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# **Engagement in Assertive Outreach: Compliance or Alliance?**

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A thesis submitted in partial fulfilment of the requirements for the degree of  
Doctor of Clinical Psychology

Coventry University, Faculty of Health and Life Sciences

and

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## **ABBREVIATIONS**

AOT	Assertive Outreach Team
BEM	Bexley Engagement Measure
CSEM	Child Services Engagement Measure
CSQ	Client Satisfaction Questionnaire
DoH	Department of Health
EM	Engagement Measure
HAQ-II	Helping Alliance Questionnaire-II
HEAS	Homeless Engagement and Acceptance Scale
MDT	Multi-Disciplinary Team
NPAO	Network of Psychologists in Assertive Outreach
SAQ	Service Attachment Questionnaire

SES	Service Engagement Scale
TA	Therapeutic Alliance
TCM	Traditional Case Management

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## DECLARATION

The research presented in this thesis was carried out under the supervision of Dr. Jeremy Tudway, Dr. Alan Meaden and Dr. Chris Jones, in addition Dr. David Giles contributed to the methodological design and analysis of brief empirical paper. Dr. Julia Wane assisted with access to participants and in data collection in South Warwickshire NHS PCT and Miss Megan Earl-Gray co-facilitated the focus group and provided a measure of coding reliability for the brief empirical paper.

Aside from these collaborations, all the material presented is the candidate's own work. Authorship of any papers arising from this thesis will be shared with the above named individuals. This thesis has not been, or will not be, submitted for a degree at any other university.

Chapter one is to be submitted to the American Journal of Psychiatric Rehabilitation. Chapters two and three have been submitted to the Journal of Mental Health. Chapter four has been submitted to Clinical Psychology Forum (see appendix M: Notes for Authors). Provisional authorship for these papers are respectively as follows:

Bradley, S., Meaden, A., Tudway, J., & Jones, C. (2006). What is a meaningful way to conceptualise engagement? To be submitted to *American Journal of Psychiatric Rehabilitation*.

Bradley, S., Jones, C., Meaden, A., Tudway, J., & Wane, J. (2006). The psychometrics of measuring engagement in assertive outreach. Manuscript submitted to *Journal of Mental Health*.

Bradley, S., Meaden, A., Tudway, J., Earl-Gray, M., Jones, C., Giles, D., & Wane, J. (2006). What do service user views tell us about engagement? Manuscript submitted to *Journal of Mental Health*.

Bradley, S., Tudway, J., & Meaden, A. (2006). Can clinical psychologists retain professional therapeutic working relationships when working within an assertive outreach team? Manuscript submitted to *Clinical Psychology Forum*.

The brief empirical paper has been presented as a poster presentation:

Bradley, S., Meaden, A., Tudway, J., Earl-Gray, M., Jones, C., Giles, D., & Wane, J. (2006, April). What do service user views tell us about engagement? Poster session presented at the National Forum for Assertive Outreach, Keele, UK.

## SUMMARY

Assertive outreach teams intended to engage clients with complex severe and enduring mental illnesses with services, are now common across the United Kingdom. Chapter one explores what is meant by the term 'engagement' and attempts to define the construct as it is used within assertive outreach. This chapter also gives consideration to the validity with which engagement is currently measured.

Chapter two, the main empirical paper, examines the psychometric properties of the current observer-rated measures of engagement used by assertive outreach teams. The results indicated that whilst the measures were all found to be reliable, there were a number of differences between the measures in terms of their construct validity.

Little is known about client experiences of services in relation to engagement, with a number of methodological limitations identified with the few qualitative studies that have been conducted. Chapter three reports on the findings of a focus group study with clients under the care of an assertive outreach team. Whilst generally more satisfied with the assertive outreach approach, the participants identified a number of tensions regarding service delivery, which if addressed, may enable teams to further facilitate client engagement.

The model of assertive outreach calls for clinical psychologists to work in increasingly non-traditional ways, with a strong emphasis on forming flexible and open relationships with clients. Items in the current engagement measures concerning the relationship between client and clinician have been shown to be related to outcome. Furthermore, the findings of qualitative studies report that clients find the relationship they have with individual team members pivotal for their engagement with services. Chapter four, therefore, reflects on the required changes to traditional professional boundaries for clinical psychologists working within assertive outreach teams and the impact of these changes on their working relationships with both clients and colleagues.

## **Chapter 1: Literature Review**

**What is a meaningful way to conceptualise engagement?**

Chapter word count: 7245

(excluding abstract, 220; illustrations, 860 & references, 2033)

## **Abstract**

Assertive outreach teams are intended to engage clients with complex severe and enduring mental illnesses with services. At present, however, no clear definition exists of what the term 'engagement' means. The aim of this review is to explore the current use of the concept in an attempt to define the construct. Once defined, the review is further concerned with exploring whether the construct of engagement is distorted by the current methods of concept measurement.

The paper reviews 'engagement' as represented within the literature, in addition to associated concepts: therapeutic alliance, compliance and participation. The review concludes that therapeutic alliance is the quintessential element of engagement, through which active collaboration and participation occurs, involving both client and clinician. It is also noted that at times compliance and acquiescence can be misconstrued as engagement and that a careful balance must be sought between coercion and engagement.

Through examining the current methods of measuring engagement, the review finds that attendance and retention have limited utility as engagement measures. Additionally, multi-dimensional scales designed to measure engagement, whilst generally reflecting the construct as newly defined, at times misrepresent compliance as engagement. Furthermore, omissions are noted in some scales regarding the openness and activeness of the relationship, in terms of both client and clinician roles.

Based on the review findings, clinical and research implications are discussed.

## Introduction

Assertive Outreach Teams (AOT) were developed as a specialist approach to case management for clients with severe mental illness (SMI) who are known to have difficulty engaging with services. Acknowledging engagement is an essential tenet of the approach (e.g. Fiander & Burns, 2000), the Sainsbury Centre for Mental Health (SCMH, 1998), identified a need to examine factors that affect engagement. Furthermore, ways to identify both clients at risk of disengagement and then specific dimensions of engagement that require focused interventions need to be available (Hall, Meaden, Smith, & Jones, 2001). In addition, these services designed to improve engagement need to be evaluated as a whole (Mowbray, Cohen, & Bybee, 1993), as do the tailored interventions that they offer (Cupitt, Wolfson, & Gray, 2006). This clinical and research agenda is compromised, however, as the construct of engagement is yet to be fully conceptualised (Tait, Birchwood, & Trower, 2002). Whilst the term is widely used, there is no clear consensus as to what engagement actually denotes and so questions remain as to what epitomises engagement and whether, when transposed between settings and disciplines, the meaning becomes distorted. In addition, the effectiveness of research and clinical interventions not only depends on a clear consensus of what exactly is meant by engagement, but also what is the most appropriate means of assessing it.

Recently a number of standardised questionnaires have been designed to measure the concept. These have been developed in the absence of a clear working definition of the construct, instead relying on underlying shared assumptions about the concept. Consequently, the possibility exists that these measures do not assess engagement as



originally intended.

The purpose of this review is twofold; initially an investigation is undertaken to explore the meaning of the construct of engagement, through reviewing the concept as it is used within the literature. To consolidate this, concepts that have been closely associated with engagement have been examined; specifically therapeutic alliance (TA), compliance and participation. Secondly, consideration is given to whether the construct of engagement, as newly defined, is distorted when translated into tools intended to measure it.

Literature is reviewed regarding AOT, SMI and other pertinent areas where engagement is a key issue in providing services and treatment (e.g. homeless clients, those with substance misuse problems and those in child protective services). See appendix A for literature search terms and strategy. Finally, consideration is given to clinical implications and important areas for further research, with particular attention devoted to engagement within AOTs.

## **Section I: Exploring the Concept of Engagement**

### *TA and Engagement*

In exploring the phenomena of engagement the first area to be investigated is that of TA, as treatment delivery occurs within and through the relationship between client and service. TA is considered the quintessential element of that relationship and has often been reported to be a close approximation to, if not synonymous with, engagement (e.g. Catty, 2004; Meaden, Nithsdale, Rose, Smith, & Jones, 2004).

The relationship between the client and clinician is considered central for client engagement in treatment, as a stand alone intervention and as a vehicle for the delivery of other interventions (McCabe & Priebe, 2004; McGuire, McCabe, & Priebe, 2001). Common across disciplines (Martin, Garske, & Davis, 2000), it is of interest when thinking in terms of Multi Disciplinary Team working (MDT) in AOT. Originally conceptualised within psychotherapy, the construct of TA appears valid in psychiatric settings, even when considering their more statutory nature (McGuire et al., 2001). Despite there being a number of theoretical perspectives on TA, that of Bordin (1979), seems to have the best fit with MDT case management (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003), and as such will be taken as the definition of TA here. Bordin's pantheoretical model of the TA has three components: Goals (agreed upon outcomes), Tasks (mutually accepted responsibilities of client and clinician to achieve goals) and Bonds (relationships between client and clinician, including trust, acceptance and confidence). This model builds on the 'core conditions' model described by Rogers (1951), where clinician

characteristics of acceptance, empathy and genuineness are considered not only 'necessary' but also 'sufficient'. The theory sees these 'core conditions' as components of TA (McLeod, 2003), and combines aspects of other theories which see TA more as a 'means to an end' (Egan, 1998).

The growing literature on TA and SMI shows a consistent relationship with outcome, regardless of therapy style (Horvath & Symonds, 1991). This relationship is, however, weaker than that found with clients with less severe illness (Martin et al., 2000). Klinkenberg, Caslyn and Morse (1998; 2002) suggest that the weaker effect may be because community services are usually less psychologically intensive and more multidimensional. TA has also been shown to take longer to form with clients with SMI, ranging from 3 months (Klinkenberg et al., 1998) to 6 months (Frank & Gunderson, 1990). This is particularly interesting when considered in-conjunction with findings of Herinckx, Kinney, Clarke and Paulson (1997) who found that clients were at greatest risk of drop-out during their first 9 months with services. Despite these factors, improved outcomes have been reported in a number of areas e.g. reduced drop-out rates, increased medication compliance, and improvements in social functioning (Frank et al., 1990), time spent in hospital (Priebe & Gruyters, 1993), quality of life (Solomon, Draine, & Delaney, 1995), satisfaction, symptom severity (Klinkenberg et al., 2002) and engagement (Hall, Smith, Meaden, & Jones, 2001).

From the literature reviewed it would appear that TA is a pervasive element of the relationship between client and service, and whilst influenced by presenting problems and style of service delivery its constancy as a key factor of engagement remains. It would therefore appear that the concept of TA is relevant to the engagement of clients

through MDT working in AOT, and as such there would be some merit when exploring the concept of engagement, to examine clinician and client characteristics associated with both TA and engagement.

### *Client factors associated with TA and Engagement*

When trying to disentangle the meaning of engagement it is necessary to explore what factors have been found to be associated with it, as this will have implications for defining the construct. A number of client demographics and characteristics have been found to be related to TA and service engagement, as it is variously measured, these are presented in table 1.

In considering the findings presented in table 1 it is also interesting to note that Drayton, Birchwood, and Trower (1998) found that a sealing-over recovery style was associated with having a history of insecure attachment, and that Hall, Smith et al. (2001) report that TA was related to recovery style. Furthermore, in considering the somewhat inconsistent findings regarding insight and clients denial of illness, it may be useful to reflect upon the findings of Derisley and Reynolds (2000). They found that low 'contemplation' in the Transtheoretical Model of Change (TTM) (i.e. aware of a problem, but no decision to change, considering options) was found to be predictive of premature termination, 'pre-contemplation' (not thinking about change) was nearly, but not quite significant. In addition, they reported that clients who had high 'contemplation' scores were predictive of clients being able to build more positive initial alliances with their therapist. Their findings therefore suggest that there is some merit in considering level of contemplation when trying to engage

clients in therapeutic work. Derisley et al. (2000) suggest the characterisation of the stage as being aware and ready to discuss problems, sits well with the processes expected in therapy of talking about problems. Interestingly, low contemplation (not aware of problems, and not ready to discuss them) was associated with premature termination and lower alliance.

**Table 1: The relationship of client factors to TA and engagement**

<b>Relationship to TA/engagement</b>	<b>Factor</b>	<b>Studies</b>
<b>NOT related</b>	Gender, Ethnicity, Diagnosis, Marital status, Length of time under care of AOT/with most involved worker in AOT, Insight	Klinkenberg et al. (1998; 2002) Mowbray et al. (1993) Mulder, Koopmans & Hengeveld (2005) Hall, Smith et al. (2001) Tait, Birchwood & Trower (2003)
<b>Negative Association</b>	Problems with criminal justice system, Lower global assessment of functioning scores, Substance abuse, Negative experiences of early maternal care	Greeno, Anderson, Shear & Mike (1999) Mulder et al. (2005) Hall, Smith et al. (2001) Klinkenberg et al. (1998; 2002)
<b>Positive Association</b>	Longer psychiatric careers, Satisfaction, Older Clients, Recovery style (integrative), Paternal care, Less denial of illness, Client's perceived usefulness of treatment	SCMH (1998) Draine & Soloman (1996) Greeno et al. (1999) Tait et al. (2003) Hall, Smith et al. (2001) Klinkenberg et al. (2002) Fiorentine, Nakashima & Anglin (1999)

The research presented regarding client factors associated with TA and engagement would appear to show that intrinsic factors such as gender or ethnicity are not as important as people's life experience and the relationships that they have. The

findings regarding attachment and alliance arguably influence the development of recovery style, coping strategies and the perception of problems and treatments. In order to understand the concept of engagement the definition must embody the mechanism by which individuals view important relationships, how open they are to treatment and how useful they consider it to be. Therefore, the importance of these relationship experiences with clinicians and services suggests that an in-depth investigation of these factors is imperative.

### ***Clinician and Service factors associated with TA and Engagement***

A number of service, intervention and clinician characteristics have been found to be associated with TA and engagement. Ackerman and Hilsenroth (2003) explored clinician characteristics and interventions that have been shown to positively impact on the quality of TA and found that clinicians who were perceived as trustworthy, experienced, understanding, supportive, warm and friendly, respectful and interested, flexible and active in their work were appreciated. In addition, they also found that interventions such as actively noting client progress, facilitating talking about experiences, working collaboratively, addressing issues arising in the relationship, and using self disclosure were also favourably received. They concluded that these characteristics and generic interventions gave clients confidence in the service, leading them to invest more of themselves in the process, which in turn further developed TA.

Addressing issues arising in the relationship is a point also raised by McCabe et al. (2004) who report that Foreman and Marmar (1985) found that TA was positively

related to the open discussion of client defences and feelings in relation to the therapist. This is even more interesting when coupled with the findings of Safran and colleagues (Safran, Crocker, McMain, & Murray, 1990; Safran, Muran, & Wallner-Samstag, 1992, as cited in Horvath & Luborsky, 1993), who found that positive outcomes were related to successful repairs of ruptures to the TA, rather than time in therapy itself. Ackerman et al. (2003) also discusses this point, considering it important for the clinician to acknowledge their part in the rupture experience.

With specific regard to TA and engagement in AOT, an increasing way that services have tried to engage clients is through employing consumers as team members (Craig, Doherty, Jamieson-Craig, Boocock, & Attafua, 2004). Solomon et al. (1995) found no difference in the TA between clients and consumer/non-consumer case managers. In addition, Hewitt and Coffey (2005) report on a study by Hattie, Sharpley, and Rogers (1984) that found that non-professional helpers were as effective as professional colleagues. These findings suggest that it is alliance, and not the use of specialist techniques that is important. In regard to intervention style and based on the findings of their conversation analysis study, McCabe, Heath, Burns, and Priebe (2002), hypothesise that clinician verbal interaction with clients, such as a narrow questioning focus and avoiding answering questions, can negatively impact on engagement. Focusing on specific intervention techniques, as found in CBT, rather than the relationship, has also been reported to adversely effect TA, with clients feeling that they are not listened to, which actively reduces the likelihood that they will disclose their thoughts and feelings required for the intervention (Collins and Cutliffe, 2003, as cited in Hewitt et al., 2005).

It is perhaps interesting to reflect here on how the findings presented so far on clinician and service factors relate to Rogerian, non-directive client-centred approaches. In particular considering the core clinician characteristics of being accepting, empathic and genuine, and how the Rogerian model considers these factors to be sufficient in their own right (e.g. McLeod, 2003). Furthermore, the use of the clinician and the clinician-client relationship within interactions, as discussed above, is an approach promoted by client-centred approaches (e.g. Mearns & Thorne, 2002).

Previous negative experiences of services, especially when found to be devaluing and oppressive, have been associated with poorer engagement (SCMH, 1998; Onyett, 1999). Whilst coercive referrals have also been associated with reduced engagement, responding to referrals in a timely manner can facilitate engagement (Greeno et al., 1999). Considering the AOT approach in particular, higher numbers of contacts and number of services provided have both been associated with better engagement and TA (Klinkenberg et al., 1998; 2002). The general style of service offered by AOT has also been shown to increase engagement (Wane, Owen, Sood, Bradley, & Jones, 2006). In their review of 21 randomised controlled trials and quasi-experimental design studies, Rapp and Goscha (2004) report on the principles of effective case management. These are: providing all services where possible from within the team, working with clients informal support networks in the community, operating a small, shared caseload facilitating a high frequency of contacts, offering a time unlimited service, 24-hours a day over a 7-day week, with case managers (both professional and para-professional), and the active facilitation of choice. The persistence of case managers and working with clients at their pace has also been identified as being important by Addis and Gamble (2004).



In trying to understand the impact of clinician and service factors on engagement when exploring the meaning of the construct, it is essential that the views of AOT service users are considered. Qualitative studies exploring client experience of AOT correlate with a number of the points raised above. Priebe, Watts, Chase, and Matanov (2005) interviewed 40 clients and found that a 'desire to be an autonomous and able person', 'lack of active participation and poor therapeutic relationships' and 'loss of control due to medication and its effects' were related to client disengagement with services. Whilst 'time and commitment', 'social support and engagement without a focus on medication' and the 'partnership model of therapeutic relationships' were found to be central to client engagement. They reported that 'not being listened to' was key to the breakdown of therapeutic relationships and disengagement with services as a whole. Bradley, Meaden, Tudway, Earl-Gray, Jones, Giles, & Wane (2006) also report on client experience of the AOT approach. They cite clients 'feeling treated as an individual' through staff being 'interested and respectful' left clients feeling 'equal, valued and heard'. In addition they found that clients 'appreciated the supportive elements of the relationship' in terms of 'practical, social and emotional' support and the general experience of clinicians and approach of the service as a whole. Bradley, Meaden et al. (2006) also identified a number of tensions regarding AOT service delivery that the increasingly publicised superior engagement and satisfaction findings may mask. These concerned clients 'feeling treated like a child, as subordinate' where clients sometimes experienced AOT staff 'as judgemental and disrespectful' leaving them feeling 'controlled, manipulated and depersonalised'. A number of findings presented previously have been related to the Rogerian client-centred model (1951). The findings of these qualitative studies would also seem to correlate with this approach, where attending, actively listening

and trying to appreciate the client's frame of reference are found to be respectful, and communicating this understanding through empathy are key to engagement (Egan, 1998). The specific aspects of interactions that clients felt important, in terms of clinicians being non-directive and transparent verses more directive and perhaps manipulative in their interactions is a point also discussed by Mearns et al. (2002) in their chapter on the importance of the clinician's use of self in interactions with clients in person-centred counselling.

To summarise, the characteristics of clinicians and services important when conceptualising engagement predominantly concern the TA and the style of therapeutic interactions. Clearly, active, client-centred, and respectful interventions foster better outcomes, where clinicians and services enter into more personal relationships with clients. It would appear that, from the findings presented, what is of importance is *how* clinicians and services conduct themselves, rather than specific techniques they offer or, as with client factors, their intrinsic characteristics.

It is thought that the positive clinician and service factors described above demonstrate to clients that the team are genuinely interested in them and that they are trustworthy (Chinman, Allende, Bailey, Maust, & Davidson, 1999). From their study Chinman et al. (1999) have developed a preliminary model of recovery for AOT clients which includes many of the factors presented above:

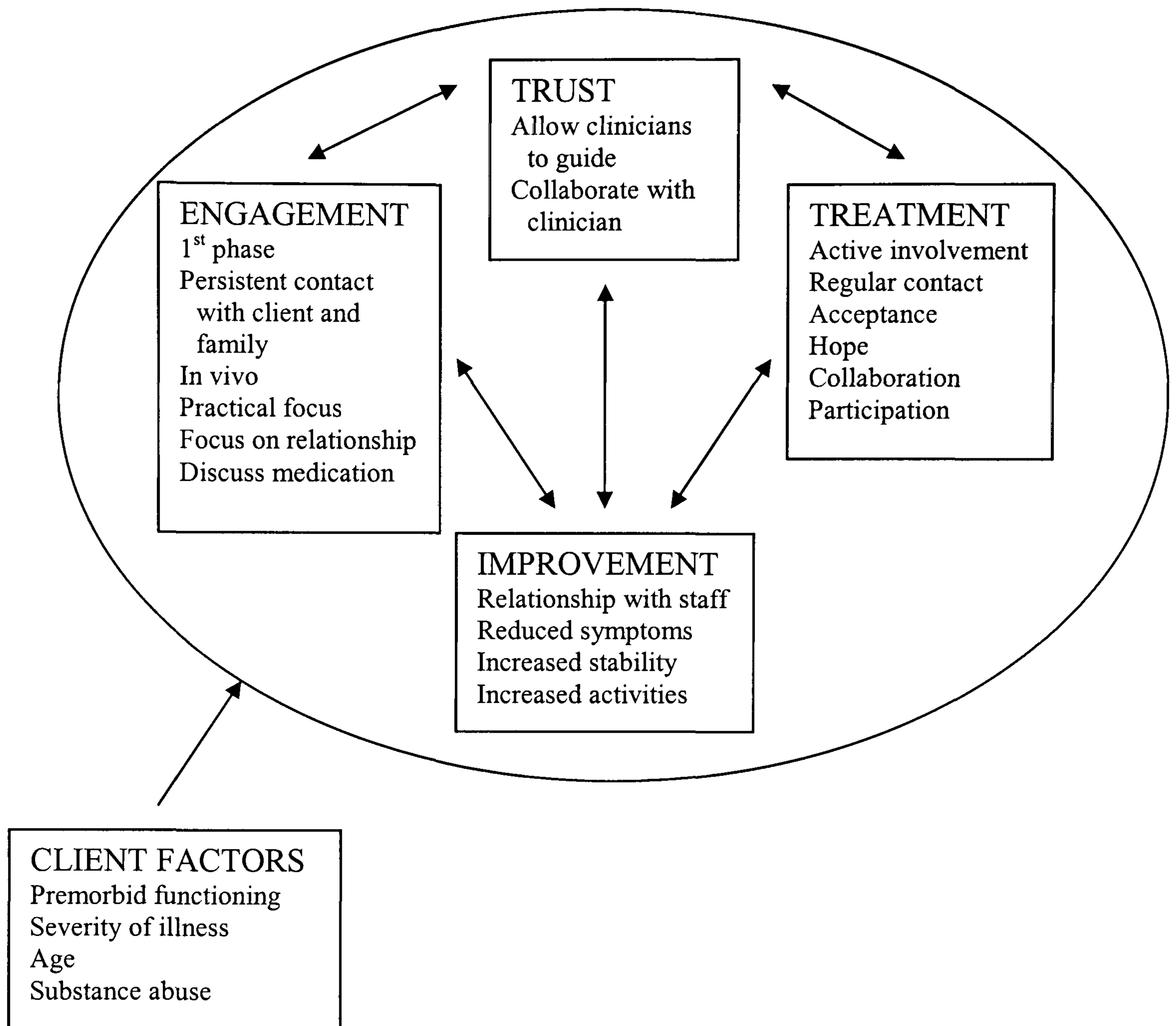


Figure 1: Preliminary model of recovery for AOT Clients

(Adapted from Chinman et al., 1999).

From the exploration of the literature so far it would appear that the relationship between client and service is paramount to engagement, where both positive and negative relationships can influence service engagement and disengagement. As can be seen from the model presented by Chinman et al. (1999) the relationship between client and clinician occurs within all of their key modules of recovery: engagement, trust, improvement and treatment. It is therefore interesting to consider how the

relationship and TA in particular, as discussed, a concept traditionally reserved for psychotherapy, translates into the often more medicalised arena of AOT.

In summary the TA between client and service is quintessential to engagement and individual personal characteristics appear less important than style of interaction and how clinicians and clients behave, think and feel towards one another. It appears that balance within the relationship is pivotal to engagement, where imbalances can lead to services being perceived as coercive, leading to clients disengaging or simply acquiescing and complying with service demands.

### *Compliance and Engagement*

Based on the findings presented above, it would appear that whilst relationships between clients and services are essential, they are not sufficient in their own right, and that what is of importance is the active role each party plays in the relationship. It would, therefore, seem important to consider the role of coercion and compliance in relation to engagement as often compliance has been taken to mean engagement. Catty (2004) discusses how, within psychiatry, the term 'engagement' can mean: medication compliance, attendance at appointments or collaborative involvement in a therapeutic relationship. Considering that all involve collaboration to some degree, Catty (2004) reports that only collaborative involvement in a relationship is considered to match the meaning of TA (as defined by Bordin, 1979). With specific regard to AOT, Catty (2004) reflects on the complexity of applying the construct of TA, where increased contact may not equate with a stronger TA. In such circumstances the inverse may be true and clients may feel intruded upon by repeated

attempts to make contact with them, weakening the TA, however, because of poor engagement, clinicians may make further efforts to make contact.

McPhillips and Sensky (1998) in their chapter on coercion, adherence and collaboration with medication, describe compliance in terms of patient acceptance of recommended behaviours. This is akin to an early definition of compliance from the first international conference on compliance with therapeutic regimes in May 1974, where it was defined as “the extent to which a person’s behaviour (in terms of taking medications, following diets, or executing lifestyle changes) coincides with medical or health advice.” Haynes (1979); as cited in Blackwell, p5 (1997). McPhillips et al. (1998) further discuss how interventions designed to manage medication non-compliance can be coercive, for example in terms of compulsory admissions, progressing through to more collaborative interventions, where clients are fully involved in developing problem management strategies. They perceive compliance to be the passive acceptance of clinician advice by the client, with adherence characterised by clients having a more active, collaborative role. Although adherence through collaboration is more desirable, they acknowledge that to some extent compliance cannot be completely abandoned when working with clients with SMI. With this point in mind, Coffey (2003) reports on the importance of balancing connection and autonomy in client-clinician relationships, raising that complete autonomy is not always beneficial and that sometimes direction is needed.

AOT itself has been considered to be a coercive intervention, Morgan (2000) reflects that the current political climate influencing services is one focused on ‘risk elimination’ p16, raising concerns that AOTs will become restrictive and forced to

focus on medication compliance in an attempt to reduce risk. Considering that this may lead to the realisation of the fears of some regarding 'aggressive outreach' p.16, which ironically, will increase users' avoidance and potential risk further. Additionally, Stovall (2001) considers that the AOT approach can potentially be seen as coercive and intrusive, and not collaborative or respectful of the rights of the individual. Gomory (2002) is also highly critical of the approach, considering AOTs to have aggressive workers who force clients to comply with treatment programmes, which in turn provide data that seems to suggest that the model is effective.

Fisher (1997), in his chapter on informed choice and the importance of personal participation in the healing process, discusses the relationship between compliance and informed choice. Considering that compliance is paternalistic and objectifies the person, he favours informed choice, characterised by active participation. Fisher discusses how compliance in which clients follow orders in an uncritical fashion, undermines empowerment, alternatively increased control by the client over recovery is something that has been shown to be vital to this process (e.g. Romme & Escher, 2000). Fisher (1997) also refers to the findings of Parsons (1951) who reported that doctors define sick-roles and whilst relieving the patient of responsibility, this then results in the patient assuming a 'child-like' position relative to the doctor. It is interesting to consider this view in light of the findings of Bradley, Meaden et al. (2006) who found that clients differentiated positive and negative experiences of services based on whether they felt the services treated them 'like a child' or 'as an individual'.

From reviewing the literature regarding the links between compliance and

engagement it would appear that at times clients may appear to be engaged, but if they are actually complying with coercive service demands, passively accepting of interventions, then the engagement relationship is not active or collaborative. Compliance seems to reflect an imbalance in the power relationship between client and clinician, where overly active, even aggressive interventions are coupled with passive, submissive responses. What has been highlighted as being important to the concept of engagement, and what has been identified as missing in compliance, is the active nature of the client's involvement in treatment; their participation.

### *Participation and Engagement*

Participation entails clients actively being involved in the engagement relationship. Kazdin, Holland, and Crowley (1997) report that problems with participation include poor attendance, lack of engagement, early termination, non-compliance and pro forma involvement in outpatient mental health settings. Similarly it would seem that poor engagement, has been, and can also be thought of in terms of poor participation, attendance, compliance, involvement and early termination. Indeed, in their article examining client participation, Littell, Alexander, & Reynolds (2001) report that a better understanding of the phenomenon of participation could lead to improved interventions designed to engage clients in treatment. Considering the overlapping terminology used by services; participation, engagement, involvement, compliance and cooperation, they introduce a two dimensional framework for conceptualising participation in terms of level of activity (passive to active) and valence (negative to positive):

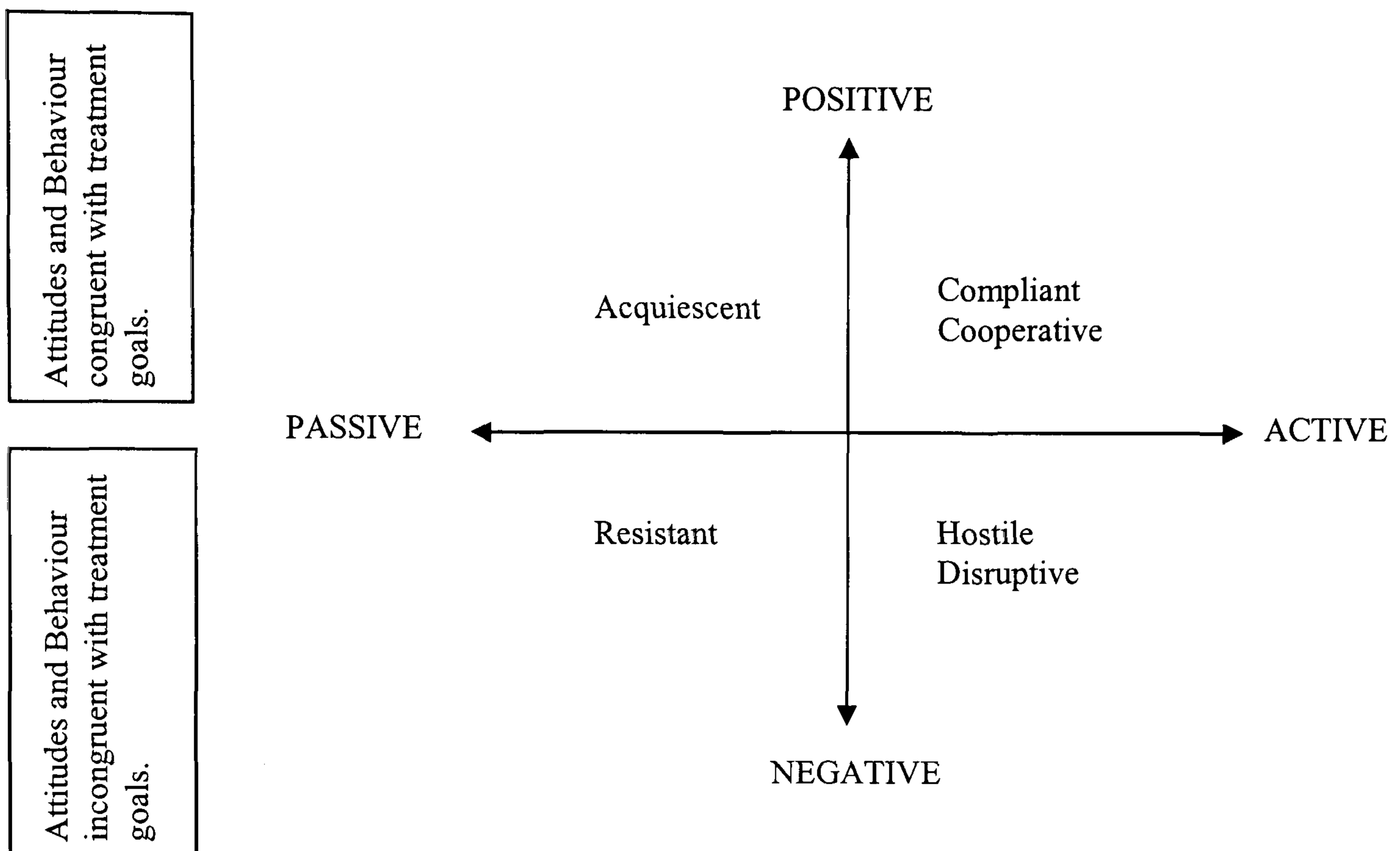


Figure 2: A framework for participation (adapted from Littell et al., 2001).

In considering the framework, it is important to be mindful that attitudes and behaviours may be perceived and categorised differently by clients and clinicians (Littell et al., 2001). Littell et al. (2001) also regard participation to be dynamic, influenced by client beliefs, goals, external constraints and experience of services which in turn are influenced by clinicians, settings, social and cultural factors, an opinion which correlates with the factors previously presented regarding engagement.

Thinking of engagement in terms of a relationship in which clients participate would, therefore, seem to reflect the literature that has been reviewed. Where clients and clinicians are actively involved in a participatory relationship, that is not negative and coercive or simply pro-forma, but positive and collaborative. A collaborative relationship that is dynamic and influenced by factors related to personal experience.



### *Limitations of the Literature*

It is important to note that the findings of these studies must be interpreted with some caution. Some of the studies were conducted in the U.S.A. (e.g. Greeno et al., 1999) and Netherlands (e.g. Mulder et al., 2005) and, as such, may not be generalisable to the different cultural circumstances, service provisions, and client demographics of those in the U.K. Additionally, some studies investigated unique client groups, such as those who are homeless (e.g. Klinkenberg et al., 1998; 2002; Mowbray et al., 1993), those with additional substance misuse problems (e.g. Klinkenberg et al., 1998), those presenting with 'non-chronic' schizophrenia (Frank et al., 1990) and those without psychosis (Derisley et al., 2000). These different client groups have specific needs which, taken together with service delivery adaptations, mean that it may not be possible to extrapolate their findings beyond the specific populations studied. Additionally, clients involved in the Tait et al. (2003) study had relatively short psychiatric careers (7/10 less than 5 years since onset) and other studies, although conducted in the U.K., had very small sample sizes (e.g. Chinman et al., 1999 n=3; Hall, Smith et al., 2001 n=26). Moreover, all of the studies presented used different measures of engagement, from attendance to standardised measures (see Section II for a description of implications for measurement of engagement).

Furthermore, some of the studies did not use standardised measures of TA and those that did, utilised measures developed for use with psychotherapy clients and, as such, may not be applicable to assess the relationships formed between clinicians and clients in AOT. Effects of this are further compounded as some studies used client ratings and some clinician ratings of TA, but it has been reported that client ratings of

the TA have been less predictive than those made by clinicians (e.g. Gehrs & Goering, 1994; Neale & Rosenheck, 1995). Neale et al. (1995) also reported that client's ratings of TA were significantly higher than case managers, which it is suggested may be due to the effects of social desirability. Despite these limitations within the literature, a speculative definition of the concept of engagement is still possible.

***So what does 'Engagement' mean?***

The relationship built on collaboration, bonds and roles, formed between clients and clinicians is the key common factor to emerge in effective interventions. In other words, what is important is *how* clients and clinicians interact.

From reviewing the literature, engagement emerges as a multi-dimensional process, not only referring to the initial stage of interest formation, but to the development of trust and rapport and ongoing involvement in interventions. Engagement means more than attendance and retention, it concerns not only to the quantity but also the quality of interactions, including client affect and attitudes as well as behaviour. Engagement is influenced by past experiences, current perceptions and future expectations. It is a process where clients are actively involved in collaboration and participation, it is not compliance and adherence to pre-determined service defined goals, or passive perfunctory pro-forma involvement. Relationships are pivotal to engagement, influenced by early experiences, where engagement-attachment relationships are subsequently formed between clinicians and clients, through which and in themselves interventions are delivered. Engagement can thus be viewed as being on a

relationship continuum, at the one end of which lies coercion and compliance and at the other, collaboration and *true* engagement.

## **Section II: Measuring the Concept of Engagement**

Section one has explored the construct of engagement, concluding that the construct concerns the active nature of the relationship between client and clinician. What is interesting to consider here, in section two, is whether this working definition is accurately reflected in tools designed to measure the concept.

### ***Attendance and Retention***

Within individual studies, attendance and retention have been used as proxy measures of engagement (Mowbray et al., 1993). These have often been recorded as dichotomous variables (whether clients attend or not), the number and duration of sessions, or the number of cancellations and failures to attend e.g. Craig et al. (2004). Others have measured engagement as the product of the average number of weekly sessions multiplied by the number of weeks spent in treatment (e.g. Fiorentine et al., 1999).

A number of reviews have also reported overall service retention as a measure of engagement (e.g. Marshall & Lockwood, 1998). Bond, McGrew, and Fekete (1995), defining this as ‘uninterrupted reception of services’, reported that AOT clients were better engaged with services at one year follow-up (84% as opposed to 54% of controls).

Other studies have tried to obtain more qualitative information, Mowbray et al. (1993) developed an engagement status classification system, based on a weekly team consensus. 'Fully Engaged' clients were clients who completed assessments, negotiated plans and accepted services in the community, those who were classified as having 'Limited Engagement' were accepting some assistance, but had not fully completed assessments, formulated a plan or accepted community services and 'Not Engaged' clients who had refused all help. Despite these weekly classifications, the authors took the highest classification over the first four months of the study as the measure of client engagement. They found that the classification was related to number of contacts and durations of contacts, with the median number of contacts reported as 30.5, 4.0 and 1.0 respectively. The considerable differences between the 'fully' and 'limited' engagement group, suggests a lack of sensitivity in their measurement scale and taking an average rating over 4 months implies that they perceive engagement to be a relatively static construct.

When considering engagement, these types of measurement tell us very little, as physical presence does not equate with active involvement, and attendance can also be used to measure adherence and compliance (Littell et al., 2001). Furthermore, attendance and retention are service driven outcomes that do not always accurately reflect the perspectives of clients and the optimal balance in activeness of both parties within the relationship. It is interesting to explore measures of attendance and service retention with specific regard to the AOT approach. In AOT clients are often taken to appointments, whilst this could be seen as supportive, it could also be perceived as coercion and as such these figures do not tell us if clients are *choosing* to engage. Furthermore, in AOT clinicians often make home visits, frequently 'cold calling',

how are these contacts recorded? At best, these involve the client passively, at worst become intrusive and coercive. Furthermore, what does good attendance really mean? For example a high number of service contacts could mean that a person is well engaged in a number of activities or that they are relapsing and that the team is providing additional services. Consequently, it would appear that quantitative counts are too blunt as measures to assess the construct of engagement in a meaningful way. Littell et al. (2001) report that the quality, rather than the quantity of client participation is important, and as such attendance and retention tell us little about the construct, indeed it is questionable whether they are they even measuring it.

### *Multi-dimensional measures of Engagement*

Recently, a number of questionnaires assessing client affect and attitude, in addition to attendance, have been designed to measure engagement (see appendix G). These multidimensional questionnaires have been designed by clinicians working within community mental health settings and include concepts such as cooperation, involvement, collaboration, participation and TA. There are currently three observer-rated measures of engagement designed specifically for use in AOT (Hall et al., 2001; Tait et al., 2002; Wolfson & Cupitt, 2001), one measure designed for use with homeless mentally ill (Park, Tyrer, Elsworth, Fox, Ukoumunne, & MacDonald, 2002) and one self-report measure (Gillespie, Smith, Meaden, Jones, & Wane, 2004). A measure has also been developed within child protective services to assess family engagement (Yatchmenoff, 2005). A comparison of these measures is presented in Table 2.

**Table 2: Comparison of engagement measures**

MEASURE	STRUCTURE/COMPONENTS	ITEMS	DEVELOPMENT	RATER	RATING FORM	PSYCHOMETRIC PROPERTIES
BEM <sup>1</sup> Wolfson & Cupitt (2001)	Contact Participation Collaboration Openness Help-Seeking Treatment	6	Discussion amongst authors. Post development literature review & interviews with 5 clinicians. 8 expert reviewers.  SMI, UK	Clinician	4-point Likert  Over the past month	Good test re-test reliability (client n=38/ clinician n=4) (Pearson's R 0.86 total score; 0.68-0.84 item scores) Good face validity (experts/clinicians feedback)
EM <sup>2</sup> Hall, Meaden, Smith & Jones (2001)	Appointment Keeping (2 items) Client-therapist Interaction (1 item) Communication/Openness (3 items) Client's perceived usefulness of treatment (1 item) Collaboration with treatment (3 items) Compliance with medication (1 item)	11	MDT discussions and based on previous measure used by AOT.  SMI, UK	Clinician	5-point Likert	Good internal reliability (n=44) (Cronbach's alpha 0.89) Good test re-test reliability (n=44) (Spearman's R 0.90 total score; 0.71-0.84 subscale scores) Good inter-rater reliability (client n=22/clinician n=2) (Spearman's R 0.95 total score; 0.86-1.00 subscale scores) Good face validity (feedback from clinicians) Good discriminatory capacity (>33 = good engagement)
SES <sup>3</sup> Tait, Birchwood & Trower (2002)	Client Availability (3 items) Collaboration (3 items) Help Seeking (4 items) Treatment Adherence (4 items)	14	Literature Review. Discussion amongst authors.  SMI, UK	Clinician	4-point Likert	Good internal reliability (client n=66/ clinician n=5) (Cronbach's alpha 0.91) Good test re-test reliability (n=15) (Spearman's R 0.90 total score; 0.80-0.97 subscale scores) Good criterion validity (reported by authors)
EM <sup>4</sup> Gillespie, Smith, Meaden, Jones & Wane (2004)	Appointment Keeping (2 items) Client-therapist Interaction (1 item) Communication/Openness (3 items) Client's perceived usefulness of treatment (1 item) Collaboration with treatment (3 items) Compliance with medication (1 item)	11	Authors rephrased Hall et al. (2001) measure  SMI, UK	Client	5-point Likert	Good internal reliability (n=25) (Cronbach's alpha 0.80) Good test re-test reliability (n=12) (Pearson's R 0.85 total score) Concurrent validity with EM (Hall et al., 2001) (R=0.49, p<0.05) Not predictive of engagement at 6 months

1 = Bexley Engagement Measure; 2 = Engagement Measure; 3 = Service Engagement Scale; 4 = Engagement Measure

**Table 2: Comparison of engagement measures (continued)**

MEASURE	STRUCTURE/COMPONENTS	ITEMS	DEVELOPMENT	RATER	RATING FORM	PSYCHOMETRIC PROPERTIES
HEAS <sup>5</sup> Park, Tyrer, Elseworth, Fox, Ukoumunne & MacDonald (2002)	How the client feels about the worker The degree to which the client can be engaged The client's attitude to help The clients attitude to housing The way the client engages with others	5	Discussion with MDT to develop items. Pilot resulting in clarification of wording. Expert review of items by MDT and external reviewers. SMI & Homeless, UK	Clinician	5 and 4 – point Likert	Good internal reliability (n=110) (Cronbach's alpha 0.85 total score) Good inter-rater reliability (n=21) (Intra-Class Correlation Coefficient R=0.77) Good Face and content validity (as assessed by MDT) Good Construct validity (Items 1,2, & 5 significant relationships with items on a measure of social behaviour Good predictive validity (accommodation and adequacy of support networks at 12 months predicted by score at 3 months)
CSEM <sup>6</sup> Yatchmenoff (2005)	Receptivity (4 items) openness to receiving help, recognising problem and need for help Expectancy/Investment (8 items) perceiving a benefit, feeling that things changing for the better with the help of the agency/commitment, active participation, goal ownership and help seeking Working relationship (4 items) good communication with worker, sense of reciprocity within relationship Mistrust (3 items) believing the service to be manipulative and malicious, with intent to harm client	19	A number of separate discussions with clinicians and service users to explore the concept, generate items and later refine items, including from different cultural perspectives and preliminary factor analysis on an initial scale with 37 items. Families of Children referred to Child Protective Services, USA	Client	5-point Likert	Good internal reliability (n=287) (Cronbach's alpha = 0.95 total score; 0.81-0.91 subscale scores) Construct validity Comparison with measures of: Interpersonal helping relationship, Personal support, Global overall engagement and Compliance Interpersonal reln. significantly related to engagement summary score and subscales (r=0.36-0.0.75, p<0.001) Personal support significantly related to engagement summary score and subscales (r=0.4-0.78, p<0.001) Global measure significantly related to engagement summary score and subscales (r=0.51-0.79, p<0.001) Compliance significantly related to engagement summary score (r=0.17, p<0.05); expectancy/investment (r=0.21, p<0.01); and mistrust (r=0.14, p<0.05). No significant relationship was found between compliance and receptivity or compliance and working relationship

5 = Homeless Engagement and Acceptance Scale; 6 = Child Services Engagement Measure

The measures presented in table 2 all assess a variety of aspects of engagement and can be broadly categorised as client adherence to service goals (e.g. being available for appointments and taking their medication), and being actively involved in treatment (e.g. being open and collaborating with treatment). The measures themselves all include slightly different questions, and give different priorities to different areas, as evidenced by the different subsections and the number of questions per subsection. Whilst most ask about collaboration, others tap into different aspects of service use, for example the SES explicitly asks about medication and treatment, but not about openness and communication. Furthermore, items regarding medication compliance assume that clients should be taking medication (Cupitt et al., 2006). The concept of engagement derived in this review suggests that how individuals view important relationships, their openness to treatment and how useful they consider treatment to be, are also imperative to include in measures designed to assess engagement.

The reviewed measures have different numbers of items, ranging from 5 (HEAS) to 19 (CSEM), with some scored on 4 and others scored on 5-point likert scales, with implications for their ability to detect difference and change over time. With regard to this, only the BEM gives a time frame for which it is to be assessed over. All of the measures, as can be seen from the development section of the table, have been produced by clinicians, with varying degrees of robustness. Items have been generated based on clinical experience and literature review (pre and/or post original item generation). Some have consulted MDTs, and independent 'experts', however, clients were only consulted on the development of the CSEM. Additionally, of the



six measures, only two are designed to be completed by clients, of which one is a rewording of an existing clinician-scored scale (Gillespie et al., 2004).

Despite these differences in their development, all of the scales appear to have good reliability, although some of the reliability assessments are less valid than others when considering the sample size ( $n=12$  ranging to  $n=287$ ). What is evident from the psychometric properties of the measures presented in table 2, with the exception of the CSEM, is that in-depth assessments of the validity of the scales are lacking. In considering the construct of engagement as defined previously, where a distinction is made between compliance and engagement, it is interesting to note that Yatchmenoff (2005) reports a weaker, if any association between compliance and their subscales of engagement.

Identifying a lack of comparison across the measures of engagement designed for AOT and the lack of data regarding their validity, a study to investigate their psychometric properties was undertaken by Bradley, Jones, Meaden, Tudway, and Wane (2006). All of the measures studied were associated with participation and were equally reliable, however, when subjected to a regression analysis, the measures were found to differentially assess variables previously considered to be related to the construct of engagement (satisfaction, TA, participation and insight). Participation was the only significant association for the BEM measure (as assessed by the 'Involvement in treatment' item on the 'Response to care' subsection of the FACE Health and Social Assessment Measure, FACE Recording & Measurement Systems, 2000). The SES was found to be significantly associated with insight (as scored on the Insight Scale, Birchwood, Smith, Drury, Healy, MacMillan, & Slade, 1994),

whereas the EM (Hall et al., 2001) version was found to be associated with TA (scored using the Helping Alliance Questionnaire-II, Luborsky, Barber, Siqueland, Johnson, Najavits, Frank, & Daley, 1996) and satisfaction (recorded using the Client satisfaction questionnaire, Larsen, Attkinson, Hargreaves, & Nguyen, 1979). In addition, it should be noted that none of the measures were significantly associated with medication compliance (as assessed by the 'Taking of medication' item in the 'Response to care' subsection of the FACE Health and Social Assessment Measure, FACE Recording & Measurement Systems, 2000).

It would appear that, when examining the construct validity of the SES, EM BEM and CSEM, a collaborative and open therapeutic relationship is more associated with engagement than compliance. Overall, these significant associations appear to correlate with the construct of engagement as it is now defined. It is also interesting to consider how these measures are related to other areas of literature, in particular that of attendance and the qualitative studies exploring service-user views. These findings suggest that engagement, measured at times by attendance, may actually be reflecting compliance due to the sometimes coercive experience of services. Therefore, it would appear that the current tools, which include items regarding attendance, may also be measuring compliance in addition to items explicitly rating compliance with medication.

It is also relevant to consider the findings of Meaden et al. (2004), who reported that some items on the Hall et al. (2001) measure were more related to outcome than others. In particular, those concerning: client-therapist interaction, client's perceived usefulness of treatment, openness and the client's collaboration with treatment. The

weakest predictors of outcome were compliance with medication and appointment keeping, findings which correlate with the evidence previously presented about key features of the construct of engagement.

Furthermore, Gillespie et al. (2004) when comparing observer and client engagement scores, found that clients and clinicians ranked the importance of items on the EM (Gillespie et al., 2004/Hall et al., 2001) measure(s) differently. They also found differences between the two measures in terms of how individual items correlate with the total score of each measure, finding that initial high correlations of client and clinician ratings of engagement reduced after a six month time interval. Additionally, they found that clients rated their engagement significantly higher than their clinicians initially, but after the 6 month interval, there was no significant difference between these scores. The authors suggest that this may reflect clinicians taking an overview of engagement, but that client scores may reflect their feelings on that day. This is of relevance when, with the exception of the BEM, the measures do not define the time period over which the assessment is to be made, a concerning omission when considering the previously discussed dynamic nature of engagement and indeed the goal that engagement should change over time. Interestingly, Martin et al. (2000) also report that clients tend to view TA as stable, whereas clinician ratings appeared to be more sensitive to change.

Finally, characteristics of clinicians and services are also important to consider when developing valid tools for measuring engagement. These centre around the style of interaction as an active, client-centred, and respectful process; emphasising *how*

clinicians and services conduct themselves and the reciprocal nature of these relationships.

In summary, using attendance and retention as proxy measures of engagement can be misleading as these do not capture the qualitative aspects of the relationship in terms of the active nature of participation. Examination of the current standardised engagement scales has shown that to some extent, whilst they address this short coming, the construct of engagement can become distorted and items concerning behaviours closer to compliance may be inaccurately recorded as engagement. It is, perhaps, useful to retain the idea by Blackwell (1997) that “simple measures are not accurate and accurate measures are not simple” p6. Taking account of this and the findings presented that clients and clinicians perceptions differ, and that attendance and retention are not adequate measures of engagement, a combination of measures, that examine the affect, attitudes and behaviours of both clients and clinicians may prove more useful in assessing engagement.

### **Section III: Implications**

#### ***Clinical Implications***

A number of factors have been associated with engagement in terms of attachment and recovery style, therefore, it is suggested that assessing these factors at service intake will enable teams to tailor individual interventions to facilitate client engagement. As such, further clinical and research efforts should focus towards

developing a format for developing rigorous assessment and formulation protocols for teams.

It is particularly encouraging to note that engagement seems to be related to processes within the relationship with clinicians and not so much about static client characteristics, and as such, factors that seem to affect engagement are modifiable and make improved engagement possible.

The importance of the TA and the focus on the interaction between clinicians and clients, as opposed to who they are or what they do, raises the need for appropriate training (focusing on non-directive, client-centred approaches, such as that described by Rogers, 1951) and the need for ongoing supervision for clinicians, a point discussed by Bradley, Tudway, and Meaden (2006). Through supervision the coercive-collaborativeness of interventions should be considered to ensure paramount importance is given to the client's experience of the relationship and that engagement is active. This is particularly important when considering the desired lasting effects of engagement and AOT, and that if engagement is passive and forced, change will be less meaningful and perhaps more subject to erosion overtime than if clients become actively engaged in the therapeutic process.

With current government targets suggesting AOTs should increase caseload size, there is a risk that less time will be available for the client-centered interventions described above that facilitate the development of engagement. With clinicians forced to revert to more of a traditional community mental health team medical model

of medication monitoring and crisis intervention, quality engagement may become more elusive.

### ***Research Implications***

Further investigation of the factors that affect engagement, particularly regarding teams with high fidelity to the model in the UK, would help to facilitate the development and further refinement of interventions designed to promote engagement.

Although Gillespie et al. (2004) have tried to develop an engagement measure for clients to express their views, a measure designed with clients, for clients, may enable a greater understanding of the construct.

The AOT is a team approach and, as such, a tool designed to measure engagement with the whole team may also prove beneficial. The Service Attachment Questionnaire (SAQ), designed to assess the ability of adult mental health services to meet client attachment needs (Goodwin, Holmes, Cochrane, & Mason, 2003) may be useful to investigate as it has previously been discussed that clinicians and services can function as temporary attachment figures for clients.

### **Summary and Conclusions**

Engagement is a dynamic multidimensional process, with TA as its central tenet characterised by how clinicians and clients actively interact with one-another. At

present the construct of engagement is open to distortion by the current scales designed to measure it, where compliance can at times be taken to imply engagement. It is also important to retain the broader issue that these findings regarding engagement also highlight. Whilst the AOT model is considered state of art it is not without its flaws, considered by many to be superior to TCM, it is still a compromise between service and user-led ideals and, as such, attempts to investigate and improve service delivery and client experience of services must continue. The final implication of this review is that services need to be aware of whether they are fostering compliance or alliance.

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## **Chapter 2: Main Empirical Paper**

### **The Psychometrics of Measuring Engagement in Assertive Outreach**

Chapter word count: 4895

(excluding: abstract, 196; illustrations, 550 & references, 951)

## **Abstract**

**Background:** Questionnaires intended to measure client engagement with services have recently been developed, the comparative psychometrics of which are unknown.

**Aims:** This study examined the psychometric properties of three observer-rated engagement questionnaires, assessing their internal, inter-rater and test-retest reliability. Additionally, their construct validity was assessed in terms of their concurrent and nomological validity (by assessing their relationship to satisfaction, helping-alliance, participation and insight).

**Method:** Thirty-eight participants and their care-coordinators participated in this study, with independent ratings of engagement provided by an RMO.

**Results:** Whilst found to be equally reliable the questionnaires were differentiated with regard to their validity. All the questionnaires were significantly associated with participation, the only significant association for the Bexley Engagement Measure (Wolfson & Cupitt, 2001). In addition, the Service Engagement Scale (Tait, Birchwood, & Trower, 2002) was further significantly associated with insight, and the Engagement Measure (Hall, Meaden, Smith, & Jones, 2001) with helping-alliance and satisfaction.

**Conclusions:** Based on the associations found with participation, satisfaction and helping-alliance, the Engagement Measure (Hall et al., 2001) would appear to be the most reliable and valid questionnaire.

**Declaration of Interest:** The co-authors Dr. Jones and Dr. Meaden were involved in developing the Engagement Measure (Hall et al., 2001).

**Keywords:** assertive outreach, engagement, measurement

## **Introduction**

### ***Engagement and the Assertive Outreach Team (AOT) Approach***

AOTs were developed as a specialist approach to case management for clients with severe mental illness (SMI), who are known to have difficulty engaging with services.

A key element in the National Service Framework for Mental Health (Department of Health, 1999) and the NHS Plan (Secretary of State for Mental Health, 2000), these teams have been reported to be effective at maintaining contact with clients, reducing hospital use and improving social functioning (Marshall & Lockwood, 2001).

Engagement is acknowledged as an essential tenet of the AOT approach (e.g. Fiander & Burns, 2000), and has recently been conceptualised as a multidimensional process concerned with the active nature of relationships between clients and clinicians. It includes affective, attitudinal and behavioural elements, where collaboration and a strong therapeutic alliance are central (Bradley, Meaden, Tudway, & Jones, 2006).

Whilst agreed that it is important to examine factors that affect engagement (Sainsbury Centre for Mental Health, SCMH, 1998), and evaluate services designed to promote engagement (e.g. Mowbray, Cohen, & Bybee, 1993), the utility of these investigations is dependent on valid measurement of the construct.

### ***Measuring Engagement in AOT***

Service retention and attendance have both been used as proxy measures of engagement (Mowbray et al., 1993) although these measures may be misleading as physical presence does not necessarily equate with active involvement. A number of

questionnaires assessing client affect and attitude in conjunction with attendance have recently been produced to measure engagement. These multidimensional questionnaires (see appendix G) have been designed by clinicians working within community mental health settings and include concepts such as cooperation, collaboration, participation and helping alliance (e.g. Engagement Measure (EM) Hall, Meaden, Smith, & Jones, 2001; Service Engagement Scale (SES) Tait, Birchwood, & Trower, 2002; Bexley Engagement Measure (BEM) Wolfson & Cupitt, 2001).

These measures assess a variety of aspects of engagement that can broadly be categorised as clients adhering to service goals (e.g. being available for appointments and taking their medication), and clients being actively involved in treatment (e.g. being open and collaborating with treatment). The measures have different numbers of items, ranging from 6 (BEM) to 14 (SES), scored on either 4 or 5-point likert scales, with implications for their ability to detect difference and change over time. Item generation was based on clinical experience and literature review (pre and/or post item development), with some authors also consulting multi-disciplinary teams (MDTs), and independent 'experts' (EM and BEM), but only one scale gives a time frame for which it is to be assessed over (BEM). The measures themselves all ask slightly different questions, and give different priorities to different areas, as evidenced by their different subscales and the number of questions per subscale. For example the SES measure has 4-items, in contrast to a single item on the BEM, regarding 'treatment adherence'. Furthermore the SES measure does not include items about openness or communication, whilst the BEM has 1 item and the EM 3-items regarding this. Interestingly, the SES and EM both contain items specifically

about taking medication, but this implies that clients should be taking medication (Cupitt, Wolfson, & Gray, 2006). Despite these differences, all of the scales have been reported to have good reliability, although data regarding their validity is somewhat lacking (see method section for full descriptions), and as such questions remain as to whether they are really assessing engagement as it has been defined (Bradley, Meaden, Tudway, et al., 2006).

Concerns about the utility of some of the items, at least in the EM, were raised by Meaden, Nithsdale, Rose, Smith, and Jones (2004), who reported that a number of items were more related to outcome than others. In particular; those concerning the client-therapist interaction, the client's perceived usefulness of treatment, openness and the client's collaboration with treatment. The weakest predictors of outcome were compliance with medication and appointment keeping, suggesting that some items may be more valid in assessing the construct of engagement than others. To date it has been difficult to assess the validity of the new scales in depth because, as they have only recently been developed, there have not been other standardised measures to compare them against. Furthermore, no validity checks have been made with factors that have been shown to be related to engagement, such as satisfaction, therapeutic alliance (TA), the activeness of participation and insight. The importance of these factors and their relationships to engagement will now be discussed in turn, in more detail.

## *Constructs Associated with Engagement*

### *Engagement and Satisfaction*

Satisfaction has consistently been related to client engagement with services, with previous negative experiences of services associated with poorer engagement (SCMH, 1998). A number of studies have reported that clients are more satisfied with AOT when compared to other types of case management (e.g. Burns & Santos, 1995), but satisfaction is a complex concept, including perceptions of staff, procedures and location of service provision (Larsen, Attkinson, Hargreaves, & Nguyen, 1979). Herinckx, Kinney, Clarke, and Paulson (1997) report that clients receiving standard case management were more than twice as likely to drop-out of treatment due to dissatisfaction than those under the care of an AOT. Taking specific aspects of the AOT model, higher numbers of contacts and the number of services provided have both been associated with better engagement and therapeutic alliance (Klinkenberg, Caslyn, and Morse., 1998; 2002). Recently, Priebe, Watts, Chase, and Matanov (2005) reported that ‘time and commitment’, ‘social support and engagement without a focus on medication’ were related to the process of engagement. Taken together, these findings show the inter-relatedness of satisfaction and service engagement, and would therefore suggest that the findings of any engagement measure should be associated with scores on a standardised measure of satisfaction.

*Engagement and TA*

Engagement has been considered to be a close approximation to TA, a concept within the psychotherapy literature that has been extensively researched (Meaden et al., 2004). The relationship between the client and clinician is generally considered central to client engagement in treatment, as a stand alone intervention and as a vehicle for the delivery of other interventions (McCabe & Priebe, 2004; McGuire, McCabe, & Priebe, 2001). Common across disciplines (Martin, Garske, & Davis, 2000), it is particularly relevant in MDT working in AOT. Originally conceptualised within psychotherapy, the construct of TA appears valid in psychiatric settings despite their more statutory nature (McGuire et al., 2001), with the growing literature on TA and SMI showing a consistent relationship with outcome (Martin et al., 2000). Furthermore, how clients experience the therapeutic relationship has been identified in qualitative research as central to the processes of engagement and disengagement; Priebe et al. (2005) report that a 'poor therapeutic relationship' was related to client disengagement with services, whilst a 'partnership model of therapeutic relationships' was found to facilitate engagement. In addition, they report that not being listened to was key to the breakdown of therapeutic relationships and disengagement with services as a whole. Bradley, Meaden, Tudway, Earl-Gray, Jones, Giles, & Wane, (2006) also report on clients experience of relationships with AOT staff. They found that clients 'feel treated as an individual' through staff being 'interested and respectful' leaving clients feeling 'equal, valued and heard'. Additionally, clients 'appreciated the supportive elements of the relationship' in terms of 'practical, social and emotional' support and the general experience of clinicians and approach of the service. Bradley, Meaden, Tudway, Earl-Gray, et al. (2006) also identified a number



of tensions regarding these relationships that the increasingly publicised superior engagement and satisfaction findings may mask. These concerned clients 'feeling treated like a child, as subordinate' where clients sometimes experienced AOT staff 'as judgemental and disrespectful' leaving them feeling 'controlled, manipulated and depersonalised'. The demonstrated importance of TA to engagement in the literature would therefore suggest that it should be expected that a valid measure of engagement would be related to a valid measure of TA.

### *Engagement and the Activeness of Participation*

Engagement has recently been conceptualised in terms of the level of active client participation in interventions (Bradley, Meaden, Tudway et al., 2006). This has been considered to incorporate the level of activity (passive to active) and valence (negative to positive) of client behaviour (Littell, Alexander, & Reynolds, 2001). It has been suggested that compliance, which has been defined in terms of client acceptance of recommended behaviours (McPhillips & Sensky, 1998), is often misattributed as engagement, where clients passively acquiesce to service demands. Some even consider that AOTs employ 'aggressive outreach' that forces clients to comply with treatment programmes, which in turn provides data that seems to suggest that the model is effective (Gomory, 2002). The sometimes coercive experience of AOT was highlighted earlier by Bradley, Meaden, Tudway, Earl-Gray et al. (2006) and was also found by Priebe et al. (2005), who identified that 'desire to be an autonomous and able person', 'lack of active participation' and 'loss of control due to medication and its effects' were related to the level of client engagement with services. The research presented reveals the importance of the level of client

participation in service engagement, in particular the voluntary nature of their participation. Therefore, it would seem appropriate that a questionnaire intended to measure engagement should, in addition to satisfaction and TA, be related to the level of client participation in treatment.

### *Engagement and Insight*

Insight refers to an appreciation by an individual that they are unwell and that their unusual experiences are symptoms of their illness (Sackeim, 1998). It has been hypothesised that individuals who do not adhere to psychosocial interventions are more likely to have poor insight (Lysaker, Bell, Bryson, & Kaplan, 1998), however, Tait, Birchwood and Trower (2003) found no correlation between insight and service engagement. Interestingly, lower denial of illness (Klinkenberg et al., 2002) and client perception of the usefulness of treatment (Fiorentine, Nakashima, & Anglin, 1999) have been found to be related to TA and engagement. Furthermore, Derisley and Reynolds (2000) found that low 'contemplation' in the Transtheoretical Model of Change (i.e. aware of a problem, but no decision to change, considering options) was found to be predictive of premature termination. These somewhat inconsistent findings suggest that engagement may, on some level, also be associated with insight, and as such some association between a valid measure of insight and engagement may reasonably be expected.

*Aims*

The present study aims to compare internal, test-retest and inter-rater reliability of the EM, SES and BEM. In addition, the study aims to explore construct validity by assessing the nomological validity of the measures through comparing them to measures of related concepts in terms of satisfaction, TA, the activeness of participation and insight. Construct validity will also be assessed by calculating their concurrent validity with an independent rating of engagement.

**Method***Participants*

Thirty eight participants were recruited from two AOTs for inclusion into this study.

<b>Table 3: Participant characteristics</b>		
<i>Variable</i>	Sample No.	(n=38) %
Gender		
Male	28	(74)
Female	10	(26)
Age		
Mean	37.68	
Range	21-65	
Diagnosis		
Schizophrenia	23	(61)
Schizoaffective Disorder	10	(26)
Bi-polar Disorder	5	(13)

Clients were excluded from selection if they were new to the team (less than six months) or if they were considered unable to give informed consent. Others were excluded if they were presenting with active positive symptoms of mental illness and required extra services or if their care coordinator considered that participation would be detrimental to their mental health. See appendices B, C, and D for ethical, and research and development approval for the study.

### *Measures*

- *The Service Engagement Scale (SES)* (Tait et al., 2002) is a 14-item observer-rated measure. Four dimensions of engagement are rated on a 4-point likert scale, with high scores indicating poor engagement. The dimensions assessed are: client availability (3 items), collaboration (3 items), help seeking (4 items) and treatment adherence (4 items). The scale is reported to have good internal reliability (Cronbach's Alpha 0.91), good test-retest reliability (total score Spearman's  $R=0.90$ , subscale range from 0.80-0.97) and good criterion validity.
- *The Engagement Measure (EM)* (Hall et al., 2001) is an 11-item observer-rated questionnaire. Six dimensions of engagement are rated on a 5-point likert scale, where high scores indicate good engagement. The dimensions are: appointment keeping (2 items), client-therapist interaction (1 item), communication/openness (3 items), client's perceived usefulness of treatment (1 item), collaboration with treatment (3 items) and compliance with medication (1 item). The scale has been shown to have good discriminatory capacity (scores of more than 33 indicate good engagement), face validity, inter-rater reliability (total score Spearman's  $R=0.95$ , item correlations range from 0.86-1), test-retest reliability (total score Spearman's  $R=0.90$ ,

item correlations range from 0.71-0.84) and internal reliability (Cronbach's Alpha 0.89).

- *The Bexley Engagement Measure (BEM)* (Wolfson et al., 2001<sup>1</sup>) is a 6-item observer-rated measure, where the items are scored on a 4-point likert scale, with high scores indicating good engagement. The items address client contact, participation, collaboration, openness, help-seeking and treatment. Although unpublished, the authors did undertake a reliability study with 38 participants (Cupitt et al, 2006), where the correlation between administrations of the measure at a two week interval was found to be good (Pearson's  $r$  0.68-0.84 for the subscales and 0.86 for the total score).
- *The Client Satisfaction Questionnaire (CSQ)* (Larsen et al., 1979) is an 8-item self-report questionnaire, marked on a 4-point likert scale. The questionnaire has been shown to have good internal reliability (Cronbach's Alpha 0.93). Two supplementary questions are added here, asking what the client likes least/most about the service, as described by Cleary, Horsfall and Hunt (2003).
- *The Helping Alliance Questionnaire-II (HAQ-II)* (Luborsky, Barber, Siqueland, Johnson, Najavits, Frank, & Daley, 1996) is a 19-item questionnaire assessing the therapeutic relationship. Items are scored on a 6-point likert scale, high scores indicate stronger relationships (total scores range from 19-114). The questionnaire has been shown to have good test-retest reliability (Spearman's  $R=0.56$ ), internal reliability (Cronbach's Alpha 0.93). Furthermore, convergent validity with other alliance measures has also been demonstrated by Luborsky et al. (1996).
- *The Health and Social Assessment Measure* (FACE Recording & Measurement Systems, 2000) is a 38-item questionnaire designed to measure clients' health and

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<sup>1</sup> See appendix H for permission to use BEM, as currently unpublished

social care needs. Items are rated on a 5-point likert scale. This study only uses the subsection concerning clients' 'Response to Care' which contains 2 items regarding engagement (1. level of active involvement in treatment and goal planning/achievement 'FACE involvement', 2. compliance with prescribed medication 'FACE medication'). Clifford (2004) reports that the measure has satisfactory levels of inter-rater reliability (weighted kappas > 0.7), good internal reliability (Cronbach's alpha = 0.8-0.85); face, and concurrent validity (correlation with Brief Psychiatric Rating Scale = 0.71).

- *The Insight Scale* (Birchwood, Smith, Drury, Healy, Macmillan, & Slade, 1994) is a self-report measure, where respondents are requested to agree or disagree with 8 statements, scores above 9 are considered to indicate good insight. Furthermore, the authors of the scale report that it has good test-retest reliability (Spearman's R= 0.90), internal reliability (Cronbach's Alpha 0.75) and construct, concurrent and criterion validity.

### ***Procedure***

Clients who met study criteria were approached by AOT staff on a routine contact, where informed consent was obtained<sup>2</sup>. The pack of self-report measures was then completed at a time convenient to the client with support provided when requested. The two most involved clinicians then completed the observer-rated engagement measures, with the most involved clinician completing the additional measures assessing alliance and response to care. Following a two-week interval, the most involved clinician again completed the engagement measures. In addition, the

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<sup>2</sup> See appendices E and F for information and consent forms for clients and staff involved in this study

Responsible Medical Officer (RMO) for each AOT, provided an independent dichotomous rating of engagement for each participant (well engaged/poorly engaged).

## Results

### *Reliability of the Scales*

#### *Internal Reliability*

Cronbach's alpha coefficients were calculated based on the results of the first administration of the engagement measures, as completed by the most involved clinician.

**Table 4: Internal reliability of the measures**

<b>Measure</b>	<b>Subscales</b>	<b>No. items per subscale</b>	<b>Cronbach's Alpha</b>
<b>SES</b>	Availability	3	0.82
	Collaboration	4	0.83
	Help-Seeking	4	0.82
	Treatment Adherence	4	0.81
	<b>Total Score</b>	<b>14</b>	<b>0.90</b>
<b>EM</b>	Communication/Openness	3	0.87
	Collaboration	3	0.87
	<b>Total Score</b>	<b>11</b>	<b>0.90</b>
<b>BEM</b>	<b>Total Score</b>	<b>6</b>	<b>0.86</b>

Table 4 shows that all measures have high internal reliability, these findings are consistent with the earlier reported psychometrics and suggest that each of the three questionnaires provides a homogeneous measure of engagement.

*Inter-rater Reliability*

The intra-class correlation coefficients (ICC) were calculated for each of the subscales and total scores for the measures from the data gathered from the two independent ratings. The ICC provides a measure of absolute agreement between raters (i.e., the correlation between raters controlling for the absolute value of those ratings). The ICC coefficients and associated significance tests are presented in the table below.

Measure	Subscales	Rater 1		Rater 2		ICC	F	Sig
		Mean	SD	Mean	SD			
SES	Availability	1.37	1.94	1.87	2.08	0.76	4.28	0.00
	Collaboration	3.53	2.45	3.32	2.44	0.67	2.97	0.00
	Help-Seeking	3.87	3.05	3.08	3.05	0.73	3.85	0.00
	Treatment	2.71	2.80	2.08	2.46	0.70	3.46	0.00
	Adherence							
	<b>Total Score</b>	<b>11.47</b>	<b>8.33</b>	<b>10.32</b>	<b>8.16</b>	<b>0.81</b>	<b>5.24</b>	<b>0.00</b>
EM	Appointment	7.84	1.87	7.5	1.74	0.55	2.24	0.01
	Keeping							
	Client-Therapist	4.08	0.78	3.82	0.69	0.47	1.96	0.02
	Interaction							
	Communication/	10.71	2.49	10.97	2.56	0.60	2.46	0.00
	Openness							
	Usefulness	3.47	0.98	3.74	0.82	0.58	2.44	0.00
	Collaboration	10.21	2.75	10.56	2.72	0.69	3.15	0.00
Medication	3.87	0.99	4	0.90	0.62	2.65	0.00	
	<b>Total Score</b>	<b>40.18</b>	<b>7.62</b>	<b>40.76</b>	<b>6.64</b>	<b>0.77</b>	<b>4.21</b>	<b>0.00</b>
BEM	<b>Total Score</b>	<b>16.95</b>	<b>5.22</b>	<b>17.12</b>	<b>4.22</b>	<b>0.69</b>	<b>3.14</b>	<b>0.00</b>

Table 5 shows that although there is a small difference between the ICC for the different measures, they all have good inter-rater reliability, with a correlation of 0.81 for the total score on the SES, 0.77 on the EM and 0.69 on the BEM.



*Test-retest Reliability*

The Pearson Product Moment Correlation ( $r$ ) coefficients were calculated for each of the measures from the data gained by the clinician most involved in the client's care, when they completed the measures twice with a two week interval. The coefficients for each of the measures' subscales and total scores are presented in the table below.

**Table 6: Test-retest reliability of the measures**

Measure	Subscales	Time 1		Time 2		$r$	Sig
		Mean	SD	Mean	SD		
SES	Availability	1.37	1.94	1.37	1.79	0.73	0.00
	Collaboration	3.53	2.45	3.24	2.48	0.71	0.00
	Help-Seeking	3.87	3.05	4.13	3.46	0.68	0.00
	Treatment	2.71	2.80	2.92	2.83	0.68	0.00
	Adherence						
	<b>Total Score</b>	<b>11.47</b>	<b>8.33</b>	<b>11.63</b>	<b>9.13</b>	<b>0.83</b>	<b>0.00</b>
EM	Appointment	7.84	1.87	8.32	1.58	0.84	0.00
	Keeping						
	Client-Therapist	4.08	0.78	4.12	0.76	0.80	0.00
	Interaction						
	Communication/	10.71	2.49	10.82	2.28	0.83	0.00
	Openness						
	Usefulness	3.47	0.98	3.63	0.97	0.79	0.00
	Collaboration	10.21	2.75	10.79	2.61	0.77	0.00
Medication	3.87	0.99	3.89	0.86	0.80	0.00	
	<b>Total Score</b>	<b>40.18</b>	<b>7.62</b>	<b>41.55</b>	<b>7.21</b>	<b>0.91</b>	<b>0.00</b>
BEM	<b>Total Score</b>	<b>16.95</b>	<b>5.22</b>	<b>16.53</b>	<b>5.44</b>	<b>0.86</b>	<b>0.00</b>

Table 6 shows that although there is slight variation in the actual  $r$  for each of the measures, they all have good test-retest reliability, with a correlation of the total scale score for the SES of 0.83, 0.91 for the EM and 0.86 for the BEM. These findings are again consistent with previously reported psychometric data.

### *Construct Validity of the Scales*

Construct validity concerns the extent to which a measure behaves in a theoretically sound manner and involves exploring the relationships between the measure under investigation and measures of other concepts/characteristics within a theoretical framework (Diamantopoulos & Schlegelmilch, 1997).

### *Nomological Validity*

Nomological validity is a specific form of construct validity that assesses the extent to which a measure is related to measures of other concepts in a manner consistent with theoretical expectations (Diamantopoulos et al., 1997). To assess the nomological validity of the engagement measures, an ordinary least squares regression was performed to estimate the degree to which the total score of each of the measures shares variance with the variables thought to be associated with the engagement construct i.e., satisfaction (as scored on the CSQ), TA (as scored by the HAQ-II), involvement/compliance with treatment (as scored using the FACE response to care subsection), and insight (as scored on the Insight Scale). The regression analysis predicted each of the total scores for each of the engagement measures on the basis of the scores on the CSQ, HAQ-II, FACE response to care (involvement and medication items), and Insight Scale total scores.

For this analysis the SES was recoded such that a high score indicated positive engagement and was therefore comparable to the scoring of the other measures of engagement.

For all of the regression analyses, the following preliminary diagnostic statistics and checks were performed; checks for normality of independent and dependent variables using the Kolmogorov-Smirnov one-sample test; a scatterplot of standardised residuals against standardised predicted values was drawn up to check for problems with the linearity and heteroscedasticity of the dataset; outlying values of the independent and dependent variables were assessed using leverage values and values of the studentised residuals respectively; Cook's D was used to check for cases in the analysis that may exert an extreme influence on the line of best fit, and tolerance values of the independent variables were used to assess multicollinearity issues. No problems were found with any of these checks.

For the SES, this analysis resulted in a model  $R^2 = 0.74$  ( $F_{5,32} = 18.53$ ;  $p < 0.01$ ), the standardised (Beta) and unstandardised (B) regression coefficients are presented in Table 7.

	Unstandardised Coefficients		Standardised Coefficients	T	Sig.
	<i>B</i>	<i>Std. Error</i>	<i>Beta</i>		
<b>(constant)</b>	19.10	5.87		3.25	0.03
<b>Alliance Total</b>	0.04	0.04	0.10	0.94	0.35
<b>FACE Involvement</b>	-4.98	0.92	-0.60	-5.41	0.00
<b>FACE Medication</b>	-1.21	0.88	-0.14	-1.38	0.18
<b>Insight Total</b>	0.54	0.25	0.22	2.11	0.04
<b>Satisfaction Total</b>	0.20	0.17	0.13	1.20	0.24

As can be seen from Table 7, a statistically significant association was observed between the SES total score and FACE involvement (Beta = 0.60;  $t = 5.41$ ;  $p < 0.01$ ) and the total score of the Insight Scale (Beta = 0.22;  $t = 2.11$ ;  $p < 0.04$ ).

The regression for the EM resulted in a model  $R^2 = 0.76$  ( $F_{5,32} = 19.85$ ;  $p < 0.01$ ). The standardised (Beta) and unstandardised (B) regression coefficients are presented in Table 8. As can be seen from Table 8, a statistically significant association was observed between the EM total score and Helping Alliance (Beta = 0.22;  $t = 2.06$ ;  $p < 0.05$ ), FACE involvement (Beta = -0.48;  $t = -4.45$ ;  $p < 0.01$ ) and the total score of the CSQ (Beta = 0.25;  $t = 2.35$ ;  $p < 0.03$ ).

**Table 8: Standardised and unstandardised regression coefficients for the EM**

	Unstandardised Coefficients		Standardised Coefficients	T	Sig.
	<i>B</i>	<i>Std. Error</i>	<i>Beta</i>		
<b>(constant)</b>	25.74	5.24		4.92	0.00
<b>Alliance Total</b>	0.08	0.04	0.22	2.06	0.05
<b>FACE Involvement</b>	-3.65	0.82	-0.48	-4.45	0.00
<b>FACE Medication</b>	-1.11	0.78	-0.14	-1.42	0.16
<b>Insight Total</b>	0.38	0.23	0.17	1.69	0.10
<b>Satisfaction Total</b>	0.35	0.15	0.25	2.35	0.03

The regression for the BEM resulted in a model  $R^2 = 0.66$  ( $F_{5,32} = 12.49$ ;  $p < 0.01$ ).

The standardised (Beta) and unstandardised (B) regression coefficients are presented in Table 9.

**Table 9: Standardised and unstandardised regression coefficients for the BEM.**

	Unstandardised Coefficients		Standardised Coefficients	T	Sig.
	<i>B</i>	<i>Std. Error</i>	<i>Beta</i>		
<b>(constant)</b>	8.37	4.23		1.98	0.06
<b>Alliance Total</b>	0.05	0.03	0.21	1.71	0.10
<b>FACE Involvement</b>	-3.03	0.66	-0.59	-4.57	0.00
<b>FACE Medication</b>	0.27	0.63	0.05	0.43	0.67
<b>Insight Total</b>	0.28	0.18	0.19	1.55	0.13
<b>Satisfaction Total</b>	0.17	0.12	0.17	1.38	0.18

As can be seen from Table 9, the only statistically significant association was between the BEM total score and FACE involvement (Beta = -0.59;  $t = -4.57$ ;  $p < 0.01$ ).

A comparison of the profiles of the Beta weighting for each of the engagement measures, by each of the variables assessed in this analysis are presented in Figure 3:

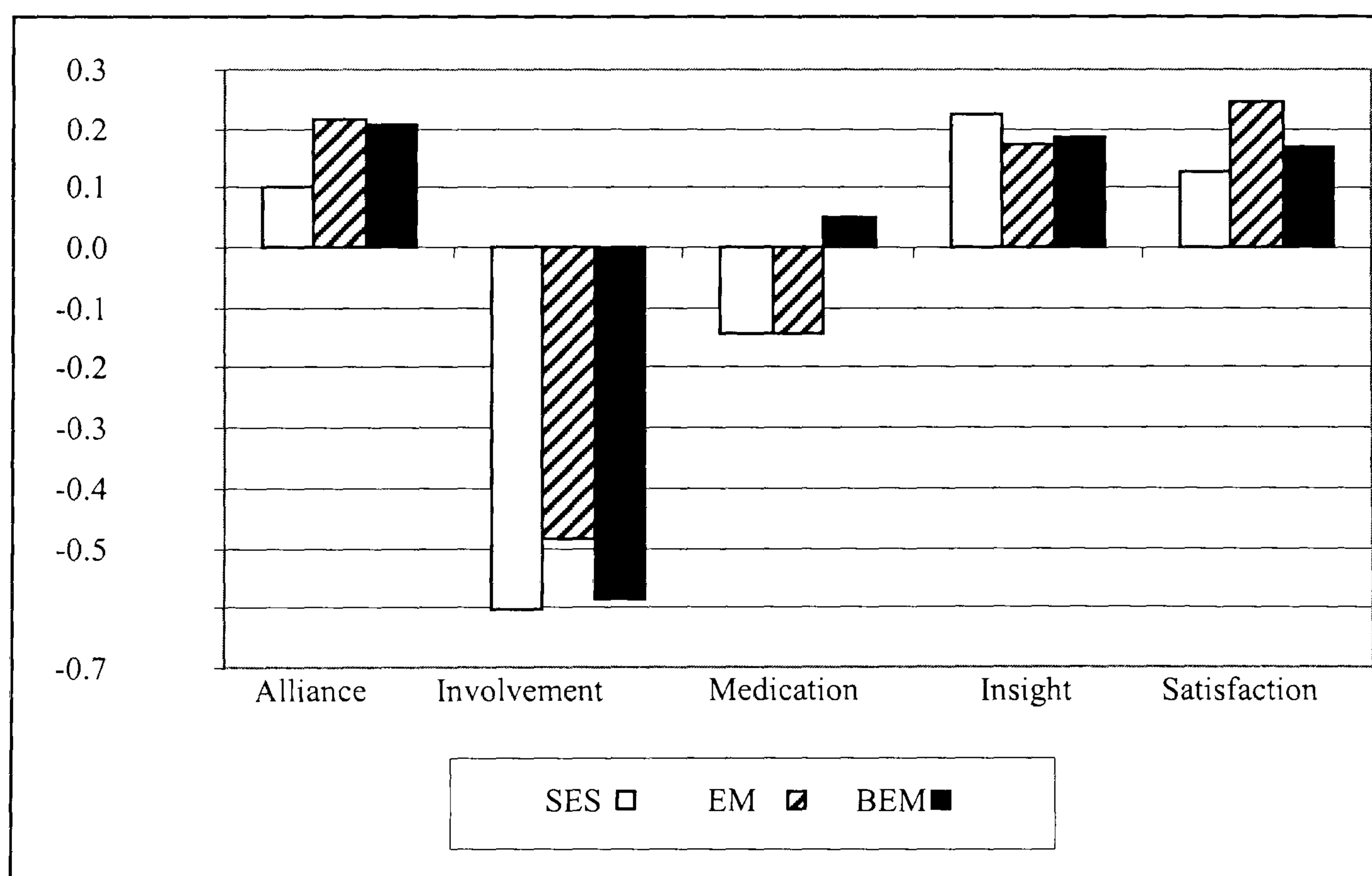


Figure 3: Beta weightings of the observer measures of engagement

From figure 3 it can be seen that there is very little difference between the three engagement measures. The EM and BEM appear to assess alliance as measured on the HAQ-II more than the SES, however, only the EM was significantly associated with the HAQ-II total score, as presented in Table 8. All measures were shown to significantly assess involvement as scored on the Involvement in Treatment and Care item of the Response to Care subsection of the FACE. This is reported as a negative relationship as low scores on this item are equated with having no problems with involvement. As presented in tables 7, 8 and 9, none of the measures were significantly associated with the item measuring the Taking of Medication in the Response to Care subsection of the FACE. Graphically, there is no difference between the SES and EM, with both measures having a negative relationship, as again low scores on the FACE item indicate no problems with medication compliance. Although not significant, the BEM appears to have a different relationship, with high engagement scores indicating medication compliance issues, but this may perhaps be an artefact of the wording of their item ('How often does the person enter into negotiation about treatment options e.g. psychotropic medication, psychotherapy?'), where 'negotiation' does not reflect 'compliance' as it has previously been presented. Each of the three engagement measures show a similar association to insight, although as presented in table 7, only the SES was significantly related to insight. There is more variation between the measures in regards to assessing satisfaction, with both the EM and BEM appearing to be more related to satisfaction than the SES, however, only the EM was shown to be significantly associated with this, as presented in table 8.

*Convergent Validity*

Convergent validity is a form of construct validity which assesses the extent to which a measure is positively related to other measures of the same concept, when obtained by independent methods (Diamantopoulos et al., 1997). Within the sample (n=38), 27 clients (71%) were considered to be well engaged by their RMO, whilst 11 clients (29%) were considered to be poorly engaged with their respective AOTs. A between subjects t-test was calculated to assess the convergent validity of the RMO rating of engagement with the total score on each engagement measure.

**Table 10: The convergent validity of the engagement measures.**

Measure	Mean		t-value	df	P
	<i>Well</i>	<i>Poor</i>			
<b>SES</b>	8.78	18.09	-3.60	36	0.00
<b>EM</b>	42.74	33.91	3.77	36	0.00
<b>BEM</b>	18.33	13.55	2.79	36	0.01

As can be seen from Table 10, the total score for each of the engagement measures were significantly related to the independent dichotomous rating of engagement provided by the RMO.

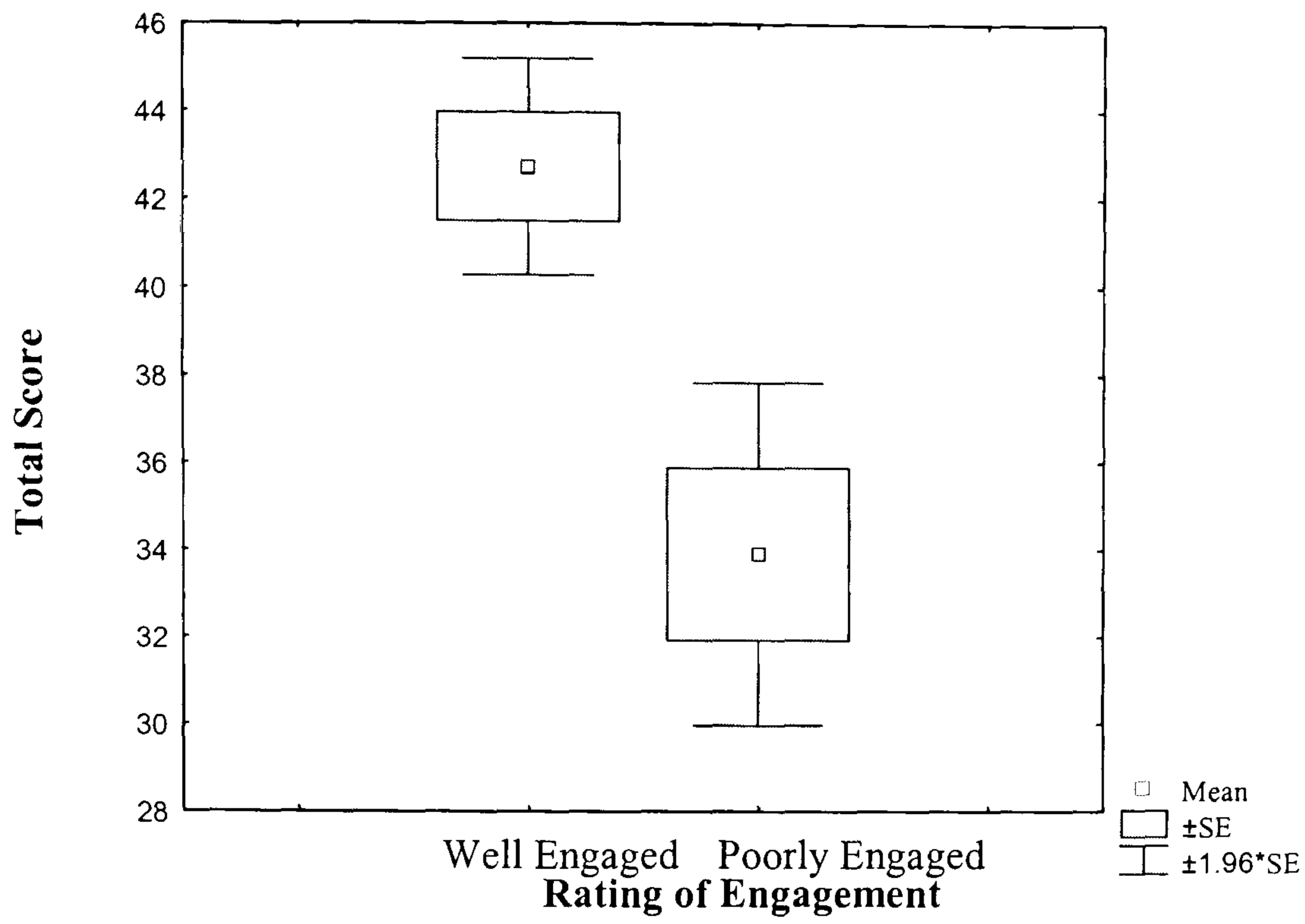


Figure 4: The difference between total scores on the SES, when client engagement is classified as good or poor by the RMO.

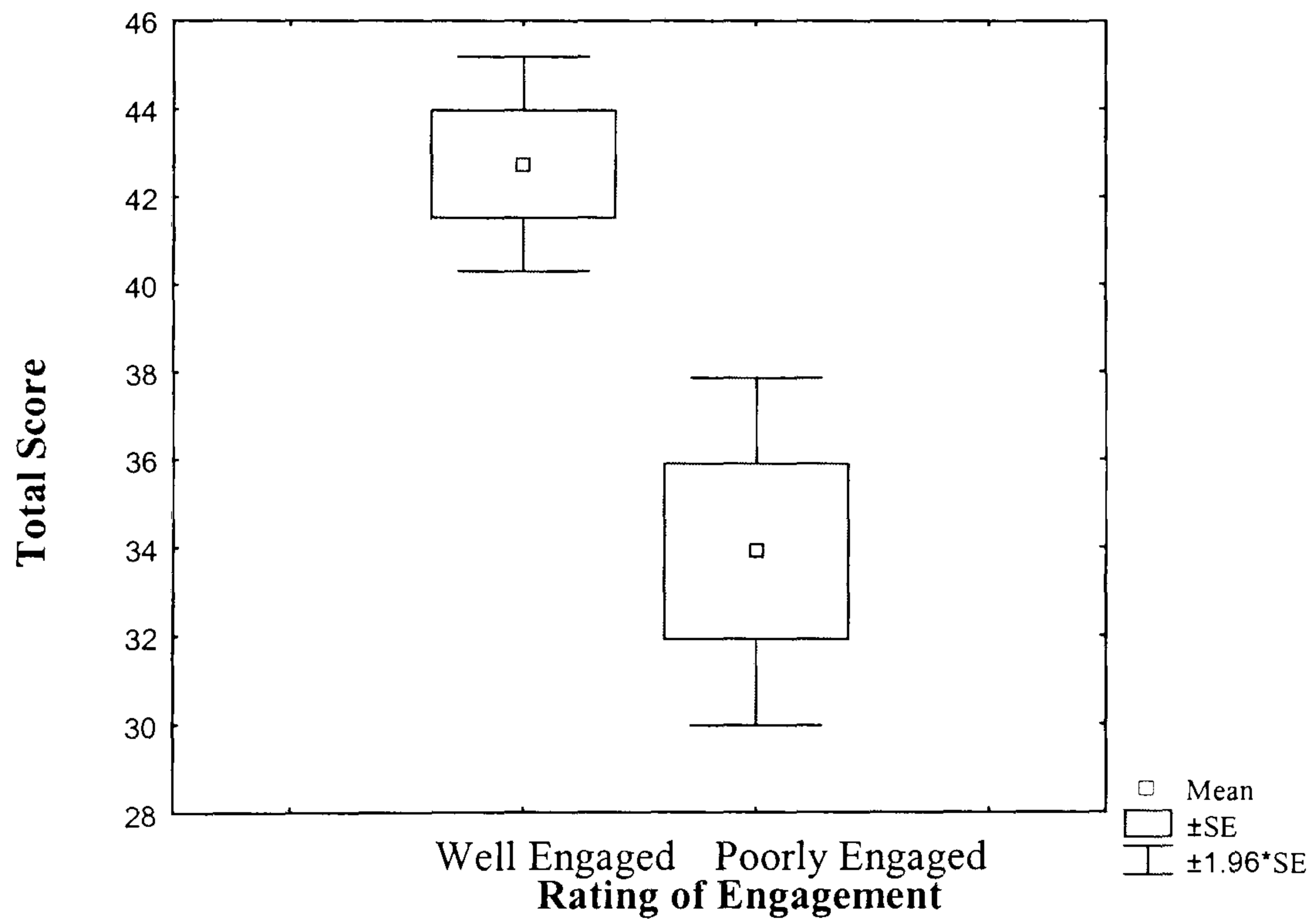


Figure 5: The difference between total scores on the EM, when client engagement is classified as good or poor by the RMO.



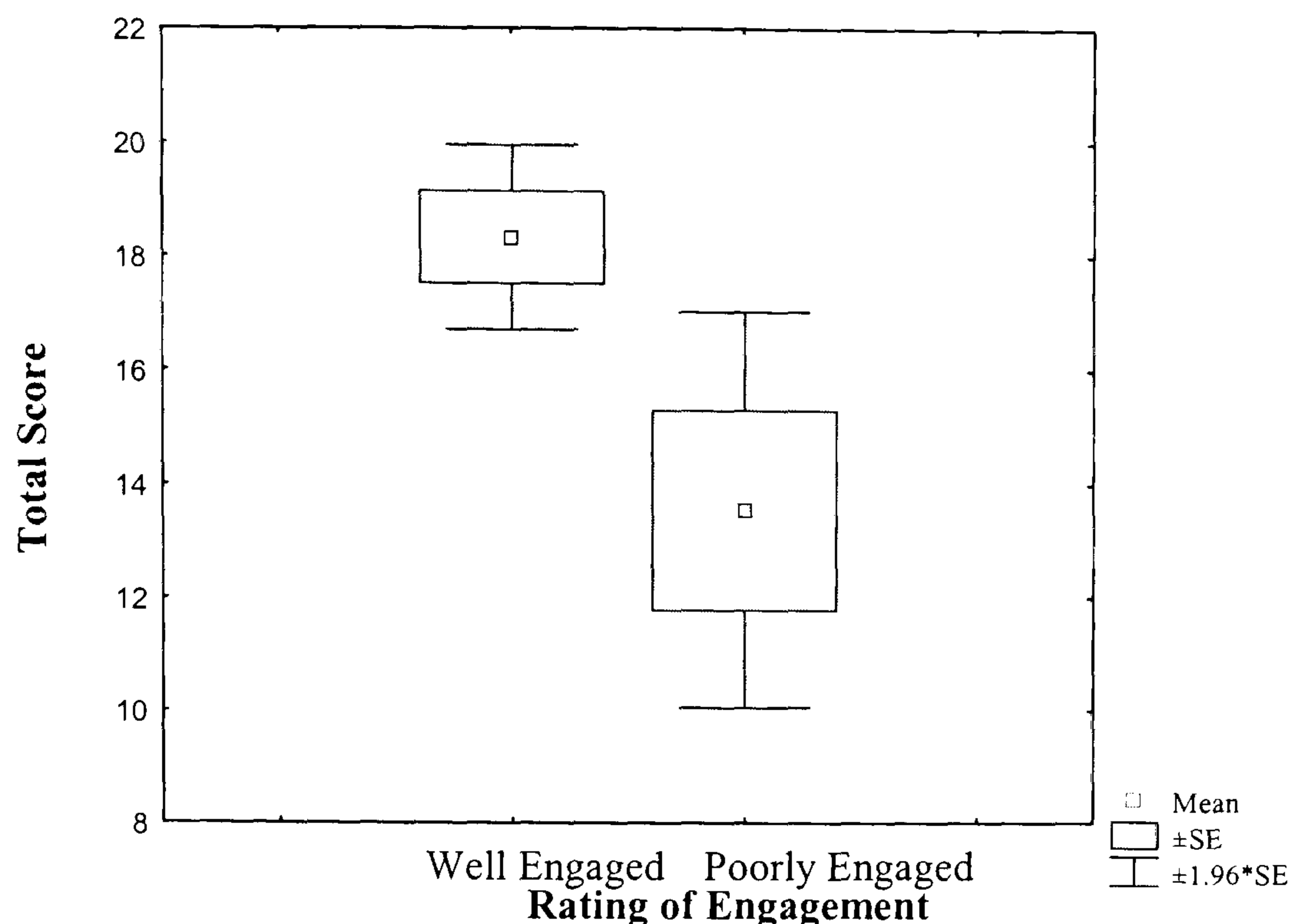


Figure 6: The difference between total scores on the BEM, when client engagement is classified as good or poor by the RMO.

Figures 4, 5, and 6 represent the difference between the total scores on each of the engagement measures when client engagement is classified as good or poor by the client's RMO. They show that whilst all of the measures appear to differentiate between these groups, the BEM shows less sensitivity to these differences than the SES or EM, as demonstrated by the overlapping whiskers.

## Discussion

All the questionnaires assessed (SES, EM and BEM) were found to be reliable measures of engagement with regard to their internal, inter-rater and test-retest reliability. As engagement is considered dynamic and therefore differences between ratings at two time points may reflect changes in engagement and not necessarily flaws in the measure, Cupitt et al. (2006) have questioned the utility of assessing test-

retest reliability. Furthermore, they also raise conceptual difficulties with assessing inter-rater reliability, as the measures talk in terms of a relationship with an individual clinician and not the team as a whole, a limitation of the measures in general as AOT is a specialist team approach.

Studies report that satisfaction, especially regarding client experiences of the therapeutic relationship and the active participation of clients in these relationships are essential to engagement (Bradley, Meaden, Tudway, Earl-Gray et al., 2006; Priebe et al., 2005), suggesting that a valid measure of engagement should be found to assess these factors. The present study found interesting differences between the measures when investigating their construct validity. With regard to nomological validity, the measures were found to be differentially related to factors thought to be associated with engagement, whilst all measures were related to participation, only the EM was additionally significantly related to satisfaction and helping alliance. Interestingly, Cupitt et al. (2006) raise some concerns regarding the association between satisfaction and engagement, suggesting that clients who are more engaged with services may feel more able to be open, and therefore communicate criticisms of services, and as such, reported dissatisfaction may not necessarily reflect poor engagement. Furthermore, in the analysis only the SES was significantly related to insight, something of perhaps lesser importance in light of the studies presented earlier, which failed to find a link between engagement and insight, however, caution should be expressed as these studies all used the same measure of insight, and as such, a different association may be found if an alternative measure of insight were to be used. It is also interesting to note that none of the measures were found to be significantly related to medication compliance, a factor which has previously been

found to be a weaker predictor of engagement (Meaden et al., 2004). Despite the differences between the measures regarding their nomological validity, all were found to significantly differentiate between well and poorly engaged clients as classified by an RMO.

### *Clinical Implications*

The studies originally introducing the questionnaires discussed the clinical utility of measuring engagement in terms of identifying clients at risk of disengaging with services (Tait et al., 2002), identifying specific dimensions of engagement requiring focused interventions (Hall et al., 2001) and evaluating change over time and the effectiveness of interventions (Cupitt et al., 2006). The findings of the present study suggest that the EM may be the most useful measure to use as, like the other measures it has been found to be reliable but, in addition, it has also been shown to be the most closely related to satisfaction, TA and client involvement in treatment. It also has good convergent validity with the RMO rating of engagement and good reliability. Furthermore, the scale contains 11 items scored on a 5-point likert scale suggesting that it may be more sensitive to change, however, this is yet to be formally assessed.

With regard to clinical implications, it is also useful to reflect on the perspectives of those clinicians involved in this study. Their preference was also for the EM, reporting that they considered it to be more comprehensive than the other measures, however, some awkward wording was noted. One item that they particularly struggled with concerned whether clients attended appointments with/without

support, as for some clients they were always visited at home. The clinicians also reported that they found the BEM to be very brief, with a number of problems identified with the items, for example regarding negotiating treatment. Clinicians stated this item was ambiguous, as it could mean clients being actively involved in treatment planning or that a client was trying to disengage with the service. Finally, the SES was reported to be repetitious and medically focused, omitting aspects of the relationship regarding the ability of the client to openly engage with the service and discuss how they were feeling.

### ***Research Implications***

Although the current paper goes some way to addressing the lack of psychometric validation for the engagement measures studied, further analysis would be beneficial, specifically with regard to the predictive validity of the scales. Furthermore, little is known about how sensitive to change these measures are. As the AOT approach is designed to improve engagement, and these questionnaires may be used to evaluate the effectiveness of interventions or as outcome measures, it is important that they are able to detect even small changes in the engagement of individual clients with teams and as such this is a potential area for further research.

There is a conceptual limitation with the current engagement measures as they only investigate the relationship between the client and an individual clinician, as opposed to the whole team, something of importance when thinking in terms of the MDT approach in AOT. It may therefore be useful to consider the possibility of adapting the current measures or at least comparing the validity of the current measures to a

measure recently developed to assess the ability of adult mental health services to meet client's attachment needs; the Service Attachment Questionnaire (SAQ), (Goodwin, Holmes, Cochrane, & Mason, 2003), which includes items that seem to correlate with the construct of engagement as previously described (Bradley, Meaden, Tudway et al., 2006).

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## **Chapter 3: Brief Empirical Paper**

### **What do service user views tell us about engagement?**

Chapter word count: 3083

(excluding: abstract, 173; illustrations, 198 & references, 710)

## **Abstract**

### **Background**

Research has identified greater client engagement and satisfaction with Assertive Outreach Teams (AOT) as opposed to Traditional Case Management (TCM) although, to date, qualitative exploration of service-user views of engagement is limited.

### **Aims**

The present study explored engagement from the perspective of service-users, from a semi-rural area of the UK with a team that has high fidelity to the AOT model.

### **Method**

Five clients participated in a focus group, transcripts of which were analysed using thematic analysis.

### **Results**

Four themes emerged: Feeling treated like a child, Feeling treated like an individual, Appreciating the supportive elements of the relationship and Valuing treatment and care. Both AOT and TCM received negative comments regarding Feeling treated like a child, but positive comments in the other categories were mainly reserved for AOT.

### **Conclusions**

The findings suggest that existing measures of engagement, coupled with reported satisfaction with AOT, could mask negative aspects of the approach as experienced by clients, thus reducing the identification of problems in service delivery.

### **Declaration of Interest**

None

**Keywords:** assertive outreach, engagement, service-users

## Introduction

Assertive Outreach Teams (AOTs) were established to provide services to clients presenting with complex mental health needs, who had previously disengaged with services. This model of care delivered by multidisciplinary teams emphasises an intensive yet flexible community-based approach, designed to facilitate engagement.

Engagement is a complex multidimensional concept; it refers to the active nature of the relationship between clients and services, including affective, attitudinal and behavioural elements, where collaboration and a strong therapeutic alliance are central (Bradley, Meaden, Tudway, & Jones, 2006). Attempts at measurement include clinician-scored (e.g. Hall, Meaden, Smith, & Jones, 2001; Tait, Birchwood, & Trower, 2002; Wolfson & Cupitt, 2001) and client-scored (Gillespie, Smith, Meaden, Jones, & Wane, 2004) questionnaires. Each, to some degree assess: Appointment keeping, Client-therapist interaction, Collaboration and Openness, Active level of participation, Client perception of the usefulness of treatment and Compliance with treatment, however, these measures have been developed by clinicians and may not fully assess the construct of engagement (Tait et al., 2002). Interestingly, Meaden, Nithsdale, Rose, Smith, and Jones (2004) found that some items on the Hall et al. (2001) measure were more related to outcome than others, particularly: Client-therapist interaction, Client's perceived usefulness of treatment, Openness and Collaboration. The weakest predictors were Compliance with medication and Appointment keeping, demonstrating the importance of psychological and relationship factors in the assessment of engagement (Meaden et al., 2004).

Furthermore, Prince, Demidenko and Gerber (2000) found that clients and clinicians ranked the most important and least liked aspects of AOT differently and, in comparing observer and client engagement scores, Gillespie et al. (2004) found that clients and clinicians ranked the importance of similar items differently and that some items were more significantly related to the total score than others. They also found a lack of correlation between clinician and client ratings at certain times and proposed that qualitative research be undertaken to explore what engagement means to clients and whether it differs from what engagement means to clinicians.

Recent client-based qualitative studies have predominantly used questionnaires scored on likert-type scales (e.g. Ben-Porath, Peterson, & Piskur, 2004; Caslyn, Morse, Klinkenberg, Yonker, & Trusty, 2002; Chue, Tibbo, Wright, & Van Ens, 2004; Gerber & Prince, 1999; Graham, Denoual, & Cairns, 2005; Samele, Gilvarry, Walsh, Manly, van Os, & Murray, 2002). Whilst reporting high satisfaction with the approach, especially regarding relationships with teams, this methodology provides limited qualitative information and depends on respondent motivation and literacy skills.

Other studies have adopted semi-structured interviews, often conducted by service-users (e.g. Beeforth, Conlan, & Graley, 1994; Graley-Wetherell & Morgan, 2001; Hayward, Ockwell, Bird, Pearce, Parfoot, & Bates, 2004). These studies also report that clients appreciate the model of working and the therapeutic relationship with staff, additionally, they highlight some dissatisfaction with some clients feeling forced to take their medication. Again, the questions used were originally developed by professionals thus limiting the potential for disclosure outside topics which they

believe to be important. Furthermore, these studies offer limited descriptions regarding their method of analysis, raising questions about reliability and validity.

Only one qualitative study has explicitly investigated disengagement and engagement; Priebe, Watts, Chase, and Matanov (2005) interviewed 40 clients, finding three factors related to client disengagement: Desire to be an autonomous and able person, Lack of active participation and poor therapeutic relationships, and Loss of control due to medication and its effects. Not being listened to was considered key to the breakdown of therapeutic relationships with staff and disengagement. They also identified three themes associated with engagement: Time and commitment, Social support and engagement without a focus on medication, and the Partnership model of therapeutic relationships. This inner-city study may not be representative of other services, however, where social circumstances and service delivery may differ from more rural teams. Furthermore as previously discussed, the depth of information collected can be limited when questions solely designed by clinicians are used, and the interview format may have left clients feeling pressurised, reducing their responses.

Recently, Krupa, Eastabrook, Hern, Lee, North, Percy, Von Briesen, and Wing (2005) using a focus group method, found that the AOT approach and relationships with the team improved community adjustment. They also identified a number of tensions regarding service delivery: the authoritarian and intrusive approach and the strict professional boundaries of some team members, however, as the participants came from small cities in rural Canada, and the authors failed to identify the team fidelity to the model, it is difficult to extrapolate these findings.

It appears that clinician-designed measures of engagement may not fully assess issues considered important by clients. Furthermore, a number of methodological factors have been found limiting the generalisability of the current studies investigating service-user views. The present study explores engagement from the perspective of service-users from a semi-rural area of the UK, with a team that has high fidelity to the model of AOT, using a robust focus group methodology.

## **Method**

### *Design*

An exploratory focus group was employed to gain an understanding of participant experiences, thoughts and feelings about their engagement with services, following the guidelines of Kitzinger, (1995), Krueger and Casey (2000) and Morgan (1997). Litosseliti (2003) reports that focus groups are less easily influenced by the researcher and are more able to explore views, particularly negative views, than one-to-one interviews (Kitzinger, 1995). Additionally, by using an explicit methodology and analysis trail it will be possible to demonstrate the study's reliability and validity (Elliott, Fischer, & Rennie, 1999).

### *Participants*

Five clients participated in this study, their demographic characteristics are given in table 11. Clients were excluded if they were unable to give informed consent, presented with active positive symptoms requiring extra services, if their care



coordinator considered that participation would be detrimental to their mental health or if they had been with the team for less than six months.

**Table 11: Participant characteristics.**

<i>Characteristic</i>	<i>No.</i>
Gender	
Male	4
Female	1
Age (years)	
Mean	37
Range	32-40
Diagnosis	
Schizophrenia	4
Schizoaffective Disorder	1
Time with AOT (Months)	
Mean	44
Range	24-58
Length of Psychiatric History (Years)	
Mean	10
Range	6-14

*Team Characteristics:* The AOT involved was an established multi-disciplinary team, operating with a case load of 8 clients per care-coordinator, working flexible hours over a 7 day week. Team fidelity to the AOT model was measured using the Dartmouth Assertive Community Treatment Scale (Teague, Bond, & Drake, 1998), with results indicating a high fidelity to the AOT treatment model (average item score = 4.5/5).

*Researchers Perspective:* The researcher SB completed the study as part of her doctoral training in clinical psychology, under the supervision of the authors JT, AM, & CJ. Having previously worked as an assistant psychologist in AO, SB developed an interest in researching the approach, particularly from the client perspective.

### *Procedure*

Clients who met the study criteria were approached by AOT staff on a routine contact, where informed consent was sought<sup>3</sup>. The 90-minute focus group was facilitated and tape-recorded by SB and ME-G, in a private room in a local community centre. The questions originally developed by SB, were reviewed and amended after discussions with the other authors. Following a funnel style (Litosseliti, 2003), they explored participant views about and behavioural responses to different services they had experience of, progressing to more specific questions regarding the AOT approach.

### *Analysis Trail & Reliability*

Transcript data was analysed using thematic analysis (Boyatzis, 1998). SB transcribed the focus group verbatim with the transcript highlighted independently by SB and ME-G to identify discussion that was relevant to the research question. SB identified themes from these sections, which were then grouped into major categories and compared to the original transcript data for accuracy and amended as appropriate. SB and ME-G then independently coded all sections of the transcript previously identified as relevant, using the themes developed by SB. Rater coding of the presence of the themes were then compared, with percentage agreement ranging from 55-86% agreement (based on the method described by Boyatzis, (1998) for expert-rater reliability<sup>4</sup>). Any discrepancies in coding were then discussed, until 100% agreement was achieved. The accuracy of the themes were also checked by three of

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<sup>3</sup> See appendices I and J for information and consent sheets for clients and staff involved in this study

<sup>4</sup> See appendices K and L for excerpt of transcript, coding frame and calculation of expert-rater reliability

the original focus group participants with the findings also triangulated with data obtained for another study (Bradley, Jones, Meaden, Tudway, & Wane, 2006), as suggested by Elliott et al. (1999) and Mays and Pope (1995). As part of this study, 17 clients who received their care from a different AOT were asked two open questions in a service satisfaction survey; ‘What do you like most about the service?’ and ‘What do you like least about the service?’.

## Results

Four main themes emerged about client experiences of services and their subsequent relationships with them.

**Table 12: Comparison of the occurrence of themes between AOT & TCM**

Major Category	Sub-theme	AOT		TCM	
		(No.)	(%)	(No.)	(%)
Clients feel treated like a child, as subordinate	Controlled	21	20	12	22
	<i>Positive</i>	20	19		
	<i>Negative</i>	1	1		
	Manipulated	6	6	3	6
	Depersonalised	4	4	5	9
Clients feel treated as an individual	Staff as judgemental	7	7	10	18
	Staff as disrespectful	3	3	10	18
	Staff as interested/respectful	7	7	4	7
	<i>Positive</i>			1	2
	<i>Negative</i>			3	5
Clients appreciating the supportive elements of the relationship	Equal, valued, heard	11	11	5	9
	<i>Positive</i>	10	10	1	2
	<i>Negative</i>	1	1	4	7
Clients valuing their treatment/care	Practical support	7	7	0	0
	Social/Emotional support	7	7	0	0
	Limited support	9	9	0	0
Clients valuing their treatment/care	Clinicians expertise	4	4	5	9
	<i>Positive</i>	2	2		
	<i>Negative</i>	2	2	5	9
	Satisfaction with service approach	16	15	1	2
	<i>Positive</i>	16	15		
<i>Negative</i>			1	2	

*(Some sub-themes included representations of both positive and negative instances of the code).*

*Clients feeling as if they are “treated like a child”, as subordinate.*

Several participants described feeling services “treated them like a child”, 40% of comments regarding the AOT were classified in this major-category, compared to 73% of comments regarding TCM. The majority of comments in this major-category were coded as *Controlled*, (forced to do things against their will, not ‘allowed’ to do things), with many of these comments regarding medication:

“I think with this medication thing, you know, they are forcing me to take medication I don’t want to take.” (AOT)<sup>5</sup>

An equivalent percentage of the total codeable comments were categorised as *Manipulated* (taken advantage of, deceived) for both types of case management.

“I think they tend to get the wool pulled over their eyes more...I’ve just noticed that some of the people who are more ill...they get treated like unfairly more.” (TCM)

Both types of case management were coded as being *Depersonalising* (as if their illness is their identity).

“...they see people coming in and out of hospital and its kinda [sic] like a production almost....they see so many people...they don’t seem to accept that

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<sup>5</sup> Quotations are attributed to services if it is not explicit in the text to which service the quotation is referring.

people are different...I think they tend to overlook people's individuality..."

(TCM)

Experiencing *Staff as judgemental* (dismissive of their views, e.g. pathologising) accounted for 18% of the comments regarding TCM as opposed to 7% of the comments regarding AOT.

"I was just thinking about something I said to one of the nurses at the hospital once and she, she sort of floated in and I said you look like something off Star Trek, you look like a space priestess or something and later on in ward round she said Ooh, you've got issues, she made it into this whole big thing you know, it was just sort of a comment."

18% of comments regarding TCM were coded as *Staff as disrespectful*, (rude towards clients or using humour inappropriately) in comparison to 3% of comments regarding AOT.

"I'd say 'who's taking me back?', 'oh you're going in the boot'. I didn't find it very funny..." (AOT)

"...when the nurses were in the office with the door open you could hear them all over the ward taking the piss out of the patients, you know like, you know really unprofessional, you could hear them in there, women nurses talking about their sex lives, you could hear it all over the bloody ward, they were really...snotty with patients. I thought they were really bad news."

***Clients feel treated as an individual***

Although the percentage of total comments for this category was not dissimilar between the two types of case management, those regarding TCM were negative, as opposed to the positive comments expressed regarding AOT.

***Staff as interested and respectful.***

“...everyone I’ve met in the Outreach Team, like they treat you with respect. They don’t treat you like an idiot, or like a little kid or something.”

***Feeling heard by services, (having a close relationship with staff).***

“We’ve kind of got to this stage where we are more friends than you know nurse and patient.” (AOT)

***Clients appreciating the supportive elements of the relationship.***

These comments were all regarding the AOT approach.

***Practical Support.***

“Yeah, she’s helpful isn’t she, she cleaned my bathroom out for me.”

*Social Support.*

“They are really helpful, the outreach team are. They take you out for outings, swimming, the art group and things. It gives me something to do.”

*Limitations of Support.*

“On the whole I’ve had a lot of support from the nurses...and I’ve got quite close to them, but I think it is difficult because they obviously have to keep a professional relationship with you and so you always feel as though you can’t quite close those boundaries, you know become real friends.”

*Clients valuing their treatment/care.*

Overall, the participants expressed more satisfaction with the AOT approach.

*Clinician’s expertise.*

“...she’s a slightly older woman, you know she’s got experience, I respect her.”

(AOT)

“I just don’t think they are sort of trained enough in that area to understand.”

(TCM)

*Satisfaction with service approaches.*

“...the last few years I’ve got better, and it is all down I think to the outreach team you know, having more visits you know, right down from the doctors to the support workers you know.”

*Post analysis discussion with participants.*

Three of the original focus group participants were available to comment on the analysis. All agreed with the coding frame as it was presented. One participant stressed ‘*Clients feeling treated like a child, as subordinate*’ was not relevant to his experiences of the AOT at all, stating that they treated him “more maturely”.

*Triangulation with Bradley, Jones et al. (2006).*

All of the responses to the questions ‘What do you like most/least about the service?’ were able to be coded using the coding frame developed on the focus group data. Responses regarding what was liked were coded as ‘*Staff as interested and respectful*’, ‘*Feeling equal valued and heard*’ and clients appreciating the ‘*Practical*’ and ‘*Social/emotional*’ support:

“My CPN she is very friendly, very helpful and the rest of the team are understanding and caring...without their help and support I feel my life would not be, or it would be very poor.”



Responses regarding what was least liked were coded as *'Limited support'*, and concerned the availability of team members.

“There is nobody there to help when I phone.”

## **Discussion**

Broadly consistent with the studies previously presented, it is interesting to reflect on the importance of the clinician's style of interaction with clients and how, when following non-directive, client-centred principles (e.g. Rogers, 1951), in terms of the 'core conditions' of being accepting, genuine and empathic, positive relationships are fostered (for a fuller description of the approach see Mearns & Thorne, 2002). Whilst holding this theory in mind, it is also interesting to note the number of negative themes regarding the different approaches to case management, and in particular the experience of the AOT as controlling, and the subsequent negative impact of this experience on engagement. This is especially important as Priebe et al. (2005) reported that feeling controlled and depersonalised was key to service disengagement. Whilst the greater satisfaction with the AOT can be attributed to specific characteristics of the model, it is interesting to consider how the experience of AOT as coercive is reflected in the current measurement of engagement.

The existing measures contain items concerning aspects of engagement broadly categorised as clients adhering to service goals (e.g. being available for appointments and taking their medication) and clients being actively involved in treatment (e.g. being open and collaborating with treatment). It appears therefore that on this

'involvement' level, the existing measures register something important to clients, however, total engagement scores also include items that could be considered to measure 'adherence'. It would therefore seem that the current questionnaires do not fully reflect that which is important to clients, or rather they do, but adherence due to coercion is counted positively and as such high engagement scores may be partially attributable to 'adherence' and not solely 'engagement'. Furthermore, the current measures do not assess some aspects of service delivery which the present study has identified as being important, for example, there is little reflection in the current measures of client choice.

### *Limitations*

It is possible that the idiosyncrasies of the single focus group could explain the findings (Litosseliti, 2003), and as those who were more engaged with the service were more prepared to participate, it may not be possible to extrapolate the findings beyond those involved.

SB had previously worked with the team and was known by the group members. Whilst it was considered that this may have reassured some participants, others may have perceived this as a potential compromise to confidentiality, restricting their contribution to the group. Additionally, the participants were acquaintances, however, Stewart and Shamdasani (1990) found only modest effects of this on group discussions.

Finally, using a focus group methodology enabled the participants to lead more of the discussion, with the researcher not asking all the planned questions as the topics had already been covered. There is the possibility through the questions that did exist and through the researchers own experience impacting on the analysis, that the findings may be open to bias.

### ***Future Research and Clinical Implications***

The study demonstrates the utility of conducting focus groups with this client group, particularly in accessing negative views (Kitzinger, 1995). The findings suggest that how clients experience the service is not always reflected by current measures of engagement and that overall satisfaction and engagement may mask some negative aspects of service delivery. It is recommended that additional research is undertaken to explore this issue further using a larger sample, although the findings are broadly consistent with earlier large scale studies, perhaps questioning the need for large-scale studies when researching qualitative aspects of services.

Based on the current findings, modifications to how engagement is measured are suggested, with engagement scored on a sliding scale, going from avoidance through passive compliance to active involvement. Furthermore, it is important to investigate the level of choice, whether the clients feel listened to and whether their views are taken into account, with a view to developing a measure with clients, for clients (previously suggested by Tait et al., 2002).

Despite overall satisfaction with the AOT approach, the study identified a number of negative experiences regarding the service, leading the authors to suggest that teams participate in recurrent training to remain faithful to the model ideals of staff-client collaboration. It may also be beneficial for training to focus on clinicians developing skills in the client-centred 'core conditions' of acceptance, empathy and genuineness (Mearns et al, 2002), and in developing skills in attending, active listening and communicating understanding through empathy (Egan, 1998). It is perhaps also interesting to consider training regarding appropriate boundary keeping, as whilst clients report that they welcome relaxed boundaries, the maintenance of professional boundaries are essential for safe, productive therapeutic relationships. In addition, management must support teams in following the model if they are to continue to intervene in ways that have made them successful at engaging clients in therapeutic working relationships.

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## **Chapter 4: Reflective Review**

# **Can Clinical Psychologists retain Professional Therapeutic Working Relationships when working within an Assertive Outreach Team?**

Chapter word count: 1982

(excluding: abstract, 25 & references, 320)

**Abstract**

Using the literature and personal reflections, this paper explores how the traditional therapeutic boundaries of clinical psychologists are challenged when working in Assertive Outreach Teams.

## Introduction

Assertive Outreach Teams (AOTs) are specialist teams intended to work with clients who require intensive and sustained efforts, using creative and flexible approaches to engage them in treatment. The Mental Health Policy Implementation Guide (Department of Health, DoH, 2001) defines the British model of AOT. It describes key features of the approach as extended hours of service and multi-disciplinary interventions including: assertive engagement, support with daily living skills, crisis intervention and medication home delivery. This new way of working for psychologists challenges their traditional bounded approach to interventions, and requires careful reflection in order to adapt working practices to facilitate engagement without reducing their therapeutic nature. It is interesting to consider that Topor, Borg, Mezzina, Sells, Marin, and Davidson (2006) found that a common factor for clients in their recovery, was a relationship with a clinician who broke the rules and did something different, something more than what their traditional role required and what was expected of them. Recent studies exploring service-user views of AOT have reported that how clients experience the therapeutic relationship with clinicians is central to their engagement with services, with clients even coming to view some clinicians as friends (e.g. Bradley, Meaden, Tudway, Earl-Gray, Jones, Giles, & Wane, 2006; Hayward, Ockwell, Bird, Pearce, Parfoot, & Bates, 2004; Priebe, Watts, Chase, & Matanov, 2005).

In recent years there have been a number of articles considering the role of clinical psychologists in AOTs (Cupitt, 1997; 2001; Meddings & Cupitt, 2000; Yates, 2004), with a briefing paper newly prepared for the British Psychological Society (Cupitt,

Meddings, Amphlett, & Thomas, in press). The following article considers the impact of altering professional boundaries in order to facilitate engagement, drawing upon the above papers and my own clinical experience of working as both an assistant psychologist and a third year trainee clinical psychologist, in two different AOTs.

### **Working as an integrated team member**

Being a fully integrated AOT member is desirable if psychologists are to maximise their effectiveness at inputting into care plans, team client-centred formulations, and providing a psychological perspective on such issues as challenging behaviour and risk (Cupitt et al., in press). It has been argued that these activities are facilitated if the psychologist works flexibly alongside other colleagues in the community, through which they can be seen to be accessible and approachable.

### ***Balancing Generic and Specialist Interventions***

In AOTs some psychologists are also expected to partake in generic working. Focusing on practical needs identified by clients, these interventions often involve supporting clients in activities of daily living, providing advocacy and befriending. Consequently psychologists can become involved in helping with housework and having lunch with clients. Through these activities it has been suggested that clients can be introduced to psychological ideas that may facilitate subsequent engagement in more focused interventions (Cupitt et al., in press), whilst also providing an opportunity to build trusting relationships with the team (Cupitt, 1997).

From my own experience of this more informal generic approach I have been able to form relationships with clients that appear to have enabled them to be more open with me. Actually being there alongside someone when they have been distressed has been a useful process for developing relationships. Working in this way is not without drawbacks, however, as it can be hard for clients to separate focused and generic interventions. This is something of increased importance when working with sensitive issues that need to be addressed in a more contained setting and manner. There is also a broader concern around this approach to service delivery in terms of creating dependency, and that a loss of fidelity in psycho-social interventions may reduce their effectiveness. Burgess (2006) explores the balance required by clinicians: the risks of being too boundaried, under-involved and as such neglectful of the essential needs of clients, and being over-involved, enmeshed in relationships and at risk of undertaking activities with clients for the clinician's own gratification.

Yates (2004) conducted a survey of 34 psychologists working in AOTs from the Network of Psychologists in Assertive Outreach (NPAO) and found that whilst reduced clarity of roles can allow for increased flexibility and creativity, it may also lead to feelings of uncertainty and concern over the under-use of clinical skills. From my own experience this seems to be a particularly challenging issue for psychology, and the other minority disciplines working in AOTs where, due to lower numbers, they are unable to partake in equivalent amounts of generic work. Furthermore, whilst initially being involved in engaging clients, once established, the psychologist may need to pull-back and focus on more specific interventions (Cupitt et al., in press). Team members (often under pressure due to limited resources) may not appreciate the need for this and most importantly the client may not either,

particularly if they have come to see the psychologist as offering support and friendship. Burgess (2006) suggests that it may therefore be useful for clinicians to actively discuss and model appropriate boundary setting with clients, particularly in terms of being 'friendly professionals and not professional friends', and by openly acknowledging the power differentials in the relationship.

### *Care Coordinating*

This can be a challenging role when trying to provide specific psychological interventions with someone for whom you are the care-coordinator. Cupitt et al. (in press) suggest that where psychologists are care-coordinators, they carry a smaller caseload than other team members to ensure that they have enough time to work with other clients on the team caseload. They also suggest that allocation of clients is negotiated to reduce the potential conflict of interests between their different roles. Furthermore, clinical psychologists receive no explicit training to deal with housing or benefit issues or managing acute crises; making them ill-equipped for this role. This skills-deficit is something that Yates (2004) also reports, suggesting that extra training be provided in order for psychologists to fulfil these roles.

### *Community Sessions*

As previously discussed, there can be a number of advantages to seeing clients in community settings and meeting clients in their own homes can be essential for some, however, this is less contained, particularly when exploring traumatic experiences. Cupitt et al. (in press) discuss that, whilst the traditional clinic room may not be

accessible for clients, it need not always be the client's home where they are seen. Other, more neutral locations can be used that are separate, safe and free from distractions, however, confidentiality can still be difficult in such circumstances where the informal settings can limit what is shared.

Working in this way also requires reflection in terms of issues around power imbalances, in particular when clients experience services repeatedly attempting to make contact with them, often in their own home or under section of the Mental Health Act (1983), thus potentially contravening client choice and consent to treatment.

### ***Delivering Medication***

Psychologists in AOT can be requested to deliver medication. This is a very complex issue; on the one hand if the client finds medication beneficial then delivering medication can be helpful to both the client and the team, however, if the client struggles with pharmacological treatment, seeing the psychologist aligned with this, can potentially limit their openness and willingness to engage in psychological interventions. This issue is discussed in research exploring user views of services, where clients have reported sometimes feeling forced to take their medication by AOTs (e.g. Bradley et al., 2006; Hayward et al., 2004; Priebe et al., 2005). In my own experience I have sometimes been a client's most regular contact with the team, and it has seemed appropriate for me to deliver their medication. Nevertheless our sessions continued work towards the client developing psychological strategies to reduce the need for medication. For other clients who struggle with medication, it has

been helpful that I can say that psychologists do not prescribe. This is an issue which requires careful reflection. For many colleagues and clients medication is perceived negatively, whilst for some the beneficial effects out-weigh any side effects. Clearly the merits of medication must be considered on individual need and an individually tailored, psychotherapeutically orientated need-adapted approach should always be adopted (Alanen, 1997).

### ***Confidentiality***

The nature of the team approach, working closely with colleagues and with client's families and carers requires a high level of information sharing, particularly as teams operate shared caseloads and shared notes. This challenges the traditional highly confidential nature of psychological work. For me the sharing of some information is highly beneficial; indeed the advantages of sharing information and supporting teams develop client-centred formulations and the benefits of the team being aware of early-warning-signs and relapse-plans is clear. There are, however, times when consideration needs to be given to 'who needs to know' some information, for example around the specific details of past trauma and when clients explicitly request that colleagues are not informed. This issue can be exacerbated by MDT working, where different disciplines may have different philosophies, training and practices around the sharing of confidential information. Based on my own experience, some information can be reported in shared notes, but teams and trusts need to have clear documenting procedures in place for highly sensitive information and process notes.



### *Self Disclosure*

Working within the AOT model often calls for increased self-disclosure. Perkins and Dilks (1992) note that when working with clients presenting with severe social disabilities, who often have few other close relationships, some sharing of information facilitates the formation of therapeutic relationships. Based on this principle, a number of teams now include consumer employees to facilitate engagement (Craig, Doherty, Jamieson-Craig, Boocock, & Attafua, 2004). Clients served by AOTs are often suspicious of professionals and it is considered that self disclosure may facilitate a more open trusting relationship, however, this has implications for some theoretical models, as the psychologist is no-longer a 'blank-slate'. As ever, boundaries are essential to protect both the client and the clinician, and should be reflected upon in individual and team supervision. Cupitt et al. (in press), even suggest that these discussions are documented. My own experience of self disclosure, intended to help clients view me as fallible and not the 'expert,' has helped to normalise some of the client's own thoughts and experiences. During this process it has been important for me to use supervision to reflect on the reasons behind disclosure, to ensure that there is therapeutic value for the client.

Through my own experience I have also been challenged to reflect on the different professional boundaries of colleagues who have given clients personal contact details, and socialised with clients outside of their working role. At times clients have also told me that they have not discussed problems with colleagues, as they know they are going through difficult times themselves. Whilst the client may appreciate the openness of the clinician, clients need to feel that they can be open with the team,

particularly in times of crisis. Through raising these issues with teams, I hope that colleagues have been able to reflect on the potential impact of their actions on the therapeutic nature of their relationships with clients.

A further interesting dynamic can be personal boundaries with team members. From my own experience of working in AOTs, the teams have been very close, often socialising together, however, this raises issues regarding professional boundaries with colleagues. This is particularly pertinent for psychologists who often have multi-dimensional roles, providing training and supervision to colleagues, which requires that they are able to be objective and containing.

## **Conclusions**

Working as a clinical psychologist in AOTs poses a number of challenges to traditional boundaried working practices. Through reflection, supervision, following guidelines and peer support (such as that provided by the NPAO), working in these more relaxed ways can facilitate both client and colleague engagement in psychological approaches, and as such, clinical psychologists *can* retain professional therapeutic working relationships when working within an AOT. Furthermore, as illustrated there is a role for psychologists to play in supporting colleagues to reflect on these issues; through team work, training and supervision.

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## **APPENDIX A:**

### **LITERATURE SEARCH TERMS AND STRATEGY**

Literature Search performed using Dialog Datastar Web.

Databases searched:

- Allied and Complementary Medicine 1985 to date
- British Nursing index 1994 to date
- DH-DATA 1983 to date
- EMBASE 1974 to date
- King's Fund 1979 to date
- MEDLINE 1951 to date
- CINAHL 1982 to date
- PsychINFO 1806 to date

Following initial literature searches, abstracts were obtained and articles screened for suitability. Those considered relevant were obtained in full-text. In addition to the electronic literature searches undertaken, additional relevant articles were sought based on the reference sections of those articles originally identified as suitable for inclusion. Furthermore, 'engagement' was entered as a key term into an automatic update website, (<http://journalsonline.tandf.co.uk>) which emailed monthly notifications of potentially relevant articles published during the course of the research

Search Terms:

	<i>AND</i>	<i>AND</i>
Assertive OR Intensive OR Active	Outreach OR Community Treatment OR Case Management	Acquiescence OR Adherence OR Agreement OR Alliance OR Appointment Keeping OR Avoidance OR Collaboration OR Communication OR Compliance OR Concordance OR Conform OR Contact OR Engagement OR Help Seeking OR Involvement OR Openness

**APPENDIX B:**

**LONDON MULTI-SITE RESEARCH ETHICS COMMITTEE  
APPROVAL LETTER**





**London MREC**  
The Old Refectory  
Central Middlesex Hospital  
Acton Lane  
London  
NW10 7NS

Telephone: 0208 453 2336  
Facsimile: 0208 453 2488

06 June 2005

**Ms Sally Bradley**  
Trainee Clinical Psychologist  
Coventry & Warwick Doctorate in Clinical Psychology  
School of Health and Social Sciences  
University of Coventry  
Coventry  
CV1 5FB

Dear Ms Bradley

**Full title of study:** Engagement with assertive outreach services: What is engagement and what is the best way to measure it?  
**REC reference number:** 05/MRE02/23

Thank you for your letter of 20<sup>th</sup> May 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice Chair, in consultation with one member.

#### **Confirmation of ethical opinion**

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

However, it was requested that the title for the Team Consent Form for both the main study and the pilot study be replaced with the title "Consent Form for Staff", in line with the revised Information Sheet for Staff.

#### **No local investigator status**

The Committee agreed with your declaration that this is a "no local investigator" study. Site-specific assessment is not required for sites involved in the research and no information about the study needs to be submitted to Local Research Ethics Committees. However, you should arrange for the R&D Departments of all relevant NHS care organisations to be notified that the research will be taking place before the research commences.

#### **Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

#### **Approved documents**

The documents reviewed and approved at the meeting were:

*The Central Office for Research Ethics Committees is responsible for the operational management of Multi-centre Research Ethics Committees*

Document	Version	Date
Application	1	29 March 2005
Investigator CV	CV for Ms Sally Bradley	(None Specified)
Protocol	2	29 March 2005
Covering Letter	Letter to Ms Cox from Ms Bradley	29 March 2005
Peer Review	Comments from two peer reviewers	(None Specified)
Compensation Arrangements	Letter from Dr Cushway	10 January 2005
Interview Schedules/Topic Guides	Draft Focus Group Schedule Version 1	13 May 2005
Copy of Questionnaire	Engagement Measure - Observer Version (Hall, Meaden, Smith & Jones 2001)	(None Specified)
Copy of Questionnaire	Engagement Measure - Observer Version (Tait, Birchwood & Trower 2002)	(None Specified)
Copy of Questionnaire	Bexley Engagement Measure (Wolfson & Cupitt March 2001)	(None Specified)
Copy of Questionnaire	The Helping Alliance Questionnaire - Therapist Version	21 February 1997
Copy of Questionnaire	Response to Care from FACE 2000	(None Specified)
Copy of Questionnaire	Engagement Measure - Client Version (Hall, Meaden, Smith & Jones 2001)	(None Specified)
Copy of Questionnaire	Insight Scale	(None Specified)
Copy of Questionnaire	The Client Satisfaction Questionnaire (Larsen, Atkinson, Hargreaves & Nguyen, 1979)	(None Specified)
Participant Information Sheet	Staff Information Sheet Version 2	12 May 2005
Participant Information Sheet	Volunteer Information Sheet - Pilot Study Version 3	13 May 2005
Participant Information Sheet	Volunteer Information Sheet Version 3	12 May 2005
Participant Information Sheet	Staff Information Sheet - Pilot Study Version 2	12 May 2005
Participant Consent Form	Client Consent Form Version 2 Pilot Study	29 March 2005
Participant Consent Form	Team Consent Form Version 1 Pilot Study	29 March 2005
Participant Consent Form	Client Consent Form Version 2	29 March 2005
Participant Consent Form	Team Consent Form Version 1	29 March 2005
Response to Request for Further Information	Letter to Ms Cox from Ms Bradley & Responses to Concerns Raised by the London MREC	20 May 2005
Other	Guide to Questionnaires	29 March 2005
Other	Letter from Mr David Soley	(None Specified)
Other	Response to London MREC Concerns	29 March 2005

#### Management approval

You should arrange for all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research at a NHS site must obtain management approval from the relevant care organisation before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

#### Notification of other bodies

The Committee Administrator will notify the research sponsor (Optional) and the R&D Department for NHS care organisation(s) that the study has a favourable ethical opinion.

#### Statement of compliance

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

05/MRE02/23

Please quote this number on all correspondence

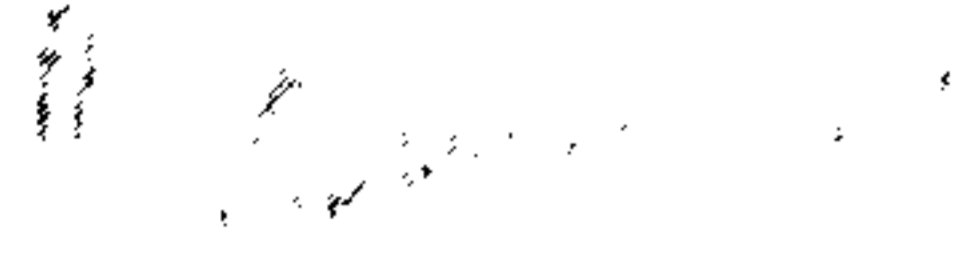
SF1 list of approved sites

05/MRE02/23

Page 3

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

Yours sincerely



**Dr John Keen**  
**Vice Chair**

Email: [louise.cox@rwlh.nhs.uk](mailto:louise.cox@rwlh.nhs.uk)

Enclosures

Standard approval conditions

SI 1 list of approved sites

## **APPENDIX C**

### **SOUTH WARWICKSHIRE NHS PCT RESEARCH & DEVELOPMENT APPROVAL LETTER**



C/o South Warwickshire PCT  
Westgate House, 21 Market Street  
Warwick, CV34 4DE  
DDI: 01926 493 491 ext 252  
[rd.office@swarkpct.nhs.uk](mailto:rd.office@swarkpct.nhs.uk)

5 July 2005

Ms Sally Bradley  
Trainee Clinical Psychologist  
School of Health & Social Sciences  
University of Coventry  
Coventry  
CV1 5FB

Our ref: SWA140205SM

Dear Ms Bradley

I am pleased to confirm that South Warwickshire PCT have reviewed the research entitled "Engagement with Assertive Outreach services: What is engagement and what is the best way to measure it?" and give approval for this study to take place within the Trust. Your research has been entered into the Trusts' database (if applicable this will be entered onto the National Research Register) and will appear on the PCT website.

Please reply to this letter confirming the expected start date and duration of the study. As part of the Research Governance Framework it is important that the PCT are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. We may also request brief updates of your progress from time to time, dependent on duration of the study. Similarly, if at anytime details relating to the research project or researcher change, the R&D department must be informed.

If you have any further questions regarding this or other research you may wish to undertake in the Trust please feel free to contact me again. The Trust wishes you success with your research.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Helen Williams', is written over a faint circular stamp.

Helen Williams  
R&D Office – West Midlands South Joint PCT RM&G

**APPENDIX D:**

**BIRMINGHAM AND SOLIHULL MENTAL HEALTH TRUST  
RESEARCH & DEVELOPMENT APPROVAL LETTER**

**Birmingham and Solihull**   
Mental Health NHS Trust

Research and Development Unit  
Queen Elizabeth Psychiatric Hospital  
Mindelsohn Way  
Edgbaston  
Birmingham  
B15 2QZ

Tel: 0121 678 2123  
Fax: 0121 678 2655

Ms Sally Bradley  
Trainee Clinical Psychologist  
Coventry & Warwick Doctorate in Clinical Psychology  
School of Health and Social Sciences  
University of Coventry  
Coventry  
CV1 5FB

3<sup>rd</sup> October 2005

Dear Ms Bradley,

**Re: "Engagement with assertive outreach services: What is engagement and what is the best way to measure it?"**

Thank you for returning your completed Trust Research Application Form for the above project. This research has now been approved by the Director of Research & Development and we have notification of favourable ethical opinion. You may therefore commence the work.

Please note that the Trust's approval of this research is given on the understanding that you are aware of and will fulfil your responsibilities under the Department of Health's *Research Governance Framework for Health and Social Care*, including complying with any monitoring/auditing of research undertaken by the Research & Development Unit.

Please do not hesitate in contacting the Research & Development Unit should you require any advice or support on any aspect of your project. When contacting us it would be helpful to quote our reference number for this project: **721**.

With best wishes  
Yours sincerely,



Theresa Morton  
Research Manager

Chair: Dr Jonathan Shapiro Chief Executive: Sue Turner


**BIRMINGHAM & SOLIHULL  
MENTAL HEALTH NHS TRUST**

**APPROVAL**

In conducting this research I agree to abide by the policies and procedures of  
Birmingham & Solihull Mental Health NHS Trust.


I am aware of and will fulfil my responsibilities under the  
Department of Health's Research Governance Framework for Health and Social Care,  
including complying with internal and external monitoring of my project.

Name of applicant: Ms Sally Bradley

Signature: 

Date: 1/2/05


Name of supervisor\*/manager: Dr Jeremy Tudway

Signature: 

Date: 3 2 05.

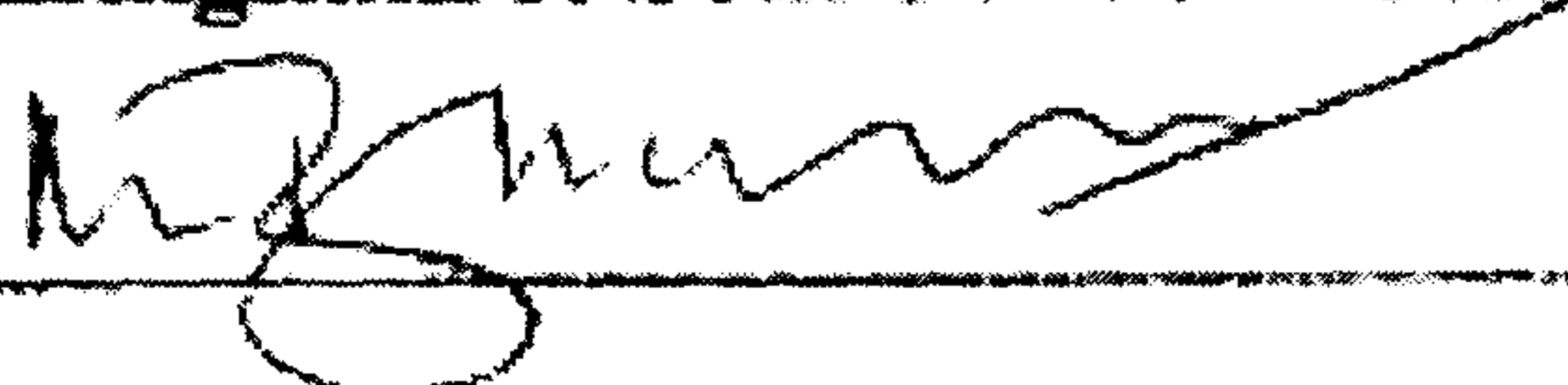
\*Supervisors from Universities are asked to complete the declaration overleaf

**Approved by the Programme Lead:**

  
\_\_\_\_\_

Date 1.8.05

**Approved by the Director of R&D on behalf of  
Birmingham & Solihull Mental Health Trust:**

  
\_\_\_\_\_

Professor Max Birchwood, Director of R&D

Date 6/9/05



**APPENDIX Ei:**

**INFORMATION SHEET FOR MAIN EMPIRICAL PAPER**

**CLIENT VERSION**

Programme Director  
Doctorate Course in Clinical Psychology  
Dr Deborah Hall  
BA (Hons) & PhD MPP (National Defence)  
School of Health and Social Sciences  
Coventry University  
15, Spon Street, Coventry, CV4 7EB  
Telephone: 0247645 9422  
Fax: 0247645 9397



COVENTRY  
UNIVERSITY

**Engagement with Assertive Outreach Services: Coventry**  
**What is the best way to measure it? A Pilot Study Warwick**  
**Volunteer Information Sheet**

Version 3: 12/05/2005

Ref No: 05/MRE02.23

You are being invited to take part in a research study. Before you decide it is important to explain why the study is being done and what you will have to do. Please take time to read the following information carefully and discuss it with others if you wish and ask if there is anything that is not clear, or if you would like more information.

**Thank you for reading this.**

**Title:** Engagement with Assertive Outreach Services: What is the best way to measure it?

**Who is running the study?**

Sally Bradley is a Trainee Clinical Psychologist on the Coventry and Warwick Doctoral Programme in Clinical Psychology. Sally is running the study and is being supervised by staff from Birmingham and Coventry Universities and by two Clinical Psychologists who work with Assertive Outreach Teams.

**What is the aim of the study?**

The aim of the study is to compare three questionnaires about client engagement with Assertive Outreach Services.

**Do I have to take part?**

You do not have to take part in this study, if you want to, you will be asked to sign a piece of paper to show that you understand and agree to take part. Even if you want to take part now you are still free to

stop, at any time and do not have to give a reason. Your decision will not affect the service you receive in any way.

**What do I have to do?**

You will have to complete some questionnaires at a time and place that suits you. This should not take more than one-hour. If you want, this can be done in more than one session. An envelope is provided for you to place the finished questionnaires in, so no-one else can see your answers. These answers will be confidential and only the researcher and their supervisor will see them.

The researcher will also collect some basic information about your medical history and appointment keeping.

**What are the possible disadvantages of taking part?**

It is unlikely that there are any disadvantages to taking part in this study, however, if you do get upset when filling-in the questionnaires, the assertive outreach team will give you support.

**What are the possible advantages of taking part?**

The results of this study will give the Assertive Outreach Teams information that they can use to make the service better.

**What happens to the information?**

All information is confidential once collected, it will be entered onto a computer that is kept in a secure, locked room at the University. This computer is protected by a password that only the researcher knows. Volunteers for the study, will be identified by a computer reference number only. This study is part of a Doctorate in Clinical Psychology and the results will be analysed and written up as part of a thesis and may also be published in a professional psychology journal. The results will also be given to the Assertive Outreach Teams involved in the research. If individual clients taking

part in the study wish to receive a copy of the results, these will be sent to them. At the end of the study, all paper copies of individual responses will be destroyed.

**What do I do if I wish to make a complaint?**

If you have a complaint about the research then you can contact the assertive outreach team, the researcher, the research supervisors or Dr Delia Cushway, Programme Director (024 76888328).

**Contact for further information**

Researcher: Sally Bradley

Doctoral Programme in Clinical Psychology

Coventry University

Priory Street

Coventry

CV1 5FB

024 76 888328

**Academic Supervisors:**

Dr Jeremy Tudway

Doctoral Programme In Clinical Psychology

University of Coventry

Priory Street

Coventry

CV1 5FB      024 76 8883328

Dr Chris Jones

School of Psychology

University of Birmingham

Edgbaston

Birmingham

B15 2TT      0121 4143341

**Thank you for your time**

**APPENDIX Eii:**

**INFORMATION SHEET FOR MAIN EMPIRICAL PAPER**

**STAFF VERSION**

Programme Director  
Doctorate Course in Clinical Psychology  
Lea Valley Gateway  
B43 7EY (The Leazes Road) Phoenix Park, Coventry  
School of Health and Social Sciences  
Coventry University  
Priory Street, Coventry CV1 1PL  
Telephone 024 7655 3322  
Fax 024 7655 3324



COVENTRY  
UNIVERSITY

Date:

Name:

Job:

**Engagement with Assertive Outreach Services:  
What is the best way to measure it? A Pilot Study**

**Staff Information Sheet**

Version 2:12/05/2005

Ref No: 05/MRF02/23

You are being invited to take part in a research study. Before you decide about participating, it is important to explain why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with the researcher if you wish. Please ask if there is anything that is not clear, or if you would like more information.

**Thank you for reading this.**

**Title:** Engagement with Assertive Outreach Services: What is the best way to measure it?

**Who is running the study?**

Sally Bradley is a Trainee Clinical Psychologist on the Coventry and Warwick Doctoral Programme in Clinical Psychology. Sally is running the study and is being supervised by staff from Birmingham and Coventry Universities and by two Clinical Psychologists who work with Assertive Outreach Teams.

**What is the aim of the study?**

The aim of the study is to compare three questionnaires that have been designed to measure client engagement with Assertive Outreach Services.

### **Do I have to take part?**

You do not have to take part in this study, if you decide to, you will be asked to sign a piece of paper to show that you understand and agree to the conditions of the study. Even if you decide to take part now, you are still free to withdraw at any time and do not have to give a reason for your decision.

### **What are the staff being asked to do?**

- Match clients against the study inclusion and exclusion criteria.
- Organise for those clients meeting these criteria to be approached on a routine contact, where the study will be introduced by the staff member who will then give the client volunteer information sheet to them.
- If they agree to participate, the client will be asked to sign the pre-prepared client consent sheet.
- After a cooling-off period of no less than 24 hours, contact the client to arrange a time for them to complete the questionnaires, with a staff member who is NOT their care co-ordinator.
- At the arranged appointment, verbally confirm that the client is happy to proceed with the study.
- Provide the client with the questionnaires and a sealed envelope to return the completed questionnaires in.
- Be available if assistance is required to complete the measures.
- Provide emotional support in the unlikely event that completing the questionnaires has distressed the client.
- Return the questionnaires in a sealed envelope to the researcher.
- Identify the two most involved staff members with the client and ask them to complete the three engagement measures in the staff pack.
- Identify the most involved clinician and ask them to complete the additional measures in the staff pack.
- Return the questionnaires completed by the staff to the researcher.
- The RMO is also being asked to give an independent rating of engagement for each client included in the study.

**What are the possible disadvantages of taking part?**

Participating in the study will make additional demands on your time, however, the assertive outreach team leader has agreed for you to be approached and will be supportive if you decide to participate.

**What are the possible advantages of taking part?**

It is hoped that the results of the study can be used to develop Assertive Outreach Services, to the benefit of staff members and clients under the care of such teams.

**What happens to the information?**

All information is strictly confidential. Your name will not appear on any information available to anyone other than the researcher. When the information has been collected, the anonymous data will be entered onto a computer in a secure, locked room in the University and protected by a password that only the researcher knows. The results will be analysed and written up as part of a thesis and may also be published in a professional psychology journal. The results will also be reported to the Assertive Outreach Teams involved in the research and individual clients participating in the study on request. At the end of the study, all paper copies of questionnaires will be destroyed.

**What do I do if I wish to make a complaint?**

If you have a complaint about the conduct or the content of this research then you may contact the researcher, the research supervisors or Dr Delia Cushway, Programme Director, Doctoral Programme in Clinical Psychology, Coventry University (024 76888328). As an NHS Ethics committee has passed this research, you may also make a complaint through the NHS.



**Contact for further information**

Researcher: Sally Bradley  
Doctoral Programme in Clinical Psychology  
Coventry University  
Priory Street  
Coventry  
CV1 5FB 024 76 888328

**Academic Supervisors:**

Dr Jeremy Tudway  
Doctoral Programme In Clinical Psychology  
University of Coventry  
Priory Street  
Coventry  
CV1 5FB 024 76 8883328

Dr Chris Jones  
School of Psychology  
University of Birmingham  
Edgbaston  
Birmingham  
B15 2TT 0121 4143341

**Thank you for your time**

**APPENDIX Fi:**

**CONSENT FORM FOR MAIN EMPIRICAL PAPER**

**CLIENT VERSION**



**APPENDIX Fii:**

**CONSENT FORM FOR MAIN EMPIRICAL PAPER**

**STAFF VERSION**

**Programme Director**  
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**Engagement with Assertive Outreach Services:  
 What is the best way to measure it? A Pilot Study**

**Staff Consent Form**

Version 1: 29/03/2005

Ref No: 05/MRE02/23

I have signed the bottom of **this** form to show that I agree to take part in this research project. By signing this I also agree that the results of this study can be published, but understand that no one will be able to identify anyone who has taken part in the project from the results.

I also confirm that:

- I understand the purpose of the study.
- I understand what I am being asked to do as outlined in the information sheet.
- I agree to undertake the tasks outlined in the information sheet.
- I understand that the researcher (Sally Bradley) will answer any questions I may have about this study, and will be available for support and assistance during the study.
- I understand that my participation is completely confidential and that I can withdraw from the study at any time.

Name of Team Member (please print): ..... Date:.....

Signature of Team Member:..... Date:.....

Signature of Researcher:..... Date:.....

**APPENDIX G i:**

**SERVICE ENGAGEMENT SCALE**

**TAIT, BIRCHWOOD & TROWER (2002)**

**Service Engagement Scale**

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Date Rated:

Client's Name:

Rater:

Therapist's length of involvement with client:

For each area please circle the number that best describes the client at the current time.  
*Terminology: 'Treatment' refers to the whole treatment package, not just medication.*

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**Area 1) Availability.**

**1) The client seems to make it difficult to arrange appointments**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Not at all/ Rarely	Sometimes	Often	Most of the time

**2) When a visit is arranged, the client is available**

<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Most of the time	Often	Sometimes	Not at all/ Rarely

**3) The client seems to avoid making appointments**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Not at all/ Rarely	Sometimes	Often	Most of the time

**Area 2) Collaboration**

**4) If you offer advice, does the client usually resist it?**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Not at all/ Rarely	Sometimes	Often	Most of the time

**5) The client takes an active part in the setting of goals or treatment plans**

<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Most of the time	Often	Sometimes	Not at all/ Rarely

**6) The client actively participates in managing his/her illness**

<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Most of the time	Often	Sometimes	Not at all/ Rarely

**Area 3) Help Seeking**

**7) The client seeks help when assistance is needed**

<b>3</b> Most of the time	<b>2</b> Often	<b>1</b> Sometimes	<b>0</b> Not at all/ Rarely
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**8) The client finds it difficult to ask for help**

<b>0</b> Not at all/ Rarely	<b>1</b> Sometimes	<b>2</b> Often	<b>3</b> Most of the time
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**9) The client seeks help to prevent a crisis**

<b>3</b> Most of the time	<b>2</b> Often	<b>1</b> Sometimes	<b>0</b> Not at all/ Rarely
------------------------------	-------------------	-----------------------	-----------------------------------

**10) The client does not actively seek help**

<b>0</b> Not at all/ Rarely	<b>1</b> Sometimes	<b>2</b> Often	<b>3</b> Most of the time
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**Area 4) Treatment Adherence**

**11) The client agrees to take prescribed medication**

<b>3</b> Most of the time	<b>2</b> Often	<b>1</b> Sometimes	<b>0</b> Not at all/ Rarely
------------------------------	-------------------	-----------------------	-----------------------------------

**12) The client is clear about what medications he/she is taking and why**

<b>3</b> Most of the time	<b>2</b> Often	<b>1</b> Sometimes	<b>0</b> Not at all/ Rarely
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**13) The client refuses to co-operate with treatment**

<b>0</b> Not at all/ Rarely	<b>1</b> Sometimes	<b>2</b> Often	<b>3</b> Most of the time
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**14) The client has difficulty in adhering to the prescribed medication**

<b>0</b> Not at all/ Rarely	<b>1</b> Sometimes	<b>2</b> Often	<b>3</b> Most of the time
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**APPENDIX G ii:**

**BEXLEY ENGAGEMENT MEASURE**

**WOLFSON & CUPITT (2001)**

**BEXLEY ENGAGEMENT MEASURE**

Engagement is the process of building a trusting relationship between a mental health worker and client. The BEM aims to measure the degree to which this relationship has formed at any point in time.

Date rated:

Client's Name:

Completed by:

Over the last month,

Contact:

How often is it possible to have planned contact with the person?

4 always      3 usually      2 sometimes      1 rarely      0 never

Participation:

How often does the person participate with you in a shared activity that does not require them to share much about themselves, e.g. going to the shops?

4 always      3 usually      2 sometimes      1 rarely      0 never

Collaboration:

How often does the person collaborate with you in completing a task that requires them to share significant things about themselves, e.g. filling in a form?

4 always      3 usually      2 sometimes      1 rarely      0 never

Openness:

How often does the person talk openly about their thought and feelings?

4 always      3 usually      2 sometimes      1 rarely      0 never

Help Seeking:

How often does the person ask for your help and advice?

4 always      3 usually      2 sometimes      1 rarely      0 never

Treatment:

How often does the person enter into negotiation about treatment options e.g. psychotropic medication, psychotherapy?

4 always      3 usually      2 sometimes      1 rarely      0 never

Total Score:

Add the score on each domain \_\_\_\_\_

**APPENDIX G iii:**

**ENGAGEMENT MEASURE (Clinician Version)**

**HALL, MEADEN, SMITH & JONES (2001)**

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**Engagement Measure – Observer Version**

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Date Rated:

Client's Name:

Rater:

Therapist's length of involvement with client:

For each area please circle the number that best describes your client at the current time.

*Terminology: 'Treatment'* refers to the whole treatment package, not just medication.

*'Therapist'* refers to the person most involved with the client, this will usually, but not always, be the key-worker.

---

**Area 1) Appointment keeping.**

*(Include attendance of outpatient appointments and keeping other appointments i.e. being at home when arranged)*

**a) Without Support:** ( i.e. without key-worker bringing them)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never keeps appointments	Rarely keeps appointments	Sometimes keeps appointments	Usually keeps appointments	Always keeps appointments

**b) With Support:** (i.e. key-worker bringing client to appointments)

(Note: Even if client attends without support, please rate what their attendance would be like with support)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never keeps appointments	Rarely keeps appointments	Sometimes keeps appointments	Usually keeps appointments	Always keeps appointments

**Area 2) Client-therapist Interaction**

**Quality of Relationship**

*(The extent to which the client relates well with therapist, giving rise to a positive atmosphere during sessions)*

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never relates well with therapist	Rarely relates well with therapist	Sometimes relates well with therapist	Usually relates well with therapist	Always relates well with therapist

**Area 3) Communication / Openness.**

*(The extent to which client volunteers relevant personal material, is open in discussing feelings, problems and current situation)*

**a) Personal feelings** (i.e. anger, depression etc)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never discusses personal feelings	Rarely discusses personal feelings	Sometimes discusses personal feelings	Usually discusses personal feelings	Always discusses personal feelings

**b) Personal problems** (i.e. difficulties in current life situation)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never discusses personal problems	Rarely discusses personal problems	Sometimes discusses personal problems	Usually discusses personal problems	Always discusses personal problems

**c) Symptoms**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never discusses symptoms	Rarely discusses symptoms	Sometimes discusses symptoms	Usually discusses symptoms	Always discusses symptoms

**Area 4) Client's perceived usefulness of treatment.**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never perceives treatment as useful	Rarely perceives treatment as useful	Sometimes perceives treatment as useful	Usually perceives treatment as useful	Always perceives treatment as useful

**Area 5) Collaboration with treatment.**

(The extent to which client agrees to proposed intervention, as stated in their care plan, and is involved in carrying it out i.e. keeping diaries, practising relapse drills etc.)

**a) Agreement with treatment**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never agrees with proposed intervention	Rarely agrees with proposed intervention	Sometimes agrees with proposed intervention	Usually agrees with proposed intervention	Always agrees with proposed intervention

**b) Involvement in treatment i.e. carries out 'homework' etc**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Is never involved in proposed intervention	Is rarely involved in proposed intervention	Is sometimes involved in proposed intervention	Is usually involved in proposed intervention	Is always involved in proposed intervention

**c) Active involvement in treatment**

*(Active involvement: Client clearly wants to involve themselves in the treatment process)*

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Is never actively involved in intervention	Is rarely actively involved in intervention	Is sometimes actively involved in intervention	Is usually actively involved in intervention	Is always actively involved in intervention

**Area 6) Compliance with medication.**

*(Extent to which client agrees to take medication and will take it freely)*

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never complies with medication	Rarely complies with medication	Sometimes complies with medication	Usually complies with medication	Always complies with medication

**APPENDIX G iv:**

**ENGAGEMENT MEASURE (Client Version)**

**GILLESPIE, SMITH, MEADEN, JONES & WANE (2004)**

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**Engagement Measure – Client Version**

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Date Completed:

Your Name:

For each area please circle the number that best describes you at the current time.

*Treatment* refers to the whole treatment package as written in your care plan, not just medication.

*Keyworker* refers to the person from the team who is most involved with you i.e. \_\_\_\_\_ (name of keyworker).

---

**(1) Appointment keeping.**

**(a) Without Support**

How often do you attend appointments without \_\_\_\_\_ taking you?

(Include attendance of outpatient appointments and keeping other appointments i.e. being at home when arranged)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never keep appointments	Rarely keep appointments	Sometimes keep appointments	Usually keep appointments	Always keep appointments

**(b) With Support**

How often do you attend appointments with \_\_\_\_\_ taking you?

(Note: Even if you attend without support from \_\_\_\_\_, please rate what your attendance would be like with support from \_\_\_\_\_)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never keep appointments	Rarely keep appointments	Sometimes keep appointments	Usually keep appointments	Always keep appointments

**(2) Client-keyworker Relationship**

**Quality of Relationship**

How well do you get on with \_\_\_\_\_?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never get on well with keyworker	Rarely get on well with keyworker	Sometimes get on well with keyworker	Usually get on well with keyworker	Always get on well with keyworker

**(3) Communication / Openness with keyworker.**

**(a) How often do you discuss your personal feelings (i.e. anger, depression etc) with \_\_\_\_\_?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never discuss personal feelings	Rarely discuss personal feelings	Sometimes discuss personal feelings	Usually discuss personal feelings	Always discuss personal feelings

**(b) How often do you discuss your personal problems (i.e. difficulties in current life situation) with \_\_\_\_\_?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never discuss personal problems	Rarely discuss personal problems	Sometimes discuss personal problems	Usually discuss personal problems	Always discuss personal problems

**(c) How often do you discuss your symptoms with \_\_\_\_\_?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never discuss symptoms	Rarely discuss symptoms	Sometimes discuss symptoms	Usually discuss symptoms	Always discuss symptoms

**(4) Usefulness of treatment.**

**How often do you see your treatment as useful?**

Treatment = Your care package, as written in your care plan. This includes carrying out tasks that your keyworker has set you.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never see treatment as useful	Rarely see treatment as useful	Sometimes see treatment as useful	Usually see treatment as useful	Always see treatment as useful

**(5) Involvement with treatment.**

Treatment = Your care package, as written in your care plan. This includes carrying out tasks that your keyworker has set you.

**(a) How often do you agree with your treatment?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never agree with treatment	Rarely agree with treatment	Sometimes agree with treatment	Usually agree with treatment	Always agree with treatment

**(b) How often do you go along with your treatment?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never go along with treatment	Rarely go along with treatment	Sometimes go along with treatment	Usually go along with treatment	Always go along with treatment

**(c) How often are you actively involved in your treatment i.e. how often do you really want to involve yourself in your treatment?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never actively involved in treatment	Rarely actively involved in treatment	Sometimes actively involved in treatment	Usually actively involved in treatment	Always actively involved in treatment

**(6) Taking medication.**

**How often do you take your medication as prescribed by your psychiatrist?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Never take my medication	Rarely take my medication	Sometimes take my medication	Usually take my medication	Always take my medication



**APPENDIX G v:**

**HOMELESS ENGAGEMENT & ACCEPTANCE SCALE**

**PARK, TYRER, ELSEWORTH, FOX, UKOUMUNNE & MacDONALD (2002)**

## *Homeless Engagement and Acceptance Scale*

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Please circle the letter of the statement that comes closest to your assessment of the client for each item. If the client's attitude or mood has changed over the course of your assessment please rate them as they are at present.

**1. This rating concerns: How the client feels about you as the worker.**

- a) The client is well disposed toward me and looks forward to my visits (4)
- b) The client is mildly positive towards me (3)
- c) The client is neutral in attitude towards me (2)
- d) The client is overtly hostile and antagonistic towards me (0)

**2. This rating concerns: The degree to which the client can be engaged.**

- a) The client goes to great lengths to avoid contact (0)
- b) The client generally avoids contact and only occasionally agrees to be seen (1)
- c) The client does not seek contact but usually agrees to be seen (2)
- d) The client is was to contact and reliable over appointments (3)
- e) The client frequently initiates contact (4)

**3. This rating concerns: The client's attitude to help.**

- a) The client is keen on being helped and is an active participant in making plans (3)
- b) The client is prepared to accept help but there are difficulties in agreeing a common plan (2)
- c) The client claims not to need help but is prepared after some persuasion to accept some degree of intervention (1)
- d) The client insists no help is needed and actively resists all attempts at intervention (0)

**4. This rating concerns: The client's attitude to housing.**

- a) The client wishes to accept an form of housing OR is already settled (4)
- b) The client wants housing but has specific realistic requirements (3)
- c) The client appears to want housing but has unrealistic requirements (2)
- d) The client's interest in housing is restricted to temporary placements (1)
- e) The client refuses all offers of housing OR is unable to express a choice (0)

**5. This rating concerns: The way the client engages with others.**

- a) Active hostility towards others (0)
- b) Actively avoids most contact with others (1)
- c) Passive avoidance of others, company usually tolerated silently (2)
- d) Variable engagement, unpredictably withdrawn and friendly (3)
- e) Appropriate social engagement with spontaneous conversation (4)

**APPENDIX G vi:**

**CHILD SERVICES ENGAGEMENT MEASURE**

**YATCHMENOFF (2005)**

## Client Engagement in Child Protective Services

We're interested in your feelings about your involvement with CPS (Child protective services). There are no right or wrong answers to any of our questions. Please answer an honestly and openly as you can. Your answers will be kept absolutely confidential.

Here are some of the ways families may feel about having CPS in their lives. Some are positive and some are negative. You may have both positive and negative feelings at the same time. Please read (listen to) the following statements carefully.

Then, thinking about how you feel right now about your involvement with SCF, please indicate how much you agree or disagree with each. Thank you!

	<i>Strongly Agree</i> (5)	<i>Agree</i> (4)	<i>Not Sure</i> (3)	<i>Disagree</i> (2)	<i>Disagree Strongly</i> (1)
I believe my family will get help we really need from CPS.					
I realise I need some help to make sure my kids have what they need.					
I was fine before CPS got involved. The problem is theirs, not mine.					
I really want to make use of the services (help) CPS is providing me.					
It's hard for me to work with the caseworker I've been assigned.					
Anything I say they're going to turn it around to make me look bad.					
There's a good reason why CPS is involved in my family.					
Working with CPS has given me more hope about how my life is going to go in the future.					
I think my caseworker and I respect each other.					
I'm not just going through the motions. I'm really involved in working with CPS.					
My worker and I agree about what's best for my child.					
I feel like I can trust CPS to be fair and to see my side of things.					
I think things will get better for my child(ren) because CPS is involved.					
What CPS wants me to do is the same as what I want.					
There were definitely some problems in my family that CPS saw.					
My worker doesn't understand where I'm coming from at all.					
CPS is helping me take care of some problems in our lives.					
I believe CPS is helping my family get stronger.					
CPS is not out to get me.					

**APPENDIX G vii:**

**SERVICE ATTACHMENT QUESTIONNAIRE**

**GOODWIN, HOLMES, COCHRANE & MASON (2003)**

## *Service Attachment Questionnaire*

Below is a list of 25 statements about mental health services and the experiences people might have whilst receiving them. Please read each item and then respond to each one by indicating how close the statement is to **your own experience and feelings about the service you are currently in contact with**. Write the number in the space provided using the following rating scale:

1	2	3	4
Not at all	Sometimes	Quite Often	Always

1. I have somebody who listens attentively to me. \_\_\_\_\_
  2. I have regular time with the same person that knows me and my problems. \_\_\_\_\_
  3. I feel under pressure to get better and be discharged. \_\_\_\_\_
  4. I have a feeling of being looked after. \_\_\_\_\_
  5. I have the feeling that I'll be accepted for who I am, whatever I say. \_\_\_\_\_
  6. I'm helped to realise that it's not just me – other people have similar problems. \_\_\_\_\_
  7. I don't feel listened to, or taken notice of. \_\_\_\_\_
  8. I get frustrated because I have to wait too long to see my keyworker/therapist. \_\_\_\_\_
  9. I feel confident that support will be provided when I am discharged. \_\_\_\_\_
  10. I feel suffocated by the service rather than feeling safe. \_\_\_\_\_
  11. I can't relate to/get on with certain people in the service. \_\_\_\_\_
  12. It feels like there's a 'them and us' attitude from the staff. \_\_\_\_\_
  13. I feel that people in the service understand my needs and problems. \_\_\_\_\_
  14. I know that the same person is there for me consistently. \_\_\_\_\_
  15. I worry that I won't be better within the allocated time and will need longer. \_\_\_\_\_
  16. I feel safe within the service. \_\_\_\_\_
  17. I don't feel judged, just accepted. \_\_\_\_\_
  18. I feel patronised and stigmatised by the service. \_\_\_\_\_
  19. I don't feel that people really want to listen to what my problems are. \_\_\_\_\_
  20. I worry that I'll be discharged without any follow-up from my keyworker/therapist. \_\_\_\_\_
  21. I feel confident that if I need more time and help, over longer, that it will be given. \_\_\_\_\_
  22. I feel frustrated at my lack of freedom within the service. \_\_\_\_\_
  23. I feel I have a partnership with my keyworker/therapist and that we work together. \_\_\_\_\_
  24. I have the feeling my keyworker/therapist is really interested in me and wants to help. \_\_\_\_\_
- I am made to feel that I am a burden to the service and outstaying my welcome. \_\_\_\_\_

**APPENDIX G viii:**

**HELPING ALLIANCE QUESTIONNAIRE-II**

**LUBORSKY, BARBER, SIQUELAND, JOHNSON, NAJAVITS, FRANK &  
DALEY (1996)**

***THE HELPING ALLIANCE QUESTIONNAIRE***

Instructions: These are ways that a person may feel or behave in relation to another person—their therapist. Consider carefully your relationship with your patient, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

	Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
The patient feels he/she can depend upon me						
He/she feels I understand him/her						
The patient feels I want him/her to achieve the goals						
At times the patient distrusts my judgement						
The patient feels he/she is working together with me in a joint effort						
I believe we have similar ideas about the nature of his/her problems						
The patient generally respects my views about him/her						
The patients believes the procedures used in his/her therapy are NOT well suited to his/her needs						
The patient likes me as a person						
In most sessions, we find a way to work on his/her problems together						
The patient believes I relate to him/her in ways that SLOW UP the progression of the therapy						
The patient believes a good relationship has formed between us						
The patient believes I am experienced in helping people						
I want very much for the patient to work out his/her problems						
The patient and I have meaningful exchanges						
The patient and I sometimes have unprofitable exchanges						
From time to time, we both talk about the same important events in his/her past						
The patient believes I like him/her as a person						
At times the patient sees me as distant						



**APPENDIX G ix:**

**HEALTH AND SOCIAL ASSESSMENT MEASURE  
(Response to care subsection)**

**FACE RECORDING & MEASUREMENT SYSTEMS (2000)**

## RESPONSE TO CARE (subsection of FACE)

Rate over past week

X = not known

Y = not applicable

### Involvement in treatment and care

(excludes compliance with medication, rated below)

- |                 |   |
|-----------------|---|
| 0 = None        | Fully involved in assessment, planning and implementation of care. Works towards realistic personal goals.                                  |
| 1 = Mild        | With support involved in assessment, planning and implementation of care. Occasional reluctance/resistance to comply with care plan.        |
| 2 = Moderate    | Significant difficulties in engaging with treatment plan and/or formulating personal goals  |
| 3 = Severe      | Major difficulties in engagement with care. Refusal or passive compliance with some aspects of care. Cannot agree realistic personal goals. |
| 4 = Very Severe | Will not comply with most aspects of treatment/care plan. Refuses to/unable to engage in realistic discussion of goals.                     |

### Taking of Medication

- |                 |  |
|-----------------|--|
| 0 = None        | Takes as prescribed  |
| 1 = Mild        | Usually takes as prescribed but some prompting/monitoring required                         |
| 2 = Moderate    | Consistent difficulty in ensuring takes medication. Regime not consistently maintained.    |
| 3 = Severe      | Major difficulties in compliance. Often does not take. Therapeutic dosages not maintained. |
| 4 = Very Severe | Will not comply; rarely takes medication   |

**APPENDIX G x:**

**CLIENT SATISFACTION QUESTIONNAIRE**

**LARSEN, ATTKINSON, HARGREAVES & NGUYEN (1979)**

## *The Client Satisfaction Questionnaire*

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We are interested in your honest opinions, whether they are positive or negative. Your answers are anonymous. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we appreciate your help. Please circle your answers.

6. How would you rate the quality of service you received?

<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Excellent	Good	Fair	Poor

7. Did you get the kind of service you wanted?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
No, definitely not	No, not really	Yes, generally	Yes, definitely

8. To what extent has our service met your needs?

<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

9. If a friend were in need of similar help, would you recommend our service to him/her?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

10. How satisfied are you with the amount of help you received?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

Engagement: Compliance or Alliance?

11. Have the services you received, helped you to deal more effectively with your problems?

- |                               |                           |                             |                                      |
|-------------------------------|---------------------------|-----------------------------|--------------------------------------|
| <b>4</b>                      | <b>3</b>                  | <b>2</b>                    | <b>1</b>                             |
| Yes, they helped a great deal | Yes, they helped somewhat | No, they really didn't help | No, they seemed to make things worse |

12. In an overall, general sense, how satisfied are you with the service you received?

- |                |                  |                                    |                    |
|----------------|------------------|------------------------------------|--------------------|
| <b>4</b>       | <b>3</b>         | <b>2</b>                           | <b>1</b>           |
| Very satisfied | Mostly satisfied | Indifferent or mildly dissatisfied | Quite dissatisfied |

13. If you were to seek help again, would you come back to our service?

- |                    |                      |                 |                 |
|--------------------|----------------------|-----------------|-----------------|
| <b>1</b>           | <b>2</b>             | <b>3</b>        | <b>4</b>        |
| No, definitely not | No, I don't think so | Yes, I think so | Yes, definitely |

What do you like the most about the service?

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What do you like the least about the service?

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Further comments

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**APPENDIX G xi:**

**INSIGHT SCALE**

**BIRCHWOOD, SMITH, DRURY, HEALY, MacMILLAN & SLADE (1994)**

## INSIGHT SCALE

Please read the following statements carefully and then tick the box which best applies to you:

	AGREE	DISAGREE	UNSURE
Some of my symptoms are 'all in my mind'			
I am mentally well			
I do not need medication			
My last stay in hospital was necessary			
The doctor was right in prescribing medication for me			
I do not need to be seen by a doctor or a psychiatrist			
If someone said I had a nervous or mental illness they would be right			
None of the unusual things I experience are due to an illness			

**APPENDIX H:**

**PERMISSION TO USE BEXLEY ENGAGEMENT MEASURE**

**(unpublished)**



Subject: Re: Assertive Outreach Engagement Research  
From: "Caroline Cupitt" <Caroline.Cupitt@oxleas.nhs.uk>  
To: <bradleys@coventry.ac.uk>  
Date: Fri, November 19, 2004 3:13 pm

Dear Sally,  
Thank you for sending your proposal. It looks very interesting. Of course you can use the BEM in your study. We would just ask that you let us have a copy of the results. In fact we are trying to get some more work on the BEM underway here so I have passed your proposal onto my colleague, Sangita, who might get in touch with you about it. We did do an initial study of reliability and validity and I have attached the paper.  
Caroline

>>> SALLY BRADLEY <bradleys@coventry.ac.uk> 15/11/04 21:14:46 >>>  
Dear Pauline,

Further to our conversation the other day I am attaching a copy of my research proposal regarding engagement with assertive outreach services. There are still some amendments to make, but most of the proposal will remain unchanged. I would be grateful if you could discuss it with Caroline and anyone else who would need to give their permission for me to use the measure.

I look forward to hearing from you, should you have any queries, please do contact me.

Sally Bradley  
Trainee Clinical Psychologist  
Coventry & Warwick Clinical Psychology Doctoral Program  
South Warwickshire PCT

\*\*\*\*\*

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**APPENDIX ii:**

**INFORMATION SHEET FOR BRIEF EMPIRICAL PAPER**

**CLIENT VERSION**

Programme Director  
**Doctorate Course in Clinical Psychology**  
Dr Julia Gathagier  
BA (Hons) PSY, PhD (AUS) (Psychol) (Hons)  
School of Health and Social Sciences  
Coventry University  
Trinity Centre, Coventry CV3 3EF  
Telephone: 02476 893412  
Email: j.gathagier@coventry.ac.uk



## Engagement with Assertive Outreach Services: What is Engagement?

### What is Engagement?

### Volunteer Information Sheet

Version 3: 12/05/2005

Ref No: 05/MRE02/23

You are being invited to take part in a research study. Before you decide it is important to explain why the study is being done and what you will have to do. Please take time to read the following information carefully and discuss it with others if you wish and ask if there is anything that is not clear, or if you would like more information.

**Thank you for reading this.**

**Title:** Engagement with Assertive Outreach Services: What is Engagement?

**Who is running the study?**

Sally Bradley is a Trainee Clinical Psychologist on the Coventry and Warwick Doctoral Programme in Clinical Psychology. Sally is running the study and is being supervised by staff from Birmingham and Coventry Universities and by two Clinical Psychologists who work with Assertive Outreach Teams.

**What is the aim of the study?**

To find out why clients choose to engage with services and their experiences of assertive outreach services.

**Do I have to take part?**

You do not have to take part in this study, if you want to, you will be asked to sign a piece of paper to show that you understand and agree to take part. Even if you want to take part now you are still

free to stop, at any time and do not have to give a reason. Your decision will not affect the service you receive in any way.

### **What do I have to do?**

People who agree to join the discussion group will be contacted to arrange a time to attend the group. At the group, people will be asked to talk about their experiences of Assertive Outreach Teams and their ideas about engaging with these services. There will be about six people in the group, which should last about an hour and a half.

### **What are the possible disadvantages of taking part?**

It is unlikely that there are any disadvantages to taking part in this study, however, if you do get upset by the discussion group, the researcher will let your care co-ordinator know, so that they can organise support for you.

### **What are the possible advantages of taking part?**

The results of this study will give the Assertive Outreach Teams information that they can use to make the service better.

### **What happens to the information?**

The discussion group will be tape recorded and written-up later. This information will be stored securely at the University of Coventry in a locked filing cabinet and will be destroyed at the end of the study. Clients who come to the discussion group will only be identified in the write-up by a reference number. Only the researcher and the supervisor will have access to this information. The results will be analysed and written up as part of a thesis and may also be published in a professional psychology journal. Copies of the results will also be given to the assertive outreach teams involved in the research. If individual clients taking part in the study wish to receive a copy of the results, these will be sent to them, . At the end of the study, all paper copies of individual responses will be destroyed.

**What do I do if I wish to make a complaint?**

If you have a complaint about the research then you may contact your key-worker, the researcher, the research supervisors, or Dr Delia Cushway, Programme Director (024 76 888328). As this research has been passed by an NHS Ethics committee, you may also make a complaint through the NHS.

**Contact for further information**

Researcher: Sally Bradley

Doctoral Programme in Clinical Psychology

Coventry University

Priory Street

Coventry

CV1 5FB

024 76 888328

**Academic Supervisors:**

Dr Jeremy Tudway

Doctoral Programme In Clinical Psychology

University of Coventry

Priory Street

Coventry

CV1 5FB      024 76 8883328

Dr Chris Jones

School of Psychology

University of Birmingham

Edgbaston

Birmingham

B15 2TT      0121 4143341

**Thank you for your time**

**APPENDIX Iii:**

**INFORMATION SHEET FOR BRIEF EMPIRICAL PAPER**

**STAFF VERSION**

**Programme Director**  
Doctorate Course in Clinical Psychology  
Dr David C. Greenwood  
BA (Hons) HNC, PhD, HPS, CPsychol (C), FHEA  
**School of Health and Social Sciences**  
Coventry University  
Priory Street, Coventry CV1 5EP  
Tel: 024 7655 3100  
coventry.ac.uk



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## **Engagement with Assertive Outreach Services:**

### **What is Engagement?**

### **Staff Information Sheet**

Version 1: 29/03/05

Ref No: 05/MRE02/23

You are being invited to take part in a research study. Before you decide it is important to explain why the study is being done and **what** it will involve. Please take time to read the following information carefully and discuss it with the researcher if you wish. Please ask if there is anything that is not clear, or if you would like more information.

**Thank you for reading this.**

**Title:** Engagement with Assertive Outreach Services: What is Engagement?

**Who is running the study?**

Sally Bradley is a **Trainee Clinical Psychologist on the Coventry and Warwick Doctoral Programme in Clinical Psychology**. Sally is running the study and is being supervised by staff from Birmingham and Coventry Universities and by two Clinical Psychologists who work with **Assertive Outreach Teams**.

**What is the aim of the study?**

The aim of the research is to **find out why** clients choose to **engage** with services and their experiences of **Assertive Outreach Teams**.

### **Do I have to take part?**

You do not have to take part in this study, if you decide to, you will be asked to sign a piece of paper to show that you understand and agree to the conditions of the study. Even if you decide to take part now, you are still free to withdraw at any time and do not have to give a reason for your decision.

### **What are the staff being asked to do?**

- Match clients against the study inclusion and exclusion criteria.
- Organise for those clients meeting these criteria to be approached on a routine contact, where the study will be introduced by the staff member, who will then give the client volunteer information sheet to them.
- If they agree to participate, ask the client to sign the pre-prepared client consent sheet.
- Give the client details to the researcher, so that she can contact them to organise the focus group.
- In the unlikely event that a client in the focus group becomes distressed, the researcher will notify their care co-ordinator who will then be responsible for organising appropriate emotional support for the client.

### **What are the possible disadvantages of taking part?**

Participating in the study will make additional demands on your time, however, the assertive outreach team leader has agreed for you to be approached and will be supportive if you decide to participate.

### **What are the possible advantages of taking part?**

It is hoped that the results of the study can be used to develop Assertive Outreach Services, to the benefit of staff members and clients under the care of such teams.



### **What happens to the information?**

No information will be collected from staff members for this study, other than consent forms. The focus group will be tape recorded and transcribed later. This information will be stored securely at the University of Coventry in a locked filing cabinet and will be destroyed at the end of the study. Only the researcher and the supervisor will have access to this information. The results will be written up as part of a thesis, given to the assertive outreach teams and individual clients on request. The findings may also be published in a psychology journal. All the results will be anonymous and it will not be possible to identify anyone who has taken part from these results.

### ***What do I do if I wish to make a complaint?***

If you have a complaint about the conduct or the content of this research then you may contact the researcher, the research supervisors, or Dr Delia Cushway, Programme Director, Doctoral Programme in Clinical Psychology, Coventry University (024 76 888328). As this research has been passed by an NHS Ethics committee, you may also make a complaint through the NHS.

### **Contact for further information:**

Researcher: Sally Bradley  
Doctoral Programme in Clinical Psychology  
Coventry University  
Priory Street  
Coventry  
CV1 5FB 024 76 888328

Academic Supervisors:  
Dr Jeremy Tudway  
Doctoral Programme In Clinical Psychology  
University of Coventry  
Priory Street  
Coventry  
CV1 5FB 024 76 8883328

Dr Chris Jones  
School of Psychology  
University of Birmingham  
Edgbaston  
Birmingham  
B15 2TT 0121 4143341

**Thank you for your time**

**APPENDIX Ji:**

**CONSENT FORM FOR BRIEF EMPIRICAL PAPER**

**CLIENT VERSION**

**Programme Director**  
**Doctorate Course in Clinical Psychology**  
 21, Dore Road  
 Ryton (Leam) MS1 3FD AF3PC (Psychol (Clin Foren))  
**School of Health and Social Sciences**  
 Coventry University  
 Priory Street, Coventry CV4 7AL  
 Telephone: 02476 893444  
 Fax: 02476 893447



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**Engagement with Assertive Outreach Services:  
 What is Engagement?**

**Client Consent Form**

Version 2: 29/03/2005

Ref No. 05/MRF02/23

I have signed the bottom of **this form** to show that I agree to take part in this research project. By signing this I also agree that the results of this study can be published, but understand that no one will be able to identify anyone who has taken part in the project from the results.

I also confirm that

- I understand the purpose of the study.
- I understand that this study will involve attending a discussion group.
- I understand that the discussion group will be audiotaped and that the tapes will be typed into a transcript. These transcripts will be held in a locked filing cabinet at the University of Coventry and will be destroyed at the end of the study.
- I agree that the researcher (Sally Bradley) can access some basic information about my clinical history and attendance from my medical notes.
- I understand that taking part will not change my treatment in any way.
- I understand that the researcher will answer any questions I may have about this study.
- I understand that this study is completely confidential and that I can withdraw from the study at any time and this will not effect my treatment.

Name of Participant (please print): .....

Date.....

Signature of Participant: .....

Date.....

Signature of Researcher:.....

Date.....

Please send me the results of the study

Yes

No

**APPENDIX Jii:**

**CONSENT FORM FOR BRIEF EMPIRICAL PAPER**

**STAFF VERSION**

Programme Director  
**Doctorate Course in Clinical Psychology**  
 100,000,000  
 100,000,000 (Psychological Form)  
**School of Health and Social Sciences**  
 Coventry University  
 Priory Street, Coventry, CV5 9EF  
 Tel: 02476 893100  
 Fax: 02476 893100



COVENTRY  
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**Engagement with Assertive Outreach Services:  
 What is Engagement?**

**Staff Consent Form**

Version 1; 29/03/2005

Ref No: 05/MRE/02/23

I have signed the bottom of this form to show that I agree to take part in this research project. By signing this I also agree that the results of this study can be published, but understand that no one will be able to identify anyone who has taken part in the project from the results.

I also confirm that:

- I understand the purpose of the study.
- I understand what I am being asked to do as outlined in the information sheet.
- I agree to undertake the tasks outlined in the information sheet.
- I understand that the researcher (Sally Bradley) will answer any questions I may have about this study, and will be available for support and assistance during the study.
- I understand that my participation is completely confidential and that I can withdraw from the study at any time.

Name of Team Member (please print): .....

Date.....

Signature of Team Member:.....

Date.....

Signature of Researcher:.....

Date.....

Dean of School of Health and Social Sciences, Coventry University, 100,000,000, Coventry University, Priory Street, Coventry, CV5 9EF, UK. Tel: 02476 893100, Fax: 02476 893100.  
 Dept. of Applied Psychology, Coventry University, 100,000,000, Coventry University, Priory Street, Coventry, CV5 9EF, UK. Tel: 02476 893100, Fax: 02476 893100.

**APPENDIX K:**

**EXCERPT FROM TRANSCRIPT WITH CODING FRAME**

### Notes on excerpts and coding frame

- **Speaker:** refers to researcher (SB) or participants who are identified by pseudonyms, (chosen by the participants themselves as an ice-breaker activity).
- **Initial thoughts:** original notes written in margin by SB as reading transcript, used to develop codes.
- **SB Code:** Code given to dialogue by SB
- **ME-G code:** Code given to dialogue by ME-G
- **Final Code:** Final code given to dialogue following discussion between SB and ME-G
- **\*\*:** Denotes removal of text that may identify the client or identifies another individual not present in the group.
- *Text in italics:* Identifies dialogue about TCM
- **Standard formatted text:** Identifies dialogue about AOT

### Key to Codes:

A: Clients feel treated like a child, as subordinate

- 1: Controlled
- 2: Manipulated
- 3: Depersonalised
- 4: Staff as Judgemental
- 5: Staff as Disrespectful

B: Clients feel treated as an individual

- 1: Staff as interested/respectful
- 2: Equal, valued, heard

C: Clients appreciating the supportive elements of the relationship

- 1: Practical support
- 2: Social/Emotional support
- 3: Limited support

D: Clients valuing their treatment/care

- 1: Clinicians expertise
- 2: Satisfaction with service approach

Not(code number): opposite of code

## Excerpt 1:

Speaker	Dialogue	Initial Thoughts	SB Code	ME-G Code	Final Code
SB	I wondered if they had handled issues, like around medication any differently? If there was a difference between the different services?				
Raphyr	Um, I dunno				
Amy	<i>No, I've found that they have all been the same really, going on about it. Um, I was an inpatient in **** when it first started, and they were kind of really, really strict. You know?</i>	Nagging Controlling	A1	A1	A1
Sharron	<i>I've found that everyone that I've been with before has been really easy about medication.</i>		B2 D2	D2	D2
SB	Thanks for that, because that might have been a bit hard to say, because it is obviously quite a different experience. Is there anything that you would like to add to that Anthony?				
Anthony	They just give me medication and I take it.	Passive 'done to'	A1	A1	A1

## Excerpt 2:

Speaker	Dialogue	Thoughts	SB Code	ME-G Code	Final Code
Raphyr	Another thing that does my head in, they keep going on, for me anyway, I've moved on the last few years, I'm gradually starting to get my shit together, you know what I mean, but some of the doctors *** they keep going back to stuff that was in your notes * or * years ago, you know what I mean?	Nagging Past	A2	A2	A2
Amy	They won't let you grow up will they? Let you move on?	Infantilise Past limits future	A2	A2	A2
Raphyr	It keeps sticking with you. It's like a bloody weight around your neck, aint it? And I'm cool about it, I keep saying look that was ages ago, but	Labelled Judged Not listened to	A2	A2	A2



	you just can't get it through to them, that you have moved on and that things are different. You know what I mean, they keep bringing up stuff. It's out of date and meaningless now.	Focus on past			
Sharron	I've noticed that the outreach team they don't ask you things, they just like to get to know you, they don't look back at your notes to find out about you. They just leave me to do my own thing. They don't bother me, they just ring me and say, ah, do you wanna come to sports group, but if I don't it's alright.	Person centred Freedom Choice	B1 B2	D2 B2 C2	B1 B2 C2 D2
SB	Is that different to how other people have been with you?				
Sharron	<i>Yeah, like other doctors and other teams, I was with ****, and they used to come round and check on you and things like that, and other teams from like the past, just checking on you all the time.</i>  The outreach team don't do that to me.	Controlled	A1  Not A1 D2	A1  B2 D2	A1  Not A1 B&D2
SB	Have you got any thoughts to add Anthony?				
Anthony	They are really helpful the outreach team are, they take you out for outings, swimming, the art group and things. It gives me something to do.	Helpful Meaningful social activity	C2	C2	C2

**Excerpt 3:**

Speaker	Dialogue	Thoughts	SB Code	ME-G Code	Final Code
Robert	I reckon the women in the outreach team have got too much to say, there should be blokes doing more, especially for men. The women should do more for Amy, and say **, someone like him, doing more for the blokes.	Gender issues re staffing	C3	C3	C3
	They plant seeds in your brain aint it? It crops up every so often, certain	Manipulative Controlled	B1 A4	B1 A1&4	B1 A4

Engagement: Compliance or Alliance?

	words and it does bug me, it plays on me mind. I keep thinking they are playing head games.				
Amy	I know exactly what you mean. I keep thinking pills, all the time pills, pills, pills. Its like they shove them down your throat so much	Forced	A1 A4	A1	A1
Raphyr	Personally, I much preferred, the last few years I've got better, and it's all down I think to the outreach team, you know? Having more visits, you know? Rights down from the doctors to the support workers, you know? Just having more social interaction.  <i>I didn't enjoy me time in hospital, there was a couple of nurses in hospital I had a personality clash with, and was kind of, I just didn't like it there, I just didn't like the lack of respect you get in the hospital, you know what I mean?</i>	More visits from all team  Lack of respect	C1 C2  A3	D2  A3 A5	C1 C2 D2  A3
SB	That is something you have said about a couple of times, about respect, can you tell me more about that?				
Raphyr	<i>Just, just they treat you like a little kid sometimes, you know what I mean?</i>	Infantilised	A1	A2	A1 A2
Robert	It doesn't make you feel like a man either, being mentally ill. When you gotta keep running to the doctors or the staff and that, saying that you got problems, like anxiety or you're getting funny thoughts.	Supported but dependent	A5	A1	A5

## **APPENDIX L:**

### **EXPERT-RATER RELIABILITY**

Expert-rater reliability was calculated following the guidelines in Boyatzis (1998).

$$\text{Percentage agreement on presence} = \frac{2 \times (\text{No. times both SB and ME-G saw code})}{(\text{No. times SB saw code} + \text{No. times ME-G saw code})}$$

CODE	NUMBER OF TIMES SB RECORDED CODE	NUMBER OF TIMES ME-G RECORDED CODE	NUMBER OF TIMES BOTH RATERS RECORDED SAME CODE	PERCENTAGE AGREEMENT
A1	33	30	26	83
A2	15	14	12	83
A3	11	11	8	73
A4	8	11	8	63
A5	9	6	5	67
B1	13	16	10	69
B2	22	22	14	64
C1	8	3	3	55
C2	6	6	5	83
C3	6	8	6	86
D1	13	19	13	81
D2	13	20	12	73

**APPENDIX M i:**

**NOTES FOR AUTHORS:**

**AMERICAN JOURNAL OF PSYCHAIITRIC REHABILITATION**

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## Submission of Manuscripts

Manuscripts should be submitted to the Editor-in-Chief via email attachment with a letter asking for a review to [corrigan@iit.edu](mailto:corrigan@iit.edu). Alternatively, manuscripts in hardcopy triplicate and on floppy disk can be mailed to: Editor-in-Chief, Patrick W. Corrigan, Psy.D., Professor, Institute of Psychology, Illinois Institute of Technology, 3424 S. State Street, Chicago, IL 60616 USA. Specify whether you are submitting a regular article or first person account. Dr. Corrigan will assign the paper to an action editor who will seek at least three reviews of the paper and attempt to respond to you with an editorial decision and copies of the reviews in 90 days. The editor will strip the document of identifying information so that it will be blind reviewed.

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## **Person First Language**

Mental illness and psychiatric disability describe a condition where there is loss of social, cognitive, and/or vocational skills. In order to appropriately represent this experience, and respect those who live it, do not use terms such as patient, psychotic, or schizophrenic. Put people first, not their disabilities. Use phrases such as “man with mental illness” or “people with psychiatric disorders.”

## **Illustrations**

Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- sized to fit on journal page
- EPS, TIFF, or PSD format only
- submitted as separate files, not embedded in text files

Color illustrations will be considered for publication; however, the author will be required to bear the full cost involved in their printing and publication. The charge for the first page with color is \$900.00. The next three pages with color are \$450.00 each. A custom quote will be provided for color art totaling more than 4 journal pages. Good-quality color prints or files should be provided in their final size. The publisher has the right to refuse publication of color prints deemed unacceptable.

## **Tables and Figures**

Tables and figures should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet. All original figures should be clearly marked in pencil on the reverse side with the number, author's name, and top edge indicated.

## References

Should be listed on separate pages following the text and should be typed double-spaced. References should be listed alphabetically. Be sure all references have been cited in the text.

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**APPENDIX M ii:**

**NOTES FOR AUTHORS:**

**JOURNAL OF MENTAL HEALTH**

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**Submissions.** All submissions, including book reviews, should be made online at Journal of Mental Health's **[Manuscript Central site](#)**. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. **Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting.** Authors will be asked to add this information in section 4 of the on-line submission process.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

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