

Research Article

A Realist Evaluation of Mechanisms and Contexts for Facilitating the Implementation of Supported Self-Management in Community Stroke Care (The IMPETUS Study)

Lisa Kidd ¹, Julie Brown,² Helen Mason,³ Terry Quinn,⁴ Katie I. Gallacher,⁵ Fiona Jones,⁶ Rebecca Fisher,⁷ Therese Lebedis,⁸ Mark Barber,⁹ Katrina Brennan,⁹ Betty Gilmour,¹⁰ Colin Fraser,¹⁰ Patricia Mooney,¹⁰ and Audrey Taggart¹⁰

¹School of Health & Life Sciences, Glasgow Caledonian University, Glasgow, UK

²School of Medicine, Dentistry & Nursing, University of Glasgow, Glasgow, UK

³Yunus Centre for Social Business & Health, Glasgow Caledonian University, Glasgow, UK

⁴School of Cardiovascular & Metabolic Health, University of Glasgow, Glasgow, UK

⁵School of Health & Wellbeing, University of Glasgow, Glasgow, UK

⁶Population Health Research Institute, St Georges University of London, London, UK

⁷Division of Rehabilitation, Ageing and Wellbeing, University of Nottingham, Nottingham, UK

⁸NHS Grampian, Aberdeen, UK

⁹NHS Lanarkshire, Bothwell, UK

¹⁰Patient & Public Partnership Group to IMPETUS, Glasgow Caledonian University, Glasgow, UK

Correspondence should be addressed to Lisa Kidd; lisa.kidd@gcu.ac.uk

Received 21 December 2023; Revised 24 June 2024; Accepted 24 July 2024

Academic Editor: Helen Skouteris

Copyright © 2024 Lisa Kidd et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

The past decade has seen a growing recognition of the role of supported self-management in the provision of long-term care and support for stroke survivors in primary and community care. However, its implementation and delivery across different contexts and models of community stroke care is inconsistent and patchy. This realist evaluation explored how and in which circumstances supported self-management is enacted and delivered within community stroke rehabilitation. Specifically, the study aimed to identify and explore contexts, mechanisms, and outcomes related to the delivery of collaborative supported self-management. It comprised a realist synthesis, Q-methodology study, and realist-informed interviews and focus groups with stroke survivors ($n = 20$), community-based stroke practitioners ($n = 20$), and community service delivery managers/clinical leads ($n = 8$) in stroke. The findings revealed that delivering supported self-management effectively and consistently in community stroke rehabilitation starts with *embedding the ethos of collaborative supported self-management* across staff, teams, and the organisation and involves collaborative relationships with stroke survivors that aim to *build trust, confidence, and resilience*. The findings identified specific mechanisms and facilitatory and inhibitory contexts that influence how well this is enacted and achieved in practice. A realist approach in this study is novel and has helped to generate new insights and perspectives how and when supported self-management approaches work in community stroke rehabilitation. The findings expand on and complement existing research on the efficacy of supported self-management in stroke and are of clinical importance for informing how collaborative, relational supported self-management approaches can be implemented, personalised, and tailored to people's needs and evaluated within current healthcare systems.

1. Introduction

Supported self-management features as a core component of long-term condition care in the United Kingdom and across global health policies [1–3]. More specifically within the field of stroke, supported self-management is advocated for within national clinical guidelines and current stroke policies [2, 4–8]. Although stroke is considered an acute event, its complex, prolonged, and significant impact on stroke survivors and their families is firmly recognised [9–11]. In spite of this, community-based rehabilitation services and long-term care after stroke have frequently been a neglected part of the stroke pathway, with greater attention afforded to the acute and subacute phases of stroke care [12]. A recent UK-based James Lind Alliance Stroke Priority Setting Partnership, conducted by the Stroke Association, identified two top ten research priorities as being (i) how to best resource and organise effective community stroke services and (ii) how to help stroke survivors to better manage the longer-term impact of their health and wellbeing after stroke [13]. Recent reports from stroke organisations capturing people’s lived experiences in the UK and across Europe highlight that personalised and consistent support for life after stroke remains an unmet and often poorly addressed need [11, 14, 15].

Supported self-management is often positioned as being part of the longer-term stroke pathway and community-based rehabilitation [4, 5]. It is conceptualised as as multidisciplinary approaches and interventions, which help people with long-term conditions to develop the skills, knowledge, and confidence to manage the medical, social, and emotional impact of their condition(s) and to live as well and personally meaningful a life as possible [16, 17]. Engaging in self-management is beneficial for some stroke survivors and their families [18–22], and there is evidence of the effectiveness of theory-based stroke-specific self-management interventions, such as the Bridges programme in the UK [23] and the Take Charge programme in New Zealand [24, 25] on outcomes such as health-related quality of life, independence, and self-efficacy. Whilst this evidence is valuable, traditional randomised controlled trials alone may underplay the complexity of intervention fidelity and what the implementation of supported self-management in community stroke care involves from the perspectives of those who are involved in delivering and receiving it. This can lead to failure of the implementation of supported self-management interventions in “real-world” settings outside of the research environment.

Significant variation in rehabilitation practice and delivery models for long-term support across UK and European community stroke care exists [12, 26, 27]. Whilst some areas have services such as early supported discharge in place, others have different models which can comprise a combination of specialist stroke or generic rehabilitation and voluntary sector support [12]. Against this backdrop, the delivery of supported self-management in community stroke care is further hampered because of the influence of contextual factors from environmental, geographical, and organisational to personal and interpersonal factors [28]. As

a concept, supported self-management is ambiguous and ill-defined; it shares overlaps with other person-centred and collaborative models of care such as shared decision-making and personalised goal setting. This, coupled with a lack of clarity and evidence on the optimal components of supported self-management approaches in stroke, leads to uncertainty over how supported self-management in stroke care works and how it can best be delivered [28, 29], resulting in continued reporting of long-term unmet needs amongst stroke survivors [10, 11, 14, 15].

Thus, optimising and tailoring the delivery of supported self-management in long-term community stroke care requires a research approach that enables an investigation into how it is enacted and delivered by rehabilitation teams and how it is received and works best for people affected by stroke [23, 28]. An understanding of this could help clinicians, service providers, and commissioners to better identify what is likely to work best in the differing contexts of their care, services, and local areas. This would help to support stroke survivors’ engagement in their self-management in ways that have a better chance of meaningfully addressing their longer-term needs and priorities in a more sustainable way. It would also help to reduce the risk of waste and inform more appropriate resource allocation so that the approaches offered fit with the needs of, and can feasibly be transferred to and delivered within the scope of, the local context and the existing organisation of care delivery. Insights into how, for whom, and why supported self-management works also help to forge a shift in the evidence base from *what works* to *how* things work encouraging researchers and clinicians to think differently about developing supported self-management approaches that align with people’s needs, a sense of how they will work for them, and what will fit with the complexity of the system, organisation, or community in which it is being delivered. This would help to ensure that the evidence from trials supported self-management approaches and their benefits has a stronger chance of being translated into and embedded within stroke guidelines and real-world care delivery. The following paper reports on a realist evaluation study that aimed to address existing gaps in relation to *how* supported self-management in community stroke care works, *in which contexts* it works best and *why*.

2. Materials and Methods

2.1. Study Design: Realist Evaluation Methodology. This study followed the RAMESES II reporting guidance [30] for realist evaluations. Realist evaluation focuses on building, testing, and refining generative causal programme theories which are designed to explain the *how* interventions work, in what *contexts* they work, and why [31, 32]. Realist evaluation posits that interventions produce observable outcomes through a set of hidden mechanisms, which are offered by the intervention strategies or components of an intervention and which are triggered (or not) by characteristics of the surrounding context (e.g. individual, interpersonal, or organisational factors) in which the intervention is being delivered [32]. Programme theories in realist evaluation are

used to describe how an intervention is intended to produce its outcomes and are articulated using a heuristic known as CMOCs (Context-Mechanism-Outcome configurations). These terms are further defined in Table 1.

The methodological approach underpinning this study has been described in detail elsewhere [36]. Briefly, however, the study was undertaken across two phases comprising programme theory development (Phase 1) and programme theory testing and refinement (Phase 2) (Figure 1).

2.2. Setting, Sampling, and Recruitment. The approach to sample selection, eligibility criteria, and recruitment processes have been previously outlined [36]. However, to reiterate briefly, the participants included stroke survivors ($n=20$), community rehabilitation practitioners ($n=20$), and managers or clinical leads for community teams ($n=8$) from four Scottish health board areas. Participants were selected based on their likelihood of being able to provide rich insights into their experiences of organising, delivering, or having been offered or received community-based supported self-management [37, 38]. Participants were identified by a local collaborator in each site who was independent from the research team and the same participants took part in both phases of the RE. This design allowed for flexibility, as Manzano [38] described, in being able to revisit and explore initial ideas around the programme theories with participants as the research moves from the theory gleaning to testing stages. The health board areas selected offered a mix of organisational structures and service delivery models, plus different regions of Scotland, which involved remote and rural, and urban communities. Comparison across the case study sites allowed for an understanding of how and why mechanisms and outcomes differed depending on their context.

2.3. Data Collection

2.3.1. Phase 1: Theory Development. Phase 1 comprised a combination of approaches to develop and refine an initial set of programme theories (expressed as CMOCs) [36]. Briefly, the methods incorporated a realist synthesis of primary and secondary research on supported self-management in stroke (and other long-term conditions), a scoping and mapping of the delivery of supported self-management across the study sites, and a Q-methodology study to involve stakeholders in developing, refining, and prioritising the initial programme theories. Realist synthesis is a common approach used to identify and outline mechanisms, contexts, and outcomes which can be built into a set of initial programme theories for later testing [39]. The specific purpose of the literature search in a realist synthesis is to identify the most relevant evidence that informs, explores, and explains what works, for whom and in what contexts in relation to a specific topic, in this case, supported self-management. The review protocol, outlining the specific approach taken, was registered in PROSPERO (CRD42020166208). Included papers were categorised according to high, moderate, and low relevance to the developing programme theories and are listed in

supplementary information 1. The scoping and mapping of study sites (supplementary information 2) allowed for a greater insight into contextual factors likely to influence how supported self-management was delivered in community rehabilitation services within these specific regions.

Finally, the Q-methodology study enabled prioritisation and clarity of the initial CMOCs, building in further insights and explanations ahead of testing in Phase 2. Q-methodology is a novel approach in realist theory development and is a mixed-methods approach which helps to identify and describe shared viewpoints on a subject, revealing areas of consensus and disagreement [40]. This seemed appropriate for a study of supported self-management which is a highly ambiguous concept and interpreted in many different ways. The Q-methodology study has been described in more detail elsewhere [41]. Briefly, however, the Q-methodology study involved presenting stroke survivors, community rehabilitation practitioners, and managers with a series of written statements relating to the underpinning initial CMOC ideas (referred to as a Q-sort) and inviting them to rank order the statements from most to least important according to the question: What is most important to make supported self-management work? The Q-sort ranking stages were conducted face-to-face with each group of participants separately. Once the ranking process was complete, participants were asked to explain their ordering of the statements. Statements in the Q-sort were developed from the realist review and the initial stages of programme theory development where the initial CMOCs were hypothesised. All possible statements were collated into a list by the research team who independently reviewed and discussed these for important insights and overlaps between the statements. The list was refined to 32 statements, which is typical of other Q-sorts [40], that reflected the balance and coverage of the initial programme theories and the articulation of the statements was reviewed by, and refined with the help of, our patient and public involvement group members. The ranking of the statements was statistically analysed and explanations for people's perspectives on these used to support the overall theory development process. The integration of the methods described here helped to identify the key components of what supported self-management in community stroke care comprised, the variation of this across study sites, and the different contexts and mechanisms operating across study sites which appeared to shape the delivery and outcomes of supported self-management.

2.3.2. Phase 2: Theory Testing and Refinement. Phase 2 focussed on testing, synthesising, and consolidating the CMOCs generated in Phase 1. This allowed for the development of a robust explanation of how community supported self-management works, for whom and in what contexts. Realist-informed interviews and focus groups with stroke survivors, community rehabilitation practitioners, and clinical managers were specifically designed to test the CMOCs from Phase 1. An example of the interview schedule used with health professionals and clinical managers is

TABLE 1: Summary of definitions underpinning the study.

Programme	For the purposes of clarity in this manuscript, we will refer to supported self-management as a programme
Programme theory	Programme theories are ideas or hypotheses about “...about how, and for whom, to what extent, and in what contexts a programme might ‘work’” [30]
CMO	The Context-Mechanism-Outcome configuration is abbreviated to CMO. CMO is a heuristic or hypothesis important to building and refining theory in realist studies. The CMO configuration is used to demonstrate generative causality by unpacking how and why a programme works at a granular level. CMOs are embedded within programme theories
Context	Context tells us for whom and in what circumstances a programme may or may not work. Context can be thought of as anything that happens in the backdrop of a programme, e.g., relational and dynamic or observable [33] that triggers or inhibits the firing of a mechanism to produce an outcome. Context can include individual, interpersonal, or organisational factors
Mechanism	Mechanisms tell us how or why a programme may or may not work. In realist evaluation, mechanisms are often hidden as they often include the reasoning or decisions that people make in response to resources offered by the programme. Thus, mechanisms comprise both the intervention resources and how these are acted on or responded to by actors [34] and are influenced by the context in which the programme is enacted. It is the combination of mechanism and context that generates outcomes
Outcome	Outcomes can be intended or unexpected consequences of a programme, produced by the combination of context and mechanisms [31]
Intervention strategy/component	Intended plans of action or components of an intervention and/or its delivery [35]. Intervention strategies and components are the “seen” parts of an intervention in contrast to the mechanisms, which are hidden

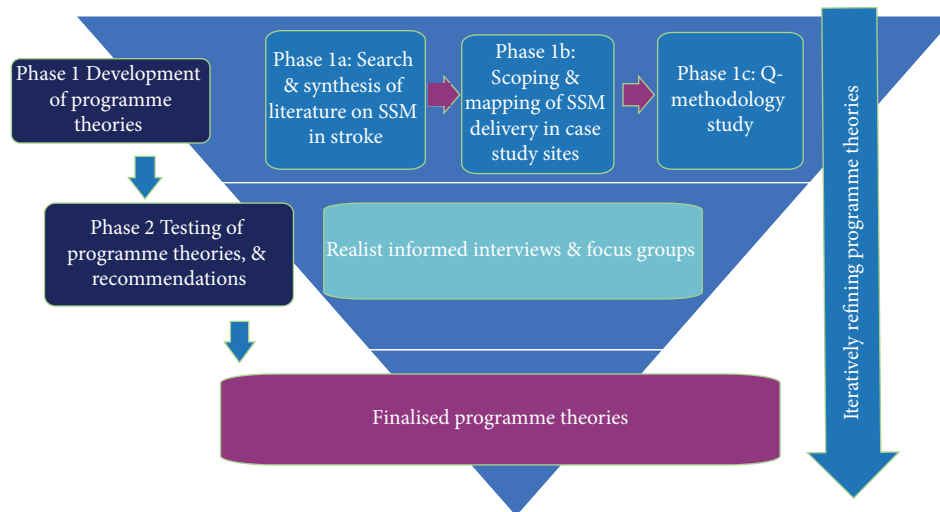


FIGURE 1: Summary of design and stages of study.

shown in supplementary information 3. All data collection in this phase was conducted online given the current COVID-19 restrictions at that time. Interview guides contained questions that directly asked participants about the CMOs and participants were invited to comment on these with a view to refuting or confirming their content and helping to refine their articulation [38]. Interviews and focus groups were audio recorded and transcribed verbatim.

2.4. Data Analysis. Data analysis for programme theory development and refinement was undertaken in accordance with the RAMESES II guidelines [30] and involved

framework analysis [42]. The data analysis was retroductive [30, 43], applying both deductive and inductive logic and moving back and forth between the initial list of CMOs and the data. Two authors were involved in the analysis (LK and JB), which aimed to seek evidence to confirm, refute, and refine the articulation of initial CMOs or new CMOs where relevant. The analysis in both phases involved identifying and coding CMOs and presenting these connected chains of contexts, mechanisms, and outcomes sitting related to the programme theory areas. The analysis aimed to identify patterns, known in realist studies as demi-regularities, which reveal the CMOs with more evidence to support these and are synthesised back into the

articulation of the CMOCs. This iterative process was repeated multiple times in reaching a refined set of programme theories.

2.5. Ethics Approval. Ethical approval was received from the East of Scotland Research Ethics Committee (19/ES/0055) and Research and Development approvals from the participating health boards. All participants provided informed consent to participate and their identities and organisations were anonymised.

2.6. Patient and Public Involvement. The study was informed and guided by a patient and public involvement group that comprised four people with lived experience of stroke. The group provided guidance, expertise, and support from research design through to study recruitment and data collection, and producing the final study reports. The group helped in the piloting of the Q-methodology and interview processes in phases 1 and 2 and were involved in the dissemination of project outputs. The group members also helped to prepare and agreed to be co-authors of the final manuscript.

3. Results

The demographics of the participants are described in Table 2. Participants had all experienced or were involved in the delivery of different forms of self-management support, mostly through peer-based self-management programmes, ongoing rehabilitation, or during a one-to-one clinical interaction. None of the participants reported delivering a structured self-management intervention such as the Take Charge programme [24]; however, some had been trained in the principles of the Bridges programme [23], despite this not being a formalised and integrated component of their community rehabilitation delivery.

The analysis identified two programme theories to explain how supported self-management is delivered and what “makes it work” in different contexts of community stroke care: (i) *embedding the ethos of collaborative supported self-management* and (ii) *building trust, confidence, and resilience*. Table 3 depicts each CMOC with examples of supporting evidence from the multiple data sources in the study. The intervention strategies or components of supported self-management, the underlying mechanisms of action that they give rise to, and the facilitatory and inhibitory contexts that influence how each of the specific mechanisms works (or don't work) are discussed in the following sections. Evidence of examples of evidence to support hypothesised inhibitory contexts for the activation of CMOCs is also presented in Table 4.

3.1. Embedding the Ethos of Collaborative Supported Self-Management (Programme Theory 1). Programme theory 1 focuses on how the organisational and cultural conditions for delivering supported self-management can be developed and spread. The realist synthesis captured professionals' perspectives of self-management revealing differences in how supported self-management is articulated, encouraged,

and measured within and across organisations. These nuances affect narratives about local and organisational priorities and the degree of autonomy that professionals seem to have in working flexibly and collaboratively to enact and deliver supported self-management [29, 46–51]. The realist synthesis also emphasised that supporting self-management may require professionals to draw on a different set of skills or approaches that prioritise collaborative working and a focus on “doing with” or “being with” rather than “doing to” and help to create a shared language and understanding around person-centred supported self-management [50, 52]. However, practitioners need to feel supported, confident, and sufficiently trained to work collaboratively and flexibly with stroke survivors in addressing their priorities [28, 44].

The empirical data from our study reinforced these aspects as being essential for embedding an ethos of collaborative supported self-management, which led to the construction of this programme theory. Three CMOCs through which an ethos of collaborative supported self-management could be developed, spread, and embedded in an organisation were identified and confirmed in the analysis. These include the following: feeling inspired and encouraged to “do” supported self-management (CMO1); learning and reflecting together (CMO2); and cohesion and connectedness (CMO3).

3.1.1. Feeling Inspired and Encouraged to “Do” Supported Self-Management (CMO1). Creating and communicating a clear and consistent vision across the layers of the organisation for delivering supported self-management and engaging key stakeholders in securing “buy-in” for person-centred approaches at all levels was fundamental for inspiring and motivating staff to feel confident to “do” supported self-management. This was believed to facilitate flexible and collaborative working with stroke survivors and their families.

Leaders and champions (intervention strategy) who took the time to get to know their staff, who demonstrated a passion for, and were experienced in supporting self-management, and who role-modelled person-centred values when engaging with staff (facilitatory contexts) engendered a feeling of authenticity and trust, which helped to offer sustained encouragement, reassurance, and inspiration. This kind of engaged and aligned approach where leaders could tailor their “pitch” according to their audience, as opposed to a command-and-control approach (inhibitory context), was more effective for creating team cohesion and building confidence amongst staff. This context also sparked staff's motivation to find new or creative ways to reconfigure and deliver services and support that addressed the needs of people rather than being dictated by fixed service level agreements or workforce issues and staffing.

In contexts with little facilitation or direct support from leaders and champions (inhibitory context), staff frequently spoke of the delivery of supported self-management as being unworkable within the time and resource constraints of their current service. Consequently, staff did not feel inspired or motivated to work differently and generally stuck to the status quo of their practice and often reported feeling frustrated and isolated.

TABLE 2: Participant characteristics.

Stroke survivors ($n = 20$)	Median age: 65.6 years (range 34–82 years)
	Female: $n = 7$; male: $n = 13$
	Median time poststroke: 18 months (interquartile range (IQR) 1–3.5 years)
	Median mRS: 3 (IQR 2–3, range 1–4)
Community rehabilitation practitioners ($n = 20$)	Median NIHSS language score: 0 (IQR 0–1, range 0–2)
	Median short form MoCA: 12 (IQR 12–14, range 8–14)
	Physiotherapist: $n = 6$
	Occupational therapist: $n = 6$
	Nurse: $n = 3$
	Speech and language therapist: $n = 3$
Managers/clinical leads ($n = 8$)	Clinical psychologist: $n = 2$
	Median number of years' working in stroke: 16.5 years (IQR 14.5–22.8 years)
	Median number of years working in community stroke rehabilitation: 12 years (IQR 8–15.1 years)
	Median number of years working in management/leadership role: 13.5 years (IQR 9–18.5 years)

mRS: Modified Rankin Score, NIHSS: National Institute of Health Stroke Scale, MoCA: Montreal Cognitive Assessment, and IQR: interquartile range.

3.1.2. Learning and Reflecting Together (CMOC2). Collaborative working with stroke survivors takes confidence and trust and, as reinforced in participants' narratives, can be challenging to implement in practice because of staff shortages or service model restrictions. Such challenges can restrict the autonomy that teams perceive they have over what and how supported self-management is delivered. The availability of, and access to, opportunities for regular, repeated, and interdisciplinary training and learning about supported self-management (intervention strategy)—both formal and informal—was an important strategy for implementing collaborative approaches to supporting self-management. These opportunities provided a space where teams could learn from and connect and reflect with each other, share experiences and concerns, build confidence, and together develop a shared understanding about what supported self-management involves.

When staff were offered regular opportunities to engage with training or discussions around supported self-management (facilitatory context), they reported feeling supported, valued, and invested in by the organisation and by their colleagues, which led to greater confidence and motivation to “do” supported self-management. In contrast, when staff perceived a few opportunities for learning about supported self-management or had to seek these out themselves (inhibitory contexts), they perceived that supporting self-management was not valued or seen as a health board priority and so did not feel any impetus or drive to change their current practice. Our data revealed that staff working in such contexts also had a fractured understanding across their teams of what supporting self-management involved and its potential impacts, which led to patchy implementation in practice.

3.1.3. Cohesion and Connectedness (CMOC3). Being supported by and connected with colleagues who can help each other to learn and gain insights into “doing” supported self-management was identified as important for nudging, spreading, and embedding an ethos of collaborative working

across teams and the organisation. Although leaders and champions (intervention strategy) and training and learning opportunities (intervention strategy) were seen as important for creating a shared understanding and sense of purpose of delivering supported self-management, having a network of practitioner support (intervention strategy) was also valuable for reinforcing the diffusion of this across team members. Knowing who to reach out to for support and advice strengthens cohesion and connectedness both within and across teams and helps to build practitioner's confidence in implementing and engaging people in self-management in their practice. Role modelling amongst peer colleagues can act as an eye opener and a way to demonstrate and model the subtleties and nuances of what person-centred working feels like. This includes the language and types of conversations that supporting self-management involves, prompting a common understanding of what it is and greater confidence in delivering it in practice.

The data identified that colocation in a shared office with colleagues, having worked together for a long-time, and being able to connect with colleagues informally (facilitatory contexts) through discussions at the end of team meetings or bumping into someone in a corridor helped develop trust between colleagues and a sense of psychological safety within teams. This prompted them to feel more confident and autonomous about challenging the status quo of their current practice and exploring ways to flexibly and creatively to address stroke survivors' priorities. On the other hand, remote working, working in a generalist rehabilitation team or a perceived lack of opportunities to informally connect with colleagues (inhibitory contexts), was found to limit capacity for connections and cohesion. Staff working in these contexts reported that they often felt isolated and lacked direction on how to change and improve their practice or service model.

3.2. Building Trust, Confidence, and Resilience (Programme Theory 2). Programme theory 2 focuses on the quality of the interactions and relationships between stroke survivors and

TABLE 3: CMOCs with supporting evidence.

CMOC	Evidence to support CMOC
<p><i>Programme theory 1: embedding the ethos of supported self-management</i></p> <p>CMOC 1: Feeling inspired and encouraged to do supported self-management When practitioners feel that SSM is perceived as important and valued in their organisation (context), they are more likely to work collaboratively with stroke survivors to support self-management (outcome) because they feel inspired and encouraged to “do” SSM (mechanism resource) and as a result feel more confident to work in different ways or try out new skills to support stroke survivors’ self-management (mechanism response)</p>	<p>“...everyone in the rehabilitation team needs to feel supported by their managers and leaders in order to work in new and innovative ways...flat hierarchical structures lead to more open and supportive environments for supported self-management.” (Jones [44], realist synthesis)</p> <p>“[we need to] think outside the box. Some people may struggle to be creative but [we] need to foster (that)...it links to flexibility.” (WML, Q-methodology)</p> <p>Interviewer: has there been specific training for supported self-management for you within your organisation? ECI: I suppose for us [the leader] is such big ambassador for self-management so we’ve had a lot of informal training and discussions. So I guess it’s become such a known concept for us...we probably have had formal training but I think it’s all the informal talk as well, it’s just a culture we’re so aware of. ECI (focus groups/interviews)</p> <p>“It’s partly about leadership, it’s partly about ensuring the service’s capacity to do it, it’s partly about modelling behaviour and modelling conversations and interactions and engaging the whole team in that process so they all get experience of how to do it and therefore once the team feel comfortable with that, I can step back.” (EML, focus groups/interviews)</p> <p>“If you’ve got someone that’s got a really keen interest in something and they’re really really motivated then they can take that time out to go and look at you know developing a service or building that into the service...and they help to motivate other members of the team as well and then other members of the team feel as though they’ve got someone...a champion that they can go and just have a wee word with. I think that’s really important when you’re trying to implement any kind of change like that.” (SM2, focus groups/interviews)</p>

TABLE 3: Continued.

CMOC	Evidence to support CMOC
<p>CMOC 2: Learning and reflecting together</p> <p>When opportunities and strategies for learning about SSM are offered to interdisciplinary teams, on a regular basis and these recognise that a “one size fits all” model for supporting self-management isn’t appropriate (context), teams are more likely to work collaboratively with each other and have a sense of ownership and autonomy in shaping and delivering high quality, tailored support for self-management (outcome) because they have an opportunity to listen to each other, learn together and from each other and to reflect on current practice and share their perspectives of SSM (mechanism resource) and so they develop mutual trust, a better understanding of each other’s roles and a shared understanding of what delivering SSM consistently as a team involves (mechanism response)</p>	<p>“Interprofessional teamworking affects outcomes and patient experience through mechanisms of shared purpose, critical reflection, innovation and leadership. . . several practitioners commented that the interaction with others during training had been enjoyable and that meeting and learning with and from others across the boundaries of professional roles led to enrichment as well as critical reflection on own roles and practices.” (Kulnik [45], realist synthesis)</p> <p>“If we are encouraging our patients to think and act creatively, then we should be able to work this way too. Using skills, being innovative. We get ‘hung up’ on resources.” (SC2, Q-methodology)</p> <p>“The training is part of your approach, you’re modelling how that looks in practice and potentially nudging others around you to come on board with that way of working as well.” (SC3, focus groups/interviews)</p> <p>“I probably work closer with those disciplines now [physios, OT, speech and language therapists] than I ever have and actually I’ve got a much better understanding of their role and where we can blur those roles. . . I think before it was always kind of you’ve got a bit of an idea of what they can do but actually the more discussions I hear them having amongst themselves, I learn actually that they can do that too and that’s really interesting and I think the same goes for, in the other direction as well.” (EC5, focus groups/interviews)</p>

TABLE 3: Continued.

CMOC	Evidence to support CMOC
<p>CMOC 3: Cohesion and connectedness When practitioners have opportunities for informal and peer support with colleagues (context), they work better as a team and have more confidence to work in different ways to address people's SSM needs and involve stroke survivors more collaboratively in their self-management (outcome) because peer and informal support creates trust and a psychologically safe space for practitioners (mechanism resource), which allows teams to learn from each other, be vulnerable together, and support each other (mechanism response)</p>	<p>“Practitioners talked about the importance of interprofessional collaboration and good communication across professional and team boundaries to facilitate supported self-management.” (Kulnik [45], realist synthesis)</p> <p>“In community, staff can feel isolated. There may be one of the same discipline in each team and a feeling of isolation. If doing something well, share it. All the same problems come out and its reassuring and can give a boost. Allow staff time to get together to see how to do things differently.” (SM2, Q-methodology)</p> <p>[Interviewer: you obviously have a degree of trust built up in each other, does that give you the confidence to work in a different way and [to use] different skills?] I think we maybe take it for granted but yeah [helps us] be more flexible, adaptable, yes. Because we've worked together for quite a while, there's all sorts of non verbals. . . we can tap in and support each other. It does give you the confidence to do it [SSM]. . . I don't think anybody is shy in saying “I'm, not sure” and that's what I really like about our teams, it's not like a competition, about who's got the most knowledge, it's about who could help me today because I'm not sure what I'm doing. I think that's just as important as formal supervision. We've worked in that way for so long, I just think we're not hierarchical, we're just not that kind of team. We see each other's strengths and. . . we don't pick on anything that feels maybe like a weakness to somebody. We're talking about person centred for patients, we're person centred with individuals. (EC2, focus groups/interviews)</p> <p>“Because we're quite a close team, because we're quite small. . . and we have been co-located in the same office, informally you know we're very used to just kind of sharing ideas, talking about different patients. . . and we'll sort of bounce ideas around about how we're getting on with them and see what the others; experiences have been like and do a bit of problem solving together.” (EC5, focus groups/interviews)</p> <p>“It's not a bad thing to hold your hand up and say 'I'm struggling here' or even just checking in 'am I doing the right thing' 'is this approach the right one to use' . . . and who didn't make any mistakes? There're other people in places that are much more remote. I do think that sharing ideas and shared practice and shared learning is vitally important, even more so for people who you know are scattered.” (SC2, focus groups/interviews)</p>

TABLE 3: Continued.

CMOC	Evidence to support CMOC
<i>Programme theory 2: Building trust, confidence, and resilience</i>	<p>“...the key to the success of this approach [person centred supported self-management] was finding out about the stroke survivor. Knowing what they used to do, activities they enjoyed prior to their stroke, became more than contextual notes of interest but key to the process of rehabilitation itself. What was critical to this description was the intent when asking the stroke survivor about their lives. The therapists involved in this study had always interacted with the patient's histories and individual stories...but they also accepted that their self-management training had opened their eyes to a different way of listening.” (Norris and Kilbride [46], realist synthesis)</p> <p>“Listening is one of the most underrated skills. If done properly, it empowers individuals to feel worthy. It gives them permission to think and work out issues.” (NC6, Q-methodology study)</p> <p>“I always think having a bit of humour with somebody if I think it's appropriate is a good way...you want the person to trust you and open up to you and see that it's someone that cares about them or at least is here to get to know them and not just to be formal almost. I mean you want to be professional but you also want to be a person, someone that can offer support and be valuable to them as a contact.” (WM1, focus groups/interviews)</p> <p>“She made herself feel as if she was equal to me you know or I was equal to her...it wasn't a case that she was a [health professional] and I was just the patient. It got to a stage where she was talking about her youngsters, it was her birthday and they were going to have a birthday party and that became, it became more personal that way.” (WS5, focus groups/interviews)</p> <p>“I actually felt that they were my pals you know at the end...I didn't feel oh this is a professional relationship here...and I'm well aware of the boundaries because of the job that I done and how people can feel...they were just kind of honest...I felt it was personal...they didn't come in [and think] this is a job...it was like, I'm your pal, what can I do for you...that made me feel straight away you know, guards down whereas you are always a bit guarded if somebody comes and [you have] felt uncomfortable with.” (SS4, focus groups/interviews)</p>
CMOC 4: Building a rapport	<p>When practitioners take the time to listen to stroke survivors and are interested in their priorities and concerns (context), it allows open, honest conversation and builds a respectful, trusting relationship (outcome) because they have a rapport together (mechanism resource) which helps stroke survivors feel heard, listened to, valued and safety to be themselves (mechanism response)</p>

TABLE 3: Continued.

CMOC	Evidence to support CMOC
<p>CMOC 5: Sharing responsibility for self-management</p> <p>When practitioners and stroke survivors have mutual respect for each other and engage in collaborative conversations which encourage an open discussion about expectations for, and roles in, self-management (context), it builds stroke survivors' confidence, independence and resilience (outcome 1), contributes to a positive sense of self-worth and emotional wellbeing amongst stroke survivors' (outcome 2) and supports practitioners to adopt a more tailored, coaching role (outcome 3). This is because a sense of shared responsibility for self-management is developed (mechanism resource) which encourages stroke survivors to develop their self-management skills and have ownership over their self-management goals but in a supported way (mechanism response 1) and strengthens practitioners as their confidence in stroke survivor's capacity to self-manage (mechanism response 2)</p>	<p>"The Bridges approach has attempted to move beyond the idea of patient engagement whereby individuals are expected to take on responsibility for making choices related to their condition, towards a practice-based approach... that takes the social context in which the individual is self-managing into account. This required professionals to critically reflect on their own assumptions about how an individual should self-manage and create a space whereby the way to self-manage is jointly determined." (Jones [44], realist synthesis)</p> <p>"Professionals cannot decide what is best for the person as it's not their choice to make. If they do, this could demotivate the person if the professional's goals do not match theirs. The person is less likely to try to achieve the goal if it is not theirs." (SC5, Q-methodology study)</p> <p>"If support is tailored, it leads to confidence." (ES1, Q-methodology study) (Interviewer) how does asking what's important to people help them in their self-management...?</p> <p>"I think it gives them a platform to let them know that it's important to us that [we know about it]... as opposed to us coming in and saying 'right well this is what we think you should be doing. You know it might be important to somebody to go fishing and we might think it's important that they walk the length of the street so it's important... then they're more likely to... (SC4)... take the lead (SC2)... it also gives them a bit of trust in the way you're going to support them, if [you are] interested in them." (SC4)... [and] it gives patients the confidence to try and fail knowing that you're there alongside them... you'll help them to figure it out and pick up the pieces. (SC6) (focus groups/interviews)</p> <p>"[tailoring] there's quite a lot of benefits in that everything's individualised. It makes teams think about how they're approaching everything and maybe trying to come up with bespoke ideas instead of just kind of standard ideas. I think it makes them have to get to know the person that they're caring for more, you know and build a relationships with them... so I think it helps build relationships and gets people thinking differently about what they can do and trying to be imaginative about things." (NM2, focus groups/interviews)</p> <p>"We've changed how we deliver our service in terms of asking patients what they want and focussing on goals so that has helped us as a team to understand better where our involvement lies with patients because it's very much directed by the patient and not by us. So we have moved away from the 'we do X amount of things in X amount of time' to it very much being led by the patient. So they tell us what they need and that allows us then to reconfigure our workload around patients' expectations which sometimes you have to pull back if someone's expectation is that you should see them much more than you've got capacity to... but very much focussing on what they need and what they want within the confines of the resource that you have to deliver that." (SM1, focus groups/interviews)</p>

TABLE 3: Continued.

CMOC	Evidence to support CMOC
<p>CMOC 6: Peer support</p> <p>When stroke survivors are open to the idea of engaging with peer support (context), it builds confidence in their own self-management skills and abilities (outcome 1), a sense of motivation (outcome 2) and helps with managing the emotional impact of stroke (outcome 3) because they are able to share their experiences with others (mechanism resource) which helps them to learn about what works and what doesn't (mechanism response) from others with shared experiences</p>	<p>No data from literature review as this programme theory emerged from the empirical data in phase 2</p> <p>"I had no experience of stroke in my adult life and hearing from other people [with stroke] is interesting. I was negative in the way I thought stroke would affect people. Hearing other things [from stroke survivors] gives you tips which is invaluable." (SS4, Q-methodology study)</p> <p>"I think you have to experience it to understand it...you can't put a value on that...not only are they giving something back but they've got something from watching others improve. And it's a psychological motivation...you see it, you experience it, you see others and they're all pushing and you're pushing as well." (ES1, focus groups/interviews)</p> <p>"I think peer to peer support can be extremely valuable...I suppose the biggest one [benefit] is emotional and psychological because certainly with the people I've been involved with, their biggest concerns are emotional and psychological. Physical things improvement yes and the tips important, but that's the biggy in the background all the time." (ES5, focus groups/interviews)</p> <p>"Don't get me wrong the occupational health girls and the stroke nurses, with the best will in the world, they try and they were obviously trained professionals, they were really well trained but on the other hand they guy that was sitting next to me, he's been there, he's walked the walk...so aye, I was more inclined to connect with a stroke survivor than I was with the stroke nurse. That particular guy was maybe about my age actually and everything he kind of went through, you know I was going through...essentially when I was sat at the class, you listen to what other folks are saying...aye I learned a lot off folk...we bounced off each other and we helped each other and we still keep in touch which is great." (SS1, focus groups/interviews)</p>

TABLE 4: Inhibitory contexts.

	Evidence of inhibitory contexts for activation of CMOC
CMOC 1: feeling inspired and encouraged to do supported self-management	<p>“I feel as if we’re trying to tick all of the boxes but without any of the background understanding and support. When you bring it up, there’s no one that’ll be prepared to fund it really...there’s just no money for it. We’re just expected to do it, we’ll get scrutinised on it but it should be something you do as a professional therefore why do you need training or why do you need to invest in it... it doesn’t seem to be recognised as something that is needing some additional skill and needs to be trained [in]. It’s not a subject covered in our stroke MDT or core subject training...we don’t talk about self-management...there’s nothing that pushes this in any way and I don’t know how you would get it on the radar a bit more because when I’ve brought it up, some of the leads of the strategic meetings and things you know [it] just gets brushed over really, it’s not a priority compared to some of the other aspects of stroke care like thrombectomy...I don’t think it’s seen as important as it should be.” (WM1, focus groups/interviews)</p> <p>“I think it [quality of organisational support] impacts on ability to maybe kind of drive [action]... there’s no impetus to make any changes or look at improvements, there’s not that kind of focus on the service... everybody knows what to do and where to go, but there’s nobody kind of planning for what to do next.” (NM2, focus groups/interviews)</p> <p>“I don’t think we have a consistent approach...it’s not just about one person or one part of the service being in control of self-management, it’s about every single therapist that’s working with stroke patients...it needs to be about every single therapist on the ground feeling confident with that and supported with that. You’ve got control over what you do but you don’t have everything in place for everyone on the ground to have the same understanding of supported self-management and to do it to the same level... you’re kind of expected to do supported self-management but it’s not necessarily integrated into the service. We want to encourage people to self-manage...but I think it’s confidence and awareness of what’s out there and getting access to these things. I don’t think there’s apathy, people realise how important it is to the patient and to the service, I just think there’s lots of things that get in the way of doing it properly.” (SM2, focus groups/interviews)</p> <p>“I think the people who aren’t able to do this well [SSM] are people who have a low opinion of their own abilities or who don’t have the skills to carry something out or believe that somebody else can do it [better].” (SM1, focus groups/interviews)</p> <p>Context where staff/team/service development is not prioritised leads to low morale, frustration and sense of firefighting</p> <p>“That’s the thing, there’s no development, we’re just pounding away, doing the same stuff over and over again and we just cannot expand on what we’re doing.” (NC7, focus groups/interviews)</p> <p>“I think having had training would have been good...I probably would have found that useful. Just to get clarity that you’re doing the right things and on the right tracks. I don’t often get to meet up with other professionals. If say, four or five people had gone on the training, then you could maybe get together and work together on what you might do so that you’re not [on your own]...a lot of us are doing things but there’s no point in reinventing the wheel...we should be sharing what we’re doing...for me if I’m in a group that’s driving something forward, it’s easier because sometimes when you’re working yourself, it’s hard to keep going, particularly if it’s hard and you hit brick walls.” (NC4, focus groups/interviews)</p>
CMOC 2: learning and reflecting together	

TABLE 4: Continued.

	Evidence of inhibitory contexts for activation of CMOC
CMOC	<p>"I think there is a benefit of having that informal discussions. . . working in the community [just now] I don't have that colocation. I used to be collocated with a [AHP] so that was great, I learned so much and kind of bounced ideas around and moved little pieces of work forward, could take objectives forward but sometimes in the community, I don't even know the name of the OT or the physio because I'm not there often enough and that can be challenging. It takes a little bit more effort, it doesn't come as naturally when you don't know people. It's about relationships, making friends with your colleagues and that in the long run helps the person." (NC2, focus groups/interviews)</p> <p>"I'm in a general rehab team. . . I feel like say, I wanted to try something new, I'm the one that's got to have the confidence in that and I think that's probably like a limitation of a general team is that you're completely dependent. . . so actually I feel a lot of the time I've got to pull on my own experience to actually have the confidence to do that." (EC3 focus groups/interviews)</p> <p>"You can go looking for the OTs but it could take you a couple of days to find out who you're actually looking for. They've got a different office now which is a bit daunting to even walk into so you have to sort of brace yourself there before you even walk in but everyone is working differently some of them are working from home so it's very difficult to actually catch up and emails don't always give the right tone or the right message, they can sometimes be a bit nippy. . . you know it's not the right tone, you just want an informal chat you know." (NC7, focus groups/interviews)</p>
CMOC 3: cohesion and connectedness	<p>Several practitioners did, however, report that inconsistency in staffing made it difficult to build the rapport and trust with clients they felt was needed for successful supported self-management." (Kulnik [45], realist synthesis)</p> <p>"[not being listened to] invalidates stroke survivor's capacity to make decisions. Reduces trust." (ES1, Q-methodology study)</p>
CMOC 4: building a rapport	<p>I was going through emotional problems. . . I phoned [the nurse] after about six months and she said we're taking you off the list now, we don't really need to see you anymore. I felt like there was nobody there for me you know to call if I needed help. . . I had quite bad fatigue at one time and I did phone them up and said to them. . . and basically, it had gone from being kind of personal thing to oh you'll be okay, this is a normal thing. It was a short and swift call so. . . you trusted them. . . but in that moment when you were kind of needing that support you didn't get in return. (SS5, focus groups/interviews)</p>

TABLE 4: Continued.

CMOC	Evidence of inhibitory contexts for activation of CMOC	<p>“...an environment in which professionals protect patients from making what they perceive as irrational and irresponsible choices or prioritise “realistic” goals runs the risk of creating an imbalanced relationship from the start, rather than good care which is jointly shaped by reciprocal and open interactions.” (Jones [44], realist synthesis)</p> <p>“I think staff who aren’t confident regardless of how long they’ve been doing the job. If they’re not confident in their own practice and potentially not confident in what other people might do. So if they’ve had a bad experience with somebody it may be difficult for them [to work collaboratively].” (SM1, focus groups/interviews)</p> <p>Interviewer: there’s this idea when practitioners and stroke survivors work collaboratively together, it helps to share responsibility for self-management decisions and actions, has that been your experience? “. . . it gets very difficult to have those kind of conversations in any depth [with people with aphasia] cause you’re dealing with a language issue and maybe they don’t have the knowledge or the ability to know how they could take things forward. . . and also you’re dealing with a lot of people who are emotionally not stable and maybe they’re just not cognitively able to come up with solutions and consider the whole insight sort of thing as well, being able to look at themselves and understand what they feel their limitations and abilities are so I do think there are a lot of barriers to it [encouraging self-management]. . . those conversations can be quite difficult. . . and you don’t want to end up depressing the person more by having conversations about what they’d like to do in case it upsets them.” (WMI1, focus groups/interviews)</p>
CMOC 5: sharing responsibility for self-management		<p>“I think there’s still that kind of view in society possibly about that kind of ‘you’re the expert’ so you fix me or you treat me and perhaps that’s still what a lot of people prefer or what they are expecting. There’s something quite reassuring about being told. Stroke recovery can feel so uncertain and people are just needing a bit of certainty so that certainty of ‘you’re going to give me six appointments to work on this’ let’s do that. I think it’s that living with that uncertainty and sometimes having to make choices isn’t what we want.” (NC2, focus groups/interviews)</p> <p>“Well I think personally I was glad of them telling me because I really didn’t know. I really didn’t understand what I could or what I couldn’t do.” (SS4, focus groups/interviews)</p> <p>“I think there’s always that tension between the notion of risk and keeping your patients safe and ultimately what’s best for the patient. . . I suppose from my point of view you are dealing with people with mental health issues, you’re dealing with people where there is that risk and safeguarding issues. . . quite a lot of the time you can’t necessarily always be patient centred and you’ve maybe got to make those decisions around patient safety.” (WC6, focus groups/interviews)</p> <p>That should be our ethos [consistently supporting self-management in a person-centred way] and I think that’s what we’re all aiming towards but sometimes it can be difficult. It’s all about the system. . . having resources that are well organised and that we’re able to signpost [patients] to different things. It’s having that kind of infrastructure there you know, being able to go and look at resources, see what you can signpost patients to and different things. Having all of that in the background going on and I think that can be difficult for staff because it’s quite difficult to navigate through things. . . everything’s just so time pressured and you just don’t get enough time to do these sorts of things and build up your knowledge in different areas. . . I think it’s a confidence and awareness of what’s out there and getting access to these things (SM2, focus groups/interviews)</p>

TABLE 4: Continued.

CMOC	Evidence of inhibitory contexts for activation of CMOC
CMOC 6: peer support	<p>"I've seen others in the stroke unit on the ward and didn't find it helpful as I didn't have a severe stroke as some others have. Seeing the state they are in felt lucky but didn't help, felt depressed seeing very disabled people." (NS4, Q-methodology study)</p> <p>"... I went into a room with 12 people [peer support group] and noticed that I'm probably in the bottom 25% for physicality... I didn't think [the others] were maybe in the same boat as me... it was kind of like rubbing it in my face... [refers to another stroke survivor with less severe impairment]... I thought the problems that guy's going to have aren't in the same league [as mine], if you're really really physically impaired then it's a different lot of issues that you're going to have than a man that can walk down the street and you wouldn't know he's had a stroke... so I didn't really feel like opening up." (SS3, focus groups/interviews)</p> <p>"I was a manager I was used to speaking in teams and all that... I can understand why some people might not want to put themselves out there because you're in a room with maybe 12 other people who have had strokes... if you were a quiet, reserved, shy person you might not want to be in that forum." (SS4, focus groups/interviews)</p> <p>"I suppose it hasn't really affected my self-management at all, because I'm not the sort of person who would pick up the phone to another stroke sufferer to, you know, ask them advice. I'm more likely to speak to professionals. But obviously if I'm in a room with someone, I'll exchange with them, but I'm not likely to directly contact someone because I'm not willing to put my needs above theirs." (SS2, focus groups/interviews)</p>

health professionals, or with peers, in building trust, confidence, and resilience for engaging in and sustaining long-term supported self-management. The realist synthesis captured both the perspectives of people affected by stroke and professionals', and highlighted the importance of being listened to and feeling heard, being involved in making decisions about one's health and wellbeing, and being supported to push boundaries in discovering their own abilities and building their confidence to self-manage [44, 45, 53, 54]. The empirical data from our study confirmed support for these priorities and highlighted a new mechanism of personal experience (CMOC6) leading to the construction of this programme theory. Three CMOCs through which trust, confidence, and resilience can be built were identified and confirmed in the analysis. These include the following: fostering a connection (CMO4), sharing responsibility for self-management (CMO5), and sharing and learning from personal experience (CMO6).

3.2.1. Fostering a Connection (CMO4). Fostering a connection with stroke survivors and acknowledging the patient as a person lays the foundations for a trusting and supportive relationship, which is crucial for building confidence and sustaining engagement in long-term supported self-management. Open and honest conversations (intervention strategy) allow practitioners insight into the personhood of someone with a stroke and the context of their lives and what is important to them. The data identified that when practitioners showed they were really listening, shared aspects of their own personhood, or their humour (facilitatory contexts), it could help to engender a sense of safety where stroke survivors perceived they could be themselves. As a result, they reported feeling more trust and greater confidence to share their ideas about their self-management, knowing that these would be valued and respected. Having a rapport with practitioners was also found to strengthen stroke survivors' sense of self-worth.

However, in some contexts, where there was a lack of continuity in or shortages of staffing or where practitioners explicitly spoke of feeling uncomfortable at disclosing personal information about themselves (inhibitory contexts), fostering a connection with stroke survivors was more challenging. Stroke survivors also reported that in situations where they felt their priorities and preferences were not listened to or had been trivialised or dismissed or when staff showed a lack of interest in them as a person (inhibitory contexts), it affected their sense of trust. Rather than building a connection with practitioners, stroke survivors often found themselves disengaging from open, honest, and potentially collaborative conversations.

3.2.2. Sharing Responsibility for Self-Management (CMO5). When health professionals recognise the limits of their professional expertise or capacity, and involve stroke survivors' experiences in shaping and informing self-management decision-making and plans (facilitatory context), it creates a sense of shared responsibility for self-management where both stroke survivors and health

professionals see themselves as having a valuable contribution to make. Open, honest conversations about expectations for self-management (intervention strategy) strengthen an understanding of the skills, assets, and experience that both stroke survivors and health professionals bring in working together. The findings identified that when this happens, stroke survivors feel more ownership over setting and working towards personally meaningful goals, even when these ideas converge with those of health professionals. Stroke survivors frequently spoke of the sense of confidence and self-belief that came from doing and achieving, having permission to fail, and renegotiating goals that they had set as part of their self-management, knowing they had still had support if needed from health professionals (facilitatory context). Sharing responsibility for supported self-management also engendered a greater sense of trust amongst practitioners in stroke survivors' capabilities for self-management and helped them to flex the kinds of support that they offered, being able to vary and tailor their support to what stroke survivors needed most at a specific time.

All of the practitioners in the study perceived the involvement of stroke survivors in self-management as important. However, in situations where practitioners faced staffing shortages, caseload, and waiting times pressures; perceived a lack of organisational support for collaborative working; or were lacking in personal confidence to implement supported self-management (inhibitory contexts), a genuine commitment to a sense of collective responsibility for self-management was less likely to be achieved.

3.2.3. Sharing and Learning from Personal Experience (CMO6). Stroke survivors' accounts identified the importance of peer support (intervention strategy) in helping to build their confidence, motivation, and skills to self-manage the impact of living with stroke. The opportunity to share and learn from the personal experiences of fellow stroke survivors can help with managing the emotional impact of stroke, particularly in addressing social isolation that many stroke survivors experience after a stroke. Stroke survivors reported that peer support offers a safe space where people can be themselves and work towards feeling comfortable with how their stroke has impacted on them, knowing that others around them "get it" (facilitatory context). Learning about self-management strategies and tips from other stroke survivors encourages a degree of reflection on one's own circumstances, social support, and assets that can help people to work out what might be suited to them (and what wouldn't) in their own self-management.

However, preferences for peer support varied across stroke survivors in the study. Those who perceived themselves to have had little long-term impact from their stroke or who expressed a preference for health professionals' expertise over experiential expertise (inhibitory contexts) appeared to value peer support less with some even commenting that it could be unhelpful and unsettling. Some of the stroke survivors saw peer support as burdening others with their problems or that peer support was not "their

thing” whilst others commented that a lack of a shared connection with peers beyond the stroke itself or issues with distance and travel (inhibitory contexts), curbed their desire to engage with peer support.

4. Discussion

The importance of supporting self-management has been reinforced in recent stroke guidance and national policies [4–8], and there is a growing evidence base on its efficacy in people affected by stroke [18–22]. In spite of this, what supported self-management is, how it can best be delivered, and what needs to be done to support its consistent delivery across different models, geographies, and organisational contexts of community rehabilitation to support life after stroke remains unclear. This realist evaluation aimed to uncover the mechanisms and contexts, which can facilitate or impede the integration, delivery, and impact of supported self-management approaches in routine practice and community-based stroke services.

Contemporary notions of supported self-management position this as a collaborative approach, which involves working in partnership with people and putting their priorities and preferences at the centre of care delivery [17]. However, organisational targets and the delivery of rehabilitation in piecemeal ways that prioritise specific disciplines or problems [55] within a capped service model drive the majority of rehabilitation services across the UK. In this context, the consistent delivery of person-centred supported self-management can be impeded or frequently perceived as impossible. The findings from the current study are grounded in this context but importantly highlight how the social tissue of rehabilitation teams and organisational culture influences practitioners’ capacity to nurture and create the conditions that help to build trust and social cohesion across and within teams. It is these conditions that help build practitioner’s confidence to work flexibly and collaboratively in supporting stroke survivors’ longer-term self-management in a person-centred way. Two concepts drawn from the world of organisational psychology; psychological safety [56] and emotional culture [57], hold particular relevance to the findings from the current study in the pivotal role they play in supporting the diffusion of culture change towards working differently and flexibly within the limits or confines of the healthcare system and its challenges. In particular, having a strong sense of psychological safety within rehabilitation teams and a positive sense of the emotional temperature of individuals within those teams can help to facilitate greater integration and interdisciplinary working across staff and teams so that collaborative and cross-disciplinary working becomes “just how it’s done here.”

The term self-management frequently evokes notions of personal responsibility and agency. The findings, however, support a conceptualisation of supported self-management as a broader, relational approach for supporting life after stroke rather than simply being about preparing people for discharge or asking them to do more themselves to increase the dose of therapy outside of professional therapy time.

Recovery and rehabilitation from stroke does not follow a linear trajectory and people affected by stroke consistently report a significant unmet need in relation to life after stroke [11, 14, 15, 58, 59]. Rather, navigating life after stroke can be slow and complex, disempowering, and laden with uncertainty as people deal with their ongoing recovery and work on adapting to and rebuilding their lives [41, 58, 60–64]. Stroke and its impairments create a state of flux and can have wide-ranging impacts on people’s identity, their social networks, friendships, relationships, and intimacy, their self-worth, freedom and hope, and their familial roles and financial status as well as their physical self and wellbeing [14, 54, 63, 65–67]. Rehabilitation activities and life after stroke support can commonly feel disconnected from the identities that stroke survivors hold for themselves and their priorities within the contexts of their lives [65, 68]. The findings show that when self-management is supported through good relationships characterised by trust, rapport building, and emotional investment from both stroke survivors and practitioners, it helps significantly to build stroke survivor’s confidence, resilience, and sense of agency. Other authors have also acknowledged the importance of rapport building in relationships and being able to provide that sense to someone that they are known and heard [68–70]. Doing so enables opportunities for conversations and sharing of stories that provide richer insights into peoples’ lives and their priorities and “where they’re at” that qualitatively differs from, and has more meaningful impact on engagement than, a process-driven patient history [68–71]. The current study highlights that when time and space for nurturing relationships is valued and prioritised within community teams, it supports a redressing of the traditional professional-patient power imbalance where stroke survivors feel like equals. In these contexts, responsibility for self-management can be shared and stroke survivors feel safe and supported in articulating their needs and preferences for coconstructed self-management support.

The study findings expand those from previous research on the effectiveness of supported self-management in stroke [18–22] by offering a richer and deeper understanding of the complexities of how supported self-management is delivered in real-world community stroke care, from both health professionals’ and stroke survivors’ perspectives. This is useful because it can be used to help determine the transferability of supported self-management approaches to specific contexts and strengthen the quality and personalisation of feasible, relevant, and meaningful supported self-management approaches in community stroke care for supporting long-term wellbeing and life after stroke. The findings are valuable for shifting the orientation of narratives of stroke recovery, rehabilitation, and long-term support towards what we do with rather than *to* people. We argue that the findings challenge two dominant narratives evident in self-management research and practice; that self-management is only about personal agency, motivation, and self-efficacy and that long-term relationships with stroke survivors create a fear of dependency and passivity. Conversely, the opposite of both of these seems to be true in

many contexts as is borne out in the study findings. Relationships and relational working, supported by a team culture, which values collaboration with stroke survivors and their families, are the very scaffolding that is necessary for achieving outcomes such as increased self-efficacy, confidence, knowledge, and skills and for long-term wellbeing and independence following stroke. Relational work, however, is complex, dynamic, and fragile [72]. It is challenging for practitioners to have the time and space to nurture and invest in relationships in the context of the technical and time-bound aspects of rehabilitation and care delivery that prioritises physical recovery and patient throughput, meaning that relational work risks being overlooked and delegitimised rather than seen as a fundamental and necessary part of care delivery [73]. Practitioners in the current study spoke of feeling unable or ill-equipped to prioritise relationship building and person-centred self-management even though they understood its importance. Our findings from this and our previous research demonstrate that a lack of practitioner confidence and organisational and team support for collaborative working can preclude practitioners from challenging the status quo of their practice and so they frequently stick to the habits and routines that they know will work and that they are familiar and comfortable with. The dialogue around what should be prioritised and why, and the approaches and language we use in supporting wellbeing and life after stroke needs to start in education settings where future stroke practitioners are being trained and educated to equip them with the skills, knowledge, and confidence to work flexibly and collaboratively with stroke survivors and their families in their future care delivery. Furthermore, the dialogue needs to be continued to influence and inform stroke care within the contexts of guideline and policy development, strengthening opportunities for further implementation and diffusion of a culture and ethos towards collaborative supported self-management across teams and organisations. Practitioners working in community stroke care need training and time for reflection, and support from their organisations as well as their colleagues that helps them to work in a psychologically safe space and to develop, test, and integrate collaborative, relational supported self-management approaches into local services and pathways. Further evidence on the implementation and impact of collaborative, relational approaches to supported self-management in community stroke care will help to support and develop practitioners' confidence and skills in integrating it into their repertoire of support for people living with stroke.

4.1. Strengths and Limitations. The study findings are of clinical importance, but they also contribute to shifting the focus in the evidence base on self-management in stroke from trials that address *what works* to broader methodologies that inform *how* supported self-management approaches work and can be embedded into clinical practice. The inclusion of a Q-methodology approach within this realist study helped to ensure that different stakeholder's

perspectives were incorporated into the development and prioritisation of the programme theories. The approach also highlighted the different outcomes of supported self-management that are important to different stakeholders, which could help to inform how supported self-management can be embedded into practice and measured and evaluated. Grounding the initial programme theory development in a realist review of the literature was valuable; however, the focus on delivery of supported self-management meant that research on stroke survivor's experiences of engaging in self-management and perceptions of self-management needs was not included. This literature may have helped offer insight into additional mechanisms and contexts that would have been important to include.

The intervention strategies, mechanisms, and contexts discussed here have been differentiated for the purposes of this realist evaluation and for aiding a clearer understanding of the nuts and bolts underpinning how supported self-management works in community stroke care, but in reality, they overlap and work synergistically together. A particular challenge in the study was aligning mechanisms to specific contexts and accurately describing how these connect to individual intervention strategies for supported self-management. The evidence-based core components of supported self-management are still unclear, and in the absence of this kind of framework, we identified intervention strategies from the data itself. It is plausible that there are additional intervention strategies to consider and that specific strategies can give rise to several of the mechanisms described here rather than the ones we have opted to align these to. This will be important to explore in future research.

It is also important to note that the programme theories presented here are context-specific and the mechanisms may trigger or interact differently in different contexts. However, what they do provide is insights into *how* different contexts influence the mechanisms and subsequently outcomes of doing supported self-management. This understanding is important for identifying the characteristics of contexts in clinical practice that are likely to influence implementation of supported self-management so that tailored implementation strategies can be developed to facilitate and support future implementation. Whilst this research focussed on community stroke care, it is plausible that an exploration of supported self-management in acute stroke care settings would reveal different contexts and mechanisms through which supported self-management is enacted and delivered. Future research understanding how the programme theories apply to and could be refined for understanding supported self-management in acute stroke care would be valuable.

Finally, the findings come at a time when addressing health inequities in stroke is high on the agenda of clinicians, researchers, voluntary sector organisations, and funders. Whilst this research included people living in urban and rural communities in Scotland, the sociocultural profile of the participants was limited. It would be important to understand experiences of supported self-management from the perspective of people from diverse backgrounds and how

the programme theories operate for teams working with stroke survivors from with different needs and experiences due to sociodemographics and stroke impact.

5. Conclusions

Adopting a realist approach in this study has been valuable for offering a theoretically informed framework to understand how person-centred supported self-management is delivered in community stroke care and what this comprises. The findings argue for an emphasis on supported self-management as a relational, collaborative approach that helps to support and address people's needs for a good life after stroke. Supporting self-management, whilst being a personalised and individualised approach between stroke survivors and practitioners, depends on benefits from a number of factors that operate at the organisational and team levels that shape and guide understandings towards and the delivery and impact of supported self-management approaches in practice. The findings could be used to help determine the transferability and feasibility of supported self-management approaches to different contexts and inform the development of context-specific strategies that can help teams to tailor, optimise, and personalise the provision of supported self-management that aligns with the priorities of stroke survivors in a timely and meaningful way.

Data Availability

The literature review, Q-methodology, and qualitative data used to support the findings of this study have been deposited in the OSF repository and are available at <https://osf.io/>.

Disclosure

The study was undertaken whilst Prof Lisa Kidd was employed at the University of Glasgow.

Conflicts of Interest

The authors have no conflicts of interest to declare.

Acknowledgments

The study was funded by the Stroke Association (Grant Number SA PG 18\100067). We wish to acknowledge and thank our patient and public involvement group members and advisory group members for their support and advice throughout the project. We also wish to thank Dr Justin Jagosh from the Centre for Advancement in Realist Evaluation and Synthesis (CARES) for his methodological guidance and Mr Paul Cannon, College Librarian for Medical, Veterinary and Life Sciences, University of Glasgow, for his guidance during the realist synthesis. Open Access funding was enabled and organised by JISC.

Supplementary Materials

Supplementary File 1: list of papers included in the realist synthesis, categorised by high, moderate, and low relevance

(phase 1 of the study). Supplementary File 2: example of the IMPETUS stroke service pathway scoping and mapping template used (phase 1 of the study). Supplementary File 3: example of interview guide questions used with healthcare professionals and managers (phase 2 of the study). (*Supplementary Materials*)

References

- [1] World Health Organisation, *Innovative Care for Chronic Conditions: Building Blocks for Action Geneva Report*, World Health Organisation, Geneva, Switzerland, 2022.
- [2] NHS England, *The NHS Long Term Plan Department of Health*, NHS England, London, UK, 2019.
- [3] NHS Scotland, *Realistic Medicine: Doing the Right Thing Chief Medical Officer for Scotland Annual Report*, Scottish Government, Edinburgh, UK, 2023.
- [4] Intercollegiate Stroke Working Party, in *National Clinical Guideline for Stroke for the UK and Ireland*, Intercollegiate Stroke Working Party, London, UK, 2023.
- [5] National Institute for Health and Care Excellence, *Stroke Rehabilitation in Adults*, National Institute for Health and Care Excellence, London, UK, 2023.
- [6] Department of Health Northern Ireland, in *Health and Wellbeing 2026 Delivering Together Department of Health*, Department of Health, Ireland, 2016.
- [7] Scottish Government, *A Progressive Stroke Pathway*, Scottish Government, Edinburgh, UK, 2022.
- [8] The Welsh Government, *The Quality Statement for Stroke Cardiff*, The Welsh Government, 2021.
- [9] Chest, Heart and Stroke Scotland, *No Life Half Lived Strategy 2023–2028*, Chest, Heart and Stroke Scotland, Edinburgh, UK, 2023.
- [10] K. I. Gallacher, G. D. Batty, G. McLean et al., "Stroke, multimorbidity and polypharmacy in a nationally representative sample of 1,424,378 patients in Scotland: implications for treatment burden," *BMC Medicine*, vol. 12, no. 1, p. 151, 2014.
- [11] L. Legg, E. Stevens, C. McKeivitt, and C. Wolfe, *A Life Saved is a Life Worth Living. The Unmet Needs of Stroke Survivors in Europe: A Scoping Review of the Literature on Life After Stroke*, Stroke Alliance for Europe/Kings College, London, UK, 2022.
- [12] J. Howe, *Delivering evidence-based rural community stroke services: a realist evaluation*, Ph.D. thesis, University of Nottingham, Nottingham, UK, 2022.
- [13] Stroke Association, *Shaping Stroke Research to Rebuild Lives: The Stroke Priority Setting Partnership Results for investment London Stroke Association*, 2021.
- [14] Stroke Association, *Thriving After Stroke*, Stroke Association, London, UK, 2023.
- [15] Chest, Heart and Stroke Scotland, *No Life Half Lived 1 in 5 Report 2023*, Chest, Heart and Stroke Scotland, Edinburgh, UK, 2023.
- [16] H. L. Parke, E. Epiphaniou, G. Pearce et al., "Self-management support interventions for stroke survivors: a systematic meta-review," *PLoS One*, vol. 10, no. 7, Article ID e0131448, 2015.
- [17] A. De Iongh, P. Fagan, and J. Fenner, *A Practical Guide to Self-Management Support London*, The Health Foundation, London, UK, 2015.
- [18] F. Jones and A. Riazzi, "Self-efficacy and self-management after stroke: a systematic review," *Disability & Rehabilitation*, vol. 33, no. 10, pp. 797–810, 2011.
- [19] S. Lennon, S. McKenna, and F. Jones, "Self-management programmes for people post stroke: a systematic review," *Clinical Rehabilitation*, vol. 27, no. 10, pp. 867–878, 2013.

- [20] G. Warner, T. Packer, M. Villeneuve, A. Auduly, and J. Versnel, "A systematic review of the effectiveness of stroke self-management programs for improving function and participation outcomes: self-management programs for stroke survivors," *Disability & Rehabilitation*, vol. 37, no. 23, pp. 2141–2163, 2015.
- [21] C. E. Fryer, J. A. Luker, M. N. McDonnell, and S. L. Hillier, "Self-management programmes for quality of life in people with stroke," *Cochrane Database of Systematic Reviews*, vol. 2016, no. 8, Article ID CD010442, 2016.
- [22] F. Wray, D. Clarke, and A. Forster, "Post-stroke self-management interventions: a systematic review of effectiveness and investigation of the inclusion of stroke survivors with aphasia," *Disability & Rehabilitation*, vol. 40, no. 11, pp. 1237–1251, 2018.
- [23] F. Jones, C. McKevitt, A. Riazi, and M. Liston, "How is rehabilitation with and without an integrated self-management approach perceived by UK community-dwelling stroke survivors? A qualitative process evaluation to explore implementation and contextual variations," *BMJ Open*, vol. 7, no. 4, Article ID e014109, 2017.
- [24] V. Fu, M. Weatherall, K. McPherson et al., "Taking charge after stroke: a randomized controlled trial of a person-centered, self-directed rehabilitation intervention," *International Journal of Stroke*, vol. 15, no. 9, pp. 954–964, 2020.
- [25] H. McNaughton, M. Weatherall, K. McPherson et al., "The effect of the take charge intervention on mood, motivation, activation and risk factor management: analysis of secondary data from the taking charge after stroke (TaCAS) trial," *Clinical Rehabilitation*, vol. 35, no. 7, pp. 1021–1031, Article ID 269215521993648, 2021.
- [26] NHS National Services Scotland, *Scottish Stroke Improvement Programme Annual Report*, Public Health Scotland, Scotland, UK, 2023.
- [27] E. Stevens, E. Emmett, Y. Wang, C. McKevitt, and C. D. A. Wolfe, *The Burden of Stroke in Europe Stroke Alliance for Europe*, Kings College London, London, UK, 2017.
- [28] L. Kidd, J. Booth, M. Lawrence, and A. Rowat, "Implementing supported self-management in community-based stroke care: a secondary analysis of nurses' perspectives," *Journal of Clinical Medicine*, vol. 9, no. 4, p. 985, 2020.
- [29] L. Kidd, M. Lawrence, J. Booth, A. Rowat, and S. Russell, "Development and evaluation of a nurse-led, tailored stroke self-management intervention," *BMC Health Services Research*, vol. 15, no. 1, p. 359, 2015.
- [30] G. Wong, G. Westthorp, A. Manzano, J. Greenhalgh, J. Jagosh, and T. Greenhalgh, "RAMESES II reporting standards for realist evaluations," *BMC Medicine*, vol. 14, no. 1, pp. 96–33, 2016.
- [31] R. Pawson and N. Tilley, *Realistic Evaluation*, Sage Ltd, London; UK, 1997.
- [32] G. Westthorp, *Realist Impact Evaluation: An Introduction*, Overseas Development Institute, London, UK, 2014.
- [33] J. Greenhalgh and A. Manzano, "Understanding context in realist evaluation and synthesis," *International Journal of Social Research Methodology*, vol. 25, no. 5, pp. 583–595, 2022.
- [34] S. M. Dalkin, J. Greenhalgh, D. Jones, B. Cunningham, and M. Lhussier, "What's in a mechanism? Development of a key concept in realist evaluation," *Implementation Science*, vol. 10, no. 1, p. 49, 2015.
- [35] J. Jagosh, P. L. Bush, J. Salsberg et al., "A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects," *BMC Public Health*, vol. 15, no. 1, p. 725, 2015.
- [36] L. Kidd, J. D. Millar, H. Mason et al., "Supported self-management in community stroke rehabilitation: what is it and how does it work? A protocol for a realist," *BMJ Open*, vol. 12, no. 1, Article ID e055491, 2022.
- [37] N. Emmel, *Sampling and Choosing Cases in Qualitative Research: A Realist Approach*, Sage, London, UK, 2013.
- [38] A. Manzano, "The craft of interviewing in realist evaluation," *Evaluation*, vol. 22, no. 3, pp. 342–360, 2016.
- [39] J. Rycroft-Malone, B. McCormack, A. M. Hutchinson et al., "Realist synthesis: illustrating the method for implementation research," *Implementation Science*, vol. 7, no. 1, p. 33, 2012.
- [40] S. Watts and P. Stenner, "Doing Q ethology: theory, method and interpretation," *Qualitative Research in Psychology*, vol. 2, no. 1, pp. 67–91, 2005.
- [41] J. Duncan Millar, H. Mason, and L. Kidd, "What is important in supporting self-management in community stroke rehabilitation?" *Disability & Rehabilitation*, vol. 45, no. 14, pp. 2307–2315, 2023.
- [42] J. Richie and L. Spencer, "Qualitative data analysis for applied policy research," in *Analysing Qualitative Data*, B. Bryman and R. G. Burgess, Eds., pp. 173–194, Routledge, London, UK, 2002.
- [43] F. C. Mukumbang, E. M. Kabongo, and J. G. Eastwood, "Examining the application of retroductive theorizing in realist-informed studies," *International Journal of Qualitative Methods*, vol. 20, Article ID 160940692110535, 2021.
- [44] F. Jones, E. Livingstone, and L. Hawkes, "Getting the balance between encouragement and taking over: reflections on using a new stroke self-management programme," *Physiotherapy Research International*, vol. 18, no. 2, pp. 91–99, 2013.
- [45] S. T. Kulnik, L. Hollinshead, and F. Jones, "I'm still me—I'm still here! Understanding the person's sense of self in the provision of self-management support for people with progressive neurological long-term conditions," *Disability & Rehabilitation*, vol. 41, no. 11, pp. 1296–1306, 2019.
- [46] M. Norris and C. Kilbride, "From dictatorship to a reluctant democracy: stroke therapists talking about self-management," *Disability & Rehabilitation*, vol. 36, no. 1, pp. 32–38, 2014.
- [47] S. M. van Hooft, J. Dwarswaard, S. Jedeloo, R. Bal, and A. van Staa, "Four perspectives on self-management support by nurses for people with chronic conditions: a Q-methodological study," *International Journal of Nursing Studies*, vol. 52, no. 1, pp. 157–166, 2015.
- [48] F. Jones, A. Riazi, and M. Norris, "Self-management after stroke: time for some more questions?" *Disability & Rehabilitation*, vol. 35, no. 3, pp. 257–264, 2013.
- [49] S. Mudge, N. Kayes, and K. McPherson, "Who is in control? Clinicians' view on their role in selfmanagement approaches: a qualitative metasynthesis," *BMJ Open*, vol. 5, Article ID e007413, 2015.
- [50] N. Anderson and G. Ozakinci, "It all needs to be a full jigsaw, not just bits: exploration of healthcare professionals' beliefs towards supported self-management for long-term conditions," *BMC Psychol*, vol. 7, no. 1, p. 38, 2019.
- [51] S. Fletcher, S. T. Kulnik, S. Demain, and F. Jones, "The problem with self-management: problematising self-management and power using a Foucauldian lens in the context of stroke care and rehabilitation," *PLoS One*, vol. 14, no. 6, Article ID e0218517, 2019.
- [52] F. Jones, C. Waters, L. Benson, C. Jones, J. Hammond, and N. Bailey, "Evaluation of a shared approach to interprofessional learning about stroke self-management," *Journal of Interprofessional Care*, vol. 26, no. 6, pp. 514–516, 2012.

- [53] T. Satink, S. Josephsson, J. Zajec, E. H. Cup, B. J. de Swart, and M. W. Nijhuis-van der Sanden, "Self-management develops through doing of everyday activities—a longitudinal qualitative study of stroke survivors during two years post-stroke," *BMC Neurology*, vol. 16, no. 1, p. 221, 2016.
- [54] F. A. S. Bright, C. M. McCann, and N. M. Kayes, "Recalibrating hope: a longitudinal study of the experiences of people with aphasia after stroke," *Scandinavian Journal of Caring Sciences*, vol. 34, no. 2, pp. 428–435, 2020.
- [55] D. T. Wade, "The future of rehabilitation in the United Kingdom National Health Service: using the COVID-19 crisis to promote change, increasing efficiency and effectiveness," *Clinical Rehabilitation*, vol. 35, no. 4, pp. 471–480, 2021.
- [56] A. Edmonson, "Psychological safety and learning behaviour in work teams Administrative," *Science Quarterly*, vol. 44, no. 2, pp. 350–383, 1999.
- [57] M. D. Robinson, E. R. Watkins, and E. Harmon-Jones, *Handbook of Cognition and Emotion*, Guilford Press, New York, NY, USA, 2013.
- [58] S. Rutherford, "Managing after Stroke," Auckland University of Technology, Auckland, New Zealand, 2023, PhD thesis.
- [59] A. Theadom, S. J. Rutherford, B. Kent, and K. M. McPherson, "The process of adjustment over time following stroke: a longitudinal qualitative study," *Neuropsychological Rehabilitation*, vol. 29, no. 9, pp. 1464–1474, 2019.
- [60] T. Satink, E. H. Cup, I. Ilott, J. Prins, B. J. de Swart, and M. W. Nijhuis-van der Sanden, "Patients' views on the impact of stroke on their roles and self: a thematic synthesis of qualitative studies," *Archives of Physical Medicine and Rehabilitation*, vol. 94, no. 6, pp. 1171–1183, 2013.
- [61] M. Manning, A. MacFarlane, A. Hickey, and S. Franklin, "Perspectives of people with aphasia post-stroke towards personal recovery and living successfully: a systematic review and thematic synthesis," *PLoS One*, vol. 14, no. 3, Article ID e0214200, 2019.
- [62] C. M. Pereira, N. Greenwood, and F. Jones, "From recovery to regaining control of life—the perspectives of people with stroke, their carers and health professionals," *Disability & Rehabilitation*, vol. 43, no. 20, pp. 2897–2908, 2021.
- [63] C. M. Murray, S. Weeks, G. van Kessel et al., "Perspectives of choice and control in daily life for people following brain injury: a qualitative systematic review and meta-synthesis," *Health Expectations*, vol. 25, no. 6, pp. 2709–2725, 2022.
- [64] T. L. T. Lo, J. L. C. Lee, and R. T. H. Ho, "Recovery beyond functional restoration: a systematic review of qualitative studies of the embodied experiences of people who have survived a stroke," *BMJ Open*, vol. 13, no. 2, Article ID e066597, 2023.
- [65] C. Arntzen, T. Borg, and T. Hamran, "Long-term recovery trajectory after stroke: an ongoing negotiation between body, participation and self," *Disability & Rehabilitation*, vol. 37, no. 18, pp. 1626–1634, 2014.
- [66] K. Quinn, C. D. Murray, and C. Malone, "The experience of couples when one partner has a stroke at a young age: an interpretative phenomenological analysis," *Disability & Rehabilitation*, vol. 36, no. 20, pp. 1670–1678, 2014.
- [67] J. Kelly, A. Dowling, S. Hillier et al., "Perspectives on rehabilitation for Aboriginal people with stroke: a qualitative study," *Topics in Stroke Rehabilitation*, vol. 29, no. 4, pp. 295–309, 2021.
- [68] N. M. Kayes, C. Cummins, K. M. McPherson, L. Worrall, and F. A. Bright, "Developing connections for engagement in stroke rehabilitation," *Brain Impairment*, vol. 23, no. 1, pp. 42–59, 2022.
- [69] F. A. Bright, N. M. Kayes, C. Cummins, L. M. Worrall, and K. M. McPherson, "Co-constructing engagement in stroke rehabilitation: a qualitative study exploring how practitioner engagement can influence patient engagement," *Clinical Rehabilitation*, vol. 31, no. 10, pp. 1396–1405, 2017.
- [70] M. Lawton, G. Haddock, P. Conroy, L. Serrant, and K. Sage, "People with aphasia's perspectives of the therapeutic alliance during speech-language intervention: a Q methodological approach," *International Journal of Speech Language Pathology*, vol. 22, no. 1, pp. 59–69, 2020.
- [71] C. Rixon, "Connection: stories not statistics," *Brain Impairment*, vol. 23, no. 1, pp. 4–8, 2022.
- [72] F. Bright, S. Attrill, and D. Hersh, "Therapeutic relationships in aphasia rehabilitation: using sociological theories to promote critical reflexivity," *International Journal of Language & Communication Disorders*, vol. 56, no. 2, pp. 234–247, 2021.
- [73] F. A. Bright, C. Ibell-Roberts, K. Featherstone et al., "Physical well-being is our top priority: healthcare professionals' challenges in supporting psychosocial well-being in stroke services," *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, vol. 27, no. 2, Article ID e14016, 2024.