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‘Dale’: An interpretative phenomenological analysis of a service-user’s experience with a Crisis Resolution / Home Treatment team in the UK.

Nelson, Louise J. (B.A., RMN, Dip. Nursing, MBA, PGCLTHE, PhD)

University of Cumbria, Fusehill Street, Carlisle CA1 2HH

Ashman, D. B.A.(Hons)

Miller, Paul K. (BSc., M.A., PhD).

University of Cumbria, Bowerham Road, Lancaster LA1 3JD.

Corresponding author: Louise J. Nelson; Department of Nursing, Health and Professional Practice, University of Cumbria, Fusehill Street, Carlisle.

Email: louise.nelson@cumbria.ac.uk. Tel: 01228 616009.

Accessible summary

What is known about the subject?

This paper describes Crisis Resolution/Home Treatment (CRHT) teams, which are part of mental health services in the UK. CRHT is expected to assist individuals in building resilience, and work within a recovery approach.

What this paper adds to existing knowledge?

This paper arises from an interview with one individual, Dale, as part of a larger study exploring service users' experiences of CRHT. It adds to the body of narrative knowledge in CRHT through Dale's co-authorship of this paper, reflecting on his original interview four years later, with co-authors providing critical interpretation of his experience, in turn supported by cognate literature.

What are the implications for practice?

Implications for practice are considered, themselves mediated through Dale's own descriptions of how CRHT interventions impacted upon him. These impacts are analysed with respect to three themes: Resilience, Recovery and Power.

It is centrally contended that clinicians need to more clearly comprehend three core matters. Firstly, what resilience 'is' *for* service users as well as the complex process through which these individuals move in developing resilience. Secondly, the distinction that service users might make between 'recovery' and 'functionality', and how this in turn can impact on individuals both in personal and socio-economic sense. Finally, the mechanics of power within CRHT contexts, and how these interpersonal dynamics can affect the relationship between service user and clinician in practice.

Keywords: crisis resolution; home treatment; resilience; recovery; power.

Introduction

CRHT is part of the spectrum of mental health services in the UK. CRHT has developed since the early 1970s and is based on the ‘preventive psychiatry and crisis theory’ approach of Caplan (1964 p.56) who recognised that crisis occurs when normal coping strategies cease to work. The Department of Health (2001) mandated that CRHT would form part of current mental health services and gave clear direction on the setting up of these services. This policy implementation guidance clearly regarded these services as having the ability to not only offer services 24:7 in people’s homes but also to assist individuals in developing resilience to future crises. The National Institute for Health and Clinical Excellence (2011) categorically states that CRHT is still a major component of mental health services. The Department of Health (2014) agreed that mental health services and agencies would work collaboratively to ensure that support was given to those in mental crisis and that this type of crisis would be recognised as equal to physical crisis requiring 24 hour access. They very specifically also identified that the service should promote recovery to try to reduce further crises.

Theoretical, Historical and Policy Background

In 2001 the Department of Health in the UK formally adopted the broad CRHT approach as a model on which to base some aspects of its mental health services delivery. In line with requirements outlined by the UK National Audit Office (2008 p.4) regarding ‘...the clear scope for more comprehensive research [into] service users’ experiences of CRHT services’.

CRHT services have operated in a diversity of forms and locations since the early 1970s, although across this period they have been accorded a number of labels including ‘crisis

intervention’, ‘crisis assessment’ and ‘intensive home treatment’. Contemporary CRHT takes as its key antecedents the ‘crisis theory’ pioneered by Lindemann (1944), and the practical developments thereof advanced by Caplan (1964). The former, through an analysis of coping strategies among survivors of the Coconut Grove fire in 1943, developed a conceptual framework for preventive psychiatry that remains the basis for most crisis work in mental health today. The latter built upon this framework by particularly highlighting the importance of service users’ own capacities to draw upon local social resources (such as family, carers and community) when addressing a given mental health problem, and the resultant ‘crises’ that can occur when such resources are either unavailable, insufficient, or not used effectively (Caplan,1964).

Although grounded in Caplan’s (1964) assertion that a ‘crisis’ occurs when normal coping mechanisms and networks are not sufficient to deal with a particular problem, this short definition reflects only the locally remedial aspect of the intervention. Crisis theory today is also, and equally, concerned with Caplan’s own concern to encourage an individual in crisis to *learn* from the situation (Carroll *et al.*, 2001, Polak and Jones, 1973); i.e. each crisis should be addressed in such a manner as to facilitate the services user’s capacity to diminish, or even obviate, the chance of its recurrence (Chisholm and Ford, 2004, Bridgett and Polak, 2003a). It is within this learning process in particular that the CRHT approach places significantly stronger emphasis upon the importance of the social world that the service user inhabits (interpersonal connections, relationships, networks etc.) than in many approaches to mental health intervention (Gruenberg, 1967, Polak, 1971, Bridgett and Polak, 2003a, Bridgett and Polak, 2003b, Polak and Jones, 1973). The underlying philosophy of contemporary CRHT is visibly grounded in a ‘social systems’ (Bertalanffy, 1968) position. Such ‘systems thinking’ is reflected in a body of international work on the topic that has consistently explored and

documented the practical importance of understanding and bolstering social support networks in this form of mental health intervention work (Stein *et al.*, 1975, Muijen *et al.*, 1992, Hoult *et al.*, 1983). Moreover, central to the understanding thereof, and therefore the terms of effective care, is the provision of a voice for service users and their networks alike (Pai and Kapur, 1983, Brimblecombe and O'Sullivan, 1999, Cohen 2008, Morton 2009, Winness *et.al.*, 2010) which makes requisite a shift in traditional 'power roles' between professional and patient (Chisholm and Ford, 2004, Bracken and Cohen, 1999).

CRHT in the UK

The key issues highlighted above are, today, demonstrably ingrained in UK health policy regarding the treatment of individuals who have a severe mental illness and/or are deemed to be experiencing a mental health crisis due to an acute exacerbation of a mental illness. The UK CRHT service was initially designed to augment and improve the delivery of broader mental health services, and to be culturally competent, rapid and accessible 'around the clock' (Department of Health, 2001).

It was the manifest intention of UK CRHT to assist service-users in understanding firstly the *nature* of their own mental health crises, and secondly, how these crises might be avoided in the future (Department of Health, 2001). Consequently, CRHT team staff members were also mandated to offer practical guidance relevant to the fundamentals of daily living, providing education and support and with executing tailored interventions aimed at increasing the SUs resilience. Using a problem-solving approach whenever possible, this CRHT model embedded a teamwork doctrine and, resonant with the core tenets of crisis theory itself, was designed to (a) actively involve service users themselves and (b) place a high value on input from families and carers (Chisholm and Ford, 2004). It is, however, unambiguously noted in

the UK *Policy Implementation Guide* (Department of Health, 2001) that service users and other involved persons may also need to be *furnished* with the (potentially unfamiliar) skills of expressing their detailed views on the service itself (Staley, 2009). In line with the observations found in both Chisholm and Ford (2004) and Bracken and Cohen (1999), the policy reflects an understanding of the traditionally mono-directional character of mental health care models (professionals tell, patients listen, or ‘the doctor knows best’) and, thus, a recognition that education may be needed in terms of how to contribute.

Research approach and methodology

An Interpretative Phenomenological Approach (IPA) (Smith *et al.* 2009) was used as it is viewed as an appropriate way of discovering participants’ experiences. The data was collected using a semi-structured interview to develop a narrative story which was then analysed using the principles of IPA. The implications of this study are relevant for various reasons: it is important for practice to use the experiences of service users in developing services and designing services as they change; (National Audit Office 2008, Hicks *et al.* 2015), it gives service providers the opportunity to consider the findings in relation to their own services; and it looks at the model of CRHT, particularly with regard to the underlying principles of Resilience, Recovery and Power as described by Dale.

This paper examines the case of ‘Dale’, himself a recipient of the service, in order to illuminate situated examples that draw attention to the unpredictable ways in which service users can sometimes interpret the actions of healthcare professionals. The interpretative case study approach narrative analysis explores, in-depth, Dale’s own account of a range of issues pertinent to the practical delivery of the CRHT he received.

The empirical sections below provide an illustrative single-case analysis of a SUs experience of CRHT services in the UK. Single-case studies can be a particularly powerful tool for highlighting specifics (Silverman, 2010, Finlay, 2011). In short, single-case analysis can be instructively utilised to illuminate novel or unforeseen aspects of participant experience that may otherwise be overlooked by a more traditional deductive process of pattern explanation (Smith, 2004). With respect to issues such as CRHT, there is a lack of detailed context-sensitive data, therefore this mode of investigation has a particularly important part to play. The consonant principle of ‘giving patients a voice’ is, of course, valued in all areas of nursing and nursing research (Edwards *et al.*, 2000, Staley, 2009). Lucock *et al.*, (2007), however, emphasise not only the need for service users to *have* a voice but for these voices to direct research priorities themselves. In these terms, it is essential that participant narratives are interrogated and themes identified by those participants, rather than as an outcome of a predefined analytic frame. In line with such imperatives data was collected and interrogated using the techniques of IPA.

IPA has not yet been used with reference to service-user experience of CRHT where it could provide precisely the kinds of insight that the UK National Audit Office (2008) has called for. Larkin *et al.* (2006 p. 102) identify that IPA is not just about the participant telling their story, but also that the researcher gives voice to the concerns of the participants and contextualises and analyses claims or concerns that the participant shares. In this case, Dale tells about his experience of CRHT through a semi-structured interview and further retrospective narrative and the first author ‘Louise’ interprets and contextualises what he says, and supports it with extant literature. Through this process implications for practice are identified.

Participant recruitment

The participant, 'Dale', disclosed his own experience of the CRHT service as part of the main study. All data discussed herein was collected and is represented in strict accordance with the mandated conditions of the regional NHS Research Ethics Committee. Louise identified in her ethics application how the participants would be supported through this process, and what plans would be put in place if a participant identified issues of bad practice. As a co-author Dale gave express permission to be identified within this paper and does not want a pseudonym to be used instead of his real name. The NMC Council Code of Conduct, Performance and Midwifery is the basis of the ethical and professional framework.

Data Collection and Analysis

Data collection was via a semi-structured interview (Smith and Osborn 2008) to allow Dale maximum freedom to contextualise key issues within his own life and personal experience. Smith and Osborn (2008) describe semi-structured interviewing as the 'exemplary' data collection method for IPA studies: 'This form of interviewing allows the researcher and participant to engage in a dialogue whereby initial questions are modified in the light of the participants' responses and the investigator is able to probe interesting and important areas which arise' (p.57).

Dale

Dale was in his thirties and lived alone in a very isolated rural area at the time that he had experience of CRHT, and had been working in mental health services. Dale's family lived over a hundred miles away, though he did have regular contact with his young son in the next village.

Dale's recollection of his experience of Crisis Resolution/Home Treatment (CRHT) is set initially within an interview (identified with *indented italics*). Dale then created a further retrospective narrative on this experience four years later (identified in *italics*). Both interview and narrative are then interpreted by Louise, and supported in terms of the cognate literature in relation to three key areas; Resilience, Recovery and Power.

As a co-authored piece of work Dale introduces the interview and then introduces his personal definitions on the concepts of Resilience, Recovery and Power. Louise interprets and contextualises this against the extant literature, before pulling together the concepts in the conclusion:

In reflecting on the interview that Louise conducted with me in 2011 as part of her research in to CRHT services, I find myself looking back on an earlier version of myself who in turn is recalling an even earlier stage in my life when the support of my local CRHT played a crucial role in my life. I am peering in to a mirror that is reflecting back to me an image in a second mirror.

Whilst in many respects both my time with the CRHT team and the later interview seem so very distant to me, in others they remain vividly close. In terms of my mental health and its management I have made great progress. I struggle to imagine a state of mind where I would need such close support and intervention. Yet at the same time, I vividly recall what transpired at that time and I can never quite shake the feeling that somewhere in the shadows still may lurk the 'not quite resolved issues' (for want of a better term) that precipitated those events in the first instance.

However, on re-reading the interview (and of course with the benefit of many years hindsight, not to mention, therapy) there are some things I'd wish to emphasise myself, these will be highlighted under the three headings, Resilience, Recovery and Power.

Resilience

Let me start with Resilience. I define this as the ability to survive life threatening situations, circumstances or events – and in this context, that means emotional trauma that can lead to life threatening situations or death.

The beginnings of Resilience can be expressed simply in the words of John Lennon:

“Whatever gets you through the night, it’s alright” (Lennon et al. 1974). One cannot fight another day if one fails to survive the night. And the night is often the most dangerous of times.

Clearly some ways of getting through the night are better than others. Talking things through with a good friend and then sleeping on it, is a good way. Getting a razor blade out and cutting yourself, or drinking or taking drugs to the extent where you forget and collapse in to unconsciousness, is not so good. But as long as you wake up in the morning there’s another chance.

There is a saying erroneously attributed to Churchill, which states “Success is the ability to go from failure to failure without losing your enthusiasm”. Perhaps this can be adapted to say “Resilience is the ability to survive crisis after crisis without losing your life.”

I felt that one of the great strengths of the CRHT team was to listen to your story, identify where and how you’d survived crisis and REMIND you: 1) that you’d done it; 2) how you’d

done it; and 3) that there was no real logical reason why you couldn't do it again albeit it that it might require some extra help.

I'm aware that there are various theories that propose that Resilience is built from a combination of individual character, family circumstances, education, social structures, life experiences etc. Whilst I am not totally at odds with this concept I feel it neglects to understand that many of these structures that claims build Resilience in an individual, can equally totally undermine a person's Resilience. If you have good family circumstances, education, social structures and life experiences the chances are you won't need much Resilience at all – everything should be dandy. A failure of those influences can result in circumstances arising where an individual requires Resilience to get through them and survive.

In such cases, where does Resilience come from? Surely it must grow from what the saying hints at: "the ability to go from failure to failure without losing your enthusiasm". It seems to me this must come from the individual.

The CRHT team had discussed with Dale if he had been in 'crisis' beforehand and how he had coped in that situation, as a means of determining how they facilitated 'learning from previous crises', and how resilience to crisis was developed. Leipold and Grieve (2009 p.41) describe resilience as a phenomenon which is defined by: 'The success (positive developmental outcomes) of the (coping) process involved (given the circumstances)'.

Dale's resilience in terms of support systems was limited, but, in relation to the definition above, the CRHT team were developing positive developmental outcomes in his personal situation. Ungar (2015) discusses the socio-ecological understanding of resilience. His work reconceptualises resilience from a deficits approach to a strengths approach, based on the

interplay between an individual and the systems that create their environment. In Dale's case, he sees it as coming from within or specifically from the team, therefore the team focused on what they could do to help him. A direction they could have taken, was to consider how they could facilitate the growth of social systems around him, if they did not naturally exist. This in effect moves from the personal to the systemic. In Dale's case the team could have assessed factors such as support in the community, vocational or paid employment opportunities, access to voluntary mental health services. Ungar (2015) supports using adiaagnostic criteria to assess and then build resilience and this may be a consideration for practise. Dale had a very positive experience of this aspect of CRHT. He felt they were good at exploring with him what had worked before, and saying things like:

' could you try that, can we facilitate that, what have you done in the past, what's been helpful, have you tried that, can you implement that again, is something in the way of that, is there anything we can do to help that' (interview)

Dale described the team as 'personable'; they 'gave of themselves'. Clarification of this was that they chatted about everyday things; they developed a collaborative relationship; going for walks with him; they sat on the floor and when visiting, they washed dishes. They discussed medication management. In terms of practical support, they assisted him to contact his solicitor and visited, or contacted him, at times to suit him. They constantly reminded him of how many skills he had and also emphasized the positives in his life. Dale recognised that when he is in crisis he feels vulnerable, and that he needs to be able to control his own crisis. He felt the team would bring out skills and resources that he already possessed.

[CRHT] 'constant reminding of and support of how many skills you've already got and also emphasising the positive things in your life, remind me about my son and

things you were doing right and that you've been through similar times before and that you had got coping strategies that were really useful'(interview)

Retrospectively, we discussed Dale's understanding of resilience in comparison to Harper and Speed 2012 (p.10). They identify that 'resilience' refers to 'an ability to respond to, and cope with, adversity'. Harney (2007) based his understanding of resilience on the work of Bronfenbrenner's Person-Process-Context Model. My understanding at the time of the original interview was based on the 'here and now' but, through Dale's retrospective narrative we started to talk about the analogy in Harvey (2007) of the Russian dolls, with each doll representing part of a person's life. In consideration of how that resilience is developed, we talked about the essence of Dale; his home life, schooling, relationships with family and friends, work, the communities he has lived in and the bigger picture of nation. All these experiences make him what he is. The team used some of these 'dolls', albeit without that analogy, to look at developing resilience, but, perhaps importantly, it was because of some of the 'dolls' that Dale had to construct his own individual resilience with the help of psychotherapy. Hermann *et al.*, (2011) support this view by arguing that clinical implications include renewed emphasis on the value of the clinician. Dale recognises that it took many years of psychotherapeutic support to build up a resilience that could then be utilised by the CRHT team at this particular point in his life. Returning to Ungar (2015) it is apparent that resilience is not something you either have or you don't. Dale could be resilient in some aspects of his life and not others, as can we all. The team went some way towards power-sharing, but it felt somewhat superficial. A thorough and complex understanding of resilience is required by the CRHT team to develop a formative approach to it. Leipold and Grieve (2009) discuss resilience in terms of a conceptual bridge of coping and development

(p.40). In terms of the ‘dolls’ analogy you may only have some of these dolls and need to develop others, however it is unlikely that Dale, nor you or I would have a full set.

Dale recognized that the team were available to him in different ways, both day and night.

This happened from the very first visit when they:

‘...left me with the 24:7 number and a full explanation of how to do that [contact them], particularly about cost from a mobile...they always arranged next visit/telephone contact before they left, always on your terms, i.e.: not before 9 in the morning as I wouldn’t be up. Never a time when they did not show’ (interview)

Of course, there were things that the team did that he felt was not helpful. In particular he identified three aspects of their working practise that he was disappointed in. On one occasion he had needed in-patient care, but he was disappointed that he could not go back to them as part of the discharge process; he also felt that it was an unnecessary step to need to be referred from a general practitioner (GP); and lastly, he mentioned that as CRHT is a team approach, he sometimes did not know who he was talking to and occasionally they had different approaches.

Dale identifies an internal traffic light system as a means of understanding his own crisis. It is very personal and individual to him and reinforced the need to personalise and recognise that each individual crisis will be dependent on the person’s experiences and individual social situation. This, in turn, increases the need to have personalised care plans and relapse plans within the Department of Health Care Programme Approach (2008).

Caplan (1964) identified this personal understanding as ‘learning from the situation’ (Carroll *et al.*, 2001, Polak and Jones, 1973). It is necessary that individuals learn from these

situations, and that this learning is recorded by both the team and the individual creating a positive record of what can be done to enable someone to diminish or obviate the chance of its reoccurrence (Chisholm and Ford, 2004; Bridgett and Polak, 2003a). It demonstrates to the person in crisis that their resilience techniques and behaviours are valued by the crisis team and that the model on which crisis resolution is built is collaborative in nature.

On reflection, Dale makes the following comments on Resilience in terms of its wider socio-political context:

One of the problems with this model of Resilience, i.e. that is within and belongs to the individual, is that it exonerates the state and society from taking any responsibility for the need to acquire it in the first place, and, by emphasising the Resilient qualities in the individual also abdicates much of its responsibility to do anything much about it. It can seem like a case of 'our socio-economic-political setup contributed greatly to your mental health problems, but sorry -it's up to you to sort them out for yourself'.

I feel on reflection, the mental health teams generally and CRHT teams specifically, need to understand what Dale so clearly states; that resilience might be about 'the ability to go from failure to failure without losing your enthusiasm'. He understands this as an individual responsibility, but it is also the responsibility of the team and is related to the principle of giving hope which is part of the recovery approach (National Audit Office, 2005). The implications for practice are several. The clinician needs to understand what resilience means and that it is not only resilience in the here and now. They need to take the time to understand how that resilience has developed at different points in a person's life. They need to understand what it means to the individual and also what it means in a health and social system. Without this complexity of understanding, lip service can be paid giving all

responsibility to the individual who has the label of service user. It would be helpful for teams to consider the multi-dimensional assessment of resilience as described by Ungar (2015), in approaching an understanding and development of resilience in relation to power-sharing as a principle of CRHT.

Recovery

It is important to distinguish the concept of recovery from resilience. Recovery or discovery in Dale's case is a consequence of resilience. Resilience and recovery can be seen as interlinked and interdependent. Although it can be argued that recovery can be seen as the ability to function in society in a similar way as other people within that community. Deegan (2005) makes the point that resilience and recovery are 'two sides of a multi-faceted phenomenon'(p.29). Dale talked about recovery and his recovery principles in the interview. He described the team as *'personable'*. The evidence he gave for this, such as *'the team sitting on the floor when visiting'*, demonstrated a move towards equalizing the power differential. The team members *'washing dishes'* is most certainly an aspect of the role in offering practical support. Borg and Davidson (2008 p.138) found that service users saw recovery as a social process and that to 'understand recovery....you need to see that the trivialities of life are anything but trivial'. This type of recognition by the team can then enable normal tasks, such as keeping the house clean, to be done with the person as part of their life and personal recovery.

Dale's traffic light system is part of resilience but also part of recovery. He knows when he is becoming unwell and he believes other people know and at some point he requires help, although this can mean he is not in control. In the interview I asked if this traffic light system is shared with someone so they can get help. He responded:

It's not formally, but if I showed it to people who know me well. [They would say] ...they are the things we'd see when you're getting unwell but I've never formally shared it ...cos I wouldn't want them to be in a position to make that call...it relies on and puts quite a lot of responsibility on that person [family, friends and professional] and it takes it away from me...which I'm not happy about, it's against my recovery principles...it might work if I had a live in partner.(interview)

Dale then further discussed it in his narrative:

Recovery is perhaps the most difficult concept of all. Far too often it is still defined in socio-economic terms. It is often confused with functionality. If a service user progresses to the stage where they can hold down a job, pay National Insurance and taxes, earn a wage, get off benefits and not cost the NHS too much they have 'recovered'. This definition, which is sadly propounded by so many mental health professionals, fails to take in to account emotional and psychological states of the service user, or at what the cost is to these individuals in being 'functional'. I know many 'ex' service users who have jobs and can be functional through the day – pharmacists, teachers, care workers –... and who then get home and get out the razor blades, the red wine, the diazepam. This is not Recovery. Back in 2005, I wrote "Define your own Recovery". I still stand by that.

However, the discussion has moved on and increasingly the concept of "Discovery" is being discussed and defined as a more expansive concept. This is particularly of relevance to me and to others who struggle with mental health issues such as Personality Disorder.

Inherent in the concept of Recovery is regaining a previous state. This may be legitimate in terms of conditions such as Post Traumatic Stress Disorder (PTSD), depression, post-natal-depression and other illnesses where a previously 'well' person has become 'ill'. However it makes no sense at all to someone whose experience of reality has been very different from their early years – in essence there is nothing to 'recover'.

In this situation it makes far more sense to think about 'Discovery' and to learn a brand new way of living, but I would still say: "Define your own Discovery".

However, we must again be aware that the ability of an individual to define that Discovery is limited by the context of the society in which they find themselves. After twenty years of therapy and experience, I know that living in the countryside, being engaged with conservation, historical and modelling projects are all things that I can flourish in and have a natural skill for, and as such provide an environment where my mental health problems impact less on my day to day life. Yet I cannot find paid work in these areas and my local Department of Work and Pensions office would much rather I was stacking shelves in Tesco.

Recovery is now the principle on which all mental health services function (NIMHE 2005).

Ridgway (2001) identifies recovery as ‘reclaiming a meaningful life’ (p.335), but Dale would argue that the starting point for recovery is what the reality of a person’s life is. It is not about recovering your previous life, it is about creating a brand new way of creating attachments you have not experienced previously, so that you can do all the things in life that would contribute to recovery and resilience and hence it is certainly discovery. Collier (2010 p.17) argues that the problem with the term ‘recovery’ is that it can mean two very different things: ‘the traditional definition of recovery, referring to cure from illness’; and ‘the contemporary ideas about recovery referring generally to a process of change and personal growth’. Turner *et al.*, (2011 p.341) identify that ‘mainstream attempts to provide a recovery model for all have been met with concern and dissent from the service user/survivor movement’. For this paper, we are accepting that recovery is about change and personal growth, but in Dale’s words considering it as ‘a new process of discovery not reclamation of a previous state’. Turner *et al.*, (2011) completely support Dale’s view in relation to self-discovery and personality disorder in that, service provision based on recovery is often in conflict with people with this diagnosis, due to a lack of development previously in their lives. Rhodes and DE Jager (2014) see recovery as focusing on the person and not their symptoms and that recovery is based on a community of narrative stories, which aids

clinicians in understanding the experiences that individuals present. Dale understands community or society as part of Rhodes and DE Jager's ultimate point, which is that community stories aid recovery. This supports Dale's view that recovery is not simply the province of the patient, but, of society. Unfortunately this focus on socio-economic policy has a fairly narrow framework, in that being able to function at work, equals recovery.

I believe that it is hard for healthcare professionals to completely understand what recovery/discovery means and perhaps part of their training should be about their own journey of discovery. To understand what someone is going through is not easy and it takes time - it is not a one off process, but a dynamic one. You need to hear the story, ask questions and build up a community of experiences that are then viewed as of equal importance as any other clinical tool. The use of narrative is an approach to caring (Aloi 2009). Baker (2015) in her editorial for the Journal of Psychiatric and Mental Health Nursing clearly points out the value of narrative and co-production, being that the individual is not written about but written with. In this case Dale and Louise were able to co-produce a paper that translates directly from research into practice..

Power

Dale needed to stay in control and feel like he was in the driving seat. He talked about an equal power base and this was demonstrated to him with his first interaction with the CRHT team.

They [CRHT] give a bit more of themselves'. It was refreshing and real and must be difficult to do sometimes, to know when to do it, to know when it is appropriate, to know when it is safe to.... The very first two that came out, it was odd but nice - I sat on a chair, they sat on the floor in front of me even though there were two other chairs. I have never seen a mental health professional do that. I thought about it a few weeks later: I was higher than they were, that works psychologically, it's clever you are used to being 'done to', 'telling you what to do', 'people in authority'(interview)

Dale needed to feel safe, accepted and understood. Dale analyses this further in his narrative:

I still have a very vivid memory of the first night [as above] I recall that, as I shook and cried in a chair, they sat on the floor in front of me, attentive and engaged. This was a great shift from the usual service-user/professional power dynamic that I was used to.

What I was unable to express in the interview was that in contacting the crisis team one of the driving factors was to relinquish responsibility. It is a fundamental part of asking for help: "I can't do this on my own anymore." I had tried to pass that responsibility to family and friends, but whilst willing, they didn't know how or lacked the capacity. The CRHT team were there specifically to take on that responsibility and had the skills and resources to be able to do it.

Crucially though, their strategy was to take responsibility yet at the same time to immediately begin to hand it back to me. By sitting on the floor, they not only disrupted the usual power dynamic that renders a 'patient', 'client' or 'consumer' helpless, but through giving me some say in my next moves also immediately gave me back some responsibility for my situation. It was so subtle as to be unnoticeable. They explained what they could do (e.g. dispense medication, liaise with other agencies) but asked me what I wanted to do. I had to make a decision. I was given both the power and the responsibility to do that.

The team seemed to have recognised that Dale had experienced more traditional 'power roles' previously. Professional power is not a tenet of the recovery approach (Chisholm and

Ford, 2004; Bracken and Cohen, 1999; Karlsson *et al.*, 2008). The team in this case recognised that CRHT teams need to engage with people's lives and not view their role as simply being there to 'treat an illness' (Middleton *et al.*, 2011). In relation to power during the narrative, Dale was able to use an analogy to explain this:

I encountered this strategy very recently when my son had his first guitar lesson with a private tutor. My son can be quite shy and I'd decided that I'd let them get to know each other and sort out between themselves how they were going to progress. The lesson went very well and afterwards I asked my son whether they'd sat in the upright chairs I'd put in the room (thinking these might be easier to play guitar on) or the comfy chairs. "No Daddy," said the little man smiling widely, "I sat in the comfy chair and [tutor] sat on the floor." This seems to me exactly the same strategy with the same aim – to give my son the feeling of having some control over his own learning and at the same time engender a sense of responsibility for his learning.

Of course, my son has as little understanding of what is happening in his guitar lessons as I had in that first meeting with the CRHT team – and perhaps that is the basis of its effectiveness in that the service-user – or the student – feels a sense of ownership of their treatment or lesson.

There remains, however, a higher power dynamic at play in both situations. What happens if Dale does not take any responsibility for his own situation? What happens if his son does not buckle down and learn his guitar despite the tutor appearing to take a more subservient role? On one hand, the CRHT team have the power of sectioning or abandonment and, on the other; Dad can stop the guitar lessons or insist on a strict regime of practice. To my mind, there can never be an equality of power between the SU and the Service Provider in these

situations – inevitably it comes down to the SU saying “I know what is best for me” and the professionals saying, “No, we know what is best for you.” And there is very little ground in between for meaningful compromise. As Nathaniel Lee famously put it on his admission to Bedlam: “They called me mad, I called them mad, and, damn them, they outvoted me!”

Foucault (1963), Goffman (1961) and Szasz (1972) had recognised the imbalance of power between patients and staff in psychiatric systems. This belief has endured over time and certainly is present in Dale’s understanding, if not his experience, at this particular time. Power, it would seem from Dale’s experience, can be changed in relation to a therapeutic relationship between ‘professionals’ and ‘service users’, but it is evident that it includes ‘empathy...and appropriate self-disclosure’ (Welch 2005 p. 161). Hopkins and Niemiec (2007) also found in their research that service users valued the worker ‘being almost like a friend’ (p.314). Winness *et al.* (2010) found that clients ‘appreciate flexible professionals who were open for negotiation and personal choices, and were interested in users’ own coping strategies and understanding of the situation’ (p.79).

Dale said that his friends recognised he was in crisis and that at that stage he could not see it. Dale did not identify a large social system of support during the interview but it is the utmost importance to maintain his place and keep him functioning within that social system. It is one of the cornerstones of CRHT to be grounded in social systems. For instance, going to see his solicitor was very important to him in accessing legal advice. They were also able to advise other professions when he did have to go into hospital, and he felt that made the transition less difficult. Sjolie *et al.*, (2010) found that it was essential to work together with the person’s family and network. Dale had a period of in-patient care whilst with the team. It

is hugely important to reassure, both emotionally and practically, anyone accessing in-patient services that their home is secure and safe and will still be there on their return.

In terms of power and the power dynamic, I have already commented on how the balance between empowerment and responsibility in the CRHT team's approach was fundamental to my engagement and success with them. I think it is important that I point out how rare this has been in my 25 years' experience of mental health services. It is far more common for a service user to find themselves powerless, unheard and dictated to. Whilst at the turn of the millennium there were many initiatives to involve mental health service users in the provision of services and their individual care, these have largely gone by the way in the age of Austerity. Service users are once again mainly powerless, not only having to just put up with the cuts in their services, but increasingly being ordered about by the Department of Work and Pensions who presume to know more about their lives and difficulties than doctors.

Dale recognises that, during his period with CRHT, the power dynamic shifted, and that his role was valued in that partnership. On reflection, he questions how genuine that would be if he had not agreed with the plan and approach taken. In order to create a more genuine partnership, the power dynamic needs to be understood by health professionals.

Conclusion

Co-production is about developing services with people rather than for them (McCloughes *et al.*, 2011, Hicks *et al.*, (2015). The implication is that co-authorship can instigate this person-centred process through active participation of the SU with the service provider (Hicks *et al.*, 2015 p.18). The literature on CRHT is extensive and demonstrates that this type of approach

is internationally recognised. There is a gap in the literature regarding the service user's narrative experience of CRHT whereby they have the opportunity to tell their stories. There is limited research on how resilience can be built up as part of the function of the clinical team and, thus, this research builds upon the qualitative and narrative literature that is starting to emerge in this area [Hopkins and Niemiec (2007), Lyons *et al.*,(2009), Borg and Davidson (2008) and Middleton *et al.*, (2011)]. In terms of strengthening the service user perspectives and affecting policy positively, narrative accounts should hold as much credence as more quantitative studies. Single case analysis is relevant as it values the service user voice and can positively affect how CRHT teams function. Without doubt this experience will have resonance with all CRHT teams, either in terms of reassurance of what they do and how they do it, or in terms of 'food for thought'. Dale's experience of CRHT was generally very positive. He felt that he was practically, socially, psychologically and educationally supported by the team. An example of the relationship they built and the recovery principles it is based on was his recollection of them taking him to see his solicitor. This would not be considered an appropriate function by many mental health services, but as Dale was so concerned that he needed to see his solicitor he may not have been able to engage in the psycho-educational aspect of their work without his practical needs being prioritised. Staff reminded him of his strengths and helped build his resilience by considering what worked for him in the past and tried to facilitate those behaviours during his period of crisis. Deegan (2005) found that the 'concept of recovery and resilience shift clinician's attention away from the disease processes and onto the whole person in the life context' (p. 30). Resilience needs to be seen as socio-ecological and that it not the province of people labelled as 'service users'. CRHT teams can develop these skills by reflecting not just on practise but on themselves, hence addressing the shortcomings of having a normative approach to resilience. Deegan (2005) identifies a

concept called ‘personal medicine’ (p.29) and this fits into both recovery and resilience in recognising what can assist individuals in promoting their own mental health. Again this is not the province of a service user, but of all members of society. Resilience is developed through learning from experiences and, in Dale’s case, he described the CRHT team as ‘memory jogging,’ implying positive learning. However, he also recognised the difficulty in maintaining that learning whilst in an episode of crisis.

This paper has emphasised the importance of the service user’s voice in mental health, and specifically, in CRHT. It is as important to consider: Dale’s reflections on his original interview; resilience needs to be considered in relation to what the individuals experiences have been in the past and CRHT teams and mental health teams generally need to spend the time to understand that complexity and not take it for granted. In terms of recovery, it is about the individual discovering a different life, not reclaiming a previous one. Dale’s experience of power with the CRHT was positive as the team attempted not to take responsibility from Dale. But on reflection, he sees that this may not have been the case if he had not responded positively to their intervention. This balance of power, generally between SUs and mental health staff, is without doubt a feature of current mental health services, and health services generally, and this needs to be acknowledged for change to occur.

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