Exploring engagement and the usefulness of The AIM Cards with 'hard to reach' adolescents; hearing views and experiences from young people and clinicians.

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Part one of this volume presents a review of the literature exploring what maximises engagement amongst hard-to-reach young people. It considers what is meant by the term engagement, what facilitates engagement when supporting hard-to-reach young people and what are the barriers to engagement. It discusses findings in relation to psychological theory and clinical implications derived from the empirical data.

Part two comprises of a qualitative empirical paper which captures practice-based evidence by exploring clinician and young people's experiences of an assessment and engagement tool, known as the AMBIT AIM Cards. Thematic Analysis is used to synthesise reports and develop overarching themes relating to the use of The AIM Cards and experiences of engagement. It presents the first empirical findings regarding the use of these cards and discusses their use in supporting both assessment and engagement.

Part three is a critical appraisal of conducting the research project. It is a personal reflection of the research journey, from setting up and designing the project through to data collection, analysis and write up. It considers design and implementation challenges and includes personal learning experiences.

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Part 1

Literature Review

What maximises engagement with 'hard to reach' adolescents in mental health services?

Abstract

Objective: Hard-to-reach adolescents are considered the most vulnerable, complex and at risk adolescent clinical population. These young people present with complex needs such as substance misuse, conduct problems, severe depression, anxiety and psychosis. Often intensive intervention and support is vital for a good prognosis. However, engaging these young people is particularly challenging for mental health services and often requires outreach service models. This review aims to address the question of what maximises engagement amongst this population by reviewing studies of service users experiences and engagement strategies employed by clinicians and services.

Method: Studies that explored the views of young people with complex needs and studies evaluating service or clinician engagement strategies were included. Sixteen studies were identified including five qualitative, one case study, three experimental and seven service evaluations.

Results: General themes across all the papers argue that the engagement process relies on a complex interplay of individual, clinician and service level factors. Findings showed implementing engagement strategies to be a central predictor for young people to access support and led to better outcomes, however a clear definition of engagement is lacking in the literature.

Discussion: Findings are discussed within the context of attachment and ecological theory, and clinical and research implications for supporting hard-to-reach young people that emerge from this literature are provided.

Introduction

This review will provide a brief overview of how engagement is defined in the literature and discuss identified factors that influence engagement considering three levels; service user, clinician and service context. These findings will then be discussed in light of their research and clinical application. However, firstly when considering what maximises engagement amongst hard-to-reach young people in mental health services, the most important thing to address is who are the hard-to-reach?

Hard-to-reach young people are defined by Kessler et al. (2010) as young people with a complex profile of mental health and social needs. They propose this client group present with severe mental health problems and are the most vulnerable to high risk behaviour and poor outcomes. By their very nature hard-to-reach young people are therefore a group who are difficult to engage but are probably the most in need of support. According to their definition, typical presentations of hard-to-reach young people would include; substance misuse, conduct problems, offending behaviour, psychosis, severe mood disorders, self-harm and suicidal ideation. Co-morbidity amongst these young people is high and there is often a wider context of familial dysfunction and lack of educational attainment. The poor outcomes and high risk behaviour associated with this group provide rationale for researching and identifying how best to support and engage them in order to create optimal support frameworks to reduce risk and promote better long term outcomes.

Hard-to-reach young people are also a challenging group to research. Complex needs, chaotic lifestyles and a reluctance to engage with services makes interviewing, data collecting and evaluations difficult. Services which are designed to support this group are often small as most support is intensive and expensive. Gathering large samples and implementing strict randomised control trials are perhaps the most challenging as they require larger numbers and a requirement to strict adherence to research procedures. However, engaging hard-to-reach young people in research is important if we are to understand how to engage and support them effectively.

Broadly speaking the literature focusing on hard-to-reach young people is limited. Dembo et al. (2011) argues that most research with hard-to-reach client groups has been with adults and very little is known about younger populations. However, the small body of literature focusing on supporting hard-to-reach youth has identified the role that engagement plays on producing better outcomes (Dembo et al., 2011; Meaden et al., 2004; Gillespe et al., 2004; Karver & Carporino, 2010).

Meaden et al. (2004) looked at the role engagement played with hard-to-reach young people in reducing hospital admissions. They found engagement predicted fewer admissions; specifically perceived usefulness of treatment on the part of the young person and client-therapist interaction, although no specific definition of what this term means is given. Dembo et al. (2011) claims identifying strategies that enhance engagement is vital for young people with substance misuse (identified as a hard-to-reach group). They propose flexible working and brief interventions can support high risk young people and families to engage with services. Karver and Carporino (2010) reviewed the literature on building the therapeutic relationship amongst young people with oppositional defiant disorder and found it to play a central role in facilitating engagement amongst this challenging client group. Additionally, although engagement has played a central role in the developing research within this field, there are differences among researchers in how they define engagement. Staudt et al. (2012) asks for clear understanding and conceptualization of engagement. They carried out interviews with clinicians who described engagement as a complex interaction that is influenced by relational, clinical and organisational factors.

There are consistent views across the literature that hard-to-reach young people are a complex group with multiple needs. They are at most risk for poorer outcomes, which also has implications for becoming increasingly reliant on services throughout their adolescence and potentially adulthood. They are a challenging group to support due to high dropout rates, chaotic familial systems and multiple service involvement. As a result it is important to understand and implement strategies and service structures that promote maximum engagement. This paper will review the literature examining what maximises engagement amongst hard-to-reach adolescents being supported by community mental health services. Following initial searches and identification of relevant papers research questions will be developed.

Method

Search Strategy

Scoping searches were carried out amongst three databases (PsycINFO, Medline and Web of Science). Specific search terms were identified to ensure studies would be researching engagement amongst adolescents within mental health services. An initial search focused on identifying papers researching engagement by searching the term *engag** to include *engaging, engage and engagement* (search 1). A second search used the term mental health (search 2). The first and second searches were then combined (using the 'and' function) to identify all papers focusing on engagement within articles mentioning mental health (search 3). A fourth searched the term adoles* so it would include adolescent and adolescence (search 4). Another search used the term young people (search 5). Search 6 combined (using the 'or' function) searches 4 and 5 to ensure papers were captured who referred to population as either adolescents or young people. Searches 3 and 6 were then combined to ensure identification of all papers researching engagement amongst adolescents or young people within mental health services. This same search strategy was used within three databases and identified a total of 2,856 articles (PsycINFO; n=1218, Medline n=1045, Web of Science n=593). The large number of papers was a result of a broad searching criteria. This was to ensure all literature is captured due in consideration of the lack of universal definition of engagement and the lack of consistency of the use of the term 'hard-to-reach'.

Inclusion and Exclusion Criteria

Once potentially relevant papers were identified through scoping searches, titles and abstracts of each paper were screened against the following inclusion criteria:

- Study population: hard-to-reach adolescents as evidenced by young people and young adults experiencing one or more of the following; substance misuse, conduct problems, severe depression, severe anxiety, offending behaviour and psychosis.

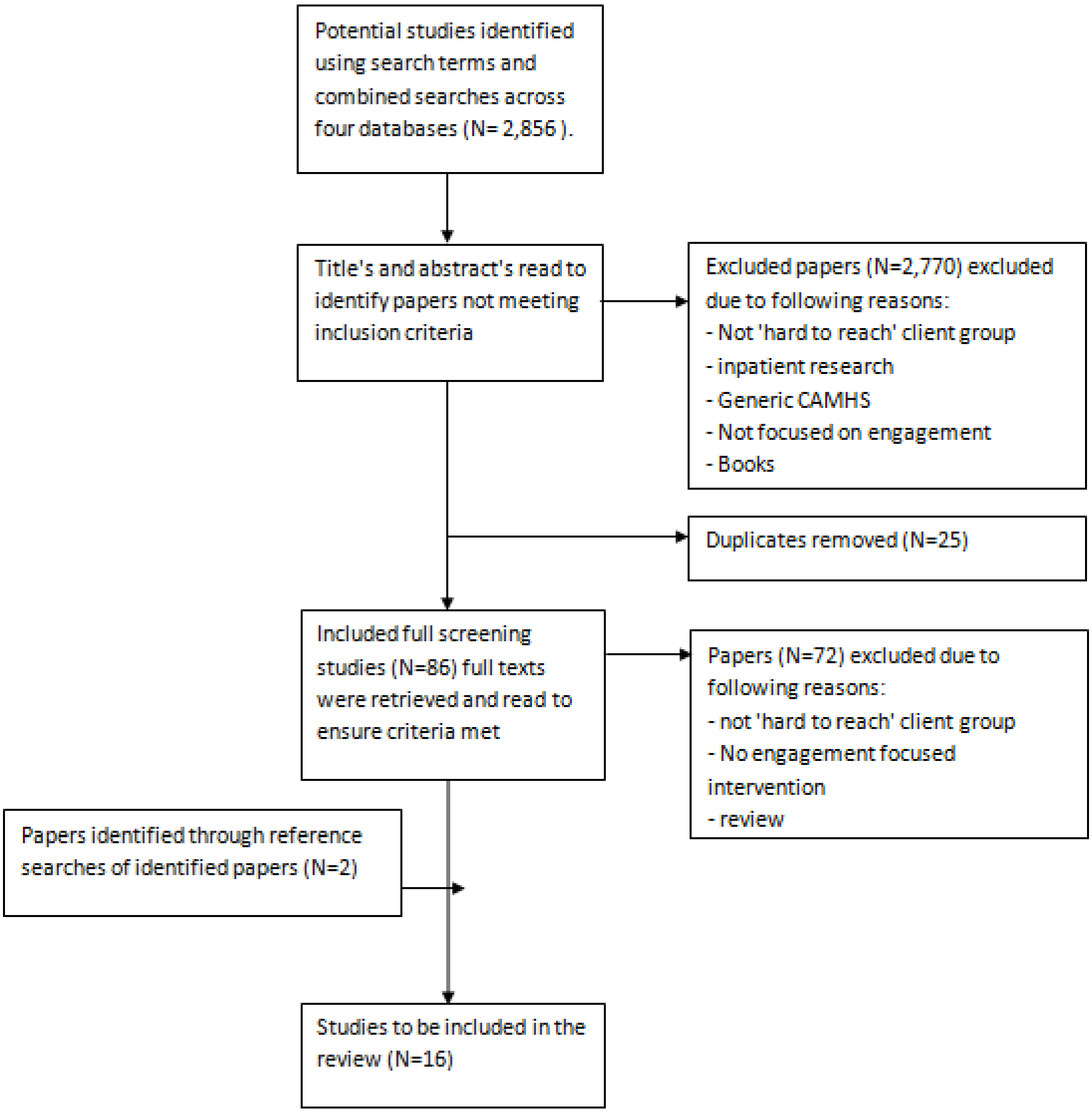
- Intervention: papers examining engagement experiences and/or strategies through the following methods; service user experiences, clinician reports, service evaluation or service audits.
- Service context: mental health services in the community.
- Due to small literature base, studies were also included if they had interviewed adults regarding their experiences as an adolescent being supported by mental health services.

Additionally, one specific exclusion criteria was identified;

- Papers simply reviewing types of engagement strategies were not included to ensure the review focused on papers which identified whether strategies were effective either through quantitative or qualitative methods.

Once abstracts had been read a total of 111 papers were identified for full screening, duplicates were removed (25) which left 86 papers for full screening. These Papers were read in full to ensure all inclusion and exclusion criteria were met. See Figure 1 for flow chart of search strategy which lead to 16 papers being reviewed.

Figure 1. **Flow Chart of identifying papers**



Research Questions:

Once the review papers were identified, research questions were developed to address key themes within the literature on engaging hard-to-reach adolescents. The methodologies used were varied and comprised of service evaluations, predictive studies, qualitative research, experimental studies and one case study. Questions were developed to address this mix of research to include a review of both the experience and effectiveness of the engagement processes and strategies used within services:

1. How does the literature define engagement?
2. How effective are implemented engagement strategies?
3. What are the identified barriers to engaging hard-to-reach adolescents?
4. What do service users consider helps to promote engagement?

Results

A total of 16 studies were included in the review (see table 1). Table 1 shows the data extracted whilst studies were critically appraised. The findings are presented by summarising the methodologies, followed by addressing the four research questions including a critical review of the papers within each section.

Summary of Methodologies

Seven of the sixteen studies comprised of service audits (2) and predictive studies (5) evaluating the effectiveness of engagement strategies and identifying factors which predict dropout, linking engagement to retention and treatment outcomes and evaluating clinician engagement strategies. Five papers interviewed service users aiming to capture their experiences and opinions on how to engage hard-to-reach young people or young adults. One case study documented the use of email as an engagement strategy with a young person who had previously disengaged from services. The remaining three papers comprised of one randomised control trial evaluating the effectiveness of a telephone reminder engagement strategy and two quasi-experimental studies with one paper measuring effectiveness of parent-focused engagement strategies and one paper measuring effectiveness of waiting times on treatment drop out.

1. How does the literature define engagement?

Definitions of engagement are varied and inadequate. For instance, there is a recurring practice of identifying engagement as crucial for this population in all the papers but then providing no specific definitions of what is meant by engagement. For example, some papers refer to a consistent approach as important to the process of engagement and change, but at no point do they state what they consider engagement to be (Assan, 2008 & Pycroft et al., 2015). Pycroft et al. (2015)

Table 1. **Reviewed Studies**

No.	Authors	Title	Research Type	Sample Size	Focus	Discussion
1.	Assan et al., 2008	The Adolescent Intensive Management Team: an intensive outreach mental health service for high-risk adolescents	Service audit	70 young people with complex MH needs, Australia	Engagement & retention audit	- effectiveness for intensive outreach support - 100% engagement & retention for 'hard to reach' YP - Flexible working and idiosyncratic support as key predictors - Evidence for outreach and assessment with this population
2.	Ross et al., 2012	An engagement and access model for healthcare delivery to adolescents with mood and anxiety concerns	Service audit	93 young people, Canada	Evaluating a model which incorporates an engagement strategy	- Outreach to educational settings is effective - High % would not have been referred by GP - Evidence for outreach and assessment with this population
3.	Perez, Ezpeleta & Domenech, 2007	Features associated with the non-participation and drop out by socially at risk children and adolescents in mental-health epidemiological studies	Predictive study	Data from longitudinal study with focus on at risk population. Spain	Regression analysis between factors which predict drop out of treatment	Drop out associated with: - Lower socioeconomic group - Unemployed families - Minority cultures - Low school performance - Adolescents - Pervasive psychopathology
4.	Dakof & Tejeda, 2001	Predictors of engagement in adolescent drug abuse and treatment	Predictive study	228, YP with substance misuse, High proportion of ethnic minority, America	Discriminant function analysis completed to identify adolescent and parent characteristics that predict engagement	Factors which supported engagement in order: - parental expectations of education achievement - higher parental reports of youth externalising symptoms - Higher levels of family conflict perceived by youth
5.	Mensinger et al., 2006	Adolescent and therapist perception of barriers to outpatient substance abuse treatment.	Predictive Study	600 YP with substance misuse and their clinicians, America	Self-report questionnaire analysis identifying factors associated with barriers to engagement and treatment dropout	Both YP and clinicians identified the following factors with are important for engagement: - interpersonal connectedness (feeling safe) - perceived relevance of treatment - Practicality of getting to treatment Barriers to engagement: - low SES - Severity of symptoms - Different ethnicity of therapist to YP
6.	Schley et al., 2012	Does engagement in intensive	Predictive study	44 young	Is better engagement after	- good client engagement was achieved after 6 weeks of intervention

		outreach service predict better treatment outcomes in 'high risk' youth?		people (15-25 yrs) presenting with complex MH needs Australia	initial assessment a predictor of positive outcomes at discharge?	- Better engagement after assessment was a predictor or reduced hostility risk and improvement of functioning at discharge - Collaboration, perceived usefulness & client-therapist interaction was engagement dimensions related to improved treatment outcomes.
7.	Watt & Dadds, 2007	Facilitating treatment attendance in CAMHS	Predictive study	58 clinician's working with families of young people with CD in Australia,	Relationship between clinician engagement strategies and client attendance via clinician self-report	Identified strategies that fell within 2 types of engagement strategies: - Structural; accessibility*, timeliness, family incentives, feedback & clinic atmosphere - Therapeutic; relationship*, empowerment, achievable gains, client expectation & broad-based needs - * most commonly used
8.	Pycroft et al., 2015	Participation, engagement and change: A study of the experiences of services users of a UAT.	Qualitative	6 young people aged 15-21 with complex needs. UAT England	IPA exploring YP views on experiences and engaging with an intensive outreach service	- flexible working, being there when they are needed - Feeling listened to - Being helpful - Clinician warmth and understanding - Other methods of communication; drawing, activities
9.	Green et al., 2012	Engaging youth with serious mental illness in treatment: STARS Study consumer recommendations	Qualitative	177 (16 - 84 years) ex service users With complex needs America	Thematic Analysis exploring views on better methods to engage young people in MH services	Five areas of clinician strategies identified as important - use age appropriate response - foster development of autonomy - use individual/personal approach - be empathetic, gentle - create a safe and supportive environment
10.	Kapur et al., 2014	The experience of engaging with mental health services among young people who hear voices and their families. A mixed methods exploratory study	Qualitative	Stage 1: 2 adolescents with Psychosis (11 yr female & 17 yr male) Stage 2: 32 young adolescents with psychosis and their parents England	IPA exploring views on engaging. Stage 1 determined themes and Stage 2 tested generalisability of themes	- Need for holistic approach - Clinician's to be patient, listen, interested - Seen as an individual - A space for parents and young people

11.	Golden & McElvaney, 2014	A bit more understanding: Young people's views on mental health services in Northern Ireland	Qualitative	8 Young adults ages 18-27with complex needs Ireland	Thematic Analysis exploring Young adults views (in care) experiences of engaging with mental health services	Identified key areas relating to engaging YP in MH services -giving choice and control to YP - engaging through non-verbal methods - clinician persistence - YP feeling heard - individualised care and assessment approach
12.	Tindell et al., 2015	Factors influencing engagement with case managers: Perspectives of young people with a diagnosis of first episode psychosis	Qualitative	7 Adolescents with psychosis, Australia	IPA explored young people's experiences of the engagement process with their clinicians	Identified: - engagement as a process - therapeutic relationship important - client empowerment
13.	Roy & Gillet, 2008	Email: A new technique for forming an alliance with high risk young people failing to engage with mental health services	Case study	Female, 17 years with severe depression and self-harm, history of disengagement with services England	Use of email an engagement strategy	- Geographically flexible - Increase of disclosure - Provided a sense of distance and control – safety - Identified disadvantages; confidentiality, clinician lack of control, risk management?
14.	Watt et al., 2007	Treatment Participation amongst young people with Conduct Problems: The role of telephone reminders	RCT	214 Young people with CD problems Australia	Examined the role of telephone reminders on treatment attendance	Individual's with CD higher risk of dropout and complex psychosocial vulnerabilities. Telephone reminders increased engagement for young people with elevated conduct symptoms,
15.	Waldron et al., 2007	Engaging resistant adolescents in drug abuse treatment	Quasi-Experimental	42 Parents of YP with substance misuse America	Exploring effects of involving parents to increase engagement of YP	Parental engagement strategies learnt as part of CRAFT programme were found to support engagement process into treatment.
16.	Westin et al., 2014	The effect of waiting time on Youth Engagement to evidence based treatment	Quasi-experimental	2,054 Young people (9-19ys) from minority ethnic background African America Sample	Does waiting time predict treatment refusal/premature treatment drop out?	- longer waiting times prior to start of treatment was found to be a significant predictor of treatment refusal (non-engagement) - Longer waiting times not a predictor for early treatment drop out for MST but was identified for FFT. Discussion explored use of intensive engagement strategies as part of MST as moderator.

also refer to participation, but offer no clarity about whether this also means engagement or whether it is a separate concept, while Watt and Dadds (2007) focuses on treatment attendance as the sole predictor of engagement. Similarly, Green et al. (2012) do not offer a specific definition of engagement but they do refer to unwillingness to attend treatment sessions, reduced treatment readiness and reluctance to follow treatment recommendations.

While these studies do not specifically define engagement as a construct, they implicitly demarcate engagement by measuring it through treatment attendance and behaviour. Waldron et al. (2007) and Dakof et al. (2001) fail to define engagement but they measure an engaged young person by how many sessions they attended. Mensinger et al. (2006) focus on identifying treatment attendance barriers with the view to apply findings to support treatment retention. These attempts to define engagement has enabled some consistency amongst the research in terms of being able to identify whether service users are accessing support offered. However this definition is insubstantial when considering the many different ways young people engage with services, as well as the well-known challenges when engaging hard-to-reach young people. At the same time, there are several papers reviewed here that focus on relational aspects of engagement, specifying a crucial aspect of the construct.

Roy and Gillett (2008) address an interpersonal component of engagement by studying whether service users feel listened to and feel comfortable in their contacts with services. Watt and Dadds (2007) identify the importance of treatment attendance but they also focus on identifying clinician engagement strategies, implying that engagement is promoted by specific practices employed by clinicians in their interactions with clients. These papers point towards engagement being multi-layered as they propose a more dyadic process to engagement, one that starts to consider the role of clinician behaviour and the relationship between the young person and their worker.

Only three of the sixteen studies attempt to specify what they term the word engagement to mean. Westin et al. (2014), examines the relationship between waiting time and treatment engagement among 2,054 youths from ethnic minority groups and conceptualises engagement into two distinct types; treatment entry and ongoing engagement. They consider both important for predicting optimal treatment outcomes. Tindell et al. (2015) carried out a qualitative study which aimed to understand how young people experienced engagement with their workers at an early intervention service. They interviewed seven young people with psychosis about their views on engagement to the service. They propose engagement in intervention is the journey from a crisis to 'normal life' and is influenced by factors which pull towards that end goal (such as motivation, meeting of needs and a therapeutic relationship) and factors which pull towards disengagement (such as ambivalence, stigma and waiting times). This definition offers a more comprehensive definition which includes constructs which can be measured and researched consistently. They have managed to articulate and present how complex engagement is and its dynamic and fluid structure which is influenced by both behavioural and relational factors. However, this model was based on a small sample size with a specific population group and so questions arise over generalisabilty.

Schley et al. (2012) is the only paper that addresses the lack of clarity of the term engagement in the literature. They propose that there is no accepted definition and that the term is used interchangeably to describe treatment adherence, service contact and compliance. They clearly define engagement and measure it using a standardised assessment measure of engagement developed by Hall et al. (2001). This measure is a clinician rated tool measuring six identified facets of engagement; appointment attendance, client interaction, communication/openness, client perceived usefulness of treatment, collaboration and medication compliance. This model integrates individual and clinician related factors in their definition of engagement.

In summary, whilst the literature lacks a clear definition of engagement, there is a general consensus that engagement is a predictor of positive outcomes amongst hard-to-reach youth. Findings from the research have demonstrated a number of factors which affect engagement: practical (such as waiting times), behavioural (treatment attendance) and relational (clinician understanding, feeling empowered within the therapeutic relationship). This provides evidence that engagement is complex and influenced by multiple factors. There is a need to develop a concise model of engagement with hard-to-reach young people which could then have clearer clinical implications for engaging and supporting this population.

2. How effective are implemented engagement strategies?

Nine papers in the literature reviewed evaluated implemented engagement strategies. The literature ranges from measuring the effectiveness of specific engagement strategies from parents and clinicians, at the point of referral (Ross et al., 2012) and during the intervention (Assan et al., 2008; Dakof et al., 2001; Mesinger et al., 2006; Perez et al., 2007; Schley et al., 2012; Waldron et al., 2004; Watt & Dadds, 2007; Westin et al., 2014),

Waldron et al. (2007) evaluated the effectiveness of parent engagement strategies amongst treatment resistant young people with substance misuse difficulties. Using a carer-focused intervention designed to help parents facilitate their children into early treatment (Community Reinforcement and Family Training, CRAFT), they targeted engagement levels of young people who were initially resistant to support. By enhancing the psychosocial functioning of parents, and building their skills to support the engagement process, they found that 71% of young people who had previously resisted treatment engaged in an CBT intervention for substance misuse. This study suggests that adding a familial component to engagement of substance misusing young people may increase engagement when trying to work with this group of hard-to-reach young people. Watt et al. (2007) carried out a randomised control trial to look at the effectiveness of telephone call reminders on treatment attendance for young people with conduct problems. They found that reminder telephone calls to parents one day prior the appointment for the first five sessions increased treatment attendance. Whilst the use of a comparison group strengthens the findings, limitations of this study include; single sample group (conduct problems) and young people were only recruited if there was parental involvement with the service. These recruitment restrictions lead to concerns regarding generalisability.

Watt and Dadds (2007) measured the effect of clinician engagement strategies and their attitudes towards such strategies on treatment attendance for young people with conduct problems (anti social, aggressive and disruptive behaviour). Initially clinicians completed the Strategies to Enhance Treatment Engagement (SETE), which asks them to write a list of as many structural and therapeutic strategies they use. These responses were then coded according to five components of each category.

For the structural strategies the components were; accessible service, timeliness, client incentives, clinician feedback, and comfortable atmosphere. The five therapeutic components were therapeutic relationship, empowerment, achievable gains, client expectations and broad-based needs. Clinician perception of each strategy and how often they used them was then obtained using the Clinician's Perceptions of Treatment Engagement Strategies (PTES) and the Clinician's Use of Treatment Engagement Strategies (Clinician's UTES). Results reported a total of 434 strategies identified with the top two most reported strategies being accessible service (structural) with 91% of clinicians reporting this as a strategy and the therapeutic relationship (therapeutic) reported by 93% of clinicians. Clients reported using therapeutic process strategies significantly more than structural. Client attendance was then monitored and compared with clinician perception and usefulness rating. Results found clinicians who perceived themselves as more competent, and were more willing to use therapeutic process strategies (that they rated as more useful) had greater rates of client attendance. These findings indicate the subtle differences between engagement strategies and their focus. It also introduces the concept of clinician attitudes and confidence towards strategies and its impact on client attendance. Additional to structural and therapeutic process strategies, the paper identifies clear referral and intake procedures and effective communication as influencing engagement.

Watt and Dadds (2007) findings have clinical implications; firstly for services to encourage the use of engagement strategies and secondly for clinicians to be offered training in such strategies in order to improve their confidence. This study demonstrates clinicians are aware of the strategies they are using, but reliance of their self-report may introduce bias. Additionally the coding structure applied during analysis was limited as an additional 82 strategies were reported that were unable to be coded. This highlights the difficulty in balancing the need to adhere to research criteria and trying to provide a full clinical picture.

Ross et al. (2012) collected and analysed data on an outreach model that aimed to facilitate engagement through an 'easy access' referral model for young people and young adults experiencing psychiatric difficulties. The study aimed to evaluate a mental healthcare delivery system that identified young people experiencing significant distress and encourage them to seek help. The young people in this sample were defined as hard-to-reach as 95% reported severe anxiety with a large number of co-morbid presentations such as Post Traumatic Stress Disorder, Bipolar Disorder, depressive symptoms and suicidal ideation. 71% of the young people had reported accessing previous mental health care support and so Ross et al. (2012) considered them treatment resistant. The outreach model implemented was designed to offer young people a chance to access a mental health service without having to visit their general practitioner. Engagement sessions providing psycho-education on mood/anxiety were delivered in schools, medical health centres and youth community centres. Following these sessions referral pathways were then monitored with the largest three groups being self-referral (33%), referrals from educational institutions (23%) and referrals from family or friends (21%). Conclusions from the study identified the need to consider how outreach services can incorporate flexible referral pathways in order to capture the needs of young people and families who may be reluctant to visit their general practitioner. Unfortunately as the study had no comparison group it is difficult to ascertain the exact cause of a increase in referrals. However, the high number of service users who had previously been supported by services and had been reluctant to visit their GP again despite still having mental health difficulties provides rationale for thinking more creatively about how to use engagement strategies prior to referral.

Assan et al. (2008) looked at the effectiveness of services which have been specifically designed to support young people with high-risk complex needs by evaluating an intensive outreach service model. They carried out an audit across a year on an Adolescent Intensive Management (AIM) Team. The AIM team is a specialist outreach team integrated in a CAMHS service. It retains a separate identity with after-hours support and consultation to families and professional networks. Using a multi-disciplinary approach, referrals are considered for young people who have been identified as hard-to-reach through typical service models. The paper carried out a retrospective review of the files of all clients receiving support across a twelve month period. In accordance with this service model designed for hard-to-reach youth, demographic data showed young people had high levels of co-morbid psychiatric difficulties, with 21% meeting criteria for two diagnosable conditions and 61% meeting criteria for three. A third of the young people were not engaging in education and

72% had parental risk factors of mental health difficulties. There was a high retention rate (100%) of clients referred to the team and some indication of return to engagement.

Assan et al. (2008) conclude this outreach method as effective when supporting a hard-to-reach client group. The use of the telephone 'on call' support system is highlighted as an important part of the model as it supports families through crisis periods which minimises emergency service use which has financial implications for healthcare providers. It emphasises the need for follow up studies as the majority of young people continued to require support after discharge, even after receiving a high intensity intervention. While these are promising findings when thinking about designing an assertive outreach service for hard-to-reach young people, without control groups or more in-depth analysis including follow up, it is difficult to provide evidence for why, how and for how long these types of services are effective.

Schley et al. (2012) does focus on treatment outcomes by carrying out an audit of standardised outcomes measures on young people who have been supported by an intensive mobile youth outreach service (IMYOS). They aimed to see if improved engagement after initial assessment was a predictor of steady engagement and whether there was significant improvement across outcomes at discharge. Data was collected on forty-four clients and engagement measures comprised of a six component engagement model (Hall et al., 2001 discussed in detail further on in this review). Outcome measures used were the Nation Outcomes scale for Children and Adolescents (HoNOSCA) or the Health of the Nation Outcomes Score (HoNOS) for adults. The Global Assessment of Functioning (GAF) scale was used to capture psychological, social and occupational functioning. Data was collected at referral (T1), after initial assessment (T2) and at discharge (T3). Results found that engagement was significantly higher after initial assessment and young people remained engaged as there was no significant engagement scores between T2 and T3. There was a significant improvement across functioning between T2 and T3. When considering the implications of these findings, the limitations of clinician rated outcome measures must be noted, including self-report bias particularly in the current climate when commissioning is heavily reliant on good outcomes.

This study also found that risk was reduced with sixty-six percent of young people having significantly reduced sociality and hostility scores at discharge. Results from the engagement measures provided evidence for the dimensions of collaboration, perceived usefulness and client therapist interactions as most consistently associated with improved treatment outcomes. This paper has gone further than simply collecting data on whether an intensive outreach model can predict reduced treatment dropout. It has started to explore engagement at the beginning of treatment as a predictor for engagement at discharge. It also starts to unpick the concept of engagement and how it impacts on treatment adherence amongst hard-to-reach young people.

In summary, the findings provide evidence that hard-to-reach young people have complex needs and require intensive support from multi-disciplinary teams. This involves supporting young people and their family in an outreach capacity. The literature suggests specific strategies for fostering engagement can implemented and be thought of as service related (such as flexibility of referral pathways), clinician focused (including identifying popular strategies and the impact confidence has on effectiveness) and finally wider systemic strategies (parental involvement). The identification of such strategies and their effect on treatment with hard-to-reach young people is empirically-supported amongst this small body of literature (Assan et al., 2008; Dakof et al., 2001; Mesinger et al., 2006; Perez et al., 2007; Schley et al., 2012; Waldron et al., 2004; Watt & Dadds, 2007; Westin et al., 2014). What is less clear from the literature is how these specific strategies work to promote engagement and the discrete sample populations make findings difficult to generalise. A distinct absence of cultural diversity adds to this question of ecological validity. Additionally, the studies show significant limitations including no comparison groups and limited follow up data. Nonetheless, findings suggest that engagement is a crucial process when working with hard-to-reach youth and the challenges of researching it only emphasises its complex nature which presumably reflects its clinical presentation too. What is evident is how small the literature base is considering the important clinical and financial implications it has.

3. What are the barriers identified to engaging hard-to-reach adolescents?

Alongside the literature identifying what promotes engagement, research has been focusing on identifying barriers to engagement amongst hard-to-reach client groups. Westin et al.'s (2014) quasi-experimental study collected data on 2,054 young people with complex needs who had been referred for family functional therapy (G1) or multi-systemic therapy (G2) as part of a state-wide intervention of child and family evidence based treatments. They aimed to see if longer waiting times was a predictor of treatment refusal or early treatment drop out. For both groups longer waiting times was a predictor of treatment refusal, but not a significant predictor of engagement, once treatment had started. In young people who did drop out of treatment there was a significant difference between treatment condition, with those who were being supported by family functional therapy more likely to drop out of treatment than those receiving multi-systemic therapy. These findings show that the more intensive multi-systemic therapy model may serve as a more effective treatment in engaging hard-to-reach families regardless of how long they have had to wait for treatment.

Perez et al. (2007) and Mensinger et al. (2007) both aimed to identify barriers to treatment engagement with hard-to-reach young people. Perez et al. (2007) carried out an audit amongst young people (aged 9 to 13 years) engaging in mental health services identified as socially at risk. They identified that treatment drop out was associated with the following factors; lower socioeconomic group, unemployed families, minority cultures, low educational achievement and adolescents. These findings were echoed by Watt et al. (2007). Similarly Mensinger et al. (2007), carried out an evaluation with 600 young people being supported for substance misuse and also identified sociological factors as predictors of treatment drop out. Both low socioeconomic status and severity of symptoms were predictors of treatment dropout. They also considered adolescent and clinician perceptions as important to the engagement process and gave questionnaires exploring views on what factors were important to ensure continued engagement. Results found both adolescents and clinicians viewed interpersonal connectedness (feeling safe), perceived helpfulness of treatment and practically of getting to treatment as important predictors of engagement. They discuss the implications of these findings to suggest that services are designed to be flexible and ensure 'easy access' for young people and consider the role of the client therapist relationship and its impact on treatment outcomes.

Dakof et al.'s (2001) paper can also be included within this category as they aimed to identify factors which predicted treatment engagement and therefore informs us about barriers. They carried out an evaluation using discriminant functional analysis on 228 young people with substance misuse. A large number of the sample was an ethnic minority population, which had previously been identified in the literature as a potential barrier to engagement. Their results identified three predictors of engagement; parental expectations of educational achievement, higher parental reports of youth externalising symptoms and higher levels of family conflict perceived by youth. These findings suggest young people and their families are more likely to engage with services if they consider there are difficulties which they want support with. In particular parents who reported higher levels of externalising behaviour considered difficulties serious enough to keep their child in treatment.

In summary, the findings of the literature focusing on barriers to treatment have identified factors comprising from sociological, psychological and perceived attitudes towards symptoms as important predictors of barriers. What is missing from the literature is the application of theoretical frameworks to understand why these barriers or predictors are present. The research lacks a coherent narrative of how these factors impact on engagement and without this it's difficult to consider how to change this help seeking behaviour. What might be beneficial is to consider the role of more in-depth research using qualitative methods to explore individual experience and attitudes towards what fosters engagement and what the barriers are.

4. What do service users consider helpful to promote engagement?

Five papers in the review focus on gathering service user views on what they consider would be helpful when trying to engage hard-to-reach young people in mental health services. This literature is qualitative and comprises of interviews with young people who are being supported by a service and one paper who interviewed adults with enduring mental health difficulties about their experiences being supported as an adolescent. The literature in this area is more cohesive with the possibility of dividing the main findings into three parts. Firstly clinician qualities and strategies that can be used to promote engagement, secondly service level strategies and finally consideration of engagement as a process.

Common clinician qualities appear through the interview transcripts and comprise of individual personality, communication styles and strategies to support and foster autonomy of the young person. Being warm and understanding and supporting the young person to feel listened to is considered to be important (Pycroft et al., 2015), as is being empathic and gentle in their approach (Green et al., 2012). Kapur et al. (2014) found young people wanted clinicians to be patient, be able to listen and be interested in their young people.

Young adults interviewed by Golden and McElevaney (2014) also referred to the importance of clinicians making sure that young people felt heard and a clinician should be persistent when trying to engage young people. Findings from this study identified that giving choices and control to the young people would help support the engagement process. Creative communication styles such as non-verbal methods, drawing and activities were also considered important (Pycroft et al., 2015; Golden & McElvaney, 2014). Finally one paper highlighted the need to ensure clinicians gave age appropriate responses and specified this to include showing respect for the young person and having respect for their culture and lifestyle. Comments also referred to the transitional period of adolescence and being sensitive to their adolescent development and respecting autonomy.

Service level strategies to support engagement included enabling workers to be flexible so they could be available when young people reached out (Pycroft et al., 2015). Clinicians were also encouraged to be persistent which would require a service that allows a prolonged engagement process (Golden & McElvaney, 2014). The creative methods mentioned by clinicians would also require resources and would also rely on services being flexible in the way they work with different young people. Green et al. (2012) identified a theme common amongst the participants that was called 'creating a safe and supportive environment.' This comprised of issues such as emotional safety and also addressing the service's confidentiality boundaries. A holistic approach was another important factor and therefore has implications for service structure, as a multi-disciplinary approach may be best suited to address the multiple needs of young people being supported in the service (Kapur et al., 2014). Finally this paper also found that young people thought a space for their parents was also important and leads to a need to adopt a systemic approach within a service.

Tindell et al. (2015) interviewed young people with psychosis and asked them their opinions about their engagement with the service. Themes of a fear and hopelessness and a feeling of having to engage were present, alongside being worried about stigma and practical challenges of the service impacting on the motivation to engage. The therapeutic relationship was considered an important factor which promotes 'the engagement journey.' The main findings from the study discuss the concept of disempowerment and its influence. They propose that disempowerment is evident at the start of the engagement process as service users feel disempowered and out of control of their life and seek help and support. However, if they experience disempowerment during their engagement with the service such as waiting for appointments, a change of keyworker or a sense of invalidation, then they are likely to pull away from engagement. This offers a helpful narrative about how a concept such as disempowerment impacts on the engagement and has real clinical and implications when trying to promote engagement. However, the interviews were carried out by a clinician working in the service. raising the issue of how free service users felt regarding talking and criticising a service or the interviewer's colleagues.

Whilst the results of qualitative interviews can provide rich data of the experiences of service users as well as the incredibly valuable opinions of people working clinically in these settings, these advantages must be balanced with the limitations of these studies including small sample sizes and biased sampling groups. The very nature of the research means that only young people who have engaged with the service are interviewed, which in itself is problematic as the experiences of young people who were not able to be engaged are absent. There is also a lack of transparency of the coding procedures and a full accounting of the data analysis is not reported. The small sample sizes of specific population groups is another limitation, one of which is echoed throughout all the literature reviewed, including the quantitative studies. These qualitative studies also fail to provide transparency regarding the researcher's own perspective (Golden & McElvaney, 2015; Green et al., 2012; Kapur et al., 2007; Pycroft et al., 2015; Tindell et al., 2015), something which Kmet et al. (2004) identifies as researcher reflexivity and important when critically appraising qualitative research. Qualitative research and analysis is a process that is in-depth and should be all consuming for the researcher. The process of analysis should include explicit acknowledgement of the researcher's own thoughts and feelings to the context and data.

In summary, the main themes that arise from the qualitative research are for services to recognise the adolescent development and complex needs of the young people they are trying to support and to respond to those needs promptly and flexibly. Additionally, there are identified clinician qualities and strategies that can be employed to create an optimal environment to support young people to attend sessions and subsequently feel safe to open up whilst also ensuring autonomy is fostered.

Discussion

There is a general consensus in the reviewed literature that engagement is important when supporting hard-to-reach young people; firstly to access services and secondly for positive treatment outcomes. However, there is a lack of clarity regarding a conceptual definition of the term, with a large part of the research using the term without any substantial explanation. Alternatively it is defined as either something concrete such as treatment attendance or as a more abstract multidimensional construct related to experiences.

The findings raise important questions that need to be addressed when considering the definition of engagement. The literature identifies a large number of strategies implemented both at a service structure and clinician level that can promote engagement, suggesting that engagement is an on-going process that is defined by the interaction of both services and young people. In light of this emphasis in engaging hard-to-reach young people, it is important to recognise the power im-balance when young people access mental health services. A large number of hard-to-reach young people will have involvement with multiple services and may be very used to attending sessions because other people believe they should. What is lacking in the literature is a greater evaluation of the impact of this power imbalance, including eliciting the views of young people regarding engagement and what they consider to be important when designing a service that would promote maximum engagement.

Three studies specifically address the lack of clarity of the term engagement and attempt to define it. Westin et al., (2012) refer to McKay et al.'s (1998) model of engagement which conceptualises engagement as having two distinct yet related steps; treatment entry and ongoing engagement. This fits well with the literature as it alludes to the importance of engaging hard-to-reach young people at the point of referral and then addresses the challenges to protecting early treatment drop out. However it does not address the complex factors that influence ongoing engagement identified in several studies (Roy & Gillet, 2008; Tindell et al., 2015; Waldron et al., 2007; Watt & Dadds, 2007).

Two more comprehensive models are Hall et al.'s (2001) model cited by Schley et al. (2012) and Tindell et al.'s (2015) engagement process model. Both these models propose engagement as a multifaceted, dynamic process which is influenced by relational and service related challenges. These models support factors identified in the literature; behavioural signs such as attendance and compliance with medication with client perceptions and an interpersonal element of the therapeutic relationship. In addition they complement the evidence pointing to engagement being a dyadic process that occurs within treatment and should be measured across different behavioural, cognitive and relational levels.

Systemic factors are also implicated when studies refer to ‘chaotic families’ and the use of parent reminder strategies. However there is a distinct lack of engagement models that include a social context component amongst the literature with hard-to-reach young people. In a wider search of the literature, Pullmann et al. (2013) developed a model of engagement after interviewing 31 adults working with young people. It is called the CARES model of engagement and it identifies five key domains; Conduct, Attitudes, Relationships, Empowerment and Social Context. Each domain is clearly explained in terms of its definition, examples of what it looks like and exampled of dimension from existing models. What is helpful about the model is it provides a theoretical framework that can be used as a foundation for the defining engagement literature.

It is important for research to clarify what is meant by the term engagement to enable consistency about which models are used to measure it. This will enable a fuller understanding of what are the most influential factors within a population group. For example, if research in this field all consistently subscribed to key domains such as those identified by Pullmann et al. (2013), then more studies could identify what the mechanisms are towards engagement as a defining characteristic when supporting hard-to-reach young people and predicting positive treatment outcomes.

One key theme embedded in the research is the recognition as adolescence as a transitional period. It recommends young people need to be supported through this period by empathic clinicians who create a safe environment whilst ensuring empowerment and autonomy development. It is hypothesised that if this is done successfully this promotes engagement. Both Attachment Theory (Bowlby, 1969) and Theory of Adolescent Development (Erikson, 1959) can be considered when understanding these findings within a theoretical framework.

Some important findings from the research are that young people believe there are individual clinician qualities which helps their relationship with them. This suggests the importance of the relationship when promoting engagement, a foundation of which would be the attachment. Bowlby's Attachment Theory (1969) defines attachment as an enduring emotional bond between one person and another. It is characterised by specific behaviour in children such as seeking proximity to the attached figure when stressed or feeling threatened. Reciprocal attachment behaviour from the adult includes sensitivity to the child's needs and responding appropriately. The responses from service users during interviews about clinician qualities suggest how important it is for young people to develop an attachment to their therapist. Clinician qualities such as empathy and warmth promote a sensitive response to the needs of a young person. Karver and Caporino (2010) explored strategies for building the therapeutic relationship amongst adolescents with oppositional defiant disorder and make lots of references to attachment related behaviour by the clinician such as emotional validation, warmth and responding flexibly to individual needs. Supporting this is research carried out by Bevington et al. (2014) who looked at applying attachment theory with hard-to-reach young people and argues the importance of facilitating and supporting the young person's attachment with a keyworker.

Erikson's Theory of Adolescent Development refers to the developmental stages which occur in adolescence. Identity development is considered to be the most prominent stage and it includes; adolescent understanding, finding their role within their family, community and society. During these times young people may experiment with behaviour and identity formation (Erikson, 1994). This provides a framework to support literature's findings which highlights the importance of clinicians respecting this developmental stage and recognising young people's need to become autonomous whist being supported and guided towards pro-social and emotional development.

The research focusing on exploring the experiences of young people and clinicians also identified numerous service related factors such as enabling clinicians to include parents and be flexibly persistent with their engagement approach. These findings further support evidence for a systemic framework that needs to be considered when working intensively with young people who are considered hard-to-reach. To support these findings theoretically, Bronfenbrenner's Ecological System's Theory (1992) can explain how the various levels of influences surrounding a young person can help to facilitate engagement. These systemic principles place importance on the influence of the familial system on young people being supported in mental health services (Wagner et al., 2006). It puts emphasis on the dynamic role that occurs both relationally within and between each family system and facilitating change occurs by creating difference within systems. Bickerton et al. (2007) propose that when working with young people with complex needs such as suicidal ideation and self harm it is vital to involve the family and consider the relational system surrounding the young person. This supports the findings in this review from Waldron et al.'s (2007) paper which found parental strategies as important in facilitating the engagement process.

Effective communication with the professional networks was another service related factor identified when working with hard-to-reach adolescents (Ross et al., 2012). Bevington et al. (2013) propose an integrative therapy model when working with hard-to-reach young people and part of this model is fostering and developing relationships within the professional network, which targets the two levels already discussed; attachment and an ecological approach . The model is called Adolescent Mentalisation Based Integrative Treatment (AMBIT) and proposes a mentalising network which can support the professional network around young people who are considered hard-to-reach.

Whilst this current review has identified some important findings which can be integrated into well-established theoretical frameworks, findings must be considered in light of the review's limitations. There are significant limitations to the research into engaging hard-to-reach adolescents highlighted throughout the review such as a small number of experimental studies and a lack of generalisable findings due to single group populations. Additionally, the qualitative literature reviewed here has several limitations. Firstly, it must be recognised that the young people's views are from adolescents or adult service users who have been engaged with mental health services with no studies documenting interviews with the population of young people who have not engaged, therefore limiting our understanding of engagement and particularly factors that lead to dis-engagement. Additionally questions should be asked as part of qualitative studies of hard-to-reach populations regarding how comfortable young people are to express their opinions honestly when being interviewed by researchers. Power imbalances and confidentiality concerns may well play a role with influencing young people to criticise their worker or services they are being supported by.

The findings from this review suggest several clinical implications both at the service and clinician level. The need for services to consider holistic and intensive treatment plans has been addressed and must be taken into account when developing services aimed at supporting hard-to-reach young people in order to support their complex needs. A repeated finding from this review is the importance placed on creative and persistent approaches to engaging hard-to-reach young people with effective strategies being intensive and resource heavy. This calls for service design and delivery to be flexible and adaptive to young people reaching out, including making allowances for longer time periods of initial engagement and including families to support the process . This has financial implications for health care providers and commissioners. However, rationale can be given for such intensive services as this client group is most vulnerable to inpatient admission, being placed into care or becoming part of the criminal justice system all of which are more costly. At a clinician level the findings which identify the role of the clinician in the engagement process, including clinician confidence to use such strategies. This has implications for resources being made available to train clinicians and offer support for implementation. The feedback regarding clinician relational qualities stresses the importance of awareness of a warm empathic approach whilst also highlighting specific strategies that can promote engagement and promote an attachment with the young person.

Finally, the review has identified multiple gaps in the literature and the need for future research in this area. Firstly there is a need to clarify and consistently address the concept of engagement and what it means. There needs to be explicit definitions that are agreed upon and replicated in future research. Questions need to be asked of clinicians and service managers regarding their agreements with concepts. Secondly the initial scoping searches found most engagement research has focused on generic CAMHS populations with very few focusing on the population where its research would be most valuable. More research is needed to evaluate effective engagement strategies with other hard-to-reach groups such as young offenders, high risk suicidal behaviour, and severe mood disorders, using robust methodologies in order to see if findings are generalisable. The challenging aspects to supporting this client group will no doubt be apparent when completing research, so the strategies identified in this review should be considered and implemented in order to aid effective research. Further exploration should be carried out into clinician views of how they balance the challenging dynamic interaction of the engagement process whilst also adhering to service models and service constraints. Finally what may be most clinically useful would be a clear model of how to maximise engagement with this client group, one that could be applied across services regardless of delivery model.

In conclusion engaging hard-to-reach young people is multifaceted and is influenced by a complex interplay of individual, service related and systemic factors. Whilst the concept of engagement is loose and inconsistent the important role it plays when supporting this client group is unanimously agreed upon by clinicians and supported by the small body of available research (Kapur et al., 2014; Mesinger et al., 2006; Perez et al., 2007; Ross et al., 2012; Schley et al., 2012; Westin et al., 2014). Whilst clinical and service delivery implications have been discussed, a more robust evidence base would provide strength to the argument for flexible, integrated and resource intensive services as the most cost effective way of supporting these young people. It provides rationale for engagement and service models to be thoughtful, creative and adaptive to suit this diverse client group and above all make engagement a priority.

References

Assan, B., Burchell, A., Coffey S., Weir, J., Hammond, S., & Woods, B. (2008). The Adolescent Intensive Management Team: an intensive outreach mental health service for high-risk adolescents. *Child and Adolescent Psychiatry, 16*, 423 - 426. doi:10.1080/10398560801886021

Bevington, D., Fuggle, P., Fonagy, P., Target, M., & Asen, E. (2013). Innovations in Practice: Adolescent Mentalization-Based Integrative Thearpy (AMBIT) - a new integrated approach to working with the most complex mental health needs. *Child and Adolescent Mental Health, 18*, 46 - 51.

Bevington, D., Fuggle, P., & Fonagy, P. (2014). Applying attachment theory to effective practice with hard-to-reach youth: the AMBIT approach. *Attachment and Human Development, 17*, 157 - 174. doi: 10.1080/14616734.2015.1006385

Bickerton, A., Benstock, T., Ward, J., & Wallace. (2007). Safety First: A model of care for working systemically with high risk young people and their families in an acute CAMHS service. *Australian and New Zealand Journal of Family Therapy*, *28*, 121 - 129.

Bowlby, J. (1969). *Attachment and Loss*. Basic Books, England.

Bronfenbrenner, U. (1992). Ecological Systems Theory in Ross, V. (Ed). *Six Theories of Child Development: Revised formulations and current issues.*.pp. 187 - 249. London, Jessica Kingsley Publishers.

Dakof, G., Tejeda, M., & Liddle, H. (2001). Predictors of engagement in adolescent drug Abuse treatment. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 274 - 281.

Dembo, R., Gulledge, L., Robinson, R., & Winters, K. (2011). Enrolling and engaging high-risk youths and families in community-based brief intervention services. *Journal of Child and Adolescent Substance Abuse, 20,* 330 - 350. doi: 10.1080/1067828X.2011.598837

Erikson, Erik H. (1994). *Identity: Youth and crisis*. No. 7. WW Norton & Company,

Golden, M., & McElvaney, (2014). A bit more understanding: young adults' views of mental health services. *Children and Youth Services Review, 51,* 1-9.

Green, C., Wisdom, J., Wolfe L., & Firemark, A. (2012). Engaging youths with serious mental illness in treatment: STARS study consumer recommendations. *Psychiatric Rehabilitation Journal, 35,* 360-368.

Gillespie, M., Smith, J., Meaden, A., Jones, C., & Wane, J. (2004). Clients' engagement with assertive outreach services: A comparison of client and staff perceptions of engagement and its impact on later engagement, *Journal of Mental Health, 13,* 439 - 452.

Hall, M., Meaden, A., & Jones, C. (2001). Brief report: the development and psychometric properties of observer-related measure of engagement with mental health services. *Journal of Mental Health, 10,* 457 - 465.

Karver, M., & Caporino, N. (2010). The use of empirically supported strategies for building a therapeutic relationship with an adolescent with oppositional-defiant disorder. *Cognitive and Behavioural Practice, 17,* 222 - 232.

Kapur, P., Hayes, D., Waddingham, R., Hillman, S., Deighton, J., & Midgley, N. (2014). The experience of engaging with mental health services among young people who hear voices and their families: a mixed methods exploratory study. *BMC Health Services Research,14*, 527 - 536.

Kessler, R., McLaughlin, K., Green, J.,,,,,,& Williams, D. (2010). Childhood adversities and adult psychopathology in the WHO world Mental Health Surveys. *British Journal of Psychiatry, 5,* 378 - 385.

Kmet, L., Robert, L., & Cook. L. (2004). Standard quality assessment criteria for evaluating primary research papers from a variety of fields.

McKay, M., Stoewe, J., McCadam, K., & Gonzales, J. (1998). Increasing access to child mental health services for urban children and their caregiver. *Health and Social Work. 23*, 9 - 15.

Meaden, A., Nithsdale, V., Rose., Smith, J., & Jones (2004) Is engagement associated with outcome in assertive outreach? *Journal of Mental Health, 13*, 415 - 424.

Mensinger, J., Diamond, G., Kaminer, Y., & Wintersteen, M. (2006). Adolescent and therapist perception of barriers to outpatient substance abuse treatment. *The American Journal of Addictions, 15*, 16 - 25.

Perez, R., Ezpeleta, L., & Domenech, Jose. (2007). Features associated with non-participation and drop out by socially-at-risk children and adolescents in mental-health epidemiological studies. *Social Psychiatry Epidemiology, 42*, 251-258.

Pullmann, M., Ague, S., Johnson, T., Lane, S., Beaver, K., Jetton, E., & Rund, E. (2013). Defining engagement in adolescent substance abuse treatment. *American Journal of Community Psychology, 52*, 347 - 358. doi: 10.1007/10464-013-9600-8

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. *British Journal of Social Work, 45*, 422-439. doi:10.1093/bjsw/bct089

Ross, E., Vingilis, E., & Ousuch, E. (2012). An engagement and access model for healthcare delivery to adolescents with mood and anxiety concerns. *Early Intervention in Psychiatry, 6*, 97 - 105.

Roy, H., & Gillet, T. (2008). Email: A new technique for forming therapeutic alliance with high-risk young people failing to engage with mental health services: A case study. *Clinical Child Psychology and Psychiatry*, *13*, 95-103.

Schley, C., Yuen, K., Fletcher, K., & Radovini. (2012). Does engagement with an intensive outreach service predict treatment outcomes in 'high-risk' youth? *Early Intervention in Psychiatry, 6*, 176-184.

Staudt, M., Lodato, G., & Hickman, C. (2012). Therapists talk about the engagement process. *Community Mental Health Journal, 48,* 212 - 218.

Tindell, R., Francey, S., & Hamilton, B., (2015). Factors influencing engagement with case managers: perspectives of young people with a diagnosis of first episode psychosis. *International Journal of Mental Health Nursing, 24,* 295 - 303.

Wagner, I., Munt, G. & Briner, P., 2006. Introducing evidence based family assessment and therapy in child and youth mental health services: applying systemic principles to maintain, sustain and build capacity, *Australian and New Zealand Journal of Family Therapy*, 27, 4: 187–198

Waldron, H., Kern-Jones, S., Turner, C., Peterson, T., & Ozechowski, T. (2007). Engaging resistant adolescents in drug abuse treatment. *Journal of Substance Abuse Treatment, 32,* 133-142.

Watt, B., & Dadds, M. (2007). Facilitating and treatment attendance in child and adolescent mental health services: A community study. *Clinical Child Psychology and Psychiatry, 12,* 105 - 116.

Watt, B., Hoyland, M., Best D., & Dadds, M. (2007). Treatment participation amongst children with conduct problems and the role of telephone reminders. *Journal of Family Studies, 16*, 522 - 530.

Westin, A., Barksdale, C., & Stephan, S., (2014). The effect of waiting time on youth engagement to evidence based treatments. *Community Mental Health Journal, 50*, 221-228.

Part 2

Empirical Paper

Exploring engagement and the usefulness of The AIM Cards with 'hard to reach' adolescents; hearing views and experiences from young people and clinicians.

Abstract

Young people with complex mental health and social needs are considered 'hard to reach.' Engaging these young people is challenging and creativity is important when trying to offer support. The AMBIT AIM Cards have been developed as a collaborative assessment tool that covers a broad range of strengths and difficulties common amongst young people, and facilitates engagement with this challenging client group. Currently the cards are being used in some services but so far no research has explored their usefulness. This study aims to extend preliminary favourable reports by clinicians on the clinical utility of The AIM Cards by conducting qualitative interviews with young people and clinicians eliciting their opinions and experiences of the cards, and specifically their function as an assessment tool and a method for facilitating engagement. Audio-taped interviews were transcribed and analysed using thematic analysis. The results identify key strategies that clinicians can utilize to foster engagement with this client group, and the valuable contribution The AIM Cards make during the assessment and engagement process. The findings reported are the first empirical evidence that The AIM Cards can contribute to the assessment and engagement process by creating a structure which promotes a young person-led, goal orientated assessment which includes facilitating understanding and communication between young people and clinicians.

Introduction

Adolescence is a challenging time of emotional and physical development. It is unsurprising that adolescents are vulnerable to experiencing mental health difficulties and it is critical for services to recognise the complex emotional and social context which surround these individuals. Burns and Birrell (2014) emphasise that despite mental health difficulties intensifying during adolescence, help seeking behaviour is low. Specifically, a sub-group of young people known as 'hard to reach' are particularly vulnerable. Kessler et al. (2010) defines hard-to-reach young people as having complex and severe mental health problems which are present alongside multiple social vulnerabilities. They are adolescents who are often disengaged in education, are misusing substances, and present with severe psychiatric difficulties and/or engage in high-risk behaviour (either self-harm or offending). Multiple social vulnerabilities often result in complex care networks, multiple service involvement and increased financial implications for local healthcare providers (Bevington et al., 2013). Long-term prognosis can be poor without appropriate support and intervention, which, in turn, puts pressure on adult services (Kessler et al., 2010). Bearing this in mind, any intervention or support for this group must address their complex needs.

Services which have been identified as effective for this client group are assertive outreach services (Assan et al., 2008; Pycroft et al., 2015; Schley et al., 2012). These are resource intensive services which often deliver specialised support by matching to the needs of the hard-to-reach population. Research evaluating these types of service models has found that clinician flexibility, persistence and engagement, along with increased level of intervention intensity, may account for improved treatment outcomes (Green et al., 2012; Schley et al., 2012). It is proposed that these assertive outreach services have the means to 'reach out' to young people who would ordinarily find it challenging to seek help and engage with traditional outpatient services (Ross et al., 2012).

Engagement is a key word when supporting hard-to-reach young people (Schley et al., 2012). Whilst the definition of engagement is currently still debated, Tindall et al. (2015) provide a useful definition encompassing attendance, treatment compliance, the existence of a therapeutic relationship enabling young people to work towards client-centred goals. Factors associated with poor engagement include (but are not limited to) prolonged duration of difficulties, forensic history and lack of familial support (O'Brien et al., 2009), all of which are common amongst hard-to-reach adolescents.

Two key themes emerge from the growing literature on engagement with hard-to-reach young people. Firstly, there is a need to develop a model of engagement which is aimed specifically at targeting hard-to-reach young people. Secondly, for service design to include flexible and collaborative approaches, to provide holistic, individualised interventions, and to employ clinicians who are genuine, empathetic and are informed of the crucial role engagement plays when supporting these young people (Green et al., 2012; Perez et al., 2007; Pycroft et al., 2015; Tindall et al., 2015; Schley et al., 2012). This engagement literature supports the assertive outreach model as the preferred approach to support hard-to-reach young people, while identifying the need to develop innovative strategies to work effectively with this population.

Building up the literature in this area is challenging. In parallel to the difficulties clinicians face when maintaining engagement with hard-to-reach young people, researchers face the same difficulties. Recruitment issues, consistent engagement and follow up challenges, are all barriers to research participation. As a result studies into effective engagement strategies or intervention outcomes with hard-to-reach young people are mainly carried out with small samples of disorder specific populations (Dakof et al., 2000; Westin et al., 2014)). Setting up robust and rigorous intervention research is difficult when services that are evaluated are often pilot schemes or 'wraparound' services which makes it hard to disentangle the factors leading to successful or unsuccessful intervention. Despite the limited evidence-base for services with this population, practice-based evidence suggest that successful clinicians employ creative and flexible methods to engagement with hard-to-reach young people.

Holmqvist et al. (2016) defines practice-based evidence as the study of the effects of psychological treatments as they are delivered in routine clinical care. When developing practice-based evidence, allowances are made for different service contexts, variation in patient symptoms, co-morbidity and differing levels of therapist competence. The idea of practice-based evidence is to explore and analyse what services are doing 'on the ground,' with the hope of turning it into data which can inform future systematic research studies to create evidence-based practice. These two forms of evidence gathering are therefore complementary and serve to create a flowing system of research and implementation. Perez et al. (2007) identified the fewest participant groups in experimental research are from those individuals from lower SES backgrounds, exhibiting lower school achievement, and who are adolescents, characteristics of many of the young people designated as hard-to-reach. Implementing practice-based research could there therefore be an opportunity to include participants from such groups.

The use of the practice-based evidence process lends itself well to the challenges of carrying out research with hard-to-reach young people, who may be difficult to recruit through more formal methods. Its emphasis on 'real life' research and allowances of variations in demographics and service contexts, means that the integrated models of working and individualised intervention packages offered to young people with complex needs, can be captured simply by monitoring and analysing what services are already providing. Overall the benefit of capturing practice-based evidence is its ability to bridge the gap between clinical practice and academic research, and therefore engage and provide ownership of the research to practitioners and service users. This will ultimately highlight important clinical implications for service development and delivery of care.

Adolescent Mentalisation-Based Integrative Therapy (AMBIT) is an organisational framework for integrating a range of practices and evidence-based treatments for teams working with hard-to-reach adolescents. This model incorporates local expertise and therapeutic practices and thus practice-based evidence to a substantial degree. It uses a mentalisation-based approach with its main focus being an effort to develop an attachment relationship between a single keyworker (Fuggle et al., 2015) and the young person. Mentalisation is the understanding and communication of behaviour (of self or others) developed through attachment relationships (for a comprehensive description of mentalisation-based approaches see Bateman & Fonagy, 2012). One of the AMBIT core principles is to adapt practice to suit the needs of the specific client group and service context and encourages documenting practice-based evidence referred to manualisation. This enables dissemination via an online resource for teams to document and share good clinical practice. More than 40 UK statutory and voluntary sector teams have now been trained in the AMBIT approach, each of which are continuing to support young people according to their service delivery model, but hold in mind core AMBIT principles (Bevington et al., 2015).

As part of AMBIT's integration of practice-based evidence into its framework, assessment and outcome measures are being created that are tailored to specific populations such as hard-to-reach youth and that have ecological validity in building an evidence base for the AMBIT approach (Bevington et al., 2015). The AIM Cards are an example of an AMBIT tool which aims to assess young people, with the possibility of identifying key problem areas for intervention. Its development comes from a 40 item clinician-rated measure called the Adolescent Integrative Measure (AIM), an adaptation from the validated Hampstead Child Adaptation Measure (HCAM) which is a measure that assesses young people's emotional development and impairment by identifying levels of pro-social functioning (Target et al., 2000). The AIM Cards were developed as a young person friendly version of the AIM. They are a pack of cards which explore the young person's strengths and difficulties using a young-person led goal focused approach, which includes an option for non-verbal communication. They cover a wide range of areas of the young person's life including individual, relational, educational and social factors. Each card has one strength or problem area written on it and the clinician supports the young person to identify cards which are relevant to them and discard cards which are not. The young person is then encouraged to choose top priority cards which then can inform support or an intervention. In keeping with the AMBIT principles the AMBIT AIM Cards suggested protocol is available freely at https://www.youtube.com/watch?v=OzvOwNlgP2E .

The AIM Cards fit well with the engagement literature with hard-to-reach young people, as it underscores the need to use collaborative methods to assess and engage them. The cards provide the opportunity for a young person to be in control of an assessment by holding and choosing cards and to consider what is important for them, both as strengths and difficulties. The AIM Cards have become part of the AMBIT tool kit and clinicians are currently using them as part of their practice when assessing and engaging young people with complex needs. Currently there has been no research into the utility cards, despite anecdotal reports from both clinicians and young people describing them as helpful and specifically tailored for hard-to-reach young people.

Aims and Rationale

Previous research focused on supporting hard-to-reach young people emphasise the need to develop innovative, creative ways to engage and intervene with this group. At present there are services which are using innovative approaches in order to improve attendance and intervention effectiveness. However, there have been few studies evaluating such methods or exploring the views of both professionals and young people who are sharing these experiences. The aim of this research therefore is to capture a form of practice based evidence transpiring in AMBIT teams serving hard-to-reach people in South West England, by conducting qualitative interviews to elicit and explore the opinions and views of young people and professionals in these services on their experiences using The AIM Cards. Specifically, it aims to address the usefulness of The AIM Cards in assessing young people with complex behavioural, emotional and social needs and as a tool to engage them.

A qualitative approach was chosen to evaluate the clinical utility of The AIM Cards for several reasons. Qualitative approaches are a useful way of gaining comprehensive understanding of the complex psychological and interpersonal processes present in therapeutic interventions (Pistrang & Barker, 2010). These approaches are particularly important when trying to elicit important information about subtle processes that may be missed when carrying out hypothesis-testing research and enable new themes to emerge (Elliot, 2010). Moreover, there is increasing understanding of how important service users and practitioners experiences and values are, particularly when thinking about health-care provision (Ahuja, 2010). Government policy documents such as "No decision about me without me" (2012) and the CY_IAPT initiatives (2013) underscore the need to include young people in research which concerns support affecting them. The use of qualitative research enables participation from those about whom any research findings matter the most; i.e. clinicians (those providing the support) and young people accessing these services (those receiving the support). This project therefore aims to contribute to research on hard-to-reach young people by systematically providing them with the opportunity to communicate their experiences and feedback related to support they have received.

Finally, there are aspects of qualitative methodology that may be suited to address the broader challenges researching this population. Chaotic lifestyles and on-going crisis management can make following strict research guidelines required for controlled studies difficult to adhere to. Whilst participant numbers may be smaller, the rich data gathered during this process can be extremely informative and important data. Finally a qualitative approach has been chosen as the most appropriate method for measurement of the cards utility as a clinical tool at this stage in their development as a psychometric measure. Specifically, the use of qualitative interviews with clinicians and young people is aimed toward capturing an accurate initial understanding of how and why these cards are being used, as well as their impact on young people and their engagement with professionals.

Method

Setting

Participants who were aged between 11 and 17 years were recruited from three services supporting hard-to-reach adolescents. Service 1 is a Youth Offending Service comprising a team of multi-agency professionals working with young people aged 10 - 17 years who have committed an offence or are in danger of doing so. Service 2 is an Intensive Outreach Service based in Social Care. It is a multi-agency service supporting young people aged 10 - 16 years who are at risk of becoming looked after due to family breakdown, or who are already looked after and their placement is at risk. These young people and families have severe and complex needs including anti-social behaviour, substance misuse, mental health problems, learning difficulties, social exclusion and offending. Service 3 is an outreach service supporting young people aged 14 - 25 years with complex needs such as substance misuse, psychosis, PTSD and severe mood/anxiety disorders.

Procedure and Participants

Ethical approval was obtained from an NHS research Ethics Committee (Appendix A) and local approval Research and Development approval was obtained for each research site. Both the clinician and young people sample was an opportunistic sample as the criteria for recruitment was that individuals had to have used the AMBIT AIM cards on at least one occasion. For clinicians this meant using them as part of their practice and for young people this meant having used them during an intervention with their worker. To begin the recruitment process the researcher made contact with a clinician at each service who volunteered to be a lead contact. This individual sent an email to clinicians asking if they would like to participate. Interviews were then arranged via email contact with the researcher and carried out at a time that was convenient to the clinician, either via telephone or at the service location. Recruitment of young people took place in a similar fashion. An email was sent by the service contact asking clinicians if they could identify young people whom they thought would be suitable to be approached for interview. Suitability was based on clinical judgement and asked clinicians to consider whether the young person would be able to tolerate being interviewed for thirty minutes by a researcher, in light of their current personal situation and ongoing needs. Young people were not approached if there were concerns about their mental health and clinical needs. Once young people were identified, clinicians working with the young people asked them if they would like to be interviewed and they were informed they would be paid £15 for their participation.

A total of ten clinicians and eight young people agreed to be interviewed. Of the ten clinicians interviewed there were seven females and three males. Five of the clinicians worked in the Youth Offending Service and five worked in the Intensive Outreach Service, with different professional titles (2 Clinical Psychologists, 2 Assistant Psychologists, 5 Intervention Workers and 1 Senior Intervention Worker). Of the eight young people interviewed, seven were male and one was female; their ages ranging from 14 to 17 years old, with a mean age of 15 years. Two were Asian British, three were White British and three were Black British. Four young people were recruited from the Youth Offending Team who had been referred to the service following committing a criminal offence and presented difficulties including, but not limited to; problem solving, anger management, anxiety and low mood. Four young people were recruited from the Intensive Outreach Service who were referred due to familial breakdown, with difficulties including but not limited to; socio-emotional difficulties, high levels of anxiety, low mood, deliberate self-harm and/or anger difficulties.

Prior to interview written information about the study (Appendix B) and consent forms (Appendix C) were given to each participant. For young people under 16 years parental consent was obtained.

Clinician interviews were completed at the service site or via telephone using a semi-structured interview schedule. Interviews with young people took place in a quiet, private room attached to each service. Semi-structured interviews were conducted in order to capture the potential variability of participant experience (Appendix D). Whilst there was a separate interview schedule for the clinician and the young person interviews, three broad topics were covered across all interviews; engagement, therapeutic relationship and experiences of The AIM Cards. The AIM Card questions were based on the researchers own experiences of the cards and anecdotal comments of clinician's experiences of how and why they used the cards. Follow up questions were used and prompts were used to elicit or elaborate accounts accordingly. The aim was for participants to feel they could express themselves honestly and describe their experiences in their own words, and this was explained to them at the start of the interview. In order to obtain an accurate reflection the interview encouraged participants to describe 'helpful' and 'unhelpful' aspects of the cards.

The AIM Cards

The AMBIT AIM Cards are an adaptation from a clinician checklist known as the AIM which covers psychiatric symptoms, social ecology, relationship qualities and resiliencies. For more information go to http://ambit-amass.tiddlyspace.com. They are a pack of 40 cards with each card representing its own symptom, strength or difficulty with a problem rating scale of 0-4. The cards identify an issue and provide a description, for example 'worrying a lot' has the description 'most people worry about things at times, but some people worry a lot and find it hard to be reassured by anything or anyone.' At present the protocol for using the cards is based on the young person initially sorting the cards into two piles (relevant and irrelevant cards). Then they choose which cards are strengths and difficulties from the pile of relevant cards. Both the young person and clinician explore the cards which have been identified as strengths before focusing on the difficulty pile to identify three priority cards they might want some support with, which can be scored at different points during the intervention to monitor progress. This protocol is supposed to be adaptive to the young person, and the time it takes to sort through the entire pack can vary, as can any involvement from the clinician. See Appendix E for scanned images of all 40 cards.

Ethical Considerations

Whilst the interview topics did not cover any information related to individual difficulties, it was recognised that confidentiality and anonymity must be a priority. Only three people knew the identity of each young person being interviewed; the researcher, the lead clinician and the young person's keyworker. At the start of the interview the researcher took care to explain to the participants that they were going to be asked for their thoughts and opinions and that there was no 'right answer.' It was explained to them that taking part or refusal to take part would have no impact on the support they were receiving. Following the interview the recordings were transcribed anonymously and deleted from the recording device. Quotes used to illustrate themes have been anonymised.

Researchers Perspective

The interviews and analyses were conducted by a Trainee Clinical Psychologist who was a 30 year old white female with previous experience of using the cards as a clinician. She is skilled in interview techniques and has experience of working with hard-to-reach young people. Prior to analysis the researcher considered her preconceptions and experiences of the cards. Whilst she was aware of her positive views towards the cards, she tried to put them to one side during both the interview and the analysis process.

Method of Analysis

Interviews were recorded via a secure recording device and transcribed verbatim by the researcher (See Appendix F for transcript example). Braun and Clarke's (2006) method of thematic analysis was used to systematically identify patterns of responses within participants' account. This process involved developing codes to describe opinions expressed, grouping these codes to create initial sub-themes, synthesising to form main themes and selecting quotations from the transcripts to illustrate each theme. Initially four transcripts were coded before generating sub-themes. The remainder of the transcripts were then coded according to the sub-themes, with new themes being generated where appropriate (see Appendix G for example). Clinician and young person interviews were analysed separately, being treated like two distinct data sets. The identifications of main themes were informed by the frequency of relevant material, both across and within individual transcripts. Although most themes and subthemes were supported by data from all participants, some themes applied to only a subset of participants.

Analysis was guided by Barker and Pistrang's (2005) established quality criteria for qualitative research in order to ensure it was a systematic and rigorous process. Themes and interpretations were grounded in the data by sticking closely to the transcripts during coding and development of initial themes; for example, many of the sub-theme titles are direct quotations from transcripts. Whilst the trainee took a lead in the analysis, the supervisor was involved in the synthesis of codes and the generation of themes. This was to avoid relying on a single researcher's perspective. Adaptations to sub-themes and main themes occurred throughout the process before reaching final agreement. Once analysis was completed on both sets of transcripts (clinician and young people), the main themes across both data sets were compared and synthesised. This enabled overlapping meta-themes to be identified which captured experiences and the usefulness of the cards from both the clinician and the young person's perspective. The results from the two topic areas of engagement and use of The AIM Cards will be reported on separately.

Results

Clinician Data

The analysis of the clinician data on engagement generated three main themes, each with sub-themes (see Table 1). The results propose engaging hard-to-reach young people is a tripartite process, firstly getting to know the young person, followed by encouraging them to attend sessions by offering them something meaningful and finally being a non-judgemental clinician who balances the need to demonstrate their humaneness by sharing their own experiences while also creating a boundaried therapeutic relationship. Each theme will be described by summarising each of the attendant sub-themes and by providing direct quotes from clinicians to illustrate these sub-themes, which are presented in italics along with clinician number, i.e. C1 for clinician 1.

Engagement

Engagement Theme 1: Who Are They?

All clinicians identified the importance of getting to know the young person as part of the engagement process. The first sub-theme **Getting A Bit Interested (1a)** relates to clinicians being curious about the young person outside of their difficulties or what brought them to the service by *"being OK about just talking about their (i.e, the young person's) day (C9),"* and allowing space in a session to learn about "*that young person's life (C7)."*

The sub-theme **"Meeting Them Where They Are At" (1b)** emphasised the need to consider each individual and where they might be in terms of their readiness to engage, with two clinicians using this exact phrase *(C4 & C8)*. Clinicians felt part of their role was to use a *"range of strategies, (C2)"*, such as agreeing with the young person to take *"five minutes of your time (C9)"* when they are not yet ready to meet for a whole session. Whereas one clinician stressed the need to continue to be *"re-evaluating and re-thinking (C10)"* when thinking about trying to meet with someone who might be reluctant to meet them.

Table 1. **Main Themes and Sub-themes related to Engagement, reported by Clinicians**

Theme and Sub-Theme	Two example quotations	Prevalence (No. of Transcripts)	Frequency (No. of times in data set)
1. Who are they?		**10**	**53**
a) Getting a bit interested	*"Finding out what their interests are" "Finding out more about them"*	6	12
b) Meeting them where they are at	*"Being perceptive to where they are at""Not kind of jumping straight into work"*	8	21
c) Put yourself in their shoes	*"How they view the world" "Really work out what is going on for them"*	10	20
2. Make it worth their while coming		**9**	**52**
a) Shared enjoyment	*"Finding an activity they like" "Doing things like baking and going for walks"*	6	12
b) Helping them to connect and share difficult feelings	*"Making sure they have a voice" "Build a certain level of rapport and trust"*	6	16
c) If I had the world at my disposal	*"There is a bit of pressure to have results quickly" "Slow them down"*	5	9
3. Their safe space to talk		**9**	**54**
a) Shared contained space	*"Somebody is going to listen, feel validated" "non-judgemental"*	6	15
b) Explain a purpose	*"Transparency" "Clear expectations on both parts"*	6	12
c) Giving a bit of yourself and working together	*"Yourself to be engaging" "Having a two way thing"*	9	27
d) Feel safe	*"Non-judgemental" "Genuineness"*	5	10

The final sub-theme **"Putting Yourself In Their Shoes (C4)" (1c),** expressed by all clinicians in their responses, relates to understanding and *"trying to get a perspective on what things are like through their eyes (C9).*" This sub-theme identifies the need to understand a young person within the context of their life.

Engagement Theme 2: Make It Worth Their While Coming

This second facet of engagement relates to services offering the young person something in order to make sure there are *"benefits to them (C2)."* The first sub-theme **Shared Enjoyment (2a)**, describes the clinician and young person spending time doing things together and *"finding the thing that fits for that young person and you can base it around their interests (C10)."* Part of this sub-theme was the idea of *"doing things alongside sitting down and talking (C4)"* and *"taking them outside of the office environment (C6)"* which results in *"getting the young person on board (C6)."*

The second sub-theme is **Helping Them To Connect And Share Difficult Feelings (2b),** which is another way to make it worth their while coming. This means clinicians expressed the need to facilitate *"building that rapport (C9)"* and to create an environment where the young person *"feels safe enough to disclose (C2),"* including the idea that *"reducing that power dynamic (C9)"* helps with this. The final sub-theme **If I Had The World At My Disposal** (2c) captures the challenges clinicians face whilst trying to facilitate this part of the engagement process, for example being free enough in their practice to think about all the different ways to encourage a young person to attend, reflecting that *"if I didn't have time constraints (C3)"* then they could put more time and energy finding the right approach and appropriate activities.

Engagement Theme 3: Their safe space

This final theme arose from the interview questions relating to the importance of the therapeutic relationship. The first sub-theme **A Shared Contained Space (3a),** Clinician 2 refers to *"establishing a unique rapport"* that enables *"honesty from the young person"* and Clinician 4 reported that young people should feel a *"sense of containment (C4)"* and it should be a "*relationship* *that is robust enough to withstand challenge."* The second sub-theme is **Explain A Purpose (3b)** by being transparent and *"clear about boundaries (C9),"* which provides purpose to the relationship between the young person and their worker.

The third sub-theme **Giving A bit Of Yourself (3c)** describes the importance of working together by the clinician showing the young person *"that you are human (C6)"* and that engaging someone is *"not just one sided (C9)."* Finally it is important to ensure the young person is made to **Feel Safe (3d).** This requires a clinician to be *"non- judgemental (C10)"* which then helps the young person to *"normalise their experience (C1)."* Five clinicians used the word non-judgemental which stresses its importance when fostering the relationship during the engagement process.

AIM Cards

The analysis of the clinician data relating to use of The AIM Cards generated four main themes, each with their own corresponding sub-themes (see Table 2). These results describe the cards as helpful in three main ways. Firstly, they create a space which helps the young person to communicate what's on their mind more easily. Secondly, they provide opportunity to identify young person lead goals which can be reviewed collaboratively and thirdly they add to clinical practice by helping the clinician to understand the young person and improve clinician confidence when sessions may feel unstructured. Finally clinicians reported some limitations relating to the cards. Specifically they identified being aware of the sensitive nature of the cards and the young person’s ability to read and understand what is written on them.

AIM Card Theme 1: They Empower A Young Person To Talk

All clinicians reported The AIM Cards as a helpful tool to support young people to communicate. The first sub-theme is **A Shift In Power; They Choose, They Decide (1a)**. Clinicians described that the structure of the AIM Card process enables the young person to decide what is important to them by being in the "*driving seat of their life (C10),*" *"being able to have quite a lot of control in the session (C7)"* and that the cards promote *"a real sense of ownership (C2)."*

Table 2. **Main Themes and Sub-themes related to the use of The AIM Cards, reported by Clinicians**

Theme and Sub-Theme	Example Quotations	Prevalence (No. of Transcripts)	Frequency (No. of times in data set)
1. They empower a young person to talk		**10**	
a) A shift in power; they choose, they decide	"Power balance gets shifted" "Inviting them to choose"	9	33
b) Helps them verbalise what is on their mind	"It gets their voice heard" "Might say things they would not verbally"	8	26
c) Other people have these difficulties too	"This is a tool we use with all young people, and then it isn't about them so much"	5	7
d) The presence of the cards creates a physical barrier between the young person and their difficulties	"physically hold them" "takes away from the intensity"	9	38
2. Creating a focus amongst chaos		**10**	
a) Making links	"They were able to see how they all linked together" "Said these are all linked to that"	7	11
b) Kids forget conversations but they remember cards	"Visual focus and reminder" "Giving the YP a prompt"	10	22
c) Creating a focus through specific goals	"Focuses your work" "Robust way to identify goals"	7	26
d) Ranking and reviewing collaboratively	"Reviewing progress" "When ranking...can see the most serious problem"	8	16
3. Adding to clinical practice		**10**	
a) Enables a better understanding	"covers a broad range of topics" "They are telling me what's important"	10	28
b) Identifying positives	"They are about the good things, really nice"	6	6
c) Clinician can think differently	"Allows you to go different directions and have different discussions"	7	22
d) Improving Clinician confidence	"Another way of checking your assessment is correct" "They help with my nerves"	7	15
4. Things to hold in mind		**8**	
a) They can be overwhelming	"Can be quite intense" "Overwhelming"	6	13
b) They can be hard to understand	"Young people find them difficult to understand" "Lack cognition"	8	14
c) They can be challenging to implement	"Narrow time frame for getting it done" "Additional work"	4	14

The second sub-theme **Helps them to Verbalise What Is On Their Mind (1b)** relates to clinicians believing that holding a card which describes difficulties is easier than verbally talking to a professional. For example, Clinician 2 said *"young people tell you stuff on the cards they wouldn't tell you in conversation"* and Clinician 3 referred to a young person who *"didn't really like speaking and so the cards did a lot of speaking for him."*

The third sub-theme, **Other People Have These Difficulties Too (1c)** refers to the acknowledgment that the cards were written for all young people. Clinician 3 said *"It's on the cards, everyone is getting asked these questions...they don't feel persecuted or interrogated"* and Clinician 8 said *"saying these are things we do with lots of young people, breaks down some of the barriers."*

The final sub-theme **The Presence Of The Cards Creates A Physical Barrier Between The Young Person And Their Difficulties (1d).** There was a sense from clinicians that the cards *"create a break between the intenseness of the session (C1).*" Clinician 10 referred to them as being like *"a third object in the room"* which they described as helping them to communicate their issues, saying *"something about not having to commit to the threat verbally, so not having to connect with the difficult feelings around that."*

AIM Card Theme 2: Creating a focus amongst chaos"

All clinicians referred to the idea that the cards were helpful to create structure when linking assessment and treatment planning. The first sub-theme **Making links (2a)** describes the cards as a way to help the young person understand their issues. Clinician 9 said the cards *"helps them link things together and see how one can contribute to another"* and Clinician 10 referred to the cards allowing them to show the young person an unhelpful behaviour cycle by *"creating a CBT hot cross bun, but using the cards."*

The second sub-theme **Kids Forget Conversations Yet They Remember Cards (2b)** is a reference to the cards being a *"visual reminder (C9)."* Two clinicians (C4 & C9) said they take photos of the cards and use the pictures in future sessions to remind young people of what they agreed to work on.

The third sub-theme **Creating A Focus Through Specific Goals (2c)** relates to the usefulness of the cards as a goal setting tool. Clinicians referred to the cards helping to create *"new set of goals and plans (C2)."* This method of goal setting helps to increase motivation with one clinician saying the cards *"gave us some focus (C6)"* and provided the reason as *"the young person is picking those cards themselves and so in that way they are more inclined to work on them."*

The final sub-theme **Ranking And Reviewing Collaboratively (2d)** refers to being able to rank and score the cards which facilitates a joint review process and create opportunities to follow up and measure change. Clinician 2 described the cards as useful as *"creates a bit of thread I suppose through the work."*

AIM Card Theme 3: Adding To Clinical Practice

This theme refers to the cards specific usefulness to a clinician. The first sub-theme **Enables A Better Understanding (3a)** considers the cards helpful for the clinician to *" get a better perspective (C2)"* on what is going on for a young person. The sub-theme **Identify Positives (3b)** considers the role the strength cards play which means clinicians can spend time exploring what is going well for that young person. Clinician 7 said *"I always ask them which ones they want to be working on and the positives as well, we always want to be working on the positives."*

The third sub-theme **Clinicians Can Think Differently (3c)** relates to the cards introducing an alternative perspective. Clinician 3 described using the cards means the assessment *"comes at a different angle."* There is also a sense that the cards can be a *"different way of chatting (C7)"* and create a *"different structure to the formulation process (C4)."* Finally, the fourth sub-theme **Improving Clinician Confidence (3d)** identifies the cards as providing comfort for the clinician. Clinician 10 said there is *"something quite comforting about knowing actually this is where we are going to start"* and Clinician 1 said *"it gives you a bit of confidence as a therapist."*

AIM Card Theme 4: Things To Hold In Mind

The final theme refers to some of challenges of using the cards, or when they might not be helpful. The first sub-theme **They Can Be Overwhelming (4a)** relates to the large number of cards, many of which name sensitive issues. Clinician 3 said *"young people might feel overloaded"* and Clinician 4 said the timing of the cards was important by reflecting *"you have to be in quite a calm place to be able to think through and consider it."* The second sub-theme **They Can Be Hard To Understand (4b)** highlights a required level of cognitive functioning. Clinician 9 said if a young person had *"literacy or learning needs, it would be a challenge"* and Clinician 2 said *"make sure they understand what the card is saying."*

The final sub-theme **They Can Be Challenging To Implement (4c)** relates to the cards being an additional burden for clinicians and a sense that they conflict with service demands. *"I have certain things I have to say to cover myself"* was something a Clinician 3 said when talking about how using The AIM Cards at assessment creates more work for him. Clinician 2 said *"the only drawback is it takes time"* and they felt using the cards *"might not be feasible"* if the pressures of work become too much.

Young Person Data

Engagement

The analysis of the Young Person data on engagement generated two main themes, each with sub-themes (see Table 3). The first theme relates to what clinicians can do to support engagement. Young people identified qualities and approaches clinicians should use, speaking to young people in accessible language, not being so formal and being a fun person to be around. Additionally clinicians should create a space where the young person feels comfortable to speak to them and show their understanding whilst also being able to offer advice without telling the young person what to do. The second theme identifies the service factors that are important, offering the young person something to

Table 3. **Main Themes and Sub-themes related to Engagement, reported by young people**

Theme and Sub-Theme	Example quotations	Prevalence (No. of Transcripts)	Frequency (No. of times in data set)
1. What Clinicians Can Do To Engage YP		**8**	
d) Be on my level	*"Not be so formal" "Engaged with the youth"*	8	21
e) Be fun to be around	*"Be friendly" "Enthusiastic" "YOT workers need a lot of tolerance"*	7	22
f) Be someone I can talk to	*"That they understand what the YP is going through" "Get into their head"*	7	29
g) Be helpful	*"little words of wisdom" "Talking to you every lesson and that"*	5	16
2. What Services Can Do To Engage YP		**8**	
d) Offer me something	*“Offering something, free food” “Give them money”*	5	10
e) Have freedom and flexibility	*“I would ask them what is a convenient time for you” “Like going to the park”*	4	8
f) Doing rather than talking	*“Music, games” “Not just talking about stuff”*	5	9

give up their time, flexibility within the service for clinicians to be able to meet at a place that feels comfortable for the young person and spending time doing activities rather than just talking.

Engagement Theme 1: What Clinicians Can Do To Engage Young People

The first sub-theme **Be On My Level (1a)** relates to clinicians interacting with young people in a way that shows *"like they can relate to you (YP 1)."* This involves *"talking to them like they would (YP 7)"* and *"think about stuff which makes the young person laugh (YP 3)."* This sub-theme also identifies the clinician can show they relate by being *"open with the youth (YP 2)"* and two young people (YP 7 & 8) said they thought it would be helpful if the clinician had experienced similar experiences and to share them in order to make the young person feel more comfortable.

The second sub-theme **Be Fun To Be Around (1b)** is about the experience the young person has with their worker. Results identify personality characteristics that make it more likely the young person will want to spend time with them *"they need to be gentle (YP 4)",* and *"like happy (YP 7)."* What is also important is the approach should change as it *"depends on what the young person likes (YP 1)".*

The third sub-theme **Be Someone I Can Talk To (1c)** is about creating a space where the young person feels able to talk to the clinician and feels understood. This occurs by the clinician making an effort to *"build a relationship...so like going out with them and talking gradually (YP 4)"* and being able to show that they *"understand what the young person is trying to get across (YP 8)."* Two young people (YP 1 & 8) said they thought it is important for the clinician not to share information with other people.

Finally, the fourth sub-theme **Be Helpful (1d)** relates young people wanting support and advice, as described by Young Person 2 who said *"you want other people's opinion as well to make decisions."* Results showed clinicians should give some advice, *but "not just saying - you should do that, you should do this, they should actually break it down and help you (YP 2)"* with one young person (YP 7) describing this can happen by the clinician giving *"various selections of things to go about it,"* referring to solving a problem.

Engagement Theme 2: What Services Can Do To Engage Young People

The first sub-theme **Offer Me Something (2a)** describes the need to acknowledge that you might not want to be there. One young person (YP 7) reported that it would help if services offer young people *"something that people enjoy, to bring them in"* which could be something concrete, for example *"a little snack."* Another young person said "*rewards…but not even just like physical reward, just like an emotion (YP 8)"* which was reference to the opportunity to enable someone to express some difficult emotions as something that would be helpful to them and so might mean they come back.

The second sub-theme **For There To Be Some Freedom and Flexibility (2b)** relates to the service structure. Two young people commented on service design saying you should think about *"what type of kids are coming (YP 1)"* and there should be *"different kinds of services for people, so different people with the same issues can mix…it might help them (YP 4)."* There should be freedom for where and when young people meet their worker with one young person (YP 5) saying *"maybe a café, or walk around the park"* and elaborated on this by saying *"when you are out you can breathe a bit more."*

The final sub-theme **Doing Rather Than Talking (2c)** considers what should happen during a session. Five young people thought it was important to do different things "*rather than sitting face to face and being thrown loads of questions at…I think just making it feel more relaxed (YP 5)"* and when this was questioned further she reported this could be *"playing a game or something."* Other young people reported *"activities (YP 6)"*, *"fun games, or good music (YP 7)"* and *"I would be showing them photos and everything (YP 3)."* For one young person it was important that people heard other's stories *"Do a programme where I would tell them what I am going through in YOT and how I obviously overcame it (YP 2)."*

AIM Cards

The analysis of the young person data relating to use of The AIM Cards generated three main themes, each with their own corresponding sub-themes (see Table 4). All main themes were reported by all 8 young people, with various distributions amongst the sub-themes. The first theme describes the cards as a useful tool to support young people to work out what is going on for them, specifically the cards being able to break down their issues and explain what difficulties look like. Also within this theme was an acknowledgment that the cards are not always helpful. The second theme describes the cards as useful when goal setting and problem solving. In particular their collaborative and young person led approach means the cards support the young person to set their own goals and place ownership on them to solve their problems. The third theme relates to the cards as facilitators of communication. The visual nature of the cards appears to make it easier for young people to digest information about their issues. The physical presence of the cards means this information can be communicated to their worker more easily (and often non-verbally) which in turn means the young person feels more understood by their worker.

AIM Card Theme 1: The Cards Help Me Work Out What Is Going On

This theme relates to the cards as useful to the young person to reflect and think about what they are experiencing, The first sub-theme **Help Me Understand Who I Am And Give Me Space To Think About My Life (1a)** was reported by all 8 young people. It identifies the use of cards as a process which involves thinking and reflection *"It helped me realise what is actually going on in my life and what is relevant (YP 1)"* and *"You can really think about how badly it is affecting you (YP 5)."* This process of reflection was related to both behaviour *"I don't really think before crimes and it made me think sometimes before I do things"* and identity *"it actually helps you understand who you actually are (YP 2)."* Within this sub-theme was also reports of how these difficulties *"wouldn't even enter my head (YP 3)"* without the cards *"because I never really thought about it but when I saw it there I had to think about it (YP 1)."*

Table 4. **Main Themes and Sub-themes related to the use of The AIM Cards, reported by Young People**

Theme and Sub-Theme	Example Quotations	Prevalence (No. of Transcripts)	Frequency (No. of times in data set)
1. The cards help me work out what is going on for me		**8**	
e) Help me understand who I am and give me space to think	*"understand yourself" "You actually think about it with the cards there"*	8	54
f) They break my issues down	*"It really broke it down" "On the cards you are only seeing it on like one or few cards"*	5	16
g) They explain my difficulties and teach me things	*"A lot was explained on them" "They learnt me and taught me stuff"*	6	34
h) They are not always helpful	*"There were barely any relevant cards to me so it didn't help"*	6	13
2. They give me more control over my life		**8**	
e) Help me set my own goals	*"Playing a game of goal setting" "Its good the young person can pick out the card"*	7	34
f) Taught me I can solve my own problems	*"Using The AIM Cards you can start to get your life back in control" "you kind of own it"*	5	40
3. Playing with the cards is easier than talking		**8**	
e) You breathe them in more than words	*"They are print on your head, you can just picture it" "It just sticks in your mind"*	7	24
f) They make me feel comfortable to talk	*"It was right there, coming out of my head and sometimes you don't have to word it"*	5	27
g) They help my worker understand me	*"So she can know what's wrong with me" "She knows all about me cause of those cards"*	7	31

The second sub-theme **They Break My Issues Down (1b)** describes the cards as *"much easier than heavy going thinking (YP 5)"* as they are *"not confusing for the user, it's just one simple question and you can just put them into categories (YP 3)."* Young people reported that by reading the cards *"it's more clear (YP 2)," "you realise it's not such a big thing (YP 7)"* and *"you are breaking down the issues and focusing on each one, which I think is helpful (YP 5)."* Two young people (YP 2 & YP 6) referred to the cards separating strengths and difficulties as helpful.

The third sub-theme **They Explain My Difficulties And Teach Me Things (1c)** describes the cards as helping the young person to understand their issues by *"explaining the definition of it (YP 6)"* and *"It would explain it more to me the difficulties and stuff (YP 7)."* Young people were referring to the written explanations on each card *"It's like anger or something and then it says different things like how you get angry, then when you think about it I think the description it gives you underneath is helpful cause you think, oh yeah, I got angry (YP 7)."* Alongside explaining difficulties three young people reported the cards *"teach you good things (YP 3)," "cause they are telling you about what choices you can make and not (YP 2)"* and *"the cards say that's why I got angry (YP 7)."*

The fourth sub-theme **The Cards Were Not Always Helpful (1d)** acknowledges that *"sometimes it has not helped (YP 7)"* Six young people made comments about when the cards were not helpful, or made little difference. Young people gave different reasons, such as *"for the little things it's useful but for the bigger things it's not that useful (YP 7)"* and *"The thing is the stuff on the cards I probably would have told him so it might not have made a difference (YP 6)."* Other comments made reference to some caution when using the cards with one young person saying *"they might make someone upset (YP 2)"* and *"I had a lot of trouble to think does this mean with family or with friends (YP 5)."*

AIM Card Theme 2: They Give Me Control Over My Life

This theme is divided into two parts related to the young person leading the goal setting process and solving problems. The first sub-theme **Helped me to set my own goals (2a)** describes how using the cards is like *"playing a game of goals (YP 5)"* where the young person chooses *"cause it ain't my YOT worker assuming what is best for me, it's me choosing what is best for me (YP 3)."*

One young person reported *"it was helpful for me to see what...what I actually care about in my life and what my motives and goals are (YP 1)"* and four young people referred to the helpfulness of the ratings, for example *"numbers as really important (YP 4),* and *"like a really clear 0-4, it's like all the numbers is an easy way for you to put where you are on the scale, easier to set yourself goals (YP 5).*

The second sub-theme **Taught me I can solve my own problems (2b)** refers to young people reporting the cards helping them to make choices and decisions. One young person (YP 8) said *"before I had the cards and the mentor I would go around doing bad stuff, now I have other ways to deal with it"* and then explained *"I understood that breaking things is not the way to release my anger, like breaking things or hurting others so I would just talk to my mentor at school, so I found ways to calm myself."* There was a sense from young people that the cards influenced their ability to solve their problems and make some changes *"The cards say that is why I got angry and then you try and resolve around it (YP 7)"* and *"I have made a few changes in my life because of the cards, you know (YP 2)."*

AIM Card Theme 3: Playing With The Cards Is Easier Than Just Talking

This theme is more focused on the cards as something which helps foster communication between the young person and the worker. The first sub-theme **You breathe them in more than words (3a)** specifically relates to the visual presentation of the cards as a substitute to talking. It was helpful to see things and *"having them all out in front of you (YP 6)".* Young people described the cards as better than a clinician telling or asking you something because *"it's written down (YP 5)"* and *"instead of someone to tell you then I think that's its more helpful like I would rather read something instead of the person reading or telling me something (YP 7)."* Also within this theme was the benefit of reading through the cards yourself with one person saying *"it's better reading them cause then you can picture them in your head (YP 3)"* and another explaining *"you are going to read it from your point of you, how you understand it (YP 7)."*

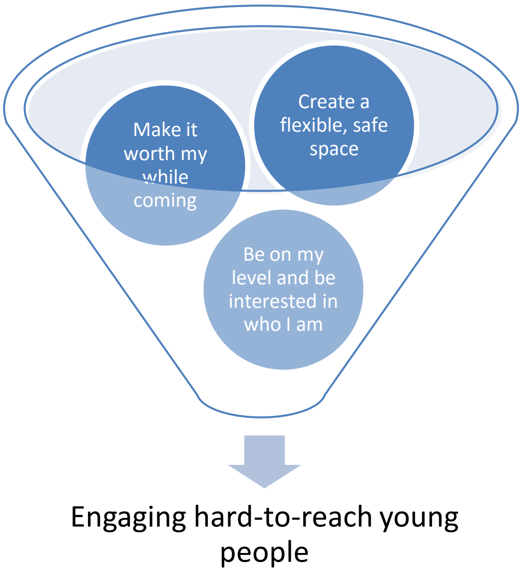
The second theme **They Make Me Feel Comfortable To Talk (3b)** describes the cards as helpful for young people to communicate to their worker what is on their mind without having to speak, *"I think it's useful if I had got a problem and I don't want to talk about or say anything about* *it....can you just bring the cards again and we can do that (YP 1)."* One young person said *"they have personal questions on but they are easier to talk about on the cards than just saying it through your voice (YP 8)"* and other said *"Maybe I would tell him eventually but the cards made me tell him quicker (YP 6)."*

The final sub-theme **They Help The Worker Understand Me (3c)** describes the cards as helpful for the worker to understand what the young person is trying to communicate with one person saying *"she would know what to talk to me about, and then she can help me and advise me...because of the cards, if she hadn't she would have made assumptions and that YP 1)."* Young people described the cards lead their worker to know more about them because *"my worker didn't realise until I showed her the cards (YP 4)"* and *"the worker could understand what I was saying and the emotions that I feel (YP 8)".* When these ideas were explored one young person said *"we talked about why I chose these cards and then it's also a way to like get you going on to a conversation and advice to be given to see what you need to work on (YP 5)"*

Discussion

Both young people and clinicians reported similar factors as important when engaging hard-to-reach young people. These similarities enabled the themes or sub-themes from all interviews to be encapsulated into a model that identifies three broad areas of engagement (see figure 1). The first component of engagement, *Be On My Level And Interested In Who I am*, is developed from the clinician engagement theme 'Who are they?' and the young people sub theme 'Be on my level.' This aspect of engagement identifies the importance of getting to know the young person and hearing their experiences in a way that is related to them. The second component *Make It Worth My While Coming*, integrates the clinician theme 'Make it worth my while coming' and the young people sub-themes relating to clinicians being 'Be fun to be around' and to 'Be helpful' and services to 'Offer me something' and 'Doing rather than talking.' This aspect is about recognising the young person's need to be connected with in a way that is credible and rewarding to them, which will mean they are willing to give up their time to attend sessions. The final component, *Create A Flexible Safe Space*, is based on the clinician theme 'Their safe space to talk' and the young people sub-themes 'Be someone I can talk to' and 'For there to be freedom and flexibility.' This aspect relates to a service making a young person feel comfortable by adapting to individual needs.

Figure 1. **A Model To Engage Hard-To-Reach Young People**



This tripartite model emerges from a close reading of the results in this study and is consistent with wider literature. *Be On My Level And Be Interested In Who I am* are components that emphasise the importance of clinicians taking the time to get to know a young person and become interested in who they are as people outside of their difficulties. Similarly, in a qualitative study of young people with psychosis, service-users described the importance of clinicians being interested in them as a person (Kapur et al., 2014), while Green et al. (2014) interviewed adults with a diagnosis of psychosis about their experiences of support when they were adolescents, and these adults retrospectively identified how important it was for clinicians of being aware of what is going on for a young person beyond reasons for referral.

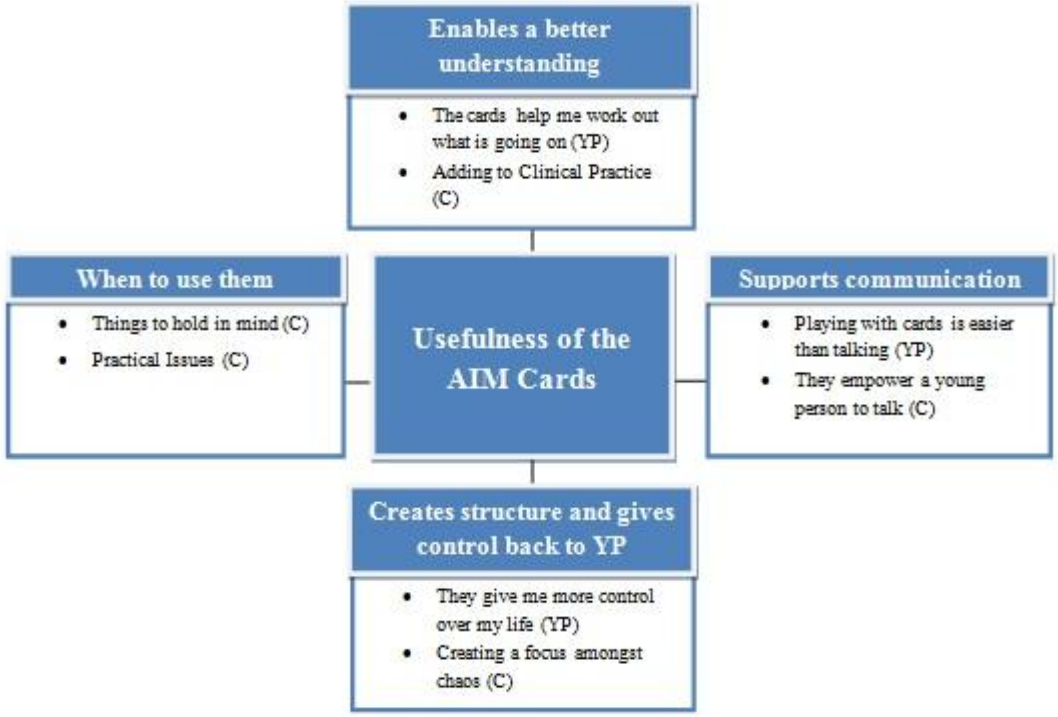
The second component, *Make It Worth My While Coming* recognises young people may not always choose to attend sessions over other things that may find enjoyable. What was most interesting from the young people interviews was the idea that clinicians need to be mindful of offering them something, which could either be concrete such as free food, or it could be something more intangible such as advice, or helping them to share difficult feelings. Watt and Dadds (2007) identified the need to offer client incentives. The practice of offering rewards and incentives for desired behaviour is not new. What the findings from this study imply is that the introduction of client incentives may involve a range of different things, and that the young people reported how important it was for them to receive something tangible from clinicians for participating in mental health services, something that goes beyond the possible emotional and psychological benefits of participation.

Finally, *Create A Flexible, Safe Space* relates to both service structure and the therapeutic relationship between the worker and the young person, which was reported as important by both clinicians and young people. For young people it was related to building trust and ensuring confidentiality. For clinicians it was important to be transparent, set boundaries and show ’humaneness’. Additionally, the interview reports from clinicians and young people suggested that this space needed to be flexible with approaches being matched to individual needs. This is supported by previous research which clearly states services need to be flexible when trying to support hard-to-reach young people (Pycroft et al., 2015; Dembo et al., 2011). The model presented here is not linear, recognising that clinicians need to pay attention to each component at different times and that part of one aspect links to another. For example, finding out about who young people are includes finding out what they would like a service to offer them in order to make it worth their while.

Overall, young people and clinician experiences of The AIM Cards were comparable to each other. Every interviewee had some positive experience with the cards, whilst recognising their limitations. A synthesis of the findings has been illustrated in a proposed AIM Card Usefulness Model (see figure 2). This model puts forward the contributions of The AIM Cards to the assessment process based on the themes identified by both young people and clinicians. Firstly, they *Enable A Better Understanding*, which is based on the young person's theme 'Help me work out what is going on' and the clinician theme 'Adding to clinical practice'. Secondly they, *Support Communication*, by offering the possibility of assessment through non-verbal methods which is based on the young person theme 'Playing with cards is easier than talking' and the clinician theme 'Empower a young person to talk.'

Thirdly they, *Create Structure And Give Control Back To The Young Person* which is based on the young person theme 'Give me more control over my life' and clinician theme ' Creating a focus amongst chaos'. The fourth element considers when they might not be helpful, and includes practical issues of using the cards, drawing on comments made during the interviews and the clinician theme 'Things to hold in mind'.

Figure 2. **AIM Cards Usefulness Model**



The theme *Enables A Better Understanding* is an aspect of the cards which encompasses both clinician and young people's understanding the issues that the young people are struggling with. Dakof et al. (2001) found engagement with hard-to-reach young people was supported if the young person perceived themselves to have issues they wanted help with. Young people in this study reflected these cards gave them space to think and learn about who they are and what they wanted from life, and that in turn fostered some behavioural changes. This is a surprising finding as the cards were developed from a clinician rated symptom checklist, not a goal or session-goal measure. Importantly improved understanding was not limited to young people, with the cards supporting clinicians to understand the young person and improve their confidence as a therapist. Previous research has shown how important it is for young people to feel understood by their worker (Pycroft et al., 2015; Golden & McElvaney, 2014) and the role clinician confidence plays in promoting engagement with hard-to-reach young people (Watt & Dadds, 2007).

According to both young people and clinicians the second distinct contribution The AIM Cards make is their ability to *Support Communication*, which occurs through their physical presence in the room. This 'third object' is reported by both clinicians and young people as a visual representation of issues and means a young person can communicate without speaking. This externalisation of the problem is similar to Narrative Therapy principles which identify the importance of seeing someone as separate to their 'problems' (White & Morgan, 2006). All young people reported the cards made it easier for them by deciding what to choose to talk about without having to respond to questions. Both young people and clinicians commented on how important the language on the cards is. Unlike symptom checklists, which provide lists of problematic or pathological thoughts, feelings and behaviours, the cards provide situation specific examples of behaviour. A common experience amongst the interviewee's was the idea that young people wouldn't have told their worker things if the cards hadn't given them the prompt, and more importantly help provide the right words to explain something. This may relate to research which documents that young people are still in the process of developing emotional language in order to be able communicate what they are experiencing (Cole et al., 2003; Greenberg, 2002; Shultz et al., 2003).

Thirdly The AIM Cards contribute as they *Create Structure And Give Back Control to Young People*. All young people said the cards made them feel more in control and all clinicians reported the cards provide a focus to what is commonly a challenging assessment of multiple needs. The cards facilitate goal setting which is decided entirely by the young person, giving them power to choose what support they would like. Golden and McElvaney (2014) interviewed service users with complex needs who reported being given control and choice is one of the most important things when trying to engage them. The cards appear to promote a young-person led goal-setting process. Interviewees describe the cards as helping the young person to make links and formulate for themselves, thereby empowering them with the understanding they can solve their own problems.

Finally and perhaps most importantly, interviewee's were not shy in sharing their experiences when the cards were not helpful. The model is not proposing the cards are an assessment tool which suits everyone and should be used at any time. For some young people, the process of using the cards may be too overwhelming, either due to difficulties in understanding the cards at an intellectual level or the number of cards to pick from. It may be that if they are not in a place where they want to recognise their issues, and in these circumstances it is likely that the usefulness of The AIM Cards as a goal-setting tool becomes more challenging and less relevant. Clinicians reported the challenges of implementing the cards, in terms of having to adhere to other assessment procedures. Therefore whilst these cards might be clinically helpful, it would be important to consider how they can fit with service delivery in order to ensure clinicians feel able to use them.

The AIM Cards Usefulness Model puts forward the cards as a tool which facilitates the process of engaging and assessing hard-to-reach young people. The findings show the cards call to attention the complexity and sophistication of the engagement and assessment process when working clinically with this population. The use of the cards not only promotes the understanding of young people and their problems, which is one of the major service goals during initial contacts, but also does not reduce that young person to simply a checklist of behaviours. This places the cards as more than an additional assessment measure which can be added to a clinician's creative toolbox. They facilitate a process which empowers both the young person and the clinician to recognise what is important and communicate this to each other in order to set young-person led goals.

One of the key aims of the proposed model of engagement is to put forward descriptive components of how to promote engagement based on young people and clinician accounts that will have clinical applicability. It also attempts to consolidate research findings into an ‘easy to read’ format which can be accessed by busy clinicians hoping to reach out to young people. In doing so, it aims to capture the complexity of engagement, while providing a framework that is easily digestible and which outlines the interplay of different strategies that will facilitate engagement with this population.

Further clinical implications can be drawn from the findings of this study. Engagement has again shown to be an important concept when supporting hard-to-reach young people. The findings support the wider literature which calls for service design to allow time for clinicians to get to know a young person, which may or may not be related to referral reason. Services should provide resources for clinicians to be creative and flexible and offer the young person something in exchange for them giving up their time to attend sessions. Specifically, the findings from this study place importance on the clinician prioritising the need to create a space which feels 'safe' to the young person. This is based on balancing the need to enforce appropriate transparent boundaries whilst showing a level of humanness.

Clinical implications for The AIM Cards identify the cards as one potential tool to foster this engagement process. Clinically they can be a practical tool which promotes a young person led assessment. This structure provides a young person the opportunity to formulate, problem solve and set goals in a way that gives them power and control of their life, which in turn might give them incentive to attend sessions. Another important clinical implication of the cards is their usefulness in helping to understand the young person and help communication between the young person and their worker, which can help the engagement process. Finally, on a practical level the cards are easy to use and can be carried around by the worker to different locations (which is beneficial whilst supporting young people in an outreach capacity). This physical presence in the room can therefore create a collaborative structure to a session and help focus the intervention in what might be a complex clinical picture.

While these qualitative findings suggest that The AIM Cards are a promising assessment tool with hard to reach young people and one that facilitates engagement, there are several limitations to the study. Firstly, there are some limitations to the generalizability of the results. Participants were only recruited from two different adolescent services and it should be acknowledged that it was an opportunistic sample which may include some bias towards a specific hard-to-reach population. This study aimed to explore the view's of hard-to-reach young people, however by restricting recruitment to young people who have used the cards it only heard from individuals who have engaged with the service. Whilst this is also a common problem amongst the wider literature base it important to think creatively to try and hear from those young people who did not want to engage with the cards. This could be done by contacting young people who are no longer being supported who may have rejected the cards during their assessment process. Additionally, presenting problems of each individual are not known as the services supporting these young people are designed to support a complex presentation and therefore specific diagnostic labels are not recorded. Whilst this raises questions of generalisability this is one of the challenges when trying to report a complex clinical picture in a research friendly format. Secondly this project was designed to explore the usefulness of a tool which is in the process of being introduced to services. This means the experiences of interviewees is based on having used The AIM Cards with a small sample of young people (in total clinicians used them with 33 different young people), and therefore more research needs to completed before any substantial claims about the usefulness of The AIM Cards can be made. Thirdly only individuals who have used and engaged (to some extent) with The AIM Cards were interviewed therefore biasing the sample towards young people who attended sessions and therefore may have failed to capture those harder-to-reach and not accessing services.

However, whilst acknowledging these limitations, Williams and Morrow (2009) refer to considering ‘trustworthiness’ when thinking about the robustness of findings from qualitative research and put forward evaluation criteria. Firstly, they refer to the integrity of data which means ensuring data is rich in quality and for researchers to be transparent about their methodology and analysis. This was the rationale for involving both young people and clinicians, and for analyzing the data by identifying broad themes with multiple sub-themes in order to capture the subtle differences between individual experiences. Secondly, they ask for qualitative researchers to acknowledge subjectivity exits and therefore a risk of bias is always present. The use of an external auditor to discuss and reflect on developed themes during the analysis stage also helped to separate researcher interpretation from participant meaning. Thirdly, they propose study findings should be clearly presented. This project has aimed to present its findings with clarity with the use of visual models. It is hoped these models can be shown to the people whom they affect the most, young people and clinicians. The discussion relating to where the findings fit with theory and previous empirical research has also aimed to make this project a piece of ‘trustworthy’ research, which can lead to important clinical implications.

This study aimed to explore the engagement and assessment process when supporting hard-to-reach young people through the use of a recently developed assessment tool, The AIM Cards. Based on qualitative themes from reports by clinicians and young people, that is from those providing and receiving support, a succinct model of engagement for working with hard-to-reach young people has been proposed. The findings suggest that engagement is complex, is a process which takes time, and may often rely on creative thinking and individual adaptation by services. Young people in the study have clearly expressed their views regarding what clinicians and services can do to make it more likely for them to want to participate in mental health services. Day (2007) proposes the importance of involving service users in research and then making it a priority to incorporate findings into service development. It is the duty of commissioners and professionals to listen to these voices and develop service models which fit with these recommendations.

Finally, the results of this study suggest that The AIM Cards show promise as helpful tool to promote engagement and to facilitate assessment. The accounts from young people and clinicians suggest that The AIM Cards may offer an innovative way of supporting young people to communicate their needs and recognise how they may struggle to verbally articulate their difficulties. In contrast to the categorical format of a symptom checklist, a relative strength of The AIM Cards is their format and manner of assessment provide clinicians and services with the opportunity to identify and explore an individual's specific problems with reference to situational examples. The usefulness of the engagement model proposed and The AIM Cards themselves should be explored further and replicated in future studies. Specifically if the young people's experiences are replicated on larger and more representative samples of hard-to-reach adolescents, then The AIM Cards may be a worthwhile option to help understand young people’s adjustment and difficulties, and to make a positive difference to their experience of mental health support.

References

Ahuja, A., & Williams, R. (2010). Telling stories: learning from patients' and families' experiences of specialist child and adolescent mental health services. *International Journal of Consumer Studies*, *34,* 603 - 609.

Assan, B., Burchell, A., Coffey S., Weir, J., Hammond, S., & Woods, B. (2008). The Adolescent Intensive Management Team: an intensive outreach mental health service for high-risk adolescents. *Child and Adolescent Psychiatry, 16*, 423 - 426. doi:10.1080/10398560801886021

Barker, C. & Pistrang, N. (2005). Quality criteria under methodological pluralism: implications for doing and evaluating research. *American Journal of Community Psychology, 35*, 201-212.

Barker, C. & Pistrang, N. (2010). Scientific, practical and personal decisions in selecting qualitative methods. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds), *Developing and Delivering Practice-Based Evidence* (pp.65-89). Chichester, England: Wiley. doi:10.1002/9780470687994.ch3

Bateman, A., & Fonagay, P. (2012). *The Handbook of Mentalizing in Mental Health Practice*. Virginia, 77 -101.

Bevington, D., Fuggle., & Fonagy, P. (2015). Applying attachment theory to effective practice with hard-to-reach youth: The AMBIT Approach. *Attachment & Human Development*, *17,* 2, 157-174, doi: 10.1080/14616734.2015.1006385.

Bevington, D., Fuggle, P., Fonagy, P., Target, M., & Asen, E. (2013). Innovations in Practice: Adolescent Mentalization-Based Integrative Therapy (AMBIT) - a new integrated approach to working with the most complex mental health needs. Child and Adolescent Mental Health, 18, 46 - 51Braun, V. & Ckarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Burns, J., & Birrell, E. (2014). Enhancing early engagement with mental health services by young people. *Psychology Research And Behaviour Management, 7,* 303 - 312.

Cole PM, Teti LO, Zahn-Waxler C (2003) Mutual emotion regulation and the stability of conduct problems between preschool and early school age. *Developmental Psychopatholgy*, 15, 1–18. doi:10.1017/S0954 579403000014

Dakof, G., Tejeda, M., & Liddle, H. (2001). Predictors of engagement in adolescent drug abuse treatment. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 274 - 281.

Day, Crispin. (2007). Children's and young people's involvement and participation in mental health care. *Child and Adolescent Mental Health,* 13, 2 – 8. doi:10.1111/j.1475-3588.2007.00462.x

Dembo, R., Gulledge, L., Robinson, R., & Winters, K. (2011). Enrolling and engaging high-risk youths and families in community-based brief intervention services. *Journal of Child and Adolescent Substance Abuse, 20,* 330 - 350. doi: 10.1080/1067828X.2011.598837

Department of Health, National Health Service. (2012). *Liberating the NHS, no decision about me, without me*. (2012). (DOH Publication No. 18444). Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf

Fuggle, F., Bevington, D., Cracknell, L., Hanley, J., Hare, S., Lincoln, J. . . . Zlotowitz, S. (2015). The Adolescent Mentalization-Based Integrative Treatment (AMBIT) Approach to outcome evaluation and manualisation: Adopting A Learning Organisation Approach. *Clinical Child Psychology And Psychiatry, 3,* 419 - 435.

Elliot, R. (2010). Psychotherapy change process research: realising the promise, *Psychotherapy Research*, *20*, 123-135. doi:10.1080/10503300903470743

Green, C., Wisdom, J., Wolfe L., & Firemark, A. (2012). Engaging youths with serious mental illness in treatment: STARS study consumer recommendations. *Psychiatric Rehabilitation Journal, 35,* 360-368.

Greenberg, L. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: American Psychological Association

Golden, M., & McElvaney, (2015). A bit more understanding: Young adults' views of mental health services. *Children and Youth Services Review, 51,* 1-9.

Holmqvist, R., Philips, B., & Barkham, M. (2015). Developing practice-based evidence: benefits, challenges, and tensions. *Psychotherapy Research, 25*, 20 - 31. doi;10.1080/10503307.201.861093.

Kapur, P., Hayes, D., Waddingham, R., Hillman, S., Deighton, J., & Midgley, N. (2014). The experience of engaging with mental health services among young people who hear voices and their families: a mixed methods exploratory study. *BMC Health Services Research,14,* 527 - 536.

Kessler, R., McLaughlin, K., Green, J.,,,,,,& Williams, D. (2010). Childhood adversities and adult psychopathology in the WHO world mental health surveys. *British Journal of Psychiatry, 5,* 378 - 385.

O,Brien, A., Fahmy, R., & Singh, S. (2009). Disengagement from mental health services: a literature review. *Society Of Psychiatry and Psychiatric Epidemiology, 44*, 558 - 568.

Perez, R., Ezpeleta, L., & Domenech, Jose. (2007). Features associated with non-participation and drop out by socially-at-risk children and adolescents in mental-health epidemiological studies. *Social Psychiatry Epidemiology, 42*, 251-258.

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. *British Journal of Social Work, 45*, 422-439. doi:10.1093/bjsw/bct089

Ross, E., Vingilis, E., & Ousuch, E. (2012). An engagement and access model for healthcare delivery to adolescents with mood and anxiety concerns. *Early Intervention in Psychiatry, 6*, 97 - 105.

Schley, C., Yuen, K., Fletcher, K., & Radovini. (2012). Does engagement with an intensive outreach service predict treatment outcomes in 'high-risk' youth? *Early Intervention in Psychiatry, 6,* 176-184.

Schultz D, Izard CE, Bear G (2004) Children’s emotion processing: relations to emotionality and aggression. *Developmental Psychopathology* 16,371–387. doi:10.1017/S0954579404044566

Target, M., Fonagy, P., Schneider, T., Ensink, K., & Janes, K. (2000). *Raters' Manual for the Hampstead Child Adaptation Measure (HCAM)*. London: University College London and the Anna Freud Centre.

Tindell, R., Francey, S., & Hamilton, B. (2015). Factors influencing engagement with case managers: perspectives of young people with a diagnosis of first episode psychosis. *International Journal of Mental Health Nursing*, *24,* 295 - 303.

Watt, B., & Dadds, M. (2007). Facilitating and treatment attendance in child and adolescent mental health services: a community study. *Clinical Child Psychology and Psychiatry, 12,* 105 - 116.

Westin, A., Barksdale, C., & Stephan, S., (2014). The effect of waiting time on youth engagement to evidence based treatments. *Community Mental Health Journal, 50*, 221-228

White, M., & Morgan, A. (2006). *Narrative therapy with children and their parents*. Australia: Dulwich Centre publications.

Williams, E., & Morrow, S. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research, 19,* 576 - 582. doi: 10.1080/10503300802702113.

Part 3

Critical Appraisal

Introduction

This critical appraisal is a reflection on the research journey I have been on whilst designing and carrying out the research project reported in Part 2 of this Thesis. It is presented as a chronological narrative, with reference to theoretical literature when appropriate. The main focus of the critical appraisal is to examine the implementation of this practice-based evidence based research. This will include learning process and challenges which occurred whilst setting up this project, followed by reflections and skill development which arose during the data collection and analysis stage. Finally personal reflections regarding the project are reported, along with implications for future research.

Stage 1: Implementing Evaluation Of The AIM Cards: Capturing 'Real Life' Research

At the start of this research journey I knew I wanted to focus my project on providing some helpful clinical applications for hard-to-reach young people. From my previous clinical experience with this population group, I knew that research is limited and so the aim was to contribute to the literature in a meaningful way. Once I decided on a target group I considered carefully where I could contribute. My initial thoughts took me to thinking about a tool I used prior to clinical training, the AMBIT AIM Cards. I thought about how positive my colleagues and the young people had been about their usefulness in some cases and so I set about to try and capture 'real life' research related to these cards. This method of carrying out research is referred to as practice-based evidence and enables studies to take place within the parameters of routine clinical practice (Barkham & Mellor-Clark, 2003). I also thought about its advantages as an approach to use when carrying out research with hard-to-reach young people, as this is a population with complex needs who are often challenging to engage both clinically (Lamb et al., 2012) and in research (Tourangeau et al., 2014).

Having decided upon the area and focus of the research, I had the task of developing a research project that both conformed to the academic standards expected from a DClinPsy thesis while capturing and synthesising data that was based in ongoing clinical practice using The AIM Cards. Given that services had only recently begun to use The AIM Cards in their assessment protocol, that the use of this measure was neither consistently applied nor widespread, the use of qualitative methods seemed the most appropriate to begin to understand the clinical utility of this measure while providing space to explore hypotheses and capture subtle processes related to the cards (Pope et al., 2000). Choosing qualitative methods has implications both clinically and logistically (Pistrang & Barker, 2010). After discussion with my academic supervisor it was decided that interviews with clinicians and young people would provide a dual perspective regarding the cards and be informative to clinical practice. The clinicians would provide views which could reflect the challenges balancing engaging a young person whilst meeting service demands, and whether the cards are helpful during assessment of hard-to-reach young people, while interviewing YP would enable understanding into what is important for the individual who is accessing the service, which might inform specific engagement and assessment priorities. I also wanted to take the stance put forward by Mauthner et al. (1997) who claimed young people should be subjects rather than objects in research. This fits with more recent research which put the inclusion of young people in research at a priority (Balen et al., 2006; Green & Hogan, 2005; Grover, 2004; Punch, 2003).

The next step was to identify teams to participate and design a project. This initial stage of my journey was the most challenging. I had to find out which services were using the cards, how they were using them and whether they had time to take part in the study. I had to balance co-ordinating meetings with teams whilst simultaneously submitting ethical approval and drafting a project proposal. Through this process I learnt how conflicting research and clinical practice can sometimes be. Clinicians and their managers were very welcoming and encouraged the project; however when faced with meeting service demands or clinical issues, the research project was not a priority. Moreover, the process was likely to be even more challenging as it was across multiple sites in order to achieve the participant numbers required to fulfil the research aims, and ideally to sample the different services using The AIM Cards. This led to several implementation issues that highlighted the challenges of implementing academic research in “real-life” clinical contexts. Firstly, from the procedural end, I had to apply for multiple local site approvals whilst simultaneously holding in mind each team's structure and participation in the project. It required me to be organised and tolerate high levels of uncertainty. In order to facilitate implementation and specifically to set up a structure that would facilitate recruitment, I set up lead clinicians in each service to try and ensure my project was on the agenda. I made myself flexible, approachable and available through this process. Tourangeau et al. (2014) discusses ethics, multiple consent issues, and reliance on staff to facilitate recruitment as the multiple challenges faced when carrying out research within services supporting young people. They propose how important it is to consider how to reduce the power of the researcher when thinking about study design. On reflection it was similar to engaging hard-to-reach young people in research as in clinical practice!

Another challenging aspect of trying to capture real-life research resulted in a fundamental change in my project design half way through the process. Initially it was going to be a mixed method design. The AMBIT AIM Cards have a feature that lends themselves as an outcome measure, specifically with young people who are hard to engage and perhaps less able to verbalise their difficulties, concerns and goals in receiving mental health support. My hope was to consider The AIM Cards usefulness as both a tool for assessment, and a tool for integrating outcomes. Integrating clinical practice and outcome evaluation can be extremely helpful with a population who have complex needs, and perhaps struggle to complete routine outcomes in the form of a questionnaire (Bickman et al., 2011; Lambert & Hawkins, 2004).

In order for me to calculate how feasible it would be to collate quantitative data alongside exploration of The AIM Cards and determine an approximate sample size, I asked teams to inform me of how many young people would use the cards in one month. This meant I could work out how many young people would use the cards across the data collection period. However, despite being proactive and meticulous with setting up the project and making sure I had the support of five teams, the 'real life' picture was disappointing. Over the ten months of data collection, progress was extremely slow. On reflection I did not anticipate this rate of progress, and whilst I had built good relationships with the teams, I underestimated how reliant data collection was on my presence. I thought as teams were already using the cards prior to my project, this would continue to happen. However I think I could have done more earlier on to ensure they were used more regularly. As a result, obtaining the numbers for quantitative analysis was not possible, so I focused on completing a well-executed qualitative project that could add substantial clinical value to services. Research identifying the challenges of research design amongst young people is limited. Alderson and Morrow's (2011) guide to research with children and young people offer comprehensive protocols when carrying out research with this group, but it's not specifically designed for harder-to-reach groups, which may present additional barriers. It would be helpful for there to be more research which considers the challenges of implementing research within an outreach service context, thinking about the barriers researchers may face in order to foresee potential obstacles and support problem solving.

Having thought carefully about the barriers I faced, I consider there to be two main learning points which would be helpful to identify and share, and could support future researchers to plan and overcome these obstacles proactively. Firstly, the service context, as CAMHS and young people services were going through restructures as part of a national review. This meant clinicians were feeling overwhelmed and uncertain in their jobs. With the support of my external supervisor, I learnt that I could be more physically present so that clinicians did not have to hold my project in mind. Half way through data collection I set up weekly slots when I would be at the service locations just so that I could be there to remind people about using the cards, or answer any questions related to collecting data. This regular contact was set up too late for the quantitative part of the project but I think it was extremely helpful in securing the eighteen interviews completed. Secondly, all recruitment teams had small caseloads, and in addition to that, not all clinicians were using the cards with every young person they worked with. Initial numbers given to me were optimistic, the real picture was a cohort who were difficult to engage and so quantitative data collection was not manageable in the short time frame.

Finally a key strength to the project, which proved to be instrumental in its implementation , was the good links I managed to form with each team. I learnt very quickly how important it was for me to be an empathic, flexible and approachable researcher. I formed positive working relationships with clinicians which enabled me to feel confident to ask for progress regarding the project. I also think these links helped when clinicians had to facilitate interviews, either by contacting families or when supporting young people to attend the interview. Without such relationships, it is almost certain that the project would have struggled to an even greater extent, consistent with available research on implementing qualitative studies. For example, Reeves (2010) found the benefits of forming positive working relationships with staff members as integral for recruitment whilst conducting qualitative research. Clark (2010) carried out a systematic review of what motivates participation in qualitative research and identified the importance of individual (such as curiosity, interest, therapeutic gain) and collective (empowerment, system change) and reported that underpinning this is the need to develop positive research relationships.

Stage 2: Implementation Of The AIM Cards Evaluation: Data Collection

My aim for the research was to enable young people and clinicians to share their individual experiences of using The AIM Cards. Semi-structured interviews offer an opportunity to collect meaningful, personal data (Willig, 2008). As research with the cards had not been done before, I wanted to be able to provide structure to each interview but also allow exploration of individual narratives. Careful consideration of the broad topic themes in the schedule occurred during discussions with my supervisor. Questions were developed through anecdotal comments from clinicians who use the cards. I also had experience using the cards and so my own understanding of how the cards are used in clinical practice, informed topic areas. Whilst this is perhaps not the most rigorous method to develop an interview schedule, it did allow the study of the cards to be an organic process, built upon clinical foundations.

My experience of carrying out semi-structured interviews was powerful. Whilst each interview followed the same flexible structure the answers given were varied and opened up different channels of exploration. This fluidity meant that the interaction between interviewer and interviewee was iterative and continuously adapting, being influenced by questions and responses. The flexibility of the structure seemed to make interviewees feel that their thoughts and opinions were being heard. I was able to follow up answers and explore what they were saying which seemed to give them confidence to share their opinions. Whilst it made some interviews repetitive as I didn't want to dismiss anything that was said, as a result I believe this strengthened my relationship with the interviewee. Adler & Adler, (2002) identify building positive relationship between an interviewee and a researcher as key component to fostering their engagement in the interview process. Borgers et al. (2004) consider the role that the interview schedule has when collecting meaningful data, they propose the use of balanced questions, which offer the opportunity for positive, negative and neutral responses in order to reduce research bias amongst young people. Similarly Murray et al. (2011) consider the use of age appropriate questions when designing an interview schedule. When designing the schedule I made sure I adhered to these principles.

My own skills conducting interviews developed during data collection. On the advice of my supervisor I completed one interview and then we met to discuss my approach. What I hadn't realised prior to starting this project was how important the interviewer's technique is in order to elicit valid and codable responses. Barker et al. (2002) encourage an interviewer style where researchers actively listen, show interest and reflect back, as a helpful way to facilitate in-depth exploration. On reflection my first interview was more directive than I would have liked, which I realised whilst listening to the recording and in discussion with my supervisor. Based on analysis and discussion of the first interview, I adapted my skills to be more reflective and allow more space for interviewees to share their own experience. Knox and Burkard (2007) provide a nice summary of what the research highlights as important to consider when carrying out qualitative interviews. They report on the findings which show interviewer characteristics which include utilising clinical therapeutic skills. Taking this one step further, my experience suggested that the challenge was in keeping to the phenomenological level of the interviewees accounts and specifically sticking with the interviewee's experiences in order to facilitate further elaboration, rather than moving straight to interpreting and validating to show understanding which come naturally as part of clinical skills.

My intention in carrying out the DClinPsy research project was to involve young people in an area meaningful to them. Curtis et al. (2004) refer to the 'participation and involvement agenda' which calls for research to include children and young people. My experience of interviewing both clinicians and young people has taught me how valuable it is to elicit the views of both, but I have come to understand that it is helpful to approach these interviews slightly differently. Mauthner (1997) refers to the power dynamic that is present when interviewing young people and encourages researchers to be explicit about their role and what the research is for. At the beginning of each interview I explained the purpose of the project and encouraged individuals to be honest. However, I appreciate that a simple explanation does not reduce the power that I present in the room, being an adult and potentially perceived as somewhat connected to the service. It is possible that young people felt obliged to say the cards were helpful, yet their honesty about what was unhelpful makes me consider that the influence of social desirability to interview responses was attenuated. Another learning point for me was the need to adapt my approach in order to make the young person feel comfortable. Haverkamp (2005) distinguishes between using clinical skills when appropriate whilst maintaining a researcher's role by keeping to boundaries. I utilised my skills as a clinician by spending some time at the start of each interview by showing interest and recognising some anxiety or apprehension on their part at the start of some interviews. What I was trying to attempt to do was to free them up to talk about their experiences, make them feel less worried that there was a 'right' answer. I wanted them to feel that they could be honest and open about the cards and that I wasn't there to just hear positive things about them. This is why I believe Clinical Psychologists can make an important contribution to research, as clinical skills are required for both research and practice.

Stage 3: Implementation of The AIM Cards Evaluation: Data Transcription And Analysis

Part of carrying out 'trustworthy' qualitative research is adhering to methodological rigour (Williams & Morrow, 2009) and this includes ensuring that transcription captures the reality of what was said. To ensure this happened, I transcribed all interviews verbatim. Whilst transcribing eighteen interviews was a time consuming task I am sure it lead to a more in-depth understanding of the data and resulted in more meaningful interpretation. Braun and Clarke (2006) refer to the process of transcription as where 'the meaning is created.' There was something significant for me about being involved in the project from interviewing, transcribing, analysis and interpretation.

However, part of the process during transcription and analysis is to consider and acknowledge what I brought to the data. This could be my previous experience, cultural ideologies, and/or research interest (Potter & Hepburn, 2005). Fischer (2009), defines 'bracketing' as helpful to understand our assumptions and not something that occurs once, but is an ongoing explicit process that should occur throughout the entire project. Part of this was making sure I was transparent about each stage of the study. For example, in the method section I included a paragraph regarding my own perspective, what Fischer (2009) describes as 'self-disclosure.' Rolls and Relf (2006) consider bracketing to include checking with an external source during analysis. This was definitely advantageous to the process, the discussions I had with my supervisor regarding coding and creation of themes enabled clarity. Talking through my choices with another person enabled me to acknowledge what interpretations I was making, where they came from and how this would fit with what the respondent was trying to communicate. This process relied on me reflecting on each interview, which was why I value my role in the entire data collection process. What I found more challenging however was balancing the need to develop overarching themes and ensuring that subtle differences in individual narratives remain heard. I consistently found myself wanting to include everything each individual was saying in its own specific theme. On reflection I think I felt this way because I really valued everything that was being said and I was afraid that synthesising and creating themes would lose specific points individuals were making. However, once I finished the analysis process I could see how well overarching themes enabled presentation of a coherent narrative, which was common amongst many individuals and provided more substantial data, thus being more valuable as a contribution to research and clinical application.

Personal Reflections And Future Directions

As I reach the end of my research journey I can honestly say that my relationship to research has changed. I have seen firsthand how helpful and clinically informative projects can be, particularly when involving the individuals who are going to be impacted the most, i.e. young people and clinicians. I feel incredibly fortunate to have taken part in interviews where young people provided rich data about how services can meet their needs. I am thankful that the young people who participated in this project felt brave enough to contribute their own thoughts and experiences. It has provided me with insight about the role that practice-based evidence can have in shaping future research.

My professional practice has also been influenced by completing this project, which I will take forward post-qualification. I have respect for the challenges of setting up and completing research when facing ongoing service restructures. I now have experience balancing meeting clinical and academic demands whilst tolerating high levels of uncertainty, particularly when my project future looked bleak. As a result I think my ability to be a scientist-practitioner has developed and I hope to continue to contribute both clinically and as a researcher to the field of Clinical Psychology.

Completing this project has also influenced my decisions about my next steps post qualifying. During the interviews with young people I got a real sense of how helpful the cards had been for some individuals. In particular one young person told me how the cards had made a real difference for him as he now understood where his anger came from and how much he now thinks about not having to break things. Another young person described understanding that he no longer needed to steal a moped because he understood what peer pressure meant. These realisations have fundamental implications for a young person's life which have been identified through setting up a project and taking the time to hear from the people whose experiences matter the most. It has provided me with an opportunity to see how assessing and formulating collaboratively with young people who have complex needs can make a real difference to their lives. As a result I have since secured a job as a Clinical Psychologist working in an adolescent forensic service after qualifying. I hope to continue to build research in this area to utilise the skill development this project has given me.

This qualitative study has contributed to understanding how to engage hard-to-reach young people and how the use of AIM Cards can facilitate the engagement and assessment process . The next step would be to take the evaluation of The AIM Cards further and conduct a quantitative psychometric evaluation, for example looking at their effectiveness alongside standard assessment measures, including their reliability and their validity. I hope to continue research in the area which aims to treat young people as experts with active roles in research (Greene & Hogan, 2005; Mason & Hood, 2011). My final reflection point must be that I have learnt how important it is to empower young people in research, to give young people a voice about matters relating to them. After all that is their right (UN, 1989), regardless of how hard-to-reach that voice may be.

References

Adler, P., & Adler, P. (2002). The reluctant respondent. In J.F. Gubrium & J.A. Holstein (Eds), *Handbook of Interview Research: Context and Method*. California: Sage.

Alderson, P., & Morrow, V. (2011). *The Ethics Of Research With Children And Young People: A Practical Handbook*. London: Sage.

Balen, R., Blyth, E., Calabretto, H., Fraser, C., Horrocks, C., & Manby, M. (2006). Involving children in health and social research: "human becomings" of "active beings." *Childhood, 13*, 29-48.

Barkham, M. & Mellor-Clark, J. (2003) Bridging evidence-based practice and practice-based evidence: developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology and Psychotherapy, 10*, 319–327

Barker, C., Pistrang, N.& Elliot, R. (2002). *Research Methods in Clinical Psychology: an introduction for students and practitioners, Second Edition.* UK, John Wiley & Sons, Ltd.

Bickman, L., Kelley, S., Breda, C., Andrade, A., (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: results of randomized trial. *Psychiatric Services, 62*, 1423 - 1429.

Borgers, N., Sikkel, D., & Hox, J. (2004). Response effects in surveys on children and adolescents: the effect of number of response options, negative wording and neutral mid-point. *Quality and Quantity*, 38(1), 17-33.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77 - 101.

Clark, D. (2010). On 'Being Researched:' Why do people engage with qualitative research? *Qualitative Research,* 10, 399-419. doi:10.1177/1468794110366796

Curtis, K., Liabo, K., Roberts, H., & Barker, M. (2004). 'Consulted but not heard: A qualitative study of young people's views of their local health service', *Health Expectations, 7,* 149 - 56.

Fischer, C. (2009). Bracketing in qualitative research: conceptual and practical matters in psychotherapy Research. *Journal of the Society for Psychotherapy Research, 19,* 583 - 90.

Greene, S., & Hogan, D. (2005). *Researching Children's Experience: approaches and methods*. London: Sage.

Grover, S. (2004). Why won't they listen to us? On giving power and voice to children participating in social research, *Childhood, 11,* 81-94.

Haverkamp, B. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counselling Psychology*, 52, 146-155.

Knox, S., & Burkard, A. (2009). Qualitative research interviews. *Psychotherapy Research, 19,* 566-575. doi;10.1080/10503300802702105

Lamb, J., Bower, P., & Rogers, A. (2012). Access to mental health in primary care: A qualitative meta-synthesis of evidence from the experience of hard-to-reach groups. *Health, 16,* 76 - 104

Lambert, M., & Hawkins, E. (2004). Measuring outcomes in professional practice: considerations in selecting and using brief outcome measures. *Professional Psychology, Research and Practice*. 35, 492 - 499.

Mason, J & Hood, S. (2011). Exploring issues of children as actors in social research. *Children and Youth Services Review, 33,* 490 – 495.

Mauthner, M. (1997) Methodological aspects of collecting data from children: lessons three research projects. *Children and Society, 11,* 16-28

Murray, A., McCrory, C., Thornton, M., Williams, J., & Quail, A. (2011). Growing up in Ireland: Design, Instrumentation and Procedures for the Child Cohort. *Department of Children and Youth Affairs*. Dublin: Government Publications.

Reeves, C. (2010). A difficult negotiation: fieldwork relations with gate keepers. *Qualitative Research*, 10, 315-331. doi:10.1177/1468794109360150.

Pistrang, N. & Barker, C. (2010). Scientific, practical and personal decisions in selecting qualitative methods. In M. Barkham, G.E. Hardy & J. Mellor-Clark (Eds.), *Developing and Delivering Practice-Based Evidence: A guide for the psychological therapies* (pp.65-89). Chichester: Wiley-Blackwell.

Pope, C., Ziebland, S., & Mays, N. (2000) Analysing qualitative data. *British Medical Journal, 320*, 114-116.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology, 2*, 281 - 307.

Punch, S. (2002). Research with children: The same or different from research with adults. *Childhood*, 9, 321-341.

Rolls, R., & Relf, M. (2006). 'Bracketing interviews: addressing methodological challenges in qualitative interviewing in bereavement and palliative care.' *Mortality, 11*, 286 - 305.

Tourangeau, B., Johnson, T., Kirk, W., & Bates, N. (2014). *Hard To Survey Populations*. London: Cambridge University Press

Willig, C. (2008). *Introducing Qualitative Research in Psychology: adventures in theory and method (2nd ed.).* Buckingham: Open University Press.

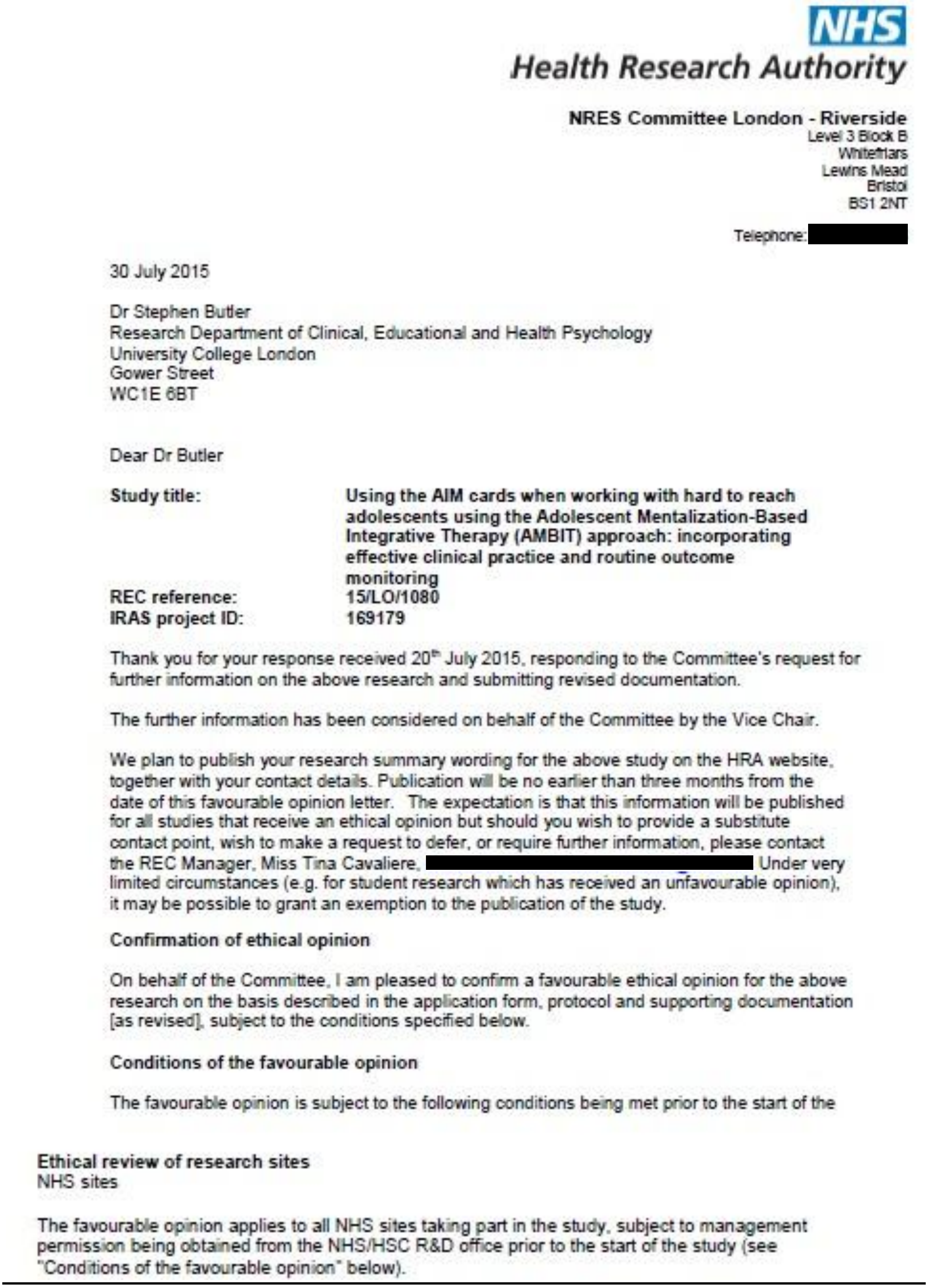
Williams, E., & Morrow, S. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, 19, 576 - 582. doi: 10.1080/10503300802702113.

UN. (1989). Convention on the Rights of the Child. Geneva: United Nations. Available at: www2.ohchr.org/english/law/crc.htm

Appendix

Appendix A.

Letter of Ethical Approval



NHS
Health Research Authority

NRES Committee London - Riverside
Level 3 Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: [redacted]

30 July 2015

Dr Stephen Butler
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
WC1E 6BT

Dear Dr Butler

Study title:	**Using the AIM cards when working with hard to reach adolescents using the Adolescent Mentalization-Based Integrative Therapy (AMBIT) approach: incorporating effective clinical practice and routine outcome monitoring**
REC reference:	**15/LO/1080**
IRAS project ID:	**169179**

Thank you for your response received 20th July 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Miss Tina Cavaliere, [redacted] Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

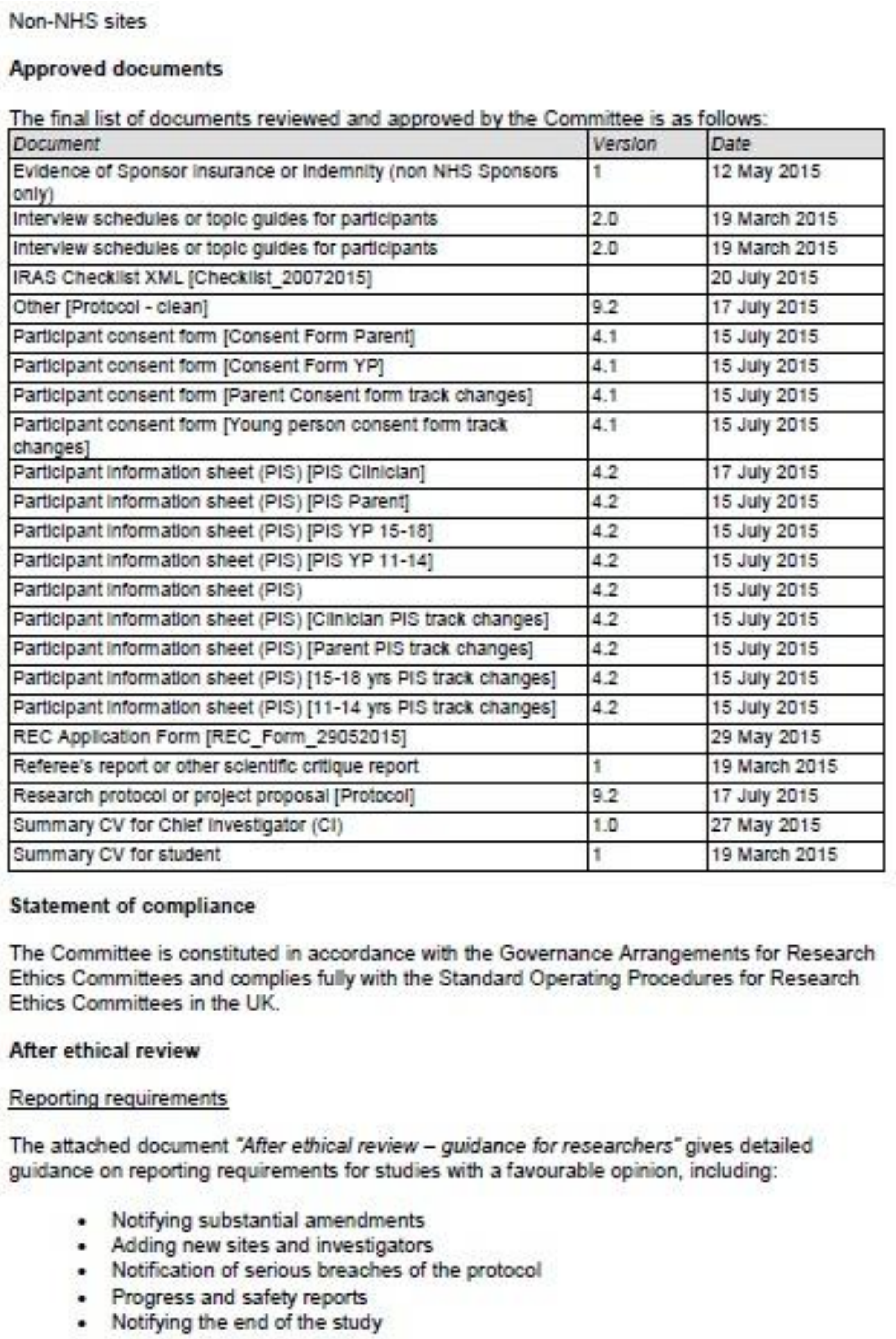
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

Conditions of the favourable opinion

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

Ethical review of research sites
NHS sites

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



Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)	1	12 May 2015
Interview schedules or topic guides for participants	2.0	19 March 2015
Interview schedules or topic guides for participants	2.0	19 March 2015
IRAS Checklist XML [Checklist_20072015]		20 July 2015
Other [Protocol - clean]	9.2	17 July 2015
Participant consent form [Consent Form Parent]	4.1	15 July 2015
Participant consent form [Consent Form YP]	4.1	15 July 2015
Participant consent form [Parent Consent form track changes]	4.1	15 July 2015
Participant consent form [Young person consent form track changes]	4.1	15 July 2015
Participant information sheet (PIS) [PIS Clinician]	4.2	17 July 2015
Participant information sheet (PIS) [PIS Parent]	4.2	15 July 2015
Participant information sheet (PIS) [PIS YP 15-18]	4.2	15 July 2015
Participant information sheet (PIS) [PIS YP 11-14]	4.2	15 July 2015
Participant information sheet (PIS)	4.2	15 July 2015
Participant information sheet (PIS) [Clinician PIS track changes]	4.2	15 July 2015
Participant information sheet (PIS) [Parent PIS track changes]	4.2	15 July 2015
Participant information sheet (PIS) [15-18 yrs PIS track changes]	4.2	15 July 2015
Participant information sheet (PIS) [11-14 yrs PIS track changes]	4.2	15 July 2015
REC Application Form [REC_Form_29052015]		29 May 2015
Referee's report or other scientific critique report	1	19 March 2015
Research protocol or project proposal [Protocol]	9.2	17 July 2015
Summary CV for Chief Investigator (CI)	1.0	27 May 2015
Summary CV for student	1	19 March 2015

Statement of compliance

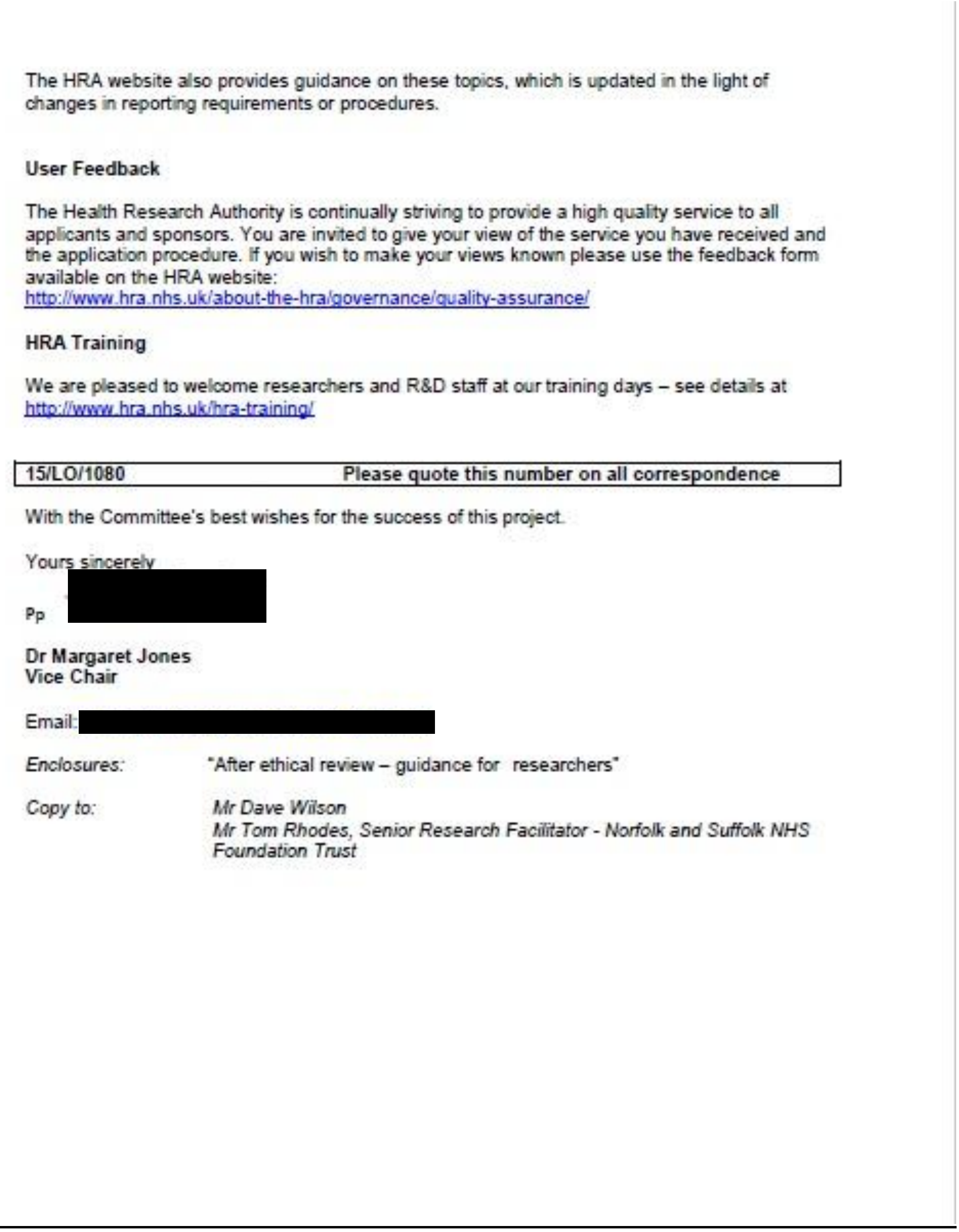
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

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

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



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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/LO/1080	**Please quote this number on all correspondence**

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

Yours sincerely

Pp [redacted]

Dr Margaret Jones
Vice Chair

Email: [redacted]

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Mr Dave Wilson*
Mr Tom Rhodes, Senior Research Facilitator - Norfolk and Suffolk NHS Foundation Trust

APPENDIX B

Participant Information Sheets

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY
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Participant information form version 4.2 (15/07/2015)

PARTICIPANT INFORMATION SHEET

(CLINICIANS)

Study Title: Exploring the AMBIT AIM CARDS as a therapeutic assessment tool and a routine outcome measure

You are being invited to take part in a research study.

What is the purpose of the study?

As part of my Doctorate in Clinical Psychology at UCL I am undertaking a research project in the use of AIM cards. The project has two parts. The first part of the project involves exploring clinician and young people's views on their experience of The AIM Cards. The second part of the study explores whether The AIM Cards are a sensitive outcome measure. Teams eligible for participation are AMBIT trained teams who are currently using the cards with young people as part of their intervention. This project is being funded and organised by University College London and ethical approval has been obtained by Riverside Research Ethics Committee and with accordance to local research governance policies.

What will happen if I take part?

My research aims to explore how useful the AMBIT AIM Cards are as a tool to help engagement, facilitate a therapeutic relationship, inform problem identification and intervention formulation. I am therefore interested in interviewing clinicians who have used the cards with at least three young people and would be interested in sharing their views and the opinions on this process. The Interview will last approximately 45 minutes and will take place in your place of work. Interviews can be arranged at a time that is suitable to you. Interviews will be recorded but will be transcribed anonymously by a private company. After the interview you will also have one week to withdraw your data from study should you change your mind about wanting to participate.

Do I have to take part?

You do not have to take part in this study. Participation in this study is entirely voluntary. If you do decide to take part you are free to end your participation at any time prior to the interview, during the interview, and up until one week afterwards.

Will my taking part in the study be kept confidential?

Participating in this research will be known by another member of your team who has been identified as the project contact. The project contact will arrange the interview for the study. . The interviews will be carried out by one researcher (Jo Carlile, Trainee Clinical Psychologist) and will be recorded. A week after the interview, the recording will be transcribed. All information from the interviews used in the final research report will be anonymous, though direct quotes may be used. Only safeguarding issues will be fed back to the team in line with standard information sharing guidelines.

What are the benefits of taking part?

Participating in this project will enable research to be carried out which explores whether the AIMBIT Aim cards are a useful tool when working with hard to reach young people. The outcomes of this project may help to improve the quality of help that young people receive.

What are the disadvantages of taking part?

It is recognised that clinician time is precious amongst services. The interview aims to be 45 minutes long and this may take clinician's away from their team duties. Wherever possible the researcher aims to carry out the interview at a time that is most convenient to the clinician.

Feedback of findings

Once the data has been analysed and the report has been written up, I will be visiting teams to present the findings from the study. This will be a chance for teams to hear about whether other clinicians and young people have found the cards useful, and also whether they might be used as a way of understanding whether or not young people are benefitting from the help that they receive. The meeting to present my findings to the team will be arranged with the project lead and all team members will be invited to attend.

You can keep a copy of this form.

Should you have any questions, please feel free to contact me at [redacted]. My supervisors for this project are Dr Stephen Butler (UCL) and Peter Fuggle (Anna Freud Centre).

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY
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Participant information form Version 4.2 (15./07/2015)

PARTICIPANT INFORMATION

(Parent/Carer)

Study Title: Exploring The AIM Cards as a therapeutic assessment tool and a routine outcome measure, as a way of understanding young people and looking at their progress in treatment

<u>You child is being invited to take part in a research study</u>.

What is the purpose of the study?

As part of my training in Clinical Psychology at UCL I am undertaking a research project in the use of The AIM Cards. These are cards that your child has been using as part of their support from the service. They are cards which identify strengths and difficulties which are common to most young people. They are used by the worker with the young person to try to help them understand what is currently going on for them. The project is interested in finding out if using The AIM Cards is a useful way to help young people by engaging them and if they are useful to plan an intervention. The unique thing about The AIM Cards is that they are a less directive method and young people have more choice to think about what they might be finding difficult.

The study has two parts. Part A is very interested in finding out keyworker and young people's views on if the cards are helpful and Part B explores if they are an effective way monitor progress and if the intervention has helped.

What will happen if your child takes part?

Your child will meet with a researcher for no longer than 45 minutes to share their thoughts and opinions about whether they thought The AIM Cards are a helpful way to support young people. The meeting will be recorded and will take place at the building where the team is based and will be arranged by your child's allocated worker. Your child can decide if they would like their worker present and they will be paid £15 for taking part. Additionally as part of this study the researcher will be looking at whether the support that you child is receiving is helpful.

Does my child have to take part?

Your child does not have to take part in this study. Participation in this study is entirely voluntary. If you decide not to take part it does not affect the support your child is receiving from the service. If you change your mind about allowing your child to take part then you can do this at any point before, during or up until one week after the interview.

What are the benefits of taking part?

If your child takes part in this study it will give them the opportunity to voice their opinions about the experiences they have had since being supported by the service. It hopes to identify what may have been helpful or unhelpful and therefore help other young people in the future to be supported in the most effective way. They will also receive a financial payment of £15 for taking the time to participate.

What are the disadvantages of taking part?

It requires a young person to give up their time to be interviewed, but the researcher will aim to be as flexible as possible. Although the interview does not ask direct questions about any difficult experiences, it does require them to talk to a researcher whom they have not met before about the service. They might find this experience makes them feel anxious. All efforts will be made to make young people feel comfortable and they will be asked if they would like their worker to be present throughout the interview.

Will taking part in the study be kept confidential?

Participating in this research will be known by your child's allocated worker and another member of the team who has been identified as the project contact. This is so the team can help to ensure interviews can be arranged. Please ask the allocated worker if there is anything you are unsure about or have any questions, or you can contact me at [redacted].

You can keep a copy of this form.

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Participant information form Version 4.2 (15/07/2015)

PARTICIPANT INFORMATION

(11-14 yrs)

Exploring the AMBIT AIM CARDS as a way of understanding young people and looking at their progress when they receive help.

You are being invited to take part in a research study.

What is the study?

My name is Jo Carlile and I am training to be a Clinical Psychologist. I study at a university and I am researching what young people think about the help they get when they go to services that are there to help children and young people.

As part of my training in Clinical Psychology at UCL I am doing a research project looking at the use of The AIM Cards. The project is interested in finding out if using AIM CARDS is a helpful way to help understand young people, both their problems and what is going well for them. The project is very interested in hearing about young people's opinions about the cards as a way to help understand them, and to look whether the help that they are receiving is useful or not. The AIM Cards are the cards that you have been using with your worker whilst they have been helping you. The AIM Cards will allow you to express some of the problems or hard things that are going on in your life, as well as the things that are going well. These problems and things that are going well for you are often things that are common amongst people your age.

The study is interested to see whether you and other young people have found these cards helpful, and will also be asking keyworker's about their opinions about the cards. It will also be looking at whether or not using the cards with you at different points in time while you are receiving help, can help us understand how useful the help is that you are getting. The reason this research is being done now is because more young people are using the cards and so it is important to hear what your experiences of the cards have been.

What will happen if I take part?

You will meet with me (the researcher) in the building where your keyworker works. The meeting will last no longer than 45 minutes and it will be recorded on a small electronic device. This is because what you say is important and I don't want to forget it! In the meeting I will ask you questions about the cards and will be interested in your opinions. You will be paid £15 for giving up your time to come and speak with me. If you would like, your keyworker can joins us for the meeting.

Do I have to take part?

You do not have to take part in this study. If you do decide to take part in the meeting you are free to stop and leave during the meeting. After the meeting you will have one week to change your mind about allowing what you have said to be used in the study. If you decide not to take part it does not affect the help that you are receiving from the service.

What are the advantages of taking part?

By taking part you are being given the opportunity to share your thoughts and opinions on the cards. This might help young people in the future get the best support possible!

What are the disadvantages of taking part?

Some people might find meeting someone new and being asked questions them feel worried or anxious. This is quite normal when meeting someone new for the first time. However, I will not be asking you any questions about problems that you may have. Instead I will be talking to you about how the cards have been helpful or unhelpful. I will do my best to make sure that you feel comfortable, and if you would like your worker to be with you in the interview that is OK too.

Will my taking part in the study be kept confidential?

The only people who will know you are taking part in this study is your parent, your keyworker, the researcher, and one other member of the service who will help us arrange your meeting. After the meeting your comments will be copied down into written format. When the report is written up it might be that a short sentance of exactly what you have said is written as an example. However at no point will people know it was you who has said it. Please ask your keyworker or me to explain this more.

Please ask your worker if there is anything else you are unsure about or have any questions. Or alternatively you can contact the me at [redacted].

You can keep a copy of this form.

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Participant information form Version 4.2 (15.07.2015)

PARTICIPANT INFORMATION

(15-18yrs)

Exploring the AMBIT AIM CARDS as a way of understanding young people and looking at their progress when they receive help.

You are being invited to take part in a research study.

What is the purpose of the study?

As part of my training in Clinical Psychology at UCL I am undertaking a research project in the use of The AIM Cards. The project is interested in finding out if using The AIM Cards is a helpful way to help understand young people, both their problems and what is going well for them. The project is very interested in hearing about young people's views on the cards as a way to help understand them, and to look whether the help that they are receiving is useful or not. The AIM Cards are the cards that you have been using with your worker whilst they have been supporting you. The cards will allow you to express the difficulties that you are experiencing as well as the things that are going well in your life, and often these are strengths and difficulties that are common amongst people your age. The study is interested to see whether you and other young people have found these cards helpful, and will also be asking keyworker's about their views about the cards. It will also be looking at whether or not using the cards with you at different points in time while you are receiving help, can help us understand how useful the help is that you are getting. The reason this research is being done now is because more young people are using the cards and so it is important to hear what your experiences of the cards have been.

What will happen if I take part?

The project is an opportunity for you to share your thoughts and opinions on the cards; whether you found them helpful or unhelpful. If you want to take part you will be required to meet with the researcher (Jo Carlile, Trainee Clinical Psychologist) for no longer than 45 minutes to give your opinions on the cards and talk about your experiences of having used them. The meeting will be recorded and take place at the building where you normally meet your worker. You can decide if you would like your worker present or not. You will be paid £15.00 to participate.

Do I have to take part?

You do not have to take part in this study. Participation in this study is entirely voluntary. If you do decide to take part in the meeting you are free to end your participation at any time prior to or during the meeting, and up until one week afterwards. If you decide not to take part it does not affect the support you are receiving from the service.

What are the advantages of taking part?

By taking part you are being given the opportunity to share your opinions and experiences about the service you have been given. This means that your opinions can be fed back to the team anonymously to help them make sure they are supporting young people in the best way possible. Anonymous feedback means that no one will know who said what because comments about young people's experiences of the cards will be described without ever relating them to specific people.

What are the disadvantages of taking part?

Some people might find meeting someone new and being asked questions about their experiences makes them feel worried or anxious. This is quite normal when meeting someone new for the first time. However the questions asked will not be directly about any difficulties you have experienced. Instead they will focus on how the cards have been helpful or unhelpful. Every effort will be made to ensure that you feel comfortable and if you would like your worker to be with you in the meeting that is ok too.

Will my taking part in the study be kept confidential?

Participating in this project will be known by the researcher, your worker and another member of the team who has been identified as the project contact. This is so that the team can help to arrange the meeting. The meeting will be recorded and afterwards the words from the tape will be written out by a private company. This enables your views to be kept confidential, which means that none of your thoughts and feelings will be associated with you if they are reported in the final report. The only time the researcher will share information is if they are worried about the safety of you or anyone else as a result of anything that is said in the meeting. If this occurs then the researcher will talk to you in the meeting about this.

Please ask your worker if there is anything you are unsure about or have any questions. Or alternatively you can contact the researcher at [redacted].

You can keep a copy of this form.

APPENDIX C

Participant Consent Forms

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Centre Number:

Study Number:

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: **Exploring the AMBIT AIM CARDS as a therapeutic assessment tool and a routine outcome measure**

Name of Researchers: **Dr Stephen Butler and Jo Carlile**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **15/07/2015** (version **4.2**) for the above study. I have had the opportunity to think about the project, ask questions and have understood the answers. ☐

2. I understand that my child's participation is voluntary and that I am free to withdraw them prior to the interview and up until one week afterwards, without their care or legal rights being affected. ☐

3. I understand that their participation in this study is anonymous which means that only the researcher, their allocated worker and another member of the team will know that they have taken part. ☐

4. I give consent for an independent company to transcribe the audio recordings. ☐

5. I agree for my child to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature .

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http://www.ucl.ac.uk/clinical-psychology/

Centre Number:

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: **Exploring the AMBIT AIM CARDS as a therapeutic assessment tool and a routine outcome measure**

Name of Researchers: **Dr Stephen Butler and Jo Carlile**

Please initial all boxes

6. I confirm that I have read and understand the information sheet dated **17/07/2015** (version **4.2**) for the above study. I have had the opportunity to think about the project, ask questions and have understood the answers. ☐

7. I understand that my participation is voluntary and I am free to withdraw up until the interview or within one week afterwards, without my care or legal rights being affected. ☐

8. I understand that participation in this study is anonymous which means that only the researcher, my allocated worker and another member of the team will know that I have taken part. ☐

9. I give consent for an independent company to transcribe my interview comments ☐

10. I agree to direct quotes from my interview being written in the report and I understand that these will be anonymous (people will not know I have said them). ☐

11. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person consenting	Date	Signature

APPENDIX D

Semi Structured Interview Guides

Document Date: 19.03.15, Version 2.0

Semi-structured interview for Clinicians

Thank you for agreeing to participate in this interview. This interview aims to explore your views on engaging young people and the usefulness of The AIM Cards. I will ask prompting questions to explore specific topic areas but feel free to elaborate or tell me things which you think are important for me to know about. It should last no longer than 45 minutes. Please try not to use any identifying names. If at any point you would like to not answer a question or finish the interview then please tell me. I am now going to start.

Promote engagement: (questions around talking during sessions, helpful in creating a space to talk about difficult issues?)

1. **What do you think is important to consider when trying to engage young people?**
2. **Tell me about your experiences when trying to engage a particularly 'hard to reach' young person**
3. **When is the first time you usually use the cards with a young person?**
4. **Tell me about your experiences of using the cards with young people**
5. **Tell me your thoughts about your initial experience with the cards during the assessment process; including advantages and disadvantages**
6. **Tell me your thoughts on whether The AIM Cards bring anything unique to the assessment process**

Develop Therapeutic relationship - How much did the young person feel understood? normalisation of problems? In what ways did it give clinician confidence regarding therapeutic relationship?

1. **What is your understanding of what promotes a therapeutic relationship between a young person and their worker?**
2. **From your point of view do the cards have an impact on your work with young people? (prompt for any skill development?)**
3. **Are there any ways in which you feel the cards are a helpful tool to facilitate your relationship with young people? (explain how?)**
4. **Are there any ways in which you feel the cares are unhelpful or get in the way of facilitating your relationship with the young person?**
5. **What do you think young people would say about the cards?**

Understand Problems - Clinician confidence at understanding what the issues are, help to support young person to gain better understanding, externalising rather internalising?

1. **If relevant, tell me any unique ways in which the cards help you to understand young people?**

2. **Tell me are there any ways in which the cards enable the young person to understand better what is going on for them?**
3. **Are there any drawbacks or difficulties using the cards as a means to help young people understand themselves?**

Develop treatment goals - Identify specific treatment priorities, agreement of focused sessions, short term, long term goals?

1. **Tell me your views on whether the cards influence the prioritisation of difficulties for young people**
2. **Are there ways in which the cards help you to plan an intervention?**
3. **Is there anything that the cards bring to this treatment planning process that is unique to other ways you have done this with young people?**
4. **Are there any disadvantages of using the cards as a tool to help with intervention planning?**

Feedback regarding use of the cards, and space for additional comments considered relevant by clinicians:

1. **Tell me about any other ways the cards might be useful?**
2. **Are there any changes that you would make to the cards for use with young people? or how you use the cards?**

Document date: 19.03.2015, Version 2.0

Semi-structured interview for young people

(Participant is given the consent form to read, discuss and sign.)

Thank you for agreeing to meet with me. I wanted to speak with you about your experience of The AIM Cards, to get your thoughts and feelings on things like what you like or find useful about them, possibly unhelpful things in using the cards, things like that. I will be asking you some questions about the cards but free to add and to tell me things which you think are important for me to know about. It should last no longer than 45 minutes. If at any point you would like to not answer a question or to finish then please tell me.

I am now going to start with some questions about what you think is important for young people when they come to get help.

Initial questions about engagement:

1. Tell me a bit about what you think is important in workers who are trying to help young people?

2. Are there things that workers can do at the beginning to make it more likely that a young person might want to be helped by them?

4. If you were designing a service that supported young people what type of things would you include to try and attract young people to that service?

AIM CARD QUESTIONS

Promote engagement: (questions around talking during sessions, helpful in creating a space to talk about difficult issues?)

7. **When was the first time you used the cards with your worker? (Do you think this was a good or bad time to use them?)**
8. **What was it like using the cards? (prompts; helpful and unhelpful?)**

Develop Therapeutic relationship - How much did the young person feel understood? normalisation of problems? In what ways did it give clinician confidence regarding therapeutic relationship?

6. **Tell me a bit about using the cards with your worker. (prompts; helpful or unhelpful?;)**

7. **Are there any ways in which using the cards affected the development of the relationship with your worker?**

Understand Problems - Clinician confidence at understanding what the issues are, help to support young person to gain better understanding, externalising rather internalising?

4. **Tell me any ways in which the cards might have helped you to understand what was going on for you?**
5. **Were there any ways in which the cards were unhelpful to understanding what was going on for you?**
6. **Are there any ways in which the cards may have helped your worker understand you ? (explore answer, checking for anything helpful or unhelpful)**
7. **What was it like seeing strengths and difficulties that are common amongst young people written down on the cards?**

Develop treatment goals - Identify specific treatment priorities, agreement of focused sessions, short term, long term goals?

5. **Were there any ways in which the cards helped you think about what was important for you to get some help with?**
6. **Tell me any ways in which the cards may have been helpful or unhelpful when working together with your worker**
7. **Was there anything that you thought was special to the cards or different about them than what you usually do when you see your worker? (explore, prompt for helpful or unhelpful)**

Feedback regarding use of the cards, and space for additional comments considered relevant by clinicians:

3. **Are there any changes that you would make to how the cards are used with young people?**
4. **Is there anything else you would like to say about your experience of using the cards?**
5. **Tell me what the main things are about the cards that you would want a friend to know about?**
6. **Tell me your thoughts on whether or not you would recommend the cards to a friend in a similar situation?**

APPENDIX E

The AMBIT AIM Cards

A 1

Doing organised activities with other people

Do you do organised school or community activites like sports, youth clubs, church groups, etc?

0+ 0 1 2 3 4

A 2

Going to School/ College/Work

Do you turn up to School, Employment or Training courses?

This is not about how well you get on when you are there, just whether you attend.

Think about the most recent school, college, training or work you have done in the past 3 months.

0+ 0 1 2 3 4

A 3

Getting on at School/ College/Work

How do you get on in your school (or employment or training)?

This means what would your teacher or employer say about your performance and behaviour compared to other young people of your age?

0+ 0 1 2 3 4

A 4

Being good at things

Do you have a particular skill or talent in any activities such as athletics, art, music, fixing mechanical stuff, computers, etc?

0+ 0 1 2 3 4

A 5

Physical health

How is your physical health?

Don't include problems that make you poorly for just a few weeks (like flu, or a sprained wrist). Just think about serious or long term problems like asthma, or eczema, etc.

0+ 0 1 2 3 4

A 6

Looking after myself

How are you at looking after yourself?

This is about stuff like keeping clean, brushing your teeth, eating healthily, and getting help if you are sick? How do you compare to other young people of your age?

0+ 0 1 2 3 4

A 7

Disabilities

Do you have any disabilities? Think about problems that make it hard to move around, or blindness, deafness, etc.

These may be things you were born with, or ones that have started later because of accidents, or illness, etc.

0+ 0 1 2 3 4

A 8

Socializing like other young people of my age?

Thinking back from when you were young, do problems crop up when you spend time with young people of your age?

Is it hard to know what kinds of things to say, and how to get along with people?

0+ 0 1 2 3 4

A 9

Getting on with other people recently

Over the last few weeks, have you enjoyed being with other people and do you think other people tend to like you?

0+ 0 1 2 3 4

B 10

Having a home

Have you got a place that is OK, and is likely to last until you are ready move on?

0+ 0 1 2 3 4

B 11

Having enough money and things to survive

Have you and your family/carer got enough money for basic things?

(Many people want more than they have, but this question is about whether you have enough to get by on.)

0+ 0 1 2 3 4

C 12

Getting on with my family

How do you get on with your family or carers?

Score the best relationship you have in your family (Q. 13 is about the most difficult ones in your family).

0+ 0 1 2 3 4

C 13

Dealing with arguments with my family

How are disagreements sorted out in your family? Do arguments last a long time or turn into screaming fights?

If you get on differently with different family members, then choose the most difficult relationship (Q. 12 is about the best relationship).

0+ 0 1 2 3 4

C 14

How my parents/ carers set and apply rules at home

Are the rules at home clear and fair and do you know what happens if they get broken?

Some parents are very harsh in their punishments, and some parents don't set any rules at all, which can also be a serious problem.

0+ 0 1 2 3 4

D 15

Helpful adults outside the family

Do you get on OK with any adults who are OUTSIDE your immediate family/home, and who are helpful and trustworthy.

People like family friends, aunts, uncles, teachers, coaches, religious leaders in the community?

0+ 0 1 2 3 4

D 16

Having friends of my age

Are you someone who seeks out and holds onto friendships with other young people of your age? Are you seen as popular?

Think about how you stay in touch with with old friends who you have known for more than a year or so.

0+ 0 1 2 3 4

D 17

Friends who do serious rule-breaking

How much are your friends getting into serious rule-breaking, or not?

Most young people do not get into violence, or trouble with the law, etc, but some do. This question is about how much your friendship groups is (or is not) into this.

0+ 0 1 2 3 4

E 18

Understanding and Learning

(when people try to teach me)

How would teachers rate you as learner?

Are you seen as very bright?
Or are you struggling to learn new things?

0+ 0 1 2 3 4

E 19

Worrying a lot

Most peole worry about things at times, but some people worry a lot and find it hard to be reassured by anything or anyone.

At worst some people have panic attacks, or extreme fears about particular things or situations.

0+ 0 1 2 3 4

E 20

Thinking obsessively (or doing the same thing over and over again)

Some people find they have to do things, or think things, in very particular ways, as if something bad would happen if they didn't do this. They often know this is unusual, or doesn't make sense, but they can't stop themselves from doing it anyway.

0 1 2 3 4

E 21

Frightening memories and feelings from the past (that I can't control)

When really frightening (or 'traumatic') things have happened, many people find they get 'flash- backs.' This is when it is as if that terrible thing were happening all over again.

Or they may suddenly be reminded of it when they were not expecting it, or find they spend a lot of time trying to AVOID being reminded of it at all.

0 1 2 3 4

E 22

Getting distracted and restless (when I am trying to concentrate)

On an ordinary day is it difficult to focus on work or tasks easily or long enough, compared to young people of your age?

(Don't count when you are tired, or especially worried, or excited about something else.)

0+ 0 1 2 3 4

E 23

Getting angry

Do you lose your temper, or just get irritated by things (or people) more easily than other young people of your age?

0+ 0 1 2 3 4

E 24

Problems with sleeping

Do have any problems with sleep?

Either difficulty getting off to sleep, waking when you should be asleep, having nightmares, etc, or feeling sleepy in the daytime?

0 1 2 3 4

E 25

Feeling sad or low (most of the time)

Over the past weeks have you found it hard to really enjoy anything?

Do you feel low, or tearful, or hopeless when you think about the future?

Is it difficult to find the energy for things that you enjoyed in the past?

0 1 2 3 4

E 26

Injuring or harming myself (on purpose)

Sometimes young people do things on purpose to injure or harm themselves.

There may be many reasons for this, but do NOT include suicide attempts: these are recorded in a separate question.

0+ 0 1 2 3 4

E 27

Problems with eating

This includes all kinds of problems with eating - eating too much, or eating too little, making yourself sick after eating, or just worrying about food more than other young people of your age usually do.

0+ 0 1 2 3 4

G 37

Understanding what's the problem for me

Being able to understand what's gone wrong for me in my life, and to talk about that with other people to get advice or help.

0+ 0 1 2 3 4

G 38

Feeling that professionals don't really help (and avoiding them)

Do you feel like the adults around you aren't often helpful, and that you don't feel like there is much point working with them to try and make things better'?

0 1 2 3 4

H 39

My problems have been around for a long time

Think of serious problems affecting your life (even if they were different problems when you were younger)

0 1 2 3 4

H 40

Problems affect ALL parts of my life (Home, School, Friends, etc)

For instance, do they just affect your thoughts and feelings? Or do they also affect relationships with your family and friends, your school/studies/work, your other interests, your physical health?

0 1 2 3 4

APPENDIX F

Section of a coded transcript (young person)

Moving on to The AIM Cards, when was the first time you used the cards with your worker?

(YP) Erm.....When I was doing my assessment...for my panel meeting I think it was...I had to do an assessment.

Was that a helpful or unhelpful time to do them?

(YP) Yeah it was good so she knew what type of person I am..and that way the panel judges or panel members knew what type of person I was...she got that from doing the cards

What was it about the cards that made her be able to know what sort of person you are?

(YP) Because the things on the cards are like normal things, or like day to day things or what's in your head...it's all on the cards and you put it into good or bad so it relates to practically everyone.

Tell me a bit about using the cards that first time, what else was helpful or unhelpful about it?

(YP) There was nothing wrong with them, it was all relevant because everything she was putting in front of me I had to put it in good or bad if it was related to me, or not if it's not...and then it was really helpful cause it was all related to me

So it was helpful to say that is part of me and that isn't?

(YP) Yeah

And what did it feel like, doing that?

(YP) Erm....I don't know it was a bit like.....what's the word....it was.....it was proper related to me....I am not sure what the word is but sometimes...it was right here, coming out of my head and sometimes you don't have to word it....so it was really helpful, for me and her, so she knows what sort of person I am...what is important and what isn't important in my life.

You said it was helpful for your worker and for you, can you tell me a bit more about why it was helpful for you?

(YP) It was helpful for me to see what I...what I actually care about in my life and what my motives and goals are

So do you think the cards helped you do that?

(YP) yeah because before I never really thought about it but when saw it there..like I had to like think about it...I didn't just go yeah, yeah, yeah...I actually had to think about where I was putting it.....is this relevant, is this good or is this bad?

What do you think it is about seeing something?

(YP) Seeing something that is relevant to you and then being....like it's placed right in front of you....erm.....it's cause like, sometimes you dwell on things but when it is in front of you, you actually have to think about it...because normally....is carrying drugs with you - good or bad? But some of it was like....I don't remember it exactly but some of them where like, yeah that is me....for example how often do you get stressed...or if you have stuff like that, yeah I actually am and so that helped to make it relevant and make a judgement on what type of person I am.

So it was helpful to think 'oh that applies to me'?

(YP) Yeah cause sometimes I didn't really like...yeah I used to put things at the back of my head, but then I was like yeah this actually is me.

And you are pointing to the table?

(YP) yeah cause I would have to look at it and think, is this relevant to me? Cause I put into a column, so yeah

Touching on what you have already said, do you think the cards helped the relationship with your worker?

(YP) Yeah because then she would know what to talk to me about, and then she can help me and advise me....because of the cards, if she hadn't she would have to make assumptions and that

Were there any ways in which they were unhelpful?

(YP) No, it was all helpful there was nothing unhelpful about it....it just helped me realise what is actually going on in my life and what is relevant...and it helped her to make an informed decision about what type of person I am

APPENDIX G

Example of Coding Analysis

Example of analysis from coding to inclusion in model - Clinician

Reference in text	**Codes**	**Sub-Theme**	**Theme**	**Inclusion in model?**
- *Put yourself in their shoes (C4)* - *Find things from their point of view (C9)* - *I'm here to hear about you and your experiences(C9)*	Understanding Learning what they are experiencing	Put Yourself In Their Shoes	Who Are They?	Be On My Level And Be Interested In Who I Am (Engagement Model)
- *Meeting them where they are at (C8)* - *Important not to jump in straight away (C1)* - *Perceptive to where they are at (C10)*	Meeting them where they are Taking time, to suit the individual	Meeting them where they are at		
- *It was really easy for me (C6)* - *Gives you a bit of confidence as a therapist (C1)* - *they help with my nerves(C1)*	Easy to use Confidence building Reduce Anxiety	Improving clinician confidence	Adding to Clinical Practice	Enables A Better Understanding (AIM Card Usefulness Model)
- *Covers a broad range of topics (C10)* - *They are telling me what is important (C4)* - *Enables you to get a better perspective (C2)*	Enables broad assessment Clinician more aware of what is going on	Enables a better understanding		

Example of analysis from coding to inclusion in model - Young People

Reference in text	**Codes**	**Sub-Theme**	**Theme**	**Inclusion in model?**
- *Have a bit of a fun connection (YP5)* - *Very nice (YP2)* - *Depends on what the young person likes (YP1)*	Nice person to spend time with Specific characteristics may vary	Be fun to be around	What Clinicians Can Do To Engage Young People	Make It Worth My While Coming (Engagement Model)
- *Little words of wisdom (YP 7)* -*Told me all about prisons and stuff (YP 3)* - *Not just saying you should do that and you should do this, they should actually break it down and help you*	Advice Teaching something	Be Helpful		
- *The cards you can really hold it, and think about it (YP 5)* - *You are going to read it from your point of view and how you understand it (YP 7)* - *Seeing something that is relevant to you and then being, like it's placed right in front of you (YP1)*	Physically holding something enables you to take it in Understanding the information Reading is better than hearing	You breathe them in more than words	Playing With The Cards Is Easier Than Talking	Supports Communication (AIM Card Usefulness Model)
- *It was right there, coming out of my head and sometimes you don't have to word it (YP1)* -*You feel more comfortable talking (YP8)*	Communicating back without words Helps talking happen	They make me feel more comfortable to talk		