part in the analytical process and that there is no such thing as a view from nowhere (Nagel, 1974). As I had already become immersed in the transcript through reading and annotating it, it was evident that my interpretations were becoming more explicitly bound up with that of the participant's interpretations of their experiences as part of the double hermeneutic process discussed earlier (Pietkiewicz & Smith, 2012). Indeed, the interpretative and iterative nature of IPA allowed for me to engage in a 'double hermeneutic' in that I was attempting to make sense of the participant who was in turn, trying to make sense of their engagement experiences (Smith & Osborn, 2008).

For stage four, I began developing super-ordinate themes for the first transcript by looking for patterns and connections between its emergent themes such as similarities, differences, and groupings. As this stage of analysis is not intended to be prescriptive, IPA researchers are encouraged to be imaginative and innovative in terms of organising data (Engward & Goldspink, 2020). Hence, I printed and cut out the list of emergent themes for the first transcript and separately placed them on large sheets of paper to scan and move them around more easily (Appendix 8). Emergent themes which represented similar or comparable understandings were clustered closely together whereas opposing or contrasting themes were placed at opposite ends of the paper. By managing the data in this way, I was provided with a more visual perspective of how some emergent themes related to each other in the transcript. Looking through the first transcript, some emerging themes acted as magnets by pulling other themes towards them. For example, emergent themes that arose across such as 'being person-centred', 'being genuine' and 'listening' gravitated more naturally together to begin developing a super-ordinate theme such as 'therapeutic dialogue'. Step five of the analytical process involved moving to the next transcript, and starting the whole process afresh, by repeating steps one to four.

I found the process of organising emergent themes together into super-ordinate themes to be a creative but messy and chaotic process. In moving to a deeper level of interpretation and analysis, the challenge was to clarify the significance and meanings of each transcript's emergent themes in the process of developing super-ordinate themes. Hence, I found myself re-visiting each transcript several times to look at logical or appropriate connections between its emergent themes that would clearly convey sense and meaning of the complex and unpredictable nature of engagement as experienced by each participant. However, additional methods of exploring the data were used, such as how frequently an emergent theme arose or looking at the use of positive and negative descriptors of engagement. Emergent themes that appeared to be subordinate, or subsumed by others, were not cast aside, but used throughout the process of analysis to re-order and refine the themes.

The sixth and final stage of IPA analysis involved looking for patterns, similarities, and differences to develop master themes that were applicable across the whole group (Smith et al., 2009). This stage involved mapping the super-ordinate themes together across the transcripts (Smith et al., 2009). As this can be a particularly creative task, all super-ordinate themes along with their accompanying emergent themes from each transcript were typed into a word-processed text table to begin the process of looking for broad correspondences across them. Thereafter, this method involved moving backwards and forwards though the data aided by using colour highlighters to identify those super-ordinate themes that were particular to individual cases but also shared across wider cases. For example, super-ordinate themes across transcripts that echoed each other such as ‘laying the foundations’ and ‘co-creating engagement’ were provided with the same colour highlighter coding to show connections across more than one case.

Some super-ordinate themes needed more work to unpick and establish their idiosyncratic differences and appropriate connections across wider cases. For example, common themes such as ‘therapeutic dialogue’ and ‘being on the same page’ across cases required further consideration as to whether these conveyed distinctly different meanings or not. An additional process to aid with this analytical stage included the construction of a word-file for each master theme with all relevant transcript extracts pasted into this file along with the transcript line number. This process helped to look at the consistency, relative broadness, and specificity of each master theme. As a result, super-ordinate themes across transcripts were combined to construct a table of master themes to show the connections for the whole group (Appendix 9).

3.3 Making sense of IPA analysis

As principal researcher, I primarily undertook the data analysis, remaining true to the phenomenological underpinnings of IPA, in which only the researcher who has engaged with participants, can truly interpret what has been seen and heard (Smith, 2004). Upon reaching the analytical stage, I was initially eager but also overwhelmed by the large volume of data that I had collected and the task that was ahead. However, it is well documented that qualitative data analysis can cause many researchers to feel overwhelmed. Kim (2015) compares qualitative data analysis to climbing a steep mountain involving the researcher undertaking a trail not yet explored. Likewise, Smith (2004) suggests that analysing qualitative data using the IPA framework can be a complex, time-consuming, and labour-intensive activity.

Initially, I felt some sense of discomfort and uncertainty in making interpretations due to my background in positivist quantitative approaches, and my professional training in evidence-based nursing practices. However, despite my initial discomfort and quantitative, evidence-based background, I found myself adapting to IPA. IPA aims through its phenomenological commitments, to get as close as possible to the lived experiences of the participant whilst interpreting them within the context of their lifeworld constructs (Smith et al., 2009). In keeping with the hermeneutic cyclical process of IPA analysis, I was trying to step into the participant’s shoes as far as possible. However, the early stages of analysing data transcripts were noted to have been influenced by some of the findings from my literature review, and supervisory discussion prompted me to re-visit, re-examine and address such biases in terms of what belonged to participants rather than what belonged to me. For example, I needed to further critically reflect on some themes generated from the literature review such as ‘person-centred approaches’ and ‘creative engagement’ that were developed into the IPA study to determine their legitimacy and relevance.

I had proposed to use computer assisted qualitative data software (CAQDAS) based on its organisational benefits and my concerns about the large volume of textual data that my IPA study would produce. It has been suggested that CAQDAS can make the coding and retrieval process faster and more efficient and enhance the transparency of qualitative data analysis (Bryman, 2012). I attended a university workshop on using NVivo for qualitative data analysis to develop a greater understanding of this software. However, having looked further into the benefits and limitations of NVivo, I decided not to use it. For example, IPA requires researchers to work with each transcript from coding to developing themes, rather than coding and theme development across the whole dataset (Smith et al., 2009). Also, having a small sample meant that the benefit of NVivo in being effective for managing large amounts of data did not apply.

3.4 Credibility, Transferability, Dependability and Confirmability

Within the qualitative paradigm, credibility, transferability, dependability, and confirmability are key components of data trustworthiness which are used to evaluate qualitative research and considered to be equivalent to reliability and validity in quantitative research (Bryman, 2012; Morrow, 2005; Shenton, 2004). To increase credibility, the study was open to scrutiny during the research process (Shenton, 2004; Morrow, 2005; Bryman, 2012). Frank discussions and data sharing were ongoing throughout PhD supervision to ensure that my assumptions were openly addressed (Denscombe, 2010; Mauthner & Doucet, 2003). Transcription and coding were openly shared with PhD supervisors to check the transparency and trustworthiness of this process. I aimed to be as open and transparent as possible throughout each stage of analysis. I regularly reflected on and discussed my analytic choices through PhD supervision, and re-examined transcripts to ensure the themes emerging from my analysis reflected the participants’ individual accounts. Moreover, my first PhD supervisor independently read a subsample of transcripts and wrote annotations and emergent themes to cross- check and discuss with my own analysis.

Transferability was increased through a clear description and justification for the phenomenon being studied (Shenton, 2004; Morrow, 2005) allowing readers to make a judgement as to whether the study is applicable to their setting (Chawalisz et al., 2008; Keen & Edmunds Otter, 2014; Lincoln and Guba, 1985). To enhance dependability, paper and electronic records have been kept for all phases of the research process, such as ethics documents, participant recruitment, interview transcripts and data analysis decisions to allow for an auditing approach if required (Bowling, 2011). In relation to confirmability, it is recognised that value-free research is impossible to achieve in qualitative studies (Bryman, 2012). However, using reflexive approaches throughout this study enabled me to scrutinise any pre-conceived ideas, personal values, and perceptions and how these may sway the conduct of the research. It is intended that addressing and minimising the risk of such interpretation biases conveys a greater level of trustworthiness and transparency throughout all research elements of the study and the findings derived from it.

3.5 Summary

This chapter began by detailing the methodology for the study and moving on to discuss my decisions for utilising an IPA approach to underpin and inform my study. I then proceeded to outline the recruitment, sampling, data collection, data analysis and ethical principles to how I conducted my area of research. The methods described in this chapter were developed through regular discussion with my PhD supervisors. By utilising IPA as my choice of methodology, I have embraced the flexible, interpretative, and iterative nature of this approach as a form of qualitative research as I have continually developed and refined my area of research. To mitigate the impact of my own values, beliefs and experiences, my reflexivity was integral to the research process. In the next chapter, I will present the qualitative findings of the study.

Chapter Four : Findings

4.1 Introduction

This chapter aims to present an overview of the findings from the study, providing an account to further understand Case Managers' experiences of engagement with service users in EIS settings. This chapter will outline the master themes that have been developed in response to the research questions. As discussed, the analysis of this IPA study used six steps as outlined by Smith et al. (2009). Following interpretive phenomenological analysis of the seven transcripts, the participant data was finally brought together under five master themes; (1) Being on the same page; (2) Engagement as an interpersonal relationship; (3) Managing self and emotions; (4) The practicalities of engagement (5) The impact of organisational factors upon engagement. Each master theme will be discussed and illustrated by participant quotes which have supported the process of analysis and interpretation.

4.2 Participant characteristics

Seven participants were recruited which provided a sample containing a range of ages and both men and women (see Table 4.1 overleaf). Across the sample, all participants were registered mental health nurses. The ages of participants ranged from 29 to 63 years and all participants worked across three EIS teams in one region for the same NHS Trust. Four participants worked in the NHS Trust in Team 1, one participant worked in Team 2, and two participants worked in Team 3. All participants were highly experienced case managers, averaging seven years of practice within the service.

Table 4.1: Participant characteristics

Participant pseudonym	Age range	Gender	Ethnicity	Profession	Length of Experience In EIS	Team number
Naomi	21-34	Female	White British	Registered Mental Health Nurse	8 years	Team 1
Jill	50-64	Female	White British	Registered Mental Health Nurse	8 years	Team 1
Kirsty	35-49	Female	White British	Registered Mental Health Nurse	4 years	Team 1
Eirian	50-64	Female	White British	Registered Mental Health Nurse	8 years	Team 1
Richard	35-49	Male	White British	Registered Mental Health Nurse	8 years	Team 2
Holly	35-49	Female	White British	Registered Mental Health Nurse	11 years	Team 3
Donna	35-49	Female	White British	Registered Mental Health Nurse	1.5 years	Team 3

4.3 Master theme 1- ‘Being on the same page’

All case managers were consistent in their beliefs that for engagement to be successful between service users and themselves, there was a need to develop a shared level of understanding and respect for each other’s contribution in the process. This meant that contact was seen as needing to be a collective effort for engagement to occur. For example, Kirsty, described understanding that there were occasions when service users needed to cancel planned appointments at very short notice. However, she emphasised an expectation that they should show the same level of commitment and responsibility as she did for communicating with them when this happened and for rearranging the appointment:

> *‘…you do get the majority like today, I’ve had a cancellation, erm…mum’s rung up and they’ve had an argument so she’s gone off somewhere else and cancelled my appointment…but mum’s given her my phone number so that she can ring me and let me know that know that erm….. I guess it’s that respect between you and your service user, isn’t it? Erm…’if, if I can’t attend, I’ll let you know’, I’d also like it if you could do the same’* (Kirsty)

Similarly, other case managers identified that being clear and upfront from the outset about the nature and purpose of their role was crucial to set the scene and to develop shared understanding about the need to be collaborative as explained by Eirian:

> ‘*Honest, erm, when I meet with somebody, er, I have a very open conversation with them about what my role is, and I will say things like I will not tell you fibs, I will not tell you something just to please you, we are here to work together and I will be honest with you, it might be uncomfortable but we will work through that honesty, that uncomfortableness together, and I take it from there’* (Eirian)

In this sense, although Eirian emphasised the importance of being clear, direct, and honest from the outset with the service user to set the scene, she also suggested that engagement is a two-way street and that an equal level of commitment is required on the service user’s part to engage. In contrast, Naomi described the unpredictable nature of engagement that could change over a course of time due to other ongoing priorities within a service user’s life:

> *‘I’ve had people ring me and say ah I can’t meet with you today coz I’m running round trying to sort my sick note out and get that to the job centre and then everything will be alright with my ESA erm, so you get the feeling that they would like to meet with you if, if those kinds of things hadn’t cropped up and similarly people might say something like ‘oh my landlord’s asking for this or I’ve got to go and do this today or a family crisis, or other social issues that could come up. So, you get the impression that they might want to, but other things have come up in their lives’* (Naomi)

It is clear from this extract that collaborative working continued to be interpreted by case managers as a key component of engagement. However, Naomi demonstrated the value of developing a shared level of understanding of the various personal barriers and challenges faced by some service users in terms of their engagement. Holly, another case manager also described the importance of listening to and understanding the service user's wishes and preferences in terms of arranging future contact:

> '*Sometimes that service user and you are quite happy to have minimal contact and, and just check in with each other, but other service users want to look at it in more detail about the mental health difficulties and and moving towards recovery and what might help, I think that some people sort of seal over, so they don't want to, really engage, but they're happy for us to maybe go round every few weeks and just check in with them, without erm, focusing in any detail on recovery work'* (Holly)

Holly has worked as a case manager in EIS settings since this specialist service was first set up in her region of the UK and has been a key figure in the ongoing development of the service. Based on her wealth of experience in an EIS setting, Holly described that a mutually agreed level of reduced contact with service users did not detract from the value and quality of engagement. She also emphasised that the trusting, therapeutic relationship was important for a mutually agreed reduced level of contact to work. Furthermore, as highlighted by Naomi, reduced contact did not need to be based on face-to-face interactions and could involve jointly agreed phone calls or text messages to facilitate engagement:

> *'…I think that the older people I've, I've asked them what do you prefer you know, can you remember yourself or should I text or ring or would you like a letter? And we've come up with an arrangement really. 'Most people are fine still with text messages erm, but if they prefer something else then, you know, that's fine, and just to ask people really, what they'd prefer'* (Naomi)

Some case managers identified working alongside a broad age range of service users aged between 14 to 65 years old in line with the requirements of EIS operational criteria. Case managers talked about how they adapted their approach to engagement according to the needs and communication style of the service user across this broad age span. For example, Naomi, suggested that she found younger men to be easier to engage with in a less direct way:

> *'I've noticed sometimes that some, some younger men I've worked with that really struggle to talk erm, if you have been driving around of whatever, they've been, they've spoken while you're driving, it's almost like, cos you can't give them your full attention or look at them maybe it's easier to, to disclose things or talk about things then. So sometimes, I think people find that one to one off-putting, erm, so yeah, whatever it takes really, and I think, in early intervention service we are encouraged to be flexible and creative in order to engage them'* (Naomi)

In the extract overleaf, Naomi perceived that different service users have different needs and that service delivery needed to reflect such needs to reach mutually agreeable goals for treatment and support. Similarly, one case manager found age and gender as an appropriate way to open further opportunities for engagement with some service users:

> *'Yeah, especially with young people cos I go in and I'm a lumpy grumpy looking old lady these days and they look at me and think er, so what do we talk about? I do this and they have a laugh at that, and then we find out things about, lads especially: Star Wars, gaming, computers, what do they, what actually is something that they thoroughly enjoy doing even when they're unwell, and we use that'* (Eirian)

Eirian is a highly experienced mental health practitioner and has worked extensively across a broad range of in-patient and community mental health settings over her thirty-year nursing career. However, Eirian frankly acknowledged seeing herself as an 'older' case manager and perceiving herself as potentially at a loss especially in relation to engaging and interacting with younger people using mental health services. Nevertheless, she also described a commitment to invest time with younger people and reach some common ground, to increase levels of shared understanding and facilitate a better level of engagement.

To further develop and establish common ground, Jill described the value of initiating conversations that could be of interest to the individual when working alongside them:

> *'…I'm a bit out of touch with fourteen-year-olds but you know references to, to erm, I don't know social media and that sort of thing that, that or to, things that fourteen-year-olds have been to, so try to, probably, not that I'm very into football either but I might make references to football or things that I think a thirty-year-old bloke might like'* (Jill)

In similarity to some Eirian's account, Jill frankly identified herself as being an 'older' case manager and at times, expressed feeling at a loss as to what to talk about that would be of relevance and interest with some younger service users. It could be interpreted that Jill's use of words such as '*out of touch' 'don't know social media'* and '*not that I'm very into football'* may suggest that she was aware of the impact of her generational beliefs and how these may differ to those of the younger people that she works with. However, in similarity with other case managers, Jill highlighted that initiating spontaneous, improvised conversations were perceived to be essential ingredients to build upon meaningful, shared connections with service users. However, some concern and caution was expressed in terms of the case manager's age in working with the broad age span of service users on EIS caseloads. Once again, Jill highlighted how the age of the practitioner and service user could potentially be a helpful or hindering factor in relation to engagement:

> *'…I mean, me as an older person I say it's quite it's quite easy to engage with older people I think, for myself, really, probably more so than younger people now, I've been doing the job for a while'* (Jill)

Jill again drew close attention to how she perceived her age to impact upon how she engaged with service users of varying ages. There is a sense that although Jill is an experienced case manager, she felt more comfortable in her interactions with 'older' service users. Conversely, Naomi emphasised the importance of mental health practitioners using a toolbox of age-appropriate strategies to establish shared understanding with service users of varying ages:

> *'…sometimes I've seen older case managers try and have 'down with the kids' conversations that maybe I would cringe at a little bit because perhaps they aren't as down with the kids as they think they are, and that younger person might be thinking like, oh you know, she's trying to talk to me here, you know, something that she thinks I'm going to be into, but if you're so far away, if you're so far away removed what younger people might be into, it might be hard for you to have those conversations, and obviously I'm not as young as some people we see and I'm not into, you know, some scenes that some young people are into'* (Naomi)

Naomi openly identified herself as being one of the youngest case managers within her team. Naomi perceived that her younger age was useful and advantageous to engaging with some young service users as they may be able to identify with her more readily and effectively than compared with her some of her older colleagues. In the previous extract, there is a sense that Naomi perceived that is important for case managers to be age-appropriate and in touch with the current issues of service users of varying ages to stay on the same page.

Another case manager called Donna was aware that treatment approaches such as medication could be a sensitive and contentious issue for some service users which could potentially impact upon their desire to further engage. Thus, Donna described utilising strategic engagement methods with service users to facilitate engagement:

> *'I've got one lady that's a bit like that erm, and the the working plan is at the moment, she, didn't want to engage and we spoke to mum and sister….one of the things we listened to was that she, wasn't, erm, tolerating the, the dose of anti-psychotic that she was on, erm, so trying to balance that sort of engagement and if we get the medic to come and, and review and look at that medication with you and try and sort of well if, we'll meet you part way if you agree to meet us? ...and she did engage'* (Donna)

Donna demonstrated an awareness around the prescribing of medication as a potential barrier to engagement, but she also alluded to strategically engaging with service users to facilitate more meaningful and collaborative engagement. In contrast, Jill, another case manager, described the importance of getting alongside the service user to positively influence engagement. For example, Jill draws attention to the importance of being attentive to the service user's feelings by displaying empathy and sensitivity.

> *'…. try and, you know, respect that it's been difficult, tell them that you understand how difficult it can be and how it can change on a ward in a matter of minutes with a new patient being admitted, erm, and, and sort of get the message across that you are there to support them, but not take over their lives, or, but you are there'* (Jill)

The above extract captures how Jill believed that empowering the service user would enable them to have a more active sense of control and ownership over their experiences with support from the early intervention service, and thus hopefully encourage and improve engagement. Similarly, Holly identified the importance of working together to promote engagement:

> '*Erm, I think we try and explain our role, and again try and explain that erm they're in control, you know we want to work with them not against them, erm, and and give them some ownership of their care, I think is really important, but often when people don't want to engage erm, it can be quite difficult, to make then understand that that's what we want to do, I think people's experiences of maybe of being sectioned or bring, you know their right has been taken away from them, they're very fearful of that, they don't want that to happen again'* (Holly)

The aim to encourage service users to become more active partners within their care and treatment was explicitly described by Richard, another case manager:

> *‘I think sometimes I try and get people to summarise at the end of the meeting what we’ve been talking about and what-what’s been the most important thing, and what maybe they’re going to do from that. But I suppose there are sometimes, things that maybe we do say where people take those away and we don’t know, and I suppose that’s a difficult bit as well’* (Richard)

Richard was highly reflective and frank about his experiences as an EIS case manager and carefully considered the pros and cons of working in a collaborative way. However, he highlighted the way that case managers see themselves as enabling the service user to develop a greater understanding and ownership of their unique experiences. Based on Richard’s interpretations, it could be further interpreted that working together in a proactive manner to complete such tasks can act as a catalyst for service users to be able to begin forming their own personal frameworks for understanding beyond those offered by the service provision. Overall, the core concept of this theme highlights the key importance of establishing common ground, mutual understanding, and collaboration to promote the conditions necessary for effective engagement.

4.4 Master theme 2- ‘Engagement as an interpersonal relationship’

In similarity to the first master theme ‘*Being on the same page*’, the second master theme ‘*engagement as an interpersonal relationships’* also captures the interdependent nature of engagement in that this is not a one-sided obligation and exists to mutually benefit the service user and the service. However, in contrast to the previous theme, this theme uniquely describes how genuine human connection is key to successful engagement. Case managers identified that they had to engage with service users as that was what they were employed to do. However, all case managers identified that they also needed to build genuine person-centred connections with service users alongside the meeting of service objectives to achieve successful engagement. All case managers described working hard to establish genuine human connection, employing strategies and techniques aimed at engaging service users.

The way that case managers connected with service users was influenced by person-centred, individualised qualities that they brought to the relationship. For example, Naomi discussed the importance of dedicating time to talk about issues that were of interest to the service user to facilitate a better level of dialogue and rapport:

> *'…sometimes erm, as well as getting information about the illness and their background*, *sometimes it might be useful to talk to people about their interests, their hobbies, their lives that are maybe a bit separate from the illness but probably still appropriate for us to, to gather that information as part of gaining some sort of relationship and rapport. Sometimes I talk about myself in, not in lots of detail, but a little detail to help with that, so you know, if they say like I don't know? that they like a particular TV programme or a particular band or whatever then I think it's ok to say oh yeah have you heard this song, or watched this? Erm, I think that's appropriate to sort of gain some sort of rapport'* (Naomi)

In this instance, Naomi, described the importance of using human connection with service users so they could be seen, heard, and understood as a person and not a patient or service user. This human connection was perceived to be one of the most vital foundations of the therapeutic relationship. Naomi believed that investing time with individuals minimised barriers to engagement such as fear, mistrust and defensiveness and fostered building of trust. In addition to building trust and rapport, case managers also identified the importance of continuity of contact to facilitate engagement:

> *'I think some of the trust will return when the service user gets better erm but just continuing to be there I think and to show that it's not just, you're not just there for them to get, go into hospital, but you're there for the right reasons and…all of those things yeah, those I've forgotten what they're called now, those basic things of er, sort of, it's, I've forgotten what…yeah just being genuine, warm yeah, an, listen, listening is a big thing'* (Holly)

Based on her long-standing service and clinical experience and expertise within EIS settings, Holly's personal view was that the qualities of being trustworthy, reliable, and consistent as a case manager not only allowed for mutual trust and respect to be developed, but also created a sense of belonging for the service user. Holly further believed that this sense of belonging may increase service user confidence in the case manager which could further facilitate engagement. Conversely, Richard felt that some service users could be challenging and often 'test' the sincerity and loyalty of a case manager due to perceived previous negative experiences within their life. For example:

> *‘I think, erm, people you know have all sorts of trust issues and actually want to see you work for it sometimes, because they’ve been let down so many times before that erm, it’s not worth going through the process if it’s you know going to be cut short again so, erm, think people just not showing up for appointments, erm, having other things on just make it I suppose all challenging’* (Richard).

It is clear from Richard’s account that he felt that engaging with service users was not an always straightforward and easy process. However, to overcome the stuck position that Richard described, he believed that building trust was a continual process to overcome feelings of service user mistrust. Similarly, Kirsty felt a way of helping some individuals overcome their initial fear, mistrust and suspicion of mental health services was for the case manager to try and put themselves more explicitly in the service user’s position:

> *‘…she said nobody understands, and I was like…well, can I share my story with you? I do understand, I know what it’s like, y’know, I just said, my brother suffers with schizophrenia and y’know, I can see it from both angles and sometimes, y’know, we don’t want to go through the stress of putting our...y’know relatives erm, into hospital under detained, under a section’* (Kirsty)

In this instance, Kirsty is expressing a desire to be somebody that the service user could relate to. Kirsty described not only trying a different and more bespoke approach, but also trying to show a more human side to embody herself in the service user’s world. It could be further interpreted that Kirsty’s use of self-disclosure is saying that she understands. It was evident that all case-managers taking part in this study adopted some unique and tailored approaches with each service user to potentially maximise engagement opportunities. Their core aim being that the service user would feel more confident with their case manager and develop greater trust and shared understanding:

> *‘…. it’s very individual, isn’t it? case management and how you engage with that person is very unique to different, each person I think, and you’ve got to assess that, when you’re getting to know that person, sort of how much they want, you know, and working with them, definitely working with them about how much they want to see you and what, what, and them guiding you really’* (Holly)

Holly’s use of descriptors such as ‘how much they want’ and ‘how much they want to see you’ highlights her perception that a more relaxed, easy going and collaborative approach with service users could improve the trusting relationship and subsequent levels of engagement. Indeed, it was felt by all case managers that empowering the service user to take more ownership in driving the focus and pace of their treatment, positively impacted upon the quality of the therapeutic relationship. Working more collaboratively with service users was seen as a valuable aspect of building the trusting, therapeutic relationship from the point at which the case manager first met with them:

> *‘With service users, if I haven’t met them in assessment, erm at the moment we’re sort of introducing ourselves on the phone just advising that I’m your care coordinator, I’ll be working with you, can we set an appointment? Erm, and then it’s just really erm, my first visit would just be about introductions really, erm…what they might sort of expect from being in the service, what they hope to sort of work on, what’s challenging them, and just slowly work from there’* (Donna)

In the above quote, it was evident that Donna was aiming to reassure service users that the case manager would be the consistent guiding figure throughout their period of support. Case managers were committed to travel alongside service users through their period of support in a therapeutic manner to promote meaningful engagement. However, Donna described that building the therapeutic relationship was not always straightforward. Some challenges were described when working alongside some service users in terms of their reluctance, mistrust, or unwillingness to engage with their case manager. Hence, Donna emphasised that she tried not to be perceived as ‘forceful’ in her early work with service users to allow for the building of trust and rapport:

> *‘That was one, and he allowed me to see his mum, so I said that’s absolutely fine, I can’t force you to see me’ erm, but I will come, you know, I said if you’re ok, I’ll come and meet up with your mum every few weeks and, he was ok with that and then I wangled my way in’* (Donna)

Although Donna’s account suggested that she took care not to be perceived as forceful, she is consciously using her professional position to establish engagement. However, it is also evident that Donna felt that being consistent, carefully taking cues from the service user, and not rushing things along could ensure the more successful development of a trusting, therapeutic relationship. This approach was further exemplified by Jill:

> *‘Well I try and, I would try and create a relaxed atmosphere and I try and be honest and genuine, you know things like if you need to go out and have a cigarette or that sort of thing, it can be quite helpful can’t it to, or if you need a break at any time or if you know, that you’d like to call a halt to it or sort of thing, erm, just trying to create a relaxed atmosphere, being open and honest, maintaining eye contact’* (Jill).

In the above account, Jill believes that being seen as an open, honest, and easy-going case manager was more empowering for service users. In contrast to Donna’s account, Jill was less deliberate in her attempts to engage with service users. Jill’s repeated use of the descriptor ‘honest’ suggested her striving to be as genuine and trustworthy as possible in all her interactions with service users.

Beyond the relationship between the case manager and service user, participants recognised that other relationships in the service user’s life may impact upon engagement. Building relationships with families and caregivers of the service users could be important in further developing trust and creating more in-roads for engagement. However, there was also a sense of this approach being used as a strategic tactic to establish future engagement as illustrated by the following quote:

> '…*but I suppose if you*, *if you are able to get a good relationship with the family, then to try and help them learn that they don't all have to be negative experiences with professionals, erm, that you're going to work with them really, you know, to work on what they want to work on, you know, we're not supposed to be working with people erm on our agendas on what we, how we think their lives should be or changed, we're supposed to be working with young people to help them change their lives in a way they want to do that'* (Naomi)

Likewise, Holly elaborated:

> *'…and speaking to the older members of the, of the family and er, just explaining to them about our role and working with them alongside their religious beliefs and not putting them aside but, but, educating them about mental illness…. I don't think I would do anything differently, it's about recognising cultural differences and working with those differences'* (Holly)

In this case, there is a perception from Naomi and Holly in that sharing information and using educational approaches was seen as a helpful and inclusive strategy to create further understanding and to build trusting relationships with families. In the wider sense, the above quotes illustrate the importance of including family members in discussions to build a shared understanding about mental health, to further facilitate acceptance of psychosis and its treatment and to support ongoing engagement. However, in some instances case managers perceived the presence and involvement of family members to be less helpful and beneficial to the building of trusting relationships with service users and this could create potential barriers to further opportunities for engagement. For example, Kirsty stated:

> *'...sometimes it's been in that family members have turned up so that they've not wanted to…engage because they don't want to see you with their family, things like that'* (Kirsty)

In the above account, Kirsty believed that some service users may not be ready to openly discuss their problems in the presence of their family members and that this may impede some individuals from readily engaging and building trust with their case manager. A similar point made by Holly stated:

> *'I've got situations now that a home visit's not beneficial, that family take over the contact, or the, you don't feel that you're getting the true picture of what that young person really feels because you're getting the family's opinion rather than their opinion, but you know that if you ask them to come to a contact centre, that if you ask them to come to a resource centre, they're not going to do that either'* (Holly)

Thus, some family involvement was perceived to be potentially interfering and could hinder upon the case manager's ability to build trust and a consistent level of connection with some service users. However, overall, case managers were mindful of the importance of being able to build positive working relationships with families and caregivers to develop a greater level of knowledge about mental health, support strategies, and treatment interventions.

The relationship between the service user and case manager could itself become a barrier to engagement:

> *'….and I think sometimes they just don't like you! And that's why they don't engage, and it's just a clash of personalities, and sometimes it would be interesting to know that because I guess sometimes, I think maybe people don't engage because they don't like you! But they don't say that and they decide to not engage with the service instead of thinking 'I'm not getting on with that person, maybe I should have a change in worker'* (Richard)

Richard recognised that not all service users and case managers would get along with each other in every instance. However, he expressed frustration at some service users who, rather than requesting another mental health worker, would instead choose to disengage from the service. By contrast, Eirian believed the onus was primarily on the case manager to be aware if the relationship was working or not and to take subsequent action to resolve this issue:

> *'There are times when you just can't get a click with somebody and I think it's up to you to recognise that, and to go and say erm, since you've said*

> *that you're going to be honest, you know I, I don't feel we're working well together, is there something I can do? is there something we can do? Would you like a change of care coordinator? I think you've got to be honest'* (Eirian)

Richard described some face-to-face experiences where he may have misunderstood the nature and intention of the interaction between service users and himself, and whether such misunderstandings in communication could have impacted upon the effectiveness of his interpersonal approach:

> *'…there might be things that you know in the way that we engage and the way we are, people might be sitting there nodding but actually there might be things that they've either they've perceived in a negative way, or they have been negative, and we haven't realised we've said it that way… Erm, I think that yeah, that can be a difficult one'* (Richard)

Based on the above extracts, it is evident that Eirian's and Richard's accounts demonstrate some contrasting viewpoints around interpersonal effectiveness with service users. For example, Eirian sees this as the case manager's sole responsibility to be aware of whether the relationship is working well or not. Conversely, Richard suggests that some of the responsibility for the effectiveness of the relationship rests with the service user, but he also openly reflects upon some of the challenges he experiences in being able to read the verbal and non-verbal cues with some service users. In contrast, Naomi described adapting her style of communication, depending on the nature of the service user’s mental health symptoms or their level of ability to understand, in order to build on interpersonal effectiveness:

> *‘I know people if they’ve not got very good attention or erm, they’re struggling or distracted with their illness, or their symptoms, then you know, they’ve not got a lot of patience at the moment, they’re going to struggle with our agendas and our paperwork that we might have to do, so I think I’ll try to stick to what I know I have to do erm, but I’ll do it in a way that I’d like to think would flow and become conversational, rather than you know, over-facing people with putting stuff on them, if that makes sense’* (Naomi)

It is evident from the above quote that Naomi regarded the building of rapport and trust as taking more priority than service-orientated objectives, to achieve interpersonal effectiveness in the engagement process. However, as highlighted by all case managers, this theme captures the importance of developing genuine, relational qualities to foster engagement.

4.5 Master theme 3- ‘Managing self and emotions’

All case managers described experiencing a high level of emotional impact in their daily work with service users and how this could affect their ability to engage. They experienced a range of feelings such as worry, fear, concern, anxiety, or guilt in their efforts to engage with some service users and discussed ways in which they would manage themselves and their emotions. To begin with, Donna openly recalled feeling anxious and fearful for her safety in some instances due to the historical risk factors identified with some service users. She highlighted a sense of feeling vulnerable, and uncertain about engaging with some service users that she had not yet established face-to-face contact with. Thus, Donna further described the importance of assessing the level of potential risk within the environment prior to visiting service users to allay her anxieties and ensure her safety:

> *'Well sometimes when, you know if somebody's got a, a forensic history you know and that, the crimes might be sort of violent crimes, so you're going into somebody's area knowing that there's a potential that they could be quite unwell and that they've got this past history, so that, I think that would play, for me, coz I've got two daughters at home I think that would be on my mind a little bit, erm, so I'd want to make sure the environment I'm seeing them in, is a safe environment'* (Donna)

In contrast, Kirsty described the direct emotional impact that she experienced as a result of her encounters with some service users who she perceived to exhibit rude or offensive behaviours towards her:

> *'Well, the last time it happened, she slammed the phone down on me right after she called it me so erm… I don't, there was no way that I wasn't even going to entertain calling her back at that point…. there was actually a colleague sat next to me who heard her scream this down the phone, so I said erm, I was mortified afterwards thinking God what did I do? But it*

> *might've been me actually, why y'know, I don't want to work with someone who's horrible and nasty'* (Kirsty)

In describing the above issue there is a sense that Kirsty was reluctant to further engage with the service user at that point in time on account of the negative behaviour she had exhibited. Kirsty's use of words such as '*scream*' '*horrible*' and '*nasty*' may convey the personal impact of her encounters and may suggest that she was trying to protect herself from further unwanted exposure to negative comments. Based on Donna's and Kirsty's descriptions, it is evident that regardless of whether contact with service users was direct or indirect, case managers could experience emotional vulnerability in different ways.

Additional views were expressed by case managers in terms of the emotions they experienced when engaging with individuals presenting with mental health difficulties other than psychosis. For example, Kirsty perceived that working alongside some individuals who were not diagnosed with first-episode psychosis could be a challenging, chaotic, and unpredictable experience:

> '*You get people that are brought into the service that…that are possibly 'high risk' of developing and y'know, they've not actually been diagnosed. You kind of, see from your experiences that it's more likely personality traits and you get a lot of…I think, non-engagement from people with personality traits…erm..they've not developed y'know, any sort of psychosis whilst you're working with them and it could be that you've worked with them for months and then, all of a sudden they start to*

> *disengage'* (Kirsty)

In relation to working alongside service users with personality disordered traits, Donna spoke openly about needing to step back, critically reflect and manage the feelings that she could experience:

> *'…some people are more difficult to, sort of, like! er… the other week I assessed somebody who was very, sort of arrogant, obnoxious, am I allowed to say that? But it was, it was er, there were lots of personality traits that were sort of evident throughout the assessment, erm just his body posture, his stance, the way he spoke to me, his expectations of, of me, his expectations of what he was prepared to offer, it was really really sort of challenging'* (Donna)

Donna's candid description of her negatively perceived encounter with a service user highlighted her struggles and potential conflicts with her own values and beliefs and how this may impact upon engagement. Similarly, Jill discussed how she would 'protect' herself when engaging with service users with personality disorders to minimise her potential feelings of professional vulnerability:

> *'…trying to have a relationship with somebody with a personality disorder is a lot more difficult because there's a lot more frustrations, for me personally, erm because they're not really bothered about engaging…..and it's those frustrations that actually kind of have, in a way, a physical erm reaction from me, so so, get this feeling in your gut this ahh*

> *this diff- not like a knot, but this kind of like, and I'm sure that some that have those sorts of personality isn't it?, so you can't be as open and honest so you do need to in a way protect yourself because especially, me, they'll run all over you in a way'* (Jill)

Jill openly expressed a need to protect herself from some behaviours that she perceived from some service users diagnosed with personality disorders. Jill's use of words such as '*difficult'*, '*frustrations*', and '*reaction'* highlights the uncertainty, and emotional challenges of trying to meaningfully engage with some individuals presenting with personality disorders.

Building upon Jill's description of protecting herself, when working alongside service users with personality disorders, Eirian was more explicit by discussing the importance of setting clear professional boundaries to manage her contacts:

> *'…we know that borderline personality disorder has a very bad name but it's borderline for psychosis so if you've got any considerations at all, you recognise the person has personality difficulties and you put in your boundaries, you write your boundaries in your care plan, you're straight with the person, and you work along those sorts of lines. And if you've said I'm only going to come and see you once a fortnight, you go and see them once a fortnight'* (Eirian)

In contrast, Jill was more open and direct about the feelings that she experienced when engaging with some service users diagnosed with personality disorders:

> *‘…there are a number of, of clients on my case load that have been on my case load that do have difficult personalities or personality type disorder things, and I do think that does make engagement hard in some respects, or it’s the internal frustration you feel with these people, or I feel with these people, and I suppose in a way a kind of like, lack of respect that comes across from them, for, for the work that we do, for what the NHS provides for them, for what the Government provides for them in terms of benefits and, and whatever and I suppose for those people it’s you know, they’ve probably had a difficult upbringing or there have been factors that have led them to be demanding or difficult or, or whatever, but the, this, this lack of responsibility that comes across from some people’* (Jill)

Words such as ‘*difficult personalities’*, ‘*internal frustration’* and ‘*lack of respect’* all convey a sense of how Jill feels and how to she can establish engagement with some individuals with mental health conditions such as personality disorders. A further but similar point was raised by Holly which highlighted the importance of how case managers managed their emotions when service users did not engage with planned appointments:

> *‘And maybe not feeling guilty every time they don’t attend an appointment, but they weren’t ready to engage with us, but acknowledging that, but giving them that choice’* (Holly)

It could be interpreted from the previous extract, that Holly demonstrated high levels of coping and resilience in relation to her experiences of poor, episodic, or non- engagement by not personalising, and by being realistic about the somewhat unpredictable nature of the engagement process. Conversely, Eirian openly spoke about the difficult feelings that she experienced because of diligently and intensively working alongside some service users over lengthy periods of time as part of the service requirements:

> *'I suppose at the end of three years there is some aspect really of almost a grief really isn't there? Because you are saying goodbye to somebody that you've worked intensely with, or you should have worked intensely with over three years…..what I tend to do is, I suppose in letting go, you make sure that the person who is taking over has a really good understanding of what has gone on with this person, where they are, what their early warning signs are and all the other things, and then you have to hope that they're going to do the same for them'* (Eirian)

In this instance, Eirian identifies an emotional cost of working closely alongside the service user during their three-year period of care with EIS. Words used by Eirian such as *'grief'*, '*saying goodbye'* and *'letting go'* all convey her sense of sadness and loss. However, case managers generally recognised that experiencing feelings such as sadness and loss were a predictable part of the job, due to investing much time, and an intensive level of effort and support when working alongside service users and their families.

In this theme, case managers emphasised the importance of feeling that their personally challenging work and efforts to engage with service users was fulfilling and rewarding. However, as case managers felt that they invested much of themselves in their engagement work with service users, their experiences of working alongside some individuals with personality disorders could be seen as unrewarding and demoralising due to challenges such as rejection of support.

4.6 Master theme 4- 'The practicalities of engagement'

Case managers believed that working in flexible, creative, and bespoke ways were important skills and qualities to promote the conditions for more successful engagement. To further open the door to engagement, some case managers described that it was important to ensure that the contact was perceived to be practically and/or materially useful and beneficial to the individual to meet their often-changeable needs:

> *'Erm, lots of people we see don't have their own transport, erm, so I think things like that are really tricky for you know, to, to do. Erm…what I was just thinking of what I was going to say, yeah, when it comes to money I think, and things to do with housing which can be very stressful and anxiety provoking things when they're not organised for people, I think really, you'd be asking too much of people to concentrate on a session, erm, with you if something like that was unresolved'* (Naomi)

Naomi perceived that there could be times when other concerning aspects of the service user's life could impact on their ability to engage with planned appointments with their case manager. In this case, Naomi felt that it was important for the case manager to be flexible and prioritise and meet the needs of the service user rather than the service's objectives and outcomes. Similarly, Holly expressed the importance of using practical and non-mental health-based approaches to creatively connect with some service users:

> *'...erm, benefits, housing, all those practical needs that you can work on, and in fact working on those erm, does improve engagement if you work on those sorts of first, you can get often the service user on side and get, build that trusting relationship to work on other things'* (Holly)

Like Naomi, Holly perceived engagement to be more effective if it was based on recognising and attending to the pressing needs and priorities in the service user's life. However, it was also clear that attending to practical and material needs was used consciously and deliberately as a method to further build on trust to engage with other aspects of the service user's life. In relation to the above extracts, Naomi and Holly worked with service users to attend to important social needs such as housing and welfare benefit applications. In this instance, Naomi and Holly perceived that their practical approach was useful, and the service users subsequently engaged with the service. Likewise, the importance of offering creative and flexible strategies that would be helpful to service users rather than meeting the case manager's agenda was reiterated by Richard:

> *'…I think that part of trying to engage with difficult to engage people is sometimes not doing er… too much harm too, doing achievable little snippets in bits when you know it's difficult for people to engage, they can take away what they need for that session, just in case you don't see them again for two months. And left thinking about all sorts of, you know different things, so do things and work with people and engage with people in a way that's going to be as useful for them, not following a format within an inch of your life approach'* (Richard)

Richard openly acknowledges how each face-to-face contact with an individual needs to be largely focused on their most important and pressing needs at that point in time due to the time-limited and unpredictable nature and pattern of engagement. Some case managers also expressed that being able to flexibly accommodate the service user's preferences for place of contact was crucial to optimise further opportunities for face- to-face connection:

> *'...y'know, where you're gonna see them, is it closer to home? Is it kind of, more convenient for them that they don't have to get on a bus for half an hour to an appointment or ask for a lift off somebody? So, seeing them in, in their own home can sometimes be, be more beneficial even er ...at a local GP surgery if you can get a room'* (Kirsty)

Kirsty perceived attendance at planned appointments to be more successful if the case manager was prepared to be flexible in meeting with the service user at a location that was preferable and manageable for them and accessible in terms of their travel time. Similarly, Naomi emphasised the value of acknowledging the service user's preferences for face-to-face contact in non-mental health settings to avoid the potential for stigma:

> *'I think the fact that we see people in their homes is helpful for trying to be non-stigmatising, so we're not asking people to come to a building where they might have to sit in a waiting room with lots of other people, so, pretty much always doing home visits unless people are willing and able to come to a base. Erm, trying to be flexible with appointment times, coz we work eight till eight, erm, and other people like service users may be busy or occupied in different hours'* (Naomi)

Both Kirsty and Naomi recognised the practical and material realities of service user's lives and how working around these realities was key to more successful engagement. The planned use of home visits was perceived to be an important aspect of this approach. In some instances, case managers described using impromptu home visits as a strategy to establish engagement with some service users:

> *'Yeah, so I've got somebody erm, that… I usually see but I can't get to see them for a bit, cold call them, just drop in, erm seven o'clock at night is generally quite a good one coz they're generally in, if they've got kids, they're in after school time, so even if it's just a face to face at the door, at least you're reconnected'* (Eirian)

Eirian justified the use of such unplanned visits on the grounds that some service users may not have maintained any engagement contact with EIS over prolonged periods of time due to the often unpredictable and chaotic nature of their lives. Furthermore, Eirian believed that this method of engaging with some service users was vital to maintain some consistency of support and to address progress with treatment. Similarly, Naomi highlighted and justified the value and usefulness of unplanned visits to achieve a more successful and consistent level of engagement:

> *'I suppose if, if we're struggling to catch people and you know the places that they are going to be. So, if people are working with other services like they might, erm, have things that they always attend and don't miss, or they have places that you expect they might be, erm, so sometimes I don't know, if you know they drop their children off at school at a certain time at a certain place, or you know they meet with their probation officer or a drug worker at a certain time or place, or they've got other appointments that you know they might be at, sometimes we can try and jump in on those, or try to arrive at the place at a similar time'* (Naomi)

The previous extract captures a sense of Naomi being creative, energetic, and tenacious in her attempts to establish successful engagement with some service users. However, words such as '*working with other services*' and '*they've got other appointments'* may also suggest that Naomi recognised that various aspects of the service user's life such as attending other appointments may at times, take precedence over contact with EIS.

To address such challenges, Kirsty also described using a range of less direct engagement methods in collaboration with families or caregivers to successfully connect with some service users:

> *'Mum's terrified that if we speak to him and say mum's been on the phone and told that there's this, that and the other and completely ruin their relationship, but I think as a practitioner there are ways and means around how you word things to people when you see them, erm y'know,…it could be his care coordinator is off at the minute, so you could kind of…just say that your care coordinator is off at the minute, erm…we notice that you've not been seen for a while, so we just thought we'd see how you are? Y'know. Doesn't need to know that mum has been on the phone at all does he?'* (Kirsty)

In the above instance, Kirsty is emphasising her hard work and efforts to adopt a creative but somewhat covert style of partnership working with family members to establish further ways to connect with some service users. There is also a sense of Kirsty working on a 'need to know' basis in relation to the sharing of information as she believes that this may avoid the potential further risk of disengagement. Likewise, Richard identified the importance of being able to anticipate and gauge as to whether social and environmental factors such as the family home, and the presence of family members would be appropriate depending on the service user's mental state:

> *'Both home environment and just the area environment, confidentiality of*

> *where you meet and what you're willing to discuss and what they're willing to discuss...erm, person's vulnerability, erm, and feeling comfortable with a certain member of staff, erm, and their past history. Family members, pets, the usual sort of things to do with home'* (Richard)

Case managers also spoke about a service user's lifestyle factors as an additional layer of complexity that could influence and impact upon future engagement. Naomi highlighted instances whereby a service user's use of substances could present as a potential barrier to engagement with their case manager:

> *'I suppose, drug use would be a big, a big factor for people engaging, if someone has a drug habit, their lifestyle can be erm, affected in a big way really, that, for example from, you know, if something comes up right I'm meeting this person here to get some drugs to go and do this then your appointment, the thought of your appointment has gone out the window really, if they've got a drug habit that., that's taking over their lives, erm, so if someone is using drugs then we would be encouraged not to see them if they were under the influence of drugs or you know, had people round at their property taking drugs, I think that would be a big factor'* (Naomi)

Eirian's quote further substantiates some of the issues surrounding a service user's drug use and as a consequence of this, some of the challenges of engagement with case managers:

> *’If you find you’ve got somebody on your case load who continues to take drugs, one the antipsychotic isn’t going to work, the way you work therapeutically isn’t going to work, you don’t enter their house if they’re high on drugs, so it makes it a very very difficult thing to do, and frustrating if they say that they’ve got no money and the dual diagnosis on benefits and they go out on the Monday night or Tuesday night, one minute past midnight, draw out all the benefits and go and spend it on drugs. What are we actually doing? we are actually feeding their drug habit with what we’re doing’* (Eirian)

Naomi’s and Eirian’s accounts both highlight how the challenges of a service user’s substance use meant the scope and ability of the service to address mental health needs could be limited and could further impact upon future engagement opportunities.

All case managers perceived time pressures to be one of the most significant and frustrating concerns of their role due to the ever-increasing numbers of people on their caseloads, the distance travelling to service user’s homes, and the requirement to set time aside to complete a range of assessment and general administration tasks. However, in spite of these pressures on their own time, case managers also described the importance of flexibly planning their diaries to fit around the service user’s schedules to achieve a more consistent level of engagement. For example, Kirsty stated:

> *‘Yeah, yeah, you’ve got to be flexible. Some people work as well, so*

> *y'know erm…quite often there's people I see that can't attend appointments between the 9- and 5-time y'know and I've got to go later or something like that. Weekends as well, erm…yeah… then opposite scale, people prefer to see you during the week because they want to go out at weekends. Yeah, so you've got to be flexible'* (Kirsty)

In similarity to an earlier point raised by Naomi within this master theme, Kirsty felt that conventional timeframes such as nine to five office hours may not work for some service users on her caseload due to other pressing commitments in their lives. Kirsty believed that her approach needed to be open, flexible, and negotiable to optimise engagement. In a similar vein, Richard described the importance of being able to flexibly work around the service user's preferences such as the time of day or venue to ensure consistency of engagement:

> *'Where possible I'd do home visits when people needed them anyway, erm, so we would be sort of working round what times of day erm, are best, is there a certain time? certain venues? er what could we be doing leading up to do we just do a bit of engagement, again just walking about erm instead of being in the house if it's feeling too cramped, so there's... it's getting sort of, being creative thinking, about you know'* (Richard)

In parallel to other case managers in this study, Richard's account draws attention to the potentially non-prescriptive nature of engaging with some service users. Richard strongly believes that there is no one size fits all approach to engagement and that each interaction needed to be adapted to fit in with the practical and social circumstances of each service user at that given point in time. In the above extracts, it could be further interpreted that case managers endeavoured to work as hard and effectively as possible with the time and resources available to them to creatively engage with service users. The importance of investing time in service users by offering alternative opportunities for engagement was perceived to be key to continually building on consistency, trust, and connection.

4.7 Master theme 5- ‘The impact of organisational factors upon engagement’

Case managers openly spoke about the influence and impact of EIS organisational factors upon the engagement process. Case managers described how various expectations set out by EIS to meet specific deadlines and targets for assessments, face-to-face contacts, and response to risks negatively impacted upon the quality of care that they could deliver. Jill openly discussed her perceived lack of time to deliver high quality, person-centred care due to her professional obligations to meet the overarching objectives and targets of the service:

> *‘...I do feel and even more so recently that erm, the focus isn’t on treatment, isn’t on what you provide for the patients, it’s all about meeting targets and I just feel that erm, that takes away a lot of the job satisfaction because you’re not able to treat people or spend the time with them that you’d like, and things are getting rushed, erm because it’s all about targets, treatment time, erm not about quality, it seems to me’* (Jill)

Jill's above description highlighted how she valued the availability of time to get to know the service user as a major and prioritising part of her role. Jill reflected on her desire to have more time to work alongside service users with less emphasis given to service targets. Similarly, Eirian described the impact of the ever-changing organisational context that she felt was moving away from the original ethos of the EIS model of care and more towards the approach adopted by a community crisis treatment team (CCTT):

> *'I do not get satisfaction from what I'm seeing going on in EIS. I see that we get managers who can't be bothered to read about psychosis, who can't pick up IRIS and read about I consider to be the founding stone and philosophy of EIS, and think that you know you can actually assess somebody for something as detrimental to the person as psychosis in one assessment, whereas erm…no, it's becoming more like a CCTT every day and a mini-crisis team and that is not the philosophy of EIS. So, managers who don't read about EIS don't understand EIS, don't want to know, are just looking at numbers and figures, are actually spoiling what is a very good service'* (Eirian)

Eirian felt that she was unable to fully perform the EIS case manager role that she originally signed up for. Eirian's use of words such as '*a mini-crisis team'* and '*spoiling what is a very good service*' highlighted her deep sense of disappointment and frustration with senior managers and her perception that they lacked understanding about the true nature and purpose of what EIS care should look like. The above extracts further draw attention to how case managers felt that EIS was being forced to adopt an increasing level of crisis-intervention as an approach due to reduced service resources which further impacted upon their available time to offer therapeutically effective contact with service users in their care.

Another key issue that caused concern for some case managers was the way that EIS was set up and designed to focus on two separate roles of both assessment and case work. Case managers described these two roles as conflicting and competing and as potentially impacting upon engagement with service users on their caseload:

> *'It impacts on my stress coz it's hard it's really hard, I like doing both erm, but it's really really hard trying to fit in all your case work stuff erm, outside of your assessment days, erm, but I'm glad I do both, I wouldn't want to give up either'* (Donna)

In the above account, Donna expressed concerns about her perceived lack of time to provide effective care and engagement with service users on her caseload. However, despite experiencing such feelings, Donna counteracted her concerns by putting a positive spin on the various strands of her case manager role. Likewise, most case managers generally developed a realistic set of expectations and acceptance and as to what EIS could offer due to finite levels of resources. This is exemplified by Holly who expressed that her current role in that EIS was not able to offer a similar type of service in comparison to her previous role in an assertive outreach team due to different levels of resource allocation:

> *‘I had to sort of step back and think erm, how do I engage with them, and I can’t engage with them as assertively, well perhaps not I can’t but should I be doing? I think from my perspective when you’re working in the assertive outreach team, you see people very frequently sometimes daily, and in the early intervention team you can’t do that, you haven’t got, well, we don’t have the resources to do that so I think yeah, I had to step back and think you can’t be there as much for these people’* (Holly)

In the above extract, there is a sense that Holly was in a state of constantly reflecting and adjusting her own standards and expectations that were appropriate to the ethos of the EIS. It could be further interpreted that Holly was maintaining a sense of realism in view of such finite EIS resources to further manage her expectations. She understood that she had less time as a case manager in an EIS setting in relation to having experienced more time for service user support in her previous practitioner role in an assertive outreach service.

In summary, the importance of having more available time as a commodity to invest in the service user has emerged consistently throughout the final theme. The finite nature of a case manager’s case work time within EIS settings because of service level factors was perceived to impact upon their capacity to engage and contributed to the overall quality and meaningfulness of their connection with service users.

4.8 Conclusion

This chapter has explored the views and perspectives of case managers from across three EIS teams in one NHS Trust of how they experienced varying levels of engagement with service users. Overall, case manager experiences of engagement were described as a complex, nuanced and multi-faceted process. Based on the many complexities that case managers faced within their daily work with service users, five master themes emerged from the analysis.

Within the first theme, case managers placed importance on establishing a shared level of understanding with service users to facilitate a better level of engagement. However, this theme also illuminated how case managers referred to service users as being jointly responsible in the process for engagement to be successful.

The second theme highlighted the importance of building a trusting, therapeutic relationship between the case manager and service user as a facilitator for engagement. EIS case managers mostly described their experiences with service users in a person-centred way. Case managers placed considerable emphasis on personal qualities such as being genuine, collaborative and empowering in their approach with service users. All case managers described having greater satisfaction within their role when a trusting, therapeutic relationship was established as it enabled them to further build on consistent and meaningful engagement opportunities with service users.

For the third theme, the emotional factors described by some case managers were perceived to influence how they engaged with some service users. This theme highlighted some of the worries and tensions that were experienced in terms of factors such as service user risk, working alongside individuals with mental health difficulties other than psychosis, dealing with service users being discharged from the service and being able to cope or manage in the face of poor or non-engagement. Feelings of anxiety and fear arose from perceived threats to the case managers' safety that most accepted as part of the job. Some case managers took measures to protect themselves as they worked to understand how to effectively manage their connections with some service users. In this case, reflection was often used to focus upon the engagement process and to learn from their practice. The high emotional cost of engagement reflected how some case managers felt tested during engagement. Poor or non-engagement was mostly perceived by case managers to be a negative experience. Although case managers did not personalise this, it was evident that this could be anxiety provoking and prompted further professional reflection to address and manage such feelings.

Within the fourth theme of particular importance was how case managers spoke about doing working around practical and material things with service users as a way of showing themselves as engaged in a meaningful, purposeful, and useful way. This theme showed how important it was to know what was helpful for service users for successful connections to be made. Furthermore, case managers identified that they needed to be resourceful by working in creative and flexible ways to ensure a more consistent level of engagement with some service users.

In relation to the final theme, case managers described many factors being outside of their control due to the influences of the EIS organisational policies and processes. Because of increasing assessment and case work tasks associated with the case manager role, they described having less time to build on connections with service users which was seen as being potentially detrimental to building further engagement opportunities. However, despite this reality, case managers described being able to creatively work with the finite levels of resources available to them to connect with service users and maintain a realistic outlook.

The next chapter will further consider the significance of the study findings and their associated meanings. It will seek to further understand the multiple, complex, and nuanced layers of engagement from the case manager perspective and how this may influence engagement with service users within EIS settings.

Chapter Five : Discussion and Recommendations

5.1 Research overview

This doctoral study has aimed to explore case managers' experiences of engaging with service users in UK EIS settings in one NHS Trust. Flexibly guided interviews were conducted with seven case managers about their subjective experiences of engagement and five master themes were subsequently developed; (1) Being on the same page; (2) Engagement as an interpersonal relationship; (3) Managing self and emotions; (4) The practicalities of engagement (5) The impact of organisational factors upon engagement. Throughout this phenomenological study, the aim was to contribute to the emerging FEP literature around case managers' experiences of engagement with service users in EIS settings. This chapter provides a critical discussion around the key findings of the study which were described in the previous results chapter.

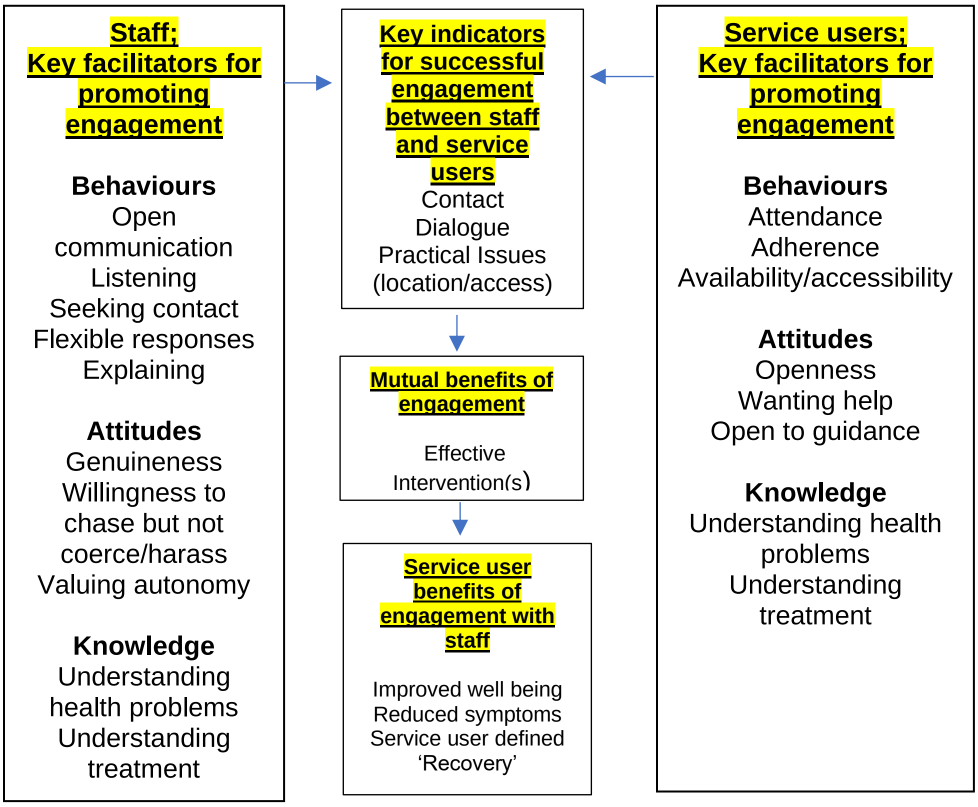
5.2 Significance of key findings

To my knowledge, this is the only qualitative study that has explored the perspectives of mental health nurses' and their engagement experiences as case managers in UK EIS settings. The findings of this research contribute to the emerging existing literature focusing on the perspectives of case managers' engagement in EIS settings. It is clear from the key findings of this study, that engagement can be understood as the context which allows implementation of treatment. This includes knowledge, behaviours and attitudes on the part of service users and staff, as well as the environment bringing them together.

Figure 5.1 outlines the various knowledge, behaviours and attitudes on the part of staff and service users to promote the conditions for engagement, effective interventions and more favourable outcomes to take place.

Figure 5.1

The context of engagement in EIS settings in relation to staff and service users



As evident in figure 5.1 above, case managers experienced engagement as involving numerous, changeable processes that they endeavoured to carefully facilitate. To cast further understanding around the multiple elements of engagement, key aspects of the study findings in relation to relevant theory and research literature are discussed below:

5.2.1 The interpersonal qualities of the case manager in engagement

The master theme entitled *Engagement as an interpersonal relationship* suggests that the quality of relationships that case managers developed in the process of providing care, treatment, and support for people using EIS services determined the overall success of engagement opportunities. All case managers who took part in this study described various elements of the trusting, therapeutic relationship as being key determinants for successfully engaging with service users on their caseloads. All case managers principally valued the importance of developing a shared level of understanding to help service users make sense of their own experiences. This concept not only included having the case manager endeavouring to understand the service user's unique experiences, but also being able to develop trust, rapport, and genuine human connection. This theme accords with the findings of previous studies cited within the chapter two systematic literature review in which *rapport, dialogue,* and *person-centredness* were seen as integral aspects of building trust to enable mental health practitioners to facilitate a more successful level of engagement (Addis & Gamble, 2004; Hitch, 2009; Wright et al., 2011; Procter et al., 2015a; Procter et al., 2015b; George et al., 2016). The study findings also resonate with a wider body of literature that emphasises the importance of the therapeutic alliance, and with person-centred approaches that focus on empathy, unconditional positive regard, genuineness, and viewing the service user as a person rather than an illness (Rogers, 1980; Frank & Gunderson, 1990; Horvath & Greenberg, 1994).

The study findings also revealed that some case managers focused on the importance of allaying a service user's feelings of fear, mistrust, and suspicion of EISs in order to reduce their fear, scepticism and reluctance to further engage with the service. This is in line with existing research, in that avoidant or insecure attachments with staff reduced engagement opportunities in EIS settings (Gumley et al., 2014), whereas secure, trusting bonds were linked with increased levels of trust and engagement (Mallinckrodt, 2011). EISs have been purposively set up and designed to provide humanistic, person-centred approaches that focus on building a trusting, therapeutic alliance, and in this sense, this study's findings confirm best practices for supporting individuals with FEP using EISs (Stewart, 2012).

EIS case managers also described the value and importance of using less formal interpersonal approaches to facilitate better levels of engagement in comparison to those used within generic community mental health services. Such approaches included talking about issues that were of interest to the service user. Similarly, some case managers spoke about being less focused on service orientated objectives in order to achieve a less formal approach as part of their contact. This is further corroborated by studies cited within the review's findings (Chapter 2) in which some mental health practitioners described how they would prioritise and consciously adopt a more human and relaxed approach that was more service user led than service led (Addis and Gamble, 2004; Wright et al., 2011; Procter et al., 2015b; George et al., 2016). The study's findings are further supported by wider research to suggest that the relationship between the case manager and service user is intended to be less formal in EIS settings than relationships in traditional mental health services (McCann & Lubman, 2012). This further correlates with a previous EIS study in which a relaxed, and more informal approach was seen as being of more therapeutic value and contributed more significantly to future engagement contacts with service users and their families and caregivers (Tindall et al., 2018).

In relation to this study, some case managers also described the importance of not being perceived as forceful or assertive particularly in the early stage of their work with service users so they could build trust, rapport, and connection. However, several case managers experienced some tension between recognising the importance of spending substantial time to build trust and rapport, and feeling under pressure to assertively establish contact often against their own clinical judgements in order to meet the objectives of the service. However, assertive engagement principles are factored as an integral part of EIS person-centred service models across EIS settings worldwide (Hughes et al., 2014). Nonetheless, it was evident that individual case managers across the three EIS sites within this study delivered this service model differently, which is in line with variations observed in the application and delivery of the model in a range of EIS settings across the UK and the rest of the world (Tindall et al., 2019). However, in the context of this study and the wider literature, it is evident that most service users irrespective of psychotic symptoms, are capable of interpreting genuine case manager intentions and can thus make decisions to develop interpersonal relationships that influence engagement.

5.2.2 Importance of establishing shared understanding and collaboration to aid engagement

The master theme *Being on the same page* highlighted the importance of contact being a collective and mutually understood effort for successful engagement to occur. Collaboration was identified as a consistent core concept to enable effective engagement, and this involved case managers acknowledging the active role and input of the service user and family members where appropriate, in agreeing and working towards mutually agreed goals. Case managers’ experiences of collaborative working were consistent with the literature review’s findings (Chapter 2) which emphasised jointly negotiating and agreeing on treatment and contact times to enable collaborative engagement (Addis & Gamble, 2004; Hitch, 2009, Procter et al., 2015a; Wright et al., 2011; George et al., 2016). Likewise, the key findings identified within this master theme align with elements inherent within the wider literature, in that successful engagement was seen as being more achievable when a collaborative approach was used to identify and establish shared understanding, mutual goal setting, and joint responsibility for contact (Lester et al., 2011; Stewart, 2012; Luckstead et al., 2015). Other key elements captured within this theme showed how some case managers embraced positive risk-taking approaches in empowering service users to take greater ownership and responsibility within the process by jointly arranging the frequency and preferred methods for contact.

The process of engagement is congruent with recovery-orientated approaches in which case managers acknowledged risk taking by supporting service user decisions to engage with services (Stanhope et al., 2009). This notion also links to the emphasis in recovery approaches on mental health practitioners not as problem solvers but as allies or supporters (Deegan, 1988). Moreover, clinical practice guidelines emphasise the importance of viewing individuals and their families as active partners in treatment, and advocate for a shared decision-making model (International Early Psychosis Association Writing Group, 2005). Likewise, the National Institute for Clinical Excellence (NICE) guidelines for treatment of psychosis and schizophrenia explicitly recommend that all professionals undertake shared decision making routinely depending on the service user’s capacity and capabilities (NICE, 2013). Thus, the findings within this theme are consistent with the wider literature in that mutual understanding and joint decision-making practices promote more effective service user engagement with mental health services.

It was also evident within this theme that case managers perceived both parties to be in a constantly changing state of trying to understand each other in order to successfully work towards appropriate and mutually agreed goals. Case managers identified that getting to know the service user as a person through their individual, age-related, and cultural preferences, facilitated a better level of engagement. In particular, the study findings suggested that case managers found that common ground was reached through investing and spending more time with service users and by flexibly focusing on non-mental health conversations as required. The relationship would therefore move from a paternalistic, protective episode of care towards a more empowering and collaborative partnership. These findings resonate with previous FEP research by suggesting that being provided with opportunities to develop personal understandings of experiences, without necessarily needing to adopt bio-medical model explanations of psychosis can be associated with better levels of engagement and positive outcomes within EIS settings (Harris et al., 2011).

5.2.3 Influence of organisational structures and processes upon engagement

In relation to the master theme *the impact of organisational factors upon engagement,* some case managers frankly spoke about the frustrations and pressures that they often experienced in being expected to carry out a combination of allocated case-work and generic roles within an EIS setting that either reduced or diluted the quality of their engagement contact with service users. Consequently, such organisational factors seemed to have a significant impact on how case managers perceived the value of engagement leading to some to adopt approaches that appeared to be more target-driven and tick-box orientated rather than bespoke person-centred care.

It is acknowledged that smaller EIS teams (as evident in this study) can encounter several operational difficulties, particularly in meeting key EIS criteria due to factors such as less complete and diverse skill mixes, fewer support, time and recovery workers, and less dedicated medical staffing time (Dodgson & McGowan, 2010). Similarly, EISs are considered to be a more complex service model to set up and implement than other specialist mental health teams such as Assertive Outreach, or Crisis Resolution and Home Treatment due to variations in local and regional needs (French et al., 2010). It is thus contended that the challenge is for such services to adapt EIS models that are relevant to the needs of a locality and ensure that this model will deliver the core features and evidence-based interventions that are required for successful EIS delivery (Sainsbury Centre for Mental Health, 1998). However, it has been argued that adapting EIS models to reflect and meet local needs can risk the intended core principles of EIS drifting away from the ethos of this service and its evidence-base (National Institute for Mental Health in England, 2003). Nonetheless, despite the limitations discussed here, it is evident that some of the challenges are related to the commissioning and setting up of services rather than problems with how EIS case managers deliver such care (Dodgson & McGowan, 2010).

A further related issue that was highlighted by case managers was having access to more time as a valuable resource to perform their role as effectively as possible. It was evident within this theme, that case managers attributed effective engagement to having more available time, but that this was limited due to ongoing capacity issues such as increasing caseload sizes, and other service demands such as assessments. These study findings correlate with the findings from the review of the literature (chapter 2), indicating that time related pressures and wider caseload commitments were seen as impacting upon the frequency and quality of contact with service users across a broad range of community mental health services and settings (Addis & Gamble, 2004; Coombes & Wratten., 2007; Killaspy et al., 2009; Wright et al., 2011; Gairns et al., 2015).

The study findings are also supported by a previous study in which hospital and community-based nurses experienced a sense of decreased autonomy as a consequence of time constraints imposed by finite levels of service resources (McGrath et al., 2003). However, it is perhaps surprising that time related pressures emerged as a key recurring issue within EIS settings. According to the wider literature, assertive outreach and EIS models of care have traditionally allowed scope for mental health practitioners to have more contact time with service users and their families in comparison with generic community mental health teams (CMHTs) due to being allocated smaller caseloads (Cuddeback et al., 2013; Tindall et al., 2019). However, the findings within this theme highlight the significance of organisational structures and processes and how these influence the engagement of the case manager with service users. It is argued that service users having access to *substantial* time with their case manager notably in the early stages of their care and treatment trajectory can foster better engagement over the shorter and longer term and build a more sound, therapeutic relationship (Tindall et al., 2015).

5.2.4 Managing the emotional impact of engagement work

As part of the master theme *Managing self and emotions,* the emotional costs described by some case managers were highlighted as having the potential to impact upon the perceived quality of their engagement contact with some service users. For example, some case managers revealed that by experiencing emotions such as fear, anxiety, and uncertainty, this could influence their clinical decision-making and motivations to engage with some service users. However, it is suggested that staff from nursing as evident in this study, is one of the health occupations most associated with high levels of emotionally loaded work (Mitchell & Smith, 2003; Mann & Cowburn, 2005). Furthermore, Gray and Smith (2009) reported that health care professionals inevitably adopt a range of coping strategies to manage their changeable emotions due to the complexity and uncertainty surrounding care and treatment experiences. Indeed, anxiety and fear about engagement work was also mirrored in the findings of the thesis review (Chapter two), in which mental health practitioners described how the potential to experience risk factors in some community mental health settings could trigger a range of strong negative emotions which could present as a barrier to further engagement contact (Clutterbuck et al., 2009; George et al., 2016).

Likewise, the findings showed that awareness of risk and being constantly vigilant were a typical part of a mental health nurse's experiences and that precautions were taken to protect themselves as they worked towards understanding their relationship with the service user. Drawing on previous studies by Carlsson et al. (2000) *and* Cowan et al. (2003), the study's findings may further suggest that case managers from mental health nursing backgrounds may experience considerably changed emotional states since engagement with service users within EIS contexts tends to involve more frequent, and high intensity contacts in comparison to generic mental health services. This echoes with previous findings which suggests that the intensity and duration of interactions with service users is an important predictor of emotional impact (Mann & Cowburn, 2005). However, some of the risks associated with the emotional impact of a case manager's engagement work may be mitigated through support, clinical supervision, and the team approach taken by EISs (Tindall et al., 2019).

It was also revealed how some case managers successfully managed to identify and regulate their emotional states by anticipating and accepting that some service users would inevitably disengage from the service at various time points over the three-year period of their care. Based on case manager descriptions, it could be assumed that the case manager’s acceptance of service user disengagement could be seen as a protective measure to avoid framing their feelings in terms of disappointment or personal rejection. However, it is argued that without the ability to regulate difficult feelings and responses in interactions with service users, health professionals such as mental health nurses might risk becoming overwhelmed or experiencing burnout (Linsley et al., 2016). Thus, in relation to the study findings, it could be claimed that central to the case manager’s ability to accept a service user’s choices to engage or not with the service was their ability to apply advanced interpersonal skills such as emotional intelligence in order to develop greater resilience within their engagement work (Bakr & Safaan, 2012). Furthermore, as it is widely known that mental health nurses often work in highly stressful and uncertain situations, it is proposed that the use of emotional intelligence to deal with difficult circumstances such as disengagement can reduce perceptual distortions that could cause further barriers to achieving shared understanding and subsequent engagement opportunities (Morrison, 2007; van Dusseldorp et al., 2011).

The findings clearly demonstrated that some case managers expressed more negative feelings, views, and perceptions when engaging with service users diagnosed with personality disorders, compared to service users identified as having a FEP. However, the remit of EISs is to cast a wide net by assessing and supporting individuals who may be at potential risk of developing FEP, including those with mental health diagnoses such as personality disorder (French et al., 2010). Nevertheless, the study's findings resonate with those of a previous literature review in which practitioners such as mental health nurses experienced high levels of negative emotions towards service users with personality disorders as well as feeling uncomfortable, anxious, challenged, frustrated, manipulated, and being less caring when engaging with this client group (Sansone & Sansone, 2013). Furthermore, it was highlighted that some case managers put up a detached, distant professional front and put some very specific boundaries in place to protect their own emotions when working alongside individuals with personality disorder.

Such perceptions and feelings are congruent with previous studies in which professional groups such as mental health nurses largely expressed more negative attitudes and perceptions when working alongside individuals with personality disorders (Westwood & Baker, 2010; Bodner et al., 2011). Additionally, previous research has suggested that mental health professionals such as nurses may experience being on a continuum that ranges from being connected to disconnected when interacting with individuals with personality disorders and as part of this process, may withdraw or suppress their emotions to make sense of the often challenging, complex, and changeable situations that they may face (Stroud & Parsons, 2013).

It was evident that case manager frustrations in this study were also attributable to EIS operational policies and processes widening the inclusion criteria as the service was increasingly accepting referrals for people with other mental health problems rather than just focusing on those presenting with conditions such as early psychosis. Additionally, case managers in this study questioned being able to successfully engage with people with personality disorders to meet their changeable needs whilst being required to work within a clearly defined model of EIS care. Notwithstanding, it has been proposed that rather than further develop specialist sets of skills and knowledge when working alongside people with personality disorders, the service context and culture needs to allow mental health staff to engage in a more fluid, flexible, and creative way to meet the complex, uncertain, and changeable nature and needs of this particular client group (Stroud & Parsons, 2013).

A further significant issue that arose from the study findings was how the case managers' experiences of working intensively and investing to establish therapeutic connections with service users over the EIS three-year period of care could leave them open and potentially vulnerable to encountering feelings of loss and grief when the service user was due to be discharged from the service. Indeed, previous research has conceptualised such nurse-patient relationships in terms of *connectedness* that contributes to patient health and nurse satisfaction in mental health settings (Hagerty & Patusky, 2003; Covington, 2005; Van Sant & Patterson, 2013). However, it is further contended that as connectedness involves an exchange of energy and self, this process can emotionally affect nurses and other professionals and adversely impact upon their emotional health and well-being (Watson, 2012). Similarly, previous studies have found that professional groups such as mental health nurses are at a higher risk for energy depletion and opening up of their vulnerable self, based on their often emotionally charged interactions with service users (Van Sant, 2003; Miner-Williams, 2007; Phillips-Salimi et al., 2012).

In my dual role as a registered mental health nurse and nursing lecturer, I have personally experienced such emotional depletion in connecting with some service users and have also witnessed this phenomenon amongst some professional colleagues and nursing students. However, it has been argued that mental health professionals need to adopt an appropriate balance of connection and emotional detachment in order to minimise personal self-damage and to maximise positive relationships with service users (Van Sant & Patterson, 2013). Nonetheless, the case managers who participated in this study were for the most part, highly seasoned professionals and demonstrated high levels of self-awareness, positive coping skills, and resilience in engaging with the complex, uncertain and changeable needs of service users in their EIS setting. Indeed, self-awareness is regarded as being key to effective connections with service users to consciously guide a professional’s behaviours and avoid self-detriment (Eckroth-Bucher, 2010). Similarly, reflective skills have been associated with improved practices in a wide range of helping professions, to develop coping and problems solving skills and enhance resilience (Grant & Kinman, 2014). Practitioners in this study identified that reflection was key to building on their self-awareness and being able to understand how their skills and abilities enabled successful engagement with service users. Additionally, practitioners recognised that important strategies to positively cope and maintain resilience included keeping perspective by not personalising poor, episodic, or non-engagement and remaining patient, resourceful, and proactive in the face of such engagement challenges. However, given that case managers in this study were required to regularly engage with service users in order to meet service aims and objectives, it could be argued that the findings further reinforce the importance of utilising self-protective, boundary management approaches to lessen the emotional impact due to the nature of such intensive levels of engagement work in EIS settings.

5.3 Strengths and study limitations

5.3.1 The research setting

To my knowledge, this is the only study that has recruited and interviewed case managers from mental health nursing backgrounds about their experiences of engagement with service users in UK EIS settings. The case managers' perspectives have provided a range of rich, detailed and insightful accounts that have enabled the study's aims and objectives to be met, and to gain a more in-depth understanding around the engagement experiences of case managers in an EIS context. However, although all participants (case managers) were considered to meet the aims and objectives for the topic under investigation, a potential challenge of this study was that it was conducted in a single EIS setting in one NHS Trust. Although the service was distributed over three large geographical areas and divided into three separate EIS teams covering a large and diverse population in relation to age, socio-economic status, and ethnicity, the findings may not be wholly applicable to similar mental health settings due to the homogeneous working practices of this service For example, EIS services including the teams in this study are not consistent across the UK in terms of complying with ‘Mental Health Policy Implementation Guide’ recommendations (DHSC, 2001), and are often dictated by the level of support and interest from local service commissioners (French et al, 2010). Furthermore, the EIS teams within this study covered the 14-65 year age range, whereas some EIS settings have reported not being able to set up services across this age span (Pugh & Lamb, 2010). Thus, in view of such local and national variations, being a single site study potentially reduces the applicability of the findings across the wider UK context. Consequently, interviewing case managers from several NHS Trusts with different operational policies, processes, and procedures may have further revealed more varied and nuanced responses regarding engagement issues. Experiences of engagement may have been described differently in terms of the opportunities and challenges inherent within other NHS Trusts across the UK.

A further consideration is that all case managers taking part in this study identified their ethnic background as white British. As such, this would not reflect national EIS caseloads, particularly in inner-city settings. The EIS teams within this study covered two University cities and also were spread over a range of small towns. Moreover, given that the demographic characteristics of two of the three geographical areas comprised of significant South Central Asian populations, this could be seen as a potential limitation in view of no case managers being from different ethnic backgrounds. Cultural variations in how mental illness is understood and the meaning attributed to it can influence how people from South Asian descent and other ethnic minority groups engage with mental health services (Singh & Kunar, 2010). Thus, had there been a more diverse mix of ethnic backgrounds within the participant sample, there may have been more varied descriptions in terms of how differing beliefs that different ethnic groups hold about EIS treatment can impact upon engagement with staff.

Another notable issue is that most of this study's participants were female. Although the proportion of women in the nursing workforce continues to remain around 90%, factors such as gender are likely to be markers for significant cultural differences (Royal College of Nursing, 2020). Such differences are reported to be of great importance for social phenomena studied in qualitative research (Allmark, 2004). In the case of this study, had there been greater representation of males, this may have provided more insight and understanding around gendered constructions and cultural differences regarding engagement.

5.3.2 Recruitment and sample size

The initial aim of this study was to recruit around eight to twelve case managers as this number is generally considered to be an appropriate and optimum sample size for small-scale qualitative research (Pope & Mays, 2006; Finlay & Ballinger, 2006; Flick, 2007; Silverman, 2010; Denzin & Lincoln, 2011). However, this number is not definitive nor prescriptive within IPA studies as the emphasis is to focus on quality, depth and richness as opposed to quantity (Smith et al., 2009; Pietkiewicz & Smith, 2012). Hence, the sample size for this study was small but reflective of the methodological design, and in keeping with other IPA studies to allow for more detailed in-depth exploration (Turpin et al.,1997; Miller et al., 2018; Chan, 2018).

There were substantial difficulties in recruiting case managers to the study across the three EIS teams. I visited all the teams on two occasions to recruit more potential participants into the study. Indeed, during the recruitment phase, two members of staff initially agreed to take part, but then declined due to their lack of available time, and other competing work-related pressures. Two other case managers agreed to take part in the study, but then without apology or further explanation, did not turn up for their scheduled interview.

Several case managers also spoke of not wanting to take part in the study as it would mean opening up about their experiences and feeling potentially uncomfortable and vulnerable about the complexities and challenges of their engagement work with some service users. However, despite the challenges, it is proposed that the successful recruitment of seven case managers can be seen as a strength of this study in view of the fact that all case managers who took part, experienced time-related pressures in their daily work in terms of managing increasing case load commitments, service user complexities, and service targets. Furthermore, the data derived from the interviews was rich, informative and insightful, and contributed to the development of five distinct master themes that generated a synthesised understanding of engagement from the individual perspectives of case managers.

5.3.3 My influence and impact as a researcher

During the recruitment phase, I introduced myself as a student undertaking a part-time doctoral study who was a registered mental health nurse and having previously worked in an EIS setting as a case manager. As discussed in chapter three, I had previously worked as a case manager in this service between 2005 and 2011 and was thus known to some participants. This also included being employed in a cognitive therapy post within the service between 2009 and 2011 and participating in number of consultative clinical case formulation discussions across the three teams to discuss FEP, and the complexity of engagement.

However, another potential limitation of this study is that being previously known to some case managers may have inhibited recruitment into the study and to generate opportunities for open and frank discussions during interviews about any engagement challenges or shortcomings of the service. Nonetheless, this was not evident within interviews in which all case managers were often open and candid about their engagement experiences and particularly critical around the perceived inflexible, pressured, and inappropriate service delivery directives that they were expected to adhere to in their roles. Upon further reflection, this appeared to be the first opportunity for some case managers to openly explore and discuss complex and contentious issues in relation to their engagement work with service users. This research gave them a voice and to actively challenge and question the barriers and opportunities to engagement work. Indeed, one case manager light-heartedly commented *‘I hope I didn’t come across as too judgemental*?’

Conversely, due to ongoing time and workload related pressures within the service, another case manager frankly remarked' *How long will this interview take? as I'm very busy'*

Due to my previous professional experiences, my knowledge and understanding of the case manager's role, FEP, complexity, and engagement may have introduced some bias into the probes, prompts and follow up questions in relation to the interview topic guide and subsequent interpretation of the data. As this study was a single student PhD project, all aspects of the data analysis approach were undertaken by me, and though these processes were critically discussed and corroborated by the PhD supervisory team, these were not subject to independent scrutiny.

It is frankly acknowledged that my previous role as a case manager in an EIS setting, had the potential to influence the collection, analysis, and interpretation of the data. However, I agree with the assertion that the researcher as a human being is embedded in their life experiences and, as such cannot negate this understanding of the world (Reiners, 2012). Nonetheless, as mentioned in chapter three, I attempted to demonstrate reflexiveness to reduce the influence of my previous experiences overshadowing the data collection and analysis stages by keeping a reflexive diary to address my biases and assumptions and through engaging in open and frank supervisory discussions.

5.4 Rationale for recommendations and areas for future research

This doctoral thesis has aimed to understand the engagement experiences of case managers in one EIS setting and how they understand, make sense of, and manage this multifaceted, and changeable process.

As discussed in Section 5.3, four areas, in which improvement was potentially indicated were: 1) Limitations of the case manager role; 2) the unhelpful impact of organisational objectives upon engagement; 3) The emotional cost of engagement; 4) the emergence of a reduced sense of autonomy in relation to engagement. As discussed earlier, this study was conducted across a single NHS Trust within North-West England, although with three distinct geographical locations. This prompts further questioning as to whether the findings are unique to this particular EIS setting, or whether they do indeed reflect the opportunities and challenges associated with engagement across the wider context of EISs in the United Kingdom (UK). Furthermore, EISs, in comparison to generic community mental health services, can be described as different and unique to study in a number of ways. EISs across the UK are usually the first point of service contact that individuals considered to be experiencing FEP are referred to for further advice, assessment, and support. Once it has been established that specialist care, support, and treatment is required, there is an expectation that individuals will engage for a three -year period with case managers and other EIS staff.

In line with the study findings, training and supervision for all EIS practitioners should further emphasise the importance of setting time aside to invest in a trusting, therapeutic and collaborative relationship. Only when a collaborative, trusting and engaging relationship between EIS practitioners and service users has been established, can effective interventions take place (French et al., 2010). Additionally, fostering realistic expectations about the changeable nature of engagement, working creatively and flexibly with individualised needs, and being able to adopt reflective learning around engagement difficulties to further develop coping skills and emotional resilience should be an integral part of any training and supervision provided for EIS practitioners.

The recommendations arising from this doctoral thesis recognise the need for further detailed exploration and confirmation of some elements of the study's findings. It is proposed that this will be achieved through further research conducted across a range of EIS settings within the UK. It is proposed that using a range of approaches including phenomenological, narrative enquiry, and mixed-methods research should be conducted to add further understandings and insights. Several research recommendations are proposed below in order to further build on and understand some aspects raised within this study's master themes.

5.5 Recommendations and areas for future research

1. Further phenomenological inquiry of engagement, from the perspectives of case managers at phase specific time-points of the three-year treatment trajectory across a range of specialist early intervention in psychosis services in the UK.
2. Further qualitative enquiry to understand the impact of organisational barriers

upon the case manager’s role, across a range of specialist intervention in psychosis services in the UK.

3. Further qualitative exploration, from the perspectives of case managers, of the emotional impacts of their engagement work with service users across a wider range of UK EIS settings.

4. Mixed-method enquiry using a cross-sectional survey approach from the wider stakeholder perspectives of case managers, service users and carers, of the potential link between autonomy and empowerment, and how this influences and impact upon the process of engagement in UK EIS settings.

5.5.1 Recommendation one

EISs across the UK, are most often the first service, people considered to be experiencing FEP are referred to. Once they have been assessed as requiring support and treatment, there is both an implicit and explicit expectation that a three-year period of collaborative engagement is offered and accepted. However, the study findings revealed that some case managers experienced differing patterns of engagement with service users at various points of their three-year period of care, notably in the early phases of treatment. Thus, attempting to further understand this particular aspect of the present study findings across the treatment trajectory by way of a larger scale qualitative study would be informative. Further exploratory qualitative research may help to increase understanding of how case managers from mental health nursing backgrounds experience engagement with service users at phase- specific time-points during their three-year period of EIS care and support.

It is thus recommended that online semi-structured interviews are conducted through a multi-site phenomenological study with a larger representative sample of case managers from several EIS settings across the UK that focuses on their engagement experiences of the first six-month period of EIS care. A larger scale, multi-site study such as this, may provide further rich data to assist in the understanding of case manager engagement with service users in EIS and to establish if there are notable patterns of engagement, partial engagement, and/or non-engagement at this specific and critical time point of their care, treatment, and support. This area of research would be highly informative in the future development and refinement of phase-specific engagement approaches within EIS settings.

5.5.2 Recommendation two

Potential constraints to effective engagement, associated with various aspects of EIS service policies and processes, were described by some case managers to be frustrating and disempowering. It is recommended that there is a need to further understand the influence and impact of organisational barriers upon the case manager's role across a wider range of EIS settings. Further qualitative enquiry using IPA methods that focuses on how case managers experience the expectations and limitations of their role may help to further clarify some of the possible mismatch between EIS case management from a policy driven perspective and real-world practices. It is expected that this will provide further rich data to assist in the understanding of developing effective engagement strategies within EISs.

5.5.3 Recommendation three

The systematic literature review (Chapter three) and the study findings' master theme (Chapter four) entitled *Managing self and emotions,* provided evidence to suggest that emotions are inextricably linked to case managers' varied experiences of engagement. It was evident from the study findings that case managers utilised self-protective strategies during some perceived risky engagement contacts or lamented the loss of contact with other service users when they were discharged from the service. This indicated that engagement has the propensity to negatively impact upon a case manager's emotional health and well-being. This has further implications for the well-being of mental health professionals, and the quality of safe, effective care and engagement across health settings (Austin et al., 2009). It is proposed that further qualitative research using narrative enquiry methods explores how case managers in EIS settings deal with a range of emotional states when faced with difficult, unpredictable, or demanding circumstances and how these impact upon the process and quality of engagement and rapport building with the service user.

5.5.4 Recommendation four

A potential link between a reduced sense of autonomy and subsequent barriers to engagement in an EIS setting, emerged from the data in this study. Case managers spoke of core EIS approaches not dissimilar to standard community mental health approaches, such as assertive engagement in order to meet imposed service targets as disempowering in nature. Likewise, some case managers perceived a sense of loss of clinical autonomy due to the ever-changing and prescriptive ethos of such service-led targets.

Empowering professionals such as mental health nurses within organisations have been shown to improve engagement and optimise patient outcomes (Curran et al., 2020). It would also be pertinent to include the perspectives of wider stakeholders in future FEP research in relation to their experiences of autonomy and empowerment in the engagement process. Using a mixed methods approach, a cross-sectional survey, including long-term follow up of service users, families, caregivers and EIS service providers across three NHS Trusts investigating how promoting autonomy and empowering approaches influence their engagement experiences would be beneficial. This would enable further comprehensive exploration and understanding around the role of autonomy and empowerment within engagement and enhance the emerging knowledge-base on this topic.

Chapter six: Conclusion

6.1 Introduction

In the previous discussion chapter, I sought to provide a bridge between the study findings and the wider body of literature, to provide more meaning and clarity to the study findings. The aim of this study was to understand the experiences of case managers from mental health nursing backgrounds in terms of their engagement with service users in one UK EIS setting. In this final chapter, I will revisit my methodological choices along with the research aims and objectives to further consider to what extent these have been achieved. Finally, this will follow with a closing reflection on my thoughts around the research process and the topic area of investigation.

6.2 Revisiting methodological choices and research aims and objectives

As discussed more fully in chapter three (methodology and methods), the research process for this study was informed by a clear epistemological position that sought to understand the nature of social meaning – social constructionism (Crotty, 1998; Burr, 2015). The constructionist process acknowledged that social dealings produce a variety of possible social constructions of events (Crotty, 1998; Bryman, 2012; Burr, 2015). In relation to the case managers who took part in this study, each description was driven by different issues and concerns about engagement. Furthermore, as discussed in chapter three, my chosen approach of IPA echoed tenets of social constructionism in terms of meaning-making of lived experiences (Smith et al., 2009).

As previously discussed, engagement strategies in EIS settings are an important consideration to reduce the potentially devastating impact of FEP, and to facilitate recovery, but this topic continues to be an under-researched area of mental health care (Tait et al., 2010). In view of the evidence base underpinning engagement strategies being in its relative infancy, the complexity of engagement has left mental health practitioners across EIS settings feeling confused and challenged as to how to build consistent and meaningful connections with service users. It was thus the intention of this study to explore the unique engagement experiences of case managers with service users in EIS settings to gain further valuable insights into this phenomenon. The key aims and objectives were to further understand what engagement means to case managers, to elicit their personal experiences of engagement, and what methods they used to foster meaningful engagement. Finally, the study aimed to establish and understand what factors were perceived to facilitate or hinder a case manager's engagement with service users within UK EIS setting. Overall, the findings suggest that case managers perceive effective engagement to be enhanced by empowering, collaborative, and respectful interactions. Conversely, the emotional impacts experienced by case managers due to the ambivalence or the uncertain, changeable, and chaotic lifestyles of some service users was perceived to be a barrier to engagement.

On further reflection, I argue that my social constructionist position and choice to use qualitative methodology and methods has allowed for rich, detailed data to be collected that has enabled the research aims to be addressed, and for the objectives to be met. The findings from this study contribute to the burgeoning evidence base, having identified a number of key themes that aid further understanding around the opportunities and barriers to case managers engaging with service users within UK EIS settings. All case managers openly spoke about the importance of the interpersonal relationship between themselves and service users and how this was perceived to be an important predictor to foster positive engagement opportunities and collaboration. However, case managers also spoke of their frustration and disappointment in regard to their difficulties in forming positive therapeutic relationships with some service users where engagement was perceived to be challenging or problematic. Some case managers considered poor or non-engagement to be an understandable response given the chaotic lifestyle choices and individual characteristics of some service users. This was described as, typically, involving substance use, non-psychotic diagnoses, psychotic relapse, family breakdown, but also reluctance from service users to engage with case managers due to fear or stigma.

The study findings also highlighted the importance of service structures and processes and how these influenced a case manager's engagement with service users. Potential organisational barriers, associated with some aspects of EIS service delivery and policies, were frankly described by some case managers as frustrating, and disempowering and impacting upon the quality of engagement. The study also found that some organisational objectives were perceived to be unrealistic and unworkable by case managers due to various other competing demands of their role and time constraints. Case managers further described experiencing emotional distress which was attributable to a number of potential causative factors including the quality of the therapeutic relationship, risk management issues, and poor engagement. This indicated that, potentially, the effort to maintain engagement in the face of various service user and organisational challenges can negatively impact on a case manager’s health and wellbeing.

6.3 Final reflections

This study has provided several unique and valuable insights into the engagement experiences of case managers in one UK EIS setting. All case managers spoke of engagement as a multi-faceted, changeable, and complex process that they creatively and flexibly facilitated to establish connections. Notably, the importance and influence of the therapeutic, and collaborative relationship between the case manager and service user cannot be underestimated. It was evident from this study, that only when a genuine, trusting, and collaborative relationship between case managers and service users was established, that effective interventions could take place. It was also apparent that case managers in this study valued opportunities to have access to more substantial time with service users, particularly in the early stages of treatment, to foster a better quality of engagement, and to build upon mutual trust, respect, and collaboration. Despite the front-line reality of having time-limited opportunities to engage, all case managers worked hard to develop and maintain trusting, therapeutic relationships with service users. Furthermore, case managers emphasised the importance of service users being fully agreeable to engage to feel a sense of achievement and success in their helping roles.

In view of the impact of organisational objectives, case managers would benefit from protected time with service users in EIS policies and procedures to further build and maintain positive engagement opportunities. However, whilst there may be service orientated challenges, none of these issues are unique to EISs, nor are they restricted to community mental health settings in general. Notwithstanding, in view of engagement with individuals with FEP being fundamental to achieve the aims of service delivery, and facilitate recovery, EIS organisational policies should revisit and review their expectations of case managers in relation to what is required to build on effective engagement strategies. Whilst this is built into the theoretical philosophies of EISs across the world, the reality in front-line clinical practice is far different, as this can vary due to locally and regionally available resources and various interpretations of the EIS model (Tindall et al., 2019). When engagement with service users does not go to plan, case managers need to feel supported by the organisation in terms of good supervision and team working. Regardless of length of clinical experience and skills and knowledge, the study findings suggest that case managers hold a common goal to develop genuine, person-centred relationships with service users to meaningfully engage and achieve a sense of satisfaction and fulfilment in their professional roles.

From a personal perspective, the process of undertaking IPA research has emphasised the qualities that I have continually developed throughout my research journey. I have found open-mindedness, determination, flexibility, and patience, to be valuable qualities as a researcher. At times, I have felt out of my depth due to the length of time taken to develop IPA research skills.

Furthermore, I have sometimes felt overwhelmed in working effectively and proficiently with large, complex, and somewhat messy volumes of qualitative data. However, I have found supervisory discussions to be very helpful and to realise that perfect data collection and analysis does not exist and that there is no-one single version of facts and events that is the absolute truth. Likewise, maintaining a reflexive approach throughout the research process and carefully considering as to how my personal values, experiences, and beliefs may have impacted upon all elements of the study, including the chosen methodology, and methods has aided me to acknowledge and better understand my conscious and unconscious biases and assumptions about this topic.

Finally, I recognise that I have held a privileged position in being able to listen and respond to the varied views and experiences of engagement that some case managers had not openly described to anyone throughout their EIS careers. I am aware that all case managers who agreed to take part in this study already felt stretched and overwhelmed due to the volumes of their workloads, various competing demands, and time constraints of their role. Furthermore, being engaged in frank descriptions about potentially problematic or challenging engagement issues within their caseloads could be anxiety-provoking for some. However, this study has given a much-needed voice to a professional group that remains largely unheard and under-researched. Given the multi-faceted and complex nature of engagement, the case manager’s voice in FEP research is critical (Tindall et al., 2019). Additionally, by capturing the views and experiences of case managers, there is scope for further research to complement the findings as identified in the previous discussion chapter, by further addressing engagement strategies that would be useful and appropriate across UK and worldwide EIS settings. Without further understanding of actual stakeholder experiences of engagement in EIS settings, and further building of the evidence-base, any efforts to continually improve engagement strategies will remain uninformed.

Words: 35802

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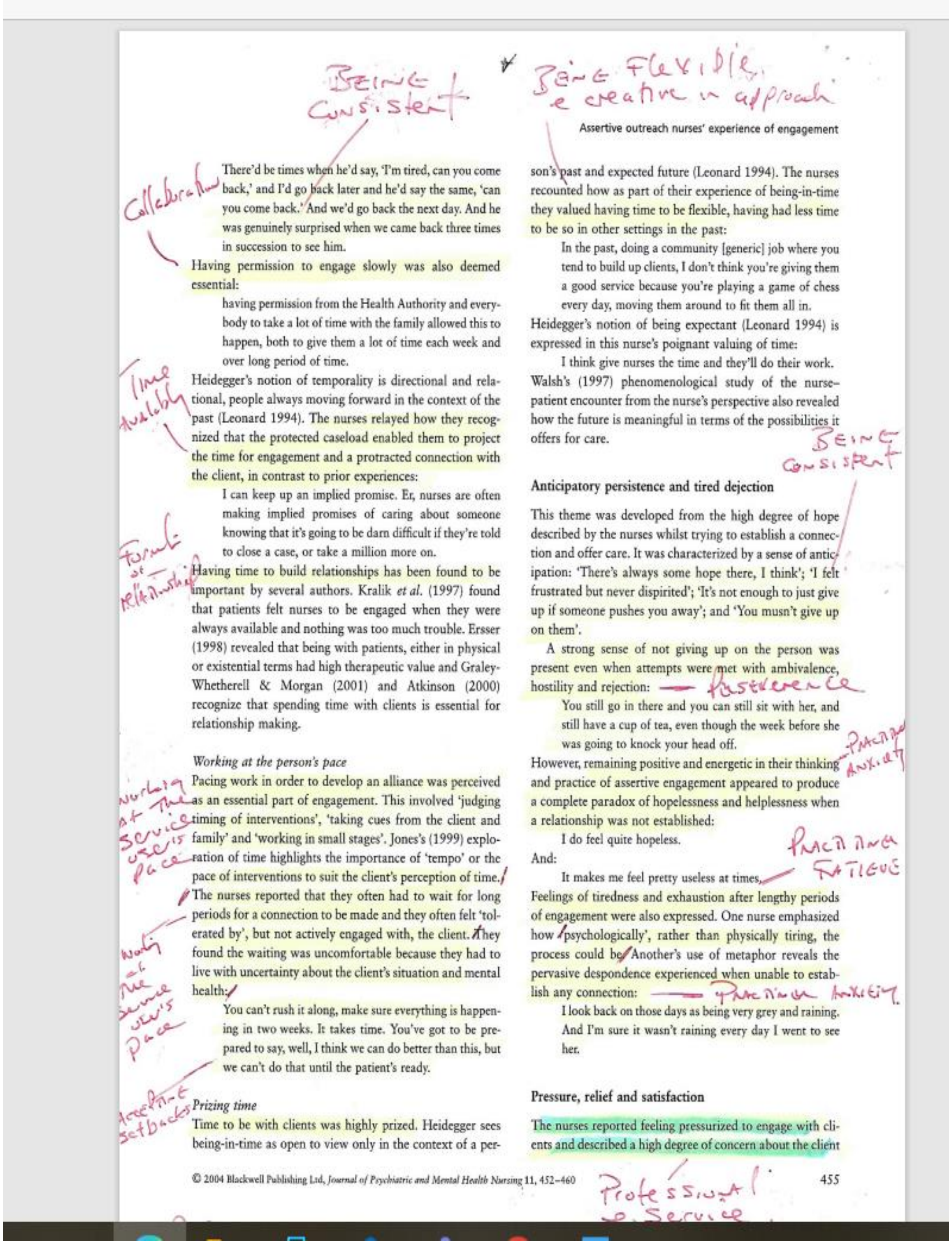
Appendix 1 : Data Extraction Form (taken from NICE-SCIE, 2007)

	Sub-heading		**For completion by reviewer(s)**
Descriptive details	Bibliographic details	Addis, J. & Gamble, C. (2004) Assertive outreach nurses' experience of engagement. *Journal of Psychiatric and Mental Health Nursing*, 11, 452-460.	PH & JB
	Name of reviewer(s)	Paul Henderson (PH) Judith Ball (JB)	PH & JB
	Nature of study	Primary qualitative study. The study sets out to explore and understand assertive outreach nurses experiences of the assertive outreach engagement process.	PH & JB
	Type of study	Primary qualitative research underpinned by philosophical hermeneutic phenomenological methodology.	PH & JB
	Types of participants	Participants comprised of 5 nurses from one UK assertive outreach setting.	PH & JB
	Study aims	To provide a constructed reality that captured nurses experiences of assertive engagement.	PH & JB
	Practitioner perspectives	One semi-structured interview that generated narratives about the nurses experiences of engagement.	PH & JB
Ethical standards		Ethical approval was obtained from the University School of Healthcare Ethics Committee and the Local Applied and Qualitative Research Ethics Committee. All participants' identities were protected.	PH & JB
Type of Practice setting	Area and health care setting	One UK-based NHS funded assertive outreach team.	PH & JB
	Details	A single assertive outreach team based in one UK location. The locality/area/county is not disclosed.	PH & JB
	Time-frame	The time frame of the study is not given.	PH & JB
Participant recruitment & selection	Inclusion criteria	The inclusion criterion is not specified.	PH & JB
	Exclusion criteria	The exclusion criteria are not specified.	PH & JB
	Selection	Selection criteria are not specified.	PH & JB
	Size	5 assertive outreach nurses took part in the study.	PH & JB
	Appropriateness	The sample was appropriate and is line with the aims and objectives as it explored the experiences of engagement nurses based in assertive outreach services.	PH & JB
Methods of data collection	Methods	One audio recorded semi-structured interview ranging from 34.49 to 95.29 minutes was conducted. A pilot semi-structured interview schedule was undertaken to establish whether the interview schedule elicited appropriate responses for the study Open ended questions were used about positive and less positive aspects of engagement and used a retrospective approach.	PH & JB
	Participant quotes	*'You learn a lot from patients, both about yourself and them, you learn how to do things from patient contact, their families'. 'It's about the things you do alongside them. You Know, your willingness to arrange things for them, or do things alongside them, drive them places, or*	PH & JB

	Sub-heading		**For completion by reviewer(s)**
		make team with them, all sorts of practical things that you use, and help them make the changes they want, or just talk to their mum and dad for them if that's what they want'	
	Role of researcher (s)	Data was collected by the lead researcher who was working as a team coordinator on a voluntary basis in the assertive outreach team under investigation.	PH & JB
	Fieldwork	All stages of the study are identified.	PH & JB
	Data analysis	Data analysis occurred concurrently with data collection The analysis was underpinned by hermeneutic philosophical thematic analysis to illuminate shared understanding, uniqueness, and diversity. Seven major themes emerged.	PH & JB
	Researcher's potential bias	The lead author openly acknowledged that transcription was done by another to interrupt the analytic process temporarily distancing the researcher from the data. Member checking took place to ensure accurate description of the data.	PH & JB
	Reflexivity	This process is not identified in the study.	PH & JB
Analytical details	Study outcomes	7 major themes emerged to construct nurses experiences of engagement.	PH & JB
	Themes and findings	Seven themes emerged of: 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.	PH & JB
	Conclusions	High emphasis is placed on developing trusting, effective relationships and caring, timing, consistency, humanness and teamness.	PH & JB
Relevance to policy and practice	Transferability	The focus on a single team provides a clear picture of the experiences of the nurses experiences of assertive engagement but the transferability of the findings to other settings requires further investigation due to the small scale of the study.	PH & JB
	Implications for policy	The findings reveal that what AO nurses find stressful is important as generic community mental health studies may not correlate well with the AO setting.	PH & JB
	Implications for practice	The findings highlight how consistency of staffing is essential to this client group given issues of trust/mistrust.	PH & JB
	Links to other references to be followed up	Gillespie, M., Smith, J., Meaden, A. *et al* (2004) Clients' engagement with assertive outreach services: a comparison of client and staff perceptions of engagement and its impact on later engagement. *Journal of Mental Health*, 13, 439-452.	PH & JB
Reviewer Decisions	Name of first reviewer Name of second reviewer	Paul Henderson Judith Ball	
	Agreement with reviewers? Disagreement with reviewers?	*Does a 3rd reviewer need to be included?*	No
	Inclusion	*Should this study be included in the final review?*	Yes
	Date	**08.10.17**	

Appendix 2 : Initial coding example taken from one included study



Assertive outreach nurses' experience of engagement

> There'd be times when he'd say, 'I'm tired, can you come back,' and I'd go back later and he'd say the same, 'can you come back.' And we'd go back the next day. And he was genuinely surprised when we came back three times in succession to see him.

Having permission to engage slowly was also deemed essential:

> having permission from the Health Authority and everybody to take a lot of time with the family allowed this to happen, both to give them a lot of time each week and over long period of time.

Heidegger's notion of temporality is directional and relational, people always moving forward in the context of the past (Leonard 1994). The nurses relayed how they recognized that the protected caseload enabled them to project the time for engagement and a protracted connection with the client, in contrast to prior experiences:

> I can keep up an implied promise. Er, nurses are often making implied promises of caring about someone knowing that it's going to be darn difficult if they're told to close a case, or take a million more on.

Having time to build relationships has been found to be important by several authors. Kralik *et al.* (1997) found that patients felt nurses to be engaged when they were always available and nothing was too much trouble. Ersser (1998) revealed that being with patients, either in physical or existential terms had high therapeutic value and Graley-Whetherell & Morgan (2001) and Atkinson (2000) recognize that spending time with clients is essential for relationship making.

Working at the person's pace

Pacing work in order to develop an alliance was perceived as an essential part of engagement. This involved 'judging timing of interventions', 'taking cues from the client and family' and 'working in small stages'. Jones's (1999) exploration of time highlights the importance of 'tempo' or the pace of interventions to suit the client's perception of time. The nurses reported that they often had to wait for long periods for a connection to be made and they often felt 'tolerated by', but not actively engaged with, the client. They found the waiting was uncomfortable because they had to live with uncertainty about the client's situation and mental health:

> You can't rush it along, make sure everything is happening in two weeks. It takes time. You've got to be prepared to say, well, I think we can do better than this, but we can't do that until the patient's ready.

Prizing time

Time to be with clients was highly prized. Heidegger sees being-in-time as open to view only in the context of a person's past and expected future (Leonard 1994). The nurses recounted how as part of their experience of being-in-time they valued having time to be flexible, having had less time to be so in other settings in the past:

> In the past, doing a community [generic] job where you tend to build up clients, I don't think you're giving them a good service because you're playing a game of chess every day, moving them around to fit them all in.

Heidegger's notion of being expectant (Leonard 1994) is expressed in this nurse's poignant valuing of time:

> I think give nurses the time and they'll do their work.

Walsh's (1997) phenomenological study of the nurse–patient encounter from the nurse's perspective also revealed how the future is meaningful in terms of the possibilities it offers for care.

Anticipatory persistence and tired dejection

This theme was developed from the high degree of hope described by the nurses whilst trying to establish a connection and offer care. It was characterized by a sense of anticipation: 'There's always some hope there, I think'; 'I felt frustrated but never dispirited'; 'It's not enough to just give up if someone pushes you away'; and 'You musn't give up on them'.

A strong sense of not giving up on the person was present even when attempts were met with ambivalence, hostility and rejection:

> You still go in there and you can still sit with her, and still have a cup of tea, even though the week before she was going to knock your head off.

However, remaining positive and energetic in their thinking and practice of assertive engagement appeared to produce a complete paradox of hopelessness and helplessness when a relationship was not established:

> I do feel quite hopeless.

And:

> It makes me feel pretty useless at times.

Feelings of tiredness and exhaustion after lengthy periods of engagement were also expressed. One nurse emphasized how 'psychologically', rather than physically tiring, the process could be. Another's use of metaphor reveals the pervasive despondence experienced when unable to establish any connection:

> I look back on those days as being very grey and raining. And I'm sure it wasn't raining every day I went to see her.

Pressure, relief and satisfaction

The nurses reported feeling pressurized to engage with clients and described a high degree of concern about the client

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Appendix 3 : Table of initial codes, development of descriptive themes and reflexivity

Descriptive themes	Illustrative quotes	Reflexivity
1. **'You can't force someone to like you'** Developed from codes: • Service users not wanting to open up • Previous negative experiences of mental health care • Differing priorities • Age-related factors • Service user lack of knowledge of severe mental illness • Service user insight • Accepting setbacks	*'Cannabis seems a big part of life and they don't see the impact. It causes problems with engagement, they just don't want to talk to us…'* **(2)** *'You know adolescents are more likely to disclose stuff to other adolescents, not authority figures, they might see us more closely allied to their parents and that can be difficult, why, why should they disclose anything?* **(4)** *'Just because I'm working in assertive outreach…you can't force someone to like you, and I think sometimes you've got to wrestle with that'* **(6)** *That's because they're scared, you know because there's always been that stereotype, and it will be around for a long time yet'* **(9)** *'I suppose the one thing I find hard with assertive outreach is working with people who really don't want you to be involved and you cause them stress when you go round and they're very hostile towards you and I just think it's all very unpleasant really'* **(7)** *'I can see where it (anger) comes from. I've been in situations where people are really disempowered, and the only thing they've got left is shouting and swearing at you, and being angry. Sometimes, it's just worth working through the discomfort'* **(1)**	As an experienced mental health nurse, I recognise how service users can be reluctant to engage with professionals for reasons that include fear of potential further actions such as being sectioned, or having the police called if they disclosed using street drugs. I have been in the position of individuals not wanting to engage with me or alternatively, they have asked to see another practitioner. I have often took this personally but as some participants have said 'you have to wrestle with that'. With increasing experience, I have come to accept the fact that not all service users will readily engage with you as they may not like or feel comfortable with you. I'm also conscious that being a white male from a somewhat marginalised, working-class background, has influenced the way that I think about engagement with service users in my professional practice. I am more sensitive to the potential power imbalances

Descriptive themes	Illustrative quotes	Reflexivity
		that may occur between professionals from middle class and/or privileged backgrounds in working alongside people who may be disadvantaged. These experiences have led me to think how the challenges of working with people who may be marginalised can be better understood and I believe that this has also led me to focus on this particular issue.
2. 'I have got a time restriction I have got to go and see someone else' Developed from codes: - Time constraints - Time availability - Practitioner anxiety - Practitioner fatigue - Professional and service level obligations	*'I have got a time restriction I have got to go and see someone else'***(10)** *'You're always going to be under the pump for time….it's all about prioritising…trauma and that sort of thing…that's really difficult when you've got another caseload of clients when your main job is to assess their mental state'* **(4)** '*You can't really see anyone more than once a week…the frustrating thing was that I didn't have the capacity to offer outreach as much as I would have liked'* **(7)** *'I also felt that he was unable to make use of the service and I actually felt very sort of useless, kind of unable, what's the word, impotent, I suppose is the word'* **(7)** *'I think you're seeing people fortnightly, but there are people like xx who need more than that, and you're just not able to offer it due to constraints placed on you by large caseloads, chronic caseloads and all the rest'* **(7)** *'It's a long term problem when you are dealing with people with complex needs like dual diagnosis, they need long-term input- you are looking at two to three years that they are going to be on your caseload'* **(3)** *'I guess I do find it difficult. If find it difficult when I've got a high*	I fully understand the worries and the tensions that practitioners experience in terms of having large and complex caseloads with little time to see people as often as they would like to. Many times, juggling a large caseload has been anxiety-provoking for me and I have been worried that I may have taken my eye off the ball in terms of important issues with service users and their families. There have been times where service users noticed that I was looking at my watch due to my own time pressures and this has then added to the tensions of further meaningful engagement. This has further added to my feelings of frustration and helplessness and I would often worry that there would be potential

Descriptive themes	Illustrative quotes	Reflexivity
	proportion of people who…are difficult because I often don't feel I've got the capacity, if people break down at the same time, and I do feel quite overwhelmed by that sometimes' **(7)** *'It makes me feel pretty useless at times'* **(1)** *'I find as a professional dual diagnosis is very frustrating because it highlights my lack of skills- I need to get skilled up'* **(3)** *'In the past, doing a community (generic) job where you tend to build up clients, I don't think you're giving them a good service because you're playing a game of chess every day, moving them around to fit in'* **(1)**	queries around my professional practice and ability to be a safe practitioner. The social and political landscape of NHS funded community mental health services has always been constantly changing and in my view, not necessarily as patient-focused as it could be. Such disillusionment led me to leave NHS community mental health care some years ago. I fully empathise with the feelings and experiences of practitioners in terms of this theme and how such issues may impact upon their own mental health and well-being.
3. '**Anxiety and fear about the unknowingness of engagement work'** Developed from codes: - Type of location/setting - Unknown risk factors - Practitioner fears - Family pressures	*'….you don't often have (police) or other clinicians…so I guess the risk assessment is really important then, to make sure that when you do engage with someone that you do have some kind of backup or…you might have to leave the person just where they are, until that support can come along….'* **(9)** *'He was worse when he smoked marijuana and in the end I couldn't work with him- he was very unpleasant towards me and left me very frightened. It was the worst situation'* **(2)** *'It can tear families apart'* **(4)** *'The people that we are working with have been shunned by the entire community. Nobody wants them to be around them; no one wants them living next door to them. They can even become verbally assaultive or threatening'* **(5)** *'A lot of times in our field (clients) get treated as a diagnosis: 'oh*	In similarity to one study here, I have been in the position of sometimes feeling vulnerable, scared or at a loss with what to do at some home visits due to the service user's , frustrations, abusive language or threatening behaviour. This has sometimes led me to be too risk aversive at times, and to visit individuals with another practitioner which could impact upon further engagement. However, I agree with the other studies in that stigma can be a barrier to engaging

Descriptive themes	Illustrative quotes	Reflexivity
	you're a schizophrenic; you need to take your medicine or whatever'. You know, a lot of time people say they're scared of them; they look at them weird, they laugh at them' **(5)** *'When you get to go out and be in their natural environment and see the stresses and the family and the conditions they have to exist within, it adds a whole new light to just what you see on their axis diagnosis. I don't know how you sum that up on a sheet of paper'* **(5)** *(involving family) 'sometimes what they think is helpful is not really helpful'***(5)**	with service users. I too have experienced stigma and discrimination due to my own personal background and I can empathise with people who use mental health services. I have often used my professional position to advocate for people who are diagnosed with a mental health problem. My own roots in a marginalised community have further influenced how I see the impacts of views, assumptions and biases towards people who may be vulnerable or disadvantaged. However, I have often experienced that such stigma may also be prevalent within services amongst some professionals based on an individual's diagnosis or level of complexity and the actual and potential risks that the person may present with. Again, I feel that such experiences have led me to focus on this particular descriptive theme.
4. '**You mustn't give up on them'** Developed from codes: - Persistence - Being flexible and creative in approach - Covert and strategic approaches	*'There'd be times when he'd say, 'I'm tired, can you come back' and I'd go back and he'd say the same, 'can you come back'. And we'd go back the next day. And he was genuinely surprised when we came back three times in succession to see him'* **(1)** *'You mustn't give up on them'* **(1)** *'You still go in there and you can still sit with her, and have a cup*	This particular theme is perhaps the most emotive one for me. It appears that practitioners make reference to qualities such as tenacity in attempting to engage with service users. The content of the quotes used here have

Descriptive themes	Illustrative quotes	Reflexivity
- Multi-faceted approach - Working at service user's pace	*of tea, even though the week before she was going to knock your head off' (1)* *'With a lot of our clients, initially, they don't want any kind of contact with us whatsoever, and we come out regardless of how many times they slam the door in our face .We do it consistently'* **(5)** *'…we'd keep on going to his house and to make sure he knew we had been there we'd pop a note through the door'* **(7)** *'It's not enough to just give up if someone pushes you away'* **(1)** *'I'd just offer him another appointment, then write to him and if it became clear that he had missed a couple of appointments, I'd try be a bit more assertive and maybe go and visit him at home'* **(7)** *'We stalk people….was it somebody or yeah it was (service user) who said I can't get rid of her she always there she's always you know no matter what I do she always comes back and doesn't give up…..she's a pain in the butt'* **(10)**	surprised me as in my experience, rather than being tenacious, I often felt as though I was 'forced' to engage with people who may not have wanted to. As part of my professional role, I was expected to actively engage with people who use mental health services at all costs. This meant that if service users 'fell off the radar', I was then expected to make cold calls, contact family members out of the blue or contact the Police in some cases, to conduct welfare checks. This is a part of my professional role that I felt very anxious and uncomfortable with as it seemed as though I was stalking or harassing service users and their families if they did not establish contact with me. However, as said, there was always a real pressure to engage due to professional obligations such as duty of care and to avoid potential charges of negligence. I feel that what is not made explicit from the studies is whether there is also a professional and organisational obligation to engage service users even if they don't want that. This

Descriptive themes	Illustrative quotes	Reflexivity
		approach to care is still strongly ingrained within my memories of community mental health practices. I find that this approach to care is reactive and appears unethical as it collides with the ethos of being empowering and collaborative with people who use services. However, I am aware that I have strong feelings and views on this type of practice and I will make every effort to address this theme with care and caution.
5. '**Building rapport so that they can feel safe'** Developed from codes: - Establishing a trusting, therapeutic relationship - Being consistent - Collaboration with family/carers - Instilling hope - Being genuine	*'…building rapport so that they can feel safe, so that you're a safe person for them to be with, so that they can start telling you more. Because if they don't feel safe they're not going to tell you hardly anything'* **(8)** *'I don't know if you have all seen the video called 'Joining Up' …When you have that moment of joining up with your client it's to me probably the most gratifying moment, but I think it is also the most important thing we can do with engaging our clients in services. If they can't join up with the case manager or team , I think it makes it harder, especially for certain clients to engage'* **(5)** *'…what's really important in my practice is issue identification. Because if you're speaking about different issues you're not on the same page. And that's where you're going to get your rapport and engagement'* **(8**) *'…when you're connecting to that (consumer) they have to get from you the feeling that you genuinely care. And if that sense of caring is not there, you can't make that connection often. And for us, in the role that we take here, that very first visit with that (consumer) is the most important thing. Because this way they*	Regardless of being a trained mental health nurse, I am a genuine people person and have a strong interest in connecting and understanding other people. I agree with the participants that you need to be on the same page otherwise trust and rapport may not develop. I have always striven to embrace respectful, trusting relationships with others. As I have always valued this particular aspect of my professional practice, most of my ongoing professional development has been focused around person-centred approaches. I considered this area of my professional practice to be the

Descriptive themes	Illustrative quotes	Reflexivity
	might continue seeing you' **(8)** *'I would say that engagement is the point and the process of…working with clients and building up a gradual relationship'* **(6)** *'….buying food, that one might sort of use, that's visible side of engagement. Then I think there's the other part that's invisible, the subjective side I would say and to me that's the relationship that you have with people, that part of it you can't always quantify.* **(6)**	most valuable and rewarding aspect to engagement as this was often the most visible as it was positively acknowledged by service users and their families. I therefore, find that this key area of my practice has influenced this choice of theme.
6. And I go with their choices, because they've got rights too' Developed from codes: • Acknowledging service user choice and autonomy • Acknowledging service user strengths • Collaboration • Information sharing • Acknowledging cultural beliefs	*'…sounds like you're not sure you really want to see us. We're wondering if there's anything we can help you with? Is there anything that you do want, that we might be able to help with? And try to let them decide what they want from you rather than us deciding what we want from them'* **(8)** *'Through respecting client choices, PACT team members acknowledge their clients' strengths and establish a foundation for engagement'* **(5)** *'In a programme, I always give them like three or four choices. And I go with their choices, because they've got their own rights too'* **(6)** *'Instead of them asking me to schedule a doctor's appointment, no, I'll give you the number and you schedule the appointment and let me know when it is and I will make sure that you get there'* **(5)**	I agree with the quotes used here that service users should have the same rights as anyone else irrespective of their health or background. This theme strikes a particular chord with me and has again surprised me as in my experiences, mental health practice has seemed largely defensive and paternalistic in its approach to a service user's care. I have already said that I am not comfortable with assertive or forceful approaches to care as this can hinder service user choice and

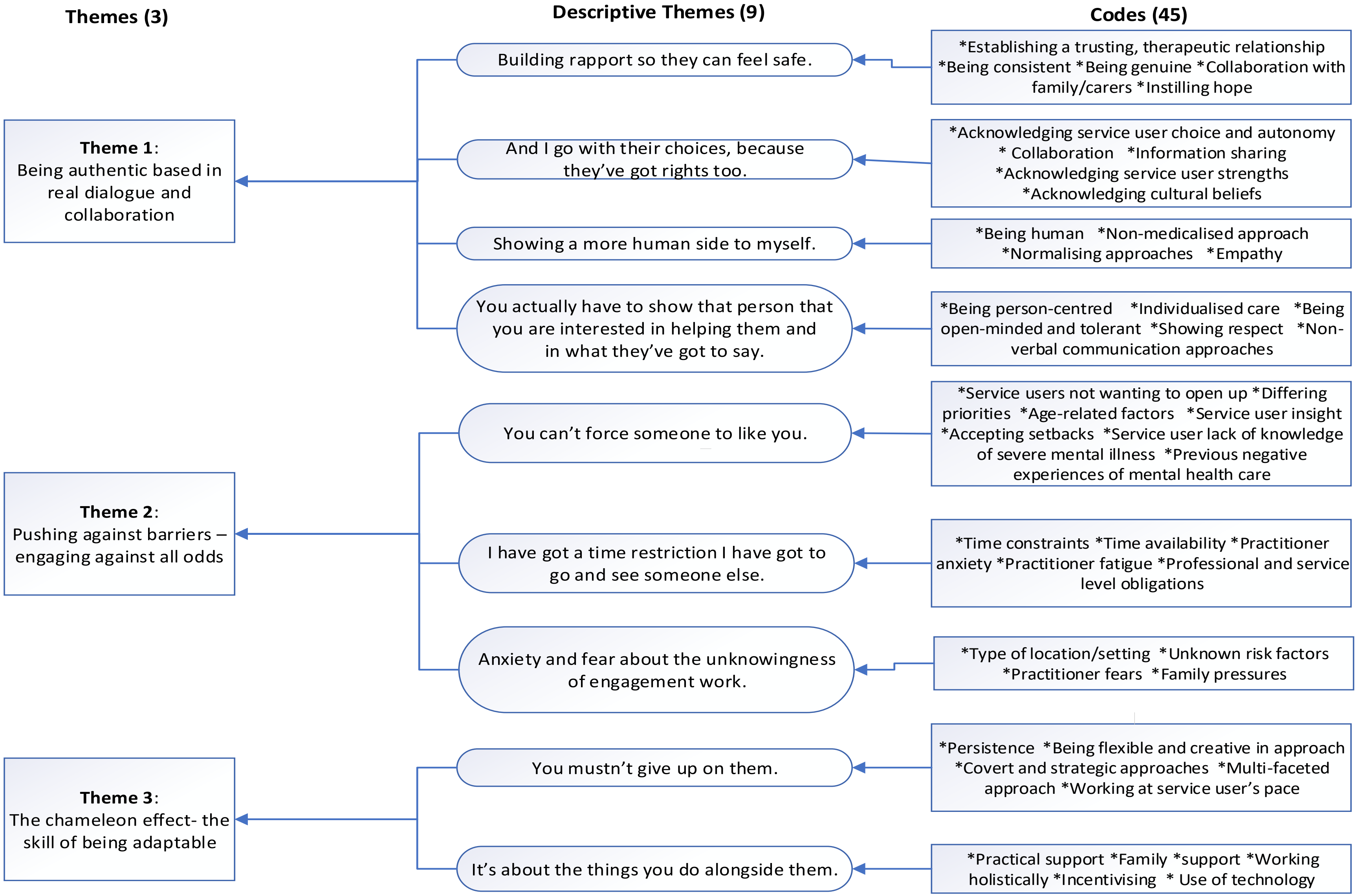
Descriptive themes	Illustrative quotes	Reflexivity
	'You can't rush it along, make sure everything is happening in two weeks. It takes time. You've got to be prepared to say, well I think we can do better than this, but we can't until the patient's ready' **(1)** *'We realized it was down to the point where she was consistently saying that she did not want services, so then we have to respect that. At some point, we have to respect her choice'* **(5)** *'…we've said that who we are and what our service does and then maybe given them the option to maybe think about whether they want the help or not'* (8**)** '*This person that you are working for you are working for them you are not deciding on what they should be doing'* **(10)**	autonomy. However, I have noticed that most of these quotes comes from North American studies which seems to have a different philosophy to service user choice. I have found that UK mental health practices tend to adopt a more paternalistic approach and this theme will need to be approached with caution in terms of cultural and international transferability.
7. '**Showing a more human side to myself'** Developed from codes: • Being human • Non-medicalised approach • Normalising approaches • Empathy	*'There's still professional objectives, but I have to be consciously more human with people, and let them see a different side of myself'* **(1)** *'Working for Assertive Outreach, without breaking professional boundaries, you can kind of become more human with people, and that's the bit I think helps engage people'* **(1)** *'normalizing their experience, so that (the client) recognize(s) that everyone has good/bad days; they aren't the only one'* **(5)** *'…you know that you sort of talk about things that interest the person, and then you can probably bring a little bit of yourself into that as well. So if they start talking about 'oh, I've got this really big dog, blah,blah,blah, you say 'oh, we've just got a new puppy….'* **(9***)* *''….you can provide a lot of comfort to a (consumer) with a strategic provision of information, but I always do it from the background of a common experience of depression or what the research tells us or what other (consumers) have shared with me. You know? Obviously generally speaking and for some (consumers) simply*	Being from a working-class background, I was the first person in my family to get a University education and to gain a degree. Coming from humble beginnings reminds me of the need to stay grounded and human with all people regardless of their background. My background has also enabled me to switch and adapt my skills from one setting to another in terms of language used, accent, colloquialisms, personal interests and communication. I fully agree with quotes used here that being human, ordinary and down to earth helps to break down barriers and aid engagement.

Descriptive themes	Illustrative quotes	Reflexivity
	being told that's actually a very common experience in depression is enormously empowering, because they didn't know that that was part of it. They thought that this was another problem that had developed' **(9)**	However, I feel that this particular skill of being human continues to be under-acknowledged in the engagement literature and influences this choice of theme.
8. '**You actually have to show that person that you are interested in helping them and in what they've got to say'** Developed from codes: - Being person-centred - Individualised care - Being open-minded and tolerant - Showing respect - Non-verbal communication approaches	*'….having a level of self-awareness plays a really big role in engaging a (consumer) because you interact and you recognise your own body language, your own voice, your own tone, when you're actually communicating with someone so that in different circumstances, you can adjust those as needed, depending on what feedback and non-verbals you're getting from the (consumer)***'** **(8)** *'….it's just about getting to know him and not going about it in a pushy way…it's futile to just talk about illness and medication when there's so much more to a person'* **(7)** *'I think you have to show interest. That's the big one. You actually have to show that person that you are interested in helping them and in what they've got to say'* **(9)** *'And don't look at your watch, while you're talking to somebody in an interview, because they think that you're going to rush them or that they're, that you're not interested or you're wanting to go somewhere else. So you're not really paying attention'* **(9)** *'…not going in with preconceived ideas, or stigma, or labels of the (consumer) but actually meeting them where they're at…***'** **(9)** *'…understanding what the (consumer's) issue is and making sure that you do actually understand what they're saying as opposed to what you think they're trying to tell you'* **(9)** *'Or actually trying to listen to where they're from what their circumstances are what their life is about and how they can still have that life but maybe access some other bits to improve it but*	I found myself being strongly attracted to this theme due to person-centred approaches being the most valued and important aspect of my own practice. I did not come across any quotes that surprised me in this instance. I fully agree and can relate to approaches such as not looking at your watch, effective use of non-verbals and active listening to aid engagement. Such qualities are universal and consistent across the literature. In similarity to the descriptive theme 'Building a rapport so that can feel safe', there are commonalities such as rapport and building a relationship to aid engagement. As I have a more positive view towards person-centred approaches as opposed to assertive ones, I am aware that I will need to address this theme in a careful and balanced way to ensure parity with other descriptive themes.

Descriptive themes	Illustrative quotes	Reflexivity
	so it fits in with their life round this other thing' **(10)** *'As part of my training we had to undergo forty hours of counselling and I think in some ways I hated it back then but actually thinking about it now I found that was really useful because I can actually see things from a service users perspective'* **(10)**	
9'. **It's about the things you do alongside them'** Developed from codes: • Practical support • Family support • Working holistically • Incentivising • Use of technology	*'….really we've used a lot of non-nursing and non-medical ways of engaging her. Going to the cinema….getting a pair of trainers…one of the really good ways of getting to see her is going to cafes'* **(7)** *'….he was out of money again. And he was talking about not wanting to go around the back of the shops and scramble for food….So I said to him, we'll get some shopping until you get your benefits you know?'* **(6)** *'The consumer's sister had been the referrer …the consumer was really paranoid, got really angry about us asking questions, because he assumed that we could read his mind and know everything. He was angry…But, he was willing to communicate with us through his sister. So we ended up thinking we're going to have to ring the police and ambulance and we didn't. He agreed to go to hospital with his sister, she'd pop inside and talk to us. And it was a rather unusual way of engaging…It was much better than getting the ambulance and police of course'* **(8)** *'…it's about the things you do alongside them. You know your willingness to arrange things for them, or do things alongside them, drive them places, or make tea with them, all sorts of practical things you use, and help them make the changes they want, or just talk to their mum and dad for them if that's what they want'* **(1)** *'I used to just let her talk and listen to what she would say for twenty minutes, but I have found (greater success by) engaging her a little differently, maybe through doing art with her'* **(5)**	As I have said already, I have always felt uncomfortable with over-assertive and forceful approaches and I found that working in the 'least restrictive' and most flexible way could enable a more human and helpful relationship to be formed. I found that offering real, practical help beyond that of taking medication and attending out-patient appointments could be more beneficial for some service users. Too many times, I had listened to service users and families saying that they perceived information and advice given by some professionals to be patronising as it did not fully acknowledge or understood their daily challenges and hardships. In the light of this, I am also aware that my own personal experiences have shaped and guided this aspect of my professional practice. I am mindful that I will go the extra mile where others may not as I

Descriptive themes	Illustrative quotes	Reflexivity
	‘The strategies which team members use can change from day to day, even not only from one client to another client, but with the same client’ **(5)** *‘Sometimes, the PACT team will use the support of collateral contacts like the family members to facilitate the engagement process’* **(5)**	am highly sensitive to the vulnerability and potential disempowerment of some groups of people that I work alongside. However, I have often explored this ‘sensitivity’ to other peoples’ plights within debriefing and supervision with my peers to understand how such feelings may support or potentially hinder this approach with service users and families. This aspect of my professional practice has always been a significant one and therefore, attempts to explain why I have focused on this particular issue.

Appendix 4 : Themes identified across included studies



Themes (3)

Descriptive Themes (9)

Codes (45)

Theme 1: Being authentic based in real dialogue and collaboration

- Building rapport so they can feel safe.
  - *Establishing a trusting, therapeutic relationship *Being consistent *Being genuine *Collaboration with family/carers *Instilling hope
- And I go with their choices, because they've got rights too.
  - *Acknowledging service user choice and autonomy * Collaboration *Information sharing *Acknowledging service user strengths *Acknowledging cultural beliefs
- Showing a more human side to myself.
  - *Being human *Non-medicalised approach *Normalising approaches *Empathy
- You actually have to show that person that you are interested in helping them and in what they've got to say.
  - *Being person-centred *Individualised care *Being open-minded and tolerant *Showing respect *Non-verbal communication approaches

Theme 2: Pushing against barriers – engaging against all odds

- You can't force someone to like you.
  - *Service users not wanting to open up *Differing priorities *Age-related factors *Service user insight *Accepting setbacks *Service user lack of knowledge of severe mental illness *Previous negative experiences of mental health care
- I have got a time restriction I have got to go and see someone else.
  - *Time constraints *Time availability *Practitioner anxiety *Practitioner fatigue *Professional and service level obligations
- Anxiety and fear about the unknowingness of engagement work.
  - *Type of location/setting *Unknown risk factors *Practitioner fears *Family pressures

Theme 3: The chameleon effect- the skill of being adaptable

- You mustn't give up on them.
  - *Persistence *Being flexible and creative in approach *Covert and strategic approaches *Multi-faceted approach *Working at service user's pace
- It's about the things you do alongside them.
  - *Practical support *Family *support *Working holistically *Incentivising * Use of technology

Participant Information Sheet

Case managers' experiences of engagement with service users in UK early intervention services: a qualitative study.

My name is Paul Henderson and I am conducting this research as a student in the PhD Mental Health programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to explore case manager experiences of engagement with service users in United Kingdom early intervention services. The study aims to find out if there opportunities and challenges with engagement and if there are certain types of support or approaches that case managers may perceive to be important to promote continuous engagement with service users within early intervention services.

Why have I been approached You have been approached because the study requires information from people who are case managers from early intervention service settings.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to meet with the researcher on a one-to-one basis to complete one audio-recorded interview. The interview will range from 45 to 60 minutes and is an opportunity for you to describe your experiences of engagement with service users in your clinical setting. It is envisaged that all interviews will take place in a suitable, quiet office space at your NHS site. If this is not possible, then another mutually agreeable and convenient NHS location will be arranged. Examples of interview questions will include: *'Can you tell me what you do to engage with service users?'* And *'What makes it hard to engage with service users?'*

Will my data be Identifiable?

The information you provide is confidential. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- Audio recordings will be destroyed and/or deleted once the project has been submitted for publication/examined

- Hard copies of consent forms and interview transcripts will be kept in a locked cabinet and securely stored for 10 years. At the end of this period, all hard copies will be securely destroyed.

- Files will be stored on the computer such as digitally recorded interviews and they will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected and stored for 10 years.

- The typed version of your interview will be made anonymous by removing any identifying information including your name. Synthesised direct quotations from your interview will be used in the reports or publications from the study, so your name will not be attached to them.

- All your personal data will be confidential and will be kept separately from your interview recordings and interview transcriptions.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to my PhD supervisors about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal such as 'Early Intervention in Psychiatry' and/or presented at a national or international professional conference. You will also be given a summary report of the study findings.

Are there any risks or benefits to taking part?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University and the local NHS ethics committee.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Paul Henderson Tel: 01695 650996
Email: paul.henderson@lancaster.ac.uk

PhD supervisory team
Dr Naomi Fisher
Email: n.r.fisher@lancaster.ac.uk

Professor Bill Sellwood
Email: bill.sellwood@lancaster.ac.uk

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact the researcher's PhD supervisors or one of the contact numbers listed below:

Research Director for Division of Health Research: Professor Steve Jones
Tel: (01524) 593382
Email: s.jones7@lancaster.ac.uk
Division of Health Research
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Mental Health Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources to get support

Should you feel distressed either as a result of taking part, or in the future, then please contact one of the following numbers listed below for help and support:

- Health and Well-being/Occupational health- Tel: 01772 695300
- Lancashire Care Well-Being & Mental Health Helpline. Tel: **0800 915 4640 (free phone) Open Monday to Friday 7pm - 11pm. Saturday & Sunday 12 midday to 12 midnight.**
- NHS Direct- Tel: 0845 4647

Appendix 6 : Interview topic guide

Interview topic guide for research exploring the experiences of case managers in terms of their engagement with service users in early intervention services

- Introduce self, explain role and research interests
- Set the scene: 'For the next 45-60 minutes, I'm going to ask you about your experiences of how you do the initial engaging of people with the early intervention services'
- Explain that the research is interested in the case manager's personal experiences of engagement with service users and that there are no right or wrong answers
- I will ask about aspects of engagement throughout the interview and then will ask you if there is anything that I have missed and should have covered

Opening questions

1. To start with, I would like to know a little more about you and how you came to work in early intervention services

2. In your own words, can you tell me what the term 'engagement' means to you in your role in early intervention?

Possible prompts: Trust, collaboration, co-operation, two-way relationship

Specific questions

3. What are the most important processes for engaging service users?

*Possible prompts***:** Trust? Being friendly? approachable? collaborative? flexible? creative?

4. Can you tell me what you do to engage with service users?

Possible prompts: What works or helps? What are the opportunities? Building rapport?

5. How do you know if a service user is engaging well with you and the early intervention team?

Possible prompts: What happens? In what way? Ask for some examples. Are measurement tools such as 'Service user engagement Scale' (SES) used to gauge level and frequency of contact?

6. What makes it hard to engage with service users?

Possible prompts: What gets in the way? What do you do? What might make it worse?

7. How do you know if your interaction with a service user is positive?

Possible prompts: In what ways? How does it compare to a difficult interaction?

8. Now I'm going to ask you about attendance of arranged meetings or visits. Have there been any instances where a service user did not attend an appointment with you but wanted to?

Possible prompts: What are the reasons? What do you do?

9. Have there been any instances when a service user intentionally chose not to attend an appointment with you?

Possible prompts: What happened? What were the challenges? What did you do?

Closing question

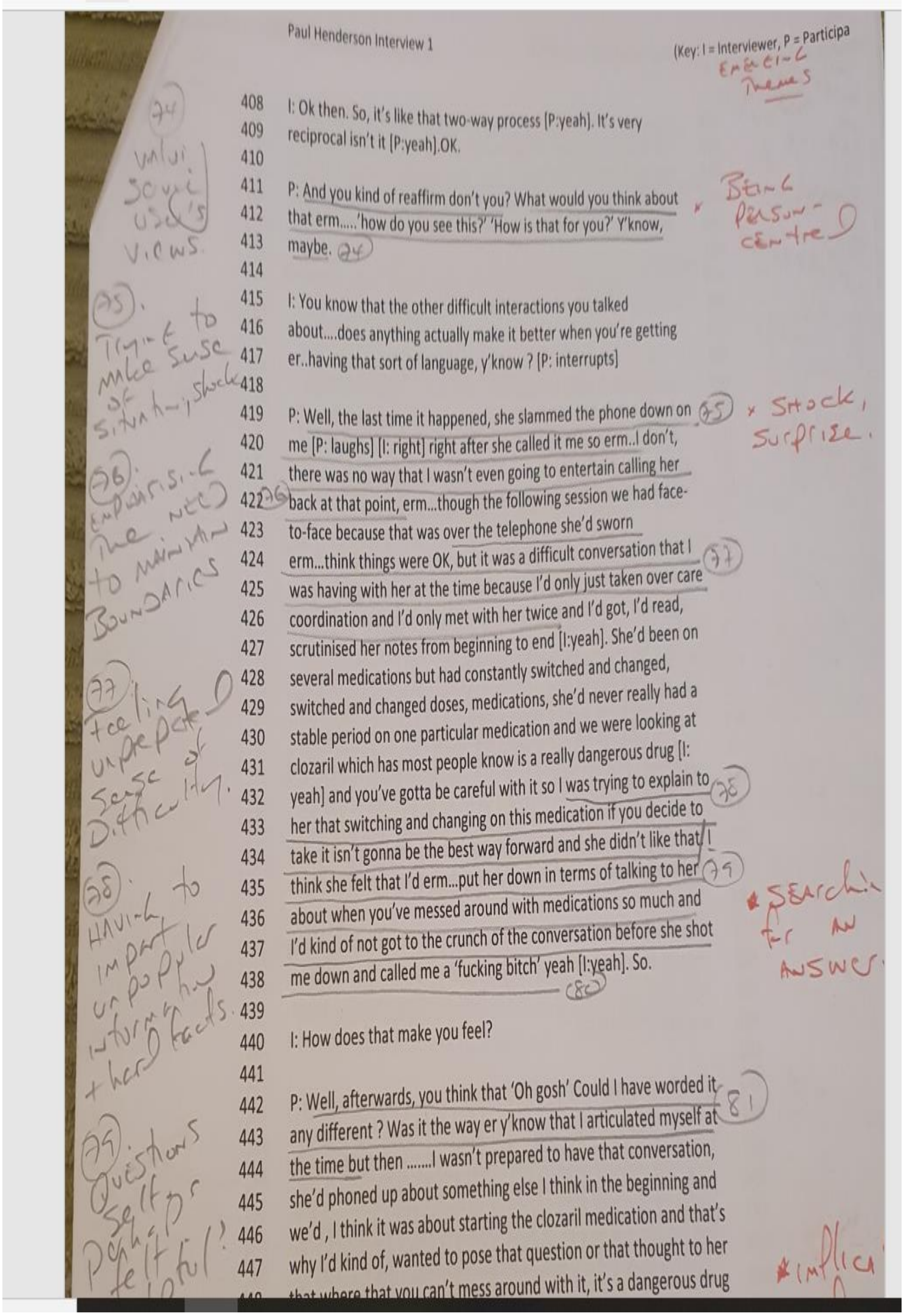
10. Is there anything I haven't asked that you think is important when thinking about how case managers engage people with early intervention services?

Follow up question

11. Great thank you for that – is there anything else you would like to add before we finish the interview?

Feedback of interview from participants

Appendix 7 : Example of transcript coding (Interview 1)



Paul Henderson Interview 1

(Key: I = Interviewer, P = Participa

Emerging Themes

I: Ok then. So, it's like that two-way process [P:yeah]. It's very reciprocal isn't it [P:yeah].OK.

P: And you kind of reaffirm don't you? What would you think about that erm…..'how do you see this?' 'How is that for you?' Y'know, maybe. (74)

I: You know that the other difficult interactions you talked about….does anything actually make it better when you're getting er..having that sort of language, y'know ? [P: interrupts]

P: Well, the last time it happened, she slammed the phone down on (75) me [P: laughs] [I: right] right after she called it me so erm..I don't, there was no way that I wasn't even going to entertain calling her (76) back at that point, erm…though the following session we had face-to-face because that was over the telephone she'd sworn erm…think things were OK, but it was a difficult conversation that I (77) was having with her at the time because I'd only just taken over care coordination and I'd only met with her twice and I'd got, I'd read, scrutinised her notes from beginning to end [I:yeah]. She'd been on several medications but had constantly switched and changed, switched and changed doses, medications, she'd never really had a stable period on one particular medication and we were looking at clozaril which has most people know is a really dangerous drug [I: yeah] and you've gotta be careful with it so I was trying to explain to (78) her that switching and changing on this medication if you decide to take it isn't gonna be the best way forward and she didn't like that/ I think she felt that I'd erm…put her down in terms of talking to her (79) about when you've messed around with medications so much and I'd kind of not got to the crunch of the conversation before she shot me down and called me a 'fucking bitch' yeah [I:yeah]. So. (80)

I: How does that make you feel?

P: Well, afterwards, you think that 'Oh gosh' Could I have worded it (81) any different ? Was it the way er y'know that I articulated myself at the time but then …….I wasn't prepared to have that conversation, she'd phoned up about something else I think in the beginning and we'd , I think it was about starting the clozaril medication and that's why I'd kind of, wanted to pose that question or that thought to her that where that you can't mess around with it, it's a dangerous drug

(74) Valuing service user's views.

(75). Trying to make sense of situation, shock

(76). Emphasising the need to maintain boundaries

(77) Feeling unprepared. Sense of difficulty.

(78). Having to impart unpopular information + hard facts.

(79) Questions self or perhaps felt [illegible]?

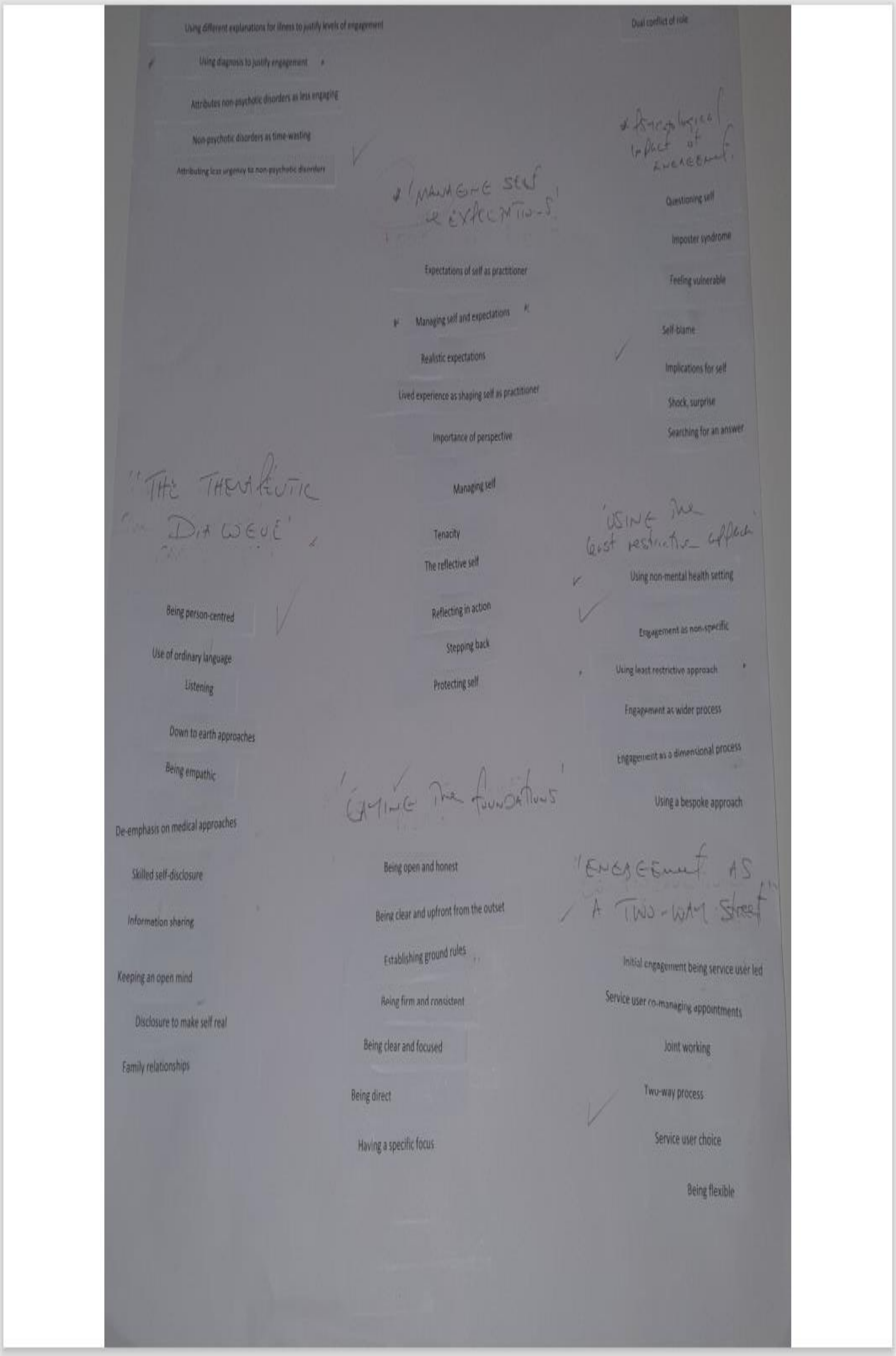
× Being person-centred

× Shock, surprise.

* Searching for an answer.

* implica

Appendix 8 : Example of development of superordinate themes for one transcript using poster paper (Interview 1)



Using different explanations for illness to justify levels of engagement

Using diagnosis to justify engagement

Attributes non-psychotic disorders as less engaging

Non-psychotic disorders as time-wasting

Attributing less urgency to non-psychotic disorders

Dual conflict of role

'Psychological impact of engagement.'

Questioning self

Imposter syndrome

Feeling vulnerable

Self-blame

Implications for self

Shock, surprise

Searching for an answer

'Managing self & expectations'

Expectations of self as practitioner

Managing self and expectations

Realistic expectations

Lived experience as shaping self as practitioner

Importance of perspective

Managing self

Tenacity

The reflective self

Reflecting in action

Stepping back

Protecting self

"The therapeutic dialogue"

Being person-centred

Use of ordinary language

Listening

Down to earth approaches

Being empathic

De-emphasis on medical approaches

Skilled self-disclosure

Information sharing

Keeping an open mind

Disclosure to make self real

Family relationships

'Using the least restrictive approach'

Using non-mental health setting

Engagement as non-specific

Using least restrictive approach

Engagement as wider process

Engagement as a dimensional process

Using a bespoke approach

'Laying the foundations'

Being open and honest

Being clear and upfront from the outset

Establishing ground rules

Being firm and consistent

Being clear and focused

Being direct

Having a specific focus

'Engagement as a two-way street'

Initial engagement being service user led

Service user co-managing appointments

Joint working

Two-way process

Service user choice

Being flexible

Appendix 9 : IPA Master Table

(**Bold text- Participant Superordinate Theme**. *Italic Text- Participant Emerging Theme*)

Master themes	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**	**Participant 6**	**Participant 7**
1. Being on the same page	**Laying the foundations** *Being open and honest* *Being clear and upfront from the outset* *Establishing ground rules* *Being firm and consistent* *Being clear and focused* *Being direct* *Having a specific focus* **Engagement as a two-way street** *Initial engagement being service user led* *Service user co-managing appointments* *Joint working* *Two-way process* *Service user choice*	**Co-creating engagement** *Respecting service user choice* *Service user led* *Engagement as a two-way process* *Being in touch* *Being on the same page* *On the same page* **Responding to diversity** *Embracing diversity* *Recognising diversity* *Being culturally sensitive* *Identifying with generational cohort* *Reflecting on age and culture*	*Importance of equal relationships*	**Engagement as co-constructed** *Engagement as co-constructed* *Being aware of service user's resources* *Being on an equal footing* *Importance of negotiation* *Giving service user permission to make choices* *Having a level of agreement* *Settings agreements for engagement* *Putting responsibility back with service user* *Joint responsibility for engagement* *Addressing power imbalance* *Respecting service user wishes* *Seeking continual permission* *Going with the flow* **Recognition of diversity** *Cultural acceptance* *Cultural interpretations of mental health* *Embracing diversity* *Being culturally aware* *Age appropriate strategies*	**Engagement as co-produced** *Contact on service user's terms* *Fitting in with service user's routine* *Handing over more ownership* *Seeking permission to engage* *Stepping into service user's lifeworld* *Service user priorities* *Being on the same page* *Being age-appropriate in approach*	**Engagement as co-produced** *Being on the same page* *Importance of taking ownership of issues* *Reaching some middle ground* *Importance of collective knowledge and experience* *Importance of collective effort* *Having permission granted* *Importance of service user having some control* *Negotiating terms of engagement* *Engagement as a collective effort*	**Being on the same page** *Establishing mutual understanding* *Process of joined up learning* *Being on the same page* *Being a negotiator* **Focusing on specific needs to engage** *Having a specific focus* *Having a specific role* *Having a clear focus* *Working in a specific way* *Work of being culturally appropriate* *Using gender-specific approaches* *Culturally appropriate approaches* *Working age-specifically*

Master themes	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**	**Participant 6**	**Participant 7**
2.Engagement as an interpersonal relationship	**The therapeutic dialogue** *Being person-centred* *Use of ordinary language* *Listening* *Down to earth approaches* *Being empathic* *De-emphasis on medical approaches* *Skilled self-disclosure* *Information sharing* *Keeping an open mind* *Disclosure to make self real* *Family relationships* *Competing priorities of service user*	**The therapeutic dialogue: Communication and relationship building skills** *Being person-centred* *Being empathic* *Being genuine* *Being honest and direct* *Being respectful* *Being consistent* *Being proactive* *Being holistic* *Embracing change* *Adapting to change*	**The qualities of the individual case manager influencing engagement** *Not forcing the process* *Being service user led* *Emphasis on engaging rather than treating* *Less is more to engage* *Use of self to transform engagement* *Good engagement not age specific* *Prove oneself to win over service user* *Being perceptive* *Being self-aware* *Reflection as a constant process* **The therapeutic dialogue: Building communication and relationship skills** *Being person-centred* *Normalising approaches* *Being recovery focused* *Using empathy* *Being genuine* *Importance of ordinary life principles* *Importance of relationships*	**The importance of presence and continuity** *Being visible* *The value of one consistent contact* *Importance of face to face* *Not a tick box exercise* *Being consistent in all cases* *Being steady and consistent* *Importance of familiar surroundings* *Importance of safe, neutral place* *Engaging with the family* *Being clear and transparent* *Clarity of role*	**Therapeutic dialogue: Communication and relationship building skills** *Being person-centred* *Using common sense* *Working holistically* *Being authentic* *Building trust* *Being consistent* *Being unconditional* *Use of positive affirmation* *Being clear and specific* *Being empathic* *Use of self-disclosure to make self real?* *Having purposeful contact* **The individual qualities of the case manager influencing engagement** *Being compatible* *Being the right fit* *Being less concerned with performance targets* *Striking a balance*	**The qualities of the individual case manager** *Being benevolent to make self seem more genuine?* *Being consistent and reliable* *Being clear and direct* *Refers to honesty and transparency* *Setting the scene* *Allowing trust to develop* *Hope as a process* *Use of small talk to draw in service user* *Refers to de-catastrophising approach* *Refers to preparatory pre-engagement work*	**Therapeutic dialogue: Building communication and relationship skills** *Being person-centred* *Seeing beyond diagnosis* *Work of being discrete* *Making self real* *Showing commitment* *Being constant* *Real contact* *Physical presence as real* *Being open minded* *The skill of de-emphasising* *Focusing on strengths* *Non-engagement as positive* *Work of managing self*

Master themes	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**	**Participant 6**	**Participant 7**
3. Managing self and emotions	**Psychological impact of engagement** *Questioning self* *Imposter syndrome* *Feeling vulnerable* *Self-blame* *Implications for self* *Shock, surprise* *Searching for an answer* *Attributes non-psychotic disorders as less engaging* *Non-psychotic disorders as time wasting* *Attributing less urgency to non-psychotic disorders* **Managing self and expectations** *Expectations of self* *Managing self and expectations* *Realistic expectations* *Lived experience as shaping self as practitioner* *Importance of perspective* *Managing self* *Tenacity* *The reflective self* *Reflecting in action* *Stepping back* *Protecting self*	**Work of managing self** *Not personalising* *Work of managing self* *Managing expectations* *The reflective self* *Protecting self* *Managing challenging situations* *Reflecting on challenges.* **Knowing when to step back** *Knowing when to step back, Maintaining professional boundaries.* *Being critically reflective* **Implications of changing role** *Reflecting on changing role* *Changing role* *Changing expectations* **Engagement as an emotional experience** *Engagement as an emotional experience* *Frustration* *Questions self* *Feeling powerless.* *Uncertainty*	**Engagement as an emotional experience** *Engagement as an emotional experience* *Coping as a process* *Frustration* *Being resilient, not personalising* *Managing difficult emotions of self* *Not personalising, managing own emotions* *Remaining optimistic* *Needing to feel useful and in control?* *Being assertive* **Managing self and expectations** *Managing own expectations* *Work of managing self* *Managing time and expectations* *Suspending own values and assumptions*	**Knowing when to step back** *Knowing when to step back* *Acceptance of boundaries* *Being aware of maintaining a fine balance* **Engagement as an emotional experience** *Managing own emotions* *Avoiding complacency*	**Managing time and resources** *Managing time* *Being pragmatic* **Knowing when to step back** *Knowing when to step back* *Respecting boundaries* *Being realistic about role* *Respecting privacy*	**Managing self and expectations** *Work of managing self* *Managing workload* *Managing expectations* *Knowing when to let go* *Using all options, being pragmatic* *Work of protecting self* *Making best use of finite resources* *Emphasis on tight gate-keeping* **Making sense of engagement** *Questions own decisions* *Making sense of unpopular decisions* *Questions genuineness of need due to diagnosis* *Making sense of difficult encounter* **Erring on the side of caution** *Needs a back-up plan* *Values personal safety* *Work of managing risks* *Risk aversive*	**Knowing when to step back** *Establishing boundaries* *Knowing when to step back* *Engaging for the right reasons* **Managing self and emotions** *Work of managing own emotions* *Frustration* *Work of developing self* *Showing resilience* *Reflecting in action* *Re-inventing self* *Grief and loss?*

Master themes	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**	**Participant 6**	**Participant 7**
4. The practicalities of engagement	**Using the least restrictive approach** *Using non-mental health setting* *Engagement as non-specific* *Using least restrictive approach* *Engagement as a wider process* *Engagement as a dimensional process* *Using a bespoke approach* *Being flexible* *Strategic tactics* *Using covert tactics*	*Being flexible* *Engagement according to need*	*Being adaptable* *Working flexibly* *Going with the flow* *Thinking outside the box* *Being prepared for the unexpected* *Being receptive to changing needs* *Being risk aversive*	**Not forcing the pace** *Using informal approaches* *Less is more to engage* *Not forcing the pace* *Working in the least restrictive way* *Use of de-stigmatising approach* *Being holistic* **The non-physical contact to engagement** *Virtual engagement* *Engagement not just physical* *A dynamic, changeable process* **Managing self and expectations** *Work of managing self* *Realistic expectations* *Being realistic with own expectations*	**Working beyond diagnosis to engage** *Importance of non-mental health setting* *Addressing basic needs as a priority* *Seeing the bigger picture* *Using non-mental health resources* *Working with uncertainty* **Thinking outside the box- being creative to engage** *Staying in touch through different methods* *Use of technology to promote engagement* *Being unconventional* *Embracing technology* *Using toolbox of skills* *Being digitally savvy* *Being persuasive* *Being opportunistic* *Family as a resource* *Not working to a script* *Safety considerations* *Working with avoidant behaviour*	**Not forcing the pace** *Not forcing the process* *Using less to achieve more* *Engagement as a slow process* *Quantity of contact less important* *Using a stepped approach*	**Working creatively to engage** *Working pro-actively* *Being opportunistic* *No-one size fits all* *Being pragmatic* *Quality over quantity* *Working with unpredictability*

Master themes	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**	**Participant 6**	**Participant 7**
5. The impact of organisational factors upon engagement	**Service user influences on engagement** *Complexity impacting upon engagement* *Attributing poor engagement to poor illness* *Attributing level of illness to engagement* **Walking the tightrope** *Being vigilant* *Walking the tightrope* *Managing crisis* **The influence of organisational expectations on engagement** *Managing workload pressures* *Managing time* *Role conflict* *Having control?* *Dual conflict of role*	**Coping with uncertainty** *Engagement as unpredictable* *Organisational pressures* *Time-wasting* *Challenges of assessment* *Creating dependency* *Limitations of role*	**Working with uncertainty** *Engagement as unpredictable* *Stepping into the unknown*	*Being in a stuck position*	**Barriers to engagement** *Severity of symptoms as a barrier* *Fear and stigma of mental health services* *Fear of change* *Challenges of change* *Finite resources as challenging* *Pressure to engage* *Pressure to make contact?*	**Barriers to engagement** *Previous poor experiences impacting upon process* *Different expectations of service users*	**Barriers to engagement** *Competing priorities* *Communication barriers*