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ADOLESCENT ENGAGEMENT IN MENTAL HEALTH  
SERVICES

Section A: *What is the current understanding of adolescent  
engagement in mental health services? A review of  
qualitative and quantitative literature*

Word Count: 7,969

Section B: *Experiences of engaging with mental health  
services in 16–18 year olds: An interpretative  
phenomenological analysis*

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## **Project Summary**

This major research project investigates adolescent engagement in mental health services.

Section A reviews available literature on what is currently understood about adolescent engagement in mental health services. Databases were systematically searched and developed inclusion and exclusion criteria applied. Summary and critique ensues. Literature search revealed a wide variety across selected papers in terms of focus and methodological quality. Conclusions are drawn around how this variety reflects the mixed understanding of adolescent service engagement. Results are synthesised and discussed in terms of clinical implications and recommendations for future research.

Section B uses Interpretative Phenomenological Analysis to explore ten 16-18 year olds understandings of their mental health service engagement experience. Through semi-structured interview, five superordinate themes emerged from the data. These related to participant's developmental stage, progression through the engagement process and their experience of services both inside and outside the clinic room. Results are discussed in relation to existing theory and research. Implications for clinical practice and further research are proposed.

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## **Section A**

*What is the current understanding of adolescent engagement in mental health services?*

*A review of qualitative and quantitative literature.*

Words: 7,969



### **Abstract**

Adolescence is thought to be risk period for the development of ongoing mental health concerns. However, this coincides with low mental health service engagement. Engagement definitions and models are mixed in their conceptualisations and lack consensus. Previous research is also varied and recent publications lack synthesis. This paper aimed to search, review and synthesise recent literature in order to ascertain the current understanding of adolescent engagement. Databases were searched systematically and hand searches ensued. Seventeen papers met inclusion/ exclusion criteria. Resulting themes emerged around: defining engagement, pre-treatment characteristics, 'diagnosis' and symptomology, therapeutic alliance/ therapist characteristics, engagement over time, beliefs, family influence, outcomes, and interventions. Qualitative and quantitative methodology is critiqued. As a result of the heterogeneity of results, consistent synthesis was a challenge. Discussion takes place around the variation in guiding definitions, chosen focus of research, and methodological quality. Recommendations are made in terms of clinical implications and future research.

*Key words: engagement, adolescents, mental health services*

## **Introduction**

The adolescent years are thought to be a significant risk period for the development of mental health concerns (Vyas, Birchwood, & Singh, 2015). As 50% percent of adult mental health symptomology begins before the age of 16, and 75% before the age of 25 (Murphy & Fonagy, 2012), policy has proposed that it is essential for mental health service commissioning to consider needs specific to adolescents (YoungMinds, 2006a), respond to the developmental stage young people enter into services (DCSF & DoH, 2008; WHO, 2002) as well as considering need (DoH, 2015). By engaging adolescents effectively, we may be able to prevent more serious and enduring problems later on in life (Birchwood & Singh, 2013). However, adolescent engagement has long been understood as a challenge (Watsford, Rickwood, & Vanags, 2013), with high drop out rates, (e.g. De Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013), and service use markedly declining around 16-18 years of age (Singh, Paul, Ford, Kramer, & Weaver, 2008; Vyas et al., 2015).

## **Definitions and Theories of Adolescence**

Adolescence has been defined as the developmental years between childhood and adulthood (e.g. WHO, 2007), and is frequently surrounded by a 'storm and stress' (Arnett, 1999; Hall, 1904) and parental conflict (Dekovic, 1999) narrative. Dahl (2004) proposed adolescence is best understood as an interaction between biological, behavioural and social domains – beginning with the biological (puberty) and ending with the social (adult roles and responsibilities). There is much debate about the precise age adolescence ends. Havighurst (e.g. 1948) suggested 18 years, Hall (1904) proposed 22 years, policy suggests 19 years (WHO, 2007) and brain development

studies have hypothesized that adolescence can continue well into an individual's 20s (Blakemore, 2012). For the purpose of this review, in order to capture a broad range of literature alongside focusing solely on adolescent-specific experiences, 'adolescence' is considered as occurring between 12-22 years of age (Hall, 1904). Diverse theories have been proposed regarding the nature, and reason, for the adolescence period, ranging from psychosexual (e.g. Freud, 1905), to cognitive (Inhelder & Piaget, 1958), moral (Kohlberg, 1971) and ecological (Bronfenbrenner, 1977). Both Rank (cited in Muuss, 1988) and Erikson (1950) made distinctions between early and late adolescence- emphasizing personality and identity development- namely in moving from dependence to independence from the family, as the adolescent grows older. Erikson emphasized the task of adolescence is to resolve the 'identity vs. role confusion' dilemma, ultimately producing a self-concept meaningful to the adolescent. Failure to achieve this can result in isolation, confusion and self-doubt. Emphasis was placed on the importance of the peer group in aiding identity formation as the adolescent ages, as well as the need to assert autonomy in order to reach 'maturity' (Bronfenbrenner, 1977; Muuss, 1988).

### **Adolescence and Service Engagement**

As some serious mental health disorders may start to emerge in adolescence (Jones, 2013), particularly older adolescence (Murphy & Fonagy, 2012), it is concerning that service use diminishes around this age. This may occur for a number of reasons. From a developmental perspective, themes of separation and loss may begin to occur as the young person moves towards a more adult identity by 'disengaging' from parents (Blos, 1967; Erikson, 1968; Winnicott, 1965) and developing emotional uncertainty about authority figures (Fontana, 1997). Therefore, they may also

experience the process of engagement differently, and feel the need to separate and increase independence from, not only families, but from services too. A biological perspective may suggest that, due to the onset of puberty, there are rapid changes to the areas of the brain that mediate emotional experience, meaning adolescents may have heightened urges for e.g. independence (YoungMinds, 2006b), and may have difficulties with decision-making “in the heat” of an emotional moment (Casey & Caudle, 2013). This could mean decisions to engage in services at a time of emotional need could be impacted. On a service provision level, for example, older adolescence is often the age that ‘transitioning’ between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) occurs. Research (e.g. Singh et al., 2008) suggests the transition period can be particularly challenging for some adolescents due to poor service planning, poor preparation for transition, and other life changes (e.g. leaving home).

***Defining Engagement vs. Help Seeking***

Help seeking has been defined as an act performed by a young person who views themselves in need of assistance (e.g. WHO, 2007; Rickwood, Deane, Wilson, & Ciarrochi, 2005). This suggests attending services can be part of the help seeking process.

Definitions of adolescent engagement lack consensus (Kim, Munson, & McKay, 2012; Staudt, 2007) despite being a term frequently used within theory, research and clinical practice. For example, McKay and Bannon, (2004) considered engagement to be, “divided into two steps: initial attendance and ongoing engagement” (p.906). Staudt (2007) suggested behavioural (e.g. attendance) and attitudinal (e.g.

emotional investment in treatment) components, proposing engagement as a continuous, dynamic process, which alters as treatment progresses. It has also been stated that the adolescent's relationship with their therapist and/or service be incorporated into engagement conceptualisations (King, Currie, & Petersen, 2014). Additionally, terms such as 'attendance', 'adherence' and 'retention' are used interchangeably within engagement research (Kim et al., 2012) adding to the idea of a lack of agreed definition. This may hinder theoretical understanding and progress (Drieschner, Lammers, & van der Staak, 2004), which is significant when considering the importance of engaging a 'difficult-to-engage' demographic.

Despite variation in the above, it appears from definitions of help seeking and engagement that there is overlap, e.g. at the point of initial attendance, making the distinction between help seeking and engagement unclear.

### **Models of Engagement**

Models specific to adolescent engagement are limited. Due to the lack of clarity between help seeking and engagement definitions, help seeking models are considered below, in addition to relevant engagement models, in order to shed light on the phenomena. Adult/ child/ family-centric models are included due to the paucity of an adolescent-specific understanding.

**Adult-centric models.** The Health Belief Model (HBM; Rosenstock, 1974) proposes an understanding for individual health-related behaviours. Based on value-expectancy concepts (Strecher & Rosenstock, 1997), the value (avoid illness/

improve health) is weighed up against perceptions of (e.g. severity, barrier and/or action effectiveness). This suggests the reduction of barriers, (e.g. psychological or environmental), could lead to health behaviour change. Despite the HBM combining multiple factors, it fails to account for the impact of societal (e.g. stigma, Eisenberg, Downs, Golberstein, & Zivin, 2009) or familial influence (Fallon & Bowles, 2004) – the impact of which may be greater for adolescents (e.g. Bronfenbrenner, 1977). Longer-term, ongoing intervention and maintenance – a possible aspect of engagement – is also unaccounted for.

The Treatment Motivation Model (TMM; Drieschner, Lammers, & van der Staak, 2004) suggests a number of ‘internal’ determinants (e.g. problem recognition, outcome expectancy) can impact on motivation to engage, and remain engaged (defined as behavioural engagement), in therapy, and this may be hindered by e.g. cognition. The TMM suggests engagement is multifaceted. However, the model is linear, rather than dynamic (Staudt, 2007) and may lack generalisability to adolescents.

**Young people models.** The help-seeking model, the Network Episode Model-R (NEM-R; Costello, Pescosolido, Angold, & Burns, 1998), takes the view that young people may not have independent access to services, and describes how their social network (e.g. parents and schools), influences help-seeking, based on the beliefs of (e.g. family). The role of decision-making, an internal process highlighted by models such as the TMM above, is proposed as having less of an influence for children due to them potentially being encouraged to attend services without a full

understanding of their nature. The model is designed to be generalizable to all young people, which may fail to acknowledge the difference between older and younger adolescent experiences, particularly around service knowledge and independence. Research has shown that peer support may be the preferred form of help for teenagers (e.g. Raviv, Raviv, Vago-Gefen, & Fink, 2009), especially as they mature. Peers and perceived impact on self-esteem (e.g. Threats to Self Esteem Model; Fisher, Nadler, & Whitcher-Alagna, 1982) may be a key-influencing factor in adolescent engagement, rather than problem recognition by families or schools.

Both the Ecological Point of View (EPV; McKay, Gonzales, Stone, Ryland, & Kohner, 1995b) and Barriers to Treatment Model (BTM; Kazdin, Hollans, & Crowley, 1997) consider potential *barriers* to treatment for children and adolescents, and overlap help-seeking and engagement, considering pre and post initial attendance. The EPV identifies barriers existing at multiple levels – the individual, family, community and agency. Failure to engage is not just about individual motivation but a combination of salient factors at all levels of the client's 'ecosystem.'

The BTM, again specific to children and families, suggests that a family's poor relationship with therapists, and not perceiving the treatment as irrelevant are barriers. These may lead to premature termination of therapy. As both models consider the role of barriers, it could be assumed the opposite of these will aid engagement; however, this is not specifically hypothesized.

Working from a substance misuse perspective, Broome, Joe, and Simpson (2001) hypothesized the Engagement Model for Adolescents in DATOS-A (Drug Abuse Treatment Outcome Studies), which combines, treatment readiness, process of therapeutic involvement, and session attributes. Background factors e.g. social support, drug abuse, are included and related to 'readiness', with the most influential background factor thought to be the adolescent's relationship to family and friends. It is hypothesized that the greater the 'readiness' of an adolescent, the more involved they will be in the therapy. This model, as with the above definitions, suggests an overlap between the help seeking and the engagement processes. As with the above models, despite being developed for adolescents, this does not distinguish between different adolescent ages, and may not be generalizable to a non-substance misuse population.

The Motivational Model of Client Engagement (King, Currie, & Petersen, 2014) considers engagement *within* treatment (as opposed to treatment entry) is proposed for children and families (Figure 1), viewing engagement as an ongoing process. Engagement is viewed from a relational perspective, between therapist and client. Three components are suggested - affective, cognitive and behavioural – with emphasis on the role of hope and confidence in the intervention. The fluctuating nature of engagement motivation is not accounted for, nor are external factors outside of a service (e.g. peer influence). As the model focuses on families, children and adolescents, an assumption is made that a child's experience is similar to (e.g. an older adolescent experience). This may limit the applicability to the unique experience of adolescent task negotiation (e.g. Erikson, 1950).



Figure removed due to copyright (Motivational model of client engagement, see King, Currie, & Petersen, 2014)

*Figure 1.* Motivational model of client engagement.

### **Research into Adolescents and Engagement**

Empirical research has been conducted with the intention of investigating adolescent engagement, however the foci, and participant ages, of these papers are highly varied. Research includes meta-analyses/ systematic reviews into the effectiveness of engagement interventions (Kim et al., 2012) and the role of the therapeutic relationship (Shirk & Karver, 2003) - but with age ranges beyond adolescence. Investigations into service dropout (e.g. Kazdin, 1990; Kazdin et al., 1997; Kazdin & Wassell, 2000; Shriver & Allen, 2008) have been extensive. Adolescent expectations and experiences of mental health services have been investigated (e.g. Harper, Dickson, & Bramwell, 2014; Ronzoni & Dogra, 2012; Watsford, Rickwood, & Vanagas, 2013; Watsford & Rickwood, 2014) with variable outcomes. Key themes included, valuing therapeutic relationships, variations in expectancies and the role of past therapeutic experiences. To date, recent research in this area has not been synthesized in order to ascertain what is currently understood about adolescent engagement in mental health services.

## **Summary**

The development of mental health concerns, and service dropout, during adolescence is marked. Definitions, model and research relevant to adolescent service engagement are varied in focus and lack consensus. Of key significance is the lack of distinction and overlap between definitions and models of help seeking and engagement. The development of a specific understanding of adolescent engagement is important for the development of specific theoretical understanding rather than e.g. attempting to understand this through adaptations of adult or child models and research (Weisz & Hawley, 2002).

Developmental models suggest the role of multiple systems (Bronfenbrenner, 1977), including peers (Erikson, 1950), in negotiation of the adolescent period. Exploration of help-seeking and engagement definitions demonstrate potential overlap at the point of service attendance. Engagement models emphasize the role of ongoing client motivation (Broome et al., 2001; Drieschner et al., 2004; King et al., 2014) throughout the therapeutic process. A multifaceted view of engagement is proposed, suggesting the influence of multiple systems around the young person (Broome et al., 2001; Drieschner et al., 2004; Costello et al., 1998; Kazdin et al., 1997; McKay et al., 1995b), in line with developmental models. There is variety in the emphasis they place on factors internal to the individual (Drieschner et al., 2004) and the role of external factors, such as families (Costello et al., 1998). Empirical research, as with models, is varied in its emphasis. Due to his variability, a synthesis of current research on adolescent engagement may begin to help make sense of this phenomenon.

## **Review: Rationale, Aim, Scope**

### **Rationale and Aim**

The conceptualisation and understanding of adolescent engagement in mental health services is highly varied. Considering that this is a risk period for, a) the development of mental health concerns and, b) not engaging and/ or dropping out of mental health services, investigating what current research understands about engagement for this age group may help to work towards improving understanding of service adherence. This paper aims to comprehensively search, review and synthesize (Moher, Liberati, Tetzlaff, & Altman, 2009) the current literature on adolescent engagement in mental health services.

### **Scope**

As a result of the variability in engagement definitions, and in order to maintain a broad scope for review, this paper is not guided by a single definition of engagement. In line with previous research (e.g. Kim et al., 2012), the terms 'retention,' 'adherence' and 'attendance' are considered to be synonymous with engagement. As suggested by engagement definitions and models, literature will be selected based on its focus from the time of being offered, entering into, and/or continuing to attend, a service.

'Mental health service' is a broad term often encompassing several professional roles. For example, many CAMH services in the UK are comprised of psychology, psychiatry, mental health nursing, and so forth. For the purpose of this review, and

in order to maintain relevance to clinical psychology as a whole, papers will not be selected if they solely focus on e.g. pharmacological or nursing-specific interventions.

## **Methodology**

### **Initial searches and search terms**

Initial searches (Appendix A) and previous research was used to develop final search terms, and inclusion/exclusion criteria. Of note, initial searches revealed the term 'young people' was used as a catch-all term, e.g. participants ranged from 10 years old (e.g. Surko, Peake, Epstein, & Medeiros, 2008) to 84 years old (Green, Wisdom, Wolfe, & Firemark, 2012). In order to maintain relevance to the review question, only papers stating the age range of participants were selected. Engagement-related search terms were guided by previous systematic review (e.g. Kim et al, 2012).

Searches were carried out in September and December 2015. The following search terms were used as keywords with Boolean operators:

a) Engage\* OR retention OR adhere\* OR attend\*

AND

b) Young pe\* OR adol\* OR teen\*

AND

c) CAMHS OR mental health service OR child and adolescent mental health service

The following limits were applied: English language, only peer-reviewed journals (to ensure quality), no books/ book chapters, and articles from the past ten years only (to capture most up-to-date literature).

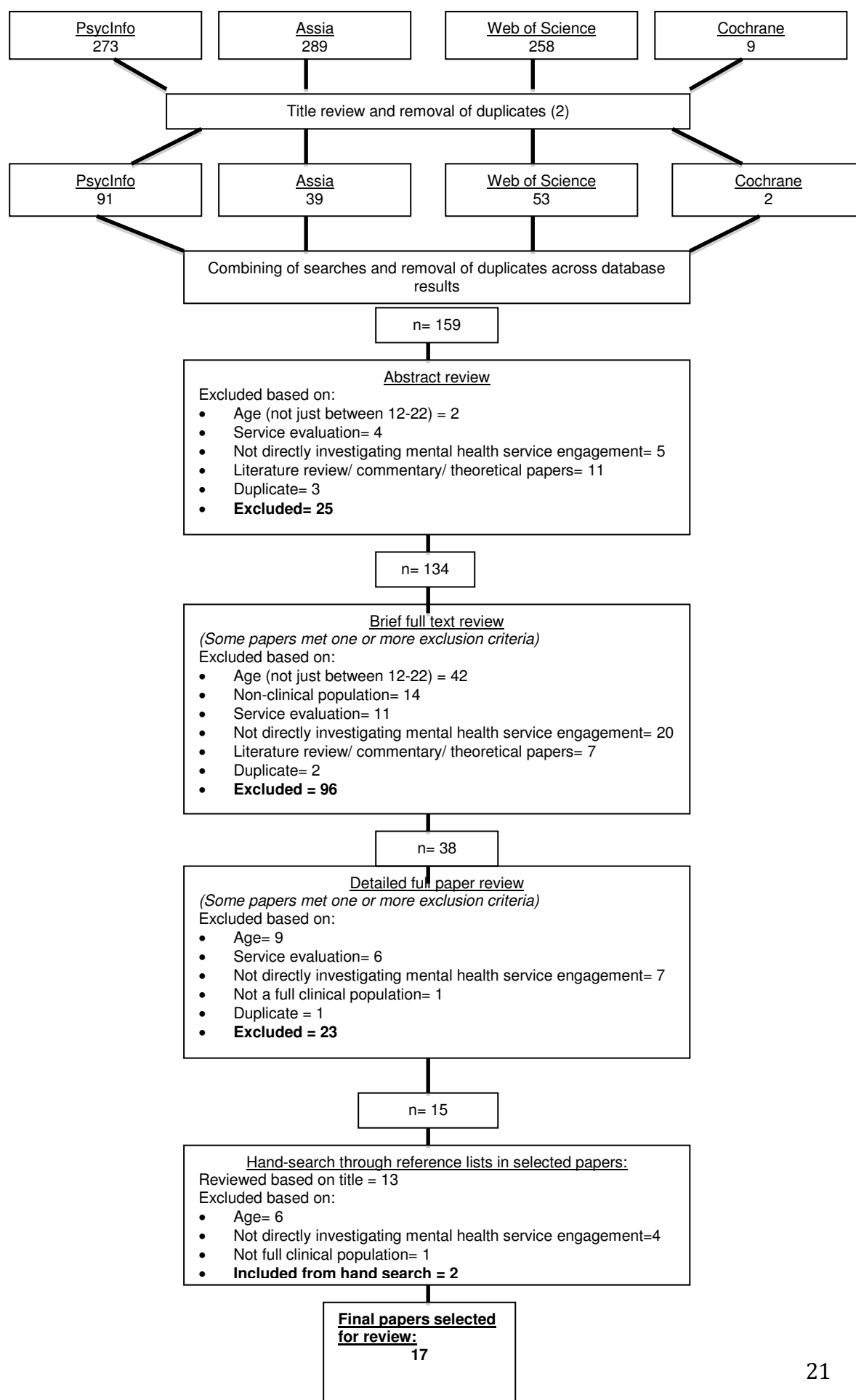
### **Databases**

The following databases were searched (Figure 2):

- 1) PsycInfo: Psychology research (273 results)
- 2) Assia: Social sciences research (289 results)
- 3) Web of Science: Science/ social sciences research (258 results)
- 4) Cochrane Review: Research reviews (9 results)

Results were combined and underwent a title review and removal of duplicates across the searches. From here, abstract, brief full paper and full paper review (Appendix B) followed.

Figure 2. Paper selection flow chart.



### **Hand searches**

The references included in each final selected paper were hand searched to ensure all relevant research was captured. Thirteen additional papers were selected via title review (Appendix C). Two were included in the final review (Cunningham, Duffee, Hawke, Huang, Steinke, & Naccarato, 2009; Hawke, Hennen, & Gallione, 2005).

### **Inclusion/ exclusion criteria**

Papers were selected using the following criteria:

**Inclusion criteria:** clinical population (to ensure relevance), empirical papers focusing on mental health service engagement, aged between 12-22 years old (see section 1.1.).

**Exclusion criteria:** non-clinical population, child (below 12 years old) or adult population (above 22 years old), no age range provided, pure pharmacological focus, whole service reviews/ evaluations, literature and book reviews, opinion/ commentary pieces, conference presentations, research participation articles, subject matter not focusing on engagement into mental health services.

A total of 17 papers were selected for review (see Table 1).

Table 1

*Details of reviewed papers*

	<b>Paper</b>	<b>Age range (mean) of participants in years</b>	<b>Power</b>	<b>Participants</b>	<b>Engagement definition</b>	<b>Research design</b>	<b>Measures</b>	<b>Key findings</b>	<b>Checklist guided by and methodology critique</b>
1	Branson, Clemmey, & Mukherjee (2013)	13-17 (15.1)	n=48 (adolescents)	Adolescents from outpatient child mental health clinic	Number of sessions attended divided by total of sessions offered over 3 month study period	Pilot study: between-group, quasi-experimental design.  Text message group vs. historical control.	<i>Presence of psychiatric disorders:</i> Global Appraisal of Individual Needs- Short Screener (GAINS-SS; Dennis, Feeney, Stevens, & Bedoya, 2006)  <i>Treatment attendance:</i> Number of sessions attended divided by total of number of sessions offered over 3 month study period  <i>Patient satisfaction:</i> 10-item, 5-point Likert scale created for the study.	Text message reminders increased session attendance to 65% compared to 49% in control. 82-100% participants showed favourable satisfaction.	<i>Long, Godfrey, Randall, Brettle, and Grant (2002)</i> - Intervention and participant population well described - Text message group and control similarities/differences accounted for



									<ul style="list-style-type: none"> <li>- Small power</li> <li>-Confounding variables not discussed/ accounted for</li> <li>- Results from one service limiting external validity</li> </ul>
2	Breland, McCarty, Zhou, McCauley, Rockhill, Katon, & Richardson (2014)	13-17 (15)	n=444	Adolescents from health care study with depression.	No explicit definition given.	Questionnaire cross-sectional design.	<p><i>Demographics and health conditions:</i> self report</p> <p><i>Depression:</i> Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, &amp; Williams, 2001)</p> <p><i>Psychological impairment:</i> Columbia Impairment Scale (CIS; Bird, Shaffer, &amp; Fisher, 1993)</p> <p><i>Anxiety:</i> Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997)</p> <p><i>Problem Substance</i></p>	Parental experience of anxiety and/or depression, and their ratings on youth symptomology, was strongly associated with depressed adolescent engagement. Youth	<p><i>Long et al (2002)</i></p> <ul style="list-style-type: none"> <li>- Large sample size</li> <li>- Comparison group used but role of this was selective in analysis</li> <li>- Some measures not validated</li> <li>- Secondary</li> </ul>

							<p><i>Use:</i>CRAFFT screener (Knight et al., 1999)  <i>Parental history of depression:</i> Self report  <i>Parental report of youth symptoms:</i> Pediatric Symptom Checklist-17 (Jellinek et al., 1988).  <i>Treatment utilization:</i> from administrative data.</p>	<p>characteristics (age, gender, symptomology or substance use) were not associated with service use however, parental characteristics were. The more psychosocially 'impaired' the adolescent, the less likely to engage in services.</p>	<p>data use</p>
3	Burns, Cortell, & Wagner (2008)	13-18 (15.6)	n=85 (adolescents)	Adolescents and parents admitted to psychiatric hospital following a suicide attempt.  Recruited	No explicit definition given.	Repeated measures, questionnaire cross-sectional design.	<p><i>Child and Adolescent Services Assessment:</i> The child and adolescent services assessment (CASA: Ascher, Farmer, Burns &amp; Angold, 1996)  <i>Helpfulness of Services Received:</i> Asked verbally, over past 6 months, which services helpful/ not</p>	<p>Adolescents with 'disruptive behaviour disorder' and/or substance misuse less compliant with individual</p>	<p><i>Long et al (2002)</i>                      - Follow up over time                      - Multiple perspectives (adolescent and parent)                      - Standardized</p>

				from larger study.			helpful? <i>Family History Interview:</i> (Cohen, 1990) assessing current parental psychopathology <i>Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3)- Youth and Parent Forms</i> (Schaffer, Fisher, Piacentini, Schwab-Stone, & Wicks, 1992) <i>Suicidal ideation and suicide attempts:</i> Three items from DISC-2.3 and three items from DISC-1 (Costello, Edelbrock, & Costello, 1985). Number of suicide attempts in past 6 months	psychotherapy . Parental perception of treatment as helpful predicted adolescent compliance in treatment. Parental psychopathology not related to treatment compliance. Adolescent's attitude not predictive. Compliance with treatment not predictive of future suicidal ideation or attempts.	measures used - High participant attrition - High economic status of participants means lacking in generalizability - No control group
4	Bury, Raval, & Lyon (2007)	17-21 (no mean provided)	n=6	Adolescents from community-based	No explicit definition given.	Qualitative: Interpretative Phenomenol	Semi-structured interview during treatment period.	Subordinate themes – seeking help/ engagement,	<i>Mays &amp; Pope (2000)/ Yardley (2000)</i>

		<p>mental health clinic providing weekly individual psychoanalytic psychotherapy</p>	<p>ological Analysis study</p>	<p>process of being in therapy and ending therapy. Engagement section themes: being in difficulty, feelings about referral and stigma, expectations of therapy. Beginning therapy themes: mixed feelings, therapist response.</p>	<ul style="list-style-type: none"> <li>- In depth engagement with topic and data</li> <li>- Transparency in methods and analysis</li> <li>- Initial reflexivity of position but assumptions etc. of researcher not discussed</li> <li>- Questions around sociocultural context of participants</li> <li>- Potential lack of generalizability outside of treatment context</li> </ul>
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									(Individual psychoanalytic psychotherapy)
5	Cunningham, Duffee, Huang, Steinke, & Naccarato (2009)	12-17 (15.5)	n=130	Adolescents receiving treatment for substance misuse within a youth residential treatment center	Engagement defined as attitudinal (readiness to change), affective (relationship with therapist) and behavioural (e.g. client participation)	Development of measure of engagement in youth residential treatment centers.	Qualitative interview data used from a previous treatment pilot study	Engagement measure developed focusing on themes of 'readiness to change' 'bond with staff' and 'collaboration on goals and tasks'	<i>Holmbeck and Devine (2009)</i> - Attention to content, construct and criterion validity - Reliability evaluation and norms not analysed/ provided - Response format missing - Sensitivity to change (utility) not evaluated
6	Donnellan, Murray,	12-16 (15)	n=3	Adolescents engaged in	No explicit definition	Qualitative: IPA study	Data from semi-structured interview	Engagement exists on a	<i>Mays &amp; Pope (2000)/</i>

	&Harrison (2012)			CAMHS service receiving CBT	provided			continuum, changing over time – emotional detachment/ lack of decision- making to being actively involved in therapy. Suggests engagement can be an unspoken agreement between therapist and adolescent.	<i>Yardley (2000)</i> - Attention to negative cases - Thorough data collection and analysis  - Reflexivity of researcher’s position missing - May lack generalizabili ty outside of treatment context (CBT)
7	Flicker, Turner, Waldron, Brody, & Ozechowski (2008)	13-19 (15.7)	n= 86 (43 families in each group)	White or Hispanic families with an adolescent who abuses substances	Defined as ‘retention status’ meaning completing all scheduled therapy sessions (12-	Cross- sectional, observational , retrospective design.	<i>Measure of substance misuse: Timeline Followback Interview (Miller &amp; Del Boca, 1994).</i>  <i>Measure of therapeutic alliance: Vanderbilt Therapeutic Alliance</i>	Therapist ethnicity (White or Hispanic) not linked to average or imbalanced therapeutic	<i>Long et al (2002)</i> Standardized measure of alliance  - Alliance not client rated

					14 sessions)		Scale- Revised (Hartley & Strupp, 1983).	alliance. Alliance imbalance between parent and adolescent linked to family ethnicity and retention status	- Not generalizable to other cultures? - Only focused on first treatment session rather than engagement over time
8	Gogel, Cavaleri, Gardin, & Wisdom (2011)	15-21 (17.1)	n=28 (adolescents), 30 (parents), 29 (staff)	Adolescent, parents and staff from a residential substance misuse programme	Distinguishes between attendance, engagement, retention and participation. Engagement 'initial' and ongoing.	Qualitative semi-structured interview design.	One off semi-structured in-depth interviews. Coded thematically.	Adolescents, parents and staff reported more barriers to engagement than facilitators during treatment. These included, mixed client population, cultural barriers, transportation,	<i>Mays &amp; Pope (2000)/ Yardley (2000)</i> - Good theoretical basis - Variety of perspectives - Lack of reflexivity as multiple raters - Lack of rationale for

								rules, changing staff, communication with parents/ staff.	method - Engagement with topic lacking in depth
9	Hawke, Hennen, & Gallione (2005)	13-18 (17)	n=185	Adolescents from five residential substance misuse programmes	Unclear but equated 'active' engagement to therapeutic involvement. Therapeutic involvement meant the client accepting his or her own contribution to the maintenance and resolution of the problem.	Cross-sectional, correlational survey design.	Client Survey Questionnaire developed for the present study using items from the Global Appraisal of Individual Needs (GAIN-QS; Dennis et al, 2002).  <i>Self-esteem/ self-efficacy:</i> Client Evaluation of Self and Treatment Scales (CEST; Simpson & Knight, 1998)  <i>Spirituality:</i> Personal Experience Inventory (Winters & Henly, 1989)  <i>Therapeutic Involvement:</i> A mixture of items from CEST, DATOS and Working Alliance Inventory (WAI;	Female gender correlated with less therapeutic involvement, as was problem-severity ('deviancy' and substance misuse). Ethnic minority clients reported better working relationships with their therapist, which was assumed to equal 'active' engagement,	<i>Long et al (2002)</i> - High power - Client rated - No control group. - No study aims stated - Inclusion/ exclusion criteria not clear



							Horvath & Greenberg, 1989)	as per the paper's adopted definition. Therapeutic alliance was closely related to engagement.	
10	Lee et al., (2012)	12-18 (no mean provided)	n=2,191	Adolescents from 28 outpatient substance misuse treatment sites	Distinction made between treatment 'initiation' and 'engagement'. 'Initiation' was seen as attending a second appointment within 14 days of the initial session; 'engagement' was attending two more appointments within 30 days of initiation.	Cross-sectional, retrospective study.	<i>Client demographics, clinical factors, behavioural problems: Global Appraisal of Individual Needs (GAIN; Dennis et al., 2002)</i>	Adolescents more likely to initiate treatment when assigned to therapist Pay for Performance condition. Less likely to engage if not part of dominant ethnic group and/or engaged in truancy. Gender not a factor.	<i>Long et al (2002)</i> - High power - Study aims clearly presented  - Secondary data - Use of only one outcome measure, administered once - Ecological validity effected by population being from

									similar socioeconomic background
11	Marchionda & Slesnick (2013)	12-17 (15.5)	n=18 (families)	Families with substance misusing and runaway adolescents, living at local runaway shelter	Completers/ fully engaged = attending 12+ sessions of family therapy Middle drop out = 4-8 sessions attended Drop out= less than 4 sessions attended	Cross-sectional, observational design.	<p><i>Session communication:</i> Coding ratings of communication in first session of family therapy</p> <p><i>Substance misuse measure:</i> Form 90 (Slesnick &amp; Tonigan, 2004)</p> <p><i>Psychological functioning:</i> Beck Depression Inventory II (Beck, Steer &amp; Brown, 1996b)</p>	Families that completed treatment or dropped out midway had more therapist-parent communication in first session. Those that dropped out had more adolescent-therapist communication.	<p><i>Long et al (2002)</i></p> <ul style="list-style-type: none"> <li>- Results fit with previous research</li> <li>- Consideration of confounding variables</li> <li>- Re-analysis of data from a wider study</li> <li>- Lacking in generalizability due to very specific study population</li> <li>- Only analysed first session</li> <li>- No measure</li> </ul>

									of client/ parent/ therapist views on engagement
12	Munson, Floersch, & Townsend (2010)	12-17 (15)	n=70	Adolescents from outpatient clinic in a community mental health hospital. Parents also interviewed about treatment compliance.	No explicit definition given.	Opportunistic cross-sectional questionnaire design.	<i>Mental health:</i> Parent report or Kiddie Schedule for Affective Disorders for School-Age Children Present and Lifetime Version (K-SADS-PL; Kaufman, et al., 1997). <i>Adherence:</i> Determined by self and parent report on a 4 point scale. <i>Illness perception:</i> Illness Perception Questionnaire Revisited (IPQ-R; Moss-Morris, Weinman, Petrie, Horne, Camerson, & Buick, 2002) <i>Attitudes:</i> Attitudes Towards Seeking Mental Health Services (IAS-MHS; Mackenzie, Knox, Gekoski, & Macaulay, 2004).	Majority of adolescents fully adherent. 71% agreement on this between parents and adolescents. Attitudes of e.g. personal control and treatment control linked to adherence. Socioeconomic status (more income) also linked to (greater) adherence.	<i>Long et al (2002)</i> - Moderate power - Young person opinion considered  - Limits to generalizability - Adolescent mental health status mostly rated by parents, not young person. - No comparison group
13	Roy & Gillett	17	n=1	High risk,	No explicit	Case study	None	Email sessions	<i>Stake (1995)</i>

	(2008)		difficult to engage adolescents from CAMHS	definition given.			may be an effective way to engage difficult-to-engage young people	<ul style="list-style-type: none"> <li>- Sense of story, conceptual structure and development of work</li> <li>- Evidence of triangulation</li> <li>- Context of young person, outside of diagnosis, missing</li> </ul>
14	Smith, Duffee, Steinke, Huang, & Larkin (2008)	12-17 (15.4) n=130	Adolescents attending two substance misuse residential treatment centers	Engagement has attitudinal (readiness to change), relational (therapeutic alliance) and behavioural (client participation) components	Repeated measures (pre and post), cohort, questionnaire design.	<p><i>Self-esteem</i>: 7-item scale adapted from Automatic Thoughts Questionnaire – Positive (Ingram &amp; Wisnicki, 1988)</p> <p><i>Self-efficacy</i>: 7-item scale adapted from an adaptation of Self-efficacy scale (Sherer et al., 1982)</p> <p><i>School attachment</i>: 11 item scale measuring the degree to which the adolescent feels</p>	Early engagement associated with better outcome on measures of family trust, self-efficacy, self-esteem and attachment to school at treatment	<p><i>Long et al (2002)</i></p> <ul style="list-style-type: none"> <li>- Good power</li> <li>- Adolescent rated outcome measures</li> <li>- Lack of generalizability outside of substance misuse</li> </ul>

		<p>committed/ invested in school</p> <p><i>New roles/ experiences:</i> 6-item scale developed for present study, on new experiences and roles offered by service</p> <p><i>Family trust:</i> 5-item measure developed for present study on whether adolescent feels family are emotionally safe with each other</p> <p><i>Engagement:</i> 17-item scale developed for present study combining elements from University of Rhode Island Change Assessment Scale (McConaughy, Prochaska, &amp; Velicer, 1983) and Working Alliance Inventory (Horvath &amp; Greenberg, 1986).</p> <p><i>General delinquency:</i> 23 'yes/ no' items on amount/ type of 'deviant'</p>	<p>intake. At discharge, early engagement not significantly associated with self-esteem. Early engagement associated with school attachment prior to discharge. Adolescents more engaged at intake have more exposure to new roles and experiences/ receive more challenges to negative thoughts and behaviours.</p>	<p>population</p> <ul style="list-style-type: none"> <li>- Use of secondary data</li> <li>- Possible role of confounding variables</li> <li>- Inclusion/ exclusion criteria not clear</li> </ul>
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							behaviours in past 3 months <i>Peer reaction to deviance:</i> YP self report on anticipated reaction to 'deviant' behaviours <i>Family relationship:</i> 13-item, YP reported, measure on youth-caregiver communication and attachment.		
15	Thompson, Bender, Lantry, & Flynn (2007)	12-16 (no mean provided)	n=19 (families)	Families with adolescents experiencing reported difficulties with truancy, 'delinquency', running away or family conflict.	No explicit definition given.	Qualitative interview design: content analysis.	Follow-up interview after receiving family therapy sessions that included 'engagement activities.'	Adolescent and parents felt they developed collaborate relationship with therapist, appreciating authentic, calm etc. traits. Both adol. and parents appreciated direct advice and learning tasks.	<i>Mays &amp; Pope (2000)/ Yardley (2000)</i> - Attention to negative cases - Transparent data presentation  - Lack of reflexivity - Lack of respondent validation - Uncertainty

								Connections developed within families, improving relations. 3 families unable to engage, reporting therapy too overwhelming. Adolescents reported to not be easily forthcoming within interview.	how adolescent and parent perspectives formally compared
16	Waldron, Kern-Jones, Turner, Peterson & Ozechowski (2007)	14-20 (16.6)	n=42	Families with adolescents engaging in substance misuse	No explicit definition given.	Pre/post questionnaire intervention study.	<i>Parent functioning:</i> Beck Depression Inventory (BDI; Beck, Steer & Garbin, 1988), State Anger subscale of the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988) <i>Adolescent functioning:</i> Reports from parents. Child Behaviour Checklist (CBCL) and Youth Self	Therapist ethnicity (White or Hispanic) had no influence on therapeutic alliance with White or Hispanic families. Success of intervention	<i>Long et al (2002)</i> - Results inline with previous research - Use of validated measures - No control for

							Report (Achenbach & Edelbrock, 1982) Substance misuse – Timeline Followback interview (TLFB). <i>Perception of family relationship functioning:</i> Conflict and Cohesion subscales of Family Environment Scale (FES; Moos & Moos, 1986)	suggests vital role of parents in adolescent engagement. Compared parents of engaged and non-engaged adolescents and found no variation between the two groups.	intervention - No formal engagement measure - Limitations of pre/post design e.g. potential role of extraneous variables
17	Wilson, Levin, Donovan, & Nunes (2006)	16-19(18)	n=28	Adolescents living in a substance misuse therapeutic community	No explicit definition given however 'retention' in treatment was measured by amount of days adolescent stayed in therapeutic community.	Pilot study: Questionnaire, cross-sectional design	<i>Verbal abilities:</i> Test of Adolescent Language-3, Vocabulary Subtest (VOCAB; Hammil, Brown, Larsen, & Wiederholt, 1994) <i>Non-verbal abilities:</i> The Kaufman Brief Intelligence Test/ Matrices Subtest (Kaufman & Kaufman, 1990). <i>Verbal diversity:</i> Narrative Responses to Drug-Related and Therapeutic Narratives/ type-token	Treatment type-token ratio (verbal diversity in response to therapeutic material) positively predicted retention and VOCAB (higher general verbal scores) negatively predicted	<i>Long et al (2002)</i> - Use of validated/ standardized measures - Sample representative of target population - Small sample size - Lack of generalizability



		<p>ratio of participant's response</p> <p><i>Socio-emotional functioning:</i> Scores of restraint (e.g. impulse control) and distress (e.g. anxiety) from Weinberger Adjustment Inventory (WAI; Weinberger &amp; Schwartz, 1990)</p> <p><i>Retention in treatment:</i> total number of days from admission to termination of treatment.</p>	<p>retention. No other variable associated with retention (e.g. non-verbal abilities). Higher verbal skills associated with restraint. Restraint did not predict retention.</p>	<p>ty outside study population</p> <p>- No control/comparison group</p> <p>- Narrative measures not completed for all participants</p>
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## Review

Selected literature is discussed by themes and methodological critique ensues. The results are synthesized narratively (Popay et al., 2006). Conclusions are drawn in terms of clinical and research implications. The terms engage(ment), adhere(nce), attend(ance) and retention are used interchangeably, dependent on the terms selected by the papers in question.

## Themes

**Defining Engagement.** A notable amount of papers did not offer explicit definitions of engagement or similar (e.g. adherence, attendance) (Breland et al., 2014; Burns et al., 2008; Bury et al., 2009; Donnellan et al., 2012; Munson et al., 2009; Roy & Gillett, 2008; Thompson et al., 2007; Waldron et al., 2007).

Amongst those that did offer a definition, there was great variation. Three papers defined and measured engagement by the length of time an adolescent attends a service (Lee et al., 2012; Marchionda & Slesnick, 2013; Wilson et al., 2012). Hawke et al. (2005), equated 'active' engagement to therapeutic involvement i.e. client contribution.

Two papers defined adolescent engagement as having attitudinal (readiness to change), relational (therapeutic alliance) and behavioural (participation in services and collaboration with staff) components. (Cunningham et al., 2009; Smith et al., 2008). This definition complements previous models (e.g. Broome et al., 2001). However the variations between model and research definitions are evident (see

section 1.4). Variability in guiding definitions may have meant different phenomena were being investigated. This heterogeneity makes comparison across papers a challenge.

**‘Pre-treatment’ characteristics.** The role of adolescent demographics tends to be absent from models of engagement. Some of the selected literature discussed demographics or ‘pre-treatment’ characteristics, with mixed foci and frequently contradictory results. This may be due to papers have diverse working definitions, populations, aims, research designs and methods of analysis – resulting in a lack of homogeneity in outcomes (see section 5.0).

There was contradiction amongst the literature on the role gender plays. Hawke et al. (2005) found that female gender correlated with less engagement. Three papers suggested that gender plays no role (Breland et al., 2014; Lee et al., 2012; Marchionda & Slesnick, 2013). Contradictory to previous research (Singh et al, 2008; Vyas et al., 2015) older age was associated with more engagement (Munson et al., 2009) in one paper, but in another (Breland et al., 2014) age was shown to have no impact on service use.

Being part of the dominant ethnic group (Caucasian US) was suggested as a good predictor of engagement (Lee et al., 2012), however, in Hawke et al. (2005), participants identifying as an ethnic minority reported better a working relationship with therapists (assumed to equal ‘active’ engagement, as per the paper’s adopted

definition). There are obvious issues with comparing these two papers due to the differences in engagement definitions.

There was, agreement on the role 'intelligence' may have on engagement, with higher educational level (Munson et al., 2009) and higher scores verbal ability and verbal diversity tests (Wilson et al., 2006) positively associated with engagement and retention. As seen, papers showed mixed foci and contradictory results, meaning it is a challenge to draw reliable conclusions from the suggested role of demographics and pre-treatment characteristics in adolescent engagement.

**'Diagnosis' and symptomology.** There was discrepancy amongst the papers which considered the role of 'diagnosis'/ symptomology. Engagement models tend to not include the role of symptomology or 'diagnosis'. This, in part, may be due to the conceptual and methodological critiques of 'diagnosis' (e.g. Boyle, 2007) especially for adolescents (e.g. Rutter, 2011). Two papers (Branson et al., 2013; Hawke et al., 2005) recorded diagnostic presentation but did not comment on the role this played in their research findings.

Adolescents who experience behavioural difficulties were shown to be less engaged with services (Burns, et al., 2008; Lee et al., 2012), as were those with substance dependence (Burns, et al., 2008). Exploration of reasons for this was limited aside from Burns et al. (2008) commenting that adolescents with 'disruptive behaviour disorders' were "more guarded" (pp.954) and therefore dropout of treatment quickly. Other papers (Breland et al., 2014; Marchionda & Slesnick, 2013) found

substance misuse to have no association with service use. When considering the role of ‘internalizing’ problems, adolescents who remained engaged in family therapy tended to have more severely self-rated depression (Marchionda & Slesnick, 2013). To complement this, Munson et al., (2009) suggested adolescents were more likely to attend services if they view their mood disorder as having serious consequences on their lives highlighted within the Health Belief Model (Rosenstock, 1974).

The results of these papers as a whole are in support of previous research (e.g. Baruch, Gerber, & Fearon, 1998) suggesting adolescents with ‘internalizing’ presentations are more likely to remain engaged in services and those with ‘externalizing’ presentations are more likely to drop out. However, selected papers tended to not offer a hypothesis around *why* adolescents with certain clinical presentations may have been harder to engage than others, and therefore providing a limited contribution to the understanding of adolescent engagement.

**Therapeutic alliance and therapist characteristics.** In terms of therapist characteristics, ethnicity of therapists was shown to have no impact on therapeutic alliance (equating therapeutic alliance with engagement) (Flicker et al., 2008; Waldron et al., 2007), however temperament, such as appearing impartial, caring and authentic was (Thompson et al, 2007). Previous research (e.g. Everall & Paulson, 2002; Shirk & Karver, 2003) has demonstrated the importance of the relationship the adolescent has with their therapist in maintaining engagement. Models (e.g. King et

al., 2014) suggest that the therapeutic relationship is a factor, but not the only factor in adolescent engagement.

Selected research highlighted that the therapeutic relationship was closely related to engagement (Cunningham et al., 2009; Hawke et al., 2005) and was rated as more of a 'therapeutic facilitator' by adolescents than staff (Gogel et al., 2011). Attempts to 'rate' the therapeutic relationship on dimensions such as: feeling cared for, understood and trusting staff, on a developed measure of engagement (Cunningham et al., 2009), suggest that the therapeutic relationship is quantifiable. Qualitative investigation proposed that engagement is an unspoken agreement - a process - between client and therapist, and therefore needs to be explicitly explored within therapy to aid its maintenance (Donnellan et al., 2012).

An interpretative phenomenological analysis (IPA) study into adolescent experiences of psychoanalytic psychotherapy (Bury et al., 2007), found therapist response (e.g. validating experiences, providing information on therapy) had a key influence on initial engagement, especially for adolescents who had mixed feelings about attending. The themes of power and control arose, (e.g. allowing the client to make decisions about care to aid engagement), with the adolescent potentially using 'withdrawal' as a way to rebel against feelings of powerlessness. These themes were also highlighted in three other studies (Donnellan et al., 2012; Munson et al., 2010; Roy & Gillett, 2008) suggesting that client control maybe linked to adherence e.g. as engagement increased power imbalances were minimized (Donnellan et al., 2012). Roy and Gillett (2008) used email as a way to engage a 17-year-old who found

developing a relationship through the traditional means a challenge. By handing the control over to the client, it was hypothesized that this gave her a sense of safety and emotional distance that was necessary for her. Participants in two papers (Bury et al., 2007; Roy & Gillett, 2008), which highlighted control were older, suggesting age could be a factor as highlighted by adolescent development theory (e.g. Erikson, 1950). Power and control are not explicitly reflected in models or definitions.

**Engagement over time and as a process.** Three papers explicitly considered the fluctuating nature of adolescent engagement, suggesting this may not be a linear process. Cunningham et al. (2009) found adolescent engagement levels fluctuated, within and between participants, so therefore required continual engagement efforts from clinicians. Working from an IPA perspective, Donnellan et al., (2012) noted that engagement in CBT sessions changed over time and was suggestive of a continuum. This paper shed light on adolescent engagement *experience*, rather than a traditional dichotomous opinion of whether adolescents adhere or not (e.g. Munson et al., 2009). The engagement continuum ranged from emotional detachment and lack of decision to, active involvement in therapy. On this continuum, both initial help seeking and engagement were highlighted, as was the role of others (e.g. family) in initial session attendance. Engagement was also considered to be a learning process (Bury et al., 2007) - by 'learning the ropes' of therapy, adolescents were helped to engage with the process.

Even though these papers provided interesting insights into adolescent engagement as a process, they solely focused on engagement in single treatment modalities, with

a single clinician, rather than mental health services as a whole. Policy and research has suggested that, for example, adolescents also engage with the service building and physical environment (DoH, 2011; MAC-UK, 2013). Interestingly, the papers chose to focus on engagement only over the treatment period but did not adopt a more developmental perspective (Weisz & Hawley, 2002) and acknowledge engagement over the adolescent chronology, especially when recruiting participants with a wide age range.

**Adolescent beliefs and opinions.** Papers looking into the role of client beliefs and attitudes (e.g. towards services/treatment/mental health) on engagement suggested mixed results. Burns et al. (2008) suggested adolescent ratings of treatment helpfulness were not predictive of treatment compliance. In a separate study, adolescents with more positive attitudes towards services (e.g. treatment control) reported full adherence (Munson et al., 2009). This mix in results could be due to the difference in research design, population, and/or influence of other factors on engagement.

When adolescents were asked for their opinions on facilitators and barriers to engagement (Gogel et al., 2011) they identified parental involvement and the therapeutic relationship as key facilitators. Even though service 'barriers' are not a focus of this review, it is interesting to note what was identified by adolescents as these complement previous sections of this review. Barriers included, stringent service rules, exclusion from treatment planning (i.e. issues of control), and lack of time from staff (i.e. therapeutic relationship). These barriers are identified in some



engagement-related models (e.g. Kazdin et al., 1997; McKay et al., 1995b). Research also suggested that exploring adolescent feelings about referral (Bury et al., 2007) and expectations of therapy (Donellan et al., 2012), including previous unhelpful experiences with services (Gogel et al., 2011), might facilitate therapeutic engagement.

Considering the suggestion that engagement is a fluctuating process, which exists on a continuum (Cunningham et al., 2009; Donellan et al., 2012), it is interesting that the fluctuating nature of beliefs and opinions of therapy were not accounted for in the reviewed research.

**Family influence.** All papers investigating the familial role, status and characteristics, highlighted their part in adolescent engagement, as proposed by the NEM-R (Costello et al., 1998), the EPV (McKay et al., 1995b) and the BTM (Kazdin et al., 1997).

Showing contradictory results, the socio-economic status of a family was thought to impact on attendance; with lower income equaling less attendance (Munson, et al., 2009), but in another paper, annual family income was thought to have no impact on engagement (Marchionda & Slesnick, 2013).

Parent's positive perceptions of therapy were hypothesized to predict greater adolescent engagement (Burns et al., 2008). Both parents and staff identified communication between them as barriers (Gogel et al., 2011). Parental pathology

was considered to have both: an impact on adolescent engagement (Breland et al., 2014), and no impact (Burns et al., 2008; Waldron, et al., 2007)

Flicker et al. (2008) and Marchionda and Slesnick (2013) investigated first session communication patterns in family therapy. Marchionda and Slesnick (2013) concluded fully engaged families show a higher percentage of therapist-to-parent communication in the first session. 'Drop out' families had a higher percentage of therapist-to-adolescent in the first session. Flicker et al., (2008), investigating the role of ethnicity, found for Hispanic families, a balanced alliance between adolescent-parent in the first session predicted engagement. This was not found for Caucasian families, who, despite imbalance in alliance between parent and adolescent, still attended. Generalizability of these results around ethnicity may be limited, however they suggest the importance of parental engagement.

Thompson et al. (2007), found the use of 'engagement activities' in sessions may help build relationships between therapist-family as well as family-adolescent, which in turn aided engagement. The reported success of Waldron et al. (2007) CRAFT (community reinforcement and family training) intervention, which provided parental training, on e.g. activity scheduling, to help facilitate adolescent attendance at CBT sessions, provided support for the suggested role of parents in engagement. These two papers also suggest the potential role of assisting parents in aiding engagement/ therapy.

Although all papers agree on the key role families play in facilitating adolescent engagement, the mix in the results presented above could be due to variations in methodologies, definitions and foci of the papers, however, this has implications in what is understood about the specifics of familial influence in adolescent engagement.

**Link between engagement and treatment outcomes.** Three papers (Burns et al., 2008; Smith et al., 2008; Waldron et al., 2007) made explicit, empirical links between the role of engagement and therapeutic outcomes. Additionally, a majority of papers, in their introduction sections, made reference to the potential role of this, adding to the rationales for their research.

Smith et al. (2008) proposed early engagement (early involvement in residential home activities) was positively associated with scores on measures of (e.g. self-esteem and family trust). This may be inline with the 'behaviour' dimensions in models such as Broome et al. (2001) and King et al. (2014). Interestingly, the participants within this study who were *less* engaged at intake had greater, more positive, changes in therapeutic outcomes compared to those more engaged. In contradiction to the above, adolescents experiencing substance misuse who were found to be initially 'difficult to engage', were 'harder to treat' with CBT (Waldron et al., 2007), showing worse outcomes on measures of drug use. Additionally, compliance with treatment was shown to not be predictive of future suicidal ideation or attempts (Burns et al., 2008).

**Interventions.** The effectiveness of engagement interventions has previously been reviewed (Kim et al., 2012). Through application of inclusion/ exclusion criteria, four papers that detailed interventions were selected. In order to focus on the review question of engagement *understanding*, the effectiveness, feasibility and acceptability of the interventions will only be briefly mentioned if deemed necessary.

Two papers considered the use of technology to aid engagement. A pilot study (Branson et al., 2011) into the use of text message reminders in an outpatient therapy service showed improvement in attendance of 65% over a three-month period, and was reported to be favourable by participants. Roy and Gillett (2008) case study into the use of email suggested that this could be a useful engagement, and therapeutic, medium for who find face-to-face interactions a challenge. This may show the dis-inhibitory effect of email to aid leveling of power. The use of more innovative ways to engage and work with adolescents, such as modern technology, has been proposed (e.g. DoH, 2015).

Thompson et al. (2007) and Waldron et al. (2007) results around the use of 'engagement activities' with parents adds further evidence to the role families can play in adolescent engagement. Neither paper discussed the specific mechanisms associated with engagement, and what may be specifically understood about engagement, as a result of these interventions.

### **Methodological critique**

Methodological critique is guided by, but not limited to (Barbour, 2001), framework criteria. Eleven selected papers adopted quantitative designs and were critiqued using the Long, Godfrey, Randall, Brettle, and Grant (2002), checklist. Cunningham et al. (2009) developed a measure of engagement and was critiqued using the Holmbeck and Devine (2009) framework (Appendix D).

Five papers were qualitative in design (Bury et al., 2007; Donnellan et al., 2012; Gogel et al., 2011; Roy & Gillett, 2008; Thompson et al., 2007). There has been debate over the usefulness of set criteria for critiquing qualitative research (Eakin & Mykhalovskiy, 2003), however guidelines can be a useful tool to focus review. This review is guided by criteria developed by Mays and Pope (2000) and Yardley (2000). Stake (1995) criteria was used to guide critique of case study methodology.

Criteria was used to assess quality, validity and reliability. Each paper was manually rated, summarized in tabular form (Table 1), and relevant methodological themes were identified and discussed below. Due to the paucity of research, no study was excluded, or prioritised, from methodological critique, on the basis of quality.

#### **Quantitative.**

**Design.** Most selected papers adopted a quantitative design to investigate factors impacting on adolescent engagement or whether particular interventions played an improving role. The nature of the cross-sectional design of a majority of the quantitative research allowed for various factors to be investigated at once

(Sedgwick, 2014). However, engagement was only measured at one point in time, potentially making the assumption that engagement is a one-off experience, which does not fluctuate, contrary to alternative literature (e.g. Staudt, 2007). Smith et al. (2008), in their repeated measures design, took measures from two points in time to compensate for the potential fluctuating effect of engagement, potentially increasing reliability of conclusions regarding the phenomenon.

**Measures.** The adopted measures were ‘closed’ assessment tools (See Table 1 for full description of selected measures), limiting the exploration of further information beyond that already anticipated by the selected questionnaires, which may increase researcher bias. Some papers used well-validated measures (e.g. Waldron et al, 2007), and provided rationales for their use (e.g. Breland et al., 2014). Researcher bias may have been further present as some papers were selective in choosing subtests from wider measures (e.g. Burns et al., 2008; Hawke et al., 2005) or developed un-validated scales specifically for the research aims in question (e.g. Branson et al., 2013; Smith, et al., 2008). This can limit internal validity and therefore generalizability of the overall findings. Amongst papers (Flicker et al., 2008; Marchionda & Slesnick, 2013), which adopted multiple coders/ researchers, reliability checks across these were conducted when necessary with good inter-rater reliability (0.82 or above), increasing confidence in internal validity of the paper’s results.

Interestingly, a significant proportion of measure respondents were adults (parents (e.g. Breland et al., 2014; Waldron et al., 2007) or clinicians (Marchionda & Slesnick,

2013), limiting engagement understanding from the adolescent perspective. This may have been appropriate as some papers were from a family therapy perspective and the role of parents in engagement is noted (e.g. Kazdin et al., 1997). Social desirability may have played a role with parent-ratings (e.g. sensitivity of the topic of their child's mental health) and researcher bias may impact on the reliability and validity of clinician-rated measures.

Within intervention studies (e.g. Waldron et al., 2007), pre/post measures were taken, meaning there are limitations to conclusions drawn about the role of the intervention, due to the potential interference of extraneous variables. It is not in the scope of this paper to fully review efficacy and effectiveness of interventions.

Engagement measure development (Cunningham et al., 2009) evidenced content, construct and criterion validity, increasing the confidence that the full engagement phenomenon was measured. Sensitivity to change was not evidenced and external validity is lacking due to the development with adolescents based solely in residential substance misuse treatment centers.

**Population.** Due to the frequency of cross-sectional designs utilized, the participants were highly specific to the paper and source population recruited from. As eight quantitative papers investigated substance misuse treatment engagement, some recruited through the criminal justice system, generalizability is severely limited outside of this population. Frequent exclusion criteria for recruitment were psychosis, intellectual impairment/ developmental delay or high risk. Despite this

being understandable to maintain internal validity, with attempts to limit confounding variables, ecological validity is impacted when considering adolescents as a whole. The lack of generalizability is pertinent when considering engagement and the excluded populations (e.g. first episode psychosis; Doyle et al., 2014).

It is important to note a majority of the sampling took place in countries other than the UK- mostly the USA. As the USA do not offer free healthcare, it could be possible that this impacted on rates of engagement and the socioeconomic status of participants (e.g. Lee et al., 2012).

**Qualitative.** The use of qualitative methods allows for complex and phenomenological elements to be explored, facilitating the development and expansion of existing theory (Cooper, 2012). The methodologies adopted and resulting quality was mixed amongst the selected qualitative papers.

**Design and analysis.** Two papers (Bury et al., 2007; Donnellan et al., 2012) adopted methodologies appropriate to their research questions (Mays & Pope, 2000; Yardley, 2000). In both, overall validity and relevance were good, with evidence of triangulation, attention to negative cases and commitment and rigour in analysis. The validity may have been slightly compromised, in both papers, by a lack of respondent validation. However, there is debate around the role of member checking in qualitative methodology (Pope & Mays, 2006). The content analysis approach adopted by Thompson et al. (2007) was an appropriate fit with theory presented (Yardley, 2000). Data collection and analysis had depth and the discussion



of negative cases added to the validity of the resulting conclusions. Despite stating that parental and adolescent perspectives were compared, the method of analysing this was missing, impacting on the rigour of methodology and analysis. Gogel et al. (2011) did not explicitly state their selected qualitative methodology, simply commenting the interview data was coded, compromising validity (Mays & Pope, 2000) and ability to evaluate transparency and coherence of the method and data (Yardley, 2000). The depth of data analysis was limited, impacting on the conclusions that can be drawn, however, the variety of perspectives included allows for a slightly broader understanding of the engagement phenomena.

The case study design adopted by Roy and Gillett (2008) displayed evidence of triangulation, conceptual structure and the development of work. However, the context of the adolescent was missing, impacting on the sense of a story (Stake, 1995) and sense of the participant.

Inter-coder reliability checks were conducted by, Gogel et al. (2011) and Thompson et al. (2007), with good results, contributing to the reliability of the conclusions drawn.

**Population.** In all qualitative papers, due to the specific populations recruited, generalizability outside treatment contexts may be limited. Within qualitative research generalizability is a debated issue due to the methodological concern with generating a rich account of particular phenomena rather than transferability (Leung, 2015). As adolescents self-selected to participate, bias may be evident within

responses as (e.g. participants were already engaged in therapy therefore may have had more 'positive' experiences and views of mental health services).

**Reflexivity.** Evidence of reflexivity was missing from all qualitative papers, compromising validity. In order to not bias the analysis process, it is important for researchers to be aware of their prior assumptions and views about the phenomena in question (Mays & Pope, 2000). This may be especially pertinent when considering a phenomenon such as engagement, e.g. around potential power dynamics between participant and adult researcher. Only Bury et al. (2007) made reference to the researcher's role within the recruiting service, however further acknowledgement of positioning, or bracketing (Tufford & Newman, 2012), were missing.

### Discussion

Literature search and review revealed a great variety in the focus and results of selected papers. As a result of this heterogeneity, what can be concluded in response to the review question and aims, around current understanding of adolescent engagement in mental health services, is greatly mixed. This may be a symptom of the variable methodological quality of research and the lack a unified engagement definition (e.g. Staudt, 2007). It is beyond the scope of this paper to offer a new, unified definition of engagement, however, the absence of an agreed conceptualization has implications for the ability to generalize across papers as, e.g. papers may have been investigating different phenomena. The hindrance this can have on theoretical progress (Drieschner et al., 2004) is evident from the results of the current review. This variety may contribute to the proposition that what is

currently understood about adolescent engagement is around its multi-faceted nature and the variability of influences (e.g. DATOS-A; Broome et al., 2001).

Due to the paucity of research, papers were not excluded based on quality. This has obvious implications for the certainty in which conclusions can be drawn within this review. Data from papers with weaker methodologies were combined with those with more robust designs. Additionally, due to the developed inclusion and exclusion criteria, and focus on empirical papers, grey literature and theoretical papers were not part of this review. This means that the more conceptual and policy-based understandings of adolescent engagement may be missing.

### **Clinical Implications**

It may be beneficial for clinicians to consider adolescent engagement as fluctuating and on a continuum (Donnellan et al., 2012), rather than as a linear process. Viewing and defining engagement as merely 'turning up' (e.g. Lee et al., 2012) may be a reductive, one-dimensional view of engagement (Staudt, 2007), ignoring attitudinal and relational dimensions (e.g. Cunningham et al., 2009), and limiting what is seen as 'therapeutic' e.g. problems with viewing adolescents who are engaged early on as gaining more therapeutic benefits and outcomes (Smith et al., 2008). However, due to the primary focus of this research being on participants with substance-misuse concerns, results need to be applied to other populations with caution.

Review revealed that influences on engagement fluctuation are varied, ranging from relationships with therapists (e.g. Cunningham et al., 2009) to the influence of

families (e.g. Thompson et al., 2007). The precise role of families in adolescent engagement is uncertain from the reviewed papers. As the methodological quality, and focus, was varied, results need to be interpreted with caution e.g. around familial engagement interventions. Additionally, the strong familial role identified in this review may be biased by the amount of family therapy papers selected. However, models (e.g. EPV; McKay et al., 1995b) and previous research (Morrissey-Kane & Prinz, 1999) support this. Service relationships with families may need to be emphasized when planning intervention and service provision.

As the role of demographics and diagnosis on engagement were highly variable, as well as the inconsistency of the methodological strength, and ecological validity, of these papers, it is a challenge to draw conclusions about these. Some results were inline with previous research, e.g. the role of internalizing and externalizing presentations and engagement (Baruch et al., 1998). Interestingly, two papers (Munson et al., 2009; Wilson et al., 2006) concluded intelligence and verbal abilities as positively associated with engagement and retention. Additionally, Burns et al. (2008) commented on adolescents with disruptive behaviour being 'more guarded.' Again, due to issues around ecological validity, these results need to be interpreted with caution, however, research suggests that adolescents experiencing behavioural difficulties may have poorer adaptive communication skills (Clark, Prior, & Kinsella, 2002). As is within the clinical psychologist role, it may be clinically beneficial to be responsive to verbal and communication skills during engagement.

When considering the quality of the qualitative research, it may be more beneficial for clinicians, when considering engagement, to focus in on the individual experiences and needs of adolescents (including beliefs) by addressing issues of power and control (Bury et al., 2007), being transparent with treatment planning (Gogel et al., 2011), as well as considering the adolescent's stage of development (Weisz & Hawley, 2002), rather than demographic/ diagnostic characteristics. As review suggested, the therapeutic relationship is a key factor in adolescent engagement, which may be complemented, and dependent on, a family who are also engaged.

### **Future Research**

The lack of an agreed definition of adolescent engagement may impact on theoretical progressions within this area (Drieschner et al., 2004). One paper did tentatively generate a definition of engagement (Cunningham et al., 2009), which complemented engagement models and alternative conceptualizations. This lacked validation and generalizability outside of a substance-misuse population. It may be beneficial for the progression of theoretical, and therefore clinical understanding, for future research to work towards generating a more unified, valid and generalizable definition.

The fluctuating/continuum nature of engagement was highlighted, as was the potential role of beliefs and opinions. From review, it appears that research is currently sparse on the fluctuating nature of beliefs about services, therapeutic intervention and the role this may play in maintaining engagement. Due to uncertain

boundaries between engagement and help seeking conceptualizations, it is wondered whether these elements are in fact embedded within the help-seeking literature (e.g. Rickwood et al., 2005; Wilson & Deane, 2001; Wilson et al., 2005). Future research into the role of beliefs in ongoing engagement fluctuation may aid further understanding.

Despite models of adolescent development suggesting a difference between early and late adolescence (e.g. Erikson, 1950), this was markedly absent from engagement models and research. Additionally, despite being highlighted in models of adolescence and engagement, the role of peers, and stigma, were missing. This may be a result of the lack of distinction between older and younger adolescence, as the role of peers is hypothesized to be more prevalent for older adolescents (Raviv et al., 2009). Judging adolescent experience by child and/ or adult research adaptations has been criticized (Weisz & Hawley, 2002), however the problems of generalization *within* the adolescent age bracket has been widely neglected by the papers within this review. This is especially concerning as previous research has noted service use markedly dropping at 16-18 years old (Singh et al, 2008; Vyas et al., 2015). The reviewed qualitative papers mostly generated valid data on engagement experiences rather than being limited by closed, adult-centric outcome measures. It may therefore be beneficial for future research to distinguish between, and solely focus on, the engagement experiences of either younger or older adolescents from a qualitative perspective e.g. the engagement understanding and experiences of 16-18 year olds.

The need to employ more innovative and technological engagement strategies has been highlighted by policy (DoH, 2015). The two reviewed papers employed more preliminary research designs, however did display encouraging efficacy results. It may be beneficial for future research to employ efficacy and effectiveness studies into technology-based engagement interventions and consider applicability of these to service provision.

Ecological validity was a key issue highlighted throughout this review. A number of papers solely focused on a substance-misusing population outside of the UK healthcare system. A reason for these papers being generated by the literature search process maybe due to the known difficulty in engaging this population (NTA, 2007). Additionally, papers not focusing on substance-misuse selected participants engaged in specific treatment modalities (e.g. CBT) rather than mental health services as a whole. Due to this lack of generalizability, it may be beneficial for future research to look into adolescent engagement with whole services, rather than into specific types of treatment, using more robust methodological designs.

### **Conclusion**

The aim of this review was to investigate current understanding of adolescent engagement in mental health services. Seventeen papers were reviewed revealing wide variations in aims, engagement definitions, foci, methodological quality and results. Due to this, a consistent synthesis of review results was limited. Clinical implications were made suggesting attention is paid to the fluctuating nature of engagement, familial engagement, consideration of verbal ability and addressing

beliefs and power within session. Future research implications included the need for the development of a unified engagement definition, exploring the role of adolescent's beliefs and opinions of therapy in engagement fluctuation, investigating the engagement experience specific to developmental stage *within* adolescence, exploring the efficacy of technology as an engagement aid, and looking holistically towards whole service engagement.



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**Section B**

Experiences of engaging with mental health services in 16-18 year olds: An interpretative phenomenological analysis

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## Abstract

**Background.** Despite older adolescence being a risk period for the development of mental health concerns, mental health service engagement is low amongst 16-18 year olds. As therapeutic attendance is linked to clinical outcome, it is important to understand engagement in this population. There is a paucity of research looking specifically at the older adolescent engagement phenomenon. Previous qualitative research into adolescent experiences has provided rich and detailed results.

**Method.** Interpretative phenomenological analysis was chosen as the methodological approach. Ten 16-18 years olds were recruited from two London-based Child and Adolescent Mental Health Services. Each young person was interviewed in order to understand their personal experience of engaging in mental health services, and associated engagement barriers and facilitators. Interviews were transcribed and underwent analysis.

**Results.** Analysis revealed twelve subthemes subsumed within five superordinate themes: engagement begins at help seeking, strength of inner resolve, evolution of the self, in the clinic room, and, existing within service walls: physical and policy-based boundaries. Themes are discussed in detail.

**Conclusions.** Conclusions are drawn in relation to previous theory and research. When considering 16-18 year understandings of the engagement phenomena, key elements include: clinician and service developmental appropriateness, negotiation of developmental tasks in relation to engagement, experience of the physical building environment, and awareness of service policy. Suggestions for clinical practice in relation to engagement facilitators and threat are made, and recommendations for future research proposed.

*Key words: engagement, adolescents, mental health services*

## Introduction

Adolescence is thought to be a risk period for the development of mental health concerns (e.g. Vyas, Birchwood, & Singh, 2015) with older adolescence/ early adulthood seeing a significant increase in symptomology (Murphy & Fonagy, 2012; Royal College of Psychiatrists, 2012). This occurs alongside reduced mental health service use. A large proportion of service 'drop-outs' occur around 16-18 years old (Singh, Paul, Ford, Kramer, & Weaver, 2008). Traditionally, child and adolescent mental health services (CAMHS) provide interventions for young people up to 18 years. To ensure appropriate service provision, policy suggests CAMHS are responsive to client's developmental stage (DCSF & DoH, 2008) and individual need (DoH, 2015).

Engagement in services may be an important part of effective mental health treatment (YoungMinds, 2014). Elements hypothesized to be part of engagement (e.g. King, Currie, & Petersen, 2014), such as the therapeutic relationship (Shirk & Karver, 2003), may be linked to treatment outcome. For older adolescents, service engagement could be a challenge (Royal College of Psychiatrists, 2012). Alongside experiencing mental distress, they may also be faced with societal (e.g. stigma – Eisenberg, Downs, Golberstein, & Zivin, 2009), familial (YoungMinds, 2006) and developmental (Erikson, 1968) pressures. Additionally, 16-18 years is a potential time of transition between CAMHS and adult mental health services (AMHS), which may impose its own challenges (NICE, 2016; Singh, Evans, Sireling, & Stuart, 2005; Singh et al, 2008).

Despite this, little is known theoretically and specifically about 16-18 year old

engagement. Definitions have been proposed for children, families and the whole adolescent age range (e.g. Cunningham, Duffee, Huang, Steinke, & Naccarato, 2009; Staudt, 2007), which go beyond the definition of ‘merely turning up’ (Gopalan et al., 2010) or ‘dropping-out’ (Johnson, Mellor, & Brann, 2008). More comprehensive definitions incorporate multiple elements such as behavioural (e.g. attendance) and attitudinal (e.g. emotional investment in treatment) components (Staudt, 2007), as well as considering the facilitating role of the therapeutic relationship (see King et al., 2014 below). However, definitions lack consensus (Kim, Munson, & McKay, 2012), and are not specific to the older adolescence. Help-seeking definitions also incorporate elements of engagement, such as seeking professional help (e.g. Rickwood, Deane, Wilson, & Ciarrochi, 2005), meaning the overlap between the two is apparent but undefined. Theoretical progress may be hindered because of unclear definition (Drieschner, Lammer, & van der Staak, 2004).

Models applicable to adolescent engagement are limited but some have been developed. King et al. (2014) proposed a child and adolescent motivational model. This focuses on ongoing engagement *within* treatment, from a therapeutic relational perspective, considering hope and confidence to be key. Both client and therapist bring emotional, behavioural and cognitive elements to engagement, suggesting responsibility for engagement is not solely with one party. This model is not specific to older adolescents, and the fluctuating nature of engagement (Donnellan, Murray, & Harrison, 2012) is not accounted for. Broome, Joe, and Simpson (2001) developed a model for young people who experience substance-misuse. Multi-faceted elements of engagement are incorporated such as ‘background factors’ (e.g. family), treatment readiness and session attributes (e.g. therapeutic involvement). The

generalizability of this model outside of a substance-misuse population may be limited. Barriers to treatment, for children, adolescents and their families, have also been considered. The Ecological Point of View model (McKay, Gonzales, Stone, Ryland, & Kohner, 1995), coming from a family therapy perspective, suggests that barriers can exist at multiple levels (e.g. individual, community) acknowledging the role of the 'ecosystem' in engagement. The Barriers to Treatment model (Kazdin, Holland, & Crowley, 1997) proposes difficult familial relations with therapists may contribute to treatment termination. These models highlight the role of families in engagement; however, they do not focus on the unique experiences of 16-18 year olds, where families, communities etc. may be positioned differently. Research suggests adolescents may prefer peer support (e.g. Raviv, Raviv, Vago-Gefen, & Fink, 2009). Indeed, peers and perceived impact on self-esteem (e.g. Threats to Self Esteem Model; Fisher, Nadler, & Witcher-Alagna, 1982) may influence engagement.

The above models were developed through a process of scoping review, interview through pre-determined outcome measures or interview with parents (see Broome et al., 2001; Kazdin et al., 1997; King et al., 2014; McKay et al., 1995). It appears consultation with adolescents was absent. These conceptualizations are markedly adult-centric in understanding, and therefore lack an adolescent-specific phenomenological focus. Attempting to understand young people through adaptations of developmentally inappropriate models may hinder theoretical progress (Weisz & Hawley, 2002).

Empirical research related to the adolescent engagement phenomenon has been extensive. However, this tends to focus on individual elements related to

engagement, such as beliefs and expectations (e.g. Rickwood, Deane, & Wilson, 2007; Ronzi & Dogra, 2012; Watsford, Rickwood, & Vanagas, 2013), satisfaction (McCann & Lubman, 2012), interventions (see Kim et al., 2012 for review), disengagement (e.g. Schimmelmann, Conus, Schacht, McGorry, & Lambert, 2006), or role of family (see Gopalan et al., 2010 for review), rather than engagement in its entirety from the adolescent perspective. The closed, measure-led and adult-centric nature of these studies may have limited exploration of the engagement phenomena beyond that prescribed by the selected questionnaires and the research investigators. Investigating older adolescent understandings of engagement as a whole, including the barriers and facilitators suggested above, from the young person's perspective (YoungMinds, 2005), may allow for a deeper exploration, and understanding.

Some related research has adopted a more adolescent-led approach. These studies tend to use a qualitative methodology and have generated interesting and rich results. Harper, Dickson, and Bramwell (2014) investigated young people's experiences of a 16-18 year old mental health service as a whole. Themes emerged around young people valuing therapeutic relationships and the service meeting developmental needs. Adolescent understandings of engagement experiences were not explicitly discussed. Bury, Raval, and Lyon's, (2007) interpretative phenomenological analysis (IPA) investigation looked at adolescent experiences throughout a course of psychoanalytic psychotherapy. Engagement themes were evident but not explored in depth. The paper suggested paying attention to client views of psychotherapy, and issues around control and power, might help improve initial engagement. This study focused on one therapeutic modality and did not take

into account wider issues such as service provision, which may also impact on engagement (Munford & Sanders, 2015). Using IPA as part of a mixed-methods investigation, Kapur et al. (2014) looked directly into service engagement amongst two young people who experienced voice hearing, and their parents. Superordinate themes included: battling with mental health services and frustration with received care. However, one participant was 11 years old, and parent's experiences were included, meaning the study was not wholly older adolescent specific. Additionally, the focus was limited to one specific mental health presentation. As illustrated, the use of qualitative methods may facilitate in-depth and rich investigations to occur (Smith, Flowers, & Larkin, 2009), including when recruiting adolescent participants (O'Reilly & Parker, 2014).

To date, in-depth exploration of 16-18 year old understandings of their service engagement experiences, facilitators, and barriers, has not been conducted. Research into older adolescent specific understandings will contribute to a lacking evidence-base. In order to ensure services are responsive to the population they serve, it is essential to understand the unique needs and views of the targeted client group. Investigation could contribute to the effective development of older adolescent tailored services, which may impact positively on therapeutic outcomes. By engaging young people effectively in services, we may be able to prevent more serious and enduring problems later on in life (Birchwood & Singh, 2013).

### **Research Aims and Questions**

The need for further investigation is highlighted by three coexisting issues: the rise in mental health concerns in older adolescence, the high service drop-rate at this age,

and the paucity of research into 16-18 year old engagement. The current study aimed to explore older adolescent sense-making of their engagement experiences, barriers and facilitators, in order to contribute to a sparse understanding. Research questions were:

- What is the 16-18 year-old understanding of their experience of engaging in mental health services?
- What is their understanding of their experience of engagement facilitators and engagement barriers?

## **Method**

### **Research Design and Methodology**

To aid in-depth exploration of the 16-18 year old engagement phenomena, a non-experimental, descriptive design was chosen. Due to the paucity and 'adult-led' nature of previous research, and taking example from prior study designs that generated rich data, a qualitative methodology was used.

Interpretative Phenomenological Analysis (IPA; Smith, 1996) was chosen as the methodological approach. Informed by philosophical understandings of phenomenology, hermeneutics and ideography (Smith et al., 2009), IPA enables insight to be developed into specific subjective meanings and interpretations people make of an experienced phenomena. This meant in-depth understanding of the 16-18 year olds idiosyncratic sense making of their engagement experience could be generated.

## **Participants**

Inclusion and exclusion criteria were developed to facilitate recruitment of a homogeneous sample (Hefferon & Gil-Rodriguez, 2011) whilst ensuring an understanding of engagement could be ascertained across adolescent experiences.

Inclusion criteria were:

- Between 16-18 years old
- Engaged with mental health services at interview. Engagement was defined as having been offered, and was attending appointments (e.g. McKay & Bannon, 2004), for any length of time.

Exclusion criteria were:

- Active psychosis
- Significant developmental delay
- Significant risk issues

Ten participants (Table. 1) were recruited from two CAMHS services in London. All adolescents approached were interviewed and none ceased participation in the study. A small number of participants allowed for in-depth, rich data gathering and analysis. The sample size was in line with recommendations (Smith et al., 2009) and commensurate with previous IPA research (e.g. Colton & Pistrang, 2004; Huws & Jones, 2008; Roose & John, 2003).



## **Procedure**

**Ethical approval.** Ethical approval was requested and granted by an NHS Research Ethics Committee (Appendix E). Research and Development (Appendix F), and CAMHS research approval (Appendix G), was granted by the recruiting NHS Trust. The British Psychological Society (BPS, 2013) code of human research ethics was followed.

**Risk precautions.** All interviews took place during clinic hours and the researcher familiarized themselves with service risk protocol. Participant's clinicians were made aware of interview timings. Due to the potentially sensitive nature of the interview content, participants were informed of available support if they became distressed after leaving the service building.

**Recruitment.** Recruitment took place over six months. The researcher advertised the study in team meetings. Participants who met inclusion/exclusion criteria were identified by their clinician, and invited to take part at their next therapy session. If the adolescent showed interest, they were asked by their clinician to provide verbal consent for their contact details to be passed on to the researcher. Initial contact was made by telephone. Participants were invited to attend an introductory session (after a therapy session for participant ease) to read through the Participant Information Sheet (PIS) (Appendix H) and ensure they understood enough about the study to make an informed decision to participate. This was ascertained by asking them to repeat back what they understood about the study and their participation. If this was demonstrated, participants were invited back for a second meeting to sign the consent form (Appendix I) and be interviewed. All

participants demonstrated understanding and were invited back. A £10 high street voucher was given for participation.

**Interviews.** Data collection was via 1:1 semi-structured interview (Appendix J). This provided a tentative framework but allowed for open conversation about the engagement phenomena, encouraging the participant to set the parameters of the discussion.

In order to ensure adolescent understanding of the schedule, PIS and consent form, a group of five 16-18 year olds, from a local school, were consulted (Appendix K). Two CAMHS-based clinical psychologists reviewed the final schedule in order to ensure relevance to the research questions.

At the beginning of each interview, participants were reminded their participation was voluntary and were free to leave at any time. Interviews were audio-recorded, transcribed for analysis, and anonymised. Interviews lasted between 30 and 65 minutes.

**Analysis.** Transcripts were analysed following IPA protocol (Smith et al., 2009) and is described below.

- 1) Reading and re-reading: To become familiar with the data, transcripts were read whilst listening to the audio recording. This allowed for linguistic or verbal nuances to be ascertained. Transcripts were then re-read to ensure full immersion in the data, gathering an overall understanding of how different sections were connected and emerged.

- 2) Initial noting: Alongside the data, detailed notes were made on descriptive, conceptual and linguistic understandings and explorations (Appendix L). The hermeneutic cycle was experienced as interpretations were made on participant understandings of their engagement experience, whilst remaining close to the original meaning.
- 3) Developing emergent themes: The initial noting was read through closely and themes developed. These emerged by focusing on discrete chunks of data, whilst keeping in mind the interview as a whole. The developed emergent themes attempted to reflect the complexity of the data whilst drawing out key ideas.
- 4) Searching for connections across themes: Emergent themes were typed into a word document, in chronological order (Appendix M). Through a process of abstraction, themes were moved around the page, drawing together related items. Emerging patterns were developed into super-ordinate themes. The iterative nature of analysis was experienced- returning to the original transcript to ensure super-ordinate themes reflected the original data.
- 5) Moving to the next case: To move onto the next transcript, ideas from the previous interview were bracketed by noting assumptions and ideas developed from the analysis (Appendix N). Steps 1-4 were repeated for all transcripts.
- 6) Looking for patterns across cases: All emergent and super-ordinate themes were printed, cut out and laid on a large surface. Themes were moved around, using the abstraction process, until patterns and commonalities emerged (Appendix O). The hermeneutic and double-hermeneutic cycle was experienced as higher-order concepts were developed and variance amongst individuals noted. Concepts were typed out (Appendix P) and quotes collected from the transcripts (Appendix Q). Following recommendations (Smith et al., 2009) the recurrence of

the higher-order concepts was considered in table form (Appendix R). Themes that did not occur in 50% of participants, or over, were removed. Remaining over-arching, and embedded themes, were retained (section 3.0). Smith et al., (2009) states the analytic process may continue into the writing of results. Themes were re-considered and revised as writing continued.

**Quality assurance.** To ensure quality and validity, Mays and Pope (2000) criteria was followed.

1) Triangulation: To assess analytic reliability, investigator triangulation took place.

Four transcripts were analysed and coded separately by two research supervisors. These were checked against the original coding by the main researcher. There was no full disagreement on emergent themes. Minor discrepancies around theme meanings were discussed to ensure inter-coder reliability (Yardley, 2000).

2) Reflexivity: The role of prior assumptions and personal characteristics were reflected upon and discussed with a research supervisor.

a. *Age difference and engaging with researcher*: The impact of age difference was considered. It was observed that some participants mentioned difficulties with opening up to adults, fearing judgment. Additionally, the researcher had prior assumptions, from personal and professional experience, that adolescents may have been reluctant to engage with the interview process. By participating in the interview, the adolescent was experiencing a separate engagement process with the researcher. It was wondered how this may have impacted on the participant, and researcher's responses, especially in the earlier stages of

the interview.

- b. *Independence from service*: As interviews progressed, positioning and power dynamics between researcher and adolescent were noted. Reflexive conversations focused on how participants may have expressed, or altered, their opinions about clinicians or services. They may have assumed the researcher would feedback to their clinician, or alter their perception of the participant (despite being informed of the confidentiality process), giving more socially desirable responses.
- 3) Bracketing: In order to reflect on and work with these assumptions, a process of bracketing was followed using discussions with supervisors and keeping a research diary (Appendix S). Following each interview and transcript analysis, notes were made, to allow for biases or assumptions to be discussed or thought through. Before recruitment began, a bracketing interview (Appendix T) was conducted with a trainee clinical psychologist about personal or professional assumptions and experiences. The limitations of this process were noted (e.g. Heidegger, 1927/2010), around how possible it can be to 'truly' bracket off assumptions.
- 4) Attention to negative cases: Attention was paid to cases, or sections of transcripts, which 'deviated' from emerging themes, by disconfirming or contradicting analysis. This aided a process of broadening and refining themes.

Table 1

*Participant pseudonyms and their dominant themes*

<b>Participant</b>	<b>Age</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Months engaged in services</b>	<b>Current therapy</b>	<b>Dominant theme(s)</b>	<b>Example quote</b>
1. Nebi	16	F	Black British	4	1:1 Clinical psychology	<ul style="list-style-type: none"> <li>• Engagement begins at help-seeking</li> <li>• In the clinic room</li> </ul>	“... and she was like, ‘you’re really brave’ and stuff but it wasn’t in a patronizing way because if it was patronizing I wouldn’t have wanted to say anything...”
2. Anna	16	F	Black British	12	1:1 CBT with Clinical Psychologist	<ul style="list-style-type: none"> <li>• Strength of inner resolve</li> <li>• Evolution of the self</li> </ul>	“Like, I thought my therapist would be a bit weird and scary, shouting at me or something like that.... I psyched myself up and thought this is going to be a good thing so don’t get scared about it otherwise you won’t end up coming, and it was instead a really good time.”
3. Nicole	17	F	White British	6	1:1 Clinical Psychologist	<ul style="list-style-type: none"> <li>• Engagement begins at help-seeking</li> <li>• In the clinic room</li> </ul>	“I just really couldn’t get out of bed so I decided to go to the doctor. My mum said I had to go.”
4. Hannah	17	F	White British	3	1:1 CBT with CBT	<ul style="list-style-type: none"> <li>• Engagement begins at</li> </ul>	“I feel like that’s why I kept coming back a lot as well ‘cos I felt like I could manage things a lot

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					Therapist	<ul style="list-style-type: none"> <li>help-seeking</li> <li>more..."</li> </ul>
5. Caroline	18	F	Latin American/Hispanic	5	1:1 CBT with Clinical Psychologist	<ul style="list-style-type: none"> <li>Evolution of the self</li> <li>In the clinic room</li> </ul>
6. Jenny	17	F	White European	5	1:1 Integrative therapy with CAMHS Practitioner	<ul style="list-style-type: none"> <li>Evolution of the self</li> <li>In the clinic room</li> </ul> <p>"....I just feel better, I feel less anxious than I was before.... I just saw the change, I would change more and more...."</p> <p>"I have to just take whatever I can from what is being offered, erm, erm, because otherwise I just, there's no, I can't just sit and not do anything, if I want to get better I'm going to have to do something about it so like I just I'm taking whatever I can from what there is."</p>
7. Chris	16	F-M Transgender	White European	2	1:1 CBT with Clinical Psychologist	<ul style="list-style-type: none"> <li>Engagement begins at help-seeking</li> <li>In the clinic room</li> </ul> <p>"...the most important things I could talk with someone who, you know, who don't, who listens and who tries, you know, to understand you"</p>
8. Rose	17	F	White British	4	1:1 CBT with Clinical Psychologist	<ul style="list-style-type: none"> <li>Strength of inner resolve</li> <li>In the clinic room</li> </ul> <p>"Rose: That's when I asked to see someone else            Researcher: And what was that like for you actually asking to see somebody else?            Rose: I felt a bit bad but I knew it would probably be for the best."</p>

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9. Max	17	M	British Asian	2	1:1 CBT with CAMHS Practitioner	<ul style="list-style-type: none"> <li>• Engagement- begins at help seeking</li> <li>• In the clinic room</li> <li>• Evolution of the self</li> </ul>	<p>“...it was at a point that I wasn’t really comfortable in admitting everything, erm, as the appointments went along I started to admit more and more, ‘cos I was never, I never had a way of erm, an outlet of getting things off my chest and how I was feeling...”</p>
10. Noah	18	M	White British	24	1:1 Integrative therapy with Clinical psychology	<ul style="list-style-type: none"> <li>• Strength of inner resolve</li> </ul>	<p>“Researcher: And what do you think it was that made you want to go back to the next appointment, even though you felt drained? Noah: I’d like to be... I don’t want to use the word well...but I’d like to be more functional and mentally healthy than I am....”</p>

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## Results

Analysis resulted in four superordinate themes, which subsumed ten subthemes (Table 2). Superordinate themes were: engagement begins at help-seeking, strength of inner resolve, evolution of the self, and in the clinic room.

Table 2

*Superordinate themes, subthemes, and illustrative quotes*

<b>Superordinate theme</b>	<b>Subtheme</b>	<b>Example quote</b>
<b>Engagement begins at help-seeking</b>	Reliance on adult acknowledgement of distress and facilitation of professional help seeking	<i>"... so my college was really worried about me and they said that they wanted me to talk to someone, try and go to the doctors, and they spoke to my mum, my parents about it and my parents were encouraging me to go and ask about it as well, erm, then so my dad ended up, just booking me an appointment with my GP."</i> [Caroline]
	Cognitive-preparedness	<i>"I realized that if I keep this to myself I'd do something I regret so I just decided, I told myself I need to speak to people, or I need to tell someone what I'm going through or I'll go insane."</i> [Anna]
<b>Strength of inner resolve</b>	Striving against engagement threats	<i>"Researcher: I'm wondering about that, even though that was a difficult experience, what was it that made you keep on coming back here? Participant: I want to get better."</i> [Nebi]

	<p>Responsibility to others</p>	<p><i>“I felt like the duty, I had to if like... like I admitted it to my parents, so I felt like, because I had told them I didn’t want to put more pressure on my mum, I had to do like, she wanted me to try so I had to.” [Hannah]</i></p>
<p><b>Evolution of the self</b></p>	<p>Progression through suspense and release</p>	<p><i>“I was stressed what, you now, as I said, but if they don’t want to help me, they would get bad impression of me...” and later “... it was relieving because I had a, I just, the feeling that I told somebody helped me...” [Chris]</i></p>
	<p>Growth through familiarity and trust affect</p>	<p><i>“...it was just, even though I would feel a bit anxious I knew that it was helping...it was just so helpful, like I knew more and more and I didn’t.... I just felt natural kind of thing...” [Caroline]</i></p>
	<p>Negotiating as an adolescent through choice, transparency and control</p>	<p><i>“Participant: They offered, do you want mum to sit in your session but I was like, no. Researcher: What was it like for you, being given the choice about whether mum came into the session or not? Participant: Er, it was easy, I just said no....less stress... less issues Researcher: And how do you think your experience of that session would have been different if mum was in the room? Participant: Probably</i></p>

		<i>wouldn't have admitted as much stuff as I did..." [Max]</i>
<b>In the clinic room</b>	Developmentally appropriate responsiveness	<i>"...he wasn't patronizing." [Noah]</i>
	Centrality of a human relationship	<i>"She seemed like a person you could speak to anything about, she had that aura about her..." [Anna]</i>
	Tangibility of techniques	<i>"Researcher: And what, erm, what do you like about practical help? Participant: Erm, just that I feel like, erm, there's some measurable progress, whereas with [previous talking therapy] it was just... I don't know what was happening, yeah, it just feels more useful." [Rose]</i>

### **Theme 1. Engagement Begins at Help-Seeking**

This superordinate theme conceptualizes engagement as beginning at help-seeking. All ten participants discussed their help-seeking journey to aid sense-making of their engagement experiences. The boundary between the two may be overlapping for adolescents.

**Reliance on adult acknowledgment of distress and facilitation of professional help-seeking.** All participants spoke about the role adults played in acknowledging their distress and facilitating professional help-seeking, marking the start of their engagement journey. Hannah *"...explained to my mum what was happening, like, in my head and she was like, 'I think it's time we go to the GP and*

*get you some counselling'..." Max's distress was acknowledged by a teacher: "she noticed I wasn't participating as much and I was looking down.... we had a chat in her office and she said she'd put me on the waiting list for a counsellor." [Max]*

It appears reliance on adult acknowledgment may have been important for participants in times of crisis due to uncertainty about whether their distress warranted, or how to seek, professional help. For some participants, there may have been a dilemma between negotiating independence and adult-reliance, reflecting a challenging pull between adolescent-as-a-child and adolescent-as-an-adult within the initial engagement stage:

*"I think there's a part of every teenager really when your mum says something like 'oh you need help' that's like.... just don't! (laughs), erm, I think part of it was also that I was kind of worried....so the fact that she said it, I think it was necessary really..." [Jenny].*

**Cognitive-preparedness.** A theme emerged around the role of participant's 'cognitive-preparedness'- personal beliefs around their need for professional help (see Table 2), and their understanding of what could be gained from this. For example, Nebi understood: *"...to make myself feel better I had to start coming..."*

Understanding previous coping strategies were no longer beneficial played a role, for some, in developing cognitive-preparedness. Jenny *"came to the realisation*

*that...the default thing I always fell into wasn't working". Hannah felt her usual "bottle it all up" strategy had become "counterproductive as you just build up all the negativeness and it all comes out crazy (laughs)".*

Cognitive-preparedness may potentially set the stage for adult acknowledgement and facilitation of further help-seeking. Rose illustrates:

*"Researcher: What was it like for you? [Mum] saying, I think you need to get help now?Rose: It wasn't that surprising, because I did."*

Participants may have been reliant on an alignment between adult suggestion and their own cognitive-preparedness. As seen from Jenny above, this alignment however, may be experienced as a challenging negotiation between personal cognitive acknowledgement and *"the part of every teenager"* that desires independence.

## **Theme 2: Strength of Inner Resolve**

This superordinate theme relates to participant's inner determination to *"get better"* [Nebi]. There was evidence this acted as a key engagement motivator, as each participant made reference, throughout the process of their sense-making, to the impact their personal resolve had on their experience.

**Striving against engagement threats.** A sense of striving to maintain engagement in the face of ‘threats’ came through strongly from the data. All participants identified threats they had experienced throughout the engagement process. These included: mental health symptomology, engagement practicalities, and disappointments with the service.

Some participants spoke about contending with the very symptomology they were seeking help for. Despite feeling anxious, Caroline attended *“because I wanted the help”* and Anna *“psyched [herself] up and thought this is going to be a good thing so don’t get scared otherwise you won’t end up coming”*. Noah maintained engagement, despite having difficult *“draining”* sessions as *“I’d like to be more functional and mentally healthy than I am...”* Max explained how his depression impacted on his engagement experience:

*“...there are times as I said when I don’t want to get better, because I’m feeling so crap, erm... but then there are times when I know I need to get better because this is not me, I won’t do myself justice in a way, and so coming here I guess is helping with that.”*

Regarding practicalities, Nebi explained she was, *“determined to get help”* despite finding it difficult to remember appointment times. Rose felt her initial therapist was not helping her in the way she needed, so requested to see a different clinician, despite feeling uncomfortable:

*“Researcher: What happened when you were thinking about how to resolve this issue?”*

*Rose: I was nervous but I felt like if I saw someone else then it would be a lot better.”*

Jenny spoke about feeling disappointed with the care she received. When prompted to discuss what maintained her engagement despite these experiences, she explained:

*“I have to just take whatever I can from what is being offered... because otherwise I just, there’s no, I can’t just sit and not do anything, if I want to get better I’m going to have to do something about it so like I just I’m taking whatever I can from what there is.”*

What was striking from this data was the strength of participant’s inner-striving against experiences identified as difficult, and their resolve to weather storms-of-engagement. Despite there being bias in the fact all participants were actively engaged at time of interview, few had experienced a smooth journey to be where they were. It appeared they strived to maintain their engagement through an inner sense of purpose to receive, and maintain receiving help, for their distress.

**Responsibility to others.** Maintaining engagement through a sense of ‘responsibility to others’ emerged. This responsibility was mainly in relation to

parents. Noah felt *“bad about letting people down”* when he had not attended appointments in the past, and Max initially attended, in part because, *“mum and dad were, I couldn’t, you know, they urged me to go”*. When Anna thought further about her reasons for engaging she realised; *“part of it was for me and part of it was for my mum...”*

Data suggested that participants responded to an awareness of the impact their behaviour had on those around them, considering more people than just themselves were invested in their engagement journey. There appeared to be complexity around how reliance on parents/adults to aid engagement sat alongside the responsibility participants may have felt for them. It appeared once this noticing occurred, and professional help facilitated, participants may have then felt responsible to manage their engagement, for themselves, and for those around them.

### **Theme 3: Evolution of the Self**

This superordinate theme relates to participant accounts of their journey through their engagement process and the sense of themselves ‘evolving’ as this progressed.

**Progression through suspense and release.** Nine participants spoke about their experience of anticipation before initial attendance and the subsequent relief. What was marked within this pre-session build-up were the expectations participants had, mainly around anticipating the service/clinician to be *“stern”* [Nebi]



or “*not friendly*” [Chris]. They also described the “*anxious*” [Rose] or “*nervous*” [Max] feelings accompanying this.

Hannah explains:

*“It was nerve-wracking to come..... and already I was really nervous when I was in the like, erm, in the reception”*. She went on to consider the thoughts behind this: *“I thought it was going to be a really officey looking woman who was going to talk down to me.”*

The time between referral and session attendance has an element of being a no-mans-land of suspense between help-seeking and engagement, which was managed by some participants by either putting it “*out of my mind*” [Max] or “*kind of losing hope*” [Caroline]. Despite nervousness, two participants also spoke about “*looking forward to*” [Jenny] attending as they felt “*excited*” [Anna] about receiving help. This contributes to an idea of suspense before attendance rather than anxiety. Participants spoke about how this initial ‘build-up’ was followed by release, describing the “*relief*” [Caroline; Chris; Max] felt as they began their first session.

To continue following Hannah’s journey, here she illustrates this release:

*“...I’m finally talking about it and having to face things rather than bottling it up, so fizzing coke bottle, and then letting it go and letting it out...”*

The commonly expressed anticipation around ‘formality’ from the service/clinicians is interesting when considering 16-18 year old engagement. This sheds light on older adolescent’s relationships to, and expectations of adults, and hints towards the complexity of this population’s engagement experience. For example, negotiating whether they are relating to adults/clinicians as independent adults themselves, or as children. This is illustrated by Caroline, discussing independence from adults, whilst at the same time, seeing them as authority, during initial engagement suspense and release:

*“..like, I feel like in general when you’re young you kind of feel like ‘oh I’m independent, I don’t need adults’..... I feel like, if you, when you speak to an adult it just feels like they’re authority and they’re going to tell you off kind of thing so it’s nice when someone is friendly with you and not talking down on you...”*

**Growth through familiarity and trust affect.** This subtheme relates to participant’s growth as they became familiar with the engagement process. This sense of familiarity and trust appeared to be described by some participants as something *felt*. Chris explained how he “...felt support” from the service. Additionally, this “...buil[t] up slowly, like a process...” [Caroline], and felt like, “...a natural thing...” [Jenny], which made it “easier to go” [Nicole]. Through this, Max explained he “started to admit more and more”. This contributes to a sense of ‘growth’, e.g. in confidence, through the process, which encouraged participants to continue attending. For Caroline, “it just encouraged me to do it more and more.”

Trust in the engagement process appeared to develop as therapeutic gains emerged, contributing further to the idea of growth. Two participants illustrate:

*"...I've changed my attitude quite a lot... I feel like that's why I kept on coming back a lot as well 'cos I felt like I could manage things a lot more..."* [Hannah]

*"... then I realized that I'm actually getting a bit better and that every time I went and then was on my own in like normal life, I just felt a little bit better."* [Nicole]

This feeling of growth appeared to play important role in the engagement experience, 'feeling' like progressions were being made. Being able to tangibly see *"the change"* [Caroline] and *"feel like I'm getting help"* [Rose] was of key importance.

**Negotiating as an adolescent through choice, transparency and control.** This subtheme is concerned with the negotiation, from the unique older adolescent perspective, of choice, transparency and control, and the contradictions that come with this around autonomy and reliance on adult direction.

This can be seen in negotiating the balance between participants feeling clinicians were *"...trying to make me do something..."* [Max] versus, 'suggestions'. For Nicole, the subtleties between this could be seen across the interview. She spoke about how clinicians *"telling"* her what do acted as an engagement de-motivator, however, later

spoke about how *“suggesting things to help”* aided engagement. Nebi discussed how she doesn't *“really like being told what to do so I would probably wouldn't have done it”* but later replied:

*“Researcher:.... how helpful do you think it was then not being given a choice of what you had and just being told, this is what you're going to do...?”*

*Nebi: Good because I think my other therapist kind of knew me better than I knew myself...”*

Choice was also linked to perceptions of 'transparency' about the thinking behind the therapeutic process, which in turn aided the participant's sense of control over this – something which appeared important. For Rose and Max, being made aware of the usual procedure to have parents involved in early sessions gave them the opportunity to request for this not to happen. This control allowed Max to experience *“...less stress...less issues.”* For Noah, who was making the transition from CAMHS to AMHS, through discussions with clinicians, was clear about the process this involved, suggesting this *“help[s] me adjust.”* Jenny, with decisions about location of care, felt once she was made aware of the process behind this *“was fine with it 'cos we talked about it so I wasn't completely like shut out of decisions.”*

#### **Theme 4: In the Clinic Room**

This superordinate theme is concerned with participants making sense of their experiences, of both therapist and therapy, within sessions.

**Developmentally appropriate responsiveness.** This subtheme is around how participants made sense of their engagement experiences in relation to (lack of) clinician responsiveness to their developmental stage. Participants consistently touched on themes about the perception of (not) being spoken to in a “*patronizing*” manner[Nebi;Noah]. These concerns were presented as ‘advice’ to future clinicians, as explained by Max, who suggested, “*make it relatable to teens*”and Chris who put forward:

*“...understand everything from the perspective of young people because in a different age people view things differently and sometimes we, erm, an issue might be minor for adults but for young people it’s big...”*

Hannah spoke about how a risk assessment: “*...was a bit condescending*” which made her think, “*you’re talking to me like I’m five, I’m 18 this year...*”, displaying concerns about her developmental stage not being respected. Jenny discussed the differences between separate therapists in their responses to her age. A previous therapy made her feel “*a bit like a child*” by asking her to paint, however a later therapist “*... just put things in a way which made me understand...*” Interestingly, no participant spoke about being spoken to as ‘too much of an adult’ but instead,

considered being responded to in a perceived developmentally inappropriate manner as key barrier to older adolescent engagement.

**Centrality of a human relationship.** This subtheme is based around the experience of the 'human' elements to the relationship developed between participants and clinicians. Hannah sums up this subtheme succinctly explaining she experienced her clinician as: *"a real person."*

Some participants made sense of this by describing relationships with therapists as similar to that with friends, but with professional boundaries: *"... it doesn't feel like I'm just speaking to my therapist, I'm speaking to a friend... but with a lot of knowledge!"* [Anna]. Noah described his clinician as *"pro-friend-ssional"* to indicate the balance between amiability and professionalism. Others frequently used the adjectives *"nice"* or *"kind"* when considering their clinicians. This was often difficult for participants to articulate further when prompted, explaining that this was simply part of them as people e.g. *"I don't know, I think just how she was"* [Hannah].

An appreciation of authenticity was expressed, e.g. *"...I thought she was genuinely maybe concerned..."* [Chris]. Valuing the authentic was shown by some participants by talking about the antithesis of this, and of 'human' relationships, which was expressed as concerns about formality. Caroline explained: *"...if I had got someone that, like, .... ok so like this [sat up straight], I know I wouldn't be able to be honest, it just doesn't feel natural, like."* Noah expressed a concern about *"...seeing someone*

*who belonged in a bank..."* For Chris and Hannah, a lack of authenticity was displayed by sensing clinicians were 'forced to do their jobs.' The impact of this feared formality may have also impacted on the participants' sense of safety, and judgment, within the relationship. Hannah explained: *"I wouldn't want to open up as much"* but experiencing a safe relationship lead to *"the kind of environment where I felt I could say anything and I wouldn't be judged..."*

**Tangibility of techniques.** This theme centres around therapeutic techniques which have an active and practical element to them – something the young person could 'do'. Most young people spoke about appreciating the more concrete techniques, which gave them the opportunity to actively 'do' something to aid their therapy, for example, Nebi spoke about the use of thought diaries: *"writ[ing] down my negative thoughts and [writing] down another thought that contradicts that thought."* Most participants referred to the tangibility/ 'doing' techniques as *"reassuring"* [Caroline] and proving evidence that therapy *"actually helps"* [Chris]. Rose found the *"measureable progress"* of practical help beneficial, creating certainty about therapeutic aims and facilitating an experience of: *"I'm getting help."* Anna explained, *"the more she told me about how I can manage my low moods, my anxiety, and sometimes my OCD, it made me want to come here more."*

Rose and Max spoke about how *"just talking"* [Rose], *"didn't really solve anything"* [Max], and expressed the need to be actively working to reduce the impact of symptomology. This may have offered participants motivation to continue their

engagement. 'Seeing' improvement, and understanding the 'point' of therapy, signaled to participants that engagement was necessary:

*"...we would write down experiments we were doing and at first I wouldn't really do them, and then, I started to do more and more of them, so it was good."* [Nicole]

Jenny appeared to have preconceived ideas about what constituted therapy, which later conflicted with what she experienced to be therapeutic: *"...it was very practical and very skills based and we didn't really talk about my feelings, so it wasn't really therapy..."* She further explained, *"I felt more prepared for my exams and that I could handle them...we talked about specific techniques and things and, erm, yeah, it felt like I'd actually, kind of, I'd achieved something..."* Noah, the only participant who did not discuss tangible techniques, explained how engagement itself was his therapy: *"a big part of what helps about coming here is the routine of seeing people I've known for a long time..."*

### **Discussion**

The present study aimed to explore 16-18 year old sense-making of their mental health service engagement experiences and their understanding of contributory facilitators and barriers. As research focusing solely on older adolescent engagement is limited, this contributes to a sparse evidence-base.



### **Links to Previous Research and Theory**

The interplay between participant's understanding of their engagement experience, and the context of the 16-18 developmental stage, was of key importance. Dominant theories of adolescent development (e.g. Erikson, 1968) propose separation from parents/adults occurs as adolescents mature. Participants appeared to understand themselves to be reliant on adults to acknowledge their distress and facilitate professional help-seeking, possibly opposing theoretical comprehension. Older adolescent experience may differ from models suggesting this is *wholly* reliant on adult input (Costello, Pescosolido, Angold, & Burns, 1998) and partly supports models suggesting the key role of the adolescent's 'ecosystem' (McKay et al., 1995). Adult reliance sat alongside participant's own internal cognitive readiness to receive help, supporting previous models (Broome et al. 2001). As the adolescent ages, a shift may occur from total adult reliance, towards a developed sense of cognitive preparedness, inner resolve and responsibility towards others (Christie & Viner, 2005). This reveals an interplay between internal and external influences, and a complexity around the phenomenon as a whole. Indeed, as participants spoke about help-seeking to make sense of their engagement experience, further evidence is contributed to the ideas around the difficulties of engagement conceptualisation (Staudt, 2007), and the blurred distinction between help-seeking and engagement.

Intricacy was also evident within the idea of developmental appropriateness, reflected in the themes around choice, transparency and control. For some, having their older adolescent status respected by 'not-being-told-what-to-do'/not-being-

patronised' was imperative. This sat alongside appreciating 'suggestions,' 'teen-relatibility', and tangible therapeutic techniques (which by their very nature require clinician direction). This reveals an additional layer of complexity around what is understood about engagement facilitators/ barriers. The key element of developmental appropriateness supports previous research (Harper et al., 2014) as does the importance of within-session topics (Broome et al., 2001). It is wondered whether what distinguishes 'being-told-what-to-do' and 'suggestions' is transparency of process. This in turn may aid a sense of control. Indeed, the tangibility of techniques mentioned above may have also provided a sense of control, but over symptomology rather than engagement. Experiencing control is thought to be an important facilitator within adolescent engagement (Bury et al., 2007).

During engagement, it appears there is a growth and evolution within the adolescent themselves, and the relationship they have to the engagement process. As this progresses, the older adolescent inner resolve, and perceived usefulness of therapy/continued engagement, may be key in facilitating engagement. This finding supports within-treatment engagement models (King et al., 2014) around the need for client hope and the development of confidence. It is wondered whether the human, 'informal' relationship developed with clinicians may take the place of the initial trusted adult, with this engagement growth existing on the foundations of the therapeutic relationship (Harper et al., 2014). In opposition to models (Kazdin et al., 1997), the role of the relationship between parent and therapist did not emerge as a

theme. This may be due to the developmental stage of participants. Parents may have a role in initial attendance, but continued attendance is more reliant on the adolescent themselves and the therapeutic relationship, rather than alliance between parent and therapist. This may also not have been an emergent theme as some participants actively requested for parents to not attend sessions, and all therapy was 1:1 based.

The role of peers was limited within participants' narratives. Research and theory suggest, as adolescents grow older, a social shift occurs from family to peers (e.g. Bronfenbrenner, 1977). This implies their influence could have been more present in the current study, however, it may not have been considered to be of key significance to participant sense-making. Previous research suggests peers play a role within help-seeking (e.g. Rickwood & Braitwaite, 1994), however, when considering the ongoing engagement phenomenon, peer input may be less influential. The lack of peer discussion may also be due to concerns around stigma (Fisher et al., 1982). For example, peers may have been less aware of service attendance due to participant concerns about judgment. The role of stigma was also marked in its absence from emergent themes. Stigma may play more of a role when considering help-seeking (Gulliver, Griffiths, & Christensen, 2010) rather than engagement. The lack of emergence of peer and stigma themes may suggest that 16-18 engagement is less of a 'social' phenomenon than help-seeking.

The impact of symptomology on engagement, and engagement (de)motivation, is absent from models. Previous research has investigated links between drop-out and 'diagnosis' (e.g. Johnson et al., 2008). The current study suggests symptomology, rather than 'diagnosis' may play a role in engagement, especially around the interplay between initial anticipation and determination to engage. This finding supports research recommending therapist exploration of adolescent beliefs during engagement (Bury et al., 2007).

### **Study Strengths, Reflexivity, and Limitations**

The employment of an exploratory design, rooted in older adolescent lived-experience, allowed for rich, participant-centred data to emerge. Semi-structured interview encouraged participants to lead on discussions, and therefore, on the type of data collected. As emergent themes were developed from participant sense-making, the results of the study may reflect a unique 16-18 year old-centric experience of a complex phenomenon. The selection of IPA allowed for the specific older adolescent developmental context to be explored in relation to engagement understandings.

When considering reflexive research practice, participants may have experienced a separate engagement process with the researcher, mirroring their wider service engagement experience e.g. engaging, in part, due to concerns about letting others down. Power dynamics, and social desirability, may have impacted on the direction, and content of interview, as it was unclear whether participants responded to the

researcher as a clinician based within the service, or as an independent party. As the lead researcher was a trainee clinical psychologist, the role researcher-as-researcher and researcher-as-clinician may have required more conscious negotiation of positioning and adopted language, through the use of reflexivity.

Recruitment procedure required clinicians to consider potential participants from their caseloads. There is potential bias here as participants may have selected based on, i.e. quality of relationships. According to clinician reports, all adolescents approached agreed to participate. This has possible implications around power and the ability to say 'no' to clinicians, meaning some may have felt obliged to participate. There was variation in the length of engagement amongst participants, which may have influenced interview content e.g. around strength of therapeutic relationships. As engagement may be a phenomenon that varies over time (Cunningham et al., 2009), and models suggest elements of initial engagement may differ from ongoing engagement (e.g. Broome et al, 2001; King et al., 2014), it is possible participants were making sense of different stages of the phenomenon.

Respondent validation (Mays & Pope, 2000) was missing from the current study due to a tight research timeline. There has been debate about the necessity of this (Giorgi, 2006) due to the interpretative nature of IPA. Exclusion criteria dictated that more complex presentations were not included in the current study, which limits applicability. However, IPA on the whole is less focused on generalizability but more with rich, deep exploration of the selected phenomenon. Following guidance (Smith

et al., 2009), a 50% cut-off of emergent themes was adopted in order to ensure relevance to the sample as a whole. This may have resulted in a less thorough exploration of divergence across cases. As IPA is reliant on researcher interpretation, despite the employment of reflexivity and bracketing techniques, the potential for bias remained in emergent theme development reflecting researcher beliefs or preconceptions of the engagement phenomenon.

### **Clinical Implications**

The therapeutic relationship has been extensively researched (e.g. Karver, Handelsman, Fields, & Bickman, 2005). The current study suggests the area of this which may be crucial for clinicians to cultivate are the 'human' elements- remaining genuine and non-judgmental, balancing amiability with professionalism, and avoiding 'formality'. The prominence of cognitive-preparedness, determination, and anticipation before first session attendance was marked. This suggests more consideration may need to be given to engagement facilitation in the time between referral and attendance. This may lie more with refining multi-agency service provision (JCPMH, 2013) rather than direct clinical intervention. Engagement may be facilitated by clinicians discussing cognitive-preparedness (Bury et al., 2007), with adolescents at initial attendance. By making sense of help-seeking (Reder & Fredman, 1996), and avoiding separating this from engagement, clinicians may develop understanding of client's idiosyncratic engagement facilitators and/or barriers.

Emergent themes suggest the key importance of appropriate responsiveness to developmental stage, through offered control and transparency. Engagement may be facilitated by clinicians involving clients in areas there may be potential for control (such as, content of therapy sessions), transparent about areas less open to change, and discussion of potential disappointments with the service. Facilitating perception of usefulness of sessions and tangibility of techniques may also encourage engagement. The above suggests combining and balancing the relational and cognitive, by provide key developmentally-appropriate engagement facilitation.

### **Future Research**

As a key message throughout this study has been one of developmental appropriateness, it may be important when planning research, policy or service developments to consult young people on topics and design (YoungMinds, 2005; YoungMinds, 2011) in order to maintain relevance to adolescent needs.

As the conceptualizations and boundaries between help-seeking and engagement remain blurred, further research into the development of clearer definitions and models, from the adolescent view, may be beneficial to ensure developmentally appropriate theoretical progressions (Drieschner et al., 2004; Weisz & Hawley, 2002).

Research into the relationship between factors internal and external to adolescents, e.g. inner resolve/ cognitive-preparedness in relation to the role of families at this

developmental stage, may provide further insight into the engagement phenomenon. This may in turn influence the development of strategies targeting adolescents who may be at risk of disengagement, or who do not seek service help.

### **Conclusion**

Due to the paucity of research, this IPA study aimed to investigate the 16-18 year old understanding of their mental health service engagement experience, facilitators and barriers. Overlap between help-seeking and engagement understandings was demonstrated. The key role of developmental context emerged, regarding autonomy negotiation and adult reliance, and factors internal (e.g. inner resolve) and external (e.g. family) to the adolescent. Participant experiences of service buildings and policy also emerged. Implications for clinical practice involved ensuring developmental responsiveness through cultivating a human therapeutic relationship, and responding to cognitive-preparedness, control and transparency. It was suggested future research focuses on ensuring adolescent participation. Potential topics for investigation included developing help-seeking and engagement conceptualisations, and further investigation into 16-18 year old experience of service buildings and policy.



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**Section C**

Appendix of Supporting Material

## Appendix A: Notes from research diary on initial literature searches and development of search terms

**14/5/15** search as keywords in PsycInfo:

engagement (35,052)

AND

Adolescent (131,313)

AND

mental health service (5, 843)

= 26 results

Notes from research diary: Need to expand terms/ search settings to ensure all papers captured.

Explode 'mental health services' = 36,044 results – Need to refine. 58 results when combined with above.

MEDLINE produced very few relevant results (43) all duplicates or not applicable. Remove this database?

**14/5/15**search:

engage\* OR attend\*

AND

mental health OR CAMHS OR therapy

AND

Adol\* OR \*teen

= 739 results on PsycInfo

Notes from research diary: After abstract scan, need to expand adolescent related terms to ensure all papers captured.

**10/6/15** search:

engag\* OR attend\*

AND

adol\* OR young pe\* OR teen\*

AND

mental health service\* OR CAMHS OR service\*

Limits applied: 2005 to current, English language, peer reviewed journal, adolescent age

= 809 results

Notes from research diary:Noted a lot of papers use the term 'adolescent', 'young people' or 'teen(age)' to mean **any age**, depending on their research aims. No consensus between papers on what this means. Need to be specific about age/ develop my definition of 'adolescence' to ensure correct participant population captured.

**28/7/15**search:

Adol\* OR \*teen OR young pe\*

AND

Engage\* OR attend\*

AND

CAMHS OR mental health service OR child and adolescent mental health service

= 119 results on psycinfo

= 115 results on ASSIA

= 180 results on Web of Science

= Cochrane – 0 reviews and 30 trials

Limits applied: English language, peer-reviewed journal, last 10 years

= 351 results

Notes from research diary: Lots of papers using the term 'engagement' with little definition or as an 'afterthought' in abstract e.g. 'more research is needed to improve engagement.' Need to further develop engagement terms using previous research.

## Appendix B: Papers that underwent full review

	Reference	Included/ excluded: reason
1	Aisbett, D. L., Boyd, C. P., Francis, K. J., Newnham, K., & Newnham, K. (2007). Understanding barriers to mental health service utilization for adolescents in rural Australia. <i>Rural and Remote Health</i> , 7(624), 1-10.	Exclude: not a full clinical population
2	Assan, B., Burchell, P., Chia, A., Coffey, C., Floreani, S., Weir, J., Hammond, S., Wingenfeld, S., & Woods, B. (2008). The Adolescent Intensive Management Team: An intensive outreach mental health service for high-risk adolescents. <i>Australasian Psychiatry</i> , 16(6), 423-427.	Exclude: service evaluation
3	Baier, V., Favrod, J., Ferrari, P., Koch, N., & Holzer, L. (2013). Early tailored assertive community case management for hard-to-engage adolescents suffering from psychiatric disorders: An exploratory pilot study. <i>Early Intervention in Psychiatry</i> , 7(1), 94-99.	Exclude: service description/ evaluation
4	Branson, C. E., Clemmey, P. & Mukherjee, P. (2013). Text message reminders to improve outpatient therapy attendance among adolescents: A pilot study. <i>Psychological Services</i> , 10(3), 298-303.	Include
5	Breland, D. J., McCarty, C. A., Zhou, C., McCauley, E., Rockhill, C., Katon, W., & Richardson, L. P. (2014). Determinants of mental health service use among depressed adolescents. <i>General Hospital Psychiatry</i> , 36(3), 296-301.	Include
6	Breland-Noble, Alfiie M; Bell, Carl; Nicolas, Guerda. (2006). Family first: The development of an evidence-based family intervention for increasing participation in psychiatric clinical care and research in depressed african american adolescents. <i>Family Process</i> , 45(2), 153-169.	Exclude: no age
7	Breland-Noble, A. M. (2012). Community and treatment engagement for depressed african american youth: The AAKOMA FLOA pilot. <i>Journal of Clinical Psychology in Medical Settings</i> , 19(1), 41-48.	Exclude: not in age range
8	Burns, C. D., Cortell, R., & Wagner, B. M. (2008). Treatment compliance in adolescents after attempted suicide: A 2-year follow-up study. <i>Journal of the American Academy of Child &amp; Adolescent Psychiatry</i> , 47(8), 948-957.	Include
9	Bury, C., Raval, H., & Lyon, L. (2007). Young people's experiences of individual psychoanalytic psychotherapy. <i>Psychology and Psychotherapy: Theory, Research and Practice</i> , 80(1), 79-96.	Include
10	Carmen D., Shah S, Gilbert S., Russell F. (2007). <b>Improving attendance at an eating disorder clinic by means of an "opt in" letter.</b> <i>Clinical Psychology Forum</i> , 173, 22-25.	Exclude: no age range
11	Desrosiers, L., Saint-Jean, M., & Breton, JJ. (2014). Treatment planning: A key milestone to prevent treatment dropout in adolescents with borderline personality disorder. <i>Psychology and Psychotherapy</i> , 88(2), 178-96.	Exclude: not about engagement
12	Diem T., & Sunil B. (2014). Predictors for treatment expectancies among young people who attend drug and alcohol services: A pilot study. <i>Clinical Psychologist</i> , 33-42.	Exclude: not about engagement
13	Donnellan, D., Murray, C., & Harrison, J. (2013). An investigation into adolescents' experience of cognitive behavioural therapy within a child and adolescent mental health service. <i>Clinical Child Psychology and Psychiatry</i> , 18(2), 199-213.	Include
14	Edelen, M. O., Tucker, J. S., Wenzel, S. L., Paddock, S. M., Ebener, P., Dahl, J., & Mandell, W. (2007). Treatment process in the therapeutic community: Associations with retention and outcomes among adolescent residential clients. <i>Journal of Substance Abuse Treatment</i> , 32(4), 415-421.	Exclude: no age range
15	Flicker, S. M., Turner, C. W., Waldron, H. B., Brody, J. L., & Ozechowski, T. J. (2008). Ethnic background, therapeutic alliance, and treatment retention in functional family therapy with adolescents who abuse substances. <i>Journal of Family Psychology</i> , 22(1), 167.	Include
16	Garraway, H., & Pistrang, N. (2010). Brother from another mother: Mentoring for african-caribbean adolescent boys. <i>Journal of Adolescence</i> , 33(5), 719-729.	Exclude: service evaluation
17	Gearing, R. E., Schwalbe, C. S., & Short, K. D. (2012). Adolescent adherence to psychosocial treatment: Mental health clinicians' perspectives on barriers and promoters. <i>Psychotherapy Research</i> , 22(3), 317-326.	Exclude: no age range
18	Gogel, L. P., Cavaleri, M. A., Gardin II, J. G., & Wisdom, J. P. (2011). Retention and on-going participation in residential substance abuse treatment: Perspectives from adolescents, parents and staff on the treatment process. <i>The Journal of Behavioral Health Services and Research</i> , 38(4), 488-496.	Include
19	Hawley, K. M., & Garland, A. F. (2008). Working alliance in adolescent outpatient therapy: Youth, parent and therapist reports and associations with therapy outcomes. <i>Child &amp; Youth Care Forum</i> , 37(2), 59-74.	Exclude: age
20	Kapungu, C. T., Nappi, C.M., Thakral, C., Miller, S. A., Devlin, C., McBride, C., ... Brown, L. (2012). Recruiting and retaining high-risk adolescents into family-based HIV prevention intervention research. <i>Journal of Child and Family Studies</i> , 21(4), 578-588.	Exclude: not about engagement in mental health services
21	Lee, M. T., Garnick, D. W., O'Brien, P. L., Panas, L., Ritter, G. A., Acevedo, A., ... Godley, M. D. (2012). Adolescent treatment initiation and engagement in an evidence-based practice initiative. <i>Journal of Substance Abuse Treatment</i> , 42(4), 346-355.	Include



22	Marchionda, D.M., & Slesnick, N. (2013). Family therapy retention: An observation of first-session communication. <i>Journal of Marital Family Therapy</i> , 39(1), 87-97.	Include
23	Munson, M. R., Floersch, J. E., & Townsend, L. (2010). Are health beliefs related to adherence among adolescents with mood disorders? <i>Administration and Policy in Mental Health and Mental Health Services Research</i> , 37(5), 408-416.	Include
24	Pycroft, A., Wallis, A., Bigg, J., & Webster, G. (2015). Participation, engagement and change: A study of the experiences of service users of the unified adolescent team. <i>The British Journal of Social Work</i> , 45(2), 422-439.	Exclude: service evaluation
25	Robbins, M. S., Liddle, H. A., Turner, C. W., Dakof, G. A., Alexander, J. F., & Kogan, S. M. (2006). Adolescent and parent therapeutic alliances as predictors of dropout in multidimensional family therapy. <i>Journal of Family Psychology</i> , 20(1), 108.	Exclude: no age range
26	Ross, E., Vingilis, E., & Osuch, E. (2012). An engagement and access model for healthcare delivery to adolescents with mood and anxiety concerns. <i>Early Intervention in Psychiatry</i> , 6(1), 97-105.	Exclude: age
27	Roy, H., & Gillett, T. (2008). E-mail: A new technique for forming a therapeutic alliance with high-risk young people failing to engage with mental health services? A case study. <i>Clinical Child Psychology and Psychiatry</i> , 13(1), 95-103.	Include
28	Schimmelmann, B. G., Conus, P., Schacht, M., McGorry, P., & Lambert, M. (2006). Predictors of service disengagement in first-admitted adolescents with psychosis. <i>Journal of the American Academy of Child &amp; Adolescent Psychiatry</i> , 45(8), 990-999.	Exclude: not about engagement
29	Sclare, I., Michelson, D., Malpass, L., Coster, F., & Brown, J. (2015). Innovations in practice: DISCOVER CBT workshops for 16-18-year-olds: Development of an open-access intervention for anxiety and depression in inner-city youth. <i>Child and Adolescent Mental Health</i> , 20(2), 102-106.	Exclude: service description/ evaluation
30	Smith, B. D., Duffee, D. E., Steinke, C. M., Huang, Y., & Larkin, H. (2008). Outcomes in residential treatment for youth: The role of early engagement. <i>Children and Youth Services Review</i> , 30(12), 1425-1436.	Include
31	Smith, B. D., Duffee, D. E., Steinke, C. M., Huang, Y., & Larkin, H. (2008). Outcomes in residential treatment for youth: The role of early engagement. <i>Children and Youth Services Review</i> , 30(12), 1425-1436.	Duplicate of 29
32	Stevens, J., Kelleher, K. J., Ward-Estes, J., & Hayes, J. (2006). Perceived barriers to treatment and psychotherapy attendance in child community mental health centers. <i>Community Mental Health Journal</i> , 42(5), 449-458.	Exclude: age
33	Shepherd, M. (2009). Developing an outreach service in adolescent mental health to improve engagement. <i>Nursing Times</i> , 105, (32-33), 20-21.	Exclude: service development/ review
34	Thompson, S. J., Bender, K., Lantry, J., & Flynn, P. M. (2007). Treatment engagement: Building therapeutic alliance in home-based treatment with adolescents and their families. <i>Contemporary Family Therapy</i> , 29(1-2), 39-55.	Include
35	Ungar, M., Liebenberg, L., Dudding, P., Armstrong, M., & Van de Vijver, F. J. (2013). Patterns of service use, individual and contextual risk factors, and resilience among adolescents using multiple psychosocial services. <i>Child Abuse &amp; Neglect</i> , 37(2), 150-159.	Exclude: not about engagement
36	Waldron, H. B., Kern-Jones, S., Turner, C. W., Peterson, T. R., & Ozechowski, T. J. (2007). Engaging resistant adolescents in drug abuse treatment. <i>Journal of Substance Abuse Treatment</i> , 32(2), 133-142.	Include
37	Wilson, J.J., Levin, F.R., Donovan, S.J., & Nunes, E.V. (2006). Verbal abilities as predictors of retention among adolescents in a therapeutic community. <i>Child Psychiatry and Human Development</i> , 36(4), 393-401.	Include
38	Yen, S., Fuller, A. K., Solomon, J., & Spirito, A. (2014). Follow-up treatment utilization by hospitalized suicidal adolescents. <i>Journal of Psychiatric Practice</i> , 20(5), 353-362.	Exclude: not about engagement

## Appendix C: Papers reviewed from hand searches

	Title	Included/ excluded	Reason
1	Coletti, D. J., Leigh, E., Gallelli, K. A., & Kafantaris, V. (2005). Patterns of adherence to treatment in adolescents with bipolar disorder. <i>Journal of Child &amp; Adolescent Psychopharmacology</i> , 15(6), 913-917.	Exclude	Only medication adherence
2	Cunningham, W. S., Duffee, D. E., Huang, Y., Steinke, C. M., & Naccarato, T. (2009). On the meaning and measurement of engagement in youth residential treatment centers. <i>Research on Social Work Practice</i> , 19(1), 63-76.	Include	
3	Dearing, R. L., Barrick, C., Dermen, K. H., & Walitzer, K. S. (2005). Indicators of client engagement: influences on alcohol treatment satisfaction and outcomes. <i>Psychology of Addictive Behaviors</i> , 19(1), 71.	Excluded	Age
4	Gearing, R. E., Schwalbe, C. S., Dweck, P., & Berkowitz, J. (2012). Investigating adherence promoters in evidence-based mental health interventions with children and adolescents. <i>Community Mental Health Journal</i> , 48(1), 63-70.	Excluded	Age
5	Hawke, J. M., Hennen, J., & Gallione, P. (2005). Correlates of therapeutic involvement among adolescents in residential drug treatment. <i>The American Journal of Drug and Alcohol Abuse</i> , 31(1), 163-177.	Include	
6	Hogue, A., Dauber, S., Stambaugh, L. F., Cecero, J. J., & Liddle, H. A. (2006). Early therapeutic alliance and treatment outcome in individual and family therapy for adolescent behavior problems. <i>Journal of Consulting and Clinical Psychology</i> , 74(1), 121.	Exclude	Doesn't fit original search terms....
7	Mukherjee, S., Sullivan, G., Perry, D., Verdugo, B., Means-Christensen, A., Schraufnagel, T., ... & Roy-Byrne, P. P. (2006). Adherence to treatment among economically disadvantaged patients with panic disorder. <i>Psychiatric Services</i> , 57(12), 1745-1750.	Excluded	Age
8	Munson, M. R., Floersch, J. E., & Townsend, L. (2009). Attitudes toward mental health services and illness perceptions among adolescents with mood disorders. <i>Child and Adolescent Social Work Journal</i> , 26(5), 447-466.	Exclude	Help seeking focus
9	Pellerin, K. A., Costa, N. M., Weems, C. F., & Dalton, R. F. (2010). An examination of treatment completers and non-completers at a child and adolescent community mental health clinic. <i>Community Mental Health Journal</i> , 46(3), 273-281.	Excluded	Age
10	Richardson, L. P., Russo, J. E., Lozano, P., McCauley, E., & Katon, W. (2010). Factors associated with detection and receipt of treatment for youth with depression and anxiety disorders. <i>Academic Paediatrics</i> , 10(1), 36-40.	Exclude	Age
11	Slesnick, N., Kang, M. J., & Aukward, E. (2008). Treatment attendance among homeless youth: the impact of childhood abuse and prior suicide attempts. <i>Substance Abuse</i> , 29(2), 43-52.	Exclude	Age
12	Tanielian, T., Jaycox, L. H., Paddock, S. M., Chandra, A., Meredith, L. S., & Burnam, M. A. (2009). Improving treatment seeking among adolescents with depression: Understanding readiness for treatment. <i>Journal of Adolescent Health</i> , 45(5), 490-498.	Exclude	Not a fully clinical population.
13	Wisdom, J. P., Cavaleri, M., Gogel, L., & Nacht, M. (2011). Barriers and facilitators to adolescent drug treatment: Youth, family, and staff reports. <i>Addiction Research &amp; Theory</i> , 19(2), 179-188.	Exclude	Help seeking only

## Appendix D: Quantitative methodology checklists

**Quantitative methodology checklist:** Long, A. F., Godfrey, M., Randall, T., Brettle, A. J., & Grant, M. J. (2002). *Developing Evidence Based Social Care Policy and Practice. Part 3: Feasibility of Undertaking Systematic Reviews in Social Care*. Leeds: Nuffield Institute for Health.

### Evaluation Tool for Quantitative Research Studies

Building on work within a project exploring the feasibility of undertaking systematic reviews of research literature on effectiveness and outcomes in social care, a set of evaluation tools have been developed to assist in the critical appraisal of research studies. The evaluation tool for quantitative studies contains six sub-sections: study evaluative overview; study, setting and sample; ethics; group comparability and outcome measurement; policy and practice implications; and other comments. It provides a template of key questions to assist in the critical appraisal of quantitative research studies.

Review Area	Key Questions
(1) STUDY OVERVIEW	
Bibliographic Details	0. Author, title, source (publisher and place of publication), year
Purpose	1. What are the aims of the study? 2. If the paper is part of a wider study, what are its aims?
Key Findings	3. What are the key findings of the study?
Evaluative Summary	4. What are the strengths and weaknesses of the study and theory, policy and practice implications?
(2) STUDY, SETTING, SAMPLE AND ETHICS	
The Study	5. What type of study is this? 6. What was the intervention? 7. What was the comparison intervention? 8. Is there sufficient detail given of the nature of the intervention and the comparison intervention? 9. What is the relationship of the study to the area of the topic review?
Setting	10. Within what geographical and care setting was the study carried out?
Sample	11. What was the source population? 12. What were the inclusion criteria? 13. What were the exclusion criteria? 14. How was the sample selected? 15. If more than one group of subjects, how many groups were there, and how many people were in each group? 16. How were subjects allocated to the groups? 17. What was the size of the study sample, and of any separate groups? 18. Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn? 19. Is information provided on loss to follow up? 20. Is the sample appropriate to the aims of the study? 21. What are the key sample characteristics, in

	relation to the topic area being reviewed?
<b>(3) ETHICS</b>	
Ethics	22. Was Ethical Committee approval obtained? 23. Was informed consent obtained from participants of the study? 24. Have ethical issues been adequately addressed?
<b>(4) GROUP COMPARABILITY AND OUTCOME MEASUREMENT</b>	
Comparable Groups	25. If there was more than one group was analysed, were the groups comparable before the intervention? In what respects were they comparable and in what were they not? 26. How were important confounding variables controlled (e.g. matching, randomisation, in the analysis stage)? 27. Was this control adequate to justify the author's conclusions? 28. Were there other important confounding variables controlled for in the study design or analyses and what were they? 29. Did the authors take these into account in their interpretation of the findings?
Outcome Measurement	30. What were the outcome criteria? 31. What outcome measures were used? 32. Are the measures appropriate, given the outcome criteria? 33. What other (e.g. process, cost) measures are used? 34. Are the measures well validated? 35. Are the measures of known responsive to change? 36. Whose perspective do the outcome measures address (professional, service, user, carer)? 37. Is there a sufficient breath of perspective? 38. Are the outcome criteria useful/appropriate within routine practice? 39. Are the outcome measures useful/appropriate within routine practice?
Time Scale of Measurement	40. What was the length of follow-up, and at what time points was outcome measurement made? 41. Is this period of follow-up sufficient
<b>(5) POLICY AND PRACTICE IMPLICATIONS</b>	
Implications	42. To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects?) 43. To what population are the study's findings generalisable? 44. Is the conclusion justified given the conduct of the study (For example, sampling procedure; measures of outcome used and results achieved?) 45. What are the implications for policy? 46. What are the implications for service

	practice?
(6) OTHER COMMENTS	
Other Comments	47. What were the total number of references used in the study? 48. Are there any other noteworthy features of the study? 49. List other study references
Reviewer	50. Name of reviewer 51. Review date

Source: Long AF, Godfrey M, Randall T, Brettle AJ and Grant MJ (2002) Developing Evidence Based Social Care Policy and Practice. Part 3: Feasibility of Undertaking Systematic Reviews in Social Care. Leeds: Nuffield Institute for Health.

Note: This tool was developed while the lead author was at the Health Care Practice R&D Unit(HCPRDU) at the University of Salford. It has since been slightly modified.

Evaluation Tool for Quantitative Research Studies Prof Andrew Long, School of Healthcare, University of Leeds

**Measure development checklist:** Holmbeck, G.N., & Devine, K.A. (2009). Editorial: An authors checklist for measure development and validation manuscripts. *Journal of Paediatric Psychology*, 34(7), 691-696.

#### Appendix Criteria and Checklist for Measure Development Papers

1. Establishes Scientific Need for the Instrument
  - a. Reviews research and/or clinical practices to establish need for the instrument
  - b. Specifies the new contribution of the measure relative to previous research
2. Attends to Content Validity During Initial Measure Development (based on Clark & Watson, 1995; Editorial: An Author's Checklist 693 Haynes, Richard, & Kubany, 1995; Haynes, Nelson & Blaine, 1999)
  - a. Defines the construct
    - i. Reviews theory underlying the construct
    - ii. Specifies what will be included and excluded in the measure
    - iii. Specifies facets or dimensions of construct
  - b. Specifies contexts/situations for the measure
    - i. Specifies setting for completion of measure
  - c. Specifies intended function of the measure
    - i. Specifies purpose of measure
    - ii. Specifies target population
    - iii. Specifies appropriate age range
    - iv. Determines if appropriate for multiple developmental levels and ethnic groups
  - d. Selects and generates items based on:
    - i. Clinical experience
    - ii. Relevant theories
    - iii. Empirical literature
    - iv. Rational deduction
    - v. Related Instruments
    - vi. Consultation with experts
    - vii. Focus groups with target population
  - e. During item generation, matches items to facets/ dimensions
    - i. Includes appropriate numbers of items for each dimension
    - ii. Attends to test length (generates an appropriate number of items given the setting in which it will be used, generates enough items to allow for some items to be dropped during the test refinement process, generates enough items to assess the construct)
  - f. Conducts qualitative item analysis (relevance of each item, wording of items, check for redundancy across items)
  - g. Addresses literacy and reading level issues for the target population
  - h. Determines response format and scoring method
    - i. Selects response format (e.g., Likert, etc.)
    - ii. Attempts to reduce impact of response sets by not wording all items in same direction
    - iii. Scoring method is explained
  - i. Develops appropriate instructions for measure (including time frame; e.g., "During the past two weeks ...")
  - j. Has experts review the initial version of the instrument
  - k. Has members of target population review initial version of the instrument
  - l. After refinement of measure:
    - i. Additional item analysis
    - ii. Additional review by experts
    - iii. Additional review by members of target population
  - m. Conducts pilot testing of measure
3. Evaluation of Reliability
  - a. Evaluates internal consistency (subscales, full scale)
  - b. Evaluates temporal stability (test-retest)
  - c. Uses generalizability theory in assessing reliability
  - d. Cross-validates reliability estimates

4. Develops Norms for the Measure
  - a. Develops norms for different relevant populations
5. Quantitative Item Analysis
  - a. Examines whether items discriminate between relevant groups
  - b. Includes corrected item-to-total correlations
  - c. Includes average correlations between individual items and all other items
  - d. Evaluates distributions of items and eliminates items with inadequate distributions
  - e. Evaluates items using Item Response Theory (particularly if it is a measure that assesses abilities or skills)
    - i. Examines item characteristic curves (see Nunnally & Bernstein, 1994)
    - ii. Examines unidimensionality of items, the appropriateness of using a total summary score, and differential item functioning using Rasch analysis (Tennant, McKenna, & Hagell, 2004; Tesio, 2003)
6. Conducts Factor Analyses
  - a. Evaluates factor structure of measure via exploratory factor analyses/principal components analyses
  - b. Confirms hypothesized factor structure of measure via confirmatory factor analyses
7. Evaluation of Validity
  - a. Clearly articulates plan for assessing validity
  - b. Includes a priori hypotheses for major analyses
  - c. Evaluates overall construct validity of measure (which involves a general evaluation of all validity evidence for the measure)
  - d. Evaluates convergent validity, which is the degree of convergence between the target measure and other instruments purporting to measure the same construct
  - e. Evaluates discriminant validity, which is the degree to which the target measure is not associated with other measures that assess different constructs
  - f. Evaluates criterion-related validity, which is the degree to which scores on the target measure are associated with measures of non-test behaviors (includes concurrent and predictive validity)
  - g. Cross-validates validity estimates
8. Evaluates Diagnostic Utility, Clinical Utility, and Cost-Effectiveness (based on Haynes et al., 1999)
  - a. Evaluates degree of treatment utility
    - i. Is the measure sensitive to change?
    - ii. Can it be used repeatedly over the course of treatment and does it reflect improvement or worsening of symptoms? (see Kazdin, 2005)
  - b. Evaluates degree of diagnostic utility (see Bossuyt et al., 2003)
    - i. Includes estimates of diagnostic accuracy (sensitivity, specificity, positive and negative predictive power)
  - c. Evaluates degree of incremental validity (does the measure add value in clinical judgment above and beyond other measures?)
  - d. Evaluates measure's cost-effectiveness
9. Translates Measure into Other Languages
  - a. Semantic equivalence: Translation by a native speaker and back-translation by an independent native speaker. Region-specific language should be used when possible
  - b. Content equivalence: Native language speaker has reviewed content of items for appropriateness and equivalence
  - c. Technical equivalence: All language versions contain the same item and scale formatting

**Appendix E: Ethical approval letter**

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**Appendix F: Research and Development approval letter**

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**Appendix G: CAMHS research approval conformation email**

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TRUST LOGO

## Information Sheet for Young People

My name is Siobhan Jones and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide if you want to take part, it is important that you understand why this research is being done and what it will involve. Please take time to read this information carefully and discuss it with any friends and/or caregivers. Ask me if there is anything that is not clear or if you would like more information.

Thank you for your time.

### **What is the study?**

This research is looking at the experiences of 16-18 year olds going into services like \*\*\*\*\* CAMHS and what it was that helped them keep on going back. There is very little research on this. I am interested to know what you think, what your experiences are and to learn from you.

### **Why have I been invited to take part?**

You have been asked to take part because you are aged between 16-18 years old and you currently attend sessions at \*\*\*\*\* CAMHS.

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

No, it is up to you.

If you do want to take part, I will ask you to sign the consent form saying you agree to speak to me about your experiences. You can stop the interview at any time, without giving a reason. If you do choose to stop, this will not affect the help you receive in any way.

### **What will happen to me if I take part?**

I will visit you at \*\*\*\*\* CAMHS and you will be interviewed by me. We will talk for around 30 minutes to an hour. What we talk about will be recorded using a Dictaphone (voice recorder), so only our voices will be on tape. This is so I can listen back to what we talk about and write it down. I will ask you some questions around what it has been like for you going into \*\*\*\*\* CAMHS and what helped you keep on going back. If you have been to other services like \*\*\*\*\* CAMHS, we will also talk about your time there.

**How many times do I have to meet with the researcher?**

Twice. Firstly we will meet to go through the information sheet and consent form. The second time we meet will be to do the interview.

**Who else will know I am being interviewed?**

If I am worried about you after the interview, or if you leave upset, I might discuss this with your clinician. This would only take place if I had concerns about your safety or the safety of others. I would discuss this with you before consulting with your clinician.

**What happens after the interview?**

After we have spoken, I will write out our interview. I will make sure I don't write down your name or anything else that can identify you. The only people who will see this will be me and my project supervisors. The recording of our interview will be kept in a password-protected file on a computer at Canterbury Christ Church University. After the study is finished in 2016, I will delete these and the university will keep the transcripts on a CD in a locked cabinet for 10 years. After this time, they will be destroyed.

Quotes from our interview might be used in my final report, but your name will not be used next to them.

**What happens if I don't want to carry on with the study?**

If at any point you decide that you do not want to carry on with the study, you are welcome to stop without giving a reason. If you decide to leave in the middle of our interview, you can leave at any time, but I would like to still use what we recorded. If you are not happy with this, please **do not** tick that box on the consent form below.

**What happens at the end of the research?**

The results of the research will be written up in a report and published in a journal read by health professionals and



researchers. I expect the report to be published by 2016. A summary of the results will be made available to everyone who has taken part. None of your personal details will be mentioned in any publications or reports.

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

This study is designed to find out the reasons for young people going to services and reasons they may not. If we can better understand this, it may help services tailor their work to help more young people take up the help they are offered.

### **What if something goes wrong?**

If for any reason you are not pleased with how you have been spoken to or treated you can make a complaint to Dr Alex Hassett who is this project's lead supervisor. He can be contacted by email on \*\*\*\*\* or on \*\*\*\*\*.

### **Who do I talk to if I become upset?**

If you become upset because of the interview, you can talk to your clinician at your next appointment, contact them on \*\*\*\*\* or you can speak to someone at a helpline like Childline on 0800 111.

### **Who has reviewed the study?**

An ethics committee reviews all proposals for research before they can go ahead. This project has been reviewed and approved by the \*\*\*\*\* Research Ethics Committee (NRES Committee \*\*\*\*\* – \*\*\*\*\*).

### **Who do I contact for further information?**

Please contact Siobhan Jones (Trainee Clinical Psychologist) at Canterbury Christ Church University if you would like any further information on the research. If you would like to speak to Siobhan, you can leave me a message on a 24-hour voicemail phone line at \*\*\*\*\*. Please say that the message is for Siobhan Jones and leave a contact number so I can call you back. Otherwise, you can email me at \*\*\*\*\*.

If you have no further questions and are happy to take part, please turn to the consent form on the next page.



TRUST LOGO

Participant Identification Number:

**CONSENT FORM**

**Title of Project:** Experiences engagement in mental health services in 16-18 year olds: An interpretative phenomenological analysis.

**Name of Researcher:** Siobhan Jones

PLEASE INITIAL IN THE BOXES

1. I have read and understood the information sheet. I have had the opportunity to think about the information, ask questions and have had these answered.

2. I understand that taking part in the study is voluntary and I can withdraw at any time without giving any reason, and this will not affect the care I receive in any way.

3. I understand that the interview will be recorded using a Dictaphone (voice recorder) and will be transcribed (written up) by Siobhan Jones. I understand that the recording will be kept under a password-protected file on a Canterbury Christ Church University computer and my name on the transcript will be changed.

4. I understand that another member of the research team may look at some sections of the recorded interview and transcript. I give permission for these people to have access to the recorded and written data.

5. I agree that my recording can be used even if I leave the interview early.

6. I agree that anonymous quotes from my interview may be used in published reports of the study findings.

7. I understand that my clinician will be informed if risk of harm to self or others becomes clear in the interview.

8. I agree to my therapist/case worker being informed of my participation in the study.

9. I would like to be contacted after the study to be told the results.


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

Name of Participant \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

**When complete, 1 copy to be given to the participant and 1 copy to be kept by the researcher.**

## Appendix J: Interview schedule

### Introduction

- Explain who I am
- Talk through what the research is about again
- Make clear they do not have to take part in interview and can withdraw at anytime.

### **1) Tell me about your experience of the first time you came to CAMHS**

Prompts: When was this? Can you tell me more about that? How were you feeling? What were you thinking? What did you mean by....? What did the staff do? Was it what you expected?

*If participant suggests they have attended other services previously:*

### **2) How is this different to other services you have been to?**

Prompts: What were the other services like? Can you tell me more about that? How did you feel in that service? What did you mean by.....?

### **3) What do you think helped you keep on coming back?**

Prompts: What did you mean by....? Can you tell me more about that? People? Staff? Attitudes? Expectations? What could have been better?

### **4) What do you think would make you not want to attend a service like this one?**

Prompts: What did you mean by....? Can you tell me more about that? Staff? Service? Other people around the young person? What could have been better?

### **5) What do you think influenced you leaving other services? What things got in the way of you wanting to keep on going back?**

Prompts: What lead up to you leaving? Was there anything going on for you at the time? Can you tell me more about that? How were you feeling at the time? What were you thinking? What did you mean by.....?

### **6) What would you recommend to services like this one to help people your age keep on coming back?**

Prompts: Can you tell me more about that? Is there anything from your previous experience that makes you think that? Any advice you could give to others wanting help?

## **Appendix K: Bullet point notes on young person/ school consultation**

- Consultation group set up with five 16-18 year olds via a family friend who is a deputy head teacher at a local school.
- Young people were approached by the teacher, asked if they would like to participate, and they gave verbal consent.
- The day and time was set up for me by the teacher who was familiar with how the school day was structured, and to minimise disruption the young people's days.
- Consultation group took place at lunch time and lasted for 30 minutes.
- The young people were asked to read through the Participant Information Sheet and consent form.
- Verbally told the interview schedule questions and asked whether they understood what the question meant, rather than answering the questions.
- Only a few changes were made to the Participant Information Sheet. Needed to explain what a Dictaphone was and define 'anonymise' and 'transcript'. They all asked what an ethics committee is. I was unable to change this due to university/ supervisory recommendations, but after discussion, they all recommended I could explain it verbally to participants.
- No changes were made to the consent form or schedule questions.
- They suggested offering a 'high street voucher' rather than iTunes or Amazon vouchers as not all young people have iPhones or like to use Amazon. This was changed.

**Appendix L: Example annotated transcript for “Anna”**

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**Appendix M: Example emergent themes written in word document: Themes for “Anna”**

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**Appendix N: Example bracketing notes from research diary after “Anna” transcript analysis**

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**Appendix O: Example photo of theme development: Theme 1: Engagement experience begins at help-seeking**

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## Appendix P: Original concepts/ themes

### Theme 1

#### **Engagement experience begins at help seeking (10)**

- Reaching crisis point (10)
  - Adult recognition of distress and facilitation of professional help-seeking (9)
  - Peers as professional help encouragers (4)
  - Recognition of own distress (5)
  - Failure of previous coping strategies (8)
  - Beliefs about professional help-seeking (5)
- Relationship to help? (9)
- 

### Theme 2 (may add in more as analysis continues)

#### **Determination (9)** (sublimation)

- Readiness to receive help (5) – *go in theme above?*
- Belief professional help results in symptom relief (5)
- Determination vs. engagement discomfort/ anticipation (7)
  
- *Determination vs. symptomology (3)*
- *Determination vs. disappointment with service (4)*
- *Obligation to attend (4) – counter information?*

### Theme 3

#### **Evolving process (8)**

- Anticipation (7)
- Relief (8)
- Gradual evolving process (7)
- Development of familiarity/ confidence with therapeutic process (5) – *combine with above? Positive engagement evolves with development of confidence and familiarity*
- Motivation as gains emerge/ feel of getting better (5)
- *Identification with service view of symptoms/ diagnosis as language for experience (2)*

### Theme 4

#### **Choice and control – (the adolescent dilemma?)**

### Theme 5

#### **Within session experience (10)**

- Flexibility and consistency (*go in choice and control?*)
- Developmentally appropriate responsiveness
- 'Friend with knowledge'
- Tangibility of therapeutic techniques
- Authenticity, implicit, and core-therapeutic techniques

### Theme 6

#### **Engagement with the service as a whole**

- Physical environment
- Service structure and 'the system'

### Theme 7

#### **Threats embedded across engagement process**

(Combine with 'determination' theme, as this is what prevents the threats becoming too threatening? Also comes into relationship with service and clinician)

- Judgment/ rejection/ patronizing/ assumptions
- Clinical/ inflexible
- *Stigma less so...*

## Appendix Q: Example of quotes collected for an emergent theme

<u>Theme 1:Engagement experience begins at help seeking</u>	<u>Line</u>
<i>Reaching crisis point</i>	
<u>Nebi:</u>	
"I just started crying in school"	388
"... had a breakdown in school..."	393
<u>Anna:</u>	
"I got to a really low point"	136
"...that was the day I had my first panic attack..."	143
<u>Nicole:</u>	
"I went to A&E"	5
"I just really couldn't get out of bed"	61
"... and yeah, it just got worse."	138
<u>Hannah:</u>	
"...it was impacting on work, I was like stressed at home so a couple of times my parents walked in on my room when I was having a breakdown not like self harming or trying anything just like crying, being really angry 'cos it was all that bottled up frustration coming out."	274-277
<u>Caroline:</u>	
"... but then, erm, last summer, I had loads of panic attacks in college.."	101-102
<u>Jenny:</u>	
"... I had a really bad panic attack in an assembly..."	93
"I was just really sick of not understanding it"	96-97
"I think even the depression was building up around then as well 'cos I was just really exhausted and I didn't feel like going into school and it was a really tough time..."	385-388
<u>Chris:</u>	
"... during the time before I contacted it was quite depressing, I was really like, I felt kind of blockage you know and I didn't want to talk, I tried to avoid my, to avoid talking about it, I tried to pretend maybe there was no issue..."	92-95
<u>Rose:</u>	
"Erm, I dropped out of school because I had lots of panic attacks, erm, and I just felt really alone with stuff..."	160-161
"I just got to the point where I just couldn't go into school"	328-329
<u>Max:</u>	
"...er, things got worse, there was a moment, there was a day in school where I had to leave early..."	44-45
"...it wasn't that I was feeling ill, I just wasn't feeling myself and I was feeling really down..."	111-112
<u>Noah:</u>	
"I was kind of feeling worse everyday... and I took an overdose..."	443-444
<i>Adult recognition of distress/ facilitation of professional help-seeking</i>	
<u>Nebi:</u>	
"[mum] said it would be really helpful for me and she said I needed to talk to someone"	99-100
"... but it was more my mum..."	122
"Researcher: ... can I just ask, was it your decision to seek help here, or was it like your mum's decision, or...?"	380-383
Nebi: It was my mum's."	
<u>Anna:</u>	
"Well, the first I told was my mum because that was the day I had my first panic attack and she told me that you should go to your GP and talk to them about it..."	143-145

<u>Nicole:</u>	
"I just really couldn't get out of bed so I decided to go to the doctor. My mum said I had to go."	61-62
"Researcher: Ok and was there anything that mum said to you that helped you go to the GP at all?"	140-143
Nicole: Hmm, not really she just kind of told me I had to go."	
<u>Hannah:</u>	
"... 'cos they [parents] know I suffered from depression they were like more encouraging to 'you should do this, this helps that, so maybe it will help you'..."	222-224
"I explained to my mum what was happening, like, in my head and she was like, 'I think it's time we go to the GP and try to get you counselling'..."	286-288
<u>Caroline:</u>	
"... so my college was really worried about me and they said that they wanted me to talk to someone, try and go to the doctors, and they spoke to my mum, my parents about it and my parents were encouraging me to go and ask about it as well, erm, then so my dad ended up, just booking me an appointment with my GP."	102-106
<u>Jenny:</u>	
"I had this really bad panic attack in an assembly and my form tutor was there and she said that, 'I didn't even know that you were going through this, I think it's really important that you talk to somebody'."	93-95
"... I think the fact that the school actually noticed something..."	192-193
<u>Chris:</u>	
"Researcher: What, erm, you said that you contacted a charity beforehand..."	58-61
Chris: Mmmm yes, 'cos I asked them what they think I should and they told me to go to, ask for referral first."	
"Researcher: What was it that made you decide not to tell your mum that you were going to the doctors?"	256-261
Chris: To be honest I told my mum... and she said that she's busy and if I want to go then I can go on my own..."	<i>Deviant case?</i>
<u>Rose:</u>	
"I think I had a panic attack in front of my mum, a really bad one, and she said 'you need to get help'..."	161-163
<u>Max:</u>	
"... one of my teachers erm saw that I was looking down quite often during her class erm and she spoke to me about it..."	38-39
"My maths teacher, she noticed I wasn't participating as much and I was looking down and I wasn't really er as energetic as I once was apparently, erm, and so she took me back after class and said erm 'are you feeling alright?' and... er, 'do you want to talk about it?' stuff like that and then she said she would like me to talk to the pastoral agent... we had a chat in her office and she said she'd put me on the waiting list for a counselor."	76-83
<u>Noah:</u>	
Did not come up in conversation	<i>Deviant case?</i>
 <i>Peers as professional help 'encouragers'</i>	
<u>Nebi:</u>	
"Nebi: Some of my friends come here so they kind of talked to me before I went and they just made me feel a bit better."	57-70
Researcher: And what did they say about coming here?"	
Nebi: They said that everyone was really helpful and it's local so it's not very far..."	
"Erm, well, a lot of my friends were supportive about it... and they said it helped."	584
<u>Hannah:</u>	

"Erm, a couple of my friends, like the people who knew about it, erm, they were just supportive of what I wanted but people did say maybe it would help, like, just to try kind of thing, so..." 341-343

Caroline:

"...and when I kind of said I've had my first counseling appointment some of my friends were really happy (laughs)..." 176-177

"...one of my worries was not being in college because I missed a morning of college already but I made sure it [therapy sessions] fits in with my lessons that are free, and erm, one friend was like "don't care about college, just go and make sure that you feel better!" 184-187

Max:

"...my friends are very understanding of it..." 485

"Max: And then also my friends talked me into it as well, when they tried to..." 537- 543

Researcher: I see I see, ok...

Max: It would be a good thing, and they'll help you get better and stuff like that, so..."

#### *Recognition of own distress/ readiness to receive help*

##### *Recognised distress but still reliant on adult to suggest help*

Anna:

"I realized that if I keep this to myself I'd do something I regret so I just decided, I told myself I need to speak to people, or I need to tell someone what I'm going through or I'll go insane." 136

Jenny:

"it's not me admitting that I need help it's just them saying this is available" 196-197

"I think there's part of every teenager really when your mum says something like "oh you need help" that's like... just don't! (laughs) but, erm, I think part of it was also that I was kind of worried but I wasn't going to voice it so the fact that she said it, I think it was necessary really, erm and it kind of relieved me a little bit of the stress of not being able to say anything." 276-281

Chris:

"... so I decided that maybe I should do something, not just be depressed" 43-44

Rose:

"Researcher: What was it like for you? Her saying, I think you need to get help now?" 172-175

Rose: It wasn't that surprising, because I did."

Max:

"I was feeling worse and I just didn't have enough energy to go to class" 90-91

"Researcher: What did it feel like for you when they did that [suggested help]" 136-140

Max: Erm, I wasn't shocked, er, I hadn't been feeling myself for almost a year now."

#### *Failure of previous coping strategies*

Nebi:

"But it's almost like, it's not like they [friends and family] don't want to hear about it, they found it hard to hear about it" 365-366

"And I felt like they [previous therapist] had given me as much as they could and it was time to move on." 425-426

Anna:

"I thought if I keep telling people about my problems I would just be burdening them and I would be a burden to them so they wouldn't want to speak to me" 130-132

Nicole:

"I had been depressed before but school had sorted that out because I 49-51



had a counselor there so I went to see her, but I moved schools so they didn't have a counselor"	
<u>Hannah:</u>	
"... 'cos I mainly bottle it all up and like I had to deal with it but obviously that's counterproductive because you just build up all the negativeness and it all comes out crazy (laughs)..."	231-234
<u>Caroline:</u>	
"I didn't really tell people"	82-83
"I just prayed and I felt better... but then, erm, last summer I had loads of panic attacks in college"	100-102
<u>Jenny:</u>	
"... so I felt like I had for force myself to be ok.... I didn't really have the space to be able to tell them [parents] that I wasn't doing so well... 'cos at home I had to kind of shut it off a bit... but I mean that didn't last very long because I eventually, stuff got a lot worse with me..."	117-122
"I just felt at the time I just wanted to get through it by myself"	401-402
"I think I've just been really used to doing things by myself and kind of not relying on anybody, just relying on myself because it's the easiest, you can't really let yourself down, it's just, you know, a solid thing, and then, erm, with this [depression] it was just a similar thing, it was just another obstacle I had to get myself across and erm, kind of slowly it came to the realisation, I came to the realisation that this was maybe the first thing I wasn't able to pull myself through and like my coping mechanism wasn't working, the default thing I always fell into wasn't working, erm, and it was quite hard to come to terms with."	410-418
<u>Chris:</u>	
"...I tried to avoid my, to avoid talking about it, I tried to pretend maybe there was no issue..."	93-95
<u>Max:</u>	
"I thought I was doing a good job in trying to hide it, kind of... put it away and not look so, erm, down..."	152-153
 <i>Beliefs about professional help-seeking (4)</i>	
<u>Hannah:</u>	
"I didn't know what it was going to be like, I thought, I didn't know what I thought I was going to get, maybe something, someone like older who would be a bit condescending, and like 'at your age you don't, you don't like, you don't understand properly."	53-57
<u>Caroline:</u>	
"... I just expected someone to be like really serious and formal..."	317-318
<u>Chris:</u>	
"I was stressed what, you know, as I said, but if they don't want to help me, they would get bad impression of me, I really worry what other people think of me."	112-114
Previous experience influence on help now: "I thought, had this attitude that she won't help me, it won't help me at all, but actually I think it helped me, yes, and when I started to see her for the third time I had full understanding and I wanted to go here, that she may help me."	173-176
"I saw some scary stories on the internet sometimes people are not really friendly, it's, I was quite nervous that they won't, you know, try to help me."	343-345
<u>Rose:</u>	
"Just wondering what the person was going to be like and what I was going to be asked and stuff."	470-471

**Appendix R: Theme and recurrence table**

Themes	Nebi (16)	Anna (16)	Nicole (17)	Hannah (17)	Caroline (18)	Jenny (17)	Chris (16)	Rose (17)	Max (17)	Noah (18)
<b>1. Engagement experience begins at help-seeking</b>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>Reaching crisis point</i>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>Recognition of own distress</i>	Y	N	N	N	N	Y	Y	Y	Y	N
<i>Failure of previous coping strategies</i>	Y	Y	Y	Y	Y	Y	Y	N	Y	N
<i>Adult recognition of distress/ facilitation of professional help-seeking</i>	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
<i>Peers as professional help 'encouragers'</i>	Y	N	N	Y	Y	N	N	N	Y	N
<i>Beliefs about professional help seeking</i>	N	N	N	Y	Y	N	Y	Y	N	N
<b>2. Determination</b>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>Readiness to receive help</i>	N	Y	N	Y	N	N	N	N	Y	Y
<i>Belief that engagement results in symptom relief</i>	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
<i>Determination vs. engagement discomfort/</i>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

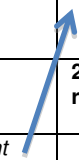
Combined with 'readiness to receive help' from Theme 2

Moved to Theme 2 and combined with 'Belief that engagement results in symptom relief'

Moved to Theme 1 and combined with Recognition of Own Distress

All 'Determination vs. x' combined

	<b>Final Themes</b>
<b>1. Engagement experience begins at help seeking</b>	<b>1. Engagement begins at help seeking</b>
<i>Reaching crisis point</i>	<i>Reliance on adult acknowledgement of distress and facilitation of professional help seeking</i>
<i>Adult recognition of distress and facilitation of professional help-seeking</i>	
<i>Failure of previous coping strategies</i>	<i>Cognitive-preparedness</i>
<i>Readiness to receive help</i>	
<b>2. Determination</b>	<b>2. Strength of inner resolve</b>
<i>Belief that engagement results in symptom relief</i>	
<i>Determination vs. engagement threats</i>	<i>Striving against engagement threats</i>



<i>anticipation / Determination vs. symptomology / Determination vs. disappointment with service</i>										
<i>Obligation to attend</i>	N	Y	N	Y	Y	N	N	Y	Y	Y
<i>Perceived lack or exhaustion of other therapeutic options</i>	Y	N	Y	N	N	Y	N	N	N	N
<b>3. Evolving Process</b>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>Anticipation</i>	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
<i>Relief</i>	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
<i>Gradual evolving process</i>	N	Y	Y	Y	Y	Y	Y	N	Y	Y
<i>Development of familiarity/ confidence with therapeutic process</i>	N	Y	Y	Y	Y	Y	Y	N	Y	Y
<i>Emergent therapeutic gains</i>	Y	Y	Y	Y	Y	Y	N	Y	N	N
<i>Identification with service view of symptoms/ diagnosis as language for experience</i>	N	Y	N	Y	N	N	N	N	Y	N
<b>4. Choice and control</b>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>'Suggestions' vs. 'being told what to do'</i>	Y	N	Y	N	N	Y	Y	N	Y	N
<i>Choice and</i>	Y	Y	N	Y	N	Y	Y	N	Y	N

Removed: less than 50%

Combined with 'Development of familiarity and confidence'

Combined with 'Gradual evolving process'

Removed: less than 50%

<i>Obligation to attend</i>	<i>Responsibility to others</i>
<b>3. Evolving Process</b>	<b>3. Evolution of the self</b>
<i>Anticipation</i>	<i>Progression through suspense and release</i>
<i>Relief</i>	<i>Growth through familiarity and trust affect</i>
<i>Development of familiarity and confidence</i>	
<i>Emergent therapeutic gains</i>	
<b>4. Choice and control</b>	<i>Negotiating as an adolescent through choice, transparency and control</i>
<i>'Suggestions' vs. 'being told what to do'</i>	
<i>Choice and control as</i>	

<i>control as engagement aids</i>										
<i>Service and clinician flexibility and consistency</i>	N	Y	Y	N	Y	N	N	N	N	Y
<i>Transparency</i>	N	N	Y	Y	Y	Y	Y	Y	Y	Y
<b>5. Within session experience</b>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>Developmentally appropriate responsiveness</i>	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
<i>'Friend with knowledge'</i>	N	Y	N	Y	N	N	N	N	N	Y
<i>Authenticity and implicit</i>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>Core therapeutic techniques</i>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>Tangibility of therapeutic techniques</i>	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
<b>6. Engagement with the service as a whole</b>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<i>Physical environment</i>	Y	Y	N	N	Y	N	N	N	N	Y
<i>Service structure and 'the system'</i>	Y	Y	Y	Y	N	Y	N	N	Y	Y
<b>7. Threats embedded across the engagement process</b>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Removed: less than 50%

Combine with 'authenticity and implicit'  
Combine with 'friend with knowledge'

Removed as a theme

Removed theme as embedded in above themes

<i>engagement aids</i>	
<i>Transparency</i>	
<b>5. Within session experience</b>	<b>4. In the clinic room</b>
<i>Developmentally appropriate responsiveness</i>	<i>Developmentally appropriate responsiveness</i>
Authenticity and amiability	<i>Centrality of a human relationship</i>
Unconditional positive regard	
<i>Tangibility of therapeutic techniques</i>	<i>Tangibility of techniques</i>

## **Appendix S: Abridged research diary**

17<sup>th</sup> April 2014

I am fully starting the process of putting together my MRP proposal now. As I am wanting to do a qualitative analysis it is recommended that I keep a reflective journal as part of this. Process of putting proposal together: This is a long process! With every meeting, with everything I read, my question, analysis and direction changes. I'm starting to wonder just how much my final research question will resemble my original one! At this stage I want to speak to young people who have dropped out of CAMHS. I am expecting these young people to have lots of 'bad' stories about CAMHS. Having read more about qualitative designs, IPA seems to fit more to what I am wanting to look into..... 'experience' and 'understanding.' Am I expecting, or even wanting, stories about CAMHS not meeting need?? Did I get these images from what I hear from the press/ previous clients? Papers I have read about how 'off the mark' clinicians are about teenage drop-out.

30<sup>th</sup> April 2014

My research question and direction has already had to be refined. I was planning to ask mental health workers opinions as well as young people to see how these opinions differ. Compare client understandings of drop out compared to clinician understandings. This is not possible with IPA according to the research department here. So, I am now only looking into young people. This actually makes me quite excited about my research, focusing on the people I am most interested in hearing from. Now that I am reflecting, I need to make sure I maintain as much a position of neutrality as possible and remain aware of my own expectations and reactions.

16<sup>th</sup> April 2014

At times I am finding this project a mixture of anxiety-provoking due to my lack of experience with research, but at other times exciting. I am now tailoring my question and project to account for engagement and the positive sides of this.. what helps... acknowledging that some things go well. The recognition of expectations from earlier diary entry has been really helpful.

28<sup>th</sup> June 2014

I had my proposal review. Upon reflection it seemed to go well. No major changes need to be made. They want me to change my title and suggested I just focus on engagement, which I started to think about in my previous diary entries. Initially I would have been disappointed with this but I now feel ok as I feel I am starting to understand the research process a lot more now. I need to refine and explain literature a lot more. This I understand as I wasn't that confident with my literature search... I found it helpful to consider and emphasise more that ultimately I want young people to get better. This seems obvious to me but this needs more emphasis/ positioning throughout the process. There are a lot of small questions to answer but it feels like the bulk of the work is in the literature review and justification for my project.

13<sup>th</sup> August 2014

I felt reassured after seeing my supervisor, giving me encouragement about my research. I passed the review process with minor changes – feeling more confident about my work but am now worried about the ethics process. Also worried about the Section A.... worried about everything! I'm realizing I 'just need to give it a go' but I am also excited about the process ahead of me.

15<sup>th</sup> August 2014

Reading a lot more into engagement models/ research/ discussion. Is all of this too blaming on the client? Locating all the issues in the client rather than looking at the context and service? E.g. the client doesn't adhere, the client doesn't do homework, the client doesn't reveal enough... needs to be a meeting of clients and service... "matched expectations."

30<sup>th</sup> August 2014

Problems with engagement definitions... is this only something that happens at the beginning? Seems to be a lot of pressure on clients when meeting definitions of engagement. They need to *do so much* to engage/ to be defined as engaged... attend ALL sessions, complete ALL homework, contribute fully in ALL sessions, maintain an appropriate and boundaried working alliance... how are we expecting adolescents to do all this?! How on earth will this translate to teenagers, especially those with complex needs and disrupted attachments. We are setting them up to fail before they have even attended. Need to remain aware of this assumption.... Do we need a different definition of engagement for adolescents??

16<sup>th</sup> September 2014

Now onto ethics! It's a long and repetitive form!

I read a more psychodynamically orientated paper about adolescents with more complex needs and engagement... about how a part of them may want to sabotage their own progress. Interesting how this fits into my original expectations around adolescent engagement. Engagement is a process.

I'm going to speak to some pupils at \*\*\*\*\* school in a few weeks to get them to help me develop my questions, information sheet and consent form.

17<sup>th</sup> September 2014

I met my supervisor for my CAMHS placement today. I'm interested to see how my expectations of CAMHS changes during this placement.

28<sup>th</sup> September 2014

Still doing ethics.... so fiddly!

10<sup>th</sup> October 2014

School consultation (Appendix L)

11<sup>th</sup> October 2014

Ethics still going on! So many unanswered questions and ones I need more help with.

6<sup>th</sup> November 2014

My REC panel is sitting as I write. I think I will know the outcome in 10 days. After this I still have to go through R&D and CAMHS research approval! This has got to be the longest admin process I have ever been through for anything. Apparently this process will teach me "patience, perseverance and tenacity" ..... !!!

28<sup>th</sup> January 2015

ALL ETHICS, R&D AND CAMHS RESEARCH APPROVED! Recruitment starts now! Excited and motivated now. I'm starting looking into Section A today. 8,000 words!

### 19<sup>th</sup> February 2015

First interview done! Reflections after interview 1: It was revealing how hard it is to switch from clinician mode to IPA researcher mode. Don't reflect back. Don't make interpretations. It's really difficult not to ask leading questions, make gestures of say things than can be leading. Positioning!

### 26<sup>th</sup> February 2015

Reflections after interview 2: Failure of external support systems... ask about any missed appointments, or is this too leading? Wondering if I need to read more theory before the next interviews. Although, will reading theory end up leading the interviews towards that rather than young person experience?

### 8<sup>th</sup> April 2015

Reflections after interview 3: Feel like I'm getting properly into the swing of interviewing now but hard to not 'comfort' especially when participant talking about how much they appreciated warmth. Weight of symptomology. Need for services to pull together. Almost feels like creaking cogs in a rusty system.

### 16<sup>th</sup> April 2015

Article on BBC news site about systems letting children and staff down. A sense of 'in it together.' "Difficult edge of lost support" at 18 years. Interesting as wanting to promote engagement for young people, but when you do engage, are there even services there for them?! It almost feels counterintuitive – stigma/ help-seeking campaigns but then an absence of a system/ service to then pick the young people up. Reflections after interview 4:

### 30<sup>th</sup> April 2015

Reflections after interview 5: All interviewees have mentioned a 'critical point' of not being able to cope any more. The need to reach crisis before asking for me. This, I suppose, is mirrored in CAMH services. The prerequisite for be "severe enough" or "in crisis" in order to be offered help.

### 14<sup>th</sup> May 2015

Reflections after interview 6: Liking to be told in advance what happens, all processes crystal clear and if they change, make young person aware of this.

Interested in the lack of boys I have interviewed. Is this a reflection of under-representation of young men in services. Or clinicians assuming boys won't want to take part in research? Male help-seeking as a whole? Needed to have 'successfully' gone through help-seeking to get to my research...

### 30<sup>th</sup> May 2015

Interested in the feelings of reluctance I am coming up against with recruiting. I have attended team meetings and feel a bit like I'm there as a 'token' and not taken too seriously. Interesting attempting to do research in busy and over-stretched CAMH services. Almost as if this is pushed aside due to pressures. Clinicians not having the time to do something that doesn't feel immediately important. Takes up time? Expectations that clients won't want to take part? Spoke to a psychologist in \*\*\*\*\* about lack of boys between 16-18 for my research. She said that boys in the service tend to be younger, have conduct disorders or active psychosis. (Conduct – perceived to be difficult to engage so not worth asking if they want to take part in my research?)

10<sup>th</sup> June 2015

Reflections after interview 7: Lack of communication to young people about service decision-making process. Why clinicians are doing what they are doing. Being heard and not judged. Keep on going back to 'means to an end'.... the hope that things will get better. Keep on engaging, not because of therapist, but because of belief that 'it will help'. Client characteristics and therapist characteristics being compatible? Family attitudes towards help-seeking – even though at this age there is a level of independence from family, also about having a good amount of support from family. Interesting in terms of theoretical suggestions.

2<sup>nd</sup> July 2015

Reflections after interview 8: Difficult to get the interview going – participant said lots of "I don't know" – felt stuck at times with how to make it flow – more general and broad questions didn't elicit too much so had to become a little bit more directive with questions. Was I leading too much? Practical elements of therapy more containing?? Especially for a young person who finds talking a challenge. Fit between therapy and client.

28<sup>th</sup> July 2015

Literature review/ introduction to Section B reflections: Scanning through abstracts realizing that a lot of articles use the word 'engagement' or reference 'engagement' but then do not expand on this. Searching for 'engagement' brings up a lot of results but with little substance. Lots on 'how to' engage through service design but very little about understanding. Lots of 'final' recommendations on engagement or saying something like 'need more research on [paper topic] to enhance engagement.' Expanding 'mental health services' term brings up way too many results, especially when coupled with engagement terms. Seeing as it's just me (!) doing this, and not a team of researchers, will need to not expand/ burst this term.

9<sup>th</sup> August 2015

Reflections after interview 9: Difficulties entangling help-seeking and engagement, again. This seems to be common throughout all interviews. Again, the mix of symptomology and engagement interesting but more as something to 'fight' against.

10<sup>th</sup> October 2015

ALL INTERVIEWS DONE! Reflections after interview 10: Very interesting and slightly more complex in presentation. Really felt the idea of a service offering containment and routine. Engagement so much more than just 'turning up' and 'asking for help'. Now onto transcribing.

20<sup>th</sup> November 2015

Thoughts after initial coding of 1<sup>st</sup> transcript: role of trusted family member – doesn't have to be whole family. Patronizing.... contradiction between being a child and not wanting to feel patronized. Experienced as a girl uncertain about herself? Worried about judgment. Determination, whole service engagement, fear of consequences, confidentiality.

20<sup>th</sup> January 2016

Thoughts after coding 2<sup>nd</sup> transcript: (See Appendix N)

22<sup>nd</sup> January 2016



Thoughts after coding 3: Different levels of initial engagement and motivation initially. Service response and flexibility key. "I want to help you" and "I am interested in you, for you". Importance of idiosyncratic responsiveness.

#### 25<sup>th</sup> January 2016

Thoughts after coding 4: Distinction between help-seeking and engagement blurred/ not possible? Need to understand individuals help-seeking process to understand their engagement process? Critical point/ incident + mum suggesting help (in all transcripts so far). How much does determination play a role in this? Engagement feels like a balancing act. Needing to balance difficult experiences vs. determination for help/ not letting people down. Engagement as a 'handing over' from parental encouragement to therapist?

#### 30<sup>th</sup> January 2016

Thoughts after coding 5: Experiencing tensions within phenomenological theory itself e.g. Husserl's idea of capturing experience of all but then the idea of honouring the individual, idiosyncratic experience. Interesting how this will emerge in my Section B write-up. Referencing therapist facilitators such as implicit 'niceness' of therapist or 'atmosphere' in aiding engagement.

#### 2<sup>nd</sup> February 2016

Thoughts after coding 6: Experience of engagement an organic process? Positive initial face-to-face experiences imperative? The unspoken, innate, sensory?? Engagement on a 'felt' level. Positivity.

#### 5<sup>th</sup> February 2016

Thoughts after coding 7: What about previous relationship to help? Engagement more than just turning up. Affective ideas around engagement. Smooth engagement

IPA not a linear process, not even circular, more ricocheting around the transcript – checking, revising, re-wording.

#### 10<sup>th</sup> February 2016

Thoughts after coding 8: Engagement beginning at help-seeking/ learned relationship to help. Arrive at services with pre-conceived ideas of help and therapy – the impact of this affective?

#### 15<sup>th</sup> February 2016

Thoughts after coding 9: 'Rules' of engagement. Expectation of rules interesting. Engagement something to be learned.... not told the rules, you have to guess them as you go along. Developmental appropriateness key.

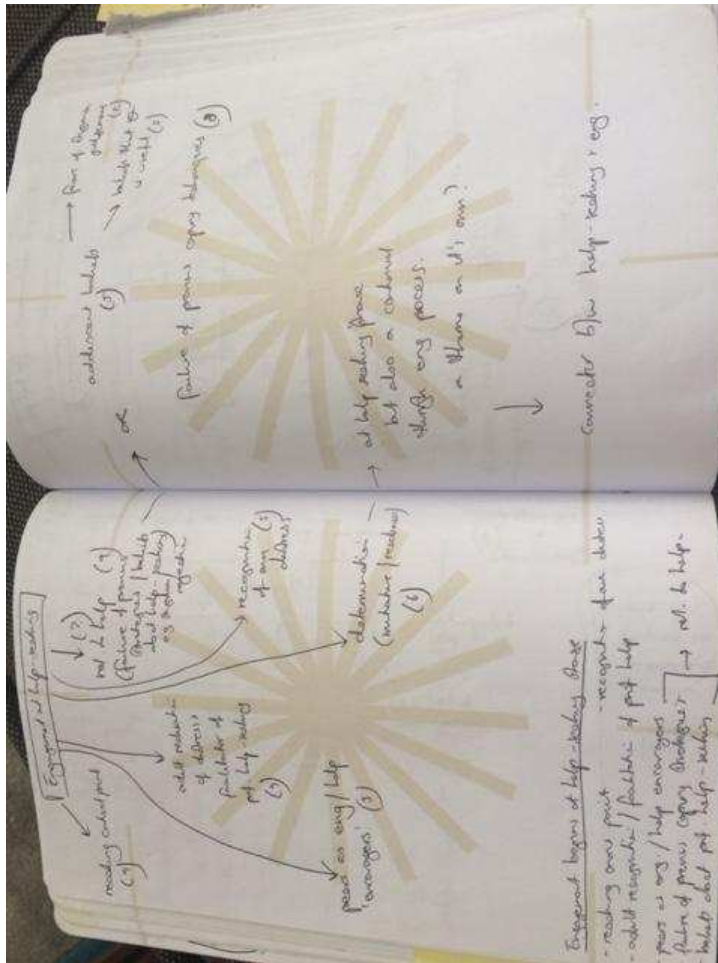
#### 21<sup>st</sup> February 2016

Thoughts after coding 10: Cultivation and growth of engagement. Facilitation, organic, natural – metaphor of throwing pottery. Something you feel your way around. Continuum nature of engagement. Engagement itself is the therapy? Service flexibility and responsiveness.

#### 27<sup>th</sup> February 2016

Beginning to lay out themes/ look for patterns across cases. Real sense of a process across experience. Initial ideas: engagement and help-seeking, as a process, whole service engagement, threats, within-session motivators/ experiences.

Theme idea development example:



9<sup>th</sup> March 2016

Collecting quotes for 'within session experience.' Difficulties in distinguishing between therapist as friend/ core therapeutic techniques/ implicit and authenticity. Difficulty in naming what the participants were unable to name, due to implicit... really seeing the interpretative nature of IPA here and the hermeneutic cycles. Collecting quotes is changing my themes.....

15<sup>th</sup> March 2016

Further development of themes: taking hermeneutics to another level it feels like I'm going further and further away from participant experience by adding in my interpretation. I keep on checking back to original transcripts to ensure I'm honouring their experiences. Progressions are still happening/ thoughts developing as I write up my results. The writing process has been key for my theme development.

**Appendix T: Themes/ points discussed within bracketing interview**

This has been removed from electronic copy

## Appendix U: Author guidelines for journal: Child and Adolescent Mental Health

### Author Guidelines

#### Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Ranked in ISI: 2014: 73/119 (Psychology Clinical); 93/140 (Psychiatry (Social Science)); 63/119 (Pediatrics); 75/133 (Psychiatry)
- 4000+ institutions with access to current content, and a further 5000+ plus institutions in the developing world
- High international readership - accessed by institutions globally, including North America (36%), Europe (41%) and Asia-Pacific (15%)
- Excellent service provided by editorial and production offices
- Opportunities to communicate your research directly to practitioners
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; rejection rate is around 84%
- Acceptance to Early View publication averages 45 days
- Simple and efficient online submission – visit [http://mc.manuscriptcentral.com/camh\\_journal](http://mc.manuscriptcentral.com/camh_journal)
- Early View – articles appear online before the paper version is published. [Click here](#) to see the articles currently available
- Authors receive access to their article once published as well as a 25% discount on virtually all Wiley books
- All articles published in CAMH are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF)

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice.

**Original Articles:** These papers should consist of original research findings.

**Review Articles:** These papers are usually commissioned; they should survey an important area of interest within the general field.

**Measurement Issues:** These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services.

**Innovations in Practice:** Submission to this section should conform to the specific guidelines, given in full below.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original article, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: [http://mc.manuscriptcentral.com/camh\\_journal](http://mc.manuscriptcentral.com/camh_journal) and *check for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal *create a new account*. Help with submitting online can be obtained from Piers Allen at ACAMH (e-mail [Piers.Allen@acamh.org.uk](mailto:Piers.Allen@acamh.org.uk))

4. Authors' professional and ethical responsibilities

#### *Disclosure of interest form*

All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

#### *Ethics*

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the [Ethical principles of psychologists and code of conduct](#) (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of

data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors ([ICJME](#)) and is also a member and subscribes to the principles of the Committee on Publication Ethics ([COPE](#)).

#### *Informed consent and ethics approval*

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study country. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

#### *Note to NIH Grantees*

Pursuant to NIH mandate, Wiley-Blackwell will post the accepted version of contributions authored by NIH grant-holders to PubMed Central upon acceptance. This accepted version will be made publicly available 12 months after publication. For further information, see [www.wiley.com/go/nihmandate](http://www.wiley.com/go/nihmandate).

#### *Recommended guidelines and standards*

The Journal requires authors to conform to CONSORT 2010 (see [CONSORT Statement](#)) in relation to the reporting of randomised controlled clinical trials; also recommended is the [Extensions of the CONSORT Statement](#) with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials should be registered in one of the ICJME-recognised trial registries:

[Australian New Zealand Clinical Trials Registry](#)

[Clinical Trials](#)

[Netherlands Trial Register](#)

[The ISRCTN Register](#)

[UMIN Clinical Trials Registry](#)

Manuscripts reporting systematic reviews or meta-analyses should conform to the [PRISMA Statement](#).

The [Equator Network](#) is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work <http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields> and on quasi-experimental <http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research> and mixed method designs <http://www.equator-network.org/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond>

#### *CrossCheck*

An initiative started by *CrossRef* to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

*Summary:* Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

*Keywords:* Please provide 4-6 keywords (use [MeSH Browser](#) for suggestions).

*Key Practitioner Message:* (in the form of 3-6 bullet points) should be given below the Abstract, highlighting what's known, what's new and the direct relevance of the reported work to clinical practice in child and adolescent mental health.

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.

7. Authors who do not have English as a first language may choose to have their manuscript

professionally edited prior to submission; a list of independent suppliers of editing services can be found at [http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

*Study funding:* Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

*Conflicts of interest:* Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

*Contributorships:* Please state any elements of authorship for which particular authors are responsible, where contributions differ between the author group. (All authors must share responsibility for the final version of the work submitted and published; if the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

10. For referencing, CAMH follows a slightly adapted version of APA Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See <http://authorservices.wiley.com/bauthor/illustration.asp> for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

### **Review Articles**

These papers are usually commissioned; they should survey an important area of interest within the general field of child and adolescent mental health disorders and services. Suggestions for topics and proposals (outline and/or draft abstract) may be sent to the CAMH Editorial Office [camh@acamh.org](mailto:camh@acamh.org)

### **Measurement Issues**

These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services: if you have a suggestion for a measurement-based overview article, please contact the CAMH Editorial Office [camh@acamh.org](mailto:camh@acamh.org) with an outline proposal.

Manuscripts for Review Articles and Measurement Issues should follow the standard format for Original Articles but to a word limit agreed at the point of the proposal being agreed.

### **Innovations in Practice**

*Child and Adolescent Mental Health (CAMH)* promotes evidence-based practice, intervention and service models. Innovations in practice, intervention and service provision may arise through careful and systematic planning, while others are responsive to need, evolution of existing services, or simply arise because of changing circumstances or technology. In this rapidly evolving field, the Editors of *CAMH* warmly welcome short *Innovations in Practice* papers which aim to allow authors to share with our wide international multidisciplinary readership knowledge and initial impact of new and interesting developments.

Manuscripts submitted as *Innovations in Practice* submissions should follow the standard format for *Original Articles* but be no more than 2500 words, including references and tables. They should briefly set out the aims and detail of the innovation, including relevant mental health, service, social and cultural contextual factors; the evaluation methods used; relevant supporting evidence and data; and conclusions and implications. Submissions may describe formal pilot and feasibility studies or present findings based on other evaluative methods. Contributions outlining important innovations with potential significant impact may be considered even in the absence of evaluative data. Close attention should be paid in all submissions to a critical analysis of the innovation.

## **Manuscript Processing**

*Peer Review Process:* All material submitted to CAMH is only accepted for publication after being subjected to external scholarly peer review, following initial evaluation by one of the Editors. Both original and review-type articles will usually be single-blind reviewed by a minimum of two external referees and only accepted by the decision Editor after satisfactory revision. Any appeal of an editorial decision will first be considered by the initial decision Editor, in consultation with other Editors. Editorials and commissioned editorial opinion articles will usually be subject to internal review only, but this will be clarified in the published Acknowledgement section. Editorial practices and decision making will conform to COPE <http://publicationethics.org/resources/guidelines> and ICMJE <http://icmje.org/> best practice.

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**Appendix V: NRES end of study form**

**DECLARATION OF THE END OF A STUDY**

(For all studies except clinical trials of investigational medicinal products)

To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee that gave a favourable opinion of the research ("the main REC") within 90 days of the conclusion of the study or within 15 days of early termination. For questions with Yes/No options please indicate answer in bold type.

**1. Details of Chief Investigator**

<b>Name:</b>	Siobhan Jones
<b>Address:</b>	Salomons Centre for Applied Psychology Canterbury Christ Church University Runcie Court David Salomons Estate Broomhill Road Tunbridge Wells TN3 0TF
<b>Telephone:</b>	*****
<b>Email:</b>	*****
<b>Fax:</b>	

**2. Details of study**

<b>Full title of study:</b>	The experience of engaging in mental health services in 16-18 year olds: An interpretative phenomenological analysis
<b>Research sponsor:</b>	Professor Paul Camic, Salomons Centre for Applied Psychology (address as above)
<b>Name of main REC:</b>	x Ethics Research Committee
<b>Main REC reference number:</b>	*****

**3. Study duration**

<b>Date study commenced:</b>	First participant interviewed: 17/2/15
<b>Date study ended:</b>	Last participant: 14/8/15 Report finished: 6/4/16
<b>Did this study terminate prematurely?</b>	<b>No</b> <i>If yes please complete sections 4, 5 &amp; 6, if no please go direct to section 7.</i>



#### 4. Circumstances of early termination

What is the justification for this early termination?	
---	--

#### 5. Temporary halt

Is this a temporary halt to the study?	Yes / No
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	<i>e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.</i>

#### 6. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	
---	--

#### 7. Final report on the research

Is a summary of the final report on the research enclosed with this form?	Yes <i>If no, please forward within 12 months of the end of the study.</i>
---	---

#### 8. Declaration

Signature of Chief Investigator:	Siobhan Jones
Print name:	Siobhan Jones
Date of submission:	6/4/16

**Appendix W: Final report on research for NRES Ethics panel and Trust R&D/ CAMHS research board**

Email covering letters:

Dear (NRES Ethics Panel),

Re: Experience of engaging in mental health services in 16-18 year olds: An interpretative phenomenological analysis

Main REC Reference: \*\*\*\*\*

I am writing to inform you the above study is now complete. Please find attached the Declaration of the End of Study and a final report.

Best wishes,

Siobhan Jones  
Trainee Clinical Psychologist

-----

Dear (R&D Department/ CAMHS Research Board),

Re: Experience of engaging in mental health services in 16-18 year olds: An interpretative phenomenological analysis

REC Reference: \*\*\*\*\*

Trust Approval Reference: \*\*\*\*\*

Dear \*\*\*\*\*,

As requested, I am writing to inform you the above study is now complete. In line with your protocol, please find attached the NRES Declaration of the End of Study and a final report.

Best wishes,

Siobhan Jones  
Trainee Clinical Psychologist

**Research Summary**

**Title:** Experiences of engaging with mental health services in 16-18 year olds: An interpretative phenomenological analysis.

**Research context:** Despite older adolescence being a risk period for the development of mental health concerns (e.g. Vyas, Birchwood, & Singh, 2015), mental health service engagement is low amongst 16-18 year olds (Singh, Paul, Ford, Kramer, & Weaver, 2008). As engagement in services may be an important part of effective mental health treatment (YoungMinds, 2014), it is important that engagement in this population is understood. Despite this, there is a paucity of research looking specifically at the older adolescent engagement phenomenon. Additionally, definitions and models of engagement lack

specificity, consensus and applicability to 16-18 year olds. Some qualitative research into adolescent experiences has elicited rich and in-depth results (e.g. Bury, Raval, & Lyon, 2007; Harper, Dickson, & Bramwell, 2014). These papers suggest the centrality of the therapeutic relationship and the need to pay attention to young people's views of psychotherapy. However, understandings of 16-18 year old engagement experiences were not explicitly elicited.

**Research aims and questions:**The need for further investigation was highlighted by three coexisting issues: the rise in mental health concerns in older adolescence, the high service drop-rate at this age, and the paucity of research into 16-18 year old engagement. The current study aimed to explore older adolescents sense-making of their engagement experiences, and barriers and facilitators, in order to contribute to a sparse understanding. The research questions were:

- What is the 16-18 year-old understanding of their experience of engaging in mental health services?
- What is their understanding of their experience of engagement facilitators and engagement barriers?

**Method:**Ten 16-18 years olds, engaged in Child and Adolescent Mental Health Services (CAMHS), were recruited from two London-based services. Each young person was interviewed in order to understand their personal experience of engaging in mental health services. Young people consented to participate following reading a participant information sheet with the main researcher and asking any questions. Interviews were audio recorded, transcribed, anonymised, and underwent Interpretative Phenomenological Analysis (IPA).

**Results:** The study achieved its research objectives. Analysis produced ten subthemes subsumed within four superordinate themes. These are briefly discussed below.

#### Engagement begins at help-seeking

This superordinate theme was concerned with the idea that participant's engagement journeys began during help-seeking. Within this emerged two subthemes. *Reliance on adult acknowledgement of distress and facilitation of professional help-seeking* shows that participants relied on an adult to notice their distress and suggest that professional help was needed. This may have been due to uncertainty about whether their distress warranted professional input, or how to go about asking for this type of help. The *Cognitive-preparedness* subtheme suggests that beliefs and cognitive processes internal to the participant 'set the stage' for adult recognition of distress. These beliefs were around recognizing their own need for help, and believing that professional help would provide this.

#### Strength of inner resolve

This superordinate theme related to participants inner determination for improvement in their symptomology. *Striving against engagement threats* was concerned with how participants maintained their engagement despite experiencing 'threats' to this. Threats included: mental health symptomology, engagement practicalities and disappointments with the service. Engagement also appeared to be maintained through a sense of *responsibility to others*, namely parents. This suggests that young people may understand that more people than just themselves are involved in their engagement journey.

#### Evolution of the self

Throughout interview, this theme emerged related to participant's journey through the engagement process and the sense that they also 'evolved' as this took place. *Progression through suspense and release* reflected the experience of anticipation that participants went through during the build-up to initial attendance and subsequent relief felt following their

first session. As participants became familiar with the engagement process, the idea of *growth through familiarity and trust affect* emerged. This was concerned with how engagement was 'felt', especially as therapeutic gains emerged. Lastly in this superordinate theme, the unique 16-18 year old developmental stage was clear within the subtheme *negotiating as an adolescent through choice, transparency and control*. Here, subtleties between 'being-told-what-to-do' and 'helpful suggestions' emerged. Participants valued being given choice, which was linked to perceptions of transparency about the therapeutic process, even if it was about an element of their care they did not have a choice about.

#### *In the clinic room*

This superordinate theme was concerned with experiences that took place within room, with regards to both therapist and therapy. Participants greatly valued *developmentally appropriate responsiveness* from clinicians by both respecting their age but also talking in a 'relatable manner'. The *centrality of a human relationship* was key in participant's sense-making, appreciating experiences of authenticity and, at times, describing the therapeutic relationship as similar to that with friends, but with professional boundaries. Alongside these, participants spoke about the *tangibility of techniques*. Some participants found the more 'doing' elements reassuring and as providing evidence that therapy 'works'.

#### **Implications for clinical practice**

- The current study suggests the area of the therapeutic relationship which may be crucial for clinicians to cultivate are the 'human' elements- remaining genuine and non-judgmental, balancing amiability with professionalism.
- The prominence of cognitive-preparedness, determination, and anticipation before first session attendance was marked. This suggests more consideration may need to be given to engagement facilitation in the time between referral and attendance. This may lie more with refining multi-agency service provision (JCPMH, 2013) rather than direct clinical intervention.
- Engagement may be facilitated by clinicians discussing cognitive-preparedness with young people at initial attendance which may help develop an understanding of client's idiosyncratic engagement facilitators and/or threats.
- Engagement may be facilitated by clinicians involving clients in areas there may be potential for control e.g. content of therapy sessions, and transparent about areas less open to change e.g. wider service provisions, and disappointments with the service.
- The above suggests combining and balancing the relational and cognitive in order to provide key developmentally-appropriate engagement facilitation.

#### **Implications for future research:**

- Due to the emphasis on developmental appropriateness, it may be important when planning future research, policy or service developments to consult YP on topics and design as per previous recommendations (YoungMinds, 2005; YoungMinds, 2011).
- As the conceptualizations and boundaries between help-seeking and engagement remain blurred, further research into the development of clearer definitions and models, from the adolescent perspective, may be beneficial to ensure developmentally appropriate theoretical progressions.
- Research into the relationship between factors internal and external to adolescents, e.g. inner resolve/ cognitive-preparedness, in relation to the role of families in this developmental stage, may provide further insight into the engagement phenomenon. This may in turn influence the development of strategies targeting YP who may be at risk of disengagement, or who do not seek service help.

Following viva voce and marking, it is planned to submit this project to the journal: *Child and Adolescent Mental Health*.

**References:**

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## **Appendix X: End of study report for participants**

Dear \*\*\*\*\*,

*Research title: Experiences of engaging with mental health services in 16-18 year olds: An interpretative phenomenological analysis.*

Thank you for your participation last year in my research study. You may remember we met at \*\*\*\*\* and had a conversation about going into services like \*\*\*\*\*. As agreed, I am writing to let you know the results that came out of the study.

### **Why was this research taking place?**

Research says that for therapy to be most successful, it is important for young people to attend their sessions. However, other studies have shown that 16-18 year olds are likely to not attend, or even drop-out, of mental health services. This can be worrying as this may also be the time when ongoing mental health concerns may start.

In order to investigate and understand something, we need to do research. Only a small amount of research has been done which looks at what older adolescents understand about going into mental health services. Because of this, the aim of my research was to ask 16-18 year olds about what they: 1) understood about going into mental health services, and, 2) what they understood about what helps them attend and maybe not attend services.

### **Results**

In total I spoke to ten 16-18 year olds. From the interviews, four main themes and two smaller themes, were found.

The key findings were:

- Young people needed an adult to recognize they were feeling distressed and to suggest getting professional help. Young people also needed to feel ready for this to happen and believe it would be helpful.
- Young people went to their therapy sessions because they were determined to get help, even when things may have happened which could have made this difficult. Such as, feeling down or anxious, forgetting appointments, or feeling disappointed with CAMHS. Some young people also felt it was their responsibility to attend, especially when they thought about their families.
- Some young people spoke about their time going into CAMHS as like being on a journey where they felt they grew as people. Some young people spoke about feeling nervous about their first sessions but felt relieved when they met their therapists. Some felt like they grew as they became familiar with sessions and started to trust their therapists. Young people spoke about, as an older adolescent, the difference between being-told-what-to-do and having suggestions made. For some, being told everything that was going on was helpful

and made them feel a bit more in control, even when they did not have much of a choice about what was happening.

- Young people spoke about what it was like being in the room with their therapists and the work that was done. Having their therapist talk to them like they were aged 16-18 was helpful and so was not feeling 'patronised.' Some young people spoke about their therapists feeling like a friend, but a friend who has lots of professional knowledge. Also, young people liked to be taught techniques they could go away and do, making them feel like therapy was useful.

### **What can we learn from this?**

Some suggestions were made about what clinicians can be doing and what we may need to do some more research on.

For clinicians, it was suggested that:

- They are genuine, non-judgmental, and are both friendly and professional at the same time.
- They speak to young people about how ready they feel to have professional help when they first meet. This may help them understand what the young person needs to help them keep coming back.
- They are clear about what is happening with the young person's care and ask what they would like to happen in their sessions.
- Services think about ways to help young people come to services by thinking more about what can be done in the time between asking for help and going to their first session.

It was suggested that more research:

- Involves young people when planning what to do research on and when planning services.
- Is done into what we know about the difference and similarities between asking for help and going into mental health services.
- Looks into how the young person's determination for help, and the what families do when suggesting professional help, come together to make the young person start to attend services.

If you have any further questions about this, please speak to your clinician. They can email me and I will happily reply to you. Thank you again for taking part. The time you spent talking to me was greatly valued and made this project possible.

Best wishes,  
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