ORIGINAL ARTICLE

"What matters to me" and 'service users', carers', and clinicians' needs' and experiences of therapeutic engagement on acute mental health wards

Sarah McAllister, Alan Simpson, Vicki Tsianakas and Glenn Robert
Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care, King's College London, London, UK

ABSTRACT: *Nurse–patient therapeutic engagement on acute mental health wards is beneficial to service users' outcomes and nurses' job satisfaction. However, engagement is not always fulfilled in practice and interventions to improve engagement are sparse and ineffective. We explored the experiences of service users, carers, and clinicians drawing from 80 hours of non-participant observations in an acute mental health ward and semi-structured interviews with 14 service users, two carers, and 12 clinicians. Analysis of these data resulted in 28 touchpoints (emotionally significant moments) and eight overarching themes. Service users, carers, and clinicians identified a lack of high-quality, person-centred, collaborative engagement and recognized and supported efforts to improve engagement in practice. Potential solutions to inform future intervention development were identified. Our findings align with previous research highlighting negative experiences and support the need to develop multicomponent interventions through participatory methods.*

KEY WORDS: *clinician experience, nurse–patient interaction, nursing interventions, patient experience, qualitative.*

INTRODUCTION

Nurse–patient therapeutic engagement is central to mental health nursing practice (Peplau 1952) with policy initiatives globally supporting its delivery in practice (Australian Nursing & Midwifery Board 2016; Department of Health 2006). Engagement is experienced as therapeutic when nurses interact with service users by listening, understanding, and responding to needs while creating an environment that facilitates emotional and personal growth (McAllister *et al*. 2019). However, evidence suggests that nurses struggle to enact therapeutic engagement (McAllister & McCrae 2017; McKeown 2015). One study found that an average of 84% of service users on an acute ward were socially disengaged at any time of day (Radcliffe & Smith 2007). When engagement did occur, it was often task orientated and instrumental (McAllister & McCrae 2017), and research suggests that both service users and nurses are dissatisfied with this aspect of care (Rose *et al*. 2015). Thus, there is an imperative to generate an understanding of the needs and experiences of both service users and clinicians to inform practice development in this area.

BACKGROUND

It has long been known that high-quality, readily available engagement has a significant positive impact on the quality and outcomes of mental health nursing care (Farrelly *et al*

2014). Service users report better perceptions of inpatient care (Wykes *et al.* 2018), and nurses report greater job satisfaction, leading to fewer sick days (Moreno-Poyato *et al.* 2018), which reduces the use of costly agency nurses who are unfamiliar to service users and the wards. Conversely, poor engagement is associated with increased levels of violence and aggression (Chaplin *et al.* 2006) and rates of absconding (Bowers *et al.* 2009). However, research from Australia, Canada, Finland, the United States of America, and the United Kingdom shows a lack of high-quality engagement in practice (Sharac *et al.* 2010).

The need to maintain safety, order and manage acutely unwell people who may exhibit challenging behaviours places pressure on nurses (Csipke et al. 2014). To cope, nurses may employ custodial methods of care which create a barrier to effective engagement (Cutcliffe *et al.* 2015). Additionally, ward practicalities such as reduced staff and administrative duties mean nurses must attempt to fulfil organizational demands alongside one-on-one nursing care (Wyder *et al.* 2017). This overwhelming workload often results in care left undone (Shattell *et al.* 2008). Nurses feel guilty and inadequate (Chambers *et al.* 2015) and may stop engaging as a means of self-protection from this emotional burden (Cleary *et al.* 2012; Gabrielsson *et al.* 2016).

While these are long-standing problems, few interventions seeking to improve engagement have been implemented. Evaluations report improvements in the amount of engagement; however, the quality of that engagement remains a persistent problem (Molin *et al.* 2018). Engagement is clearly a personal act, and understanding how it is experienced by those who both receive and deliver it may give important insights into improving its therapeutic value. National and international policies recommend the participation of service users in all aspects of mental health care, including safety and quality initiatives (Australian Government 2017, Mental Health Taskforce 2016). However, equal and active service user and clinician involvement in developing interventions to improve engagement has not been evident. Thus, the aim of this study is to gain an understanding of i) how engagement is experienced on acute wards and ii) the needs of service users, carers, and clinicians to inform future collaborative intervention development.

METHODS

Design

Data collection was undertaken as part of a larger study that used Experience-based Co-design (EBCD),

a form of participatory action research (Robert *et al.* 2015), to co-design an intervention to improve nurse–patient therapeutic engagement on acute mental health wards. This paper reports on the first phase of the EBCD approach – the experience gathering phase, which uses non-participant observations and semi-structured narrative interviews to develop a collective understanding of service user, carer, and clinician experiences. This collective understanding is then used to co-design solutions that are service user, carer, and clinician centred (Bate & Robert 2007). The data on which this paper draws comprised 80 hours of non-participant observation on an acute mental health ward in inner London and 28 interviews with service users, carers, and clinicians at the participating mental health service as we sought to explore and understand their experiences of therapeutic engagement as the first phase of intervention development. This paper is reported using the COREQ guidelines for reporting qualitative research (Tong *et al.* 2007).

Participants

A convenience sample of service users and carers were recruited through face-to-face meetings, posters, and emails at community mental health teams and advocacy groups connected to the participating organization. A whole population sample of clinicians from one ward were invited to participate via presentations, posters, email, and face-to-face meetings. SM screened all participants, specifically looking for service users and carers who had, or had cared for somebody who had, at least one inpatient admission at the organization but was not currently experiencing mental ill health. All clinicians on the participating ward were eligible. A total of 28 people participated in semi-structured interviews, including 14 service users, two carers, eight registered mental health nurses, three healthcare assistants (HCAs), and one psychological therapies clinician. Just under half were female (46%), and 35% were from a Black, Asian, minority ethnic background. Participants' ages ranged from 18 to 64 years, and service user diagnoses included psychotic disorders (57%), mood disorders (21%), and personality disorder (14%).

Data collection

Data collection took place between May and November 2019. Ethical approval for the study was obtained from the London Fulham Research Ethics Committee (reference: 18/LO/2193). Written consent was obtained

prior to interviews. Permission for observations was obtained at unit level before the study started. Posters explaining the purpose of observations were displayed in common areas of the ward. Participation in observations was on an opt-out basis, although nobody declined to be observed.

SM (a female mental health nurse trained in qualitative research methods, unfamiliar to the ward) conducted 80 hours of non-participant observations between the hours of 0730-1500 or 1330-2130, Monday through Sunday. The ward manager highlighted these as the times that most nurse–patient interaction would occur. Observations were performed in 15-minute intervals, beginning with the first nurse encountered and continued until all nursing staff had been observed. Field notes were recorded on a tablet device and focused on nurse–patient interactions, guided by Tyson *et al.* (1995). This included tone of voice, body language, patterns of behaviour, nurse–patient dynamics, influences on interactions, and general ward atmosphere (see Appendix S1 for observation template). Observations were primarily conducted on a non-participant basis, so as not to influence nurse or service user behaviour. When approached, SM had informal chats with service users and clinicians.

On completion of the observations, SM conducted 28 semi-structured interviews supported by a topic guide (Appendix S2). The topic guide was informed by a previously published systematic integrative review conducted as part of the wider study (McAllister *et al.* 2019), the observations, and behaviour change theory (Cane *et al.* 2012; Michie *et al.* 2014). Interviews explored participants' experiences of engagement and what they understood by the term, influences on engagement, and clarifying assumptions made from the observations and preceding interviews. The topic guide was piloted with a service user member of our advisory group and a nurse not related to this study. Interviews were conducted at a place of the participant's choice, for example university or community mental health team premises, or telephone and lasted between 30 and 80 min. Interviews were audio-recorded; in addition, six service users and one carer were filmed for the purpose of the wider study (Bate & Robert 2007).

Data analysis

SM independently coded and themed observation and interview data and discussed findings with AS, VT, and GR. Findings were validated with seven service users and six clinicians at two feedback workshops.

Observation field notes were uploaded to NVivo and thematically analysed (Braun & Clark 2006). Words, phrases, and scenarios throughout the field notes were coded, focusing specifically on the nature of and influences on nurse–patient interactions. Codes were grouped into sub-themes until the analysis reflected the overall story of nurse–patient interactions on the ward.

Interviews were transcribed by a professional transcriber and uploaded to NVivo. Words and phrases specific to individuals' experiences and interactions were coded. As per the EBCD approach, these codes were grouped into 'touchpoints' (emotionally significant moments) (Bate & Robert 2007). Once all transcripts were coded, touchpoints were categorized into overarching themes. Sub-themes from the observations were mapped against the themes and touchpoints from the interviews. A reflexive process that constantly challenged the researcher's assumptions such as the influence of being a mental health nurse was supported by discussion amongst the study team, participant validation, and a reflective diary. This was undertaken throughout the study.

RESULTS

Five themes associated with service user/carers and two themes related to clinicians were identified. These described needs and experiences of engagement on the ward. An eighth joint theme was identified where participants proposed potential ways of enhancing therapeutic engagement. Both observational and interview findings are discussed below under these eight overarching themes. Table 1 demonstrates how the observational data mapped onto the interview data and how the touchpoints were merged into the five overarching service user/carer and two clinician themes. The joint theme is not included within Table 1 but is presented in its own table at the end of these findings.

SERVICE USERS AND CARERS

Do not dismiss me

Service users and carers often felt their concerns were not acknowledged or taken into consideration. Nurses would either not listen, blatantly ignore, or pathologize service users' actions rather than recognize that frustrations may be a result of being ignored or detained in hospital:

> There was no insight that my frustration wasn't a symptom of my mental health, it was a symptom of what had happened to me – SU3

TABLE 1 *Coding framework with observation data mapped onto participants' interview data*

Observation sub-themes	Touch points from interviews	Overarching themes
Service users and carers		
Dismissive of service users	Nurses did not take my concerns into consideration	Do not dismiss me
	Nurses did not take my physical health seriously	
	Nurses blamed my reactions on my mental health	
Attending to immediate needs	Please respond to my requests in a timely manner	
Giving mixed messages/not explaining things/not giving reasons for decisions	Please explain what you are doing	When you tell me something, please give a reason
	Be clear about your reasons for doing something	
	Introduce yourself to me	
	Do not coerce me into doing something	
Length of interactions	All you need is to listen	Please just give me some of your time
Missed opportunities	I was left on my own	
	Lack of engagement results in fear and misunderstandings of my problems	
Setting the tone for interactions	Treat me like a human being	Validate me as a person
	Please approach me/help me to approach you	
Keeping cool in heated situations	Forgive and forget	
Length of interactions	Understand me and my situation	
	Nurses are on the computer all day	Unhelpful behaviours
Ward layout	I need privacy for one-to-ones	
Repetition	Nurses give me robotic, one-size-fits-all care	
Following procedures/robotic care		
Clinicians		
Giving mixed messages	We want better team relations	Improving ward culture
	Needs to be more openness to change within the team	
	Improvement in staff-managerial relations	
	Improve the culture around response	
	Bring the fun back into the job	
Being on the shop floor	Create better bonds with service users	Improving interactions with service users
Medication rounds		
Length of interactions	Streamline working practices to create/free up time for interactions	
Named Nurse	Improve the way things are communicated to service users	
Communicating leave	Improve the way messages are handed over within the team	

Observations showed that when service users displayed frustration or anger, privileges such as Section 17 leave were threatened to be revoked. Over following days, some service users would then completely disengage from nurses – Field notes (22.06.2019)

One carer described how her loved one absconded from the ward, which might have been avoided if the nursing team had not dismissed her concerns:

> No way, it's not my fault he ran away! I said my concerns at the beginning when he was admitted…I said to them twice, he's not taking his medication…They said maybe it's better you take him and go back to Australia…   – C2

In contrast, we observed times when nurses would be attentive to service users' immediate needs:

Many Many interactions involve a service user approaching a nurse because they need something, for example to make a phone call or ask questions about their leave. These interactions are usually short (less than five minutes), but the service user appears satisfied when they are acknowledged and given this time   – Field notes (09.06.2019)

When you tell me something, please give a reason

General dismissiveness was made worse when nurses would not explain their actions or decisions:

> A patient asks a nurse if he could be escorted on leave. The nurse ignores him and continues her conversation with another member of staff. The patient uses the nurse's name to get her attention, but still he is ignored. A bank HCA walks past and overhears

the patient asking for leave but also ignores him and starts an unrelated conversation with the nurse. After saying the nurse's name three times she finally acknowledges the patient by saying 'just a minute' before walking off without further explanation. The patient is getting visibly agitated. The nurse comes back and approaches a permanent HCA and says 'can you take this one out' without looking at or acknowledging the patient. The HCA makes no attempt to take the patient out, then walks into the office. The patient asks again if anybody can take him out, to which the bank HCA responds [without looking at him] 'I'm not doing escorts'. The patient raises his voice as the nurse walks by again and says, 'there must be somebody who can take me out!' She rushes past, mumbles inaudibly under her breath and disappears. The patient tells me that this happens every day: 'Nobody explains what is going on, everybody says they're busy, but they don't look busy, she's just sitting there!' [pointing to the bank HCA]. He is very frustrated and says, 'I want to blow their (expletive) heads off'. After about 15 minutes, the permanent HCA emerges from the office, thrusts a piece of paper in the patient's face without explaining what the patient should do with it and says, 'let's go'   – Field notes (29.05.2019)

Clearly, the HCA assumed that the service user knew she was going to take him out on leave, but this was not the case and the service user felt angry, upset, and confused. Interview data also highlight this:

I guess the nurses just take it as a given that you know why you're there and you know what to do to get better, but sometimes people are so out of it that they're not even aware that they're on planet earth   – SU8

Conversely, when procedures were explained, observations showed that service users were immensely grateful:

Thank you for explaining that to me. You're the first person who's explained that to me' said by a patient when the nurse took a couple minutes to properly explain how his leave worked   – Field notes (07.06.2019)

When explanations were not given, some service users perceived care as harsh, intrusive, and coercive rather than caring or collaborative.

Please give me some of your time

Giving time was important to service users and carers alike. However, observations showed that time was hard to come by:

Within each 15-minute time slot there is sometimes several 'interactions' but most of them are so transactional and short I cannot record it as anything   – Field notes (01.07.2019)

Giving time could be fulfilled through simply listening, which was perceived as a highly therapeutic act as discussed by a carer:

One thing that I've experienced directly myself and indirectly with my daughters is that listening could be the key to everything…We may think of…I don't know what strategy, what medication or what type of ward but honestly, listening could be the key to everything. Such an easy thing but I can tell you there is a lack of listening   – C1

Opportunities to spend therapeutic time with service users were often missed by overworked clinicians, and hearing did not always lead to engagement, as illustrated in the following vignette:

A service user made a phone call to an outpatient clinic. He was clearly anxious and confused which resulted in him saying he would not attend his appointment as he thought they were going to kill him. Two nurses heard the whole conversation, but did not approach him afterwards to explore his fears and anxieties   – Field notes (07.06.2019)

In contrast, interviewees gave examples of how nurses would give their time in an *ad hoc*

They just acted like a normal person…talking about general things, some sports and topical conversation pieces, playing basketball and just sort of being there, not just from the medication side of things cause otherwise I think people can form bonds or sort of start to stereotype people almost like, oh the nurses only give me my medication.   – SU13

, informal way to conduct positive therapeutic work:

Informal interactions where conversation occurred naturally were considered to have the most therapeutic value and left service users feeling cared for, understood, and valued.

Validate me as a person

Giving time also helped service users feel validated as a human being:

I celebrated my birthday on the ward…we did a pool competition, I won, it was really nice…the nurses also got me a cake, you know it was just a nice human experience with everybody…That was a good day.   – SU11

It was evident that residual anger from past negative experiences could create tense, non-validating interactions. Observations showed several examples of when a nurse and service user began the day upset with each other due to the previous day's events. This resulted in interactions being fraught for the remainder of the day. On one occasion, a nurse defused the situation by engaging in conversation with the service user about the reasons for their upset. This helped validate the nurse's and service user's emotions, rather than making them feel that their feelings did not matter:

> The nurse was very open and frank about why she was upset, but she first allowed the patient time to speak freely about her anger. As the conversation progressed the patient became visibly less tense. They both apologised and ended the interaction with a hug   (Field notes – 25.06.2019)

Unhelpful behaviours

Service users and carers discussed three key issues that impacted negatively upon their experiences of engagement: staff prioritizing administrative duties over interactions, poor ward layout, and robotic, one-size-fits-all care. Carers felt that 'nurses don't have much time to spend with the patients' – C1 and service users concurred:

> He would just sit and write. I wanted to know what he was writing, why are you writing, not talking to me…they don't want to listen to my personal experience.   – SU2

The ward was laid out along a corridor with the nursing station at one end and the service users' communal area at the other end. Nurses stayed around the nursing station where they took phone calls, wrote progress notes and met with other clinicians. As a result, nurses tended not to be in the vicinity of service users. To initiate interactions, service users had to enter 'nursing space'. This was not ideal for therapeutic interactions, as highlighted by our interviewees:

> They would say just come over to the nurses' station…I'll sit at one side, they'll sit at the other side and I thought actually that's not very helpful, it's not very private, people kept coming over…nurses would say I'm writing up notes and quite often that's an excuse not to have a one-to-one.   – SU11

Nurses followed strict and rigid rules, which may have been to ensure order in an otherwise chaotic environment. However, it antagonized the service users:

Section 17 leave had to be taken after morning handover at 0800. At 0800 a patient asked to take his leave. The nurse's immediate reaction was to ask him how many times he had been out on leave that day. He became annoyed and said, 'obviously I've not been out it's 8 am!' The nurse became defensive, rather than acknowledging the mistake and this set a bad tone for further interactions that day – Field notes (23.05.2019)

When nurses were strict and rigid, service users experienced interactions as robotic rather than person-centred:

> No one came to me and said, why are you so aggressive, they just said, oh it's cause you've got mental health problems…almost like a conveyor belt…come in, dose them up on medication…there was no one-on-one to explain what was happening.   – SU3

CLINICIANS

Improving ward culture

All clinician interviewees discussed the need for cultural change. Many felt that relations within the multidisciplinary team were at an all-time low:

> The staff relationship it's not at its best now…a lot has to be done about that…when it's like that they are sitting on a time bomb which could explode.   – Staff 10

Nurses feared for their safety, particularly when their team was unsupportive during incidents:

> The ward's emergency alarm rang. It was really loud, but nobody left the nursing station to investigate until the response team arrived. Even then the reactions from staff were slow, opting to leave responsibility with the response team rather than check on their colleagues who sounded the alarm   – Field notes (23.05.2019)

This created a sense of mistrust within the team which led some nurses to withdraw from patient contact:

> If 90% or 70% of people can't do their job nobody will come to my rescue […] I became very aware that when there is an incident I'm left on my own…I stopped trusting the team…I couldn't rely, therefore I needed to take a step back from the patients   – Staff 8

Others felt despondent by the perceived lack of managerial support when concerns were raised about staffing levels, serious ward incidents and team relations. This significantly impacted on their motivation to engage:

People feel they're not heard, not listened to, not appreciated and overworked. Staff will say so what's the point? If I'm not appreciated, if I'm not getting the support and the backing, what's the point? – Staff 6

All interviewees discussed a desire for change; however, attempts to implement improvements were often not welcomed by the team:

I've tried to implement one-to-one engagement on the allocation but as the saying goes, you can take a horse to water but you can't make them drink it…some people are very lazy, they can't be bothered…they've been in the system for years…they're tired – Staff 5

Improving interactions with service users

All participants felt there was a need to improve nurse–patient engagement on the ward:

We need to interact more with patients because one of the major problems on the ward is because we are a little bit distant from the patients…we need to find a bond…create time, not just give them medication, just kind of engage with them. – Staff 9

However, medication rounds were often the only time a nurse would spend one-on-one time with service users. Observations showed some nurses took advantage of medication administration as an opportunity to engage in a more meaningful way:

The nurse invites her [the patient] into the clinic room where as well as having morning meds, they discuss her anxieties about being discharged into supported accommodation. I can hear calming tones of voice and the patient was smiling when they left – Field notes (22.06.2019)

JOINT SERVICE USER, CARER, AND CLINICIAN THEME

Finding solutions

All interviewees discussed the negative impact that resource constraints, such as staffing levels, had on their ability to interact. However, many strategies for improving the quantity and quality of engagement were described. There were some similarities between service users', carers', and clinicians' solutions, although service users and carers focused more on relational aspects of care and clinicians focused more on ward routines and team relations. Examples of proposed solutions are given in Table 2.

VALIDATION AT FEEDBACK WORKSHOPS

Overall, service users, carers, and clinicians supported the findings above. Service users and carers also developed one new theme: 'help me help myself'. This theme stressed how:

Nurses must create an environment conducive to self-improvement. Nurses could do this by explaining what would happen to service users during their admission and provide practical advice and support to prepare service users for life post-discharge – Field notes (31/10/2019)

Although elements of this were incorporated within the five service user/carer themes, participants agreed that this was central to improving the quality of engagement; thus, a distinct theme was necessary.

DISCUSSION

The findings above provide insights into how the lack of engagement impacts on individuals in acute mental health wards and paves the way for the future development of interventions to improve the quality of care. Overall, our findings suggest that service users, carers, and clinicians experienced frustration at the lack of engagement; however, the events that lead to that frustration are different. Our findings are in line with previous studies which employed observational techniques and also reported a general lack of engagement on acute wards (Altschul 1972; McKeown et al. 2019a; Quirk & Lelliott 2001). Barker and Buchanan-Barker (2005) highlight the importance of time when developing nurse–patient relationships. They conceptualize time as a 'gift' that can be offered to show respect and care towards individuals. Studies have shown that nurses can be deterred from engaging due to perceptions of time (Goulter et al. 2015; Shattell et al. 2008). Conversely, research that examines service users' perceptions suggests interactions should be easily available and relatively short (McAllister & McCrae 2017). This confirms our observations where service users appeared happy when nurses met their immediate needs with short, seemingly transactional interactions. This may be because acknowledgement is as important as what happens within the conversation. Thus, future interventions must prompt nurses to acknowledge service users when they need something, even if the interaction is brief.

Rather than being therapeutic, engagement was often a source of stress for participants. Clinicians were

TABLE 2 *Examples of potential solutions for intervention development*

Service user and carer solutions	Clinician solutions
Change the professional identity of the nurse so they are not just seen as the person who gives medications, for example by running events where nurses and service users interact through ordinary activities or off the ward (SU3, SU9, SU13)	Doing groups as a more efficient way to interact with service users (S7, S8) and/or have informal interactions, for example playing some music or going for a walk (S6, S7, S9, S12)
Streamline working practices to free up time for interactions, for example combining paperwork and making progress notes more efficient (SU6, SU7)	Streamlining of written handover notes and progress notes and reduce duplicate paperwork (S5, S7, S8, S9)
Appoint a compassion champion who takes a lead role in ensuring staff and service user wellbeing (C1)	Appoint a therapeutic engagement champion who promotes engagement (S6) or allocate engagement during each shift (S2, S5, S6, S7, S8)
More training for nurses on how to address service users' problems (run by service users) (SU7, SU8, SU11, SU14)	Training for staff, for example self-awareness training, a confidence boosting workshop (S4, S6, S9, S12)
Sessions for nurses and service users to meet post-discharge to help nurses see the benefits of their work, and for service users to discuss their experiences on the ward (C2, SU3, SU6, SU10)	Nurses stop administrative duties during mealtimes and sit with service users and have a cup of tea or some food and a chat (S1, S9)
Procedures and routines must be explained clearly to service users, rather than being taken for granted that they already know or understand (C1, SU3, SU7, SU8)	Increase time nurses have to run medication rounds as this is a great opportunity to engage with service users (S9)
Ask service users to provide feedback about the quality of nurse–patient interactions on discharge and areas they think can be improved (C1, SU1, SU6, SU13)	Debriefs and case formulation meetings after serious ward incidents or when challenging service users are admitted (S2, S7)
Taking a non-judgemental approach that accepts service users for how they are now, rather than what is said about them from past admissions (C1, SU8, SU11)	To ensure smooth handing over of information write doctors/nurse in charge of next shift an email at the end of your shift setting out the things that need to be handed over (S2)
Some service users find it difficult to open up about their feelings, so provide cards that display different emotions to help service users articulate their feelings and needs (SU11, SU13)	Emphasize the importance of doing activities with patients, for example a poster or screen saver saying that engagement is not slacking off, it is a legitimate therapeutic intervention (S1, S2, S9)

stressed due to the many competing demands on their time, as documented in a review of previous research (Cleary *et al.* 2012). Service users and carers were fearful of engaging as they had previously tried to initiate engagement, but were dismissed, ignored, or even penalized. Although stressed, clinicians still wanted to engage with service users. Research shows that when reality opposes ideals, feelings of guilt, frustration, and burnout ensue (Chambers *et al.* 2015). To protect themselves from these feelings, nurses may inadvertently disengage from service users and focus on more measurable tasks such as ward administration (Gabrielsson *et al.* 2016). Adequate staffing levels are key to ensuring safe, high-quality nursing care (Baker & Pryjmachuk 2016) and can reduce the use of coercive practices that negatively impact on engagement (McKeown *et al.* 2019b). To overcome these issues and relieve clinicians' stress and service users' fears, future interventions must address the organizational pressures that lead to these experiences and support nurses to respond in a more compassionate person-centred way.

A closely related issue was that of trust within the clinical team. Several nurses spoke about experiences

of being injured by a service user and receiving little to no support from their clinical and/or managerial team. A systematic review on nursing and aggression in the workplace found that organizational support encouraged nurses to report violent incidents and was vital to enable recovery from the negative emotions these incidents triggered (Edward *et al.* 2014). When violent or aggressive incidents occur, nurses experience feelings such as trauma, anxiety, fear, rage, and sorrow (Camuccio *et al.* 2012; Edward *et al.* 2014). These emotions not only impact the individual, but may influence team dynamics, which results in uncertainty and even more fear (Cleary *et al.* 2005). Nurses react to this by reducing contact with service users (Duxbury & Whittington 2005), or strictly following standardized policies and procedures (Lakeman 2006). However, this may be counterproductive as nurses who are unavailable to service users have been found to be at higher risk of assaults (Whittington & Wykes 1994). In contrast, a virtuous circle could ensue, where improved engagement leads to fewer violent and aggressive incidents, reduced staff anxiety, less avoidant behaviour and overall a more peaceful ward environment for service users and

clinicians (McKeown *et al*. 2019c). Any future intervention must enable teams to address poor dynamics and provide support to clinicians who may be struggling.

The need to be recognized and validated as a person was evident in the experiences of clinicians and service users. High workloads and unappreciative management made nurses feel dehumanized. In contrast, service users felt they were on a conveyor belt of care, where nurse–patient interactions were standardized. In recent years, publications such as the Francis Report (2013) have brought to light serious systemic failures through, amongst other things, the delivery of impersonalized, one-size-fits-all care. To overcome this, compassion when delivering nursing care has received renewed interest in both the UK and internationally (Department of Health 2012; Department of Health Western Australia 2012). These reports emphasize the need to create a common culture of care by engaging, listening to, and supporting service users, carers, and clinicians. We previously reviewed international literature and conceptualized engagement on acute wards and found that central to engagement was the need for nurses to listen and understand the person and their illness (McAllister *et al*. 2019); however, in mental health settings 'misrecognition' – when interactions are constantly invalidating – is a collectively generated and maintained phenomena. This significantly impacts on the well-being of service users, resulting in a diminished sense of self-confidence, self-respect, and self-esteem (Rashed 2019). Thus, interventions must support nurses to recognize, understand, and validate the individual and promote compassion for service users, carers, and clinicians alike.

The breadth of improvement strategies identified by participants reinforces the lack of a clear consensus around what constitutes optimal engagement, as supported by previous research (McAllister *et al*. 2019; Moreno-Poyato *et al*. 2016). It also shows that interventions to improve engagement must adopt a comprehensive approach to ensure they address the complex nature of engagement in practice. To date, interventions have focused on just one approach, predominantly improving nurses' opportunities to engage (Thomson & Hamilton 2012). Evaluations show these interventions are yet to realize improvements in the quality of engagement (Molin *et al*. 2018). A recent systematic review of interventions that addressed the nurse–patient therapeutic alliance (Hartley *et al*. 2019) which is a closely related concept to engagement, found just one intervention to have a significant improvement on the levels of inpatient therapeutic alliance as measured by the Working Alliance Inventory (Moreno-Poyato *et al*. 2018). The intervention was developed through participatory action research, and adopted a multifaceted approach, which included dedicated time for patient interactions, reflective groups for nurses and using research to inform practice. To maximize the chances of success, interventions should address a range of mechanisms (Craig *et al*. 2008; Michie *et al*. 2011).

There are limitations to our study findings. First, the interviews and observations were conducted with participants from one acute ward; the transferability of these results to other settings may be limited. However, the sample is varied and includes people of different ethnicities, genders, ages, diagnoses, and professional roles. Second, prior experience and understanding of engagement by the authors may have resulted in bias during interviews and analytical processes. Lived experience researchers doing data collection may have offered a different standpoint and outcomes. A combination would be interesting. However, the use of a reflective diary, study team discussions, and feedback workshops to moderate and critique our themes before arriving at the results sought to negate this potential bias.

CONCLUSIONS

Service users, carers, and clinicians want therapeutic engagement with each other; however, engagement is experienced as stressful for all because of an unsupportive, chaotic ward environment. First-hand experiences of engagement can serve as a guide to develop future interventions. The pragmatic solutions proposed by participants in our study do not require large amounts of money or sophisticated technology to develop and implement. But they would require service users, carers, and clinicians to work together to further develop, iteratively test, and implement these ideas in practice. Collaborative and participatory projects of this type could usefully adopt co-design processes, including creative methods and tools which place equal importance on the experiences and expertise of service users, carers, and clinicians alike. Such processes enable participants to share their emotional touchpoints (Bate & Robert 2007), as presented in this paper, providing a space for service users, carers, and clinicians to understand their emotions and experiences in relation to others. This shared understanding can foster collective action (Mulvale *et al*. 2020; Palmer *et al*. 2019) to ensure intervention development is guided by the needs of both those who will receive and deliver care.

RELEVANCE TO PRACTICE

While nurses aspire to improve engagement with service users, it is evident they may be underprepared and insufficiently supported to do so. Services must recognize and address the complex organizational contexts in which engagement occurs. Service users, carers, and clinicians must be treated as unique individuals, worthy of support and quality care. More guidance on the content of therapeutic engagement is vital to improving service users' and nurses' experiences. A collaborative approach to addressing these issues will ensure all points of view are considered and result in solutions that address not just one, but several aspects of engagement in practice.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval for the study was obtained from the London Fulham Research Ethics Committee (reference: 18/LO/2193). Informed consent was given by all participants.

REFERENCES

Altschul, A. (1972). *Patient/Nurse Interaction: A Case Study of Interaction Patterns in Acute Psychiatric Wards*. Edinburgh: Churchill Livingston.

Australian Nursing and Midwifery Board (2016). *Registered nurse standards for practice*. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx Accessed: 22 October 2020.

Baker, J. & Pryjmachuk, S. (2016). Will safe staffing in Mental Health Nursing become a reality? *Journal of Psychiatric and Mental Health Nursing*, 23 (2), 75–76.

Barker, P. & Buchanan-Barker, P. (2005). *The Tidal Model: A Guide for Mental Health Professionals*. New York: Brunner-Routledge.

Bate, P. & Robert, G. (2007). *Bringing User Experience to Healthcare Improvement: The Concepts, Methods and Practices of Experience-Based Design*. Oxford: Radcliffe Publishing.

Bowers, L., Chaplin, R., Quirk, A. & Lelliott, P. (2009). A conceptual model of the aims and functions of acute inpatient psychiatry. *Journal of Mental Health*, 18 (4), 316–325.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77–101.

Camuccio, C. A., Chambers, M., Välimäki, M., Farro, D. & Zanotti, R. (2012). Managing distressed and disturbed patients: The thoughts and feelings experienced by Italian nurses. *Journal of Psychiatric and Mental Health Nursing*, 19, 807–815.

Cane, J., O'Connor, D. & Michie, S. (2012). Validation of the Theoretical Domains Framework for use in behaviour change and implementation research. *Implementation Science*, 7 (1), 37–54.

Chambers, M., Kantaris, X., Guise, V. & Välimäki, M. (2015). Managing and caring for distressed and disturbed service users: The thoughts and feelings experienced by a sample of English mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 22 (5), 289–97.

Chaplin, R., McGeorge, M. & Lelliott, P. (2006). The National Audit of Violence: In-patient care for adults of working age. *Psychiatric Bulletin*, 30, 444–446.

Cleary, M., Hunt, G., Horsfall, J. & Deacon, M. (2012). Nurse–patient interaction in acute adult inpatient mental health units: A review and synthesis of qualitative studies. *Issues in Mental Health Nursing*, 33 (2), 66–79.

Cleary, M., Walter, G. & Hunt, G. (2005). The experience and views of mental health nurses regarding nursing care delivery in an integrated inpatient setting. *International Journal of Mental Health Nursing*, 14, 72–77.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I. & Petticrew, M. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *British Medical Journal*, 337.

Cutcliffe, J. R., Santos, J. C., Kozel, B., Taylor, P. & Lees, D. (2015). Raiders of the lost art: A review of published evaluations of inpatient mental health care experiences emanating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia. *International Journal of Mental Health Nursing*, 24 (5), 375–385.

Department of Health (2006). *From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing*. London: DH.

Department of Health (2012). *Compassion in Practice Nursing, Midwifery and Care Staff Our Vision and Strategy*. Available from: https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf Accessed: 22 October 2020.

Department of Heath Western Australia (2012). *Summary of National and State Government Policies for WA Country Health Service Planning: Working Together for a Healthier Country*. Available from: http://www.wacountry.health.wa.gov.au Accessed: 22 October 2020.

Duxbury, J. & Whittington, R. (2005). Causes and management of patient aggression and violence: staff and patient perspectives. *Journal of Advanced Nursing*, *50*, 469–478.

Edward, K., Ousey, K., Warelow, P. & Lui, S. (2014). Nursing and aggression in the workplace: a systematic review. *British Journal of Nursing*, *23* (12), 653–659.

Farrelly, S., Brown, G., Szmukler, G. *et al*. (2014). Can the therapeutic relationship predict 18-month outcomes for individuals with psychosis? *Psychiatric Research*, *220*, 585–591.

Gabrielsson, S., Sävenstedt, S. & Olsson, M. (2016). Taking personal responsibility: nurses' and assistant nurses' experiences of good nursing practice in inpatient care. *International Journal of Mental Health Nursing*, *25*, 434–443.

Goulter, N., Kavanagh, D. J. & Gardner, G. (2015). What keeps nurses busy in the mental health setting? *Journal of Psychiatric and Mental Health Nursing*, *22* (6), 449–456.

Hartley, S., Raphael, J., Lovell, K. & Berry, K. (2019). Effective nurse-patient relationships in mental health care: a systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies*, *102*, 1–10.

Lakeman, R. (2006). An anxious profession in an age of fear. *Journal of Psychiatric and Mental Health Nursing*, *13*, 395–400.

McAllister, S. & McCrae, N. (2017). The therapeutic role of mental health nurses in psychiatric intensive care: a mixed-methods investigation in an inner-city mental health service. *The Journal of Psychiatric and Mental Health Nursing*, *24* (7), 491–502.

McAllister, S., Robert, G., Tsianakas, V. & McCrae, N. (2019). Conceptualising nurse-patient therapeutic engagement on acute mental health wards: An integrative review. *International Journal of Nursing Studies*, *93*, 106–118.

McKeown, M. (2015). The future of mental health nursing: are we barking up the wrong tree? *Journal of Psychiatric and Mental Health Nursing*, *22*, 724–730.

McKeown, M., Scholes, A., Jones, F. & Aindow, W. (2019c). Coercive practices in mental health services: stories of recalcitrance, resistance and legitimation. In: A. Daley, L. Costa & P. Beresford (Eds). *Madness, Violence and Power*. Toronto: University of Toronto Press.

McKeown, M., Thomson, G., Scholes, A. *et al*. (2019a). Restraint minimisation in mental health care: legitimate or illegitimate force? An ethnographic study. *Sociology of Health and Illness*, *42*, 449–464.

McKeown, M., Thomson, G., Scholes, A. *et al*. (2019b). 'Catching your tail and firefighting': the impact of staffing levels on restraint minimisation efforts. *Journal of Psychiatric and Mental Health Nursing*, *26*, 131–141.

Mental Health Taskforce (2016). *The Five Year Forward View for Mental Health*. Available from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf Accessed: 22 October 2020.

Michie, S., Atkins, L. & West, R. (2014). *The Behaviour Change Wheel: A Guide to Designing Interventions*. London: Silverback publishing.

Michie, S., van Stralen, M. & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, *6*, 42.

Molin, J., Lindgren, B. M., Graneheim, U. H. & Ringnér, A. (2018). Time Together: a nursing intervention in psychiatric inpatient care. Feasibility and effects. *International Journal of Mental Health Nursing*, *27* (6), 1698–1708.

Moreno-Poyato, A., Delgado-Hito, P., Suárez-Pérez, R., Lluch-Canut, T., Roldán-Merino, J. F. & Montesó-Curto, P. (2018). Improving the therapeutic relationship in inpatient psychiatric care: Assessment of the therapeutic alliance and empathy after implementing evidence-based practices resulting from participatory action research. *Perspectives in Psychiatric Care*, *54* (2), 300–308.

Moreno-Poyato, A., Montesó-Curto, P., Delgado-Hito, P. *et al*. (2016). The therapeutic relationship in inpatient psychiatric care: a narrative review of the perspective of nurses and patients. *Archives of Psychiatric Nursing*, *30*, 782–787.

Mulvale, G., Green, J., Miatello, A., Cassidy, A. E. & Martens, T. (2020). Finding harmony within dissonance: Engaging patients, family/caregivers and service providers in research to fundamentally restructure relationships through integrative dynamics. *Health Expectations*, 1–14. https://doi.org/10.1111/hex.13063

Palmer, V. J., Weavell, W., Callander, R. *et al*. (2019). The Participatory Zeitgeist: an explanatory theoretical model of change in an era of coproduction and codesign in healthcare improvement. *Medical Humanities*, *45*, 247–257.

Peplau, H. E. (1952). *Interpersonal Relations in Nursing*. London: MacMillan.

Quirk, A. & Lelliott, P. (2001). What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. *Social Science & Medicine*, *53* (12), 1565–1574.

Radcliffe, J. & Smith, R. (2007). Acute in-patient psychiatry: How patients spend their time on acute psychiatric wards. *Psychiatric Bulletin*, *31*, 167–170.

Rashed, M. A. (2019). *Madness and the Demand for Recognition: A Philosophical Inquiry into Identity and Mental Health Activism*. Oxford: University Press.

Robert, G., Cornwell, J., Locock, L., Purushotham, A., Sturmey, G. & Gager, M. (2015). Patients and staff as co-designers of healthcare services. *British Medical Journal*, *350*, g7714.

Rose, D., Evans, J., Laker, C. & Wykes, T. (2015). Life in acute mental health settings: experiences and perceptions of service users and nurses. *Epidemiology and Psychiatric Sciences*, *24* (1), 90–96.

Sharac, J., McCrone, P., Sabes-Figuera, R., Csipke, E., Wood, A. & Wykes, T. (2010). Nurse and patient activities and interaction on psychiatric inpatients wards: a literature review. *International Journal of Nursing Studies*, *47*, 909–17.

Shattell, M., Andes, M. & Thomas, S. P. (2008). How patients and nurses experience the acute care psychiatric environment. *Nursing inquiry*, *15* (3), 242–250.

Thomson, L. & Hamilton, R. (2012). Attitudes of mental health staff to protected therapeutic time in adult psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, *19* (10), 911–915.

Tong, A., Sainsbury, P. & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19* (6), 349–357.

Tyson, G. A., Lambert, W. G. & Beattie, L. (1995). The quality of psychiatric nurses' interactions with patients: an observational study. *International Journal of Nursing Studies*, *32* (1), 49–58.

Whittington, R. & Wykes, T. (1994). An observational study of associations between nurse behaviour and violence in psychiatric hospitals. *Journal of Psychiatric & Mental Health Nursing*, *1* (2), 85–92.

Wyder, M., Ehrlich, C., Crompton, D. *et al*. (2017). Nurses experiences of delivering care in acute inpatient mental health settings: A narrative synthesis of the literature. *International Journal of Mental Health Nursing*, *26*, 527–540.

Wykes, T., Csipke, E., Williams, P. *et al*. (2018). Improving patient experiences of mental health inpatient care: a randomised controlled trial. *Psychological Medicine*, *48* (3), 488–497.

SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Appendix S1. Observation template.
Appendix S2. Topic guides.