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A survey of how clinicians in forensic personality disorder services engage their service users in treatment

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Abstract

Non-completion is a significant problem in treatments for personality disorder (PD), and is associated with poorer outcomes. Clinicians routinely attend to engagement issues with people diagnosed with PD and so we accessed their views about the techniques they used to facilitate treatment engagement with service users with PD. Twenty-three clinicians from a range of disciplines were asked how they defined treatment engagement, what they thought were the causes of treatment engagement problems in people with PD, and what techniques or strategies they used to enhance engagement of people with PD. Data were analysed using inductive thematic analysis. Staff working with people with PD have broad views on the factors that are implicated in treatment engagement for their client group. Consequently, the techniques they use to engage service users are wide-ranging, addressing issues to do with services, individuals, therapies and therapists. Given the limited published data thus far, the suggestions generated may be of value to other practitioners in improving service user engagement.

Keywords

personality disorder; treatment engagement

Introduction

Treatment non-completion is a significant problem in personality disorder (PD) treatment services. A systematic review of psycho-social treatments for PD identified 25 studies reporting treatment non-completion found a median rate of 37% who did not complete treatment, with rates ranging from 15 to 80% (McMurran, Huband, & Overton, 2010). A recent review of attendance at adult psychotherapies in general found that people with a diagnosis of PD had higher dropout rates (26%) than people with other diagnoses (Swift & Greenberg, 2012). Importantly, treatment non-completion is associated with poorer clinical outcomes, such as more frequent admissions to hospital and more days spent in hospital (Karterud et al., 2003; Webb & McMurran, 2009), and associated higher costs (Sampson, James, Huband, Geelan, & McMurran, 2013; Webb & McMurran, 2009). In offenders,

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treatment non-completion is associated with higher rates of reconviction (McMurran & Theodosi, 2007), and offenders diagnosed with PD are those most likely to reoffend (Jamieson & Taylor, 2004). It is important, therefore, to identify strategies to enhance treatment engagement of those in treatment for PD.

Reviews of strategies for enhancing engagement and reducing premature termination in psychotherapy generally have identified effective strategies as educating people about what to expect in therapy, allowing the client a choice of therapies and therapist, role induction (observation or experiential), motivational interviewing and simple appointment reminders (Ogrodniczuk, Joyce, & Piper, 2005; Oldham, Kellet, Miles, & Sheeran, 2012; Swift, Greenberg, Whipple, & Kominiak, 2012). In therapeutic community treatment for PD, pre-admission visits, preparation groups and allocation of a patient 'buddy' have reduced dropouts (Birtle et al., 2007; Chiesa, Wright, & Neeld, 2003). More recently, a single goal-based motivational interview prior to the start of treatment improved engagement and attendance at therapy groups in a community PD service (McMurran, Cox, Whitham, & Hedges, 2013).

These strategies are clearly of value in reducing treatment non-completion rates, yet it is likely that more could be done to improve engagement of people in treatment for PD for whom there are specific issues regarding engagement. These are often people who have had trouble building and sustaining relationships and have difficulties regulating their emotions, which may present problems in forming a therapeutic alliance and sustaining a regular commitment to therapy (McMurran, 2012). Clinicians working in PD services routinely attend to engagement issues with their service users, and it was considered useful to identify their ideas and techniques for facilitating treatment engagement. Collating this information will allow the sharing of good practice ideas and provide directions for further research.

This study was conducted as part of the Readiness for Treatment in PD project, which sits within the mental health theme of the CLAHRC-NDL (Collaboration for Leadership in Applied Health Research and Care-Nottinghamshire, Derbyshire and Lincolnshire). The aim was to investigate clinicians' definitions of treatment engagement, perceived causes of treatment engagement problems and the techniques they used to facilitate treatment engagement with patients with PD.

Method

Participants

Participants were clinicians from Nottinghamshire Healthcare NHS Trust, which is the Trust with the most PD services in the CLAHRC-NDL group. Most of their services to people with PD are forensic, and we restricted our survey to this group. In total, 32 clinicians were approached of whom nine were unavailable for reasons such as illness or not responding to phone calls or emails. Twenty-three participants were interviewed: six from community services, nine from a medium-secure facility and eight from a high-secure facility. The mean years of working with people with PD of clinicians from medium secure, high secure and community forensic services was 6, 12 and 14 years, respectively. There were 15 women

and 8 men from a range of professions: five psychiatrists, four psychologists, nine nurses, three occupational therapists, one social worker and one assistant psychologist.

Procedure

Permission to approach staff to elicit their views was granted by the services' clinical directors, who nominated members of staff who worked with people with PD and who might be willing to participate in the project. Participants were purposively sampled to include a range of different professions. Nominated staff were contacted to explain the purpose of the interviews, gain their consent and arrange a convenient time for a semi-structured interview either in person or via telephone. All interviews were conducted by one of the authors (PF). Thirteen of the interviews were administered via telephone and ten were administered face-to-face at the participant's workplace. Notes were taken during the interviews.

Interview

A six-question interview schedule was designed for this project (see Appendix 1). We asked interviewees how they defined treatment engagement, what they thought were the causes of treatment engagement problems in people with PD, and what techniques or strategies that they use best enhances engagement of people with PD in treatment.

Analysis

Interview data were investigated using inductive thematic analysis (Braun & Clarke, 2006). Thematic analysis was chosen because of its ability to richly describe a body of data by drawing out the key points and presenting them in a format which is accessible to the majority of readers (Braun & Clarke, 2006). Notes were examined by PF to familiarise himself with the data and to begin searching for patterns and identifying possible codes and themes. Codes were words or phrases which identified issues related to treatment engagement, barriers to treatment engagement and any techniques used to facilitate treatment engagement. These were tabulated and themes were then identified by organising related codes. All authors then checked and rechecked the codes. Themes were then refined through this iterative process, ensuring that there was enough evidence to support each and, where appropriate, they were combined or split into component parts. The analysis ended when consensus was reached by all authors.

Results

Illustrative extracts are provided for each theme. Because these were taken from transcripts written up from notes taken during the interviews rather than verbatim recordings, these are not presented in quotation marks. The participant number and their profession are given after each extract. To maintain confidentiality, we grouped the social worker with the occupational therapists [OT/SW] and the assistant psychologist with the psychologists.

Definitions of treatment engagement

This consisted of one theme 'meaningful involvement in treatment'. In general, participants felt that a definition of treatment engagement should include more than just therapy session attendance; rather, the individual should take an active role in therapy by participating in a

range of meaningful activities and the daily timetable of activities in inpatient forensic services, contributing to therapy sessions and adhering to medication. A patient showing insight, reflection, application of skills they have learnt in therapy to an environment outside of the therapy, feeding back to a therapist and making positive choices when given the opportunity were all described as good signs that a patient was engaging.

It's a bit more than just attending. Some sense of contribution to sessions. You probably know if someone's engaging if they give a bit of feedback and show some insight. [P17] PSYCHIATRIST

Their taking an active role in treatment, they reflect and take responsibility for it, they are motivated and interested in what you say, they listen to it, they take it in. [P2] NURSE

Causes of treatment engagement problems

Three themes were identified: patient-centred barriers, therapy-centred barriers and service-centred barriers.

(1) Patient-centred barriers—The content of the theme relating to the patient related to personality, self-protection, relationship problems, experience of treatment and co-existing problems. Given the diagnosis of the patient group, it is not surprising that participants attributed many of the difficulties to the individual's personality.

Usually it's the person's problems themselves ... it's to do with therapy interfering behaviour and that can come from the way they've grown up, the nature of their PD, the way they think of the world, the way their emotions work, the coping strategies they've learnt to manage their impulses. [P12] PSYCHIATRIST

Participants also attributed engagement difficulties to self-protection and the patient's desire to stay safe. This resulted in them being unwilling to tackle the difficult emotions they would have to face in therapy.

Fear of failure ... especially in the early stages, they don't want to engage because they don't want to be seen to have failed. So the solution is not to engage in the first place. [P20] NURSE

Let their barriers down and, therefore, risk becoming unsafe. You want the individual to change, but this triggers their PD defence mechanisms and their competing motivations to want to progress and control emotions and their primary motivation to feel safe. Some PD patients want to reject us before we reject them. Lots of them have a history of rejection and abuse and failure, so it's a defence mechanism. [P11] PSYCHOLOGIST

Participants highlighted the difficulties individuals have with forming and maintaining relationships. Individuals may have a history of being abused, have had their feelings and experiences invalidated and have issues of trust.

A lot of patients with PD have had very emotionally invalidating experiences as they've been growing up. Often their emotional needs have been dismissed or

invalidated or ignored throughout their developmental years and so they very much come to rely upon themselves or just dismiss those emotional experiences, which means that they minimise the difficulty and the need for support, or again they feel that people haven't been there to support them when they've needed it so they're reluctant to ask for the help, because they perceive that those needs won't be met.

[P23] PSYCHOLOGIST

Participants attributed that the experience of treatment, either previous or current, impacted on engagement.

People's previous experiences of treatment can be very off-putting when accessing treatment. [P18] NURSE

The ward climate can play a big part. If lots of patients are doing well, then the others want to kind of hop on the bandwagon. If the environment is more negative, then it can stop engagement. [P9] PSYCHOLOGIST

Participants also highlighted how a range of other co-existing problems can make it more difficult to engage such as physical ill health, substance misuse, literacy and homelessness.

If they've got lots of problems, if they're in the middle of a crises, and they're a combination of exhausted and they don't have a home to live in, then they're clearly not going to be ready to deal with their personality traits. [P22]

PSYCHOLOGIST

Poor literacy or memory problems and poor concentration can also lead to issues in treatment and stop a patient engaging. – [P5] OT/SW

(2) Therapy-centred barriers—Therapy-centred barriers consisted of the influence of staff, non-individualised treatment and effect of medication. Staff members were noted to have both a negative and positive influence on engagement.

Whether the resources in the service are adequate, skilled and supported, if you've got motivated staff or staff who are burnt-out, whether you've got effective skills and staff resources in place. [P22] PSYCHOLOGIST

Rather than it actually being the patient posing the challenges to their treatment, it can actually be the teams and the experience or lack of experience or the preciousness of their one treatment over the other. [P13] NURSE

Participants highlighted the importance of providing treatment that is tailored to meet the needs of the individual.

There are problems when therapy is not individualised. There are multiple reasons for not engaging, which vary between patients and need to be dealt with individually. [P11] PSYCHOLOGIST

Medication is often prescribed to patients with PD and participants noted that the side effects can impinge on engagement.

Side effects of medication can slow down their processing and cognitive skills and this can be a problem in engaging in tasks. [P6] OT/SW

(3) Service-centred barriers—Service-centred barriers included inconsistent service provision.

I think inconsistency between services and within services. I think it is very confusing for patients if people have different approaches. [P16] PSYCHIATRIST

Participants also highlighted the lack of availability of treatment and that having to wait a long time to start treatment can make engagement difficult.

There can be quite lengthy waiting times for people to access services, which may be a barrier to people then going and asking for help, because they feel that either the problems will have resolved by the time they get seen or just they feel that it creates a sense of hopelessness that somebody won't be there to kind of support them or help them through their difficult time. [P23] PSYCHOLOGIST

Some participants also highlighted that whether a service is welcoming and user-friendly can contribute to engagement.

How user-friendly is it? If your service is organised in such a way that they felt engaged, that can be half the battle won, but we're stuck with the old fashioned building and antiquated systems and we haven't got a service that looks and feels like a service apart from when they actually meet the clinicians. [P21] PSYCHIATRIST

Techniques that facilitate treatment engagement

Techniques used by participants to enhance treatment engagement were collated into 12 themes.

(1) Preparatory work with the patient—Preparatory work included introducing referrals to service and the therapy on offer, psycho-education about PD, assessment of engagement and considering previous work.

We'll write to the patients to let them know about the service beforehand, let them know about the building, what's expected of them, who they'll be meeting, how long the meeting will last, we try and encourage them in any way we can to just get there, check do they know what it is that they're going to be expecting. [P16] PSYCHIATRIST

Often you find patients don't have a very good understanding of why they've been labelled as having a PD, so we'll take them through either ICD10 or DSM IV criteria and how that might apply to them and why that might be relevant, and we find that that gives them a really good, clear understanding of certainly why they've got this label and actually it sort of helps improve their understanding of what the problem is and therefore their engagement. [P12] PSYCHIATRIST

Pick up information from previous placements for example prison so that you're not repeating work and questions that the patient has been asked before. [P3] OT/SW

(2) Service user-focused service—A service-user focus was created by a welcoming and understanding environment, individualised treatments and letting the individual lead the therapy topic.

Encourage them along. Things like we'll give them a hot drink ... make things a bit more user friendly when they arrive, softer furnishings, softer approach, make sure reception staff try and be aware that actually someone might come along and just be a bit difficult when they first come, they might mouth off and things like that. I think even the reception staff and stuff like that can help. Reception staff understanding that given that they're an interface with the patient, they cannot re-enact the patient's expectation of abandonment, rejection really. We need a lot more friendly interface. [P16] PSYCHIATRIST

I think it needs to be personal and relevant as opposed to one size fits all. [P18] NURSE

For example, intimate relationship history – I won't formally bring up this in a session. We will both know that it is one of the treatment objectives, but I won't purposely bring it up. Instead, if they start to talk about intimate relationships in one session then I will work with that. So, I wait for a patient to bring up the topic so that the sessions on that topic are patient led. In a sense I empower them to bring up the subject matter. [P7] PSYCHOLOGIST

(3) Setting therapeutic parameters—Consistency of approach, setting boundaries and negotiating goals were considered important.

I would have the same therapy time and session time for patients every week and that time's protected for them ... things like letting them know in advance if there's going to be any change with that ... I think the main thing across patients is to really have that the consistent approach. [P23] PSYCHOLOGIST

It's easy with lots of our women to allow the boundaries to kind of slip as we get to know them for a long time, if transference kicks in you lose engagement. [P8] NURSE

I make sure that we have very clear goals set. [P10] PSYCHIATRIST

We also use treatment contracts at the start and we sign these with the patient ... I make sure that we stick to the contract and I remind them of this ... Sometimes patients do drift away from an objective though, this might be because they are fearful of the next stage etc., in these cases going back to the contract and specifying the objectives can be helpful. [P7] PSYCHOLOGIST

(4) Improving the therapeutic relationship—Building a therapeutic relationship was done by showing empathy and understanding, giving the person choices, building self-esteem, identifying engagement barriers, ensuring the individual's continued understanding of therapy, developing support networks and using humour.

Give the patients a sense that you can empathise and understand, because although they're at the extremes of normal they're not completely beyond other people's experiences. [P17] PSYCHIATRIST

Never ask the 'why' question because people can't answer that ... if someone has self-harmed, rather than say 'why have you self-harmed?', which is just the most unhelpful thing to ask, I go for more 'I'm guessing things are quite difficult for you at the minute? Do you want to tell me a little bit of what's going on?' so it just encourages patients to engage in conversation. You as a professional, you're showing that you're trying to understand. [P13] NURSE

It's important to ... listen to their interests and preferences and incorporate these as much as possible as this will help them engage in what is offered ... So, for example, finding something that they are good at, that they are deemed as the expert in, and getting them to teach you it, it helps build their self-esteem, their confidence and their trust in you. [P6] OT/SW

At every stage try and check that the patient knows why they're there, what it is that we're doing, what the likely outcome is, how that can be communicated to them, so it's very simple. [P16] PSYCHIATRIST

Is there anything that's getting in the way, because I think that motivation and engagement can vary from week to week or hour to hour in some cases. Instilling hope and optimism around PD and treatability of PD. [P18] NURSE

It's about trying to develop a circle of support around the patient with other staff. [P11] PSYCHOLOGIST

I like to use humour too, as a way of sort of breaking barriers between us down. [P5] OT/SW

(5) Developing skills, confidence and independence—Helping people develop skills through modelling and teaching, and gradually encouraging independence are integral to maintaining engagement.

I find modelling really useful, where I model behaviour, for example, at the start I will phone for them and then as time goes on, after they have watched me do it, they can have the phone and call for themselves. This is a way of teaching skills. [P5] OT/SW

The plan will be to get them to start to take more responsibility ... what I will try and do is get them to build up relationships with other people so as I am then stepping out they are then able to build that relationship and use that relationship as a means of continuing to engage within that activity, occupation, whatever it is. [P15] OT/SW

(6) Checking up, reviewing and feedback—Communication with the service user is vital to signal an interest in the individual, assist them overcome engagement difficulties and ensure that they know that they are progressing well.

If a patient doesn't attend a treatment session I make a point of following that up. I always recognise that there is a reason that that person's been absent, and I need to understand what that reason is to see if there is anything I can do to encourage that person back. [P13] NURSE

Getting them to tell me about the skills they learnt, then I can refer back to this later on. For example, if they then have problems I try access these and give them a refresher of these skills. [P5] OT/SW

Feedback, letting them know they've worked hard and that they're doing well. [P10] PSYCHIATRIST

(7) Pacing and change—Pacing of therapy and flexibility of pacing was seen as important, including allowing therapy breaks. Also considered useful were recognising advance warning signs of early termination and negotiating action plans, and early preparation for the end of therapy.

You don't want to rush things too fast, it's important to co-ordinate pace between staff too. You want the work later on in treatment to be more challenging but be careful not to start challenging work too early and chuck them in the deep end when they're still learning to swim. [P11] PSYCHOLOGIST

Scheduling therapeutic breaks can also be helpful if needed It's like a full time intervention here and sometimes people just get too tired and need to have a break, they are just too fatigued to continue. [P7] PSYCHOLOGIST

We will have had probably a drop out plan at the start of a formal piece of therapy, like you might start feeling like this, and if you do you might get the urge to stop treatment, and what are the warning signs, what could you do to prevent that, because it has led to problems in the past etc. [P12] PSYCHIATRIST

(8) Validation—Helping people understand how their past experiences have influenced who they are and how they experience the world validates their experiences and encourages engagement.

How they've been influenced by their early experience of care-givers ... I think if anything that's the most useful in terms of helping the patient understand who they are and why they're perceiving the world in the way they do. [P16] PSYCHIATRIST

We will work with them around really validating where those experiences have come from and why they might have the experiences. [P23] PSYCHOLOGIST

(9) Dealing with PD traits and diagnoses—Clinicians responded to the service user's presentation in light of their knowledge of PD traits and disorders.

I think not taking at face value what they say sometimes, like when they say I'm not bothered and I want to go back to prison, you need to understand this in terms of their PD. Keep in mind the patients underlying emotions, aggression, avoidance. [P11] PSYCHOLOGIST

With avoidant people it's trying to make sure that they don't use avoidance as a reason not to gain something from treatment. [P12] PSYCHIATRIST

With narcissistic PD it's very important to not ... it can be very tempting to almost slap them down, you know when they're presenting as sort of totally up themselves ... but remembering that actually for the most part it's all very thin-skinned and that what they're projecting as someone who knows it all, is the greatest, is fantastic, and that you're rubbish and don't match up, is a complete inversion of how they feel. [P16] PSYCHIATRIST

(10) Using evidence-based techniques—Familiarity with the literature informed practice.

I use the Good Lives model, building on capabilities and strengths. [P10] PSYCHIATRIST

I found a case study that was published of someone with very similar case to her ... so while she was denying she had ever had these problems, it was getting in the way of engagement. So we worked through the case study and talked about how she felt about that person then talked about the issues this raised with her. So, it's like bringing someone else into the room, even though they're not really there, to try and bypass her own personal guilt getting in the way. Talking about the case helps her feel less shame and guilt. [P7] PSYCHOLOGIST

Motivational interviewing techniques around highlighting discrepancies perhaps between what they view are their goals and perhaps how they're currently behaving or presenting. [23] PSYCHOLOGIST

(11) Professionalism—A broad range of professional skills were identified as important in helping people become engaged and maintain engagement. These included being honest about the expected rate of change, being persistent and accepting responsibility for the service user's engagement. Medication also has a part to play.

Be open, direct and realistic. Don't make any false promises from day one. Don't pretend, because when they find out they will then feel let down. Be realistic about the pace of things, being open honest and realistic. [P6] OT/SW

What I've found is that with some, they will push you away ... they knock you back and you just come back again, and they will use a range of techniques to get rid of you but it's literally like ... being that constant person there, and never giving up, don't give up because, at some point you know you will start to get through. [P15] OT/SW

Experienced people providing treatment don't over or undertreat, they are thoughtful, they think about what is going on for them. Early engagement is not about what you do it is about how you do it. Your skills as a therapist have a big impact, a number of patients who have a really negative reaction as a direct result of a person who hasn't managed them well. [P11] PSYCHOLOGIST

I'm always very mindful that, the patients are people they have responsibility for their own lives but equally I'm of the belief that we are doing a job and ... I believe we are expected to actively keep people engaged. [P13] NURSE

Help them with medication prescribing, this helps them get on an even keel, it's often useful to prescribe low dose medication to help them engage better with groups. [P10] PSYCHIATRIST

(12) Improving staff skills and communication

I advocate that the nurses and the psychologists for example work very closely together, so we will often have joint psychology sessions with the named nurse present and joint named nurse sessions with the psychologist present just so to build on trust and give a safe environment, and to encourage them to feel comfortable and engage in our treatment. [P14] NURSE

You can use reflection and supervision with colleagues to look at your relationships with patients and make sure you keep your boundaries and do things right. [P8] NURSE

So, just trying to skill the staff really and motivate them, so that they're not burnt-out before we start. [P22] PSYCHOLOGIST

Discussion

The aim in this paper was to investigate clinicians' definitions of treatment engagement, perceived causes of treatment engagement problems and the techniques they used to facilitate treatment engagement with patients with PD. Tetley, Jinks, Huband, & Howells (2011) defined treatment engagement as 'the extent to which the client actively participates in the treatment on offer' (p. 927). In accordance with this, the definition of treatment engagement by the clinicians we interviewed included the service user taking an active role in therapy and the ward activities in hospital settings. Definitions also included service users showing insight and applying skills they have learnt to an environment outside of the therapy. Care has to be taken to avoid tautologies in defining engagement, in that, engagement and outcomes need to be separated (Drieschner, Lammers, & van der Staak, 2004). Judging treatment engagement by its outcomes (e.g. insight; skills acquisition) risks confounding issues of engagement with programme efficacy. So, while clinicians are more sophisticated in their understanding of engagement than simply accepting the individual's presence at therapy sessions as indicative of engagement, some work needs to be done to advise people about the differences between the determinants of engagement, which are the intrapersonal, interpersonal, contextual and therapy factors that predict engagement, engagement itself and the outcomes of therapy. The Treatment Readiness Model for PD (Tetley, Jinks, Huband, Howells, & McMurran, 2012) describes and explains these issues at greater length.

The perceived causes of treatment engagement problems identified by the clinicians were generally similar to those identified in a larger sample of forensic and non-forensic clinicians and services users with PD (Tetley et al., 2012). The patient-centred barriers

identified in the current evaluation have similarities with Tetley et al. (2012) 'internal' factors domain and the 'client-specific' (circumstances) factors, which Tetley et al. included in their 'external' factors domain. While the majority of codes related to issues to do with the patient, clinicians also recognised that therapy-related and service issues were also facilitators of or barriers to engagement. Thus, this sample was familiar with concepts of engagement that go beyond intrapersonal motivation of individual service users.

The techniques for engagement generated by these clinicians reflect to some degree what is identified in the research literature relating to psychotherapy generally (Ogrodniczuk et al., 2005; Oldham et al., 2012; Swift et al., 2012). However, while offering choice, information-giving, preparing people for therapy, goal agreement, treatment contracting, building the therapeutic alliance, building self-confidence and self-esteem and feeding back treatment progress were all suggested, these strategies were tailored specifically to the needs of people with PD.

Preparatory work included introducing referrals to the service and the therapy on offer, but focused additionally on psycho-education about PD. In the recent past, detained offender patients with PD did not have their PD diagnosis formally explained to them, and introducing psycho-education improved not only knowledge but also the therapeutic rapport (Banerjee, Duggan, Huband, & Watson, 2006). There was recognition that consistency of approach, setting boundaries and a collaborative approach with the service user are important, and that these contribute to building a positive therapeutic alliance. Additionally, there was emphasis on ensuring that service users receive regular and helpful feedback, delivered in a positive manner, and that independent functioning is encouraged. These are all core principles in working with people with PD, who need stability, validation and support (Livesley, 2005). Staff having knowledge about PD traits and disorders were considered useful in reaching an understanding of the individual's behaviour. Such knowledge contributes to a valid formulation of the individual's problems, improves rapport and increases the identification of relevant treatment targets (Jones, 2011). Similarly, having knowledge about effective PD treatments informed staff choice of effective interventions. It is evident in the literature that the characteristics of the therapist are as important as the therapy in working with people with PD (Crawford et al., 2008), and skills for helping people to engage were identified, including honesty and persistence. Furthermore, the staff working in PD services, needed to take care of themselves through communication and supervision, if they were to remain resilient enough to motivate challenging service users (Roth, Pilling, & Turner, 2010).

While it was mentioned, pre-therapy preparation could be expanded to good effect. This is because most treatment dropouts occur very early on in therapy (Hansen, Lambert, & Forman, 2002) and so attending to early engagement could improve retention significantly. Motivational interviewing, developed by Miller and Rollnick (2013), has a wide range of applications. In this, the interviewing style elicits 'change talk' from the interviewee, with good effects in both treatment engagement and behaviour change. A pre-therapy goal-based motivational interview has recently shown promise in improving engagement and attendance of people in PD treatment, with people receiving the interview attending 16% more sessions in the early stage of treatment (McMurran et al., 2013). In this, the

individual's life goals are identified and links are made between therapy and overcoming obstacles to goal attainment. Premature termination of PD treatment is associated, *inter alia*, with a lack of experience with treatment (Ogrodniczuk et al., 2008). Pre-therapy preparation can also focus on boosting the skills needed for therapy, such as understanding and regulating emotions (McMurran & Jinks, 2012), thus preventing people from dropping out due to feeling incompetent or confused.

While these findings relate to forensic PD services, it is likely that many of the causes of engagement problems, and the techniques identified to enhance engagement are generalisable to clinicians working with people with PD in non-forensic settings.

Limitations

These interviews were conducted with staff in secure settings and so we did not seek to audio record their responses. Notes were taken during interviews, and these were written up by the researcher at the earliest opportunity into narrative descriptions. However, this notation method may allow the opportunity for bias, errors and omissions. All staff were employed in a single NHS Trust, and their knowledge and opinions may reflect training and development programmes available to Trust staff.

Conclusion

Staff working with people with PD have broad views on the factors that are implicated in treatment engagement for their client group. Consequently, the techniques they use to engage service users are wide-ranging, addressing issues to do with services, individuals, therapies and therapists. The suggestions generated may be of value to other practitioners in improving service user engagement.

Appendix 1. Interview

1. How would you define 'treatment engagement'?
2. Please tell me what you think are the causes of treatment engagement problems in people with PDs.
3. What, if any, of these causes are specific to patients with PDs (compared with other clinical groups)?
4. I am interested in any specific techniques or strategies that you use to initiate and maintain engagement of people with PD in treatment.
 - a. Tell me about techniques, ideas or practices that you use in the early stages of treatment to engage patients for treatment?
 - b. Tell me about techniques, ideas or practices that you use in the later stages of treatment to maintain patient engagement in treatment?
5. Do you use these techniques with all patients with PD?
 - a. If not what techniques work best with which patients?

6. Is there anything else you would like to add?

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