

Exploring the concept of mental health crisis

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Overview

The topic of this research thesis is mental health crisis, particularly as it is experienced in the work of Crisis Resolution/Home Treatment teams. These teams are a fairly recent addition to adult mental health provision in the National Health Service of the UK.

Part 1 of the research thesis provides a literature review. This review firstly considers how mental health crisis has been conceptualised in the literature. The team approach to crisis resolution is considered: team configuration is outlined, and the effectiveness of the team approach to crisis resolution is evaluated.

Part 2 of the research thesis is an empirical paper describing a qualitative research enquiry in the area. Semi-structured interviews were conducted with workers in Crisis Resolution/Home Treatment teams, and Framework Analysis used to obtain an understanding of how these workers conceptualise mental health crisis. The findings of a conceptual entity with commonalities and differences, and a concept that changes over time, are provided and discussed.

Part 3 offers a critical appraisal of the research process. This paper considers dilemmas and challenges at different stages of the research project: initial ground work; research interviewing; practical, epistemological and quality issues at the analysis stage; and reflections on the research findings. Appendices relating to Part 2 are provided at the end of the research thesis.

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Part 1: Literature Review

People in Crisis:

How has mental health crisis been conceptualised, and what is known about the team approach to crisis resolution?

Abstract

Crisis Resolution/Home Treatment teams are a recent addition to UK mental health services, and offer rapid, around-the-clock response to people in mental health crisis. This review addresses conceptual understandings of crisis, and the model and effectiveness of team intervention to resolve crisis. The literature reviewed reaches some consensus in describing the crisis phenomenon, but theoretical understandings of the concept stand in opposition rather than complement one another. While unitary, the team configuration comprises crisis resolution work *and* home treatment. Some well-designed outcome studies have clearly shown the teams can successfully reduce hospital admissions through home treatment. However, outcome studies have somewhat limited themselves to this measure of success, and measures of crisis resolution are neglected.

Introduction

The UK Government ranked mental health intervention for people in crisis as a top priority for the National Health Service, alongside those for tackling heart disease and cancer (DoH, 2000). The solution, Crisis Resolution/Home Treatment (CR/HT) teams, offers rapid and intense intervention to help people deal with and overcome a crisis. The home treatment ethos continues the move away from institutional and towards community-based care (Johnson, 2004). An earlier literature exists on the phenomenon of crisis, Crisis Theory (Caplan, 1964), although this appears largely ignored in writing on CR/HT teams.

Two questions will be addressed in this review. Firstly: *How has mental health crisis been conceptualised?* The intention is to understand how the crisis state has been understood and distinguished from non-crisis states (Slaikeu, 1990), and also to identify how theoretical ideas about the phenomenon can be integrated. It is argued that such a phenomenological understanding of crisis as it occurs in mental health services is not available, and gaining an insight would be of great benefit to practitioners and researchers in the field (Bonyngue, Lee & Thurber, 2005; Hendricks & Byers, 2002).

Secondly: *What is known about the team approach to crisis resolution?* CR/HT teams encompass two hypothetically distinct roles of crisis resolution *and* home treatment, albeit they are not separable in everyday practice and clinical research. This review aims to identify the extent to which crisis resolution is apparent in team practice and configuration. Outcome studies will also be evaluated.

This review draws on an international perspective (although limited to publications in English), particularly for the first question about the concept of crisis. However, the material will be discussed in relation to current UK practice. Health service systems and broader cultural attitudes vary between nations, and it is hoped that by relating the review to the policy and provision of one national system, contrasts across systems can be made. Therefore, this review should have interest for readers beyond the UK.

Review methodology

A systematic literature search was conducted of the electronic databases PsychInfo and Medline between 1997 and 2007. The searches included only texts in English and excluded dissertation abstracts. The search phrases were: *crisis and definition or home or resolution or team or theory*. The search strategy identified 1,854 articles across both databases.

Duplicate references were removed, and the remaining abstracts read for relevance. Abstracts making exclusive reference to the following areas were excluded: psychosocial developmental crises; physiological/medical crises; sociological crises (e.g. political, economic); and, post-traumatic stress. Also excluded were abstracts which suggested tangential content about mental health crisis but predominantly focused on specific psychiatric diagnoses, 'branded' treatments, suicidality, or mental health legislation. This left 116 papers relating to mental health crisis, which were traced and read where reasonably accessible. In addition, pertinent papers referenced in these articles were obtained. CR/HT teams' practice has been primarily with working-age adults, where this review will focus.

Conceptual understandings of mental health crisis

The literature reviewed in this section comprises theoretical writings, case studies and qualitative research. A working definition of the concept will be elaborated and the crisis concept will be considered from the perspectives of mental health practice, Crisis Theory, and other theoretical positions.

Terminology and definition

The term crisis has been defined and used inconsistently in the mental health literature (Bonyngé et al., 2005; Callahan, 1998; Heath, 2005). A range of terms has been used, although across terms there are common emphases: the sense of pathological, mental experience (e.g. acute *psychiatric* crisis), the sharp onset (e.g. mental health *emergency*), and more rarely the consequence (e.g. psychological *decompensation*).

The term crisis is sometimes used synonymously with similar but unrelated concepts, 'trauma' being a common case in point. Here, crisis is expressly used to label the *critical incident* that elicited a trauma response. Certainly, from the UK CR/HT team perspective (Burns, 2004) it is inappropriate to relate trauma theoretically to mental health crisis (Dulmus & Hilarski, 2003; Yeager & Roberts, 2003).

Given the problematic history of the term's usage and multiple definitions it is appropriate to provide a working definition at the outset of this review. The purpose of the review is to explore the concept, so establishing a working definition early risks interfering with this task. To overcome this, the

working definition provided for later comparison and contrasting has been kept broad:

- *A subjective psychological experience and response, which is temporally episodic.*
- *Associated with overwhelming negative emotion and/or impairment to everyday living.*

Additionally an assumption will be made that conceptually, crisis has nature (what crisis is) and process (how crisis happens). 'Mental health crisis' is the titular term for this review, but for brevity will be used interchangeably with 'crisis'.

Crisis from a mental health practice perspective

Crisis in UK health policy

The Department of Health in the UK identifies areas of development and sets targets for the National Health Service. The provision of CR/HT is one of its top priorities (DoH, 2000). Service models are specified for the teams, and there is a description of the types of individuals the teams should work with, however, an explicit definition or framework for understanding crisis is lacking (DoH, 2001; DoH, 2006).

There are two themes in the policy guidelines which imply something of how crisis is to be understood. Firstly, it is stated that the service should be for those with "severe mental illness...with an acute psychiatric crisis of such severity that, without the involvement of [CR/HT teams] hospitalisation would be necessary" (DoH, 2001, p.11).

Secondly, clinical populations are described as those with 'severe mental illness' and are specified diagnostically (i.e. schizophrenia, manic depressive disorder and severe depressive disorder). Other groups are excluded: milder presentations; those with brain damage, dementia or learning disability; crisis related solely to relationship issues; and substance misuse. Initially, those with a diagnosis of personality disorder were excluded (DoH, 2001), but this guidance was later withdrawn (DoH, 2006). Commentary in the literature reflects that home treatment is utilised by those individuals with personality disorder, but suggests boundaries are necessary for these service-users from the outset of care (Brimblecombe, 2001a; Harrison, Alam & Marshall, 2001).

This is as close as the policy guidance comes to communicating any conceptual definition of crisis. Such lack of conceptual clarity potentially brings confusion at the interface between NHS workers and service-users. Making a judgement based on whether "hospitalisation would be necessary" presumes that there is consistency in admission decisions, when in fact there is considerable variability (Burns, 2004; Smyth, 2003), and that the benchmark for admission remains static over time, when in fact historically there are shifting patterns in admission rates (Glover, Arts & Babu, 2006).

There are problems in using specified included and excluded diagnoses. Practically, the individual referred to the team could have one of the 'severe mental illnesses' as yet undiagnosed. Hence the team would be involved in some level of assessing whether criteria are met. Furthermore, it is neither apparent how mental health crisis might occur with only some diagnoses, nor when the threshold for crisis is reached for those diagnoses.

The term 'crisis resolution' is mentioned in the policy guidance, although not elaborated or related to the crisis state (DoH, 2001). It is used as an umbrella term, covering discharge and transfer to ongoing care. It is stated that resolution should bring some shared understanding of why the crisis occurred, and provide strategies for coping with and avoiding crisis in future.

Crisis in the international mental health literature

Efforts to elaborate the concept of mental health crisis have been made by practitioners and researchers within mental health services. A distinction is made between 'crisis' and 'psychiatric emergency'. For Heath (2005) the presence of acute psychiatric symptomology defines the latter, to which Callahan (1998) adds risk of harm. Crisis by contrast is seen as broader and related to life stress with consequent distress. Brimblecombe (2001b) separates out three categories: acute *psychosocial crisis*, acute *psychiatric condition* requiring urgent attention, and either an acute episode or psychosocial stressor as part of an enduring psychiatric condition.

Some of these definitions rely on 'mental illness' as distinct from distress caused by life pressures, with the former being framed as more serious and needing most urgent attention. Observable or self-reported risk behaviours add a clearer defining feature.

Heath's (2005) *Anatomy of Crisis* model sets out six stages over time: psychiatric disorder develops or is in a managed state; crisis is perceived by the person or another; there is initial professional contact; specialised psychiatric emergency input occurs; hospital or community treatment is

delivered; the service-user is transferred to outpatient care, where there may be remission or at some point crisis relapse. Again, the presence of psychiatric diagnosis is an imperative in this model. The distinction between stages one and two is not well elaborated; the perception of symptoms or behaviour as an emergency marks the start of crisis. The intervention, or not, of services also defines crisis, which introduces the problem of circular definition i.e. it is a crisis, because crisis services are involved.

The notion of 'severity' is invoked in relation to crisis by some of the proponents of CR/HT, who have been firm about the focus remaining on the 'severely mentally ill' (Carroll, Pickworth & Protheroe, 2001; Smyth, 2003). They consider presentations of emotional/social problems in absence of 'mental illness' are inappropriate, again making diagnosis a threshold distinct from distress.

In one of the UK research trials of CR/HT an operational definition of crisis was specified (Johnson et al., 2005a). The quasi-experimental study compared cases before and after the introduction of CR/HT and an independent panel to judge if cases met the definition was necessary. There was a tripartite definition: a substantial deterioration in mental health and/or functioning and/or a disruption to the support network of an already unwell person; increased risk to self (self-harm, neglect or exploitation) or others (violence) and/or cost to the caring support network; lastly, immediate action was required to prevent further deterioration.

The operational definition is illuminating in itself for this review. A psychiatric diagnosis is not a defining criterion, and factors relating to daily functioning and social support networks are introduced. It is also notable that

the independent judging panel rejected about 35% of the cases put before it, which were presumably judged to be crises by frontline practitioners, suggesting a mismatch between ideal practice and reality.

Some authors note the metaphorical influence that emergency physical medicine might have for providers and users in psychiatric settings. There is a sense of gravity in the situation of an individual presenting at this point; the practitioner must be decisive in intervention (Aguilera, 1994). An expectation may be created of a service to provide instant remedy in an emergency (Burns, 2004).

One crisis team in the UK adopts a 'post-psychiatry' approach in its work (Bracken, 2001). The implications are that traditional psychiatry and its values are less dominant, the service-user's own understanding is valued, and psychiatric concepts like diagnosis are used tentatively. A conceptual understanding of crisis is not elaborated by the author; rather the service philosophy is to prevent hospitalisation.

Service-user perspectives on crisis

Policy makers cite the opinions of service-users and carers as being the driver for development of crisis-related services in the community (DoH, 1999). A similar perspective is noted in the literature, which cites both user empowerment and the increasing consumerist stance in health care as factors in service change (Brimblecombe, 2001a; Burns, 2004; Johnson, 2004; Relton & Thomas, 2002). This shift may relate more to the choice of treatment at home, rather than the crisis-dedicated care aspect of the model.

Only a handful of studies have investigated the concept of crisis from the perspective of service-users. Ball, Links, Strike and Boydell (2005) conducted a qualitative interview study with individuals with severe and persistent mental illness (i.e. psychosis). The respondents were service-users in Canadian community outreach services. These authors provide a grounded theory model of the crisis experience.

The study provides an insight in to crisis as experienced by service-users, albeit a selective group. An underlying vulnerability to crisis was present in the respondents' accounts, arising from both residual psychotic symptoms and psychosocial factors (e.g. loneliness, poverty). Precipitating circumstances were identified: illness symptoms were felt to initiate and maintain the crisis; other factors at a biological level (e.g. sleep disturbance, substance misuse) and psychosocial level (e.g. interpersonal conflict, poor support) were also felt to be influential. The experiential nature of crisis involved feeling overwhelmed (with common feelings of fear and aloneness) and lacking control (of the situation and of one's own actions), with the experience being dominated by key emotional themes (e.g. anger, anxiety).

The immediate response to crisis was either the individual or others seeking help, or managing alone at home. Crisis was felt to be resolved when the individual no longer felt overwhelmed and regained a sense of control. Another paper from the same researchers indicates about 40% of individuals from this population experience crisis over a 6-month period (Links, Eynan, Ball, Barr & Rourke, 2005). The definition used in this study incorporated: an unscheduled contact with services; acute emotional upset

with a consequent failure in coping; and a need for service support within hours.

Another qualitative interview study with a similar population comes from Sayre (2000) who interviewed a US sample admitted as inpatients. The study identified attributions made in respondents' understandings for their admission. An attribution of crisis, response to a dangerous or troubling event, was the largest (38%) thematic category identified. Sayre concluded that such attributions served to protect self-worth in the face of a threatening and stigmatising process, because self-reports often conflicted with the professional perspective on the reason for admission. The paper does not describe any auditing process, and the interview analysis was done from notes and other indirect sources not transcripts. It is unclear what conclusions can be drawn from this study, other than to say individuals in this population commonly identify crisis in their lives, although the validity of such a claim is questioned by professionals.

Summary of the mental health practice perspective

UK health policy lacks a conceptual understanding of crisis despite instructing Crisis Resolution/Home Treatment teams be established. This likely makes policy implementation hard at a service level. Psychiatric conceptualisations of crisis appear analogous to diagnosis: a list of identified features such as 'acute' symptoms, risk behaviours, and changes in daily functioning. This may be helpful for identification of the crisis state, although some subjectivity remains, and certainly such conceptualisations do not provide a model for intervention. Circular definitions around service usage

seem particularly unhelpful. Most authors insist that the presence of formal psychiatric diagnosis is an essential aspect of mental health crisis; it is rare for traditional psychiatric diagnosis to be considered inessential.

Service-user perspectives on crisis have been primarily qualitative and concentrated on populations with enduring psychotic presentations. The emphasis in these accounts is on endogenous illness bringing about and maintaining a crisis, with some recognition of life pressures. In terms of the crisis concept, an experiential dimension is added in which feeling emotionally overwhelmed and losing a sense of control over one's life appears important.

Crisis Theory

Caplan's Crisis Theory

The ideas of Gerald Caplan (1964, 1969) are considered a central influence on the Crisis Theory that has been broadly adopted (Callahan, 1998; Hobbs, 1984). Caplan's theory posits that humans exist in a state of psychological 'equilibrium' or 'homeostasis'. Caplan (1964) elaborates four phases to crisis: normal problem-solving occurs first; if the usual coping fails, then distress and disorganisation began to impact on function; alternative methods of coping are tried and emergency resources are drawn upon; finally, faced with complete failure to cope then exhaustion and psychological deterioration ensue. The crisis response is considered to be normative and the theory was developed for non-clinical application (Graham & Bancroft, 2006).

There is a theoretical assumption of a temporal phenomenon, traditionally with a sudden onset and duration of up to six weeks (Callahan, 1998; Graham & Bancroft, 2006; Hobbs, 1984; Slaikeu, 1990), with an assumption that the arousal state in crisis can not be sustained beyond this time (Callahan, 1998; Hobbs, 1984). Crisis Intervention is a therapeutic approach based on Crisis Theory (Callahan, 1998; Graham & Bancroft, 2006). It is a time-limited, goal-directed therapy of one to six sessions working with the 'here-and-now'. The therapeutic aim is to reclaim a state of equilibrium, so it is neither expected that there will be a complete absence of distress, nor that the individual becomes reconciled to the triggering situation. Crisis Theory and Crisis Intervention derive from the US (Hobbs, 1984), but are cited occasionally in UK crisis literature (Bridgett & Polak, 2003; Hopkins & Niemiec, 2007; Lazaro, Kulinskaya & Tobiansky, 2001).

Developments of Crisis Theory

Some subsequent theorists emphasise the significance of individual 'appraisal' (also 'perception') in labelling the situation a crisis (Callahan, 1998; Slaikeu, 1990). This variation in appraisal explains why some might judge a situation to be a crisis yet others cope. Appraisal involves reference to lived experience, so personal meaning is placed on the situation. Individual appraisal is likely to lead to an individual coping response. From this perspective, an important aspect of overcoming the crisis is making connections between the event, and appropriateness of appraisal and response (Callahan, 1998; Slaikeu, 1990).

The presence of constitutional vulnerability or protective factors is proposed in Hobbs' (1984) *Natural History of Crisis* model, in which such factors play a role in moderating the path between the external threat and the crisis outcome. These factors include developmental influences and biopsychosocial factors (eg physical health, social adversity). Brown and Rainer (2006) note the variance in individual resistance to stress and Hendricks and Byers (2002) provide a list of risk factors for crisis. This development extends individual differences beyond the appraisal processes to include background factors.

The emotional aspect to crisis has been characterised as an experience on the boundaries of human existence (Hopkins & Niemiec, 2007). The intense emotion has been described variously as pain, misery, urgency and defeat; there is fearful uncertainty about the future, with potential for disaster (Callahan, 1998; Hendricks & Byers, 2002; Parry, 1990).

Interest in life events, particularly loss, was a founding element of Crisis Theory, with Lindemann's (1944, cited in Aguilera, 1994) work on grieving. Loss may be bereavement, but also others losses or threats of loss (eg contact with significant other, identity or status). In Slaikeu's writings (1990) he identifies a model provided by Horowitz (1976), which outlines a number of phases an individual can pass through in the process to resolution from initial outcry, through denial, intrusiveness, working through and completion. Such phase models are common in the grief/loss literature.

In terms of other life events themes, situations which bring change and transition are also linked to the crisis. Theorists have classified such life events in different ways: developmental versus situational; normative versus

traumatic (Callahan, 1998; Graham & Bancroft, 2006; Slaikeu, 1990). This life events and loss aspect provides detail to the threat aspect of Caplan's model, and theorises some of the external influences (eg changes to finances or social support) and internal processes (such as reappraisal of existing beliefs, values) that might trigger crisis.

The possibility of crisis as an opportunity or turning point is mentioned in Crisis Theory (Hobbs, 1984). The general literature notes the semantic origins denoting opportunity and possibilities for change alongside the potential threat (Burns, 2004; Parry, 1990). However, Crisis Theory does not clearly elaborate what are the opportunities, although there is brief mention of an openness to consider novel coping methods (Callahan, 1998) with some suggesting more far-reaching potential for constructive life change (Bridgett & Polak, 2003).

Some crisis theorists accept a systems theory approach and suggest an individual crisis can represent crisis in the wider system (Hobbs, 1984; Slaikeu, 1990). Bridgett and Polak (2003) are strong advocates of a social systems orientation for use in UK crisis teams. These authors incorporate Caplan's Crisis Theory model with social systems thinking and interventions. A systems' perspective assumes that an individual crisis does not happen in isolation and therefore attention to the current social context (eg family, community, culture) is necessary in assessment and intervention.

Application of Crisis Theory in mental health settings

There is debate about the applicability of Crisis Theory to those with mental health diagnoses. More recent writings from crisis theorists claim it

can be extended to the crises of those with major psychiatric diagnoses (Callahan, 1998; Graham & Bancroft, 2006; Slaikeu, 1990). They observe that there are periods of stability but also acute, time-limited disorder. It has been suggested those with severe mental health problems might have more fragile coping mechanisms (Joy, Adams & Rice, 2004). Crisis Theory arose from non-medical disciplines, primarily within the social-psychological literature, and eschewed the pathologising and medicalisation of crises proposed by emergency hospital-based psychiatry. However, crisis theorists claim a consensus position has been reached between the traditions (Callahan, 1998; Slaikeu, 1990). Bridgett and Polak (2003) claim applicability of their social systems approach in the UK crisis team context. These authors are less bound by diagnosis, and theorise from a position where psychosocial factors are as influential in bringing about acute mental distress as medical ones.

Authors outside the tradition have stated it is not applicable to a psychiatric population, particularly those diagnosed with psychotic disorders (Ball et al., 2005; Heath, 2005). The view is that external stressful life events play a minimal role compared to the issues of exacerbating illness symptoms, substance use and medication non-compliance. Furthermore, it is commonly others who seek help on behalf of the individual in crisis which does not fit with the theory's assumptions. It is felt the stereotypical previously well-adjusted individual of Crisis Theory is the exception to the rule in mental health practice (Brimblecombe, 2001a).

There is also debate about the theory's assumption of sudden onset. Traditional definitions suggest it results quickly from a single stressor, but as

a mental health concept others feel a crisis may be reached more gradually or incrementally (Burns, 2000). Interestingly, the 6-week duration suggested by crisis theorists typifies the current practices of CR/HT teams in the UK which have a similar length of contact (Johnson, 2004).

Summary of Crisis Theory

Crisis Theory provides a coherent and explanatory model of the phenomenon, which is descriptive and indicates pathways for intervention. The later developments explain individual differences in perceiving crisis and the response to crisis. Those who have developed the theory have drawn broadly on social science, namely the life events literature and systems theories. The notion of crisis as an opportunity is alluded to, but not well elaborated.

Crisis Theory was originally developed to explain rare incidents of extreme, but normative distress. Although crisis theorists believe it is widely applicable across non-clinical and clinical populations, this applicability is disputed by those writing from a mental health practice perspective. They feel Crisis Theory inadequately explains the fluctuations of a 'mental illness' in a sufferer who may not themselves label their experience as problematic.

Other theories of crisis

Psychoanalytic perspective on crisis

Crisis Theory has some origins in the psychoanalytic perspective, based on ideas of ego psychology and Eriksonian developmental stages

(Aguilera, 1994; Callahan, 1998; Hobbs, 1984). There are accounts of practice from crisis settings taking a purer psychoanalytic perspective (Christian & Jurist, 2001; Jerry, 1998; Yerushalmi, 2003). These reports are from outside the UK, with less severe presentations, and for long-term work.

These authors place greater emphasis on taking account of the internal experience (Christian & Jurist, 2001; Jerry, 1998): there is an opportunity for intrapsychic understanding and change; the wider symbolism of the situation for the individual is acknowledged; and pervasive patterns of relating are identified. The opportunity for personal growth is perceived as rare and precious and a focus on symptom removal is a wasted opportunity (Christian & Jurist, 2001; Yerushalmi, 2003). Christian and Jurist (2001) note patterns of ongoing distress in those presenting, in contrast to Crisis Theory's notion of rare aberrations against a background of a stable life.

Post-traumatic Growth

The field of post-traumatic growth has its basis in humanistic approaches, but also cites Crisis Theory (Calhoun & Tedeschi, 2006). The ideas of post-traumatic growth hold that there is potential for positive change consequently to a crisis (as well as post trauma-inducing incidents). It has parallels with Crisis Theory's ideas of cognitive appraisal and crisis as a turning point, but goes further; the individual's assumptive world (beliefs about self, relationships, and life globally) is challenged and invalidated by the crisis, but there is the possibility of dramatic change to the assumptive world and new directions in life.

Process View

Fraser (1998) provides an interesting critique of Crisis Theory and Crisis Intervention and offers a 'Process View' (based on systemic and constructivist ideas). Fraser raises a number of criticisms. Firstly, there is an over-emphasis on returning people to equilibrium. Secondly, there is an over-emphasis on dangers (i.e. risk management) and deficits in traditional approaches. Lastly, Caplan's homeostasis model of life as safe and stable has an erroneous theoretical basis and is inappropriately borrowed from a biological sciences framework.

In Fraser's (1998) Process View, based on a human social systems framework, life is conceived as in constant flux, with variability and flexibility as desirable characteristics to face challenge. Furthermore, returning someone to 'past stability' can be dangerous and atherapeutic, because the pre-crisis state may have been undesirable or even contributed to the crisis. Fraser suggests an end goal of enabling individuals to accept, respect and work with the change crisis presents.

Crisis a cultural and gendered concept

Some papers identified in the literature search commented on the interaction between mental health crisis and culture or gender. Cluse-Tolar (1997) conducted a small pre- and post- study with individuals presenting at a US hospital emergency room. Compared to men, she identified women as drawing on greater social support networks and showing significantly greater symptomatic improvements over time. She hypothesised that crisis might present a particular challenge to a male stereotype of strength and

independence, and concluded that a re-think of the interventions and approaches used with men was required.

Some UK service analyses have collected data on gender and reported higher rates of service usage by women (Brimblecombe, O'Sullivan & Parkinson, 2003; Brooker, Ricketts, Bennett & Lemme, 2007; Harrison et al., 2001). However, it is not possible to comment on the significance of these findings, due to lack of comparison with gender ratios in the sample population.

A couple of UK studies note the link between crisis presentations and social status, with a pattern of higher prevalence of mental health problems with poverty. In these studies, deprivation index scores correlated with higher rates of referral/service usage (Beecham, 2005; Brooker et al, 2007).

Some researchers in the US have written about the influence of ethnic background on crisis work (Cornelius, Simpson, Ting, Wiggins & Lipford, 2003; Zayas, Evans, Mejia & Rodriguez, 1997). The studies have commented on how beliefs held widely in a given culture may influence ideas about mental well-being and crisis, attitudes to engagement with formal services, and use of informal support at times of crisis. Cunningham (2000) has written specifically on spirituality, noting the potential two way interaction between crisis, and an individual's faith and spiritual framework.

Summary of other theories of crisis

These theories on mental health crisis offer alternative ideas to those provided earlier. There is criticism of medical approaches that deal with surface level symptoms and of Crisis Theory's principle of returning people to

a prior equilibrium state. These theories place much greater emphasis on mental health crisis as an opportunity to gain personal understanding and make major life changes. Crisis Theory's notion of life as stable with intermittent crises is also challenged; the alternative is of life in flux with the possibility of ongoing distress. Gender and cultural based differences suggest further influences on appraisal and response in crisis. These are of potential interest to crisis-dedicated services. It is noted that some of this literature theorises on work in settings that differ from UK CR/HT teams.

Section Summary: Conceptual Understandings of Mental Health Crisis

In the literature as a whole some consensus can be found on the concept of mental health crisis: an individualised appraisal is made based on life experience; there is acute distress arising from a subjective sense of being overwhelmed and lacking control; there are dramatic changes in everyday functioning; there is commonly risk of harm to self or others; and, there is recognition of the importance and protective potential of support.

Theories of crisis appear disparate rather than integrated.

Conceptualisations from mental health practice present a list of criteria, of which a diagnosed 'mental illness' is usually essential. Emphasis is placed on endogenous and biological factors, and the role of life events is minimised. These conceptualisations fail to provide an intervention model. Crisis Theory by contrast offers an explicit descriptive understanding of crisis that conveys its process and nature, and is a coherent and explanatory model which indicates intervention. However, it is criticised for its limited application in mental health arenas. The literature does not enable us to reconcile this

dispute: are there two distinct groups, the severely mental ill who are victims to their biology, and those suffering 'mere' distress in response to life? A more complex, continuum-like picture is probably the reality.

Other theories critique Crisis Theory's notions of equilibrium and more generally the superficiality of mainstream crisis interventions. It is feasible that there are varying patterns in crisis, *both* equilibrium with occasional disruptions for some at some times *and* other lives more or less in constant flux. Likewise, it may be appropriate to *both* treat mental health crisis as an opportunity for major life revision in some cases, *and* intervene less profoundly by bringing about stable functioning and reducing risk in others (without detriment).

The Team Approach to Crisis Intervention and Resolution

This section of the review considers how a team approach has been used to intervene with mental health crisis, and the kinds of outcomes obtained. Because, Crisis Resolution/Home Treatment¹ (CR/HT) teams comprise both philosophies of crisis resolution *and* a home treatment ethos this section can not solely focus on the former. The teams were developed for working-age adults, so the focus will be on this population². This section of the review will focus on UK mental health policy and service provision, unless stated otherwise.

A nationwide network of CR/HT teams is a relatively new Government initiative (DoH, 2000). The teams offer intensive home treatment around the

¹ A note on terminology. Crisis Resolution/Home Treatment is the name used in the policy guidelines (DoH, 2001), and will be adopted in this review, usually in abbreviated form: CR/HT. However a variety of team names are used (eg Crisis Assessment and Treatment Team, Intensive Home Treatment Service).

² The literature search only identified two papers from the UK with other clinical populations, both older people's services: Cooper, Regan, Tandy, Johnson & Livingston, 2007; Richman, Wilson, Scally, Edwards & Woods, 2003.

clock to those in mental health crisis as an alternative to hospital admission. The socio-cultural context in which these teams have evolved will be provided, and the team model will be described and evaluated. The outcomes obtained by these teams will then be analysed. The reviewed literature includes a randomised controlled trial and a well-controlled quasi-experimental study, some smaller experimental and evaluative studies, as well as descriptive and opinion papers.

Evolution of Crisis Resolution/Home Treatment

The UK Context

CR/HT represents the current end-point in a historical shift over time from institutional to community care (Brimblecombe, 2001a; Johnson, Zinkler & Priebe, 2001). The late twentieth century saw the closure of large asylums with a move to providing care through community mental health teams (CMHTs) and inpatient units in district hospitals. Such acute care was seen as progressive at the time (Burns, 2004), but led to cyclical patterns of caring for people in the community while mentally well, with admissions during acute phases (Joy et al., 2004). There was also a problem with ward occupancy rates exceeding full capacity (Deahl & Turner, 1997).

Shifts in mental health care in the UK have been characterised by gradual reform (Johnson et al., 2001). Crisis-dedicated teams have existed in the UK for some time, though were uncommon ten, and rare twenty years ago (Orme, 2001). The first mention of the teams in recent policy was in the *National Service Framework* (DoH, 1999), which was followed by the policy

commitment to establish teams nationwide in the *NHS Plan* (DoH, 2000). The target number of teams has been achieved (DoH, 2005).

Multiple factors are believed to have influenced the shift to CR/HT. It is part of the greater move towards community care: as well as humane concern to avoid the negative effects of psychiatric admission (see below), there are also financial benefits because inpatient care is expensive (Brimblecombe, 2001a; Burns, 2004). The need to reduce the pressure on inpatient beds, and the push from service-users and carers for better access to services have also been influential (Burns, 2004; Johnson, 2004).

As well as the move impacting on wards, generic community services have also felt the effect. CMHTs previously provided all aspects of community care, including dealing with crises. The introduction of the new teams has led to comment that CMHTs might seem outdated and under threat (Burns, 2004; Holmes, 2001).

Problems with hospital care

The proponents of CR/HT have highlighted a multitude of problems with acute care provided by inpatient wards (see Table 1). Whilst CR/HT offers part of the solution to overcoming these problems, the extensiveness of this list of criticisms provides policy-makers and professionals great scope to improve the current inpatient experience.

Table 1. Problems and Criticisms of Inpatient Care

Treatment and Care:

- Problems are medicalised with neglect of the psychosocial aspects.
- Over-emphasis on behavioural conformity.
- Wards are boring and lack meaningful activities and staff contact.

Patient Experience:

- Poor physical environments.
- Lack of privacy, liberty and autonomy.
- Feeling threatened by, or actual assault by other service-users.
- At worst, experiences can leave the patient traumatised.

Social Factors:

- Stigma related to a psychiatric admission.
- Poor record of meeting the needs of women and people from ethnic minorities.

Economic Factors:

- Large proportion of the mental health spend on inpatient care.
- Problems of over-occupancy and pressure on beds.
- Over-occupancy has led to use of expensive private sector beds.

Staff Factors:

- Low morale.
- Higher rates of sickness and burnout.
- High reliance on agency staff.

Sources: Brimblecombe, 2001a; Johnson 2004; Kennedy & Smyth, 2003; Smyth, 2003; Smyth & Houlst, 2000.

Development of Crisis Teams Overseas

The systematic literature search, limited to publications in English, identified articles describing team models in North America, Australasia and Europe. The UK model is based heavily on teams in Australia (Johnson, 2004). These teams, commonly titled Crisis Assessment and Treatment

Teams (Carroll et al., 2001; Fulford & Farhall, 2001), have been well-established there for some decades. Examples are also described in New Zealand (MacKirdy, 2006). Teams located in the Netherlands also cite their origins in the Australian model (Boomsma, Dingemans, & Dassen, 1997).

The evolution of teams in Canada (Ferris et al., 2003; Landeen, Pawlick, Rolfe, Cottee & Holmes, 2004) and the US (Bonyngue et al., 2005; Cornelius et al., 2003; Scott, 2000) appears to have occurred slightly differently. The title Mobile Crisis Program is commonly used, and teams comprise a telephone hotline for initial assessment and support, with crisis workers mobilised in emergency cases. The teams are staffed by police officers in partnerships with health professionals with some mention of residential crisis units. Bonyngue et al. (2005) describe a two-tier service distinguishing emergency cases (immediate response) and urgent cases (help is needed but a wait of a few days is not detrimental).

The Crisis Resolution/Home Treatment team model

The Department of Health has specified a service model for CR/HT teams (DoH, 2001). This is provided as guidance and may be adapted to meet local needs. Establishment of stand-alone, specialist teams is deemed preferable (DoH, 2001). Hopefully, the specification of a team model overcomes earlier criticisms that 'crisis teams' lacked shared ethos in terms of methodologies and service components (Joy et al., 2004; Orme, 2001, Sandor, 2000; Sandor, 2001).

The description of the model is elaborated in Table 2. The model comprises team features (characteristics of the team approach), team

Table 2. The CR/HT Team Model

Team Features of CR/HT

- *Availability.* Around-the-clock response, with first contact made within hours of referral. Staff will travel to the home.
- *Intensity.* Tailor the support or treatment to need, this may mean high frequency and longer visits early in crisis. Timing of appointments is not fixed, so allowing staff to remain with individuals while in crisis.
- *Assertive.* Where necessary assertive engagement with individual.
- *Engaging the network.* Support and utilise family and other significant carers. Involvement of the service-user and nominated carers is an important part of care.
- *Brief.* Time-limited involvement, commonly 6-8 weeks.
- *Multidisciplinary.* Mix of skills should be available, including medical, social care, psychology and occupational therapy.
- *Connected.* Good local knowledge and links with services.

Team Functions of CR/HT

- Gate-keeping. Assess all acute cases and direct to home treatment or inpatient admission as appropriate.
 - Multidisciplinary home treatment.
 - Involvement with the service-user until the crisis is resolved.
 - Link the service-user in to ongoing care at discharge.
 - Provide a named worker to each service-user for continuity of care.
 - Involved in early discharge from the ward.
 - Use crisis as an opportunity to reduce future vulnerability.
-

Table 2, continued

Interventions of CR/HT Teams

- Assessment (screen for service, risk, support network mapped, focus on individual resources)
- Planning (focused care plan, contract visits, involve system)
- Generic support (intensive, ongoing monitoring)
- Medication support (delivery, administration, advice)
- Daily living support (facilitating with issues like housing, benefits, childcare, managing household)
- Carer/family support (education about crisis and illness)
- Increasing resilience (problem-solving approaches, short-term goal setting, stress management, brief supportive counselling, social network maintained/improved).
- Relapse prevention (warning signs, crisis plan).
- Providing respite (e.g. day care, family-style 'crisis' home).

Source: Brimblecombe, et al, 2003; DoH, 2001; Johnson, 2004; Smyth & Hout, 2000.

functions (role performed by the team collectively), and team interventions (specific interventions practised by individual or small groups of staff).

Additionally, Brimblecombe et al. (2003) note the importance of a telephone service open to current referrals, and Marshall (2003) argues the case for day hospital care, which can provide cost-effective treatment and respite for service-users and relatives. Crisis houses are also mentioned: homely residential settings, which provide respite from the home setting (Johnson et al., 2004; Whittle & Mitchell, 1997).

Advantages and disadvantages of CR/HT

The problems of hospital treatment have been outlined and CR/HT is intended to overcome these, most importantly in eliminating the negative impact of admission, and reducing cost and pressure on inpatient beds. Proponents also highlight the benefits of working in the home context (Brimblecombe, 2001b; Ferris et al., 2003; Johnson, 2004). Psychological and social triggers are more visible to workers, and therefore coping skills can be taught and are less affected by the problem of generalisation experienced with skills taught in institutions. Also carers or significant people in familial/social networks can be included in the recovery process.

Concern has been expressed that the successes of community care have led policy makers to conclude that hospital treatment might be completely substituted (Deahl & Turner, 1997). Proponents of CR/HT have stated that it is not a panacea, and that inpatient care will continue to be necessary (Brimblecombe, 2001b; Smyth, 2003).

Pelosi and Jackson (2000) raise a number of valid criticisms about the disruption to continuity of care. For existing CMHT service-users this is particularly marked; in crisis, care is transferred from the regular CMHT keyworker to the CR/HT. This risks the keyworker losing an understanding of the problems during the crisis episode, the service-user losing their familiar keyworker during crisis, and the CR/HT losing the keyworker's experience and knowledge of the service-user.

The continuity of care problem is acknowledged by some CR/HT proponents (Brimblecombe 2001b; Johnson, 2004). There would of course be a break in continuity resulting from hospital admission anyway. Johnson

(2004) evaluates the advantages and disadvantages of having stand-alone, specialist teams, rather than contingency for crisis being offered by the CMHT. A specialist CR/HT team means: crisis cases can remain the focus without neglecting non-crisis service-users; there is the chance to develop and practice specialist skills; and centralisation may be economically beneficial. As well as a threat to continuity of care, separate centralised teams must travel further and have knowledge of a greater locality. A model of continuous co-working during crisis with ward and CMHT has been advocated by some (Harrison & Marshall, 2000; Kennedy & Smyth, 2003).

The issue of delivering care in areas where there is low density of population, such as rural areas, has also been raised (Bonyngne et al., 2005). The team approach requires travel to service-users' homes, and longer distances present practical and cost-effectiveness concerns. Although, CR/HT is touted as the cost-effective alternative to inpatient care, because up to two workers may make home visits for reasons of safety, difficulties travelling or prolonged visits diminish economic returns. This point is made by Marshall (2003) in arguing for the practical and cost-effective benefits of travel to a central day hospital to attend groups and/or appointments.

Lastly, as CR/HT represents extended care in the community it is possible it may attract the negative publicity of earlier waves of community care (Brimblecombe, 2001b; Johnson, et al., 2001). The media and political figures have argued at different points that community care is dangerous and a failure. CR/HT may have to factor in society's good will and its threshold for high risk being managed in the community (Brimblecombe, 2001b).

Evaluation of Crisis Resolution/Home Treatment

In a climate where health interventions are required to show treatment efficacy, the CR/HT team approach must also prove its worth (Kennedy & Smyth, 2003). The focus in terms of outcome has been on the reduction in admissions, with early trials claiming dramatic reductions (average rate 66%: Smyth & Houtt, 2000). The larger scale trials will be considered first, and then smaller-scale outcome studies.

CR/HT in clinical trials

A *Cochrane Review* of crisis/home treatment for people with severe mental illness (Joy et al., 2004) drew positive though cautious conclusions. Studies meeting inclusion criteria of the review were internationally based and conducted between the 1970's and early 1990's. With regards to admissions, the review found that crisis/home treatment might keep 55% of service-users out of hospital over a 12-month period. Those allocated to home treatment were also found to stay engaged with services. Other conclusions were based on limited data. Compared to hospital treatment, crisis/home treatment was found to have neither positive nor detrimental effect on self-harm, global functioning or mental state. The tendency was for home treatment to be associated with lower carer burden, higher service-user and carer satisfaction, and it was significantly cheaper.

There has been growing criticism of using the studies included in this review as evidence to support CR/HT style interventions (Burns, 2000; Glover et al., 2006; Harrison & Marshall, 2000; Johnson, 2004; Pelosi & Jackson, 2000). These studies are considered to be outdated, because they

do not make the comparison with CMHT/ward care, but were conducted in an earlier era. The care provided in the research studies was also often far longer than the 6-8 weeks of CR/HT.

Johnson and colleagues in Islington, London have conducted two trials, one quasi-experimental (Johnson et al., 2005a) and one randomised (Johnson et al., 2005b) that overcome these inadequacies. In the first study, Johnson et al. (2005a) made a comparison before and after the introduction of a CR/HT team. The researchers made excellent efforts to measure and statistically control for confounding variables. The CR/HT group were found to have reduced rates of admission: 22% less at six weeks, which dropped to 15% at six months. Client satisfaction scores favoured CR/HT, the average being five points higher on a twenty-four point scale. This indicated modest satisfaction. No significant differences were found on measures of symptomology, functioning or quality of life. The study showed good control of confounding variables, good retention of participants, and as a more naturalistic study good external validity.

The randomised control trial conducted by Johnson et al. (2005b) compared CR/HT with standard CMHT/ward care. It similarly found reductions in admissions could be achieved to an even greater degree: about 37% less admission in the CR/HT group than in the control group after 8 weeks of treatment, a rate retained at 6-month follow up. Differences in service-user satisfaction were not found until a statistical adjustment was made. Even then, the difference was one-point on a twenty-four point scale, with both groups registering modest satisfaction.

These two studies made a fair comparison of CR/HT with existing services. They both provide robust research designs, in a topic area which is ethically and practically difficult. The studies show a reduction in admission, although to an attenuated degree to earlier claims (Smyth & Hoult, 2000). The findings seem consistent with a body of literature that suggests community treatment does not present any negative impact (or positive effect) to mental health, functioning, or risk of harm. One study found a statistically significant higher rating of satisfaction for CR/HT. The external validity of the first study compliments the internal validity of the second.

Other outcome studies

Other studies have claimed reductions in admission rates with the introduction of crisis services. Jethwa, Galappathie. and Hewson (2007) looked at admissions in the two years prior to CR/HT and one year after. They report a 37.5% reduction in admissions due to CR/HT. However, this study does not control for confounding variables, other fluctuations are apparent in the data prior to CR/HT that are not explained, and beds were cut at the same time as CR/HT was introduced. Whittle and Mitchell (1997) offer a similar uncontrolled study comparing admissions in one geographical area with other areas and claimed a 17% fall in admissions.

Glover et al. (2006) provide an analysis of national admissions data considering those areas with and without CR/HT teams. Interestingly, they found a drop in admissions during the 1998 to 2004 period occurring independently from CR/HT provision. However, the drop was greater in areas with broadly defined crisis teams, and even more marked in areas with a

CR/HT team offering around-the-clock accessibility. These authors conclude an overall 20% fall in admissions where 24-hour teams were in place.

Other studies have looked at admissions and service usage data, but either mix the effect of introducing CR/HT with other service developments (Keown, Tacchi, Niemiec & Hughes, 2007), or describe services that are primary-care based (Brooker et al., 2007; Perry, Hatfield & Spurrell, 2002; Tacchi, Joseph & Scott, 2003).

No other studies considered service-user satisfaction, but one team has looked in to carer satisfaction (Fulford & Farhall, 2001). These researchers conducted a retrospective questionnaire study with relatives of service-users of an Australian crisis team. Less than half of respondents showed a preference for home treatment. These respondents were predominantly over 60 years old and living with the relative at the time, although it is not clear if this represents bias for this sample. Factors that might predict attitudes to treatment were also measured and analysed: residing with the service-user and perceiving the condition as more severe and burdensome were predictive of a preference for hospital care

These findings are out of line with the earlier literature, particularly Houlton, Reynolds, Charbonneau-Powis, Weekes and Briggs (1983), on which the authors comment. They claim this finding may be explained by earlier treatments being up to one-year long not just 8 weeks, and possibly (it was not clearly reported in earlier papers) that respondents had experienced both, not just one, form of treatment.

Weaknesses in the evidence

A number of commentators have pointed to weaknesses and anomalies in the evidence provided for CR/HT. One issue raised is researcher effects, that is, the strength of effect may be down to a 'new broom' effect of an enthusiastic team of practitioners coming together (Burns & Priebe, 2004; Deahl & Turner, 1997; Fulford & Farhall, 2001). Experimental services are known to change their practices after the research finishes and sometimes have ceased operating (Burns & Priebe, 2004). A number of studies look at teams during their inception, which is the nature of controlled trials. Supporting longitudinal data might be additionally compelling.

Burns (2000, 2004; Burns & Priebe, 2004) has noted the 'black box' element in team-based RCTs. They do not tell us much about which components of care are significant. Brimblecombe (2001b) also notes the importance of identifying what interventions workers are practising, and considering their efficacy. Burns and Priebe (2004) highlight how mental health teams are embedded in a local service culture. Comparative trials without randomisation can be particularly problematic to interpret, although even randomised controlled trials conducted in one organisation are likely to be influenced by local factors (e.g. disciplinary mix, therapeutic philosophies, wider service configuration, funding, etc) and may not therefore generalise.

It is noted that some of the studies looking at changes subsequent to introduction to CR/HT mention that bed or ward closures had taken place. The implication of cuts in the absolute number of beds should be reflected upon, when quoting reductions in admissions or costs. It is likely to have an impact and statistical adjustments should probably be made.

A couple of authors note some inconsistency on bed days data (length of stay) compared to admission numbers. A pattern has been noticed that with introduction of CR/HT, the number of admissions dropped, although the average length of admission drops less significantly or even increases (Brimblecombe, 2001b; Glover et al., 2006). At least two theories are offered for this: CR/HT teams may work disproportionately with a population who previously had short hospital stays; and, with less pressure on ward occupancy, staff may be less proactive about minimising stays. These theories remain untested.

Finally, the inconsistency and quality in measurement of satisfaction is noted. Earlier studies offered more compelling data; recent results are mixed. There are potential problems with the concept of satisfaction data as it appears in these studies, such as the power imbalance influencing response and the term 'satisfaction' itself eliciting positive ratings (Hopkins & Niemiec, 2006). There is a danger of using satisfaction to validate current practice over identifying and eradicating dissatisfaction (Hopkins & Niemiec, 2006). More qualitative feedback from service-users and their carers/relatives on CR/HT might be more meaningful and informative, and shape continued improvement.

Section Summary: Crisis Resolution Team Approach

In considering how much the CR/HT model is oriented to a crisis resolution function a number of aspects seem to be important. These include availability around the clock, flexibility on number/length of visits, engaging the support network, and the time-limited nature of the service. There are

interventions which appear relevant to crisis resolution: risk focused assessment, help with everyday issues (e.g. housing, benefits) and interventions to increase resilience. However, some elements clearly and exclusively come from an 'alternative to hospital' or 'home treatment' ethos: gate-keeping, early discharge and medication support in the home.

The dedicated CR/HT team approach offers some clear advantages, including treatment in-vivo, specialist skills within the team, and a focus on service-users in crisis without withdrawing resources from others. The approach does not claim to eradicate the need for hospital care, and solutions to overcome continuity of care problems have been offered. There is a tiering system of crisis care in the US model which may be worthy of consideration.

In terms of outcome, the Islington trials demonstrate that, against a fair comparator, reductions in admissions can be achieved to the tune of 15-37%. There is no evidence of a detriment on measures of mental health, functioning and risk. Ideally, the evidence should be backed up by trials elsewhere to overcome the criticisms that this is the result of a team of enthusiasts and that the outcome might be bound to the systems in a given locality. However, in reality, the roll-out of CR/HTs across the UK has likely ruled this out.

The measurement of outcome in these trials, reduction in admissions, has been narrow, and for this review does not represent a crisis-oriented outcome, but rather relates to the ethos of an 'alternative to hospital' service. It should also be noted this outcome is achieved against a backdrop of admissions dropping independently of CR/HT provision (Glover et al., 2006).

In an era of treatment efficacy, CR/HTs may need to extend their definition of treatment outcome to ensure their continued success and survival. Valid criticisms have been raised about the 'black box' nature of team treatment, and specific evaluation at the intervention level, or of other service components, might be more appropriate. There is also value in the criticisms that asking for satisfaction (in quantitative ratings) might conceal dissatisfactions, which teams should be working to identify and overcome.

Conclusions

This literature review considered two questions. Firstly, *'How has mental health crisis been conceptualised?'* There appears to be consensus around a descriptive account of what crisis is, which elaborates on the broad working definition set out at the start of this review. Key features are: an individualised appraisal based life experience; acute distress related to feeling overwhelmed and lacking control; changes in the day-to-day functioning abilities and risk behaviours; and, social support as important and potentially protective.

More theoretical understandings of the concept, which may be of use to intervening practitioners, are available but oppose rather than compliment one another. Crisis Theory, which has been well-developed and provides the potential to meet practitioners' needs, is criticised for failing to adequately fit with the experience and practice of those in the mental health field. There is also unresolved debate around the depth and goals of crisis resolution practices. These conclusions beg the question how are those interacting

within services – service-users, carers and NHS workers – understanding crisis and crisis resolution?

In considering the second question, '*What is known about the team approach to crisis resolution?*' the main finding is that elements of crisis resolution are apparent in the team model provided in policy, but these are combined with functions exclusively oriented to alternative to hospital/home treatment role. Furthermore, outcome studies have had a narrow focus on the home treatment-related outcome of admission reductions.

Little can be gleaned from the literature about what is being done in teams to resolve mental health crisis. A list of interventions is outlined in the national policy, but research efforts to understand the rationale and practice for such interventions to those in crisis would be beneficial as a starting point, moving to some form of outcome-based research in the area. CR/HT teams are a recent addition to the UK NHS health care system and have been heralded as desirable for service-users and as effective. However, a more robust understanding of the theoretical framework from which they operate is needed to ensure their continued development and acceptance by stakeholders.

References

- Aguilera, D.C. (1994). *Crisis Intervention: Theory and Methodology* (7th ed.). Mosby: St Louis.
- Ball, J.S., Links, P.S., Strike, C. & Boydell, K.M. (2005). "It's overwhelming...everything seems to be too much": a theory of crisis for individuals with severe and persistent mental illness. *Psychiatric Rehabilitation Journal*, 29, 10-17.
- Beecham, J. (2005). Access to mental health supports in England: crisis resolution teams and day services. *International Journal of Law and Psychiatry*, 28, 574-587.
- Bonyngge, E.R., Lee, R.G. & Thurber, S. (2005). A profile of mental health crisis response in a rural setting. *Community Mental Health Journal*, 41, 675-685.
- Boomsma, J., Dingemans, C.A.J. & Dassen, T.W.N. (1997). The nursing process in crisis-oriented psychiatric home care. *Journal of Psychiatric and Mental Health Nursing*, 4, 295-301.

- Bracken, P.J. (2001). The radical possibilities of home treatment: postpsychiatry in action. In N. Brimblecombe (Ed.), *Acute Mental Health Care in the Community: Intensive Home Treatment* (pp. 139-162). London: Whurr Publishers.
- Bridgett, C. & Polak, P. (2003). Social systems intervention and crisis resolution. Part 1: Assessment. *Advances in Psychiatric Treatment*, 9, 424-431.
- Brimblecombe, N. (2001a). Community care and the development of intensive home treatment services. In N. Brimblecombe (Ed.), *Acute Mental Health Care in the Community: Intensive Home Treatment* (pp. 5-28). London: Whurr Publishers.
- Brimblecombe, N. (2001b). Developing intensive home treatment services: problems and issues. In N. Brimblecombe (Ed.), *Acute Mental Health Care in the Community: Intensive Home Treatment* (pp. 187-207). London: Whurr Publishers.
- Brimblecombe, N., O'Sullivan, G. & Parkinson, B. (2003). Home treatment as an alternative to inpatient admission: characteristics of those treated and factors predicting hospitalisation. *Journal of Psychiatric and Mental Health Nursing*, 10, 683-687.

- Brooker, C., Ricketts, T., Bennett, S. & Lemme, F. (2007). Admission decisions following contact with an emergency mental health assessment and intervention service. *Journal of Clinical Nursing*, 16, 1313-1322.
- Brown, F.F. & Rainer, J.P. (2006). Too much to bear: an introduction to crisis intervention and therapy. *Journal of Clinical Psychology*, 62, 953-957.
- Burns, T. (2000). Letters: Psychiatric home treatment. *British Medical Journal*, 321, 177.
- Burns, T. (2004). *Community Mental Health Teams: A Guide to Current Practices*. Oxford: Oxford University Press.
- Burns, T & Priebe, S. (2004). The survival of mental health services: a pressing research agenda? *British Journal of Psychiatry*, 185, 189-190.
- Calhoun, L.G. & Tedeschi, R.G. (2006). *Handbook of Posttraumatic Growth: Research and Practice*. Mahwah: Lawrence Erlbaum Associates.
- Callahan, J. (1998). Crisis theory and crisis interventions in emergencies. In P.M. Kleespies (Ed.), *Emergencies in Mental Health Practice: Evaluation and Management* (pp. 22-40). New York: The Guilford Press.

Caplan, G. (1964). *Principles of preventive psychiatry*. London: Tavistock Publications.

Caplan, G. (1969). *An approach to community mental health*. (1st ed.). London: Tavistock Publications.

Carroll A., Pickworth, J. & Protheroe, D. (2001). Service innovations: an Australian approach to community care – the Northern Crisis Assessment and Treatment Team. *Psychiatric Bulletin*, 25, 439-441.

Christian, C. & Jurist, E.L. (2001). The relevance of psychoanalytic ideas to crisis work. *Journal of Social Distress and the Homeless*, 10, 293-304.

Cluse-Tolar, T. (1997). Gender differences in crisis recovery: rethinking crisis theory. *Crisis Intervention*, 3, 189-198.

Cooper, C., Regan, C, Tandy, A.R., Johnson, S. & Livingston, G. (2007). Acute mental health care for older people by crisis resolution teams in England. *International Journal of Geriatric Psychiatry*, 22, 263-265

Cornelius, L.J., Simpson, G.M., Ting, L. Wiggins, E., & Lipford, S. (2003). Reach out and I'll be there: mental health crisis intervention and mobile outreach services to urban African Americans. *Health & Social Work*, 28, 47-78.

Cunnigham, M. (2000). Spirituality, cultural diversity and crisis intervention. *Crisis Intervention*, 6, 65-77.

Deahl, M. & Turner, T. (1997). General psychiatry in no-man's land. *British Journal of Psychiatry*, 171, 6-8.

Department of Health. (1999). National service framework for mental health – modern standards and service models. London: The Stationery Office.

Department of Health. (2000). *The NHS Plan*. London: The Stationery Office.

Department of Health. (2001). *The Mental Health Policy Implementation Guide*. London: Department of Health.

Department of Health. (2005). Press releases: Key targets hit in mental health reform programme. www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4115237

Department of Health. (2006). *Guidance Statement on Fidelity and Best Practice for Crisis Resolution Teams*. London: Department of Health.

Dulmus, C.N. & Hilarski, C. (2003). When stress constitutes trauma and trauma constitutes crisis: the stress-trauma-crisis continuum. *Brief Treatment and Crisis Intervention*, 3, 27-35.

Ferris, L.E., De Siato, C., Sandercock, J., Williams, J.I., Shulman, K.I. & the Working Group. (2003). A descriptive analysis of two mobile crisis programs for clients with severe mental illness. *Canadian Journal of Public Health, 94*, 233-237.

Fraser, J.S. (1998). A process view of crisis and crisis intervention: critique and reformulation. *Crisis Intervention, 4*, 125-143.

Fulford, M. & Farhall, J. (2001). Hospital versus home care for the acutely mentally ill? Preferences of caregivers who have experienced both forms of service. *Australian and New Zealand Journal of Psychiatry, 35*, 619-625.

Glover, G. Arts, G & Babu, K.S. (2006). Crisis resolution/home treatment teams and psychiatric admission rates in England. *British Journal of Psychiatry, 189*, 441-445.

Graham, C. & Bancroft, J. (2006). Crisis Intervention. In S. Bloch (Ed.), *An Introduction to the Psychotherapies* (4th ed) (pp. 197-213). Oxford University Press: Oxford.

Harrison, J. Alam, N. & Marshall, J. (2001). Home or away: which patients are suitable for a psychiatric home treatment service? *Psychiatric Bulletin, 25*, 310-313.

Harrison, J. & Marshall, J. (2000). Letters: Home treatment works. *British Medical Journal*, 321, 177.

Heath, D.S. (2005). *Home Treatment for Acute Mental Disorders*. New York: Routledge.

Hendricks, J.E. & Byers, B.D. (2002). *Crisis Intervention in Criminal Justice/Social Service* (3rd ed.). Springfield: Charles C Thomas Publishers Ltd.

Hobbs, M. (1984). Crisis intervention in theory and practice: a selective review. *British Journal of Medical Psychology*, 57, 23-34.

Holmes, G. (2001). So. Farewell then CMHTs. *Clinical Psychology*, 6, 7-10.

Hopkins, C & Niemiec, S. (2006). The development of an evaluation questionnaire for the Newcastle Crisis Assessment and Home Treatment Service: finding a way to include the voices of service-users. *Journal of Psychiatric and Mental Health Nursing*, 13, 40-47.

Hopkins, C & Niemiec, S. (2007). Mental health crisis at home: service-user perspectives on what helps and what hinders. *Journal of Psychiatric and Mental Health Nursing*, 14, 310-318.

Horowitz, M. J. (1976). *Stress Response Syndromes* (1st ed.). Northvale, NJ: Aronson.

Hoult, J., Reynolds, I., Charbonneau Powis, M., Weekes, P. & Briggs, J. (1983). Psychiatric hospital versus community treatment: the results of a randomised trial. *Australian and New Zealand Journal of Psychiatry*, 17, 160-167.

Jerry, P.A. (1998). Dynamic change in crisis intervention. *American Journal of Psychotherapy*, 52, 437-449.

Jethwa, K., Galappathie, N. & Hewson, P. (2007). Effects of a crisis resolution and home treatment team on inpatient admissions. *Psychiatric Bulletin*, 31, 170-172.

Johnson, S. (2004). Crisis resolution and intensive home treatment teams. *Psychiatry*, 3, 22-25.

Johnson, S., Bingham, C., Billings, J., Pilling, S., Morant, N., Bebbington, P., McNicholas, S. & Dalton, J. (2004). Women's experiences of admission to a crisis house and to acute hospital wards: a qualitative study. *Journal of Mental Health*, 13, 247-262.

- Johnson, S., Nolan, F., Hoult, J., White, I.R., Bebbington, P., Sandor, A., McKenzie, N., Patel, S.N. & Pilling, S. (2005a). Outcomes of crises before and after introduction of a crisis resolution team. *British Journal of Psychiatry*, 187, 68-75.
- Johnson, S., Nolan, F., Pilling, S., Sandor, A., Hoult, J., McKenzie, N., White, I.R., Thompson, M. & Bebbington, P. (2005b). Randomised controlled trial of acute mental health care by a crisis resolution team: the North Islington crisis study. *British Medical Journal*, 331, 599-602.
- Johnson, S., Zinkler, M. & Priebe, S. (2001). Mental health service provision in England. *Acta Psychiatrica Scandinavica*, 104 (Suppl. 410), 47-55.
- Joy, C.B., Adams, C.E. & Rice, K. (2004). *Crisis intervention for people with severe mental illness (Review)*. The Cochrane Database of Systematic Reviews, Issue 4, Art. No. CD001087.pub2.
- Kennedy, P. & Smyth, M.G. (2003). Out of bounds. *Health Service Journal*, 113, 32-33.
- Keown, P. Tacchi, M.J., Niemiec, S & Hughes, J. (2007). Changes to mental health care for working age adults: impact of a crisis team and assertive outreach team. *Psychiatric Bulletin*, 31, 288-292.

Landeen, J., Pawlick, J. Rolfe, S., Cottee, I. & Holmes, M. (2004). Delineating the population served by a mobile crisis team: organising diversity.

Canadian Journal of Psychiatry, 49, 45-50.

Lazaro, F., Kulinskaya, E. & Tobiansky, R. (2001). Crisis intervention: the professionals' perspective. *Psychiatric Bulletin*, 25, 95-98.

Lindemann, E. (1944). Symptomatology and management of acute grief.

American Journal of Psychiatry, 101, 101-148.

Links, P.S., Eynan, R., Ball, J.S., Barr, A. & Rourke, S. (2005). Crisis occurrence and resolution in patients with severe and persistent mental illness. *Crisis*, 26, 160-169.

MacKirdy, C. (2006). Contrasting ways of delivering adult psychiatric services. *Psychiatric Bulletin*, 30, 283-285.

Marshall, M. (2003). Acute psychiatric day hospitals. *British Medical Journal*, 327, 116-117.

Orme, S. (2001). Intensive home treatment services: the current position in the UK. In N. Brimblecombe (Ed.), *Acute Mental Health Care in the Community: Intensive Home Treatment* (pp. 29-53). London: Whurr Publishers.

Parry, G. (1990). What is a crisis? In G. Parry (Ed.), *Coping with Crises* (pp. 1-17). BPS Books/Routledge Ltd: London.

Pelosi, A.J. & Jackson, G.A. (2000). Home treatment – enigmas and fantasies. *British Medical Journal*, 320, 308-309.

Perry, A., Hatfield, B. & Spurrell, M. (2002). Specialist service use following psychiatric emergency presentation: an 18-month follow-up study. *Health and Social Care in the Community*, 10, 457-463.

Relton, P. & Thomas, P. (2002). Acute wards: problems and solutions. *Psychiatric Bulletin*, 26, 346-347.

Richman, A., Wilson, K., Scally, L., Edwards, P. & Wood, J. (2003). Service innovations: an outreach support team for older people with mental illness – crisis intervention. *Psychiatric Bulletin*, 27, 348-351.

Sandor, A. (2000). Correspondence: home treatment teams. *Psychiatric Bulletin*, 24, 394.

Sandor, A. (2001). Correspondence: home treatment service. *Psychiatric Bulletin*, 25, 486-487.

Sayre, J. (2000). The patient's diagnosis: explanatory models of mental illness. *Qualitative Health Research*, 10, 71-83.

- Scott, R.L. (2000). Evaluation of a mobile crisis program: effectiveness, efficiency and consumer satisfaction. *Psychiatric Services*, 51, 1153-1156.
- Slaikew, K.A. (1990). *Crisis Intervention: A Handbook for Practice and Research* (2nd ed.). Needham Heights: Allyn & Bacon.
- Smyth, M.G. (2003). Crisis resolution/home treatment and inpatient care. *Psychiatric Bulletin*, 27, 44-47.
- Smyth, M.G. & Hout, J. (2000). The home treatment enigma. *British Medical Journal*, 320, 305-308.
- Tacchi, M.J., Joseph, S. & Scott, J. (2003). Evaluation of an emergency response service. *Psychiatric Bulletin*, 27, 130-133.
- Whittle, P. & Mitchell, S. (1997). Community Alternatives Project: an evaluation of a community-based acute psychiatric team providing alternatives to admission. *Journal of Mental Health*, 6, 417-427.
- Yeager, K.R. & Roberts, A.R. (2003). Differentiating among stress, acute stress disorder, crisis episodes, trauma and PTSD: paradigm and treatment goals. *Brief Treatment and Crisis Intervention*, 3, 3-25.

Yerushalmi, H. (2003). Facilitating personal growth. *Psychoanalytic Psychology*, 20, 363-377.

Zayas, L.H., Evans, M.E., Mejia, L. & Rodriguez, O. (1997). Cultural competency training for staff serving Hispanic families with a child in psychiatric crisis. *Families in Society*, 78, 405-412.

Part 2: Empirical Paper

**Perspectives of crisis workers on what makes for a 'crisis' in a Crisis
Resolution/Home Treatment Team.**

Abstract

Research is lacking on how the concepts of crisis and crisis resolution are understood by those working in Crisis Resolution/Home Treatment teams. To address this, semi-structured interviews with 39 multidisciplinary crisis workers explored their understanding of the crisis phenomenon. Framework Analysis of accounts revealed: working models of the crisis concept with core and supplemental features, and the crisis process over time; practice issues relating to the points of intervention commencing and ending; and, clusters of crisis pattern related to diagnostic categories. Although Crisis Theory has not explicitly informed policy or practice, many of its tenets were evident in respondents' accounts. Further research is indicated, for example on crisis outcomes, and work with challenging groups such as 'revolving door' presentations.

Introduction

The focus of this study is on the concepts of mental health crisis and crisis resolution. There has recently been a nationwide expansion of Crisis Resolution/Home Treatment (CR/HT) teams in the UK. A separate literature on Crisis Theory dating back to the 1960s exists, but is not integrated with UK policies on CR/HT teams. The conceptual treatment of crisis across these two fields will be considered, and the rationale for the current study introduced. The terms mental health crisis and crisis will be used interchangeably, and will be used to refer to a conceptual entity (which can be observed and experienced) and which happens over time.

The Crisis Resolution/Home Treatment (CR/HT) ethos

CR/HT teams are a fairly recent innovation on the landscape of adult mental health services in the UK. These teams aim to support people who are being considered for hospital admission during an acute psychiatric crisis (DoH, 2001). The teams are based on a model of care developed in Australia (Johnson, 2004). It has been a Government priority to roll out these teams nationwide (DoH, 2000); such teams were the exception in mental health services prior to this (Orme, 2001).

A number of factors have influenced the drive to provide CR/HT teams to those in crisis. Public policy cites service-user preference for such services over hospital admission (DoH, 2001), and some have noted the possible public expectation of a mental health equivalent to Accident and Emergency services in general medicine (Burns, 2004). Economic savings and the need to provide a more humane and therapeutic alternative to inpatient care have

also been cited (Brimblecombe, 2001a; Burns, 2004; Smyth & Hoult, 2000). CR/HT also offers the benefit of treating 'in vivo', so problems are observed and potential solutions tested in real world settings (Brimblecombe, 2001b; Johnson, 2004). From the community care perspective, a dedicated CR/HT team means those in crisis get specialist attention, whilst regular community service-users do not get neglected by workers in the community mental health team (CMHT; Johnson, 2004).

Clinical trials have shown the teams to be effective in keeping some of those in crisis out of hospital (Johnson et al., 2005a; Johnson et al., 2005b). These studies, one of which was a randomised control trial, achieved reductions in admissions (15-37%) with reasonable retention of effects after six months. There was neither detrimental nor beneficial impact on measures of mental health symptoms, functioning, or risk of harm. One study obtained a convincing difference on service-user satisfaction in favour of CR/HT.

These and other studies have had a focus on reduction in hospital admissions as their primary outcome, and at a policy and research level the emphasis in the literature appears to be on the 'HT' (Home Treatment, as an alternative to hospital) rather than the 'CR' (Crisis Resolution). This is somewhat ironic, given that in the field these teams are generically referred to as 'crisis teams'. The Government guidance does not define 'crisis' or 'crisis resolution', nor indicate any underlying theory or model (DoH, 2001). The guidance relates crisis to the need for hospital admission (a somewhat circular definition) and lists acceptable diagnostic groups and exclusions (which can occur independently of the crisis state, so do not elucidate the crisis concept). One of the clinical trials provided an operational definition

which gives some descriptive detail on how the concept is perceived in practice (Johnson et al., 2005a): deterioration in mental health and/or functioning; risk of harm to self or others; and a disruption of, or negative consequence for, the informal support network.

Some practice issues are highlighted in the literature with regards to CR/HT in the UK. Firstly, proponents of CR/HT emphasise the focus on 'severe mental illness' (e.g. Smyth, 2003), the concern being that teams might become involved in work at an inappropriately low level of severity. A further issue is working with people who have personality disorders and present in crisis. This was a group initially excluded from the remit of CR/HT teams in the Government guidance (DoH, 2001); a stance which was later revised (DoH, 2006). There is discussion in the literature about the complexity of work with these service-users (Harrison, Alam & Marshall, 2001).

The crisis literature outside of the UK also suggests that the term 'crisis' is poorly defined and inconsistently used (Bonyngge, Lee & Thurber, 2005; Callahan, 1998; Heath, 2005). Some of these authors make efforts to create a typology of crisis or to tier crisis severity. These variously emphasise acute symptomology and risk of harm, and reflect a dilemma of whether to include groups felt to have an endogenous mental illnesses (seen as meeting a severe crisis threshold) and those experiencing acute life stressors (seen as falling below a severe crisis threshold).

One study explored the service-user perspective of crisis. Ball, Links, Strike and Boydell (2005) considered the crisis experience in a selected sample: those with enduring psychosis who were being supported by an

assertive community team. They concluded that the symptoms of underlying mental illness themselves played the major part in vulnerability to bringing about and maintaining crisis.

Previous studies conducted with mental health professionals have been questionnaire-based, and in the UK have been limited to a focus on multidisciplinary differences in attitudes to crisis work, e.g. clinical responsibility and job satisfaction (Lazaro, Kulinskaya & Tobiansky, 2001) and attitudes towards new specialist teams including CR/HT amongst consultant psychiatrists (Harrison & Traill, 2004).

An Australian study surveyed crisis workers, and considered what competences, qualities and knowledge were perceived to be important in crisis work (Meehan & Boateng, 1997). Professional attributes rated as most important were the skill of suicide risk assessment, knowledge of crisis intervention strategies (these were not specified), and other generic skills, e.g. team working and care planning. Other than risk being an important feature, there are few clues as to the concept the teams work with.

Two studies in the Netherlands have analysed nursing records to identify key interventions practised with those in crisis (Boomsma, Dingemans & Dassen, 1997) and compared interventions in crisis care to long-term home care (Boomsma, Dassen, Dingemans & van den Huevel, 1999). The findings on common interventions speak indirectly to the crisis phenomenon: interventions dealing with ineffective coping; work with negative emotion and self-esteem; dysfunctional grieving; medication non-compliance; and intervention to improve activity deficits. To summarise, studies conducted with mental health professionals around crisis work have

been deductive and quantitative in approach, and none have focused on how mental health crisis is understood.

Crisis Theory and Crisis Intervention

An earlier and seemingly separate literature to that behind the CR/HT policy exists on the topic of mental health crisis. Crisis Theory offers a model to understand the nature and process of crisis (Caplan, 1964, 1969). The theory holds that individuals exist in a state of psychological equilibrium, which crisis disrupts. Caplan (1964) proposes four phases of crisis: a threatening stimulus raises tension and the individual performs habitual problem-solving; if this is not successful, tension rises to a level of distress; if tension continues to rise, all internal and external resources are drawn upon and an emergency problem-solving phase occurs, perhaps using novel methods of coping; if the problem can not be solved or ignored, then breakdown occurs with major disorganisation and dramatic consequences.

Crisis is theorised as time bound, with sudden onset and approximate six-week duration (Callahan, 1998). The crisis state is conceptualised as one in which an individual may be open to novel coping methods (Callahan, 1998). The goal of Crisis Intervention (the therapy based on Crisis Theory) is to return an individual to their former state of equilibrium.

There have been developments on the original Crisis Theory. These revisions have included the ideas that mental health crisis is an: individually-defined experience, based on individual appraisal and coping processes (Callahan, 1998; Slaikeu, 1990); influenced by constitutional vulnerability and protective factors (Hobbs, 1984); may be caused by life events involving loss

and change (Callahan, 1998; Slaikou, 1990); and, may indicate a wider systemic crisis (Slaikou, 1990).

The theory is only rarely cited in the UK CR/HT literature (Lazaro et al., 2001), although papers by Bridgett and Polak (2003a; 2003b) cover it in more depth. These authors advocate a 'social systems' intervention for crisis and offer a relatively rich conceptualisation of crisis, incorporating: failure of adequate coping; a presentation of acute mental illness or distress; individual and external resources are likely exhausted; there may be denial or avoidance of facing the crisis; and there is the notion of a turning point with both danger of further regression, and the opportunity for constructive growth and change.

Crisis Theory offers practitioners and researchers a coherent psychological model of mental health crisis. It has potential utility to those working in the CR/HT field. However, it is criticised as having shortcomings for mental health teams, because it was based on non-clinical populations, i.e. for otherwise well functioning individuals experiencing a one-off 'crisis'. It has been claimed that the theory is not applicable to clinical populations, such as those seen by CR/HT teams: life stressors in this context are thought to effect minor influence, and presentations are infrequently those of otherwise well individuals seeking help for themselves (Ball et al., 2005; Heath, 2005). Therefore, an unresolved debate remains about whether Crisis Theory is applicable to crisis as it presents clinically.

Others have criticised Crisis Theory, and general psychiatric crisis approaches as superficial and reactive. These views come from both psychoanalytic (Christian & Jurist, 2001) and systemic/constructivist

perspectives (Fraser, 1998). Theorists from these traditions argue that crisis has some wider intrapsychic or systemic meaning, and that it signals that more profound life changes are required. Regaining a sense of psychological equilibrium and functioning is seen as simplistic and wastes the opportunity for self-exploration and change.

Rationale and aims of the current study

It is unclear what theoretical understandings of crisis and crisis resolution are being used by workers in CR/HT teams. Although policy guidance provides a list of interventions, it is unclear what exactly is being offered, its effectiveness and the rationale for its use. Therefore, exploratory research into the experiences of those working in crisis services may provide valuable insight into the frameworks used by professionals in these teams.

This study aimed to explore how multidisciplinary workers in CR/HT teams understand the concepts of crisis and crisis resolution. Given the exploratory nature of the investigation, and the aim of gaining a workers' perspective on conceptual understanding and practice rationale, a qualitative analysis based on semi-structured interviews with CR/HT workers was most appropriate. Framework Analysis (Ritchie & Spencer, 1994) was used, as it is an established method used in public policy research.

The researcher took a primarily inductive approach to remain open to the ideas as they existed for crisis workers. However, some assumptions were made about the concept: it had a nature (features which distinguish it from other mental states) and a process and is time-limited (its features change within a time-frame). The research question addressed in this project

was: How do CR/HT workers define and understand the concept of crisis as they experience it in their work?

Method

Research Setting

The research setting was four CR/HT teams in the South East of England. The population covered by the teams was approximately 925,000. Teams were based in the main town of each district and covered the surrounding rural area which included smaller market towns and villages. An Index of Deprivation (2004) was available for the 354 English districts, where rank position 1 signifies highest deprivation (ODPM, 2004). The nine districts covered by the teams had rankings ranging from 38 to 307 (median 198).

The four teams – referred to as A, B, C and D – were administered by one NHS mental health trust. Teams C and D shared some senior staff; these teams, and teams A and B evolved independently of one another. All teams operated around the clock, and performed the role of A&E psychiatric liaison alongside CR/HT. The characteristics which varied between the teams are shown in Table 1.

Table 1. Characteristics of the four CR/HT teams

| Team Characteristics | Team A | Team B | Team C | Team D |
|------------------------------|--------|--------|--------|--------|
| Ward 'gate keeping' function | Y | Y | N | N |
| Allocated crisis beds | Y | Y | N | N |
| Access to crisis house | N | Y | N | N |
| Includes crisis day service | Y | Y | N | N |

Participants

To be included in the study, all respondents had to be in frontline, clinical roles and have worked in a CR/HT team for at least three months. The intention had been to use purposive sampling to recruit a sample representative of the teams' multidisciplinary mix. However, this was achieved naturally through voluntary participation (see below and Table 2).

The researcher presented the project to the team at their regular meeting with an opportunity for questions. All eligible participants received an invitation letter (Appendix 1) with a participant information sheet (Appendix 2). Respondents opted to participate at the meeting or made contact with the researcher to arrange an interview. At interview, consent was taken (see Appendix 3), the respondent was familiarised with the structure and process of the interview and any questions were addressed. Demographic and professional data was collected after the interview (see Appendix 4).

A total of 80 team workers were eligible to participate, of which 39 were recruited (48.8%). Table 2 shows break downs by team and by discipline of the numbers of those invited and those recruited, together with the percentage for the achieved sample for each team/discipline of those invited to participate. This shows good representation across teams and disciplines was achieved. Two potential respondents, both nurses, came forward too late for the interviewing deadline.

Table 3 displays data on professional and demographic characteristics of respondents. The median time since professional qualification (or years of experience if no professional qualification) was 10.5 years (range 2-40

Table 2. Break down by team and by discipline for those invited and those recruited, with percentages showing representativeness of recruited sample.

| | Invited | Recruited | Percentages for those recruited of those eligible |
|---|-----------|-----------|---|
| | n | n | |
| Total | 80 | 39 | 48.8% |
| Representation for Teams | | | |
| Team A | 35 | 18 | 51.4% |
| Team B | 21 | 8 | 38.1% |
| Teams C and D | 24 | 13 | 54.2% |
| Multidisciplinary Representation | | | |
| Nursing | 47 | 22 | 46.8% |
| STR/Support Work | 13 | 6 | 46.2% |
| Social Work | 11 | 6 | 54.5% |
| Psychiatry | 4 | 1 | 25.0% |
| Occupational Therapy | 3 | 2 | 66.7% |
| Clinical Psychology | 2 | 2 | 100.0% |

Table 3. Professional and demographic characteristics of obtained sample

| | n (%) |
|--|------------|
| Prior work settings ^a | |
| CMHT | 19 (48.7%) |
| Inpatient | 27 (69.2%) |
| A&E/Psychiatric Liaison | 7 (17.9%) |
| Employment duration with team ^b | |
| Since team's inception | 18 (46.2%) |
| After team's inception | 21 (53.8%) |
| Shifts | |
| Only or mainly day shifts ^c | 37 (94.9%) |
| Only or mainly night shifts | 2 (5.1%) |
| Gender | |
| Female | 21 (53.8%) |
| Male | 18 (46.2%) |
| Age | |
| 34 years and under | 10 (25.6%) |
| 35-50 years | 21 (53.8%) |
| 51 years and over | 8 (20.5%) |
| Ethnic background | |
| White UK | 32 (82.1%) |
| White Other | 5 (12.8%) |
| Black | 2 (5.1%) |

^a Some respondents worked across multiple settings prior to CR/HT, so percentages add up to more than 100%.

^b All teams were in full operation for a minimum of three years. For those joining after the team's inception the median duration of time with team was 21 months (range 4-48 months).

^c Daytime described as between 6am and 10pm.

years). Four of the respondents worked exclusively in a CR/HT day services setting.

Ethics

Ethical approval was provided by the Brighton East Research Ethics Committee (see approval letter, Appendix 5). For research governance purposes the project was registered with Sussex NHS Research Consortium (see registration letter, Appendix 6).

Interview

A semi-structured interview format was used to explore the two broad topic areas of the crisis concept and crisis resolution work. The interview schedule was piloted with a research supervisor and minor amendments made. A copy of the final interview schedule is provided in Appendix 7. There was a flexible two-part structure; each began with an open question: how the respondent understood crisis, and what they felt they did to help people in crisis. In part one, areas covered included: commonalities and differences observed in crisis, crises not accepted on to the team caseload, the imagined service-user experience of crisis, and crisis over time (how it develops, how it resolves). In part two, areas covered included: pertinent skills and knowledge (theories, models) to crisis work, the process aspects of crisis work, and differences between CR/HT function and that of CMHTs or wards.

The research presented here will focus only on: the nature of the crisis concept (commonalities, differences, presentations not accepted) and crisis as it happens over time.

Not all interviews covered all areas, and the emphasis shifted in later interviews to explore areas which had been covered less (Pope, Ziebland & Mays, 2000). The researcher remained open to respondents defining the course of the interview, whilst keeping on subject and pursuing elaboration of terms and ideas used (Willig, 2001). The interview style was non-directive and more dialogic where respondents did not naturally lead. Interviews lasted between 25 and 68 minutes (median 48 minutes). All interviews were conducted in work settings familiar to the interviewee, by the researcher, and were audio-recorded. The researcher transcribed all interviews verbatim.

Analysis

Framework Analysis (Pope et al., 2000; Ritchie & Spencer, 1994) was used to analyse the data. It is a method commonly used in policy research and has the advantages of grounding findings in the data, providing comprehensive coverage of the data-set and being open to external audit. The philosophy adopted in analysis was one of 'subtle realism' (Mays & Pope, 2000), it aimed to hold true to the (multiple) perspectives of respondents and represented them as observations of reality, whilst not claiming to attain and uncover 'the truth'.

The analysis involved five stages: familiarisation with data, drafting a thematic framework, indexing, charting and mapping (Ritchie & Spencer, 1994). Through interviewing and transcribing accounts the researcher was familiarised with emerging themes, and early drafts of a thematic framework were produced iteratively from a sample of accounts. The software package Atlas.ti was used for the process of systematic applications of the later

thematic frameworks ('indexing'). Amendments were made to the thematic framework in light of further inductive influences identified in respondent accounts. Once the finalised thematic index had been applied to all accounts (see Appendix 8 for sample), a constant comparison process was conducted (the 'charting' phase) ensuring thematic consistency whilst retaining thematic depth (Pope et al., 2000; see Appendix 9 for sample). The last stage of 'mapping' is more interpretative; here the researcher aimed to provide overall coherence and structure through visual representations of the themes.

The number of respondents contributing to themes was recorded and will be reported (Pope et al., 2000). Standards of quality set out for qualitative researchers were observed (Mays & Pope, 2000; Willig, 2001). The researcher aimed to remain reflective of his own influences and their potential impact; the analysis aimed to encompass the breadth of the data including conflicting views. Additionally, the analysis was audited by two research supervisors, one familiar with crisis work and one not. The auditing process involved a group discussion of draft thematic frameworks, and each supervisor independently assessed the framework's application to two accounts.

Researcher Perspective

The researcher was a clinical psychologist trainee who conducted the interviews in his third year of doctoral training. His theoretical approach is best described as systemic/social constructionist, an approach which values systemic context, language and multiple perspectives. The researcher had worked alongside one of the CR/HT teams included in the study early in its

development, and so experienced some of the dilemmas of crisis work which begun the idea of this research inquiry. As part of prior work and doctoral training he had also worked in inpatient and CMHT settings.

Results

Across respondent accounts there were both conceptual commonalities and differences in understanding crisis. The commonalities were in the nature of crisis (its core and more supplemental features) and the process of how crisis happens over time. Conceptual differences also emerged; respondents recounted different patterns of how crisis presents itself. The results will be provided in this order: firstly, the nature of the crisis concept, considering phenomenological commonalities and exceptions; secondly, crisis over time, from crisis origins through to point of discharge; and finally, clusters of different crisis pattern. The number of respondents contributing to each theme will be reported; this will appear in parentheses after the theme name. The respondent account from which each quotation is drawn will be reported in square brackets after each quotation.

Talking about defining crisis

Many respondents began by saying that crisis means different things to different people. They expressed a general sense that crisis has been a problematic concept because confusion exists about its meaning. This difficulty led to misunderstandings between CR/HT staff and referrers.

Respondents appeared to put in context the position from which they would be defining crisis. Some explained that there is a severity hierarchy of

crisis in mental health services, in which CR/HT crisis ranks as severe. Some felt whilst marginal differences in definition existed amongst team members, overall a largely shared understanding had evolved within teams over time. Some expressed that crisis was on a continuum with normative distress, referencing their own 'ups and downs' in life. A few respondents drew the distinction between crisis as the *psychological response* and crisis as the *event or problem*.

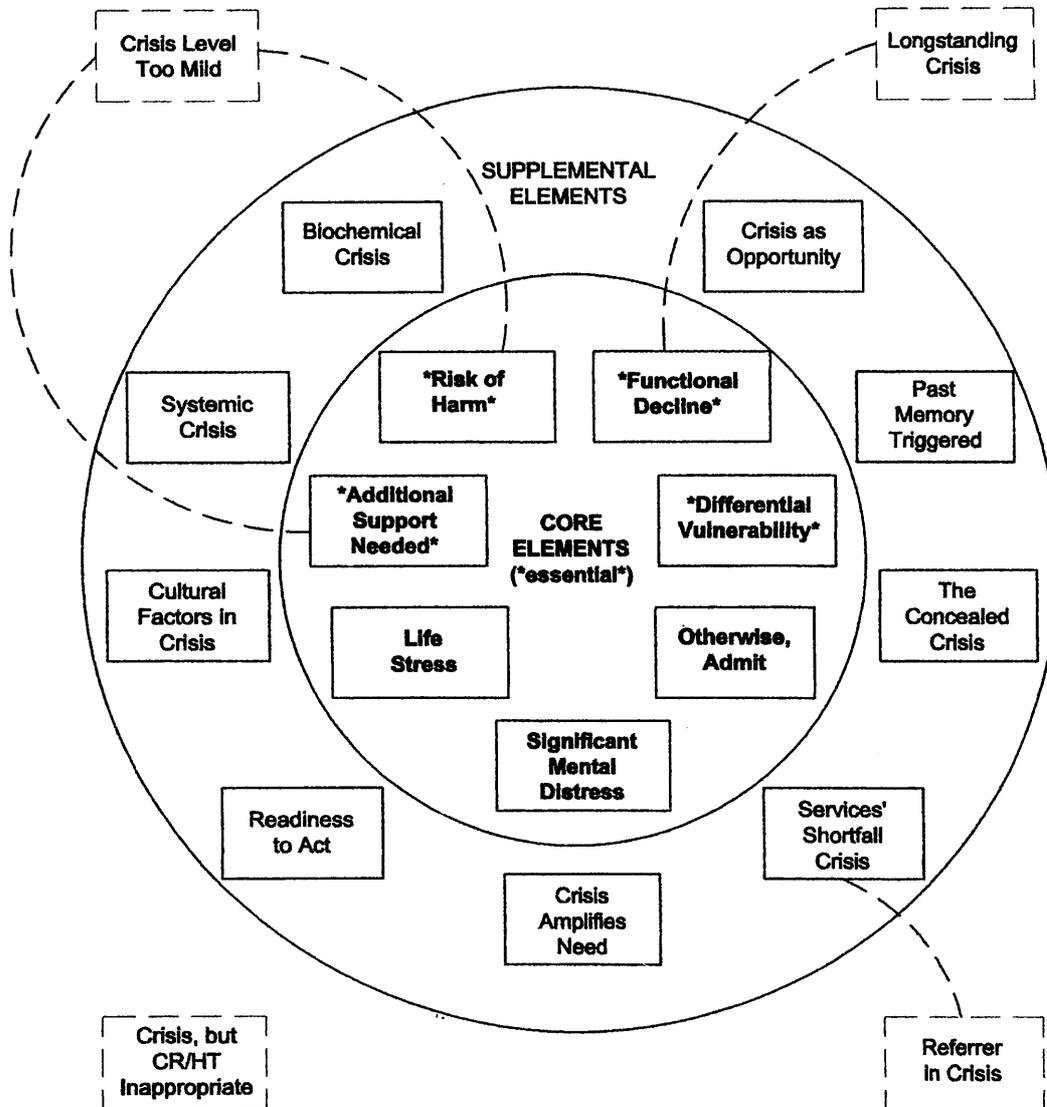
The Nature of the Crisis Concept

A number of commonalities were identified in respondents' accounts of the nature of crisis. Figure 1 depicts the mapped themes from the analysis. This model comprises core and supplemental features, and also features that marked out presentations the team might encounter but not accept, i.e. exclusions and exceptions. The core features were common across accounts and expressed descriptive aspects of the phenomenon. These were felt to apply in either all (essential) or many (common) cases. The supplemental features were less common across accounts and expressed more theoretically-oriented ideas and applicable in some but not all cases.

Core (Essential) Features

Functional Decline (33). A temporary loss of normal functioning was described, with a behavioural impact in abilities to cope with everyday challenges, and psychologically in retaining a sense of mental control. Although a separate theme of risk was identified (below), self-neglecting behaviours that might be deemed risky overlap with this theme. In some

Figure 1. Visual representation of the crisis concept as experienced by CR/HT workers



The model comprises core elements (central circle), supplemental elements (outer circle), and aspects felt to be exclusions (shaded boxes outside circles) and exceptions (*Crisis, but CR/HT Inappropriate* also in shaded box outside circles). Dotted lines that link the three exclusions themes to included themes indicate where respondents related themes to one another (see exclusion theme descriptions).

cases, functional decline was attributed to psychotic symptoms.

“they cease to function...as they do normally, their whole daily routine is disrupted to a point where they really can't cope with things” [r32]

“Something...runs away with you...where one feels out of control” [r19]

Risk of Harm (31). Risk was thought essential in defining crisis in the CR/HT context, although some respondents preferred to think of it as an associated concept rather than within a crisis definition. Risk of harm to self was most commonly cited, with risk of harm to others and from others also mentioned. CR/HT teams are less likely to work with potentially violent service-users, but may offer telephone support or hospital admission.

“whether somebody is in crisis is often heavily defined by their level of risk, in relation to suicide, harming them self, or others...so from being in the team I've probably moved... to seeing [crisis] being much more about somebody's level of risk” [r35]

“the other thing associated for me, they're twins almost, crisis and risk” [r21]

Differential Vulnerability (27). The idea that different people could experience the same event differently was common, and this difference (i.e. in declaring crisis for example) was attributed to variance in appraisal, stress thresholds, and in the coping response.

“it varies from person to person, what might be a crisis for one person might be nothing to another person” [r22]

Individual differences in vulnerability to crisis were considered to arise from different developmental histories, with greater vulnerability linked to problematic attachment relationships, traumatic life events, social adversity, and being sheltered from opportunities to learn to cope.

“people who come to us have a vulnerability to feeling less able to cope with life stressors than perhaps other people in society” [r39]

Additional Support Needed (19). Existing support might come from professionals in the CMHT, or from an informal support network, or in some cases the service-user was surviving alone. A crisis indicated whatever support was in place had failed and necessitated the level of external input that CR/HT can provide.

“they’re coming with a problem which they feel they can’t deal with on their own” [r24]

“the most obvious way that people come...is when their normal care structure can no longer contain what’s going on” [r30]

Core (Common) Features

Life Stress (37). In the vast majority of cases some evident stressor was involved in crisis arising. Such stressors ranged from everyday stresses and strains through to major life events. Excessive stressors were felt to generally apply in crisis scenarios, although in line with the stress-vulnerability model, those with lower coping abilities needed less stress for crisis to occur. This is in line with the *Differential Vulnerability* theme.

“we often get referrals for people that are having either housing problems, lots of relationship problems, problems with their children, problems with neighbours, work issues” [r36]

“it would be rare for it...to suddenly happen for no trigger, no reason...in my experience ninety-nine times out of a hundred there’s a reason” [r21]

Table 4 shows the range of life events described in respondents’ accounts and records the number of accounts in which each life event was cited.

Table 4. The number of accounts mentioning a range of life events encountered in CR/HT cases

| | n | | n |
|-----------------------------|----|-------------------------------|---|
| Family/Relationship Problem | 20 | Parenting Difficulties | 5 |
| Financial Difficulties | 14 | Own or other's illness/caring | 4 |
| Bereavement | 14 | Workplace bullying/pressure | 3 |
| Housing Difficulties | 12 | Problem neighbours | 3 |
| Unemployment | 6 | Post-natal adjustment | 2 |
| Family Separation/Break Up | 5 | Mid-life crisis | 1 |

Significant Mental Distress (29). Heightened, painful emotion was described, although within this theme, views distinguished between expecting this to occur within an existing psychiatric diagnosis and considering acute distress sufficient to accept a case as crisis.

“first of all you’ve got to make sure that the person is suffering from mental illness, and that it is severe and enduring” [r7]

“it wouldn’t necessarily be clear that there was a mental health problem identifiable...but there was distress evident...we would be a team that would be receptive to hearing about people in distress” [r26]

Otherwise, Admit (8). A minority considered the need for hospital admission in defining crisis, although this was tinged with scepticism about its utility as a defining feature.

“You might be providing a very effective crisis service, which might be ineffectual to the admission rate. If that’s the case, then that’s simply not acceptable in the NHS” [r1]

“in itself saying alternative to ward admission isn’t actually defining crisis...it’s sort of defining it in terms of something else, rather than defining it as what it is” [r8]

Supplemental Features

Biochemical Crisis (24). Imbalance in brain biochemistry was cited as underlying some crises, mostly resulting from medication issues (non-compliance, inefficacy, mixing with other substances) but also more 'natural' factors (e.g. mood rhythms, seasonal light levels).

"some people with mental health problems just might naturally have a relapse for organic reasons or just a development of their mental illness, no particular reason for it, or they may stop taking their medication, that's quite common" [r2]

A minority concern of over-medicalising crisis was expressed.

"It might be their first presentation to the GP, they've gone there despairing, and I think because we medicalise a lot of conditions, they want a tablet...that's going to take away that pain" [r29]

Crisis as Opportunity (21). Crisis presented an opportunity some respondents felt, but there were differences in the form of that opportunity. For some, it was the opportunity to reflect on current life circumstances and make revisions.

"while this must seem like the most awful experience...it can be a catalyst for change...a time to change their lives hopefully for the better" [r21]

For others, the opportunity was about learning how to prevent or minimise crisis in the future; service-users new to services were keenest in this regard.

"it actually gives a window...to understand their illness in a different way...be it the way the symptoms affect them...be it the therapy that might be effective...be it the support that the individual requires" [r1]

The learning opportunity was unused by some service-users, 'revolving door' cases particularly appeared not to learn or change established behaviour patterns. Nevertheless, workers persevered in crisis work and prevention with these individuals.

“perhaps not really learning from their mistakes, you know “Didn’t you do that last time and...we talked about maybe you could find a different way of dealing with the situation?” ” [r16]

Systemic Crisis (15). The interaction between individual and system (e.g. family) was related to crisis occurrence. Firstly, individual crisis can affect the system, for example by overburdening a carer, or impact on the community, such as neighbours or the general public.

“transference in a sense...the people around them are in crisis, or out of control, or confused...because of their reactions to their partner, their family member, or their next-door neighbour” [r5]

Secondly, a crisis in the wider system can bring about crisis in the individual, with the person in crisis being the outward sign of unrest.

“they’ve been dependent because of their mental health problems, they’ve lost status there with the family, and every so often that will lead to a crisis, because they kind of revolt...they stand up and want to be counted, but often that’s not going to be well received” [r16]

Past Memory Triggered (10). Cases were recounted where difficult material from the past was triggered by something in the present, and this resulted in emotional pain and rumination over the unresolved memory.

“something happens to them, it might link back to something that’s happened in their distant past, attachment issues, decompensation from a traumatic event...an anniversary coming up of somebody’s death” [r11]

Cultural Factors in Crisis (10). The term culture is used broadly in gathering ideas under this theme. Firstly, there was a sense that current culture elicited crisis: pressurised modern life, changes to family structures and duty, and societal pressures such as housing availability.

“Christmas is a pressure for a lot of people...families are emphasised, a lot of our patients they might be on their own...if they’ve got financial worries there’s a pressure there of people’s expectations and lots more to think about, lots of extra jobs to do” [r10]

Another idea was that culture shapes perceptions of crisis: sources such as the media and free market ideology have produced an expectation of a 'quick fix'; cultural forces in the NHS itself, epitomised by the 'target culture' periodically altered the accepted crisis threshold of teams.

"these days, especially with the rise of those... TV shows like Jeremy Kyle and whatever. I mean there's this huge element of people demanding services because the TV shows say "Oh look, you get help for almost anything these days" " [r19]

The Concealed Crisis (8). Sometimes causal factors of a given crisis were concealed at first, variously conveyed as hidden, ignored, or imperceptible. Whilst the service-user might remain unaware, workers talked of initially concealed triggers becoming apparent during work. In such cases, the service-user may be challenged, or the issue may be left.

"talk about things that are maybe elephants in the room...that can happen in crisis work, you don't actually get to the heart of the problem for quite a while" [r23]

Readiness to Act (8). In some cases, the crisis state elicited a readiness to act. This was more common with anxiety or mood-related cases identified at an early stage.

"once they realise there is a crisis, and reach out to A&E...that is an opportunity that can't be missed, then the person is ready to engage, the person is ready to institute change of their lifestyle" [r12]

However, others recounted experiences where there was a lack of motivation to act and resistance to engage and move on. This split in service-user response mirrors the *Crisis as Opportunity* theme.

Services' Shortfall Crisis (5). Reduced staffing levels due to absences in referring teams or the CR/HT influenced perceptions of what was considered to be a crisis.

“somebody presenting with a crisis of a certain level one week, might get a service sooner, than a person presenting with the same sort of crisis next week with three people off sick and four on holiday” [r26]

Crisis Amplifies Needs (2). Crisis was theorised to amplify underlying needs, which may be less visible when ‘well’. In-depth assessment during crisis was therefore considered to be useful, although identified needs might have to be referred on at discharge.

“Once something begins to breakdown...it has a knock on effect and I think that means that everything is then amplified, and things do become easier to identify” [r4]

Exclusions and exceptions to CR/HT Crisis

In conceptualising the nature of crisis, presentations that fell short of the CR/HT crisis threshold were also revealed (exclusions). Additionally, presentations were described where crisis was present but it was reasoned such cases required alternative support (exceptions). The obvious case of the latter – which is not discussed further below – is where only hospital admission was indicated.

Referrer in Crisis (10). Examples of inappropriate referrals were given, such as the referrer feeling stuck or anxious about a particular service-user, although the service-user themselves was not considered in crisis. There are parallels with the *Services’ Shortfall Crisis* theme. Respondents described having learned to decline cases if the referrer had not met with referred person, until such an assessment had been made.

“it does mean that sometimes we can be a dustbin service...where services which are very stretched and under pressure, and not knowing where to go with someone who’s in distress” [r26].

Crisis Level Too Mild (9). Some cases showed insufficient severity to warrant CR/HT involvement, specifically in relation to the core features

already discussed, low levels of risk (*Risk of Harm*) or adequate but untapped support was available (*Additional Support Needed*). Another service might be more appropriate, because the crisis was mild (e.g. primary care) or need specific (e.g. housing).

“I think [CMHTs] or primary care have robust enough services to help people in emotional distress, it’s about monitoring risk, I see as our role” [r34]

Longstanding ‘Crisis’ (9). If the core feature of *Functional Decline* was not met, the case was not judged to be a crisis. Rather, it was felt ‘chronic’ or constantly ‘chaotic’, although this realisation could occur after a referral was accepted. Respondents stated crisis should be amenable to the short-term treatment period they can offer.

“crisis is short-term, it’s only just happened, but if something’s over a long period of time I wouldn’t deem that as a crisis, no” [r7]

Crisis, but CR/HT Inappropriate (11). In some types of presentation, a significant crisis was evident but CR/HT was not judged to be appropriate. Some types of presentation were declined in line with national policy: crisis related solely to alcohol or drugs, and crisis in persons with acquired brain injury or more severe learning disability. From experience, teams had identified a proportion of service-users in certain diagnostic categories that respond less well to CR/HT intervention. Some service-users find the style of intervention exacerbates their difficulties, i.e. people with borderline personality disorder who find its intensive yet time-limited nature distressing, people with paranoia who find multiple visitors difficult, and people where ability to tolerate anxiety alone and dependency become issues. Others found it hard to engage, i.e. during manic phases.

The Process of Crisis Over Time

This section turns to address the commonalities conveyed in accounts about the crisis phenomenon as it occurs over time. As the themes of *Functional Decline* and *Longstanding 'Crisis'* testify, crisis is conceptualised as short-term. The process of crisis over time is represented in Figure 2, in a notional line graph which shows *time* on the x axis and *intensity* on the y axis. A number of phases in the crisis process have been marked out: the Crisis Developing Phase, the Crisis Resolving Phase, and the Point of Discharge. Patterns in crisis over time were variable, and within this variability two interesting 'pathways' emerged the *Window of Opportunity Pathway* and the *Crisis Peaked Pathway*. The themes relating to the process of crisis over time are described below.

Crisis Developing Phase

Crisis Anticipated (3). Infrequent cases where crisis is somewhat predictable were described, e.g. court cases, post-natal adjustment, anniversaries of significant events. Ideally pre-planning should be done around such events by service-users, their family or professionals, although, CR/HT support should be considered for high vulnerability service-users.

“things like court cases, some people their anxiety goes up, the moment the court case is over and settles you don't need to support or intervene” [r11]

Crisis Development Patterns (30). There was much variability described in crisis development patterns. In some cases it was appropriate to think of a trigger to crisis, in others not; the latter were often psychotic presentations conceptualised as 'relapse'. As identified in other themes (e.g.

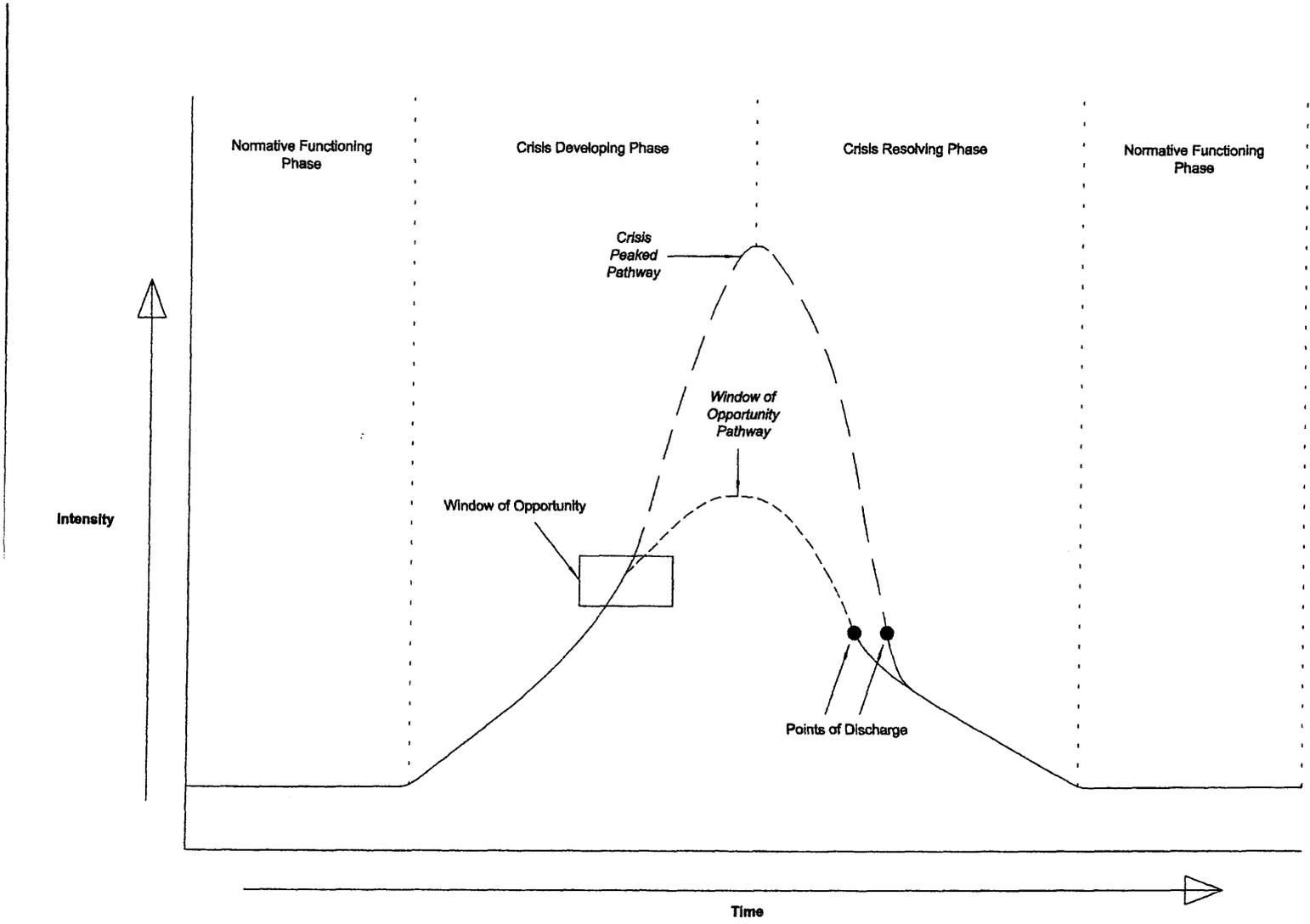


Figure 2. Notional line graph demonstrating the process of crisis over time

Life Stress, Biochemical Crisis) there is a spectrum of biopsychosocial triggers.

“it’s the deterioration of their mental health, or things are not going right in their life” [r14]

Where external stress presented in the lead up to crisis it was described mostly as an accumulation, particularly in those newly presenting to services. However, more vulnerable service-users might succumb under less stress. Variability was reported in the rate of crisis onset: sometimes rapid, sometimes gradual.

“people that have had an accumulation of events...it might not have been just in recent times, it could have been something that’s happened recently might have triggered a childhood incident...it can sometimes be just a one-off incident” [r20]

The Mundane Trigger (3). A ‘straw that breaks the camel’s back’ scenario was described, where a relatively insignificant event elicits crisis, but numerous unresolved, significant events have likely accrued.

“typical straw that breaks the camel’s back, something goes, they could of dropped a bowl at the washing-up sink that morning, and that could have just tumbled everything out, because so much has happened in their lives” [r23]

Crisis Action Phase

The Importance of Timing (14). Timing intervention appropriately was discussed and led to the idea of two pathways: *Window of Opportunity* and *Crisis Peaked*, an earlier phase when the crisis is caught in time versus a later phase when intervention is overdue.

“I think it is crucial the point where there is some sort of intervention, it is much more difficult when it’s been left a lot later” [r17]

“when is it crisis or is this just pre-crisis?, [as if CMHT worker:] “a few early warning signs, there’s a few indicators here – shall I refer today?”...there’s a big debate around that” [r36]

Preventative work was discussed, separately to anticipated crises where the event is predictable. This notion applies to populations where a gradually paced relapse occurs, believed to be unrelated to external triggers.

“sometimes it’s the case if we didn’t work with them at that point we would eventually, because...down the line they would deteriorate, either head towards hospital admission or come our way” [r33]

CR/HT workers are sometimes powerless in timing intervention appropriately and rely on the service-user presenting or colleagues referring early enough. However, cases were openly recounted where the team had delayed accepting a case for too long. Timing decisions can be presentation-specific, e.g. mania requires particularly timely intervention.

Window of Opportunity Pathway (7). If intervention can be delivered in a particular window, there is more readiness and ability on the part of the service-user to engage with intervention, and a more damaging and lengthy crisis experience can be averted. The window of opportunity might not be available in all cases.

“At the beginning, the earlier stage of the crisis I suppose when everything’s happened, they may have a little bit more sense of power and control, and doing things, actively trying to resolve the crisis” [r17]

“Some people do have a window of opportunity not to go in to a full-blown crisis” [r34]

Crisis Peaked Pathway (10). Where the window of opportunity is unavailable (e.g. due to rapid progression into crisis) or is missed, the alternative pathway is that the crisis reaches its full peak. When discussing this critical phase language expressed the sense of an extreme (‘peak’, ‘critical period’, ‘the head’), intensity (‘the heart of the crisis’, ‘full-blown crisis’,

'the crisis part of the crisis') and destructive force ('an explosion', 'disintegrating', 'burst'). Once crisis has peaked respondents expressed negativity about the rate and progress of recovery.

"when its perhaps, its been left a little bit too long, they feel very helpless...their mental health might have deteriorated to a stage where it's very difficult to pick themselves up, and therefore the crisis might last quite a bit longer" [r17]

"they've reached a point where there's no going back" [r39]

The Momentum Phenomenon (11). There was an idea that crisis gathered its own negative momentum: "get on to one of those vicious circles" [r10], "spiralling out of control" [r27], "the whole thing gets whipped up and gathers speed and pace" [r32]. Precipitants of crisis fed back and exacerbated crisis through negative thought and action patterns.

"I think it's harder once they're entrenched in that, somebody who's quite vulnerable anyway, and quite a lot of our service-users have very low self-worth, self-esteem, for them to believe they can never manage again is quite damaging" [r39]

"he'd lost his job, and felt he'd lost his identity and lost his role...he felt to be a man he needs to provide for his family. So he kind of went out and drummed up a massive amount of debt...he was hiding it from his wife so that was another kind of pressure" [r27].

Crisis Resolving Phase

An Instant Effect (10). A sudden, significant reduction in distress was reported from as little as a one assessment session. Workers observed service-users' relief and reassurance that someone was on hand, new realisations were reached and strong emotion released in the meeting, all leading to a shift in the service-user's perception of crisis. This instant effect was most prevalent in those newly presenting to services.

"actually sometimes when you sit down and you unpack a few things, all of a sudden people begin to realise...they have more in the tank

than they thought...just that awareness for them is fifty per cent of the problem done” [r3]

“The initial crisis is abated to a certain extent as soon as the person knows they’re being worked with. There’s someone there to help share this awful thing that’s happening to them” [r21]

Crisis Resolving Patterns (16). As with crisis development patterns, variability was reported. There was an idea that once crisis peaked, matters can only improve.

“it’s a bit like the anxiety curve, how big can your crisis become... you’re at the top you can’t go any other way, you might go back in and out of crisis...it’s quite hard for people to sustain that absolute overwhelming sense of emotion over a long period of time” [r39]

A fluctuating pattern of recovery was discussed, and in line with *An Instant Effect*, pace of recovery might be quick at first, but slows thereafter.

“it can go in peaks and troughs, one week they can be saying “I’m feeling much better”, then the next week it can go back to square one, it can go up and down” [r14]

“most people get eighty to ninety per cent back to their sort of normal self really quite quickly, and it’s that last ten to twenty per cent takes a bit more time” [r37]

There was disagreement amongst respondents about whether the process of resolution involves dealing with the problem (crisis situation) or the emotional reaction (crisis response).

“you look at the cause, and resolve the cause rather than the crisis” [r30]

“we don’t go in to solve the crisis or problem or trigger, we help the person become stronger themselves” [r34]

Point of Discharge

Variability existed also in respondents’ accounts of how the end-point of crisis resolution happens. Table 5 shows the mix of ideas respondents

held about this end-point; the number of accounts in which each outcomes was mentioned is provided. Respondents often held more than one idea about how the end-point of crisis was judged.

Table 5. The range of crisis end-point outcomes achieved by CR/HT, showing the number of accounts mentioning each outcome.

| Outcomes Possibly Achieved in CR/HT | n |
|--|----|
| Back to managing life: everyday coping and mental control | 18 |
| Risk behaviours are being managed | 11 |
| Improvements to distress/symptoms | 11 |
| Reduced input required/more independent/prior support used | 6 |
| Medication compliant (where appropriate) | 6 |
| Back to full life e.g. work, social life etc. | 4 |
| Strategies/skills now in place | 3 |
| Problem resolution achieved (i.e. main stressor(s) dealt with) | 3 |
| Service-user feeling an active participant in their own recovery | 2 |

There was also variability in the basis for judging or measuring change since initial contact. Again respondents often described using multiple reference points for judging resolution status. The reference points described were: service-user self-report, team records of the service-user's presentation over time (which might be qualitative or standardised instruments, e.g. risk assessment, symptom psychometric), comparison with 'pre-morbid' presentation (informed by health records or professionals known to the service-user), whether goals that were set or a care plan that was made during crisis had been achieved, and consulting others in the service-user's support network about perceived improvement.

Table 6 shows the outcomes which are not believed to be achievable in the context of CR/HT intervention.

Table 6. The range of outcomes not achieved by CR/HT, showing the number of accounts mentioning each outcome.

| Outcomes Not Achieved in CR/HT | n |
|---|----|
| Service-user is not completely better | 10 |
| The last part of recovery takes longer so may not be achieved | 3 |
| While acute risks are managed, chronic risks may remain | 3 |
| Underlying vulnerabilities remain untreated | 1 |

It was clear that at point of discharge there is still work to be done by the service-user and/or support network.

“when we discharge, it doesn’t mean someone’s completely well and recovered” [r8]

“even though the crisis might not be fully over, you might need to hand over the problem to another part of the service” [r1]

A sense was expressed that the last phase of recovery takes longest, and it is not the role of CR/HT teams to stay involved for the full recovery.

“If they were saying they were back to sort of 7 or 8 [on a 0-10 mood scale], I’d be going well that’s as much as I can see I’ll really do, I can’t see that I’ll get you that last bit”. [r37]

For some service-users, particularly those with features of borderline personality, risk may appear unchanged. A distinction between acute and chronic risk was described, with CR/HT working with the former.

“people can have long-term, chronic risk and I think for crisis we need to manage short-term, high levels of risk...there’s less incidences of self-harm or those suicidal thoughts going round and round in their head daily” [r38]

One respondent made the point that more underlying issues remain untreated.

“they’re more on an even keel, living long-term with mental health problems and getting support, but when they could actually deal with some of the underlying issues, they might get a lot better” [r10]

Different Clusters of Crisis Pattern

In parallel to talking about crisis as an overarching concept, respondents also talked about difference within the concept: clusters of crisis pattern. The term ‘cluster’ has been chosen to reflect that respondents did not talk about discrete service-user ‘groups’, but prototypical patterns from which actual cases might be more or less similar. Three clusters were identified:

- An enduring mental health presentation with a history of CMHT use. This cluster is titled: *Enduring Needs* (17).
- A first presentation to mental health services. This cluster is titled: *New Presenter* (16).
- A presentation of erratic behaviour/emotional intensity in someone diagnosable with borderline personality disorder (some respondents explicitly used this term or equivalent, others said ‘personality disorder/issues’). This cluster is titled: *Erratic/Emotional Intensity* (17).

Additionally, a ‘*Revolving Door*’ presentation was identified, which was not unequivocally related to any one of the above clusters. To compare the three patterns above, contrasts will be made between clusters based on initial presentation, crisis development pattern and crisis resolution patterns (see tables 7a through to 7c, respectively). Topical points worthy of further comment are made following each table.

Table 7a. Descriptions of initial presentation for the three clusters

| | |
|------------------------------------|---|
| <i>Enduring Needs</i> | Enduring; psychosis or chronic mood disorder; contact with existing services i.e. CMHT; may be hard to engage, if not sharing awareness of crisis situation. “this would be somebody with a diagnosed, enduring, serious mental health problem...normally managed by the CMHT” [r30] |
| <i>New Presenter</i> | Acute anxiety/depression; usually suicidal or self-harming; referral through A&E/primary care; little or no prior contact with secondary mental health services; ‘grateful’ engagement. “people that may not have had a history of mental health problems...maybe due to social reasons, or depression...come in to crisis” [r2] |
| <i>Erratic/Emotional Intensity</i> | Borderline personality-like presentation; ongoing risk with frequent self-harm; ‘crisis’ may be the norm; can be experienced as difficult and manipulative. “they’re the ones that maybe have ongoing risk” [r2] “for people with inadequate personality...they can have crisis day after day” [r15] |

Engagement with the *Erratic/Emotional Intensity* cluster was clearly challenging, with frustration evident in the accounts.

“they’re the ones that sort of up the ante...people have said in A&E, “If you don’t admit me, I’m going to kill myself and it’s your fault” ” [r2]

“Personality disordered clients, who perhaps engineer a crisis out of nowhere” [r30]

Table 7b. Descriptions of crisis development patterns for the three clusters

| | |
|------------------------------------|--|
| <i>Enduring Needs</i> | <p>Others, not self, may declare crisis; may be pattern of 'relapse' (organic) or 'crisis' (external stress); the term 'mental health crisis' is applied to this cluster.</p> <p>"they stop taking their medication, or they've had no input from other services, or they didn't see their CPN" [r14]</p> <p>"it's usually an accumulation of disadvantage" [39]</p> |
| <i>New Presenter</i> | <p>Background of accumulated stressors in excess of normative everyday levels; terms 'social crisis' and 'life crisis' applied to this cluster; may fall below CR/HT threshold.</p> <p>"for most of the first time clients, it's always a culmination of ten or twenty different things" [r19]</p> |
| <i>Erratic/Emotional Intensity</i> | <p>Inadequate coping arising from high vulnerability in background is common; trigger may seem relatively minor, but subtle and often around interactions/relationships.</p> <p>"some people it is a really small event that actually tips their scales to being in crisis or being stable" [r31]</p> |

To return to one of the earlier themes, the idea of *Differential Vulnerability* is clearly contrasted across these three clusters with differences in the threshold at which coping is breached, and underlying vulnerability activated.

Table 7c. Descriptions of crisis resolution patterns for the three clusters

| | |
|------------------------------------|--|
| <i>Enduring Needs</i> | <p>Medication compliance may be route to resolution; service-user may not learn from crisis; benefits from previous understanding of services and recovery process; disadvantaged by internal locus of problem i.e. 'illness'; fits with idea of 'HT' part of CR/HT; idea of 'management' more fitting than 'resolution'.</p> <p>"sometimes...it's more to do with ensuring concordance with meds" [r28] "we may hope they will learn...but actually they probably won't or don't" [r30]</p> |
| <i>New Presenter</i> | <p>Possibly instant relief from early input; usually positive support network to draw upon; keen to learn and prevent future crisis; unlikely to return; may need to overcome stigma and understand service structures; benefits from external locus of problem i.e. 'stressor'.</p> <p>"the clients who are new to the service...often the first visit where you are just doing an assessment makes all the difference" and "they tend to want to explore more and they tend to absorb the information that we give them" [r19]</p> |
| <i>Erratic/Emotional Intensity</i> | <p>Controversy and disagreement about appropriateness of CR/HT input; a boundaried approach seems appropriate with avoidance of emotional material and instead focus on the practical; aim to increase service-user's reflective capacities in relation to risk behaviour; change may be minimal e.g. acute risks managed, chronic risks remain.</p> |

A few topical themes emerged in the crisis resolution patterns across the three clusters. Firstly, respondents questioned whether work with a relapsing individual with an enduring presentation is 'crisis work' as such, or whether it is more purely 'home treatment'. Concern was expressed that this

home treatment role can get neglected because of more salient and pressing crisis cases.

“If somebody’s relapsing...got a psychotic illness or a mood disorder...whether that’s crisis or not, that’s where I get a bit stuck” [r33]

“the crisis overrides the home treatment bit...the home treatment is like a poor relation now” [r24]

An interesting contrast was drawn between the *New Presenter* and *Enduring Needs* cluster in relation to the relative benefits and disadvantage of having had longer term experiences of mental illness and mental health services, and also the locus of the problem for each cluster.

“a mental illness can stay with them afterwards when they recover...they really don’t want to go back there again... on the other hand, it can be used as a strength, because they know they’ve come out of it before” and “someone experiencing anxiety and depression...their primary crisis is around the problem. Someone with a diagnosed mental illness, their crisis is around their illness...you can’t make it go away in the same way” [r21].

There were clear differences of opinion on the appropriateness and most effective ways of providing treatment to those in the *Erratic/Emotional Intensity* cluster, and across respondent accounts the issue is not resolved.

“I get quite militant about people with diagnosed personality disorders being referred to crisis teams. I don’t think it’s helpful for them at all” [r26]

“It has to be very bounded I believe...and that’s not always what the client group want” [r29]

“extra intensive support may escalate some of their intensity of emotion” [r34]

“I think if you’d asked a lot of people three years ago they’d say “No, we don’t work with personality disorders...”...I actually don’t think that’s true, I think we work very successfully” [r39]

‘*Revolving Door*’ (11). It was explicit from the accounts that the *Erratic/Emotional Intensity* cluster was identified with ‘revolving door’ cases; it

is also probable that the *Enduring Needs* cluster also overlaps with this pejorative label. By virtue of their coming back into services, it is implicit that these service-users did not learn from previous crises.

“with the revolving door clients, more often than not, I hate to say this, but more often than not they don’t [acknowledge and recognise early signs of crisis]...We do try. We have to try, that’s part of our role, and we will continue to try... but you do know that some people will just keep coming back, and keep coming back” [r19]

Awareness to the possibility of inducing further ‘revolving door’ dependency was expressed.

“what it sets up, if there’s another problem in the future, the cycle has already been in place once, it repeats itself, and then somebody gets labelled a revolving door [patient] because they keep coming back to services time and time again” [r29]

Interestingly, the ‘revolving door’ cluster that teams worked with were known to be service-users who were previously regular inpatients.

“it’s the same hardcore of people come back...and those are the people, which I guess is positive movement, those are the people that were on the ward...I can think of quite a few people [who were admitted to local ward] almost on a weekly or monthly basis” [r24]

Discussion

This study considered how CR/HT workers define and understand the concept of crisis as they experience it. This was done through qualitative analysis of interviews with thirty-nine CR/HT workers, drawn from four teams and representative across professional disciplines.

Respondents began by noting the difficulty they had as individuals and as teams and within wider services of defining and understanding the concept of mental health crisis. However, across accounts there was consensus on some core conceptual features of the phenomenon. This was accompanied by less dominant ideas from a range of theoretical approaches

in mental health e.g. medical model, systems theory. Variability was described in the crisis phenomenon over time, through the phases of crisis development, action in crisis, crisis resolution, and its conclusion.

Respondents noted three different prototypical clusters of crisis pattern.

Interestingly, a number of ideas in respondents' accounts resonated with Crisis Theory (Bridgett & Polak, 2003a; Caplan 1964), although only one respondent explicitly identified the model. Crisis Theory's four phase model had interesting parallels with the pathways identified in the current study. Phase Three in Crisis Theory (Caplan, 1964) – emergency problem-solving, novel coping, all resources utilised – bore similarities to the *Window of Opportunity* pathway; and Phase Four's state of major disorganisation and defeat bore similarities to the *Crisis Peaked Pathway*. With regards the core conceptual features, Crisis Theory also contains elements of functional decline, differential vulnerability, life events, and significant mental distress.

The extent of functional decline in the CR/HT context (e.g. high-risk self-neglecting behaviours) is clearly more profound than that in Crisis Theory. The same levels of individual differences were discussed by respondents: appraisal processes; coping response; and underlying constitutional vulnerability. The range of life events reported in accounts was recorded, and reveals a list not unlike life events rankings, such as that of Holmes and Rahe (1967; cited in Burns, 2004). The level at which a life event elicits crisis was identified as potentially lower in this study, than those of Crisis Theory, with relatively minor stresses and strains eliciting crisis in more vulnerable service-users. The idea of systemic crisis was apparent in these accounts, as it is in developments of Crisis Theory. Crisis Theory mentions

the idea of opportunity to learn, and implies readiness to engage. The current study found this may apply in some cases, though in others there was a clear lack of readiness to act and/or learning. The ideas of Bridgett and Polak (2003a) of opportunity, and that crisis may be avoided or denied by the service-user, also resonated with the accounts.

Turning to policy (DoH, 2001), the 'alternative to admission' definition of crisis was infrequently cited, and there was some criticism of its unsatisfactory nature. Likewise, with significant mental distress while some operated at a threshold of accepting only those with 'severe' psychiatric diagnoses (taken to mean psychosis), others felt mental distress which had not attracted a diagnosis was equally valid work for CR/HT teams (in line with Bridgett & Polak, 2003a).

The clusters approximated to broad diagnostic categories. The *Enduring Needs* cluster probably meets the aims of policy (DoH, 2001) and more stringent threshold of CR/HT proponents (Smyth, 2003). The *New Presenter* cluster had less profound crisis, although it was not apparent their crises were any less deserving of input or less severe. Therefore, in the current study, crisis 'severity' was unrelated to the notion of 'severity' (i.e. psychosis) invoked elsewhere in the literature.

Researchers in Manchester (Hatfield, Spurrell & Perry, 2000; Perry, Hatfield & Spurrell, 2002) have looked at a cohort of emergency psychiatric presentations prior to CR/HT becoming available. In one study, they identified categories of crisis patterns, which they based on the referral source (CMHT, GP or self-referral), which bear similarities to the clusters identified in this study. These authors note that while within services we

might perceive discrete 'groups' who should access different service routes, those in crisis do not make such distinctions.

The current study identified that some element of stressor was felt applicable in almost all crisis cases respondents recounted. Others have considered social or life factors to have a minimal influence of crisis arising, citing endogenous illness as the source of crisis (Ball et al., 2005; Heath, 2005). Ball et al. (2005) conducted research with an enduring needs population; their findings contrast with the current study, where crisis eliciting life stress factors were even described for the *Enduring Needs* cluster. The differences between this and their study, is that here mental health professionals from a CR/HT have been consulted and in their study the qualitative research was with service-users in an assertive community treatment project. Therefore, the difference could be down to population perspective and/or the service context.

A useful insight was gained about terminology use. This author has used the term 'mental health crisis' generically; however, for some respondents this referred only to crisis in the context of an enduring mental health problem, and was contrasted with 'life crisis' or 'social crisis' which were used to reference crises probably elicited by social stressors.

There were a number of findings from this study that are not apparent in the existing literature. Different levels of 'crisis as opportunity' emerged: the opportunity for quite major life change, a learning opportunity for the future (akin to relapse prevention ideas), through to gaining an understanding of what elicited the crisis. It also emerged that service-users vary in the motivation to take up such opportunities. This pattern was associated with

'revolving door' cases, and indicates a potential area for further research to gain an understanding about how to increase resilience and independence for these service-users.

The idea that past memories elicit crisis does not emerge significantly in the literature, and seems most in line with psychoanalytic renderings of crisis occurrence. The current study also revealed some 'real world' aspects of crisis work, such as national, organisational and local 'cultures' that have reciprocal influence on what is deemed a crisis. The perception that CR/HT might parallel A&E in the mind of 'consumers' might not be an altogether helpful one, if this invokes beliefs in service-users that treatment will be one in which they passively 'get fixed'.

A somewhat confused picture emerged with regards to how respondents conceptualise the end-point of intervention. This may be due to there being individuality in such judgements. Alternatively, this could be an area for development in services, ideally with some consensus reached on the outcomes that should be achieved in service-users' time with the teams. Like all such services, CR/HT has to prove its effectiveness (Kennedy & Smyth, 2003), and the outcome of 'reductions to admissions' may no longer be a satisfactory measure of success, with outcomes of crisis resolution being the next progression.

Some issues emerged amongst the finding of different clusters of crisis pattern. There was an idea that of the three, the *Enduring Needs* cluster, fitted best with an idea of home treatment. Perhaps because of the nature of this cluster – more routine tasks with less proactive service-users – there was a danger they became neglected alongside the more demanding

crisis case-work. One of the supposed benefits of a CR/HT function separate from CMHT is that it avoids less dominant cases being side-lined (Johnson, 2004). The term CR/HT has been used throughout here, but the teams do adopt various names: Crisis Response Team, Intensive Home Treatment Team, etc. The finding of a more home treatment-oriented cluster of service-users does beg the question of whether home treatment and crisis resolution can be thought of as two separable functions (discussed in: Brimblecombe, 2001a; Bridgett & Polak, 2003b).

The appropriateness of CR/HT to service-users with diagnosed personality disorder, namely borderline, was raised in the current study. To be clear, respondent opinion was that input has been successful in some cases of borderline-like presentations. Therefore, referring to a diagnostic label alone may be misleading (if not marginalising). However, there was clearly a struggle with some cases and suggests further investigation would be valuable.

The execution of the current study had a number of strengths and limitations. Good practice guidelines (Mays & Pope, 2000; Willig, 2001) were followed. Framework Analysis and Atlas.ti enabled thorough, efficient and traceable fitting of the thematic framework to the original accounts. Areas of disagreement within themes were retained and reflected in the final analysis. A sample of cases was audited by secondary researchers. It had been intended to undertake respondent validation, but due to time constraints this was not possible.

It is suggested that generalisability of the current findings is appropriate. CR/HT teams are multidisciplinary and have had to evolve

quickly to meet policy demands for service availability. The current study's heterogeneous sample reflects this backdrop well: respondents drawn from four different teams with good proportional representations across six disciplines. However, there are limitations to this generalisability: none of the teams worked in exclusively urban settings; all came under one NHS Trust; and all performed a psychiatric liaison function. The latter is likely to affect the respondents' conceptualisations of crisis, crisis resolution, and the clusters of crisis pattern described. This overlap between psychiatric liaison and CR/HT is a quandry in this research area. While acknowledging the distinction is made by professionals and in some service configurations, this researcher questions the utility and sense in concluding such distinctions be separately reified for practice and research purposes.

The findings are potentially limited by their nature of being self-reports from one selected group of stakeholders (i.e. CR/HT workers). The non-judgemental and confidential interview style aimed to limit social desirability influencing self-report. Most respondents grounded their ideas in both a general perspective across the team's work and specifically cited cases. Further research with other stakeholders (i.e., service-users, family/carers, other health care profession groups) or by other methods would be beneficial in continuing to gain an understanding of the concept of mental health crisis and crisis resolution.

To summarise the implications from the current study, working models have been generated of the nature of crisis in the CR/HT context, how it happens over time, pathways through crisis, and differential clusters of crisis pattern. These are offered to practitioners as useful working heuristics, and to

researchers for further development or refutation. Further research is indicated in the following areas: improving effective treatment for 'revolving door' presentations; outcome measures of crisis resolution work; the separability of home treatment from crisis resolution as it exists in everyday practice; and more/less effective ways of working with people with erratic behaviour and emotional intensity in this setting.

References

- Ball, J.S., Links, P.S., Strike, C. & Boydell, K.M. (2005). "It's overwhelming...everything seems to be too much": a theory of crisis for individuals with severe and persistent mental illness. *Psychiatric Rehabilitation Journal*, 29, 1, 10-17.
- Bonyngne, E.R., Lee, R.G. & Thurber, S. (2005). A profile of mental health crisis response in a rural setting. *Community Mental Health Journal*, 41, 675-685.
- Boomsma, J., Dassen, T.W.N., Dingemans, C.A.J. & van den Heuvel, W. (1999). Nursing interventions in crisis-oriented and long-term psychiatric home care. *Scandinavian Journal of Caring Sciences*, 13, 41-48.
- Boomsma, J., Dingemans, C.A.J. & Dassen, T.W.N. (1997). The nursing process in crisis-oriented psychiatric home care. *Journal of Psychiatric and Mental Health Nursing*, 4, 295-301.
- Bridgett, C. & Polak, P. (2003a). Social systems intervention and crisis resolution. Part 1: Assessment. *Advances in Psychiatric Treatment*, 9, 424-431.

- Bridgett, C. & Polak, P. (2003b). Social systems intervention and crisis resolution. Part 2: Intervention. *Advances in Psychiatric Treatment*, 9, 432-438.
- Brimblecombe, N. (2001a). Community care and the development of intensive home treatment services. In N. Brimblecombe (Ed.), *Acute Mental Health Care in the Community: Intensive Home Treatment* (pp. 5-28). London: Whurr Publishers.
- Brimblecombe, N. (2001b). Developing intensive home treatment services: problems and issues. In N. Brimblecombe (Ed.), *Acute Mental Health Care in the Community: Intensive Home Treatment* (pp. 187-207). London: Whurr Publishers.
- Burns, T. (2004). *Community Mental Health Teams: A Guide to Current Practices*. Oxford: OUP.
- Callahan, J. (1998). Crisis theory and crisis interventions in emergencies. In P.M. Kleespies (Ed.), *Emergencies in Mental Health Practice: Evaluation and Management* (pp. 22-40). New York: The Guilford Press.
- Caplan, G. (1964). *Principles of preventive psychiatry*. London: Tavistock Publications.

Caplan, G. (1969). *An approach to community mental health* (1st ed.).

London: Tavistock Publications.

Christian, C. & Jurist, E.L. (2001). The relevance of psychoanalytic ideas to crisis work. *Journal of Social Distress and the Homeless*, 10, 293-304.

Department of Health. (2000). *The NHS Plan*. London: The Stationery Office.

Department of Health. (2001). *The Mental Health Policy Implementation Guide*. London: Department of Health.

Department of Health. (2006). *Guidance Statement on Fidelity and Best Practice for Crisis Resolution Teams*. London: Department of Health.

Fraser, J.S. (1998). A process view of crisis and crisis intervention: critique and reformulation. *Crisis Intervention*, 4, 125-143.

Harrison, J., Alam, N. & Marshall, J. (2001). Home or away: which patients are suitable for a psychiatric home treatment service? *Psychiatric Bulletin*, 25, 310-313.

Harrison, J. & Traill, B. (2004). What do consultants think about the development of specialist mental health teams? *Psychiatric Bulletin*, 28, 83-86.

Hatfield, B., Spurrell, M. & Perry, A. (2000). Emergency referrals to an acute psychiatric service: demographic, social and clinical characteristics and comparisons with those receiving continuing services. *Journal of Mental Health, 9*, 305-317.

Heath, D.S. (2005). *Home Treatment for Acute Mental Disorders*. New York: Routledge.

Hobbs, M. (1984). Crisis intervention in theory and practice: a selective review. *British Journal of Medical Psychology, 57*, 23-34.

Holmes, T.H. & Rahe, R.H. (1967). The Social Readjustment Scale. *Journal Of Psychosomatic Research, 11*, 213-218.

Johnson, S. (2004). Crisis resolution and intensive home treatment teams. *Psychiatry, 3*, 22-25.

Johnson, S., Nolan, F., Houtt, J., White, I.R., Bebbington, P., Sandor, A., McKenzie, N., Patel, S.N. & Pilling, S. (2005a). Outcomes of crises before and after introduction of a crisis resolution team. *British Journal of Psychiatry, 187*, 68-75.

Johnson, S., Nolan, F., Pilling, S., Sandor, A., Hault, J., McKenzie, N., White, I.R., Thompson, M. & Bebbington, P. (2005b). Randomised controlled trial of acute mental health care by a crisis resolution team: the North Islington crisis study. *British Medical Journal*, 331, 599-602.

Kennedy, P. & Smyth, M.G. (2003). Out of bounds. *Health Service Journal*, 113, 32-33.

Lazaro, F., Kulinskaya, E. & Tobiansky, R. (2001). Crisis intervention: the professionals' perspective. *Psychiatric Bulletin*, 25, 95-98.

Mays, N. & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal*, 320, 50-52.

Meehan, T. & Boateng, A. (1997). Crisis intervention workers in New South Wales: Knowledge, skills, qualities and preparation. *Australian and New Zealand Journal of Mental Health Nursing*, 6, 122-128.

Office of the Deputy Prime Minister. (2004). *The English Indices of Deprivation 2004: Summary*. London: ODPM.

Orme, S. (2001). Intensive home treatment services: the current position in the UK. In N. Brimblecombe (Ed.), *Acute Mental Health Care in the Community: Intensive Home Treatment* (pp. 29-53). London: Whurr Publishers.

- Perry, A., Hatfield, B. & Spurrell, M. (2002). Specialist service use following psychiatric emergency presentation: an 18-month follow-up study. *Health and Social Care in the Community*, 10, 457-463.
- Pope, C., Ziebland, S. & Mays, N. (2000). Qualitative research in health care: Analysing qualitative data. *British Medical Journal*, 320, 114-116.
- Ritchie, J. & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman and R.G. Burgess (Eds.), *Analyzing Qualitative Data* (pp. 173-194). London: Routledge.
- Slaikew, K.A. (1990). *Crisis Intervention: A Handbook for Practice and Research*. Needham Heights: Allyn & Bacon.
- Smyth, M.G. (2003). Crisis resolution/home treatment and inpatient care. *Psychiatric Bulletin*, 27, 44-47.
- Smyth, M.G. & Houlst, J. (2000). The home treatment enigma. *British Medical Journal*, 320, 305-308.
- Willig, C. (2001). *Introducing qualitative research and methods: adventures in theory and method*. Buckingham: Open University Press.

Part 3: Critical Appraisal

This paper appraises the foregoing research project on mental health crisis. It takes a chronological structure, considering the following stages of the project: (1) the ground work stage of choosing a topic and setting up the research (2) the experience of interviewing from the stance of a researcher (3) the practicalities and epistemological issues of applying Framework Analysis (4) and, reflections on the research findings and implications. The dilemmas and issues occurring at each stage will be explored.

Ground work: setting up the project

This project aimed to gain an understanding of the concept of crisis as it is understood in UK mental health services, particularly Crisis Resolution/Home Treatment (CR/HT) teams. The idea arose from my experiences of working in a day service setting which was merged to become part of a CR/HT team. This local change reflected the nationwide Government initiative for provision of CR/HT in 2004/05 (DoH, 2000).

Much of the literature in this area comes from a psychiatric, rather than psychological perspective. Furthermore, most CR/HT teams have few or no clinical psychologists, being predominantly comprised of nurses, with some social workers and STR (Support, Time and Recovery) workers.

However, within the literature there is a clear invitation made for generic mental health research to be done from a broad multidisciplinary perspective (Burns, 2002; Thornicroft, Bindman, Goldberg, Gournay & Huxley, 2002). These authors have cited the recent revolution in mental health policy (including the advent of nationwide CR/HT coverage) and have suggested that concepts within the policy warrant further investigation.

Furthermore, it was commented (from a psychiatry perspective) that there was a lack of 'social science' contribution.

One practical issue was gaining access to research participants. At the point of applying for Research Governance approval I had not identified the teams where I would be conducting interviews. I was directed by the Trust's Clinical Governance Department to do this before the approval process could progress, and with hindsight this should have been done earlier. I have come to realise that the research settings can be influential to the research process (e.g. team size, disciplinary configuration) and even findings (e.g. culture and shared attitudes that exist in different teams).

The process of gaining access began by using existing contacts to open the door to further contacts, and ultimately to three team managers covering four teams. I sought face-to-face meetings with the managers rather than communication through email or telephone. I felt this achieved the appropriate authority and was the best context for being open about my requirements (i.e., my attendance at a team meeting, interviewing in staff work time, booking an interview room). I felt my transparency and flexibility were important characteristics in gaining the team managers' agreement, and I was pleased by their enthusiasm about the research agenda.

Once full ethical and research governance approvals were obtained, meetings were held sequentially in each of the teams. At the first of these, attendance was low, and I realised this could be improved by forewarning potential participants of my attendance, which I did through posters and sending invitation letters in advance. The tone in these communications was to be friendly (with a photo of me) and encourage enquiries without

commitment to participate. Greater attendance was achieved at later meetings, and overall, recruitment was more successful than I could have hoped.

In the preparatory phase, two concerns emerged reflecting a common issue in this type of research, i.e. that the research enquiry can feel threatening to prospective participants (Barker, Pistrang & Elliott, 2002). One person raised a concern that despite quotations being anonymised, they might still be identifiable to colleagues in the team (i.e., if included in a later presentation). The practice of using anonymous quotations had been given ethical approval and is common in qualitative studies. However to address this concern, it is planned that at the point of conducting respondent validation (see below) respondents will be reminded that the quotations that have been selected in the analysis from their transcript may be used in presentations and publications. This offers the opportunity for their feedback, should they feel concerned.

The second issue was a sense that people felt their practice was under scrutiny. In one meeting, one team member appeared nervous about my presence and its purpose. Aware that I was going to pass round a list to sign up for interview slots, I prefaced this by strongly emphasising the voluntary nature of participation, which was fortunate as he was the only person not to sign up (he actually unexpectedly came and asked to participate some weeks later when I was interviewing at the team base).

It was also clear in many interviews that respondents were nervous about being interviewed and concerned their practice was going to be judged (despite reassurances to the contrary in literature and team presentations).

There were both explicit and implicit requests from respondents for confirmation about orthodoxy of practices and ideas. It was not appropriate to deal with these during the interview (see below). However, at debrief post-interview, the ideas a respondent shared with others were noted and individuality was (again) validated.

Research Interviews

Conducting the research interviews was a pleasant experience, and felt mutually so. The teams operate around-the-clock seven days a week, so I conducted most interviews as a 'weekend' researcher at the team bases.

Many respondents spontaneously reflected that the interview had been a positive experience. In presenting the project to potential participants, I directly addressed the potential misinterpretation of the term 'interview', and explained it would be more like a guided conversation about experiences, and neither interrogative like a job interview nor completely open with a tape rolling and an expectation that the respondent just speak. I had to vary my interview style: with more chatty respondents there were long periods of uninterrupted monologue; with less forthcoming respondents a conversation took place drawing out ideas in a validating manner. Many commented on the value of having the opportunity to reflect on an aspect of work and be gently challenged about their ideas and practice.

The boundary between researcher and practitioner was more blurred than I had expected. Establishing a rapport – showing warmth, showing interest through making reflections – is an essential part of settling and relaxing the respondent. However, this mimics the context of supervision or

even therapy. On occasions there was some challenge in persisting with the primary goal, that of research and steering the interview to collect valid and rich data to answer a research question (Willig, 2001).

The debrief at the end of the interview was a welcome opportunity to reflect on any points that felt unresolved during the actual interview, and deal with respondents seeking reassurance about their ideas and practice. However, in some interviews an empathic rather than researcher stance felt appropriate. Two respondents talked about friends who had endured mental health crisis, and they felt their own CR/HT team had let their friends down. One respondent completely unexpectedly disclosed her own experience of being diagnosed with and treated for psychosis. At these times, it felt right to wait until the person had finished expressing what they wanted to say, and it seemed like they were ready to move on, but to check this was the case, and then ask the next question.

As Willig (2001) has commented, interviewers need an awareness that the same term does not mean the same thing to all people. Whilst mindful of this in clinical practice, I was surprised by the variability with which respondents used the mental health lexicon, with terms such as 'severe and enduring', 'normalise', 'functioning' and even as basic as 'mental health problem' carrying varied meanings across respondents. It would have impeded the interview too much to query every term used, so a process of tracking the interviewee's use of terms, and returning to those that impacted on the later interpretative stage seemed natural to adopt.

Flexibility was an important quality; some interviews were more time limited or had to finish promptly, and some questions were not applicable to

all respondents. Ideally, I would have conducted analysis more concurrently with interviewing. This did occur before the last batch of interviewing, and informed a shift of emphasis in the interview schedule. However for future projects, I hopefully have a sense of when a saturation point has been reached. Saturation is when little new information is emerging that enriches themes or the overall analysis (Barker et al., 2002). In terms of efficiency, a researcher can optimise effort by adhering to the principle of saturation and therefore limit unnecessary data collection.

I recognise professional benefits for clinical practice obtained from the process of conducting these interviews. Presenting a neutral standpoint and showing curiosity about a concept has really developed the skill of deconstruction. Having the time to explore and elaborate a single concept with an individual has improved my confidence in patiently doing this with clinical problems. It was important not to contaminate the interview with my own terms and ideas, and therapeutically there have been benefits in mirroring language very closely.

Qualitative Data Analysis

On reflection, Framework Analysis (Ritchie & Spencer, 1994) worked well with this research enquiry. It offers the analyst a clear and methodical procedure to follow, particularly in the earlier stages. Such clarity makes it easy to convey to the reader what has been done, and easier for auditors to follow the process of analysis retrospectively (Pope, Ziebland & Mays, 2000).

Framework Analysis strongly encourages a comprehensive and accountable analysis that remains true to original accounts. In this application

of the method, this was possible and themes remained dynamic to the data, and negative cases or idiosyncrasies could be retained in the overall analysis and come through in the developed themes. Such integrity assists in meeting quality standards for qualitative research (Mays & Pope, 2000; Willig, 2001)

It was a suitable method for exploring a concept. In common with other thematic methods, a coding frame (here referred to as a thematic framework) is created. The stages of 'charting' (checking consistency and looking for patterns across respondent accounts) and 'mapping' (cohesive interpretation of overall themes) are more unique to Framework Analysis. The stage of 'mapping' was particularly helpful, as it encourages visual representation of the themes for the reader. A working model of the nature of crisis (concentric circles figure) and the process of crisis over time (notional line graph) added greatly to the interpretative account of the qualitative material.

Many of the features of Framework Analysis are perhaps not unique, and share similarities with other thematic analysis methods. Pistrang and Barker (in press) have noted the compulsion qualitative researchers can feel to identify with a given 'brand name' method, despite there being much overlap. The current application was more inductive, which was somewhat of a deviation from Framework Analysis's more deductive approach which is usually shaped by relevant policy.

Simple counts of the number of accounts in which a theme emerged were reported in the current study. This is not part of the orthodox application of Framework Analysis (Ritchie & Spencer, 1994), but this practice is considered permissible in qualitative methods generally (Pope et al., 2000).

The use of counts provided the researcher with a better feel for the strength of opinion behind different themes, which was particularly important in considering 'core' and more 'supplemental' conceptual features of crisis.

The analysis stage of 'charting' was followed within theme, i.e. checking all theme quotations for consistency. Charting can also occur 'by case', i.e. across respondent accounts. The latter was expected to be an important part of the process early on in the project, and data on the pattern of theme contributions by discipline and by team was 'eyeballed' to check for significant patterns. However, this confirmed the experience from interviewing and the 'indexing' stage of analysis and no significant patterns were observed. It would have also been difficult to draw conclusions from a charting process given the skewed nature of team size and disciplinary representation (the variables relevant to charting in this project).

The software package used to conduct data analysis, Atlas.ti, proved enormously helpful for manipulating and retrieving data from a large data set. It made for a time efficient and less cumbersome analysis (Pistrang & Barker, in press; Pope et al., 2000); of course this did not replace the need for the analyst to be creative and thoughtful (Willig, 2001), but neither did it get in the way of analytic activity. The software helpfully shows on outputs where passages were double-coded, and will be helpful when it comes to respondent validation (see below) because outputs are produced by transcript showing all quotations.

One drawback of having such a large data set was that a large proportion of the material – e.g. on staff's views of the service-user experience, the process of crisis work, crisis intervention tasks and

philosophies, and CR/HT function as contrasted with CMHT and ward functions – could not be reported for reasons of space. It is however planned this will be written up and submitted for journal publication.

Epistemological Issues

Pistrang and Barker (in press) have described Framework Analysis as a method based on technique rather than epistemology. In undertaking the project, I had to settle on my own epistemological perspective. Willig (2001) provides a classification of epistemologies in qualitative research methods and offers a continuum ranging between naïve realist (where a perspective on reality can be taken) through to radical relativist (where reality is considered context dependent and construed through the use, rather than content, of language).

Forshaw (2007), taking a relativist post-modernist perspective, argues that pursuit of methodology is unimportant, and qualitative researchers are epistemologically contradictory in aiming to emulate a scientific approach and identify a true and rigorous method of analysis. He suggests there are no methodological differences between literary criticism and qualitative methods. Willig (2007) has responded in defence of methodology, claiming a systematic, cyclical, critically reflective process, that is open to challenge is necessary for consumers of research to judge its quality.

In the current study a realist position was adopted, in line with Mays and Pope's (2000) 'subtle realism'. As these authors point out, relativist research enquiries do not yield unequivocal insights that can inform action,

and the purpose was to conduct an exploratory research study which has utility beyond the exercise itself.

Such philosophical ponderings have enabled greater personal and professional reflection about my position with regards a knowable reality. My conclusions are that there is not an ultimate objectively knowable reality, and in clinical work I have found approaches that claim such a philosophy difficult to apply. However, I do believe that in research and clinical practice a reality can be shared and studied through observation and discussion. I have not found the context dependency of such a reality as ephemeral as some social constructionist perspectives claim. In conducting the interviews and data analysis this position had veridical value: there were commonalities and patterns in the accounts collected; and the beauty of taking a realist qualitative approach (rather than deductive, quantitative) was that less dominant stories, and areas of disagreement, could also shine through in the final analysis.

Quality Standards in Qualitative Research

Standards for quality in qualitative research were observed in the current study (Mays & Pope, 2000; Willig, 2001), although not at the risk of: “a situation where the tail (the checklist) is wagging the dog (qualitative research)” (p.1115, Barbour, 2001). A number of quality checks were carried out.

Transferability. As has been stated, the aim was that the research could have input in to developing and improving the understanding of mental health crisis. Therefore, transferability of findings is an important issue.

Different opinions exist about the appropriateness of transferability of qualitative research findings. Willig (2001) considers it acceptable and encourages an accumulation of studies and triangulation of methods and populations as means to test out transferability. Triangulation of methods (focus groups, quantitative methods) and sources (other populations) would have added to the transferability of findings, but were beyond the scope of an already large project, and are probably better considered as stand-alone projects. Triangulation of sources also introduces other dilemmas: if with service-users or carers, then there would be ethical concern about research activity during crisis; and issues of recall and motivation to participate, if research was conducted after crisis had passed. Efforts to increase the potential transferability of findings through sampling across four teams, and collecting and reporting data on the study's participants and socio-geographical setting were made.

Data Fit. There is a requirement that the analysis fits with the original accounts, that negative cases are included, and that the overall analysis produces a coherent and comprehensive picture of the full data set. This was aided by thorough familiarisation with the data gained through interviewing and transcribing, the Framework Analysis procedures which provided clarity, the use of software to manipulate a large data set, and also the valuing of multiple perspectives.

Respondent Validation. Disappointingly, the planned respondent validation (Barbour, 2001; Mays & Pope, 2000) could not take place for write-up due to time constraints. However, I plan to conduct respondent validation on an individual basis through written communication. Each respondent will

be written to, with an explanation of the thematic framework and a copy of the selected quotations from the transcript of their interview. Feedback to the researcher will be encouraged, but will be optional. The respondent validation will cover the intervention themes (not included in Part 2) as well as the crisis concept themes. Respondent validation offers the further opportunity (in addition to audit) for the analysis to be challenged. Respondent feedback will not however be incorporated unthinkingly (Barbour, 2001; Mays & Pope, 2000), but rather influence the analysis where interpreted meaning is not true to the respondent's intended meaning.

Audit. Although an audit was undertaken, this was limited in scope by the time available to research supervisors. 'Audit' has the ring of an authoritative stamp on a piece of research, although it was interesting that the two auditors took somewhat different approaches revealing that audit can happen at different levels. One supervisor audited the process of analysis (checking that quotes contributing to themes could be traced back to transcripts); the other supervisor audited the content of analysis (with greater interest in the content of quotations and themes, and their coherence). Again, prior to journal publication an audit with greater scope covering all themes is planned with one supervisor.

Reflexivity. Adopting a mainly systemic approach clinically, I was familiar with the notion of retaining a reflexive position that was necessary to take as researcher and analyst. Themes in the analysis evoked the desire to take up a particular position, with regard to philosophies, politics and experience. Some respondent accounts resonated more with me – those interested in systemic, cultural and political issues around mental health and

service provision; more descriptive understandings and perfunctory practices, resonated less so. However, I felt able to value, understand and incorporate all accounts equally in the research process.

Research Findings and Implications

This project has generated some tentative theories about the nature of the crisis concept, pathways through crisis, and different clusters of crisis pattern. These findings have potential utility and transferability to those practising in the field, and a psychological rendering of the topic area has potential benefits theoretically above and beyond the existing psychiatric rendering.

There were some surprises in the findings, chiefly the resonance between Crisis Theory and 'theories of crisis' as they arose from respondent accounts. Respondents were asked to talk about theoretical influences on their work in the later, crisis intervention part of the interview. Only one respondent identified Crisis Theory, and even he noted how it seems to have been overlooked in the CR/HT expansion 'movement'. I have no reason to believe that respondents knew but did not explicitly identify Crisis Theory as an influence. Indeed, it was a subject I discovered through literature searches and was unknown to me previously. My tentative explanation for this surprise finding is that Crisis Theory has distilled a commonsensical understanding of the phenomenon that bears similarities to the understandings crisis workers have developed through their experiences in the teams.

Like most research enquiries this project has generated numerous questions as well as begun to answer some. The areas indicated for further

research from the current study were: getting a better understanding of why 'revolving door' service-use occurs, and how such service-users can be helped to become more independent and avoid crisis in the future; gaining an insight in to more/less effective ways of working with people with borderline-like presentations; and, considering the potential utility and advantage of more standardised crisis resolution outcome measures for future use.

I felt the finding around 'revolving door' service-users and crisis work with people with erratic behaviour and emotionally intense personalities were interesting. There were some interesting underlying philosophies of crisis work, not included in the analysis reported in Part 2, around the dependency that inpatient care has created, and an ethos that crisis work is about engendering agency and empowering people with independent abilities. It was heartening to hear that CR/HT teams are playing a role in reducing the unhelpful dependency, and sometimes working effectively with service-users with personality disorder that are claimed to be so difficult to work with. Ideally, future research can address the need for continued work in this area to improve the lives and experience of mental health services for individuals with complex presentations.

References

- Barbour, R.S. (2001). Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *British Medical Journal*, 322, 1115-1117.
- Barker, C., Pistrang, N. & Elliott, R. (2002). *Research methods in clinical Psychology* (2nd ed.). Chichester: John Wiley & Sons Ltd.
- Burns, T. (2002). Commentary: the top three plus one. *Psychiatric Bulletin*, 26, 408-409.
- Department of Health. (2000). *The NHS Plan*. London: The Stationery Office.
- Forshaw, M.J. (2007). Free qualitative research from the shackles of method. *The Psychologist*, 20, 478-479.
- Mays, N. & Pope, C. (2000). Qualitative research in health care: assessing quality in qualitative research. *British Medical Journal*, 320, 50-52.
- Pistrang, N. & Barker, C. (in press). Scientific, practical and personal decisions in selecting qualitative methods. In M. Barkham & G.E.Hardy (Eds.), *A core approach to delivering practice-based evidence*. Chichester: Wiley.

Pope, C., Ziebland, S. & Mays, N. (2000). Qualitative research in health care: analysing qualitative data. *British Medical Journal*, 320, 114-16.

Ritchie, J. & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman and R.G. Burgess (Eds), *Analyzing Qualitative Data* (pp. 173-194). London: Routledge.

Thornicroft, G., Bindman, J., Goldberg, D., Gournay, K. & Huxley, P. (2002). Creating the infrastructure for mental health research. *Psychiatric Bulletin*, 26, 403-46.

Willig, C. (2001). *Introducing qualitative research and methods: adventures in theory and method*. Buckingham: Open University Press.

Willig, C. (2007) Letters: Qualitative research – the need for system. *The Psychologist*, 20, 597.

Appendices

Appendix 1



November 2007

Dear CR/HT Team Member,

Would you be interested in sharing your perspective in a research study on working with people in crisis?

We are conducting a study in your team and are writing to ask if you would be interested in taking part. We want to find out about the perspective of workers in crisis teams. The study will use interview to explore crisis workers' understandings of the concept of 'crisis' and the interventions they practise with those in crisis.

As you are probably aware, CR/HT teams are a relatively new addition to adult mental health services in the United Kingdom. The UK Government has stated the establishment of CR/HT teams as one of its top priorities. We feel crisis is an emerging area and would benefit from exploratory research enquiry. It is hoped that by being part of the study you will experience positive benefits of being able to reflect on your work in the field of crisis, and gain some deeper insight into the concept of crisis and crisis intervention. It is intended that this research will be published in a journal. Therefore, your contribution could add to the literature in the field of crisis work.

The enclosed Participant Information Sheet tells you all that you should need to know about the study, but please ask one of us if anything is unclear. We would like to assure you that your participation in this study would be separate from your work in the team and will be completely confidential; the interview would be conducted by Simon Tobitt, a Trainee Clinical Psychologist from University College London. This research has been reviewed independently by the local Research Ethics Committee and has received favourable opinion.

If you are interested in taking part you can either: speak to Simon or Sunjeev directly; email or telephone Simon, or reply using the tear-off slip at the bottom of this letter. Simon will then arrange a time for the interview that is convenient for you. You will have the time between then and the interview to consider the information in the Participant Information Sheet.

Yours faithfully

Simon Tobitt
Trainee Clinical Psychologist
University College London

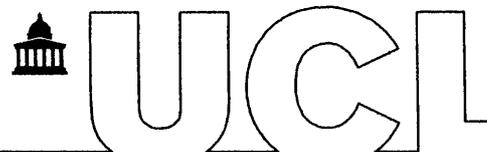
Dr Sunjeev Kamboj
Clinical Psychologist
Sussex Partnership NHS Trust and University College London

If you are interested in participating in this study you can: speak to one of us directly, or email () or telephone () Simon; or complete this reply slip and return it to Simon Tobitt at the address below.

I would be interested in hearing more about the research study

Name: (PRINT NAME clearly)

Please contact me in the following way:



Version: 2
Date: 06.07.07
REC reference number: 07/Q1907/39

The concept of mental health crisis

Participant Information Sheet

You are being invited to take part in a research study which is being undertaken as part of an educational qualification (Doctorate in Clinical Psychology). This study is asking workers in crisis teams how they understand the concept of crisis and interventions they use to help those in crisis. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve.

Part 1 of this information sheet tells you the purpose of this study and what you will have to do if you take part. **Part 2** gives you more detailed information about the conduct of the study.

Please take time to read the information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1 of the information sheet

What is the purpose of the study?

Crisis Resolution/Home Treatment (CR/HT) teams are a relatively new addition to adult mental health services in the United Kingdom. The UK Government has stated the establishment of CR/HT teams as one of its top priorities. An understanding of the concept of crisis is currently implied in Government policy and research/clinical literature. This study aims to explore how workers in CR/HT teams understand the concept of crisis, and what interventions they practise to help those in crisis. This exploration will be done through interviewing workers in at least two different CR/HT teams.

Why have I been invited to take part?

All frontline staff who have been working in your CR/HT team for at least 3 months are being invited to participate in this study. It is intended that between 15 and 20 people will be interviewed in each team; we hope, representing a good mix of disciplines within the team.

Do I have to take part?

It is up to you to decide. If you do decide to take part you will be asked to sign a consent form and you will be given this information sheet and the signed consent form to keep. If you decide to take part you are free to withdraw at any time during the study without giving any reason.

What will I have to do?

If you agree to take part, you will be interviewed for about one hour on your experiences of working in a crisis team. The interview will cover: how you understand the concept of crisis; the interventions you use (things you do to help) those in crisis; and, how you think these interventions differ from those of other services. It is necessary to audio-record all interviews. The researcher will be interested in hearing about *your* experiences and perspective; it should be stressed that the research is not looking to compare what you say to any standard definition of crisis or of crisis intervention. Your perspective will be valued and respected. This is an exploratory piece of research in an area where definitions require elaboration.

The audio-recorded interviews will be transcribed (typed up as a script). All the interviews will be analysed collectively for themes relating to the research topic: the concept of crisis and crisis interventions. All those people who take part will be provided with a summary of the themes that appeared in their interview. Each interviewee will then provide feedback to the researcher about how well they think the themes describe what they said in the interview. This stage of providing feedback is *optional*, and could happen in writing or verbally.

Expenses

There will be no expenses involved in taking part in this study. Interviews will be conducted at a time and place that is convenient to you, and with the approval of your manager. This could happen during the working day or at any other convenient time.

What are the possible disadvantages or risks of taking part?

It is very unlikely that there will be any adverse effects of taking part in this study. Taking part in the interview has the potential to be inconvenient. All interviews will be arranged to be as convenient as possible. If you were required to attend to an emergency (for example, as part of the team's work) the interview would stop immediately and a time to recommence the interview made at some later time.

What are the possible benefits of taking part?

Participants may appreciate the opportunity to reflect on their work during the interview. They may also be interested to see how what they have said is analysed and organised in to themes which aim to bring meaning to the topic of crisis. They can be further involved in the research process by providing feedback on the thematic analysis of their interview.

What happens when the research study stops?

It is expected the study will be completed by October 2008. All participants will be provided with a summary of the research findings.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in **Part 2**.

Will my taking part in the study be kept confidential?

Yes. Ethical and legal procedure will be followed and all information provided by you will be handled in confidence. Further details are included in **Part 2**.

This completes Part 1 of the Information Sheet. If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

Part 2 of the Information Sheet

What will happen if I don't want to carry on with the study?

You are free to withdraw at any time during the study without giving any reason. If you decide to withdraw from the study after the interview has been conducted, your data will be used unless you make a request to one of the research team to have your interview removed from the analysis. In this case, all records of your interview would be destroyed or deleted. It is intended that the study will be published in a thesis, published journals and may be used in presentations. Your consent will be sought to use quotations from your interview transcript.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to one of the research team who will do their best to answer your questions (see contact details below).

Will my taking part in the study be kept confidential?

All the information which is collected about you during the course of the research will be kept confidential. A code number rather than your name will be used to label the transcript. When the interview is transcribed from audio-tape all identifying information (about you or others) will be removed. All data stored on a computer will be password-protected. Any printed transcripts will be stored securely and destroyed in a secure way when the study is complete. Only the Chief Investigator (Simon Tobitt) and his supervisor (Dr Nancy Pistrang) will have access to your transcript; no-one in the team will be able to view the transcript. Participants have the right to check the accuracy of data held about them and correct any errors.

What you say in the interview will be between you and the interviewer. The exception to this is if you were to disclose any information that gave concern about your health or safety or that of others. In this case, the interviewer would inform you that action would need to be taken.

You will be asked to give signed consent to use quotations from your transcript in the thesis write-up of the study and other publications. Any quotations used would have had identifying information removed and would be anonymous.

What will happen to the results of the research study?

The study is due to be completed in October 2008, after which you will be sent a written summary of the results. It is intended to publish the results of the study in a doctoral thesis and in a scientific journal, and they may be included in presentations. You and your words will not be identified in any report or publication.

Who is organising and funding the research?

The study is being completed as part of the doctoral research of a post-graduate student in clinical psychology at University College London (UCL). The research site for the study is Sussex Partnership NHS Trust, where there is local involvement in the project (Dr Sunjeev Kamboj, Field Supervisor). There is a small amount of funding for this study from UCL.

Who has reviewed the study?

All research in the NHS is looked at by a Research Ethics Committee before it can proceed. This study has been reviewed and given favourable opinion by the Brighton East Local Research Ethics Committee.

Further Information and Contact Details

Please do not hesitate to contact one of the project team members for further information or if you have any questions about the study.

Simon Tobitt
Trainee Clinical Psychologist, University College London

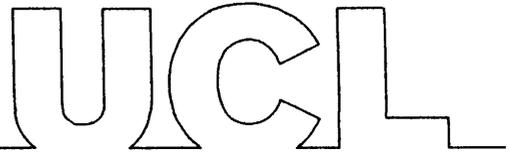
Dr Sunjeev Kamboj
Clinical Psychologist, Eastbourne CR/HT Team, Sussex Partnership NHS Trust

Dr Nancy Pistrang
Senior Lecturer in Clinical Psychology, University College London

There is a contact independent of the project team should you wish to speak with them about any aspect of the study or your participation in it:

Research & Development Facilitator
Health & Social Care Governance Support Team
Sussex Partnership NHS Trust

Thank you for taking the time to read this information sheet. Please keep it for future reference.



Version: 1
Date: 26.03.07
REC reference number: 07/Q1907/39

CONSENT FORM

Title of Project: The concept of crisis and crisis interventions:
perspectives of crisis workers in UK crisis teams.

Name of Researcher: Simon Tobitt, University College London

Please initial
this box

- | | | |
|----|--|--------------------------|
| 1) | I confirm that I have read and understood the information sheet dated 6 th July 2007 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> |
| 2) | I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. | <input type="checkbox"/> |
| 3) | I understand that the interview will be audio-recorded. | <input type="checkbox"/> |
| 4) | I understand that verbatim quotations from my interview may be used in published materials. I understand that these quotations will be anonymous and have any identifying material removed. | <input type="checkbox"/> |
| 5) | I agree to take part in the study. | <input type="checkbox"/> |

.....
Name of Participant
(PRINT)

.....
Date

.....
Signature

.....
Name of person taking consent
(PRINT)

.....
Date

.....
Signature

Appendix 4

Participant ID: _____ Date: _____

Background Information

The following questions ask for some background material about you. This information will be used to summarise the characteristics of the sample of people taking part in the research project, for example: "There were 35 participants in this study, of which 19 were female and 16 were male".

About you...

1. Please specify your gender: Female Male
2. Please specify which of the following age brackets you are in:
 Under 34 years 35-50 years Over 51 years
3. How would you describe your ethnic background?
.....

About your current job...

4. What is your current job title?
5. How long have you worked in the Crisis Team?
 Since it became a Crisis Team, or
 Please specify time in months:
6. What shifts do you work in the team?
 Mostly or only daytime (ie between 6am and 10pm)
 Mostly or only nights
 Mixture of days and nights

Your Professional Training...

What is your current profession?

- | | |
|---|--|
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Psychotherapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Support/STR Worker | <input type="checkbox"/> Other, please specify |

Approximately how many years have you been qualified in this profession?

Prior to your post in the Crisis Team, which of the following health settings have you worked in?

- | | |
|--|---|
| <input type="checkbox"/> CMHT | <input type="checkbox"/> Psychiatric inpatient/residential |
| <input type="checkbox"/> Local Social Services | <input type="checkbox"/> Mental health day-/out-patient setting |
| <input type="checkbox"/> A&E/Psychiatric Liaison | <input type="checkbox"/> General health or medical setting |
| <input type="checkbox"/> Other specialist community mental health team (eg Assertive Outreach) | |
| <input type="checkbox"/> Other(s), please specify | |
| <input type="checkbox"/> No other settings | |

National Research Ethics Service

Brighton East Research Ethics Committee

Brighton & Hove City Teaching PCT

26 June 2007

Mr Simon David Tobitt
Trainee Clinical Psychologist
University College London

Dear Mr Tobitt

Full title of study: The concept of crisis and crisis interventions:
perspectives of crisis workers in UK crisis teams.
REC reference number: 07/Q1907/39

Thank you for your letter of 24 June 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

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

| Document | Version | Date |
|-----------------|---------|--------------|
| Application | | 21 June 2007 |
| Investigator CV | | |

| | | |
|---|--------------------------|-----------------|
| Protocol | 1 | 27 October 2006 |
| Covering Letter | | 04 April 2007 |
| Peer Review | | 01 March 2007 |
| Interview Schedules/Topic Guides | 1 (Appendix of proposal) | 27 October 2006 |
| Letter of invitation to participant | 1 | 04 April 2007 |
| Participant Information Sheet | 2 | 06 June 2007 |
| Participant Consent Form | 1 | 26 March 2007 |
| Response to Request for Further Information | | 24 June 2007 |
| Certificate of insurance | | 01 August 2006 |
| supervisors CV | | |

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from <http://www.rdforum.nhs.uk/rdform.htm>.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

<https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx>

We value your views and comments and will use them to inform the operational process and further improve our service.

07/Q1907/39

Please quote this number on all correspondence

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

Yours sincerely

Chair

Email:

Enclosures: Standard approval conditions

Copy to:

Appendix 6 Sussex NHS Research Consortium

Please reply to: Research Consortium Office

Mr. Simon Tobitt
Trainee Clinical Psychologist

31 October 2007

Dear Mr. Tobitt,

RAMC ID: 0982/NOCI/2007

TITLE: The concept of crisis and crisis interventions: perspectives of crisis workers in UK crisis teams.

Thank you for your application to the Research Approval and Monitoring Committee (RAMC) for registration for this study.

A sub-committee of the RAMC have considered this study. The documents considered were as follows:

- NHS REC form parts A and B (signed and dated 22/06/07)
- NHS Site Specific Information form (signed and dated 26/09/07)
- Protocol with appendices including interview guide (version 1 dated 27/10/06)
- CV for Simon Tobitt (signed and dated 26/09/07)
- Brighton East REC approval letter (signed and dated 26/06/07)
- E-mail from Simon Tobitt with clarifications (received 30/10/07)
- E-mail from Simon Tobitt with clarifications (received 31/10/07)

I am pleased to tell you that the study was registered, and so may proceed. This registration is valid in the following Organisations:

- Sussex Partnership NHS Trust

Your RAMC registration is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
2. You notify the RAMC by contacting me, should you deviate or make changes to the RAMC approved documents.
3. You alert the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of RAMC approval.
5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.
6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the

NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS Organisations; such an extension can usually be arranged within ten working days.

Good luck with your work.

Yours sincerely,

Senior Research Governance Officer

Email:

Tel:

Fax:

cc R&D Director, Sussex Partnership NHS Trust

Appendix 7

Interview Schedule

Part 1: The Concept of Crisis

Opening:

OK, in today's interview I am **really interested** in hearing **your perspective** on crisis and crisis resolution. In the **second part** of the interview I want to hear your ideas about bringing crisis to a resolution – so **basically what you feel you do to help people in crisis**. In this first part of interview I would like to hear your ideas about the concept 'crisis'. That said, this is my structure and you can talk freely about crisis or what you do in a crisis in any part of the interview. OK? [check response].

So, this term crisis is talked about in your team and the people you work with. I wondered if you could start by telling me how you understand this thing called **crisis**?

The Crisis Concept

Individual versus team definition

Are there differences between the team's definition of crisis and your definition of crisis – what are they?

Are there commonalities in the crisis experience for the people on the team caseload – what are they?

Are there differences in the crisis experience for the people on the team caseload – what are they?

The client experience

You are working with clients in crisis in your day to day work. What do you imagine their experience of the crisis to be?

Further prompts: How are they feeling inside? How are they seeing the world around them?

Part One, cont.

Crisis Over Time

I wanted to ask about what you think happens with crisis over time:

How do you understand the development towards crisis in the people that you work with? Prompt: so at some point the person wasn't in crisis, and then they were in crisis – what happened in that time?

What happens to the crisis in the time the person is with the team, from their being accepted through to their discharge?

How do you understand resolution of crisis to work?

Do you have any ideas about what would happen to the crisis if crisis services were not available?

Exclusions from the crisis definition

Are you party to discussions in the team about referrals that are declined, because they don't meet the team's criteria? [if no, move on, if yes...]

I don't know if you feel if some of those people who are declined are 'in crisis' [look up/acknowledge], but if so how is their crisis different.

Part Two: Crisis Resolution – how are those in crisis helped?

Content of crisis work

I wanted to move on to asking about the ways that you help people in crisis. Can you tell me about what you – rather than the team as a whole - do to help clients who are in crisis?

Professional Skills

Are there professional skills or techniques that you *particularly draw on* when working with clients in crisis?

Professional Knowledge

Is there professional knowledge or theory that you *particularly draw on* when working with clients in crisis?

Experiential (optional)

I wonder if there any ideas, values, skills or talents that you draw on from your *personal rather than professional* background, that you feel are important in crisis work?

Contrast (optional)

This is a slightly political question, so you may decide you *don't wish to answer it*. Compared to generic community mental health team care (CMHT), do you think Crisis Resolution Home Treatment teams offer something unique?

Process of crisis work

You've talked about what you *do* with clients. I wonder if you have any ideas about the way you *have to be* when working with clients in crisis?

Appendix 8

Sample of 'Indexing'

| Interview Transcript for Respondent 11 | Indexing |
|---|---|
| <p>I: So the term crisis is talked about in your team and about the people that you work with, and I wondered if you could start by telling me how you understand this thing called crisis?</p> <p>R: OK, I mean, my criteria of what constitutes a crisis, is in a way quite, pragmatic. So <u>if somebody can not function, significantly, or have ordered function in their day to day living, which is creating a problem for themselves, or for the people around them, then that to me indicates a problem which has reached a crisis degree of severity.</u> The second criteria <u>I keep an eye on, the safety, if somebody is um, at risk of themselves for others, or at risk of them or they are physically neglectful of their needs, eating, drinking,</u> that's reached a severity where it would need to consider involving ourselves.</p> <p>I: OK, so those two things functioning and safety.</p> <p>R: Risk.</p> <p>I: Yeah, risk / safety, OK [.] And can I ask if you've any ideas about how crisis changes people's functioning and people's risk?</p> <p>R: OK, um, well <u>in terms of risk you know, people can become either self-harming, actively self-harming, overdosing, self-cutting, actively suicidal, um, at risk to self, then you've got your risk to others. People possibly, people's forensic history, people who are in an emotional state which makes it easier for them to react to a person's provocation and then harm others, and then that's risk to others.</u> And then you've got your, <u>neglect which is also a risk, people are not eating not very well, they're losing weight, they're not drinking, they're becoming dehydrated, that's all risk,</u> the other part of the question was?</p> <p>I: With the the functioning, um, um, really, how it is the functioning has changed because of the crisis, is that how you understand it?</p> <p>R: Probably the other way round, <u>functioning has changed in such a way as to become a crisis situation.</u></p> <p>I: Yes.</p> | <p>Functional Decline</p> <p>Risk of Harm</p> <p>Functional Decline</p> <p>Risk of Harm</p> <p>Functional Decline</p> <p>Functional Decline</p> |

| | |
|---|--|
| <p>R: Situation.</p> <p>I: OK</p> <p>R: So <u>people who, you know, can't live up to their pre-morbid level of functioning, either at home, and commitments, either at home, or at work, commitments they normally have to themselves, to their family, to their employer, mainly, you know, mainly. And if that becomes, sustained as a problem, where you've got weeks and months of it and its creating possibly other problems as well, like financial problems, which continues to feed back on their emotional state, heightening their anxieties, that's what I would, they way I would understand the answer to you question.</u></p> <p>I: So you said the functioning starts to decline, which, that is the crisis.</p> <p>R: Which indicates that, <u>if the functioning has decreased to a severe degree where they can not turn up to work, where they can't wake up in the morning and take care of the children and the family the way they used to, then that's indicating quite a level of reduction, and low functioning which is going in to the crisis territory, where we would possibly (inaudible word).</u></p> | <p>Functional Decline</p> <p>The Momentum Phenomenon</p> <p>Functional Decline</p> |
|---|--|

Appendix 9

Sample of 'Charting'

Quotations contributing to a given theme are arranged in a chart in order, for the purposes of assessing thematic consistency, and (not appropriate in this study) to identify patterns based on respondent characteristics or categories.

Theme: Past Memory Triggered

| Resp. No. | Supporting Quotations |
|-----------|---|
| 2 | "a lot of people constantly ruminating about things that have happened in the past, so it's about trying to focus on the here-and-now really, and the future, or rather than going over. But some people do need to deal with things that have happened in the past, but I think those things need to be dealt with through counselling and seeing a psychologist" |
| 6 | "like maybe it's an anniversary, or maybe they've seen something on the telly that's brought something back to them" |
| 10 | "Anniversaries, you know, of um you know there might be the anniversary of a bereavement" |
| 11 | "sometimes it's psychological processes. Sometimes people are well enough, you know, something happens to them, it might link back to something that's happened in their distant past, attachment issues, decompensation from a traumatic event in the past, and decompensate. I don't know, an anniversary coming up of somebody's death" "some things are coming along, reminding them of other things that have happened in the past, triggering psychological processes" |
| 14 | "they might have had traumas in the past that they're dwelling on again" |
| 15 | "There might well be something that repressed, that may come up, that they don't cope with very well, like an anniversary or something" |
| 20 | "even perhaps um early life time experiences" "it might not have been just in recent times, it could have been err, something that's happened recently might have triggered a childhood incident, a childhood memory. It evoked a lot of feelings of desperation in them" |
| 28 | "I guess if someone's had multiple bereavements, and it's become an issue, there might be certain times in the year when anniversaries come up that trigger those responses" |
| 29 | "maybe get someone to see those connections of things that have happened in the past, as they reflect, recurring in the person, can have an impact on someone's thought, mood, thoughts, feeling, behaviour in the here-and-now" |
| 35 | "a person more linked to external events I guess, that a particular crisis might come about because of an anniversary of a death" |