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Getting engaged: psychiatrists' perspectives of engagement in mental health services

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ABSTRACT

Disengaging from the mental health services can have severely negative health and social outcomes for patients. Extensive quantitative research into the processes of engagement has acknowledged the importance of the therapeutic relationship to patients. Qualitative research into the constituents of what leads up to and makes good engagement with the mental health services are relatively rare and when carried out tend to concern the perspective of the patient without taking into account the views of the patient's clinician. In the present study ten psychiatrists perceptions of engagement were explored. Uniquely, these views were then compared with the experiences of their own mental health patients as reported by Chase et al. (2011). This is the first known qualitative study in which psychiatrists' and patients' views on engagement have been compared in this way. It was found that patients and psychiatrists both place great value on the therapeutic relationship, the quality of which can determine levels of engagement with the mental health services. It is also clear that psychiatrists and patients are not always in agreement over the direction they want their relationship to be heading.

KEY WORDS:	ENGAGEMENT	MENTAL HEALTH	THERAPEUTIC RELATIONSHIP	PSYCHIATRIST	PATIENT

Introduction

Improving engagement of mental health patients with the psychiatric services has long been one of the Government's priorities (Department of Health, 2000). Engagement in healthcare treatment is particularly important for mental health patients because of the adverse effects for them of dropping out on both health and social outcomes. For example, those who drop out of services are likely to be more unwell and socially impaired than those remaining in contact (Killaspy, Banerjee, King& Lloyd, 2000). Furthermore it has been found that non-compliance to psychiatric interventions may lead to less favourable outcomes (Orhon, Soykan & Ulukol, 2007) and non-adherence to medication amongst people with schizophrenia has been found to lead to a 3.7 fold increase in risk of relapse compared to those who are adherent over 6-24 months (Fenton, Blyler & Heinssen, 1997). It is not only patient outcomes that suffer: the financial cost to the National Health Service (NHS) of missed appointments has been estimated at £360 million per year (Stone et al., 1999, cited by Mitchell & Selmes, 2007, p.423).

The importance of the therapeutic relationship between the health care practitioner and the patient is acknowledged as being a key component in ensuring patient engagement (Priebe et al. 2005; Junghan, Leese, Priebe & Slade, 2007). Yet, despite extensive quantitative research, the concept is still poorly understood (McCabe & Priebe, 2004). Qualitative research into the constituents of what leads up to and makes good engagement with the mental health services are relatively rare and when carried out tend to concern the perspective of the patient. For instance, Priebe, Watts, Chase and Matanov (2005) focussed on the experience of assertive outreach patients. That is, participants who had an evidenced chaotic history of engagement with services. Priebe et al. (2005) concluded that a partnership model of care between the services and the actively involved patient, along with time and commitment of staff who did not only focus on medication, were essential for engagement. More recently Chase et al. (2011) carried out a qualitative analysis of compliantly 'engaged' outpatients. Their participants were outpatients who were consistently regular attendees of psychiatric services. They concluded that fundamental to engagement was the opportunity to be treated and respected as *human agents.* They identified a number of structural and practitioner qualities that facilitated or hindered this basic need to be recognised and treated as a *human being*, including: continuity of support; time for listening during out-patient appointments; a lack of effort to understand patient experiences; and encouraging involvement in treatment decisions.

A limitation of qualitative research approaches to establishing the essentials of the engaged, or non-coercive, therapeutic relationship is that the views of the patients' clinicians were not taken into account even though they may have had adequate explanations for their behaviour and may have expressed very different opinions (Priebe et al., 2005).

A unique facet of the present study is that we have the chance to compare the views of psychiatrists on the components of engagement with the summarised experiences of out-patients who were accessing the Community Mental Health Teams (CMHT) where the participating psychiatrists worked. For the current study, ten psychiatrists have been drawn from the same catchment area in the South of England as the patients whose experiences of engagement were analysed by Chase et al. (2011). The aim of the present study is 1) to identity the factors that psychiatrists believe influence engagement with the mental health services and what strategies they use to enhance engagement and 2) compare discrepancies and similarities with the patient experiences found by Chase et al. (2011). The exploration of both client and staff perspectives may enable an improved understanding and working relationship between the groups, in turn leading to more effective and relevant services.

Method

Participants
Ten psychiatrists (5 males and 5 females, with a mean experience of 14.2 years) working in one of two CMHTs in the South of England were interviewed. These psychiatric practitioners varied in experience. All practitioners interviewed had experience in at least two different psychiatric specialties; a summary of the demographic characteristics and details of the team the psychiatrists were in at the time of the interview can be found in Table 1.

Table 1
Demographic characteristics of participating psychiatrists (n=10)

Participant pseudonym	Gender	Years of experience	Grade	Psychiatric team
Adam	male	15	consultant	adult mental health
Barbara	female	20	consultant	older persons
Cathy	female	8	registrar	older persons
Donald	male	25	consultant	adult mental health
Ella	female	8	consultant	substance misuse
Fred	male	12	consultant	assertive outreach
Gail	female	10	registrar	adult mental health
Helen	female	17	consultant	assertive outreach
Ian	male	17	consultant	adult mental health
Julian	male	10	consultant	adult mental health

The ten interviews were carried out by two researchers. The first researcher, who was a consultant psychiatrist himself, undertook nine interviews. The remaining interview was undertaken by the current author and primary researcher. The present author and interviewer did not have clinical training but did have experience of being a psychiatric out-patient.

Procedures
A semi-structured interview schedule was used (Robson, 2002). The interviews took place at the working premises of either the participants or the interviewer. The interviewees were made aware of the use of the recorder and the interview was digitally recorded. The interviewee was informed that the purpose of the study was to assess psychiatrists' understanding of the concept and nature of engagement. Following informed consent procedures, the interview began. The interview was then conducted in a free-flowing and non-directive fashion in order to encourage the participant to raise issues which were of particular significance to them. It was felt that this flexibility would give the participant plenty of time and space in which to voice views and concerns in their own way. Probe questions,

such as 'what do you mean by ...?' were used to clarify responses and draw deeper levels of answer. For instance, when one participant said 'patients are more vulnerable to having preconceptions about the psychiatrist before they see them', the follow up question was 'what do you mean by preconceptions?' The ten interviews were conducted until no new concepts or themes emerged (Corbin & Strauss, 2008). The length of the ten interviews ranged between 21 to 42 minutes.

Transcription of the data

Transcription software was used to help transcribe the interviews. The interviews were transcribed verbatim by the two researchers. Features of speech such as tone pitch and emotions were omitted. Distracting speech patterns, such as 'you know', 'like', 'right', were recorded, and pauses of three seconds or over were notated with '(long pause)'. To facilitate analysis, and the subsequent write-up, line and page numbers and pseudonyms were added to each transcript and then all ten interview transcripts were merged into a single file. The extracts used in the write-up are identified in the text by a code indicating the participant's pseudonym, years of experience as a psychiatrist, the page number and the line number in which the quotation appears. For example, (Julian, 10 yrs, pg 86, ln 25) refers to the psychiatrist 'Julian', who has 10 years experience. The extract can be found on page 86 of the combined transcripts, line 25. For the sake of brevity, irrelevant bits of some extracts used in the results section of this paper were shortened by use of square brackets and three dots: [...].All names are anonymous. See Additional Materials for a full electronic version of the entire interview data.

Data analysis and interpretation

Following transcription the data were analysed using thematic analysis. This is one of the most common approaches to analysing qualitative data, especially within the field of health-related research (Wilkinson, 2000). Thematic analysis involves coding respondents' talk into categories that summarise and systemise the content of the data (Braun & Clarke, 2006). In this instance categories were derived from the data (rather than the prior theoretical framework of the researcher). The advantage of this approach in this context is that the analysis provides a useful summary of the participants' views and experiences and an overview of the range and diversity of the ideas presented.

The researcher read through the entire transcript several times, in order to become familiar with the data and identify key issues and initial codes. Data relevant to each code was then collated and this coding was subsequently refined. Multiple coding, such as that adopted here, has been advocated as a way in which to refine coding frames and enhance rigor within qualitative studies (Barbour, 2001). The coded data were then sorted into potential themes, again by using a process whereby the identified themes were compared across the data. Interpretations of identified themes were re-assessed and re-interpreted as necessary. Direct quotes from the data were grouped under thematic headings (Breakwell, 2006) providing a clear illustration of each theme. For instance, when a participant said 'the speed of having to get people through goes against a good relationship' this was grouped under the theme of 'Time Constraints'.

Finally, the themes were refined through investigation both of similar and anomalous examples (Braun & Clarke, 2006). Towards the end of the study no new themes emerged, which suggests that the major themes had been identified (Corbin & Strauss, 2008).

Ethics

All ten interviews conducted had previously been ethically approved by the National Health Services. Prior to carrying out the tenth interview the University of Portsmouth Department of Psychology Ethics Approval form was successfully completed. Informed consent was

only sought at the time of the interview. It was also stressed that the interview would be stopped on request at any time and that no reason for termination would be needed. Further, the interviewee was told that the interview recording would also be withdrawn on request with no explanation necessary.

Results

In the semi-structured interviews, each of the ten psychiatrists was led to certain aspects of their professional world that the interviewer had judged to be relevant to engagement. These areas included qualities of the patient and the psychiatrist and their relationship, as well as qualities of the mental health services in general. Three specific themes that emerged from the data: aspects of the therapeutic relationship, management of the out-patients clinic and further time constraints. These themes are analysed independently, although issues relating to time constraints and patient autonomy are woven throughout the analysis (see Table 2). Extracts from the interview transcription are made in the text and quotations were chosen to illustrate particular points.

Table 2
Type and frequency of elements of engagement reported by psychiatrists (n=10)

Elements of engagement	Number of participants (n=10)
Aspects of the therapeutic relationship	
Fostering engagement	7
An empowering therapeutic relationship	8
Awareness of non-medical issues	5
Management of the out-patients clinic	
Developing an understanding of each other	10
Time given to consultation	10
Further time constraints	
Investing time in the therapeutic relationship	10
Continuity of care	9

Aspects of the therapeutic relationship

Fostering engagement

All of the psychiatrists interviewed were given the opportunity to express their understanding of 'engagement' in the context of patients' participation within the mental health services. A consistent definition did not emerge, but all of the psychiatrists felt that successful engagement should at least entail the patient taking prescribed medication and attending appointments. Ideally, these were the fundamental components of a treatment plan (usually a structured plan of what their treatment entailed, confirmed in writing) agreed upon in partnership between the patient and the psychiatrist. It was felt that the level of patient engagement could develop from this basis to include, for instance, greater flexibility in the treatment plan:

> 'the most absolute engagement occurs when the patient's concept of what they need and want and what their problems are coincide exactly with those of the people treating them' Donald, 25 years experience, page 26, line 33

'I think if a patient feels involved in their treatment planning they are more likely to want to proceed with it' (Cathy, 8 yrs, pg 22, ln 36)

The manner in which the treatment plan was presented also offered the psychiatrist the opportunity to enhance the patient's sense of involvement in the process:

'rather than just copying the letter you write to the GP, I personally write a letter to the patient summarising my assessment and the treatment plan' (Barbara, 20 yrs, pg 16, ln 7)

This personalised approached was in accordance with the views of seven of the psychiatrists who stressed the importance of the therapeutic relationship in fostering engagement:

'the relationship with the patient is central to everything you do, you know. I could have the best drugs in the world but if I can't have a relationship with the patient to get them to take the drugs then, you know, there's no point' (Adam, 15 yrs, pg 7, ln 36)

Four of the psychiatrists went on to note that although the consequences of disengaging from psychiatric services could be potentially harmful to the disengaged patient, their very disengagement may benefit the more engaged patients:

'when you've got a busy service you've got to balance working in a more positive way with people and then perhaps if someone isn't working positively in treatment to focus your energies on people who are going to take, make the most of the service' (Helen, 17 yrs, pg 64, ln 18)

This suggests that disengagement from the psychiatric services may in some instances be a choice made by the patient but could also be a choice made by the psychiatrist on either their own behalf or the patient's behalf.

An empowering therapeutic relationship
Eight of the psychiatrists felt that disengagement from the mental health services could be the consequence of the patients' lack of agency over their lives:

'if there's no sort of sense of self-worth and self-direction and self-autonomy, then what's the point of being alive' (Adam, 15 yrs, pg 6, ln 4)

As the therapeutic relationship develops, the psychiatrist may be able to guide the patient towards gaining insight into their situation and so enabling the patient to make decisions about their use of the services:

'you're helping them make informed decision on their own about the help they want with their problems which is what we are aiming for really' (Ella, 8 yrs, pg 37, ln 9)

The psychiatrists felt that this empowerment encourages patients' engagement and at the same time calls for the psychiatrist to understand the needs of the patients:

'you get the best engagement with people when you actually approach them with the question in your mind that, what is it that they're actually looking for rather than what it is that you think they should be looking for' (Donald, 25 yrs, pg 27, ln 1)

The level of autonomy that may be transferred to the patient is a component of risk management in which the psychiatrist's discretion can determine the balance:

'a number of our patients are at risk but I try to weigh that up with their freedom of choice, their right to live their life the way they want to live it rather than the way I want them to live it' (Barbara, 20 yrs, pg 17, ln 7)

Adjustments to the patient's level of control over their treatment means that the psychiatrist may need some flexibility in their own approach to the patient's treatment:

'if it's within the realms of not being dangerous I'll let people do it because there have been times when people have asked to increase or decrease drugs or do something that I wasn't expecting to work and it has worked' (Fred, 12 yrs, pg 44, ln 20)

Whilst patient autonomy is generally encouraged amongst psychiatrists, three of those interviewed stated that it may not always be a patient's preference to accept responsibility for their treatment:

'I certainly think of a patient with depression and I said we can do this this and this and he looked at me in despair and said you're the expert I just want you to tell me what to do. He wanted me to take the authority and just tell him what to do ' (Ian, 17 yrs, pg 72, ln 15)

Awareness of non-medical issues
Half of the psychiatrists favoured an approach to building a therapeutic relationship that encompassed non-medical matters, such as social and housing issues. Thus, attempts are made to discuss personal details not connected with the diagnosis:

'you're kind of trying to look at the person as a whole and look at all the areas that they're struggling with and how you can best help in their quality of life really ' (Cathy, 8 yrs, pg 25, ln 25)

With difficult-to-engage patients it may be necessary to approach the therapeutic relationship from a totally non-medical angle. The psychiatrists that favour a holistic method are aware of and may become involved with the patient's wider social concerns in order to further engagement:

'so the way they are trying to engage him now is that he's not happy with his accommodation and they're trying to help him with suitable accommodation and so that is the way they're trying to engage him they're using the accommodation as at least something to talk about ' (Julian, 10 yrs, pg 78, ln 22)

Management of the out-patients clinic

Developing an understanding of each other
Opportunities to improve the therapeutic relationship and thus encourage engagement largely occur within the setting of the out-patients clinic. All of the psychiatrists stressed the

need for a safe and welcoming environment in which a range of medical and non-medical issues could be discussed. Six of the participants mentioned the effort taken to engage at a personal level with the patients:

> 'it's nice if you remember something a patient told you, which isn't kind of necessarily relevant but it I think also listening to all sorts of little things, not necessarily medical' (Fred, 12 yrs, pg 42, ln 20)

All ten of the psychiatrists acknowledged that taking the time to listen to the patients has several benefits. Instead of making presumptions the psychiatrist becomes aware of the patient's agenda, expectations and concerns that could affect their future engagement with the services. The out-patients clinic may be the only forum in which the patient can raise certain issues:

> 'When they go to their GP they are told that ok, you have 10 minutes and they know the GP is writing at the same time. So, if they come to the psychiatrist and the same thing happens who is going to listen to their actual problem' (Gail, 10 yrs, pg 51, ln 3)

> 'all the patients that I see come with multiple housing social benefits I mean I think it is very rarely that you see someone in the clinic who doesn't come with a mixture of those problems ' (Ella, 8 yrs, pg 36, ln 4)

A relationship can develop, therefore, that is not solely connected to the diagnosis but also covers areas of the patient's wider social concerns:

> 'I think probably in clinic I'll talk about medication, but mainly people will come in and tell me what is going on in their life and that's what we talk about and very small stuff like that, so it might appear just like a gossip I suppose, but I rarely only do mental states or whatever' (Fred, 12 yrs, pg 47, ln 37)

The characteristics and qualities required to develop the patient-psychiatrist relationship appear to be very similar to those required of any close relationship: the psychiatrists listed the need to be open, genuine, honest, non-judgemental, show empathy and to listen:

> 'it's also about trust and accepting that they are the experts in their situation' (Adam, 15 yrs, pg 5, ln 1)

By accepting the patient's expertise the psychiatrist is able to help build the patient's sense of autonomy over their situation as well as confirming the patient's role as a partner in the formulation of their treatment plan.

Time given to consultation
All ten of the psychiatrists expressed concerns about the lack of clinic time available to invest in patients. This could lead to difficulties in covering all the patient's concerns:

> 'There's no point in us bringing somebody in, filling out the risk assessment form, this form, that form, giving them 10 minutes and kick them out' (Gail, 10 yrs, pg 50, ln 35)

> 'if twenty minutes has elapsed and there is still something that we haven't talked about I make sure that we talk about it because they've waited for six months to see me so what's the point not resolving those issues ' (Julian, 10 yrs, pg 81, ln 12)

One of the key components of engagement mentioned by all ten of the psychiatrists was attendance at planned appointments. There are many reasons, such as the nature of the illness or simply forgetting, for a patient to miss an out-patients appointment, however, failure to attend may be a calculated decision based on the patient's needs at the time:

> 'patient may turn up one day when he thinks he can get something particular out of the consultation whereas other times when they're feeling well the scales may be tipped the other way and they feel it's not worth turning up for whatever reason ' (Ian, 17 yrs, pg 75, ln 20)

Whilst sporadic attendance would not be an indication of total disengagement it could suggest that the patient has not found value in previous clinics. The unilateral nature of the patient's decision may indicate to the psychiatrist that there has been a breakdown in the therapeutic relationship. Seven of the psychiatrists recognised that patients bring their own agendas to the clinic and make efforts to manage expectations about the outcome of the clinic. These agendas need to be understood by both parties which can be difficult with the limited time available. In the following extract the psychiatrist attempts to split the burden of agenda and time management with the patient:

> 'I don't allow the patient to walk out until I know they're at peace in themselves so when they come in I ask them what are the things you think we should talk about in this meeting you know minding that we have twenty minutes so already they know how much we have ' (Julian, 10 yrs, pg 81, ln 9)

Further time constraints

Investing time in the therapeutic relationship
Time constraints interact with and are key components of the two main themes. The quality of the therapeutic relationship and the ability to achieve a warm, safe, listening environment for consultations was seen by all ten of the psychiatrists as being dependent on the time invested in these matters. An established relationship enabled mutual trust to be built between the psychiatrist and patient and allayed patients' fears of reprisals from revealing what they perceive to be delicate or potentially damaging information:

> 'I suppose that a patient should be able to convey their concerns and worries openly and they shouldn't keep back stuff just so that they know that if they say things then there will be disagreement, and they shouldn't fear in any way the doctors they are seeing' (Gail, 10 yrs, pg 49, ln 35)

The longevity of the therapeutic relationship does not only affect what the patient is prepared to reveal but can also have an effect on the treatment plan. Psychiatrists were more likely to be flexible in their treatment plan when they have an established relationship with the patient. There is a sense that as the relationship develops then so do the boundaries within which the psychiatrist is prepared to work in order to maintain engagement. The quality of the patient-psychiatrist relationship, therefore, could determine the difference between whether or not an at-risk patient is either sectioned under the Mental Health Act or allowed to continue recovery within the community:

> 'we've taken the decision not to go down the compulsory admission route but to continue working in the community and maintaining engagement because we felt maintaining the engagement was actually more important in the long term ' (Ian, 17 yrs, pg 73, ln 34)

An established relationship between the psychiatrist and patient, built up through time, also facilitates perceptive care in potential emergencies:

> 'the mother rings up to say my son's doing this and you know, you automatically know that, that is serious and that's something you need to act on. You know, that sort of understanding doesn't happen quickly, it takes time to develop.' (Helen, 17 yrs, pg 66, ln 12)

The following extract, referring to a patient who had reluctantly been sectioned, highlights how a long term therapeutic relationship between the patient and psychiatrist may facilitate continued engagement even after the potentially harmful experience of being involuntarily detained:

> 'he said you were the only one there for me when I was in, when I was out, wherever I was you were always there, and even though he hated my guts he kind of appreciated that and I think that is what's lost, the DOH or whoever, they negate the relationships ' (Fred, 12 yrs, pg 46, ln 40)

The ability to create a therapeutic relationship in which both the patient and the psychiatrist can be open and honest, also means that the psychiatrist has to be able to admit to being wrong:

> 'I just apologised [...] her and her mother remember the fact that I apologised and I said I'm sorry and I got it wrong, and that actually really built our relationship and now [...] I think I remember her because it started off as a really bad relationship and now it's become a very good relationship' (Adam, 15 yrs, pg 4, ln 31)

Continuity of care

With time available to develop the therapeutic relationship at a premium, nine of the psychiatrists felt hampered by the fragmented structure of the services. Whilst the range of mental health services available was broadly welcomed, it was also felt that the system was frustratingly difficult for patients, carers and families to understand and could undermine their efforts to build the therapeutic relationship:

> 'I think that there is a real danger that that element is so badly damaged in the setting up of these new services that it actually counteracts the positive aspects of having these services' (Donald, 25 yrs, pg 32, ln 25)

> 'If I come to you and I open my heart to you and I trust you and then later on you send your colleague and a third time you send another colleague then I will be fed up, I'll say goodbye, I don't want you' (Gail, 10 yrs, pg 51, ln 35)

Discussion

This study set out to provide an overview of psychiatrists' perspectives on engagement. These findings will be discussed along with the issues raised by the patients (Chase et al., 2011) of these psychiatrists. No clear definition of engagement emerged, reflecting the conceptual confusion reported in earlier studies (O'Brien, Fahmy & Singh 2009; Priebe et al., 2005). Despite this lack of clarity over the concept of engagement the perspectives of the psychiatrists in this study were consistent. Three multifaceted constructs of engagement in mental health services were identified, with several overlapping concepts. For example, aspects of the therapeutic relationship were found to include both awareness of non-medical issues and empowerment of the patient, while management of the out-patients clinic included time given to consultations and the development of a mutual understanding between the psychiatrist and the patient. Matters relating to the function of time emerged from all the themes. The availability of time impacts a wide range of patient interests and was regarded by all the psychiatrists as a factor in engagement.

As outlined in the introduction, an interesting and unique aspect of this study is that we have the opportunity to compare current psychiatrists' views on the constituents of engagement in the mental health services with the summarised experiences of outpatients who were accessing the CMHTs where the participant psychiatrists worked. It should be noted that while some of the psychiatrists interviewed here were involved in the treatment of the patients in Chase et al. (2011) an unspecified number of the psychiatrists were not clinicians known to these particular patients.

Developing a human connection

The 'rehumanising' qualities that the psychiatrists in this study strive to bring to the therapeutic relationship are comparable with those that are looked for by the patients in these psychiatrists' own catchment area (Chase et al., 2011). But further comparison between these two groups suggests a disparity in aspirations for the therapeutic relationship. To enable engagement it is necessary for the psychiatrist's assessed needs and the patient's expressed needs to be understood by both parties since they cannot be assumed to be equivalent (Hitch, 2009; Meddings & Perkins, 2002). The psychiatrists emphasised their efforts to see the person beyond the illness, although this was largely in the light of other areas of the welfare system, such as housing and social benefits. Chase et al. (2011) recognised a desire amongst the patients in this location to be identified as individuals, to be genuinely cared about by the psychiatrist beyond their particular diagnosis, and viewing the therapeutic relationship as a means to a human connection rather than a conduit to social welfare provisions alone.

Continuity of support

The human connection alluded to by the patients (Chase et al., 2011) has, through the concept of continuity of care, been identified as one of the essential components of patient engagement (Sainsbury Centre for Mental Health, 1998). But the psychiatrists in the current study note that the recommendation that the patient should have a continuity of responsibility of care, and by implication a stable therapeutic relationship with their psychiatrist, is hampered by the complex structure of the psychiatric services. In the geographical area covered by this research, the services are split into several teams, including: community mental health team, assertive outreach (also known as assertive community treatment team), crisis resolution team (confusingly, between them the psychiatrists used a total of seven different names for this particular team during the course of the interviews) and early intervention team. This array of teams, set up to help the patient at the varying stages of their illness, provides a continuity of service, but because of the consequential passing of patients from one team to another, there is a lack of continuity of care. Thus, the opportunity to develop a therapeutic relationship with a particular care

coordinator does not necessarily arise. 'So what happens is that I only see a few, I only see them on a few occasions and there's very little of this thing called therapeutic relationship' (Gail, 10 yrs, pg 50, ln 30). This functional fragmentation means that, perversely, the services that have been set up to provide a continuity of care are at the same time restricting the development of therapeutic relationships and possibilities for a human connection.

The importance of time
The patients also identified time available to see the practitioner as a factor facilitating the therapeutic relationship (Chase et al., 2011). Dissatisfaction with this element of the service may lead a patient to disengage from the mental health services, but this research shows that these problems trouble the psychiatrists too. The pressure on the system is such that the psychiatrists have noted the possible benefits of patients disengaging. If one patient no longer uses the services it means more resources are available for other patients. There is a possibility, then, that for psychiatrists it becomes acceptable for patients to drop out of the system. Allowing patients to lose contact with psychiatric services in this way could become the rational choice of the mental health professionals. 'There is this sense, I don't know where it comes from, that to give someone a break of treatment is going to be valuable in the future' (Helen, 17 yrs, pg 67, ln 27). The longer term implication of this is that when or if the patient re-engages with the mental health services his or her condition is likely to have deteriorated (Killaspy, Banerjee, King & Lloyd, 2000), and require greater resources than before.

Patient involvement in treatment decisions
Autonomy and choice are sought by the psychiatrists in this study and by their patients (Chase et al, 2011). Enhancing patient autonomy through creating a therapeutic partnership that allows choice is well supported in the literature (Curtis, Wells, Penney, Ghose, Mistler, Mahone, Delphin-Rittmon, del Vecchio & Lesko, 2010; Swift & Callahan, 2010) as well as and by government policy (Department of Health, 2011). It was found in this study that some patients, however, do not want to have to make clinical decisions for themselves, preferring to rely on the authority and expertise of the practitioner. Others may be felt to lack the insight requisite to taking on that level of responsibility. An established therapeutic relationship must be in place for the psychiatrist to be able to accurately recognise the element of active participation suggested by Priebe et al. (2005) that the patient is comfortable with.

Valuing the therapeutic relationship
With regard to engagement, the value bestowed on the therapeutic relationship, by psychiatrists and patients alike, could be problematic. At what points during the patient's journey do the medical model end and the therapeutic relationship begin? Or to put it another way, how much of the patient's recovery is due to the treatment plan and how much is due to the quality of their relationship with the psychiatrist? This dilemma could leave both the psychiatrist and the patient in invidious positions. O'Brien, Fahmy and Singh (2009) highlights the risk of patient dependence on mental health professionals and Graley-Wetherell and Morgan (2001) warn that changes in staff can leave the patient in distress. A detrimental response by the patient to the treatment plan may be interpreted by the psychiatrist as due to their own personality failings. This question will pose difficulties to all psychiatrists as they work to strike a balance between clinical skills and personal characteristics. In this instance the quality of the therapeutic relationship could be seen as a predictor of patient outcomes.

Limitations

It should be noted that all the participant psychiatrists in this study work in the same locality and thus are bound by a service structure unique to their region. The structures and priorities of the mental health services differ across the UK and the data gathered here may have less relevance to those other areas. Further, nine of the ten contributing psychiatrists were interviewed by a colleague psychiatrist. This could have an effect on how the interviewee responded to the questions, possibly resulting in a reluctance to speak freely.

Implications

Some of the disparities and similarities between the findings of this study and that of the patients in this catchment area should be assessed further. Chase et al. (2011) found that the patients considered the therapeutic relationship as a forum in which they wish to be treated as human beings. From this it can be deduced that the patients want to be able to regard the psychiatrist as more than a medical expert with a sole interest in treatment, but at the moment that is rarely the case. There are signs in this study that some practitioners are aware of their patients' changing demands on the relationship but are undoubtedly restricted by the balance that is required between patient autonomy and risk management. However, more clearly understanding the patients' needs, especially in domains not connected to the medical or welfare service may enable the psychiatrist to provide truly individualised care and enhance patient engagement.

This study highlights some of the effects that the systemic restriction of time has on engagement. Although all the psychiatrists interviewed for this study agreed with previous findings that engagement was dependent on the quality of the therapeutic relationship (McCabe & Priebe, 2004), the structure of the service itself is detrimental to the development of those relationships. Patients in the Chase et al. (2011) study also expressed dissatisfaction with their ability to develop the therapeutic relationship due to the structural restraints placed on them. Perhaps further research should address these structural aspects of the system that are disliked by service providers and service users alike.

O'Brien, Fahmy and Singh's (2009) review of disengagement from the mental health services found no attempt by policy makers to define 'engagement' and although in this study the psychiatrists felt that engagement indicates, at a minimal level, compliance with medication and attendance at appointments, it is likely to mean something else entirely for the patients (Chase et al., 2011). Engagement is a complex and multifaceted experience, unique to the individual and the context (Hitch, 2009). There are commonalities for the psychiatrist and the patient such as the importance of the therapeutic relationship and intrinsic and extrinsic influences. The differences lie in what they each feel the system should be able to offer. It is this that future research should evaluate and Government policy provide for.

The political landscape has shifted hugely since this research was originally planned, and the NHS is undergoing major renovations. Andrew Lansley, Secretary of State for Health, stated 'no decisions about me without me' (Department of Health, 2010) reflecting the new thinking about patient engagement and the support offered by the NHS. Under the current Coalition Government, the term 'engagement' has a broader, although no less nebulous, definition while the expectations are for the NHS to be more patient centred, with responsibility for health lying both at the clinical practitioners' and patients' doors (Department on Health, 2011). The focus of the mental health services will be on setting and achieving accountable outcomes (Department of Health, 2011). For this reason alone, the onus will be on all mental health service providers to have a more complete understanding of what patients require from the therapeutic relationship. 'we don't

appreciate the factors out there that get in the way of the patients needs' (Adam, 15 yrs, pg 3, ln 37).

Conclusion

This study was undertaken primarily to investigate psychiatrist's understanding of engagement within the mental health services. Additionally, and uniquely, we were able to compare our findings with the experiences of patients from within the same catchment area. This opportunity to obtain the views from two sides of the same therapeutic relationship has revealed inconsistencies between the experiences of the psychiatrists in the present study and those of the patients in the Chase et al. (2011) study. The findings suggest that patients and psychiatrists are not always in agreement over the direction they want their relationship to be heading, even though they may feel they are acting in accordance with each other's wishes.

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