

**REACHING BREAKING POINT: A CONSTRUCTIVIST GROUNDED
THEORY OF SERVICE USERS' UNDERSTANDING OF CRISIS**

Ross Watson

2013

Supervisors:

Dr. Andrew Vidgen

Dr. Ella Rafferty

**Dissertation submitted in partial fulfillment of the requirement for the degree of
D.Clin.Psy. at Cardiff University and the South Wales Doctoral Programme in
Clinical Psychology**

ACKNOWLEDGMENTS

Firstly, I would like to thank the participants in the research project and those that showed an interest in the project but were unable to participate. To the participants: I am extremely grateful for the time you have given to be a part of the research project and the interest you have shown.

I would like to thank Andrew and Ella for their continued support and encouragement throughout the project. Their enthusiasm for the project and general positivity kept me motivated and on track every single part of the way. Thank you also for containing me during some of those more frantic moments.

I would also like to thank my cohort for their support and encouragement.

Finally, I would like to thank my wife Leah; your support, encouragement and constant offerings of refreshments kept me going. And above all, thank you for putting up with me spending so much time glued to the computer screen.

ABSTRACT

There is a growing body of literature that offers service users' views of mental health crises, based on their experiences. Our understanding of a crisis is beginning to develop based on their views, however, what is still unclear is how service users understand a crisis. Existing theories of crisis do not adequately address the personal meanings of experiencing a crisis to service users, which is a critical element within the CRHT framework. The current study therefore, set out to explore service users' understanding of a crisis and their ways of coping. Additionally, the current study aimed to consider the implications for service delivery at the level of the formal and informal systems surrounding the individual and how these aid the resolution of crises. Semi-structured qualitative interviews were conducted with nine service users across three Crisis Service settings in South Wales. A Constructivist Grounded Theory approach was taken to analyse the data. Five themes emerged from the data that related to the process of crisis development and crisis resolution: 'Moving towards crisis', 'reaching breaking point (crisis)', 'contact with services', 'after crisis' and 'what helps'. The emergent themes were compared to the wider literature on the experiences of service users in crisis, including qualitative research generated by a systematic review. The findings have implications for CRHT at the level of planning and implementation and for clinical practice in terms of assessment, formulation, intervention and evaluation. Recommendations for further research are discussed.

CONTENTS

	<i>Page</i>
CHAPTER ONE: INTRODUCTION	
1.1. OVERVIEW	1
1.2. THEORIES OF CRISIS	1
1.2.1. An individualistic perspective	1
1.2.2. Crisis within social systems	2
1.2.3. Crisis service definitions of crisis and crisis resolution	3
1.3. CRISIS SERVICE DEVELOPMENT	4
1.31 Historical context	4
1.4. CRISIS SERVICE IMPLEMENTATION	5
1.4.1 Strategic context	5
1.4.2 Expectations of crisis services in the UK	6
1.4.3 Crisis service models of implementation	6
1.4.4 Fidelity of CRHT teams within the UK	9
1.4.5 Evidence of outcomes	11
1.4.5.1 Methodological issues and findings	11
1.5. SERVICE USER EXPERIENCE OF CRISIS	13
1.5.1 Experiences of service users in crisis	13
1.5.2 Service users' descriptions of ways of coping	16
1.6. A SYSTEMATIC REVIEW OF SERVICE USERS' EXPERIENCES OF USING CRISIS SERVICES	17
1.6.1 Introduction	17
1.6.1.1 Contextualising the systematic review	19
1.6.2 Methods	19
1.6.2.1 Search strategy	19

1.6.3	Critical appraisal	22
1.6.4	Quality	32
1.6.5	Results	33
	1.6.5.1 Low quality studies	33
	1.6.5.2 Medium quality studies	34
	1.6.5.3 High quality studies	34
	1.6.5.4 Limitations	35
	1.6.5.5 Strengths	36
1.6.6	Findings	37
	1.6.6.1 Strengths of crisis services	37
	1.6.6.2 Limitations of crisis services	39
1.6.7	Discussion	40
1.7	STUDY RATIONALE AND AIMS	41
	1.7.1 Study rationale	41
	1.7.2 Study aims	42
	CHAPTER TWO: METHODOLOGY	44
2.1	OVERVIEW	44
2.2	QUALITATIVE METHODOLOGY	44
	2.2.1 Philosophical position	44
	2.2.2. Rationale for the Qualitative method	46
	2.2.3 Constructivist Grounded Theory	46
	2.2.3.1 Rationale for using a Constructivist Grounded Theory approach	47
2.3	ENSURING QUALITY	48
2.4	PERSONAL AND PROFESSIONAL REFLEXIVITY	50

2.4.1	Researcher’s position	51
2.5	DESIGN	52
2.5.1	Research Context	53
2.6	CLINICAL GOVERNANCE	54
2.6.1	Ethical approval	54
2.7	PARTICIPANTS	54
2.7.1	Informed Consent and Confidentiality	54
2.7.2	Sample	56
2.7.3	Inclusion Criteria	56
2.7.4	Participant demographics	57
2.8	PROCEDURE	58
2.8.1	Recruitment Procedure	58
2.8.2	Construction of Interview Questions	59
2.8.3	Interview Procedure	60
2.8.4	Data Recording and Management	61
2.9	DATA ANALYSIS	61
2.9.1	Transcription of interview data	61
2.9.2	Analysis of interview data	62
2.9.3	Triangulation of emergent analysis	64
	CHAPTER THREE: RESULTS	66
3.1	OVERVIEW	66
3.2	THEME ONE: MOVING TOWARDS CRISIS	68
3.3.	THEME TWO: REACHING BREAKING POINT (CRISIS)	72
3.4	THEME THREE: CONTACT WITH SERVICES	84

3.5	THEME FOUR: AFTER CRISIS	91
3.6	THEME FIVE: WHAT HELPS	94
3.7	SUMMARY OF FINDINGS	99
CHAPTER FOUR: DISCUSSION		101
4.1	OVERVIEW	101
4.2	RESEARCH FINDINGS AND THE EXISTING LITERATURE	101
4.2.1	Theme one: 'Moving towards crisis'	102
4.2.2	Theme two: 'Reaching breaking point (crisis)'	104
4.2.3	Theme three: 'Contact with services'	107
4.2.4	Theme four: 'After crisis'	109
4.2.5	Theme five: 'What helps'	111
4.3	COMPARING THE CONSTRUCTIVIST GROUNDED THEORY WITH THE CURRENT UNDERSTANDING OF CRISIS	112
4.4	IMPLICATIONS OF FINDINGS TO CRHT SERVICE IMPLEMENTATION AND DELIVERY	114
4.4.1	Implications for clinical practice	117
4.5	STRENGTHS AND LIMITATIONS OF THE CURRENT STUDY	118
4.6	RECOMMENDATIONS FOR FURTHER RESEARCH	120
4.7	CONCLUSIONS	121
REFERENCES		123

LIST OF FIGURES AND TABLES

<i>Figure</i>	<i>Page</i>
1. A Constructivist Grounded Theory of of service users' experience of crisis	67

<i>Table</i>	<i>Page</i>
1. Summary of studies included in the systematic review	23-31
2. Participant demographics	58

GLOSSARY OF TERMS

CRHT: Crisis resolution and home treatment

CRT: Crisis resolution team

Crisis Services: This is a broad term used to refer to crisis services as a whole and includes CRHT, Ambulatory crisis services (e.g. mobile crisis services), CRT and home-based crisis treatment services.

LIST OF APPENDICES

- I: SUMMARY OF SYSTEMATIC REVIEW PROCEDURE

- II: FRAMEWORK FOR CRITICAL APPRAISAL PROCESS OF SYSTEMATIC REVIEW

- III: EMAIL FROM AUTHOR OF RELEVANT RESEARCH

- IV: CARRS (CHAIR OF THE CARDIFF AND VALE RESEARCH AND REVIEW SERVICE) APPROVAL FOR THE SCIENTIFIC QUALITY OF THE PROPOSAL

- V: CARDIFF AND VALE LOCAL HEALTH BOARD RESEARCH AND DEVELOPMENT APPROVAL

- VI: DYFED POWYS RESEARCH ETHICS COMMITTEE APPROVAL

- VII: PARTICIPANT INFORMATION SHEET (VERSION FIVE)

- VIII: PARTICIPANT CONSENT FORM FOR INTERVIEW (VERSION FIVE)

- IX: REPLY SLIP FOR INTERVIEW (VERSION ONE)

- X: PARTICIPANT CONSENT FORM FOR FOCUS GROUP (VERSION ONE)

- XI: REPLY SLIP FOR FOCUS GROUP (VERSION ONE)

- XII: LETTER OF INVITATION TO PARTICIPANTS TO TAKE PART IN THE STUDY (VERSION ONE)

- XIII: LETTER OF INVITATION TO PARTICIPANTS TO ATTEND THE FOCUS GROUP (VERSION ONE)

- XIV: LETTER TO PARTICIPANT OFFERING AN APPOINTMENT
- XV: FLOWCHART OF RECRUITMENT PROCEDURE (VERSION THREE)
- XVI: INTERVIEW SCHEDULE (VERSION TWO)
- XVII: EXTRACTS OF INTERVIEW TRANSCRIPTIONS
- XVIII: EXTRACTS FROM REFLECTIVE LOG
- XIX: EXAMPLE OF MEMO WRITING
- XX: BUILDING THE GROUNDED THEORY
- XXI: LIST OF THEMES, CORE CATEGORIES, CATEGORIES AND SUBCATEGORIES
- XXII: NOTES TAKEN FROM THE FOCUS GROUP WITH PARTICIPANTS

CHAPTER ONE INTRODUCTION

1.1 OVERVIEW

This chapter sets out to examine theories of crisis and how crisis services have been defined, developed and implemented. Models of implementation as well as the evidence base for crisis services will be discussed and critically appraised. Then, the current literature on service users' experiences of crisis will be explored in order to highlight the gaps that the current study will address. A systematic review will follow, which will consider the state of the qualitative evidence of service users' experiences of using crisis services. Finally, the study rationale and aims will be discussed.

1.2 THEORIES OF CRISIS

1.2.1 *An individualistic perspective*

Caplan (1964) originally defined an individual crisis as '*an imbalance between the difficulty and importance of the problem and the resources immediately available to deal with it*' (p. 39). He conceptualised an alteration in normal functioning caused by a situation or force, where the usual mechanisms for restoring equilibrium and thus solving the problem, are unsuccessful. As an individual begins to experience an increase in tension caused by a lack of success in resolving the problem, the problem continues to persist, leading onto subjective states of discomfort (e.g. anxiety). Caplan (1964) considered that in the event these states of discomfort are not abated and if the problem continues without successful resolution then a crisis is experienced (Caplan, 1964). He suggested that a crisis would arise because the tension would likely extend

beyond a threshold where the individual is able to marshal their own resources to successfully resolve the crisis.

Caplan's view of crisis derives more from concepts of disease than health (Rosen, 1997) and appears to be less informative to current CRHT service models, which are considered to be atheoretical (Johnson & Needle, 2008). Rosen (1997) notes that Caplan's conceptualisation of crisis excludes clinical and cultural factors and is mostly theoretical speculation. A significant limitation to this theory is that it lacks consideration of the personal meanings of crisis to those who have experienced it. Understanding these meanings are far more salient in order for recovery-oriented services to thrive (Borg & Kristiansen, 2004) and a critical element within the framework of CRHT (Karlsson *et al*, 2008).

Rosen (1997) offered an expanded view of crisis that draws more on the context in which a crisis is experienced. In this way, his view moves towards acknowledging the complexities of environmental, cultural, biological and psychological factors that might influence the experience of crisis. This model has been adopted by The Sainsbury Centre for Mental Health (2001) and used to underpin the CRHT service model. Writing about crisis management in the community, Rosen (1997) conceptualised crises in terms of *developmental* (e.g. transition points in life that might be punctuated by severe and prolonged stress), *situational* (e.g. culture or situation specific) and *complex* (e.g. trauma, mental illness) crises. Taking a more systemic view, he considered that crises may not always be experienced as single events but may occur in a connected series within multiple social systems (Bridgett & Polak, 2003a).

1.2.2 Crisis within social systems

Borg *et al* (2011) highlighted the importance of considering the person-in-context when thinking about coping with and recovery from a mental health crisis. Bridgett & Polak (2003a) suggested that by conceptualising a crisis as a breakdown within a social system, interventions could be orientated towards the support systems around the individual. Viewing a crisis in this way means

thinking about the vulnerability of systems to internal conflict and their sensitivity to external stresses. If an individual is admitted into hospital following a crisis and if the social circumstances that led to the crisis still exist, then there is a risk that the crisis may be re-activated upon discharge (Bridgett & Polak, 2003a). Social systems interventions consider exploring the factors within the individual's social environment and identifying strengths and limitations in the social support (2003b).

Whilst these theories of crisis consider the various stages of crisis and a variety of determinants that likely contribute to a crisis, crisis services define a crisis by focusing more on an individual's existing mental health difficulties or 'mental illness'.

1.2.3 *Crisis service definitions of crisis and crisis resolution*

Minghella *et al* (1998) defined crisis resolution teams as those supporting people where '*their mental health has deteriorated to such an extent they are likely to be at risk of harm to themselves or others, and are in need of urgent intensive specialist support and treatment*' (p. 6). Whilst they identify the severity of risk as an indicator of the need for intensive support, The Sainsbury Centre for Mental Health (2001) denotes a crisis as a result of serious mental illness whereby the person becomes vulnerable or disabled to an extent that requires intensive psychiatric treatment.

Crises have also been viewed as periods where symptoms of a severe psychiatric illness are most intense and interventions are therefore required to provide support to help the individual to return to stability (National Audit Office, 2007). This definition in particular echoes that of Caplan's (1964) theory where stability and equilibrium might be considered synonymous. What is commonly stated across government policy is that a crisis is such that without intensive home treatment, hospital admission would be required (Department of Health, 2001).

In summary, there has been a noticeable shift in the usage of the term crisis (Johnson & Thornicroft, 2008). The classically defined crisis (Caplan, 1964) as a

non-illness response to severe stress (Rosen, 1997) is considered to be dated (The Sainsbury Centre for Mental Health, 2001) and evidence suggests that people with no diagnosable illness infrequently present to crisis services (Johnson & Thornicroft, 2008). CRHT service provision therefore, developed on an understanding of crisis as occurring from mental health difficulties that required urgent professional intervention (Johnson & Thornicroft, 2008).

The way crisis services have been defined, developed and implemented will now be discussed before considering the evidence base for CRHT. A brief overview of the history of CRHT development and implementation will be provided initially to set the context.

1.3 CRISIS SERVICE DEVELOPMENT

1.3.1 *Historical context*

The development of crisis resolution teams can be traced back to the 1970s where in the USA, UK and Australia, teams resembling the current structure and function of CRHT teams existed within specific services (e.g. Madison, USA; Barnet family service in the UK and the Sydney community service in Australia) despite previous developments in alternatives to acute admission across Europe (Johnson & Thornicroft, 2008). Across these teams, services offered home assessments and 24-hour treatment, including in one team (The Barnet family service in the UK) seeing patients with their families at their homes with the view to understanding the crisis via family processes that might have been contributing to it (Johnson & Thornicroft, 2008). The model of CRHT that exists today has gradually evolved from these early models, including the Madison model in the USA and the pioneering work led by John Hoult in Sydney, Australia, where results from studies of both these models provided favourable outcomes, largely in terms of symptom reduction (Hoult, 2006). Of particular note is the development of the Sydney crisis team, which initiated the development of mobile crisis teams in Australia (Smyth & Hoult, 2000). These mobile crisis services developed on the basis of local service needs rather than a theoretical

model of practice (Johnson & Thornicroft, 2008) and intervene to initially assess before referring to other services to continually manage the crisis (Allen, 1996).

CRHT was introduced in the UK as a potential solution to the challenge of delivering appropriate levels of care to people experiencing acute episodes of severe mental illness within the community (Murphy *et al*, 2012). There has been a rapid increase in the development and implementation of CRHT teams since the mid 1990s (Johnson & Needle, 2008) with the national rollout of CRHT teams in the UK starting in 2000 (Hubbeling & Bertram, 2012). At this point there were only a handful of teams in existence in the UK (The Sainsbury Centre for Mental Health, 2001) with an assumption that home treatment would be more cost-effective than hospital admission and treatment, despite a limited evidence base to support it (Hubbeling & Bertram, 2012). The following section presents the implementation of CRHT in the UK in more depth.

1.4 CRISIS SERVICE IMPLEMENTATION

1.4.1 *Strategic context*

In 1999, the government released a National Service Framework (Department of Health, 1999) which outlined that people with severe mental illness receiving mental health services should expect care that optimizes engagement, reduces risk, anticipates and prevents a crisis and is accessible 24 hours a day, 365 days a year. The following year, these intentions became a national priority in the form of *The NHS Plan* (Department of Health, 2000), after it was identified that admission to hospital for an acute mental illness was the only option for individuals across many areas (Department of Health, 2000). This government strategy called for 335 crisis resolution teams to be developed and delivered over the following three years. That meant that by 2004, access to CRHT services would be available for all individuals in contact with specialist mental health services. The capacity to deliver CRHT annually to 100 000 people, including those from ethnic minority groups, was set as a national target (National Audit Office, 2007). The central aims of the strategy were to avoid hospital admissions,

reduce pressure on acute inpatient wards by 30% and prevent unnecessary out of area admissions (Department of Health, 2000).

The publication of the strategy acted as a driver for the implementation of CRHT teams in the UK, despite the fact that detailed modeling of likely demand did not help derive the 100 000 episode target (National Audit Office, 2007). This might explain the slow start in the implementation of CRHT teams nationally, with the target finally being achieved in 2005 (Hoult, 2006).

1.4.2 *Expectations of Crisis Services in the UK*

CRHT is broadly conceptualised as a departure from treating individuals experiencing an acute psychiatric crisis in hospital, to providing assessment and treatment at the individual's home (Chisholm & Ford, 2004). The Mental Health Policy Implementation Guide (MH PIG) (Department of Health, 2001) outlined the intentions of the service, stating that individuals should be treated in the '*least restrictive environment as close to home as clinically possible*' (pg. 15). The guide defined CRHT as a rapid response service available 24 hours a day, seven days a week, providing intensive intervention and support, specifically during the early stages of a crisis, for adults (between 16 to 65 years old) with severe mental illness (Department of Health, 2001). As an alternative to hospital admission, CRHT teams were defined in their role as gatekeepers to mental health services, providing a community-based, multi-disciplinary service that actively involves service users, carers and family members. An emphasis was placed on providing a range of time-limited interventions that promote the service user's resilience and foster adaptation following a mental health crisis (Department of Health, 2001).

1.4.3 *Crisis Service models of implementation*

The MH PIG (ibid) (Department of Health, 2001) outlined the model of service delivery, which identified CRHT teams as discrete, specialist teams whose staff focused on managing individuals with severe mental illness in crisis. There

would be an adequate skill mix amongst staff, established links with other mental health services and each CRHT team would be accountable for 150 000 people, accommodating 20-30 service users at one time (Department of Health, 2001).

The model of service delivery was characterized by four phases; *assessment*, *planning*, *intervention* and *resolution*. *Assessment* was defined by a rapid, problem solving approach whilst *planning* was characterised by a flexible care planning approach that considered the input from service users and carers/family. *Intervention* identified the high frequency of contact with service users and ongoing risk assessment and management. This phase also included delivering practical support, relapse prevention and considered those interventions likely to result in increased resilience (e.g. stress management and brief support counselling). Wolkon (1972) suggested that greater outcomes could be achieved at the end of treatment where interventions are delivered as close to the occurrence of a crisis as possible. *Resolution* was characterised by ensuring service users have a good level of understanding about why their crisis occurred, have explored various coping strategies and are offered the opportunity to share their views about the service (Department of Health, 2001).

Acting as gatekeepers to admission, crisis services were operationally defined to exclude individuals presenting with mild anxiety disorders, alcohol or substance misuse, organic disorders, learning disabilities, personality disorder, self harm not associated with psychosis or a severe depressive illness and social or relationship difficulties (Department of Health, 2001). The publication of *No Longer A Diagnosis of Exclusion* (Department of Health, 2003) however, encouraged mental health services to develop specialist teams to meet the needs of individuals with a diagnosis of personality disorder in crisis.

In Wales, three crisis teams were first developed in 2002 with all other teams developed and implemented between 2005 and 2007 (Jones & Robinson, 2008). The implementation of CRHT teams in Wales was identified as a health priority

by the Policy Implementation Guidelines (PIG) for Wales (Welsh Assembly Government, 2005).

The PIG (ibid) (Welsh Assembly Government, 2005) stipulated that although there would be no set structure and that a flexible design would best meet local need, CRHT services should meet the underpinning principles to achieve service delivery objectives. These objectives were; *CRHT services should work through crisis to the point of resolution, offer a range of interventions adopting a holistic approach, address social issues and support individuals in learning how to improve their mental health through collaborative practice.*

In a review of the literature that discusses the structure of CRHT services and based on their findings, Sjølie *et al* (2010) suggest that the ideal model of CRHT advocates for flexible criteria and standards and individual multi-disciplinary teams offering a range of mental health interventions. Additionally, Rosen (1997) argued for interventions to focus more on supporting individuals to learn from the crisis experience, which reflects the recovery model in empowering the individual to gain more control over their own life (Borg & Kristiansen, 2004). Rosen (1997) envisaged the community (e.g. Police, Counsellors, General Practitioners, Community Workers) and not solely psychiatric services in playing a key role in this, through formal and informal crisis support structures.

It is widely suggested that by understanding more about the role of CRHT teams in the treatment of individuals experiencing severe mental illness, services are better able to meet the needs of service users' at times of crises (e.g. Murphy *et al*, 2012). Understanding the experiences of service users at the point of contact with crisis services as well as their journey through the service, is also critical to practice innovation and development (e.g. Gullslet *et al*, 2010). In Wales for example, the service user experience is placed at the heart of the service model in the PIG (ibid) (Welsh Assembly Government, 2005).

Winness *et al* (2010) make an interesting point, suggesting that if an individual who is experiencing a crisis is extracted from their everyday life context to a

hospital setting, the opportunity to bolster their capacity to be an active agent in managing life stressors is taken away and the problem very quickly becomes a medical one, overshadowed by the hospital context. They propose that further research should examine service users' theories of crisis in order to offer service providers a better platform from which to cultivate effective response strategies. This study aimed to do just that; to explore service user's constructions of crisis based on a constructivist grounded theory approach that would support the process of accessing a deeper level of understanding as well as a richer source of evidence.

In terms of fidelity, there were suggestions that in clinical practice for example, CRHT teams focused more on alternatives to hospital admission rather than on severe mental illness as a threshold for accepting people (Chisholm & Ford, 2004). Smyth (2003) in fact argued for an improved acute service, which would be achieved through structured collaborative practice. By integrating the best elements of both CRHT and inpatient care, Smyth (2003) postulated that acute services would then be able to respond to a range of crises not necessarily only involving severe mental illness and inpatient care services would become more aware of community and social issues. The following section identifies further fidelity issues relating to the implementation of CRHT teams in the UK, following the publication of the MH PIG (ibid) (Department of Health, 2001) and PIG (ibid) (Welsh Assembly Government, 2005).

1.4.4 *Fidelity of CRHT teams within the UK*

The number of CRHT teams implemented within England had doubled from 61 to 125 teams between 2002 and 2003 (Glover *et al*, 2004). During this period however, the criteria that appeared most difficult to achieve was the provision of access to services 24 hours a day, seven days a week (Glover *et al*, 2004). This is particularly significant given that the expressed wishes of service users and carers were for the availability of freely accessible, 24-hour services (Minghella *et al*, 1998).

Onyett *et al* (2006) conducted a survey in England between 2005 and 2006 to identify the fidelity of CRHT teams to the expectations set out in the MH PIG (ibid) (Department of Health, 2001). Overall, they found an underachievement of staff and caseload with only 40% of the 243 teams identified, describing themselves as fully set up. Furthermore, 67% of the CRHT teams offered a service that was available 24 hours a day despite the criteria set by the MH PIG (ibid) (Department of Health, 2001) for high accessibility. Onyett *et al* (2006) also identified that the majority of the workforce were community nurses (54%) with psychology and psychiatry only constituting 0.4% and 2.6% of the workforce respectively. Psychiatry in particular, was not considered a significant component to CRHT service provision (Hogan, 2000).

Similarly to the survey conducted in England, Jones and Robinson (2008) conducted a survey to identify CRHT service provision in Wales between 2007 and 2008. They established that CRHT teams only existed in certain parts of Wales, there were limited alternatives to hospital admission and only 20% of the established CHRT teams offered 24 hours a day service provision. There was a majority consensus amongst the CRHT teams that stated the reason for being unable to meet the minimum government recommendations requirements was due to a lack of resources (Jones & Robinson, 2008). In England, the obstacles to implementation included a lack of training opportunities, lack of medical cover and problems between teams (e.g. CMHT capacity issues) (Onyett *et al*, 2006).

Hoult (2006) offered an explanation to why CRHT teams in many places were not meeting the implementation targets, suggesting that inefficient funding of teams resulted in too few staff to meet demand. Between 2002 and 2007, there was a rapid increase in spending on implementing CRHT services in England and Wales although regional variations have meant differences in service structure (Jones & Jordan, 2010). Furthermore, Johnson and Needle (2008) suggested that managers of CRHT services tend to prioritise practical ways of resolving difficulties in relation to their local areas.

These issues with fidelity raise important implications for the experiences of service users in crisis and present a context in which the current study aimed to explore. Before considering the existing literature that describes service users' experiences of both a crisis and using crisis services, the evidence that identifies outcomes of CRHT will be presented.

1.4.5 Evidence of outcomes

The existing evidence comprises the effects of CRHT on hospital admission, the cost-effectiveness of CRHT and service users' satisfaction with using crisis services. The service settings in which outcomes and service user satisfaction have been measured vary between emergency psychiatric services (Ruggeri *et al*, 2006), inpatient care (Keown *et al*, 2007; Osborn *et al*, 2010) and crisis services of varying description (e.g. mobile crisis services, CRHT) (Barker *et al*, 2011; Johnson *et al*, 2005a; Johnson *et al*, 2005b; Robin *et al*, 2008; Scott, 2000). The main methods used by studies measuring outcome and satisfaction included structured satisfaction questionnaires (e.g. the Client Satisfaction Questionnaire) (Ampélas *et al*, 2005; Khan & Pillay, 2003; Kalucy *et al*, 2004; Baronet & Gerber, 1997); data collected on psychiatric admissions (Jethwa *et al*, 2007; Keown *et al*, 2007) and comparative studies measuring service users' satisfaction between crisis services and standard inpatient care (Khan & Pillay, 2003; Osborn *et al*, 2010; Robin *et al*, 2008; Johnson *et al*, 2005b).

The evidence will not be reviewed in detail as this is not a main focus of the current study however, key methodological issues and findings will be presented.

1.4.5.1 Methodological issues and findings

The key methodological issues related to a lack of randomisation (Robin *et al*, 2008; Johnson *et al*, 2005a; Osborn *et al*, 2010) and limited generalisability (Johnson *et al*, 2005a; Johnson *et al*, 2005b). Studies that assessed the impact of CRHT on hospital admissions identified methodological limitations through not

having a suitable control group (Barker *et al*, 2011; Jethwa *et al*; 2007). There was also evidence of limitations in studies that assessed service user or carer satisfaction with crisis services, such as cultural differences in communicating satisfaction (Ruggeri *et al*, 2006) and lack of reliability or validity checks on predictor variables (Baronet & Gerber, 1997). As well as limitations there were also methodological strengths such as good external validity (Jethwa *et al*, 2007; Johnson *et al*, 2005a).

In terms of findings, home-based crisis resolution and treatment has demonstrated a reduction in inpatient admissions (Barker *et al*, 2011; Jethwa *et al*, 2007; Johnson *et al*, 2005a; Johnson, *et al*, 2005b; Keown *et al*, 2007) and length of admission (Barker *et al*, 2011; Robin *et al*, 2008), facilitated earlier discharge (Kalucy *et al*, 2004) and been proven cost effective (Scott, 2000) whilst still providing a similar standard of care to inpatient services (Kalucy *et al*, 2004).

There is also evidence of service users' satisfaction with home-based or community-based crisis services (Ampélas *et al*, 2005; Khan & Pillay, 2003) over and above standard care (Osborn *et al*, 2010; Ruggeri *et al*, 2006). Satisfaction appeared to be related to less coercion and negative pressures (Osborn *et al*, 2010), building a therapeutic alliance with staff (Baronet & Gerber, 1997), avoidance of stigma associated with hospital admission (Khan & Pillay, 2003), greater levels of autonomy (Osborn *et al*, 2010) and service users being able to practice their faith in an acceptable environment (Khan & Pillay, 2003). Furthermore, including service users in decisions that invite them to feel empowered in their recovery is likely to receive positive feedback (Winness *et al*, 2010).

Murphy *et al* (2012) found inconclusive evidence about the effectiveness of CRHT on hospital admission rates in a review of the effects of crisis intervention models in comparison to standard inpatient care. They suggested that differences in the applicability of 'crisis intervention' between services may account for the variations in effectiveness. Whether CRHT teams offer unique

services for service users in crisis or whether aspects of home treatment are already embedded within traditional mental health treatment (Burns, 2000), service users appear to benefit from a broad range of services (Mental Health Foundation, 2002).

Having discussed the theories of crisis, how crisis services were conceptualized, developed and operationalised and the evidence of outcomes and satisfaction with CRHT compared to standard care, the following sections will now focus on the service user experience of crisis.

1.5 SERVICE USER EXPERIENCE OF CRISIS

The experiences of service users in crisis are beginning to emerge in research, spearheaded by the extensive work by The Sainsbury Centre for Mental Health and other third sector organisations such as MIND. The following section identifies key, existing research that explores the experiences of service users in crisis in order to examine the current knowledge base and highlight the gaps in research that the current study aimed to address. Service users' ways of coping with distress prior to or during a crisis will be also be presented.

1.5.1 *Experiences of service users in crisis*

Our knowledge and understanding of the experiences of service users in crisis is developing as the evidence base is beginning to emerge, however, there is a recognised need for research to address this phenomenon (Winness *et al*, 2010). The importance of the service user experience has been considered in the provision of values driven services (Woodbridge, 2006) and has been advocated as the driver for CRHT service development (Minghella, *et al*, 1998; Rose, 2001; MIND, 2011). In recognition of the need to understand more about the theories of crisis from the service user perspective so as to improve current practice (Winness *et al*, 2010), the current study aimed to explore service users' constructions of crisis. The aims of this study were to build upon existing research that had begun to examine service users' experiences, views and

definitions (Borg *et al*, 2011; Bristol MIND, 2004; MIND, 2011; National Audit Office, 2008).

Service users have reported their experience of crisis as a feeling (e.g. depression, despair, powerlessness) or a reaction to a life event (Bristol MIND, 2004) and as either a gradual (e.g. a build up of thoughts and feelings without feeling able to share them) or an instantaneous event (e.g. sudden and unexpected) (Borg *et al*, 2011). The causes of crisis from the perspective of service users have included low self-esteem/confidence, family or relationship problems and traumatic experiences (Bristol MIND, 2004). Service users have also described how talking to other people about their emotional experiences leading up to crisis can be problematic because of the anticipated consequences of sharing experiences with professionals (e.g. worry of being sectioned or not taken seriously) (Bristol MIND, 2004). Service users have expressed ambivalent views about sharing emotional experiences with family members, as this could lead to family members becoming enmeshed in the crisis situation (Borg *et al*, 2011). In particular, there is evidence that a crisis can have a significant impact on how the needs of children are met (Khalifeh *et al*, 2009).

In terms of the experiences of service users receiving CRHT, there is some evidence that suggests that by providing acute mental health care in the service user's own home, it is more likely that feelings of normality (e.g. by continuing social roles) and safety will be experienced and better chances of sustainable recovery will be achieved (Borg *et al*, 2008). Interested in examining the 'state' of knowledge of the experiences of service users using CRHT, Winness *et al* (2010) conducted a systematic review of the CRHT literature for the period between 1995 and 2009. Their review identifies some of the experiences of service users in crisis and from their findings, they extrapolated three central themes; *access and availability, being understood as an ordinary human being and dealing with crisis in an everyday life context*. They included both quantitative and qualitative studies with a range of methodologies and sample of participants and what they discovered was that for service users to describe their experiences of using crisis services as positive, they needed to feel that they could access services as and

when they required them. Asking for this level of flexibility might well reflect the diverse, unique and unpredictable experiences of crises that service users describe (Borg *et al*, 2011). Winness *et al* (2010) found that access and availability were not the only critical elements that would contribute towards positive experiences of CRHT support at times of crisis. Being treated respectfully, which included being listened to, trusted and taken seriously, were equally valued by service users. From their findings, Winness *et al* (2010) suggested that empowering service users to take responsibility in their own recovery process might strengthen their sense of self-control and improve recovery (Winness *et al*, 2010). Furthermore, being treated at home might offer service users continuity in their lives (Kalucy *et al*, 2004).

What these key studies show is that for service users, experiences of crises can be debilitating within the context of their everyday lives. The way CRHT services are structured and delivered should address the issues that crises can present to service users (e.g. in disclosing their feelings to other people). CRHT services might maximize positive experiences by basing service planning and delivery on what service users have reported that they need.

For the purposes of the current study, these key studies also highlight several gaps in the research. Whilst Borg *et al*'s (2011) study provides a useful insight into the meanings of the subjective experiences of crisis for service users, there are some gaps in our understanding. For service users who experienced a crisis as a sudden event, what *sense* was made of what was happening and what did they think might happen next? Also, more generally, at what point does it become unmanageable for service users to cope? Furthermore, given the difficulties that disclosing to other people can present, what impact does this have?

1.5.2 *Service users' descriptions of ways of coping*

Coping is not the main focus of the current study therefore, coping as relevant to crisis and service users' views on coping with distress will be considered¹.

Knowing our own minds (Faulkner, 1997) and *Strategies for living* (Faulkner & Layzell, 2000) described service users' needs and strategies when faced with mental distress. What service users found helpful in terms of strategies included maintaining relationships with others (which helped towards feeling a sense of acceptance) and personal strategies (e.g. positive thinking). In addition to these strategies, the presence of children offered service users a reason for living. What service users have reported that they felt they needed when in distress included emotional support, acceptance, control and to find meaning in their experiences (Mental Health Foundation, 2000). What appears to be most important for service users is having someone to talk to, support and time to relax (Mental Health Foundation, 1997). Other ways of coping include contact with family or friends, keeping busy, doing nothing, using substances, exercise and contacting professionals (Bristol MIND, 2004). What is less known is *why* these strategies are important and at what stages, either prior to or during a crisis, are they most or least effective.

Service users have identified that when in crisis, what they need most is to be understood, feel supported, be within a safe environment as well as feel empowered to make their own choices (Agar-Jacomb & Read, 2009). The National Audit Office (2008) called for more research on service users' experiences of CRHT and Winness *et al* (2010) have provided a useful account of these experiences. However, the drive towards understanding service users' experiences of receiving CRHT in times of crisis (e.g. Department of Health, 2001) is likely to be best met by considering the qualitative evidence over and above outcome and satisfaction studies that say little about *why* the experiences have been positive or negative and what the essential ingredients are to providing positive experiences and aiding in successful resolutions of crises. In

¹ For a theory of Coping, see Lazarus & Folkman, 1984.

addition, it is unclear from Winness *et al's* (2010) review as to the quality of the findings presented by the studies and what conclusions we can confidently draw from the evidence base. Therefore, in light of these issues, a systematic review of the qualitative literature in relation to service users' experiences of CRHT was undertaken.

The previous sections have identified and critiqued existing theories of crisis, discussed the history of the development and implementation of CRHT and considered the evidence in support of CRHT. The emerging literature on service users' experiences of crisis has been considered and the following section will examine the literature that discusses service users' experiences of CRHT, in support of the current study.

1.6 A SYSTEMATIC REVIEW OF SERVICE USERS' EXPERIENCES OF USING CRISIS SERVICES

1.6.1 INTRODUCTION

The aims of this study were to explore service users' constructions of crisis in order to reach an understanding of *how* service users make sense of their crisis experiences and *what meaning* they attach to their experiences. This study is timely in that research is needed to provide an understanding of how these meanings might influence the service process and affect outcomes (Winness *et al*, 2010). A review of the literature revealed that following the implementation of CRHT teams within the UK, the trend in research has predominantly focused on the effectiveness of CRHT from an organizational level (e.g. in terms of cost-effectiveness and reductions in hospital admission) (see for example, Hubbeling & Bertram, 2010). Most of the existing research on CRHT is outcome-based, although over the last ten years, studies have emerged exploring the experience of using crisis services from the service user perspective. These studies are more congruent with the service user movement, which advocates for the preferences of service users to be considered at the service development level (Chisholm & Ford, 2004) and suggests that hospital admission rates would diminish if service

users received what they were asking for (Rose, 2001). User-led research is becoming more frequent (e.g. Middleton *et al*, 2011) as it is considered to align to a significant cultural shift in health care reform by championing service user involvement (Taylor *et al*, 2012).

For current practice to improve, there is a recognised need to move towards examining the 'state' of knowledge around the experiences of service users using crisis services (Winness *et al*, 2010). Therefore, a systematic review was conducted to identify what the experience of using crisis services is like, from the perspective of service users. Only qualitative studies were selected on the basis that they would provide more insight into service users' experiences of service processes than outcome studies would. Whilst much is known about whether home treatment is effective from an organisational perspective, what is beginning to emerge is *why* service users report satisfaction with crisis services. Furthermore, recent systematic reviews have been conducted that examine the state of the evidence for satisfaction and outcome studies (Hubbeling & Bertram, 2012; Winness *et al*, 2010).

This critical review aimed to update the review by Winness *et al* (2010) and provide a critique of the quality of the current research carried out to explore the experiences of service users using crisis services. This was achieved by purposively focusing on qualitative studies; expanding the search by reviewing studies published between 1990 and 2013; accessing a broader range of databases and Journals; and by including crisis houses within the review, given the emerging evidence that some service users report a preference for treatment at crises houses above treatment at home (Khalifeh *et al*, 2009). In order to provide a context for this review, the procedures Winness *et al* (2010) carried out will be detailed here before moving on to a description of the procedures used in this current review.

1.6.1.1 *Contextualizing the Systematic Review*

Winness *et al* (2010) conducted a comprehensive review and found 16 relevant articles, published between 1995 and 2009 that specifically presented service users' experiences of any home-based crisis service whose primary goal was to circumvent hospital admission. A range of keywords were used that specified two key search terms ('crisis resolution' and 'service user experiences'). The databases and keywords used by Winness *et al* (2010) were also used within this current review. The studies within their review were analysed to draw out findings related to what service users found helpful about CRHT involvement and how they coped with crisis. The findings were presented with reference to three themes that were identified from the studies, however, the authors did not offer a critical review of the quality of the studies. Therefore, this current review aimed to present the findings using quality as a framework, in order to provide evidence of the 'state' of current knowledge in this area.

1.6.2 METHODS

1.6.2.1 *Search Strategy*

Appendix I illustrates the systematic review process. To identify articles, a number of key procedures were carried out. Initially, articles were identified using searches within the OVID SP, CINAHL, SCOPUS and ISI databases to identify specific articles that yielded empirical research on *the experiences of service users using crisis services*. Searches within OVID SP were conducted using 'PsychoINFO', 'Psycharticles Full Text', 'Ovid Medline (R)', 'Embase' and 'Cardiff University Full Text Journals'. All Searches applied the same search terms and Boolean operators used by Winness *et al* (2010) (crisis resolution OR crisis assessment OR intensive home treatment OR home treatment AND user experiences OR user perspective OR client attitudes OR subjective experiences OR patient satisfaction OR consumer satisfaction OR client satisfaction) and further, additional search terms were incorporated (*experience**, *view**, *perspective**, *features*, *indicators*, *signs*, *difficulties*, *issues*, *warning signs*, *living*,

symptoms, risk factors, clues, impact, mental health, mental health crisis, crisis, support, service*, acute, psychiatric, hospital, admission, section*, screening, primary care, assessment, intervention and resolution*). These terms were searched as keywords and applied to the titles and full texts of articles that were generated. Articles were limited to the English language and published after 1990.

The search was conducted on the 5th November 2012 and generated 1133 articles in total. These articles were initially reviewed manually and screened by looking at their titles and abstracts, using the following inclusion criteria:

- All literature from 1990 - Current
- Article on service user experience and/or satisfaction from help/support by crisis services (as defined by Winness *et al*, 2010)
- UK and International research
- Mental health/psychiatric crisis (see exclusion criteria)

The definition of crisis services adopted by Winness *et al* (2010) was used which states that 'crisis services are defined as any home-based crisis service whose goal is to avoid hospital admission and facilitate earlier discharge'. Studies of participants recruited from Crisis Houses met inclusion criteria based on the function of this service, which is to offer an alternative to hospital admission for this client group.

At this stage, articles were screened based on whether their titles were relevant to the review question (*i.e. what are service users' saying about their experiences of using crisis services*). The abstracts of articles were read in cases where titles of articles were ambiguous or did not offer enough information to make a decision to retain. Following this initial review, 136 articles were retained and a second review was carried out manually by looking at the titles, abstracts and full texts (if further information was required). Articles at this stage were excluded using the following criteria:

- related crisis to accidents, catastrophic disasters, medical crises or substance use
- child, adolescent and older adult studies
- carers' or providers' views of crisis
- duplicate articles

57 articles remained after applying the inclusion and exclusion criteria. Full texts of articles were then reviewed manually and articles were further excluded on the basis of:

- no primary data
- quantitative studies (e.g. outcome studies, service evaluations that did not employ qualitative methods of data collection)
- article reports service users' experiences of crisis but not their experiences of *using* crisis services

In order to account for any additional articles that may not have been generated within the searches applied to the databases, further searches were conducted using SCIRUS, The Cochrane Library, Google, Google Scholar, several third sector organisations involved in CRHT research and crisis support (e.g. MIND, The Sainsbury Centre for Mental Health, The Mental Health Foundation), government policy and reports (e.g. National Audit Office) as well as several key journals (British Journal of Nursing, The British Journal of Social Work, Journal of Mental Health, Brief Treatment and Crisis Intervention, Stress, Trauma and Crisis, Crisis: The Journal of Crisis Intervention and Suicide Prevention). The reference lists and citations from key articles were also examined and this additional review process yielded two further relevant articles.

One of the articles (*'Mental Health Crisis – Experiences and Strategies in Everyday Life'*) was still in progress at the point that the review was carried out and was therefore unavailable (M. Gullslet, personal communication, 8 January 2013). The same author of this article was further contacted to request the data from the study, so as to confirm if it would meet the inclusion criteria for the review

but they were unable to provide the data (see Appendix III). The abstract was available, however, it was decided not to include the study in the review on the basis that the abstract did not offer enough information to provide a sufficient critique.

The second study (*'Breaking point or turning point? Service users' views and expectations of mental health crisis resolution and home intervention services: a qualitative study'*) which was identified via the reference list search, had been published by MIND who were contacted directly to request a copy of the article. They were unable to retrieve a copy from within their archives and therefore the study was not included.

Following an in-depth reading of the articles that met the inclusion criteria for the review, one article was excluded on the basis that it specifically examined the crisis experiences of service users rather than explore service users' experiences of using crisis services (Borg *et al*, 2011). A second search was conducted on the 29th April 2013 and there were no additional articles found. A total of 14 papers were then retained for the review.

1.6.3 *Critical Appraisal*

Table 1. shows the studies that were retained for the systematic review and provides a summary of the aims, methodology and findings of each study. The critical appraisal involved assessing the quality of the studies selected for the review. There were three approaches to the critical review:

- i) appraisal of quality, considering strengths and limitations of studies
- ii) review of studies discussing samples, methods and results
- iii) synthesising the findings

The results section of this review will be structured according to these approaches.

Chapter One: Introduction

Table 1. *Summary of studies included in systematic review*

No.	Author(s)	Aim	Participants	Method (design, data collection and analysis)	Findings	Comments	Quality
1	<p>National Audit Office (NAO) (2008)</p> <p>Conducted in the UK (England)</p> <p>Service Setting: CRHT teams across England</p>	<p>To examine service user and carer experiences of CRHT services and consider the implications for future service development.</p>	<p>No specific participant information provided.</p> <p>Service user participants formed three of six focus groups.</p> <p>Service user and carer satisfaction survey data were collated to inform framework of data.</p>	<p>The NAO gathered all available satisfaction survey documentation on 29 CRHT teams across England.</p> <p>Six focus groups were conducted by an advisory service (three with service users and three with carers).</p> <p>NAO performed secondary analysis on data provided by MIND (a number of focus groups exploring service users' experiences of in-patient services between 2004 and 2005).</p> <p>Transcript data from focus groups were used as additional data and along with survey material, were analysed using framework analysis.</p>	<p>Key elements of CRHT interventions included personal engagement, practical help, level of involvement and information-giving.</p> <p>Key factors affecting service users' experiences of CRHT included continuity of care (e.g. knowing which staff members will visit), phone contact, the home as a context for care and the team's capacity to deliver a service appropriate to needs of service users (e.g. brief visits or a focus on medication rather than practical support).</p>	<p>No evidence of reflexivity.</p> <p>Little information provided on service user sample, how they were recruited (e.g. inclusion criteria not described) or how focus groups were facilitated and by whom.</p> <p>No evidence of having received ethical approval or informed consent obtained.</p>	<p>7/20</p> <p>Most criteria scored 0 apart from Aims, Study Design, Data collection, Analysis & Discussion</p>
2	<p>MIND (2011)</p> <p>Conducted in the UK (England & Wales)</p> <p>Service Setting: CRHT teams across England & Wales</p>	<p>To conduct an inquiry into the state of acute care in England and Wales.</p>	<p>Approximately 350 people responded to a call for evidence. The majority of respondents included service users with experience of acute and crisis care, as well as family members and staff members.</p>	<p>MIND commissioned independent panel (which included three individuals with experience of using mental health services) to carry out inquiry. They held a call for evidence (hosted on website and promoted via networks), held seven hearings (which included experts by experience, crisis team staff and representatives of other organisations). The panel members and MIND staff also visited a range of services, groups and individual experts.</p>	<p>Positive experiences reported (friendly, caring, team responding to little changes in mental health) and negative experiences (capacity of teams, effectiveness of their help, difficulties making contact, lack of continuity and consistency of staff involved in care of service user).</p> <p>Crisis houses were seen as calmer and more personal than in-patient units.</p>	<p>No evidence of inquiry having received ethical approval or informed consent obtained.</p> <p>Unclear of the service user representation from the sample or any information regarding the service user sample (e.g. ethnicity, gender, age).</p> <p>Unclear how data were collected and analysed.</p> <p>Not all quotes are identified as provided by service users</p>	<p>8/20</p>

Chapter One: Introduction

						<p>therefore difficult to ascertain if reports are from a service user, carer or family member.</p> <p>Not all themes are substantiated by direct quotes meaning the reader is only privy to the interpretation of the author(s). No evidence of reflexivity.</p>	<p>Most criteria scored 0 apart from Aims, Literature Review, Study Design, Sampling & Discussion</p>
3	<p>Karlsson, Borg & Kim (2008).</p> <p>Conducted in Norway.</p> <p>Service Setting: Single CRHT team</p>	<p>To explore the processes within and examine the development of, CRHT teams as well as service users' experiences of the CRHT team.</p>	<p>Seven service users (five women and two men), who were included on the basis of having had contact with the CHRT service at least twice in last year, ended contact within last six months, had been hospitalised at least twice in last five years and had experience of a severe mental illness.</p>	<p>Qualitative retrospective study design.</p> <p>In-depth interviews; data based on verbatim transcriptions from interviews.</p> <p>Data analysed using hermeneutic content analysis.</p>	<p>Three themes derived ('Sense of Control', 'Opportunities for Participation', 'Being Seen and Heard').</p> <p>Service user control, participation and dignity are especially important in crisis resolution.</p> <p>Authors discuss framework for development of CRHT which includes using knowledge of how CRHT works from service user perspective and understanding service users' experiences and views of receiving CRHT care.</p>	<p>Unclear how participants were recruited and study does not provide demographic information therefore results may not be generalisable.</p> <p>No evidence of study having received ethical approval or informed consent obtained.</p> <p>No evidence of reflexivity or reliability/validity processes.</p> <p>Some integration of findings into framework for the development of CRHT teams although authors don't discuss the findings in much depth.</p>	<p>12/20</p> <p>Most criteria scored 0-1 apart from Aims, Literature Review, Study Design & Analysis</p>
4	<p>Middleton, Shaw, Collier, Purser & Ferguson (2011).</p> <p>Conducted in UK (England).</p> <p>Service Setting: Nine CHRT teams across a mixed urban/rural population</p>	<p>To investigate the experiences of receiving care from a CHRT.</p>	<p>36 service users newly referred to a CHRT within two-week census period (13 males with a mean age of 42.9 years; 23 females with a mean age of 44.3 years).</p>	<p>User-led qualitative research (people identifying themselves as having significant experiences of receiving care from mental health services or of providing care).</p> <p>Series of focus groups attended by service users and carers identified semi-structured interview schedule. Three interviews were not audio</p>	<p>Service user researchers: six themes denoting experiences as positive (e.g. reassurance, practical support). Four themes denoting experiences as negative (e.g. lack of continuity, unhelpful attitudes).</p> <p>Post-doctoral social scientist: Three</p>	<p>Conclusions drawn from findings enhanced by triangulation.</p> <p>Not clear how participants were recruited.</p> <p>No evidence of informed consent obtained.</p> <p>No evidence of consideration of limitations of study or</p>	<p>15/20</p>

Chapter One: Introduction

				<p>recorded (e.g. due to unsatisfactory recording or inadequate service user views captured in interview).</p> <p>Transcripts analysed by two parallel processes (one by group of service user interviewers; other by post-doctoral career social scientist. Broadly defined grounded theory (avoiding a priori assumptions) approach used.</p>	<p>overarching themes ('Safe', 'Accepted', 'Understood')</p> <p>Contact with CRHT was perceived as helpful if resulting in experience of feeling understood and unconditionally accepted. Contact was unhelpful if this experience was undermined in any way.</p> <p>Authors observed that having service users as interviewers led to participants giving full accounts. They discuss elements of helpful relationships <i>as</i> the therapy.</p>	<p>recommendations based on the findings.</p>	<p>All criteria scored between 1-2</p>
5	<p>Agar-Jacomb & Read (2009)</p> <p>Conducted in New Zealand.</p> <p>Service Setting: Urban inpatient unit</p>	<p>To explore the crisis needs of service users and level of support for alternatives to hospitalisation.</p>	<p>78 service users discharged from an urban inpatient unit completed questionnaires (32 male, 43 female; ages ranging from 23 to 69 years; mixed ethnicity of sample representative of population; number of previous hospital admissions ranged from one to more than ten admissions).</p> <p>Ten service user participants were selected via the questionnaires for interviews, using criterion sampling (i.e. range of views about desirability of alternative to hospitalisation; balance of ethnicity and gender;</p>	<p>Qualitative and quantitative retrospective study design.</p> <p>500 consecutively discharged service users from an urban inpatient unit were sent open-ended questionnaires, which asked about their experience of staying in hospital and what they would consider important to help them with a similar crisis in an alternative place. Other questions drawn from an adapted Patient Request Form.</p> <p>Semi-structured interviews were similar to questionnaires but with probes (e.g. experiences of crisis). First author primary interviewer and Maori Clinical Psychology student interviewed Maori participants.</p>	<p>Six main themes derived.</p> <p>What service users reported that they needed when in crisis is to be in a safe, pleasant environment and to have a break; to receive respect, holistic support and understanding and to be able to talk about what's going on; to be given choices and to have a sense of autonomy and involvement in support plan.</p>	<p>No annotations by quotes to contextualise them, meaning the narrative feels disjointed.</p> <p>No evidence of study having received ethical approval or informed consent obtained.</p> <p>Authors recognise influence of researcher on interviews and data analysis may affect validity of findings.</p> <p>Representative sample.</p>	<p>16/20</p>

Chapter One: Introduction

			<p>service user representation).</p> <p>Interview sample (four male, six female; ages ranging from 23 to 51 years; sample representative of population as above and number of admissions as above).</p>	<p>Participants ($n=52$) given opportunity to feedback on a proposal for a residential crisis service.</p> <p>Themes were drawn from questionnaire and interview data. Data analysed using thematic analysis.</p>			<p>Most criteria scored between 1-2 apart from Research Governance</p>
6	<p>*Hannigan (2010 & 2012)</p> <p>Conducted in the UK (Wales)</p> <p>Service Setting: Single, interprofessional CRHT service in Wales</p>	<p>The study set out with four objectives, one of which was relevant to this systematic review: to examine the receipt of crisis care and the service user experience.</p>	<p>Four people with past experience of using the CRHT were purposively sampled; identified by the CRHT as individuals whose crisis care had ended and were able to give informed consent.</p> <p>No information on other inclusion criteria or how those participants were selected. No demographic information provided.</p>	<p>Ethnographic case study, single, embedded design.</p> <p>Four service user participants considered as the smaller embedded units of analysis within the larger organisational case studied (CRHT).</p> <p>Data collected via semi-structured interviews. Interview data transcribed in full and transcripts checked for accuracy. Two interviews not audio-recorded although unclear if these two were part of the service user interviews. Detailed, contemporaneous notes taken instead.</p> <p>Data were analysed using a dedicated qualitative data analysis software package (Atlas.ti).</p>	<p>Service users' reported positive experiences (e.g. availability of staff, feeling safe, receiving practical support, having someone to talk to) and unwelcome system effects (e.g. different staff visiting, limited control of medication regimen, sense of staff being intrusive)</p>	<p>Reliability and validity considered but no evidence of reflexivity.</p> <p>Rigor demonstrated by checking accuracy of transcriptions.</p> <p>No discussion of findings relating to examination of service user views or how we might integrate findings into existing literature to suggest how this study has further developed our understanding of service user experiences.</p>	<p>16/20</p> <p>Most criteria scored between 1-2 apart from Discussion</p>
7	<p>Lyons, Hopley, Burton & Horrocks (2009).</p> <p>Conducted in UK (England).</p> <p>Service Setting: Advocacy</p>	<p>To gain an understanding of how service users and carers define a crisis and what range of services they considered appropriate alternatives to hospital admission.</p>	<p>Stakeholders as participants (service users, carers, staff, managers, service commissioners).</p> <p>Service user sample recruited via individual letters of invitation and mail shots to voluntary</p>	<p>Interactive research methodology (rooted in participatory action research).</p> <p>Public consultation over 16 week period informed the development of a postal questionnaire.</p>	<p>Three main themes: 'Definition of Crisis', 'Access to Services' and 'Suggested for Services'.</p> <p>Service users reported that they were unable to access timely support to prevent an escalation into a crisis,</p>	<p>Rich source of data extracted from various methods of data collection.</p> <p>No evidence of informed consent procedure.</p> <p>Unclear the exact number of service users involved in the</p>	<p>16/20</p>

Chapter One: Introduction

	<p>Organisation (26 participants were receiving inpatient treatment at the time of the study).</p>		<p>organisations. 141 service users completed postal questionnaires.</p> <p>Lancashire Advocacy carried out ten independent meetings with service users and carers (63 in total). Three meetings were held with 26 service users.</p> <p>188 service user and carers in attendance across 14 service user and carer meetings.</p>	<p>Qualitative data collected via postal questionnaires (424 sent out and 220 received) and group discussions (which were not audio recorded due to practical difficulties) and comprised of qualitative responses from questionnaires, written reports of meetings, and detailed notes from group discussions (e.g. flip chart notes).</p> <p>Group discussions held initially followed by postal questionnaires, which mainly mirrored content of group discussions. Questionnaires scrutinised by panel consisting of services users and carers.</p> <p>Data transcribed and managed by authors using interactive and reflexive process; transcripts checked against raw data. Data analysed using thematic analysis.</p>	<p>that services needed to be flexible and that the access criteria for CRHT services is stringent.</p> <p>Having immediate access to someone, to talk to who believes what you're saying, was valued as important during a crisis.</p>	<p>study nor what the inclusion criteria were. No demographic information provided.</p> <p>Unclear how stakeholders were involved in the data collection process as described.</p> <p>No evidence of reflexivity- authors are responsible for reconfiguration of services so in what way did their role influence their interpretation of results?</p> <p>Interactive approach is an emerging methodology and not yet fully tested.</p>	<p>All criteria scored between 1-2</p>
8	<p>Taylor, Abbott & Hardy (2012).</p> <p>Conducted in the UK.</p> <p>Service setting: Single CRHT team</p>	<p>To investigate the experiences and views of service users and their perceptions of the quality and effectiveness of the CRHT service.</p>	<p>392 people who had been referred to the CRHT service between Dec 2003 and Mar 2004, were contacted. 65 people initially responded but only 49 provided detailed information.</p>	<p>User-led service evaluation (retrospective qualitative study) conducted by group of service users belonging to local mental health group.</p> <p>Data collected by service user group via open-ended questionnaires (serving as interview schedule), face-to-face and telephone, semi-structured interviews. Audio records of interviews not transcribed but detailed systematic notes taken by repeated playing of tapes.</p>	<p>Two key dominant themes: importance of good communication (good listening skills, empathy, acceptance, respect) and continuity in patient-professional relationships.</p> <p>Authors comment that what service users want from services and what they receive continues to be an important area for inquiry.</p>	<p>No evidence of informed consent procedure.</p> <p>Unclear if sample is representative as no demographic information provided for participants.</p> <p>Service users' carried out study but no consideration of how their experiences may have shaped process of interviews and their interpretation of findings.</p>	<p>16/20</p>

Chapter One: Introduction

				Thematic analysis utilising grounded theory approach. Themes discussed with wider service user group to contribute to final analysis.			All criteria scored between 1-2
9	<p>Gilburt, Slade, Rose, Lloyd-Evans, Johnson & Osborn (2010).</p> <p>Conducted in the UK.</p> <p>Service Setting: four Crisis Houses across voluntary and statutory sector; one brief admission unit; one hospital service</p>	To explore patient's subjective experiences of residential alternatives to hospital and traditional hospital services.	<p>Purposive sampling. 40 current patients in residential services. No demographic information given about the sample other than 16 identified from ethnic minority groups.</p>	<p>Participants recruited from four crisis houses, one brief admission unit and one hospital service.</p> <p>In-depth interviews conducted in respective alternative residential settings.</p> <p>Data audio recorded, transcribed and analysed using thematic analysis.</p>	<p>Ten themes were identified that indicated overall preference for alternative residential care (e.g. based on experiences of having greater freedom and feeling safe).</p>	<p>Unclear why relationships were viewed as important. This is not clearly inferred from the findings.</p> <p>Some quotations poorly integrated. No evidence of reflexivity.</p> <p>Only the abstract mentions the number of participants.</p> <p>Unclear how informed consent was obtained.</p> <p>Findings tested for validity.</p>	<p>17/20</p> <p>Most criteria scored 2 apart from Literature Review, Research Governance & Reflexivity/Trustworthiness</p>
10	<p>**Hopkins & Niemiec (2006 & 2007).</p> <p>Conducted in UK (England).</p> <p>Service Setting: Home Treatment service of Crisis Assessment and Treatment Service (CATS)</p>	To develop a service evaluation questionnaire based on what aspects of contact with crisis services was most important to service users.	<p>13 service users took part in the Delphi study (what was most important while receiving the home-based treatment service) and generated 135 questions. Seven themes were identified from these questions using thematic analysis.</p> <p>21 service users agreed to take part in semi-structured interviews.</p>	<p>People were contacted who been treated at home during initial 16 months of team's existence. 70 people agreed to participate.</p> <p>Two-stage modified Delphi study used to generate a range of evaluation questions. Themes extracted from questions provided framework for semi-structured interviews, carried out by service users belonging to local service user group. The content of interviews further enriched the data.</p> <p>Data from Delphi study analysed individually and then reflexively by small group coordinating study. Thematic</p>	<p>Seven themes were derived from a final analysis, which formed the basis for the development of the service evaluation questionnaire.</p> <p>Service users reported that what was important to them was timely access to services that were readily available to them, clinicians who were aware of their crisis story, being listened to with respect, being offered the opportunity to negotiate their care and to receive a smooth transition to other services.</p>	<p>No evidence of informed consent obtained.</p> <p>No information provided on the service user participants (e.g. gender, ethnicity, age).</p>	<p>17/20</p> <p>Most criteria scored 2 apart</p>

Chapter One: Introduction

				analysis of the interview transcripts occurred.			from Literature Review & Research Governance
11	<p>Weich, Griffith, Commander, Bradby, Sashidharan, Pemberton, Jasani & Singh, Bhui (2012).</p> <p>Conducted in UK (England).</p> <p>Service Setting: Three Home Treatment teams within a single Primary Care Trust</p>	<p>To examine factors that impact on the experience of severe mental illness and use of acute mental health services.</p>	<p>Sample selected using typical case sampling method.</p> <p>40 service users (22 male, 18 female) residing in inner-city wards were approached at the time of their discharge to CRHT. Sample comprised of White ($n=16$), Black ($n=8$) & South Asian ($n=16$) ethnicity</p>	<p>Pilot interviews ($n=5$) informed topic guide for qualitative, in-depth interviews.</p> <p>Data analysed using thematic analysis. Transcription and coding of data began during interview phase. Saturation indicated end point to sampling. NVivo 8.0 used to organise data. Coding framework also developed by authors.</p> <p>Pathways to care model used as theoretical framework.</p>	<p>On the whole, service users' reported positive experiences of home treatment compared to in-patient care, associated with the appreciation from staff of the environment service users live in; showing understanding and listening, despite language barriers; treating service users with respect.</p> <p>Help seeking strongly influenced by person's efforts to formulate an understanding of their difficulties.</p> <p>Black and South Asian service users less likely to view their problems as psychological.</p>	<p>Participants met inclusion criteria if they had a clinical diagnosis of a psychotic disorder.</p> <p>No evidence of reflexivity (e.g. the ethnicity of the researchers and how this may have influenced the interview process and interpretation of findings.)</p>	<p>18/20</p> <p>Most criteria scored 2 apart from Reflexivity/Trustworthiness & Discussion</p>
12	<p>Goldsack, Reet, Lapsley & Gingell (2005).</p> <p>Conducted in New Zealand.</p> <p>Service Setting: Single Home Based Treatment service</p>	<p>To utilise service user experience of home based treatment to develop understanding of how practices might promote recovery.</p>	<p>12 service user participants were selected using purposive sampling, in order to gain representative views (e.g. ethnicity of sample representative of population using services).</p> <p>Three quarters of the sample were women, ages ranging from 21 to 48 years; two were experiencing their first episode of mental illness and the length of involvement of home based treatment varied between three to 44 days</p>	<p>Qualitative in-depth interview-based study, focused on one home-based treatment team.</p> <p>Interviews were audio recorded, transcribed and then narrative and thematic techniques were used to analyse data, supported by a qualitative data analysis programme (N*VIVO).</p>	<p>Four key themes were derived.</p> <p>Service users were positive about their experiences of the home-based treatment service (e.g. in relation to the availability of the team, their flexible working, treating people as individuals by including them in decisions, providing practical help, advice and information, connecting people with other services and conveying hope and</p>	<p>Difficult to generalise findings given study focussed on one home based treatment team and taking into account cultural factors that may affect service users' experiences of using crisis services.</p> <p>No evidence of reflexivity.</p>	<p>19/20</p> <p>Most criteria scored 2 apart</p>

Chapter One: Introduction

					encouragement about the recovery process).		from Discussion
13	<p>Khalifeh, Murgatroyd, Freeman, Johnson & Killaspy (2009).</p> <p>Conducted in UK (England).</p> <p>Service Setting: Across four CRTs within two inner city boroughs</p>	<p>To explore the experiences, treatment preferences and unmet needs of mothers of dependent children, treated at home in response to an acute mental health crisis.</p>	<p>Purposive sampling to recruit female participants treated by CRHT services in last 18 months and partial responsibility for a child younger than 18 years.</p> <p>Sample consisted of 18 mothers, ages ranging from 21 to 60 years of age, of White ($n=12$), Black ($n=3$) and Asian ($n=3$) race. The number of dependent children ranged from 1 to 4, with the children's ages ranging from 0-1 to 18 years. Half of the participants were single parents.</p>	<p>Qualitative study design.</p> <p>Participants identified through CRHT staff, within two inner London boroughs.</p> <p>Data collected via semi-structured interviews; the topic guide based on previous research in the area as well as the aims of the study.</p> <p>Interviews were audio recorded, transcribed and analysed using content analysis, with the support of a qualitative data analysis software (QSR N6 NUD*IST).</p>	<p>Four key themes pertaining to Mothers' experiences of home treatment.</p> <p>Most preferred home treatment to hospital admission although those admitted to a crisis house rated that experience higher than home treatment due to parenting issues.</p> <p>Positive aspects of the home treatment service were related to their needs as service users (feeling safer than in hospital; team showing understanding; professionals involving and empowering children who felt appreciated) whereas negative aspects pertaining to their roles as mothers whilst in crisis (difficulty meeting child's physical needs and maintaining boundaries; lack of emotional connectedness with children; children exposed to distressing symptoms; children incorporated into mother's symptoms; children overburdened with care giving responsibilities; mother's sadness at the loss of their parenting role to family members).</p>	<p>Findings not fully representative of service users with children given fairly low participation rate.</p> <p>No evidence of reflexivity.</p>	19/20

Chapter One: Introduction

					Children may be exposed to a number of risks despite home treatment meeting treatment needs of mother.		Most criteria scored 2 apart from Reflexivity/Trustworthiness
14	<p>Johnson, Bingham, Billings, Pilling, Morant, Bebbington, McNicholas & Dalton (2004).</p> <p>Conducted in the UK (England).</p> <p>Service Setting: Single Crisis House for women and acute inpatient ward</p>	<p>To investigate and compare the experiences of women admitted to a crisis house and to local in-patient wards.</p>	<p>Purposive sampling to ensure representation of a range of diverse views (e.g. inclusive of various ethnic groups, women with and without children, varying sexual orientations, psychotic and non-psychotic disorders, first time users of mental health services, those with previous history of admission).</p> <p>30 service users from Crisis House; 20 service users admitted voluntarily to acute wards, the hospital sample.</p>	<p>Qualitative study design.</p> <p>Discussions with service users from crisis house, day centre and users' forum as well as pilot interviews ($n=6$). These discussions informed interview guide.</p> <p>Data collected via semi-structured interviews and audio recordings transcribed verbatim.</p> <p>Data analysed using content analysis with support of qualitative data analysis package (QSR NUD*IST).</p> <p>Reliability and validity: consensus, through discussion amongst researchers, established final coding framework. Findings later presented to group of service users at the crisis house to assess validity of findings.</p>	<p>Eleven themes derived.</p> <p>Preferences towards crisis house based on feeling staff were more available, environment being home-like, admission less stigmatising and intimidating and other residents more supportive.</p> <p>Service users also reported feeling better informed of their care, more in control and a sense of feeling safe because of availability to talk to staff and set agreements with them felt containing.</p> <p>Service users from crisis house regarded crisis house in study as a selective service not appropriate for all.</p>	<p>Robust methodology, reliability and validity addressed, recommendations for (improved) partnerships between CRHT teams and Crisis Houses.</p>	<p>20/20</p> <p>All criteria scored 2</p>

*This is the same study however, there are two variations: the final report to the Research Capacity Building Collaboration for Wales for Nursing and Allied Health Professions (2010) and then the study published as a journal article within the Social Science & Medicine Journal (2012).

**The authors published a separate article (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, 2006) without the data but in which more information is provided on the methodology and participants. This article was reviewed in addition but constitutes the same study.

1.6.4 *Quality*

A framework was developed with the clinical supervisor, to review the quality of each study. A search of the literature was undertaken, to establish what exists in terms of useful frameworks to assess qualitative research evidence. From this search, three separate guidelines were used to inform the critical appraisal process for this review.

The first guideline was developed as both a tool for assessing service evaluations and for broader qualitative research (Spencer *et al*, 2003). Given that a number of articles that met inclusion criteria for this systematic review were service evaluations, this framework felt particularly pertinent. The second guideline (Tracy, 2010) seemed to focus more on the credibility, rigor and worthiness of qualitative studies and how meaningful the findings they generate are. Reflexivity was also considered which seemed to fit with the core principles underpinning the constructivist grounded theory approach used in the current study. Both of these guidelines provided the appraisal items that were used to critically evaluate each study within the current review.

The third guideline considered a broad overview of the qualitative method and provided some useful questions to ask during the critical appraisal process (Law *et al*, 1998). The appraisal items that formed the framework for this current review were: *aims/purposes of each study; literature review; study design; methods; sampling; research governance; data collection; analysis; reflexivity/trustworthiness; discussions/conclusions* (see Appendix II for summary of each appraisal item).

For each appraisal item, studies were scored on the basis of how well they met the criteria defined within the quality guidelines. Scores ranged from zero to two; a score of zero meant for that particular criterion of quality, studies did not include or address that criterion well or there were significant limitations. A score of one indicated that there was an acceptable level of description or evidence of process to suggest the criterion was addressed albeit with either

inadequate detail, some elements lacking, lack of clarity or some limitations. A score of two suggested the study can be considered relatively robust with respect to that particular appraisal item and that the study has adequately addressed the criterion with the process clearly explained. The maximum a study could score was 20. In order to strengthen the reliability of this appraisal process, supervision with the clinical supervisor was utilized to appraise a sample of the studies using the same framework and scoring system.

1.6.5 *Results*

The results will be divided into sections of low, medium to high quality studies followed by a discussion of the limitations and strengths. Finally, the findings from the studies will be synthesised so as to consider what can be confidently concluded about service users' experiences of crisis services. Using the scoring from the critical appraisal framework, studies were categorised in the following way: those studies that scored between 0 and 12 were categorised as low quality studies. Medium quality studies were those that scored between 13 and 16 and high quality studies scored between 17 and 20. Overall, the majority of studies were deemed to be of medium to high quality. Whilst there were common limitations between these sets of studies (e.g. limited evidence of reflexivity), the studies as a whole, capture a broad range of diverse views across a spectrum of service settings. Table 1 shows a summary of the studies included within the review.

1.6.5.1 *Low Quality Studies*

Three of the studies (1, 2, 3) were considered to be of low quality. The service settings across each of the studies were CRHT teams although two of the studies (1, 2) gathered data across multiple teams in England and Wales, in comparison to a single service (3). Whilst the latter study (3) aimed to explore the processes within CRHT teams, the larger scale studies aimed to examine the state of acute care across England and Wales (2) and consider future service development (1). Samples across the studies consisted of service user participants with experience

of acute and crisis care (2, 3) and comprised of male and female participants (3). The methods of data collection were varied and included focus groups (1), a call for evidence via a website (2), in-depth interviews (3) and visits to a range of services and groups (2). Data analysis procedures included framework analysis (2) and hermeneutic content analysis (3).

1.6.5.2 *Medium Quality Studies*

Studies where a lot of the quality indicators were scored highly but with some limitations were deemed to be of medium quality (4, 5, 6, 7, 8). The service settings these studies were conducted within varied between CRHT teams (4, 6, 8), inpatient units (5, 7) and an advocacy organisation (7). The aims of the studies addressed crisis experiences of service users (4, 6) and their definitions (7), their needs in a crisis (5), what they considered appropriate alternatives to hospital services (7) and their views on quality and effectiveness of CRHT (8). The sample sizes differed between studies, varying between 4 to 49 participants. Samples consisted of service users currently receiving CRHT (4), those discharged from inpatient services (5) and those with past experience of CRHT (6, 8). In terms of sample demographics, male and female participants were included in samples (4, 5) with mixed ethnicity (5). The ages of participants ranged between 23 years to 69 years of age.

Data collection methods varied between semi-structured interviews (4, 6) and mixed methodologies of either postal questionnaires and semi-structured interviews (5, 8) or questionnaires followed by group discussions with service users and carers (7). Methods of data analysis used were grounded theory (4, 8), thematic analysis (5, 7) and a qualitative data analysis software (6).

1.6.5.3 *High Quality Studies*

The studies that were deemed to be of high quality (9, 10, 11, 12, 13, 14) were conducted across several service settings; crisis houses (9, 14), admission services (9) and CRHT services (10, 11, 12, 13). The aims of the studies were to

explore residential alternatives with service users (9) such as crisis houses (14) and utilise service users' views on using crisis services to develop practices (12) (e.g. by developing a service evaluation questionnaire, 10). The focus of one of the studies was on the experiences and treatment preferences of mothers in crisis (13), which presented a unique client group within the CRHT literature. Attention was paid to capture a range of diverse views from different ethnic minority groups (9, 11, 12, 13, 14) as well as from service users who were experiencing a mental illness for the first time (12, 14). The samples were representative of gender and the ages of participants ranged from 21 years to 60 years of age.

Data collection methods varied between semi-structured (10, 13, 14) and in-depth interviews (9, 11, 12). The interview schedules of three of the studies were developed using pilot interviews (11, 14) and a Delphi study (10). Thematic analysis (9, 10, 12) and content analysis (13, 14) were used as methods of data analysis and many of the studies supported their analysis with qualitative data analysis software packages (11, 12, 13, 14).

1.6.5.4 *Limitations*

The limitations of studies with low quality were evident in their research governance (1, 2 & 3) (e.g. the studies provided little or no evidence of having sought ethical approval or informed consent) as well as little or no evidence of reflexivity (1, 2 & 3), sparse information on how participants were recruited (1, 3) or insufficient demographic details (1, 2 & 3). One of the studies within this category (2) presented quotes without identifying if they had been provided by service users or carers. This study also reported themes without having been substantiated by direct quotes, making it difficult to judge the fit between the themes and the raw data. Another study offered little reflection on what the researchers discovered from the data other than promoting the importance of service user values in structuring crisis services (3).

Many of the issues that were found in studies of lesser quality were evident in studies of medium quality; such as evidence of informed consent procedures not being provided (4, 5, 7, 8), lack of clarity surrounding participant recruitment procedures (4) and participant inclusion criteria (7) nor any demographic information relating to participants (7, 8). Indeed, in studies of high quality, there were a number of quality issues still evident, such as lack of evidence of reflexivity (9, 11, 12, 13).

One of the higher quality studies examined whether cultural and ethnic factors might mediate service users' experiences of crisis (11). In terms of reflexivity, the authors did not reflect upon their ethnicity and what impact this might have had on their interpretation of the data. A similar issue was reflected in other studies of medium quality (7, 8), such as user-led research that did not consider factors that might impact upon data collection and analysis (8). A study that used a methodological approach that has not yet been fully tested (7) raises questions about the validity of the findings.

As a whole, the limitations of quality are reflected in procedures of research governance, information about samples and evidence of reflexivity. Similar quality issues were found in studies of low and medium quality. On the one hand, this shows that the distinction between studies of low and medium quality is relatively slight in terms of issues that are evident. What differentiates these sets of studies is the degree to which these quality issues were addressed.

1.6.5.5 *Strengths*

One of the many strengths of the quality of the studies was the inclusion of a diverse range of views (i.e. from a variety of ethnic groups or from a significant number of participants included) (1, 2, 7, 9, 11, 12, 13, 14). Rigor was evident across studies of high quality, leading to increased trustworthiness of findings (10, 11, 12, 13, 14). This was also evidenced in studies of medium quality, where either the researchers had gathered a rich source of data from various methods of collection (7), by triangulating findings (4) or checking the accuracy of the

transcripts (6) or by acknowledging that the validity of the findings may have been influenced by the researcher, on the data collection and analysis processes (5). There was also evidence of discussions of themes within a study, with a wider user-led research group not involved in the interview process (8). What differentiated the high quality studies from studies of lesser quality was evidence of informed consent obtained (11, 12, 13, 14).

The strengths of the studies are reflected in the range of diverse views and methods of data collection. The majority of studies within this review were deemed to be of medium to high quality and there was evidence that over half of the researchers' of the studies took steps to ensure the reliability of their data. This means we can make confident conclusions about the findings and what the evidence says about service users' experiences of crisis services.

1.6.6 *Findings*

1.6.6.1 *Strengths of Crisis Services*

The findings from the studies with lesser quality should be considered tentatively. Overall, what these studies purported to have found were that service users' experiences of using services were considered positive through personal engagement with staff (1, 2 & 3), feeling respected and therefore accepted by the crisis teams (1, 2 & 3) in addition to having a sense of choice and control in their treatment (1, 2 & 3). Being seen and heard enabled service users to feel understood (2, 3) whilst also providing reassurance and safety (2). Safety in particular was a central theme (9, 12, 13, 14) and was more likely to lead to trusting relationships being built with team members (2).

Relationships with staff appeared to be a key theme and service users reported valuing the opportunity in getting to know CRHT staff (5, 6) and building positive, respectful relationships (4, 5, 8), which were achieved through, for example, empathic listening (8). Positive relationships with staff were more likely to be reported by service users depending upon the quality of the

relationships with CRHT staff (10) (e.g. where service users reported that they were made to feel like a human being) as well as where the team also offered support to the family (12, 13). Two of the studies found both service users and carers reporting that the CRHT staff involved in their care, felt more like friends (10) or members of the family (12) than working professionals. This resonates with other studies where positive experiences of CRHT were governed by the extent to which staff were 'being with' service users (5).

Positive experiences of crisis services also meant receiving practical support; both from staff (1) and wider social networks, including friends, family and communities (2). In terms of service user feedback on particular elements of service delivery, access to timely, effective responses were valued highly (2, 3, 4, 6, 7), even more so if service users were aware of which staff member was likely to visit and when or if phone contact was consistently available (1). In addition to phone contact, service users valued access to assistance or a safe house (7) and reported that their experience of using crisis services might also be improved if CRHT teams had good connections with other services (8) resulting in a smooth transition (6).

In terms of understanding a crisis from the service user perspective, service users defined crisis in a number of ways; either as a feeling and/or the inability to cope (7) or an experience of symptoms of psychosis, feeling of despair or a need to self-harm (2). What the evidence does not provide is an understanding of the relationship between these experiences or an understanding of the processes involved in crisis (i.e. what processes were involved that led service users to experience despair). CRHT staff showing understanding of someone's mental health difficulties, despite potential language barriers or cultural differences (11) was effective enough in supporting service users through a crisis (2).

Finally, Crisis Houses were seen as positive by service users, as they offered opportunities to talk over past and present difficulties and helped ameliorate parenting issues (14). The welfare of children where mothers are experiencing a crisis appears to be an emerging area of inquiry and a critical issue (11, 13, 14)

and crisis houses can at least offer a solution (13). Service users generally reported that being around other service users (e.g. within a Crisis House) could be conducive to a sense of being unified with others going through similar experiences (14). Conversely, Crisis Houses led some service users to feel unsafe because of contact with acutely unwell people (9) and so they were more preferable towards CRHT.

1.6.6.2 Limitations of Crisis Services

Whilst there is clear praise for crisis services, providing care in the individual's home could be seen as unhelpful, especially if the home feels unsafe or if the individual feels they require a break from the home environment (1). Indeed, some service users reported feeling more psychologically contained within the hospital environment (1). Feeling better protected in a hospital environment appeared to be due to staff supervision preventing self-destructive impulses (14). It was hypothesised within one study that being treated within an environment where stressors are still active (e.g. bereavement, marital problems and financial difficulties) may be unhelpful (e.g. 7).

Negative experiences of CRHT appeared to arise where service users experienced a lack of continuity (e.g. different staff visiting) (4, 6, 7), poor coordination of care (e.g. lack of communication, especially where plans of treatment might change) (5, 8), where there were stringent access criteria to crisis services (7) or where staff appeared to hold unhelpful attitudes (4).

One of the studies that explored the experiences of mothers in crisis described their experiences of home treatment being complicated by their disparate needs; both as patients and as parents (13). Trying to maintain boundaries and stay emotionally connected with their children, meet their children's (physical) needs as well as preventing their children from becoming embroiled in care giving responsibilities and being exposed to symptoms, were all difficulties experienced at home. Therefore, their experiences of being treated at home were thwarted in many ways by these difficulties and conducive to negative appraisals of home treatment services (13).

Overall, the studies suggest that CRHT can be a beneficial, helpful and therefore positive experience for service users, however, for some, being treated at home may only maintain their mental health difficulties. Service users reported an overall preference for CRHT over hospital treatment whereas for some people, Crisis Houses were preferred over home treatment, depending on a number of variables, such as parenting issues.

1.6.7 Discussion

Reviewing the current studies that provide qualitative evidence of service users' experiences of crisis services has shown that for the majority, quality issues are well addressed. There were a number of limitations in quality within several of the studies, such as little or no evidence of research governance procedures. A further limitation was limited evidence of reflexivity across the studies as a whole.

Whilst there were a number of limitations found, there were distinct strengths in quality evident. Individually, the studies offered findings captured from a variety of sources, including patients residing in inner-city or urban wards (6, 12), service users residing in crisis houses (10, 15), mothers reporting on their experiences of parenting during a mental health crisis (14) and service users discharged from services (1, 2, 3, 4, 5, 7, 8, 9, 11, 13, 14). Collectively, the studies presented views from a diverse range of participants including many from ethnic minority groups.

There were a number of variations in methods of data collection between the studies, incorporating both quantitative and qualitative methods collectively or falling on qualitative methods alone. These methods of data collection included questionnaires, surveys, service evaluations, user-led research, semi-structured interviews, focus groups, group discussions/meetings/hearings and consultations. There were also a number of variations in the methods of data analysis between studies.

Between the studies, there were an equal number of medium and high quality studies with the small minority deemed to have lesser quality. Furthermore, the difference between the low and medium quality studies in most cases appeared to be more related to *how well* quality issues were addressed. In conclusion, this suggests that we can have some confidence in the findings purported by the majority of studies that capture a representative sample of service users' experiences of using a range of crisis services.

The findings of the studies as a whole suggest that positive experiences of CRHT orientate around service users feeling understood, heard, accepted, safe, respected and reassured but these may also be experienced in the company of other service users (e.g. within a crisis house). Building trusting relationships with empathic CRHT staff was valued highly as were practical support and immediate access to timely, effective services. Developing connections with others services, such that the discharge and transition from CRHT care is made easier, were also considered important, as was having a variety of services that are more able to meet the complex and varied needs of service users in crisis.

Negative experiences were more likely to be reported where service users felt that there was a lack of continuity and coordination of care. There also seemed to be expressed concern over satisfying CRHT access criteria. Currently, in order to meet criteria, an individual's condition has to deteriorate and it has been suggested that appropriate CRHT services must therefore be available to service users and carers *before* a crisis escalates (8).

1.7 STUDY AIMS AND RATIONALE

1.7.1 *Study rationale*

CRHT is now well established within the mental health network and there is some evidence of the effectiveness of CRHT teams in reducing admissions to psychiatric hospital. There is an emerging literature base that offers the views of crisis and of CRHT from the perspective of service users although what is less

known is how service users *understand* and *construct* their experiences of crisis. The gap in our understanding of mental health crises is in service users' theories of crisis (Winness *et al*, 2010) and the personal meaning constructs of crisis, which are critical for the CRHT framework (Karlsson *et al*, 2008). As the evidence base for service users' experiences of crisis is developing, the current study is timely, relevant and responds to the identified gap in our understanding of crisis from the service user perspective.

The rationale for using a constructivist grounded theory approach is that within this approach, the focus is to explore the assumptions and implicit meanings of the participants' responses which will inform a theory about service users' constructions of crisis. Additionally, this approach addresses reflexivity, which was a significant limitation, identified within the systematic review.

1.7.2 Study aims

The existing theories of crisis do not adequately reflect the personal meanings of crisis from the service user perspective and the literature on service users' experiences of crisis is still relatively inchoate, particularly in terms of our understanding of crisis. What evidence there is that identifies either service users' experiences of crisis or of CRHT, tells us little about *why* the involvement of CRHT can be effective in resolving a crisis or what *processes* are involved in a crisis that formal (e.g. CRHT) or informal (e.g. family) systems of support best address.

The current study aimed to build upon the limitations within the existing literature that were identified from the systematic review (e.g. poor research governance and limited reflexivity). Additionally, the current study aimed to consider the implications for service delivery at the level of the formal and informal systems surrounding the individual and how these aid the resolution of crises. A further aim was to consider the theoretical implications of how service users conceptualise and resolve crises.

Therefore, the current study employed a constructivist grounded theory approach to develop a grounded theory predicated upon the personal meanings of crisis from the perspectives of service users.

CHAPTER TWO METHODOLOGY

2.1 OVERVIEW

This chapter addresses the methods that were chosen as the most appropriate in answering the research question as well as the rationale for choosing them. Following a qualitative approach, semi-structured interviews were conducted and then a focus group, which comprised of the participants within the study. Participants were identified and recruited by Senior managers and the Clinical Research Supervisor, working across three CRHT teams within South Wales, at the time of the study. A Constructivist Grounded Theory approach was adopted to analyse the data. The design for the study will be outlined, as will the procedures for each stage of the process. Quality procedures will also be outlined and addressed. Clinical and research governance will be considered.

2.2 QUALITATIVE METHODOLOGY

2.2.1 *Philosophical position*

The underpinnings of qualitative research include an interest in understanding people's lived experiences and how they might view the world (Barker *et al*, 2002), which can be accomplished through studying their emotions, behaviours, thought processes and feelings (Strauss & Corbin, 1998). Through exploring how people view and experience the world, we can learn about perceptions, which are based on multiple assumptions of others, ourselves and of the world (Barker *et al*, 2002). This relates to one qualitative tradition known as *phenomenology* where unlocking perceived meaning is more important than discovering objective reality (Barker *et al*, 2002).

Prior to the introduction of Grounded Theory, the *positivist* traditions of inquiry were driven towards finding causal explanations to phenomena in order to make predictions about a *knowable* world (Charmaz, 2006). Grounded theory arose from symbolic interactionism (a theory about human conduct and behaviour) (Annells, 1996) and is one such type of phenomenological research that moves away from positivist conceptions of objectivity (Charmaz, 2006). Epistemology is a theory about knowledge and a *positivist* epistemological position would hold an underlying assumption that the researcher acts as a *passive observer* in the research process and holds a belief that *truth* exists in the world (Charmaz, 2006).

Conversely, an epistemological position of inquiry that is more reflective of phenomenological approaches (such as Grounded Theory) considers the relationship between the researcher (e.g. the inquirer), the participant and what can be known (Annells, 1996). Meaning, in this sense, becomes co-constructed between researcher and participant (Mills *et al*, 2006). Grounded Theory reflects a pragmatist philosophical tradition that states that the self, reality and the social world are constructed through dynamic interactions where meanings and actions are created, enacted and changed (Charmaz, 2006).

Another tradition within qualitative research is *social constructionism*, which relates our knowledge of reality as being the product of our own actions (Pearce, 2009). Making meaning, to the social constructionist, is primarily a relational activity (McNamee, 2004) and our knowledge and understanding of the social world in which we exist is via communication, dialogue and discourse (McNamee, 2004). Social constructionism focuses on language and meaning that give rise to multiple realities (Barker *et al*, 2002). Constructionist theories also consider psychological research as a circular process in which psychologists themselves are objects of theory (Barker *et al*, 2002). This circular process is known as *reflexivity* and is an important aspect of qualitative research (e.g. Tracy, 2010).

2.2.2 *Rationale for the Qualitative Method*

This study aimed to explore service users' *constructions* of crisis, that is, *how* service users make sense of a crisis from their own experience of it. This meant that a method of inquiry into the subjective experiences of crisis was required. Choosing between quantitative and qualitative approaches rests on the type of research question that is being addressed and qualitative approaches suit questions asked within a discovery-oriented framework (Barker *et al*, 2002). In this instance, the current study aimed to address the gap in our knowledge about how service users *understand* crisis and therefore a qualitative approach was most appropriate.

2.2.3 *Constructivist Grounded Theory*

Constructivist Grounded Theory is derived from the philosophical view that people form mental constructions that enable them to make sense of events around them (Annells, 1996) and evolved from Grounded Theory (Charmaz, 2006; Mills *et al*, 2006). Within the research paradigm, researchers engage in a process of inquiry where knowledge is *created* through interpreting the participants' constructions (Annells, 1996). Unlike traditional Grounded Theory where theory emerges from the data separate from the scientific observer (Glaser & Strauss, 1967), Constructivist Ground Theory acknowledges that researchers are part of the world in which they study and gather data (Charmaz, 2006). Therefore, a Constructivist Grounded Theory of a phenomenon aims to provide a reconstructive understanding (Annells, 1996) by positioning the researcher as 'author' within the reconstructive process (Mills *et al*, 2006).

The Constructivist Grounded Theory approach offers a view of the world as formed by both our historical and cultural context (Mills *et al*, 2006) as well as our interactions with different people, perspectives and research practices (Charmaz, 2006). Grounded Theory refers both to a method of analysing data, using systematic procedures, as well as to an outcome of analysis (i.e. theory), grounded in the data (Barker *et al*, 2002). Constructivist Grounded Theory aimed

to move away from positivist assumptions that Grounded Theory was criticised for (e.g. Charmaz, 2006) by making explicit, the relationship between researcher, participant and the studied area of interest (Mills *et al*, 2006). Charmaz (2006) contends that a Constructivist Grounded Theory approach is *one* way of doing Grounded Theory that uses methods of practices flexibly. Taking a Constructivist Grounded Theory approach involves immersing within the data in such a way as to construct a theory that reflects the overall narrative of the participants (Mills *et al*, 2006).

The strategies used within the process of constructing a grounded theory include coding, which helps make analytic sense of the meanings and actions of participants' experiences (Charmaz, 2006). Ideas about the data and codes are explored and developed through memo-writing (Charmaz, 2006) which forms part of a continual process towards constructing a grounded theory. Through this process, certain codes then become conceptual categories and theoretical sampling enables specific new data to be sought (Charmaz, 2006). This iterative process means ideas are conceived, explored and developed throughout the grounded theory process, sticking close to the data. Asking certain questions also helps tune into what the data are indicating (i.e. in terms of process and connections between conceptual categories) which supports the development of theory (Strauss & Corbin, 1998). These strategies will be discussed in more detail in the data analysis section.

2.2.3.1 Rationale for using Constructivist Grounded Theory Approach

Charmaz (2006) describes this approach as offering an '*interpretative portrayal of the studied world, not an exact picture of it*' (p. 10). Based on this underpinning principle, this approach offers a level of transparency about how meaning is co-constructed between researcher and participant. Within the existing literature of service users' experiences of crisis this is particularly unacknowledged, as observed during the systematic review. Therefore, this approach was chosen in an effort not only to contribute to an emerging research interest but also to offer

a unique perspective on service users' experiences of crisis by acknowledging *reflexivity*.

In summary, the qualitative methodology of constructivist grounded theory was chosen as most suitable for the current study.

2.3 ENSURING QUALITY

Tracy (2010) suggests that having a framework for ensuring qualitative quality can enable the value of the work to be better communicated. The systematic review for the current study identified a number of issues of quality within the existing evidence base for service users' experiences of using crisis services. Therefore, the current study utilised a set of guidelines (Elliott *et al*, 1999) to ensure a high level of quality. These guidelines will be described below including how they were addressed throughout the current study:

i) *Owning one's perspective*

Researchers are encouraged to make explicit their theoretical orientations and assumptions, both prior to the study commencing and as they surface during the research process. This promotes transparency of the researcher's interpretations and understanding of the data and how the researcher's values, interests and assumptions may have influenced their understanding. This was achieved in the current study by outlining the researcher's position at the start of the study (see Sections 2.4.1. and 2.4.2.) as well as a statement on the development of the researcher's position during the research process (see Appendix XVII).

ii) *Situating the sample*

Providing descriptive information about the research participants enables the reader to consider how the findings might be relevant in the context of the range of individuals that have been studied and the situations in which the study took place. To achieve this in the current study, details about the participants that

were considered relevant were provided (e.g. demographics, diagnoses and history of contact with crisis services) (see Table 2).

iii) *Grounding in examples*

The researcher is encouraged to provide examples of data to illustrate the analytic procedures and the understanding that is developed. By doing so, the reader is enabled to judge the fit between the data and the interpretations made by the researcher. Within the results section of the current study, illustrations of themes, categories and subcategories will be provided (Chapter 3). Three extracts from interview transcripts will also be provided (see Appendix XVII).

iv) *Providing credibility checks*

There are a number of methods that can be employed to check the credibility of data and interpretations. These include checking understanding with the original respondents, using multiple analysts and triangulation with other data sources. To achieve credibility, the researcher in the current study discussed the analysed transcripts, emergent initial codes and focused codes and categories with the academic and clinical supervisors. An extract from a transcript was coded in the presence of the academic supervisor to check the credibility of the coding process. Furthermore, triangulation was sought through the process of a focus group with a sample of participants. During the focus group, emergent categories and themes were discussed with participants to obtain verification through their feedback. The participants agreed with the grounded theory and the emergent themes and categories. Their feedback can be found in Appendix XXII.

v) *Coherence*

Coherence is achieved by presenting the data, analysis and findings in a consistent way that forms an integrated narrative account. Frameworks or diagrammatic maps can support this process. The Results Section (Chapter 3) presents the data using a diagram and a narrative account to achieve coherence. Throughout the data analysis process, discussions about the data and the presentation of it were held with the clinical and academic supervisors. The

process of triangulation was used to ensure that participants' accounts fit with the emergent analysis.

vi) *Accomplishing general vs. specific research tasks*

The researcher is required to address the limitations of extending the findings beyond the studied context. This helps to understand whether a study intended to provide a general understanding of phenomenon or an in-depth understanding of a specific case or instance. The current study is representative of a sample of service users in Wales, who have experienced a crisis and specifically, have come into contact with CRHT services. Therefore, the findings are not considered to be generalised to any other group. The reader can judge the degree to which the findings can be applied to other research settings, based on the participant information provided. Chapter four outlines the limitations of the current study.

vii) *Resonating with readers*

In order to resonate with readers, data should be presented in such a way that supports their understanding or appreciation of it by accurately representing the subject matter. This was achieved by providing draft versions of the theory to both supervisors, in addition to the final version as well as obtaining feedback on the emergent analysis from a sample of the participants (see Appendix XXII). In order for the reader to be able to judge the extent to which the theory resonates, Chapter One outlines the relevant theoretical and clinical issues and Chapter Three details the subcategories, categories, core categories and themes.

2.4 PERSONAL AND PROFESSIONAL REFLEXIVITY

Reflexivity is considered to be an essential component of quality in qualitative research (Tracy, 2010), particularly in constructivist grounded theory (e.g. Charmaz, 2006). It describes the process of transparency on the part of the researcher, by stating their position in terms of their interests, theoretical alignment and experiences and how these may have influenced the research. Elliott *et al* (1999) recommend researchers disclose their values, interests and

assumptions and the role these might play in the development of understanding. This can aid the reader in understanding the process of co-construction between researcher and participant (Charmaz, 2006) and consider the position of the researcher as author (Mills *et al*, 2006). It is with this consideration that the researcher of the current study will position himself as author (see below).

Throughout the research process, reflexivity was considered through the use of regular supervision with both clinical and academic supervisors. Supervision was useful in discussing the shifting position of the author and factors that might have been influencing the construction of meaning during the interview process. Understanding the position of the author in relation to the research question being asked supports the readers' understanding of the author's construction (Mills *et al*, 2006). Charmaz (2006) recommends updating a reflective journal throughout the research process, in order to facilitate transparency. A reflective journal was kept and updated after every interview as well as at different points during the research process (e.g. initial, middle and final stages).

2.4.1 *Researcher's position*

In the context of writing his thesis, the author positions himself as 31 years of age, male, white, middle class, English and in his third and final year of a Clinical Psychology Doctoral training course. His professional story began with the completion of a Psychology with English Studies Honors Degree in England and was further punctuated by working in various mental health settings across England, prior to commencing the training course in South Wales. His personal identity has been shaped by his early experiences of growing up in Hong Kong prior to relocating to England. This significant transition was marked by initial experiences of feeling different from his peers, impacting upon his social integration, which later sparked an interest in cultural diversity and cultural and social integration.

The author positions himself, epistemologically, with the concept of meaning being socially constructed, that has been borne out of his interest in the 'power'

of language. He would identify himself as holding a communication perspective with a particular interest in the creation and management of meaning within the interactional process. Within the field of mental health, the author would position himself as anti-psychiatry and would certainly view the more traditional field of psychiatry through the lens of power.

The research topic was of particular interest to the author as it promoted the value of service users' voices that the author advocates. The prospect of conducting research specifically exploring *how* service users construct their experiences of crisis to lead to an understanding that could be shared with service providers, was very exciting.

In his position as a Trainee Clinical Psychologist, the author was aware of issues of power within therapy. From his clinical experiences, he had broadly come to understand these issues from the perspective of service users, as 'us vs. them' (the 'us' representing the service user population and the 'them' referring to the clinical and professional community). Through his clinical training, he has developed insight into person-centered approaches and maintaining the service user perspective at the heart of treatment. In particular, he has been interested in methods to evaluate outcomes in a meaningful way that provides a richer understanding of the service user experience. Through his clinical experiences he has found that service pressures can often lead to outcomes being measured using quantitative tools that provide little information on *why* something might have worked. He has found himself organised towards this way of evaluating outcomes, given his position as a Trainee Clinical Psychologist, despite having reservations about the usefulness of doing this.

2.5 DESIGN

The current study employed a qualitative design using semi-structured interviews to explore service users' understanding of a crisis from their experiences. Nine individual interviews were conducted to collect data from service users, who had come into contact with one of three CRHT services in

South Wales. Participants were invited to take part in the study and to attend interviews, which were led by the author. During the interviews, participants were encouraged to talk about their experience of crisis, *how* they have made sense of what happened and to describe what a crisis *means* to them.

During the phase of the research project where the research question and subsequent proposal were being developed by the author and academic supervisor, a visit was made to one of the settings used to recruit participants from. Here, the project was discussed with service users and CRHT staff, to gain their feedback on the research question so as to help shape the process of developing a suitable study design. The author also attended a CRHT operational business meeting, to present the research proposal to senior members of the team in order to discuss feasibility of recruitment and to obtain their views on the final proposal, prior to submission. Following full ethical approval, a further visit was made by the author and academic supervisor to the setting, to discuss the interview schedule with service users and obtain feedback, including any further questions they felt might be useful in understanding the topic.

Each interview was audio-recorded and then transcribed manually by the author. The transcriptions were then analysed using a constructivist grounded theory approach (Charmaz, 2006).

2.5.1 *Research Context*

The research was conducted across three National Health Service (NHS) settings within South Wales, namely, two CRHT teams and a Crisis Recovery Unit. The author travelled to interview participants, either within a consultation room at one of the settings or within the participant's own home. Where interviews were conducted in participants' own homes, the Lone Working Policy for the service settings was adhered to.

2.6 CLINICAL GOVERNANCE

2.6.1 *Ethical Approval*

The Cardiff and Vale NHS Chair of the Cardiff and Vale Research Review Service (CaRRS) approved the scientific quality of the study in May 2012. This approval was granted prior to the commencement of the study and on the basis of the research proposal that was submitted. An application to the National Institute for Social Care and Health Research (NISCHR) was made and following a presentation of the project to the Dyfed Powys Research Ethics Committee (REC) and subsequent requested amendments completed, the study was given approval on 7th September 2012. The Cardiff and Vale UHB Research and Development Department (R & D) granted full ethical approval on 25th September 2012. The Ethics Committee Panel consisted of various healthcare professionals across a range of professions, providing a diverse range of perspectives on the suitability of the author and the study.

2.7 PARTICIPANTS

2.7.1 *Informed Consent and Confidentiality*

In order for participants to make an informed choice about taking part in the study, information was provided to them at different stages before their involvement in the study. After being identified as potential participants on the basis of meeting inclusion criteria for the study, individuals were sent packs containing an information sheet, an invite letter and a reply slip (see Appendices). The information sheet provided the participants with details on:

- the aims of the research
- information about what would be involved (i.e. the procedures) and required of the participants
- the procedures that would be involved to preserve anonymity
- where the data would be stored and how the data would be analysed

- their right to withdraw at any point
- information on how and who to contact for support after their participation

Participants were contacted by telephone to arrange an interview after receiving a reply slip from them indicating that they would like to take part. At this point, they were signposted to the information sheet and reminded of their right to withdraw from the study, what would be required of them, information on the process of interview (i.e. length of interview and recording of interview) what would happen to their data after the interviews, who and how to contact for support and information on the process of preserving anonymity. Participants were also reminded at this stage of the opportunity to take part in the focus group following the interview stage. They were informed that this would be entirely voluntary and that they would receive a letter inviting them to take part, following the data analysis.

Participants were also given the opportunity to ask any questions or raise any concerns they might have about the study and their involvement in it. Participants were informed that they would also get an opportunity to ask any questions before the interview that might arise in the time between the telephone contact and meeting in person. They were also informed that they would be asked to sign a consent form prior to the commencement of the interview. The questions that participants raised during telephone contact included how their data would be used, whether their data would be kept confidential and whether they would be required to do anything else not stipulated on the information sheet.

At interview, participants were then given the opportunity to ask any (further) questions or raise any concerns and the information discussed during the telephone contact was reiterated at this stage, to ensure each participant was fully informed. In addition, participants were given another information sheet. Following this, participants were then asked to sign a consent form, which indicated that they had read and understood the information provided on the

information sheet and that they agreed to participate (Appendix VIII).

Confidentiality was addressed by informing participants, via both the information sheet and telephone or face-to face contact, that their personal details provided would be kept anonymous. They were also informed that quotes provided during the process of interview would be used in the final write up of the study, however, attempts to preserve the confidentiality of their responses would be made (e.g. by ascribing pseudonyms to quotes).

During transcription, any personal details or identifiers (e.g. names of services or locations) were excluded. The author transcribed the interviews verbatim. The complete transcripts were then kept in a securely locked filing cabinet and were accessible to the author only.

2.7.2 *Sample*

The sample consisted of service users who met inclusion criteria for the study (see below) and had come into contact with one of the three crises services within South Wales. A total of nine individuals were recruited to participate in individual semi-structured interviews. This sample size was considered sufficient based on criteria recommended for Constructivist Grounded Theory analysis (Charmaz, 2006) and guidelines for Doctoral level qualitative research (Turpin *et al*, 1997).

2.7.3 *Inclusion Criteria*

The following criteria for inclusion were used to determine an individual's participation in the study:

- Service users who are identified by CRHT teams having been recently discharged between one month and six months after discharge.
- Service users willing to participate in the research
- Service users who have the capacity to consent to participate

- Service users between the ages of 18 to 65 years of age, as per CRHT operational policy

Individuals were deemed eligible to participate in the study if they met the inclusion criteria.

2.7.4 Participant Demographics

Detailed demographic information is provided in table 2. The pseudonyms assigned to the participants have not been added to table 2 on the basis of confidentiality, which might be breached should the demographic information identify the participants. The table has been provided for the purposes of demonstrating that there was a wide variety in the heterogeneity of the participants.

Table 2. Participant demographics

Participant	Age (years)	Gender (Female:F; Male:M)	Ethnicity	Months since discharge	No. of contacts with CRHT team	Diagnosis
1	28	F	White, British	3	9	Borderline Personality Disorder
2	51	F	White British	3	1	Borderline Personality Disorder
3	56	M	White British	3	1	Depression
4	64	F	White, British	5	6	Anxiety
5	48	F	White, British	2	1	Depression
6	47	M	White, British	3	5	Psychosis
7	44	M	White, British	3	13	Psychosis
8	42	F	White, British	3	4	Depression
9	53	F	White, British	5	6	Bipolar Disorder

2.8 PROCEDURE

2.8.1 *Recruitment Procedure*

Discussions were held between the author, clinical and academic supervisors to

consider ways to access participants. The author and clinical supervisor attended a CRHT operational business meeting at one of the research settings. At this meeting, the recruitment procedure was discussed with senior members of the CRHT team and feedback was used to decide who would be involved in contacting potential participants and how this would be achieved. This was outlined in the proposal and following full ethical approval, the clinical supervisor and two senior members of the CRHT team began to identify individuals who were eligible to participate based on the inclusion criteria. The details of individuals were accessed via an electronic service user information database, used by the service settings.

There were two strands to the recruitment process (see the Flowchart in Appendix XV). The first entailed the clinical supervisor informing service users, who were at the point of discharge from the Crisis Recovery Day Service, about the project. They were asked if they would like to receive an information pack in the post and if they agreed, were sent a pack one month following their discharge. The second strand of recruitment involved the clinical supervisor and senior members of the CRHT teams identifying and contacting potential participants to inform them of the research project and then sending out information packs by post, to those interested in receiving more information. Individuals, who were interested in participating, were asked to return reply slips to the author, either indicating that they would prefer to contact the author or by providing contact information for the author to contact them. A time, date and location to conduct the interview were agreed between the author and each participant. Written consent was obtained at the point of interview.

2.8.2 Construction of Interview Questions

The qualitative semi-structured interview schedule was selected as a method of data collection as it was considered to be the most suitable method to gather data regarding the participants' personal experiences of crisis. Based on grounded theory guidelines (Charmaz (2006) and service user feedback, the author and academic supervisor devised the semi-structured interview schedule

and stem questions. These stem questions were organised around a temporal framework (*before, during and after* a crisis) and were considered on the basis that they would enable participants to reflect on their experiences freely. Several broad open-ended stem questions were selected, which is recommended for a grounded theory study (Charmaz, 2006). In line with the inductive nature of grounded theory approaches (Strauss & Corbin, 1998), stem questions were modified and revised after each interview so that the focus remained on the relevant aspects of the study (see Appendix XVI for the initial interview schedule and the schedules that were subsequently developed through the interview process).

Additional questions that drew on participants' responses from previous interviews were incorporated into each subsequent interview in order to facilitate the emergence of categories and themes (Charmaz, 2006). However, any modified changes to the interview schedule and questions remained consistent with the original temporal framework. Discussions were held with the academic and clinical supervisors as the interviews progressed, to ensure that the questions were in line with the research aims.

2.8.3 *Interview Procedure*

The author signposted each participant to the information sheet and offered to answer any questions, prior to the commencement of the interview. An interview schedule was devised which broadly set out the procedure of inviting the participant to ask any further questions, explaining the predicted length of time of the interview and reiterating that they have the right to withdraw at any point and the interview will stopped, without them having to give a reason. In addition, the author informed each participant out of courtesy that he would be timekeeping and intermittently referring to the semi-structured interviews during the interview. The way in which the questions were asked was based on the principle of interviewing as a flexible and emergent technique (Charmaz, 2006). The interview schedule ensured that each interview was conducted in a consistent and effective manner and that the author was prepared.

The interviews were conducted between November and May 2013 and were undertaken either in a consultation room at one of the three research settings or in the participant's own home. Assurance of confidentiality and anonymity were given in written and verbal form at the commencement of each interview. The semi-structured interview schedule was introduced and stem questions were asked to open up the interview and encourage the natural emergence of stories and statements (Charmaz, 2006). Data were collected in an evolving process as stem questions were modified and revised and additional questions that were tuned into themes emerging from the data were introduced to explore in subsequent interviews. As recommended in grounded theory guidelines (e.g. Charmaz, 2006) prompts were used to help the participants articulate meanings and intentions (Charmaz, 2006). At the end of each interview, participants were invited to ask any questions about issues that might have arisen during the interview.

2.8.4 Data Recording and Management

All of the nine interviews were recorded using a digital audio recorder. Each interview was then fully transcribed by the author which consisted of transcribing all speech verbatim and noting any deliberate pauses in conversation (see Appendix XVII for a sample of transcript extracts). To ensure anonymity of the data, names of participants were changed to pseudonyms.

2.9. DATA ANALYSIS

2.9.1. Transcription of interview data

The interviews were transcribed manually by the author, within a week of each interview having taken place and each interview took up to 8 hours to transcribe. The interviews were transcribed verbatim and non-word utterances were excluded. The transcripts were identified by the date and location of where the interview took place and each transcript was assigned a pseudonym.

After each interview, the author documented his reflections on process and content issues within his reflective journal. These included reflections on the questions that were asked by participants prior to the commencement of the interview, comments made by participants relating to the author (e.g. regarding the author's professional title, age, ability to manage emotional material and stage of clinical training) and how the author felt in relation to each participant.

These latter reflections (i.e. how the author felt during and after each interview) centred around themes of power, knowledge and expertise (see Appendix XVIII for a sample of reflective notes). These reflections along with reflective notes and memo-writing made during the data analysis process, contributed towards refining the categories and core categories as guided by the grounded theory method (Charmaz, 2006). They also identified emergent ideas that could be explored in subsequent interviews. This process of reflexivity is critical in qualitative research (Tracy, 2010) and in particular to a constructivist grounded theory method (Charmaz, 2006).

2.9.2 *Analysis of Interview Data*

There were several stages of analysis, which began with the author listening to the audio recordings of each interview directly after it had taken place. The author made notes on content and process and listened out for meaning (i.e. *how* participants were describing their experiences and what words they used as well as what *meaning* they ascribed to their experiences). These emergent ideas were then explored in subsequent interviews.

In addition to this process, the author read through each transcript several times in order to immerse himself in the data and to gain an initial sense of it. The other key techniques of a grounded theory approach were adhered to, which included coding, forming categories, constant comparative analysis, negative case analysis and memo-writing. These will now be referred to in more detail:

i) Coding

There were two stages to coding; initial line-by-line coding and focused coding. Coding refers to the process whereby labels are attached to segments of data that relate to propositions about how the individual perceives themselves, others and the world (Strauss & Corbin, 1998). Line-by-line coding can give direction to new leads and support the emergence of new ideas from the data (Charmaz, 2006). The names of codes utilized the participants' own words and were kept short, were action focused and were grounded in the data (Charmaz, 2006).

Focused coding is used to categorise larger segments of data and are chosen based on their significance to and frequency within the data (i.e. codes that make the most analytic sense based on the data) (Charmaz, 2006). Following initial line-by-line coding of each transcript, the author sorted the codes into focused codes and then illustrated the focused codes with data in order to ground them with examples (Elliott *et al*, 1999).

ii) Categories

Grouping together focused codes, based on their frequency and significance, formed categories. Subcategories that were developed through this process, were then integrated to form higher-level analytic categories (Strauss & Corbin, 1998). These are diagrammatically illustrated in Appendix XXI. During the interviewing process, using the principles of *theoretical sampling* (Charmaz, 2006), categories were elaborated and refined by seeking data in order to develop the emerging theory and to ensure that no further properties emerged.

iii) Constant Comparative analysis

This describes an iterative process of creating further sub-categories by exploring similarities and differences within and between categories (Willig, 2008). The events, views and categories of the participants are compared so that the categories and themes become tighter and more theoretical (Strauss & Corbin, 1998).

iii) Negative case analysis

During the process of identifying connections between categories, those categories that did not 'fit' (i.e. did not link well with other categories) were explored in more depth. This process ensured that the full complexity of the data were captured in the emerging theory and contributed to credibility checks.

iv) Memo-writing

Memo-writing is considered an important stage of constructivist grounded theory and presents an opportunity to analyse ideas about the codes in creative ways (Charmaz, 2006). Memo-writing was used to open up ideas about focused codes and memos were written after assigning a focused code to segments of data. This ensured that the author remained close to the data at the time of writing and meant that the memo could be used to explore both the focused code and the meaning of the data. Memos were also written about categories and comparisons between codes and categories, which helped identify gaps in the analysis (Charmaz, 2006). (Appendix XIX illustrates a sample of memo-writing).

2.9.3 *Triangulation of emergent analysis*

In response to the limitations of quality observed during the systematic review, the author took steps to ensure the study adhered to quality guidelines (e.g. Elliott *et al*, 1999). One of these steps included frequent consultation with both clinical and academic supervisors, to ensure that the fundamental principles of constructivist grounded theory were being followed.

A second step involved facilitating a focus group, which was held after the data analysis. All of the participants involved in the study were invited to attend and were informed of the focus group at various stages; via the information sheet, the initial telephone contact, at interview and then via letters of invitation. Four participants attended the focus group, the purpose

of which was to check the credibility of the categories and themes against the participants' experiences, in line with guidelines (Elliott *et al*, 1999). Themes and categories were read out to the participants, who were asked to reflect upon whether they did or did not 'fit' with their experiences.

The focus group was held in May 2013 at one of the research settings that was considered the most convenient venue to hold the group. Contemporaneous notes were taken during the focus group and participants' responses were verified during the group, to maximise their accuracy. The author responded to participants' feedback in his subsequent analysis in order to continue to remain grounded with the data. This meant that limitations that had been found in previous studies could be addressed (i.e. as identified by the systematic review).

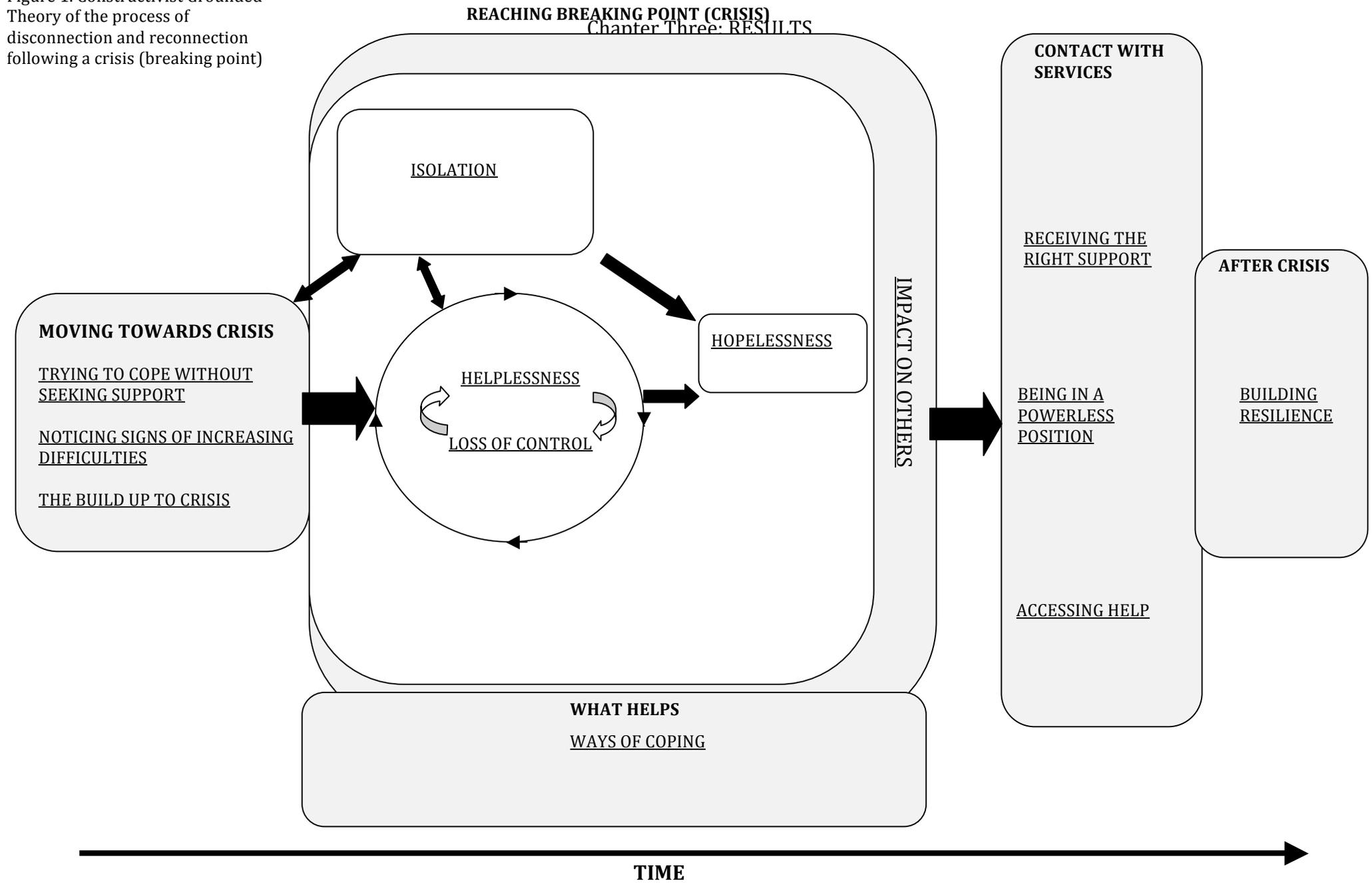
The following chapter presents the analysis of the data.

CHAPTER THREE RESULTS

3.1 OVERVIEW

In this chapter, the Constructivist Grounded Theory will be presented, which has arisen from the analysis of the data collected from nine individual interviews. There were five key themes that were identified; **MOVING TOWARDS CRISIS, REACHING BREAKING POINT (CRISIS), CONTACT WITH SERVICES, AFTER CRISIS** and **WHAT HELPS**. Across the five themes there were 13 Core Categories, 13 Categories and 8 sub-categories. The **THEMES** will be presented in bold capital, CORE CATEGORIES in capital, Categories will be underlined and **sub-categories** in bold. Figure 1. presents the Constructivist Grounded Theory of the process of disconnection and reconnection following a crisis (breaking point), based on the participants' experiences of crisis. A list of the themes, core categories and subcategories can be found in Appendix XXI.

Figure 1. Constructivist Grounded Theory of the process of disconnection and reconnection following a crisis (breaking point)



3.2 THEME ONE: MOVING TOWARDS CRISIS

Moving towards crisis is characterised by increasing stress or distress over time, associated with everyday living and/or specific environmental factors, which either significantly impacted upon the management of the participants' existing mental health difficulties (e.g. the symptoms of their mental illness) or led to significant mental health difficulties, beyond their capacity to cope. This theme incorporates three core categories: THE BUILD UP TO CRISIS, NOTICING SIGNS OF INCREASING DIFFICULTIES and TRYING TO COPE WITHOUT SEEKING SUPPORT. Each core category will be discussed in turn and will be followed by a summary of the theme.

CORE CATEGORY ONE: THE BUILD UP TO CRISIS

The participants described a build up to crisis as a build up of stress or distress, over a period of time that led to their experiences of crisis. This phase is characterised by 'everything building up', which was described by the participants as leading to a point of crisis; namely a point at which they became unable to manage the stress or distress they had experienced (i.e. associated with everyday living or specific environmental events) and cope with their increasing mental health difficulties. This build up of stress or distress also appeared to contribute to a worsening of existing mental health difficulties. Relationship difficulties, work related stress and financial problems were all described as factors that appeared to place a strain on the participants' resources to cope. One of the participants even described how a combination of events were the cause of her experience of 'everything building up':

Lynne: "I think the cause of it (crisis) for me was a combination of things. I was losing my house, my partner had left and the mortgage was impossible for me to pay - debt was spiraling out of control."

Relationship difficulties (such as unresolved familial issues) appeared to be a common feature in the participants' stories. Experiencing problems in

relationships seemed to magnify the participants' experiences of 'everything building up' by increasing their isolation. This had the effect of increasing their chances of reaching breaking point (crisis), especially when combined with other 'events' that were occurring in their lives and thus placing additional strain on their abilities to cope. This was the case for Rebecca who identified that the cause of crisis for her appeared to stem from longstanding relationship issues with members of her family, that when combined with a number of significant losses she had suffered, built up to a point at which she could no longer manage:

Rebecca: "I had been very depressed, well most probably for many years and I think everything just got to me with certain people in my family and a build up of things over the years".

Before reaching a stage of crisis, the participants talked about noticing signs of their increasing mental health difficulties that they were beginning to find difficult to cope with. Some of the participants with previous experiences of crisis were alerted to recognisable signs of this happening. Those participants who had not made contact with CRHT services previously, described having an awareness that they were experiencing increasing mental health difficulties that were placing significant demands upon their coping resources. All of the participants attributed their increasing mental health difficulties with 'everything building up'. The next core category identifies the participant's responses related to this stage.

CORE CATEGORY TWO: NOTICING SIGNS OF INCREASING DIFFICULTIES

The participants identified a stage at which they began to notice signs or 'symptoms' that raised their awareness to their mental health difficulties increasing beyond their capacity to manage them. The 'symptoms' noticed by Ceri suggested to her that she was on the verge of experiencing a crisis, based on previous experiences of becoming unable to manage her mental health difficulties:

Ceri: "It's like you notice little symptoms in yourself. I guess in a way because I notice those things I can sense that I'm very near the edge."

Whilst the participants did not describe the signs or 'symptoms' in detail, with some identifying that loss of sleep was an indicator, they described a sense that they knew something was wrong, simply by recognising a difference in how they felt. Sadie began to notice a few weeks before she experienced a crisis, that she had reached a peak in the symptoms of her mental illness. She had noticed signs that informed her that she was likely approaching a crisis:

Sadie: "I knew I didn't feel right for a couple of weeks before it happened. I can't tell you what was wrong, as I can't remember a lot of things, which seems to be the normal when I've reached that critical point in my illness. I didn't feel myself. Something was telling me something wasn't right."

Following the recognition of signs of increasing difficulties, the participants either chose to resist against the increase in their mental health difficulties or decided to ignore them. Either way, they were reluctant at this stage to seek help but chose instead, to make continued attempts at managing their increasing mental health difficulties.

CORE CATEGORY THREE: TRYING TO COPE WITHOUT SEEKING SUPPORT

After experiencing a build up of 'everything' and becoming aware of an increase in mental health difficulties and the subsequent strain on their resources to cope, several of the participants described how they chose not to ask for help immediately. There was a sense that the participants were intent on 'working through' their difficulties for a number of reasons, including the stigma associated with reaching out for help with mental health problems. The decision made by some of the participants to 'work through' their difficulties meant putting up with increasing mental health difficulties for long periods of time, driven by a belief that by doing so, a crisis would be avoided:

Anwen: "I tend to let it roll a lot and put up months and months of it (depression), trying to work through it myself. I might get depressed once a year but only twice have I ever been in the crisis house in 20 years...there is different levels... Sometimes you can work yourself out of that depression and it's not going to get to a crisis."

The responses by the participants appeared to reflect cultural sensitivities to seeking help, driven by societal assumptions that having a mental health problem suggests a sign of weakness or inadequacy:

Anwen: "That's how you get a lot of people who are mentally ill, their families didn't know it was coming because they tend to put on this mask, that they are coping. In society if you cope, you're a strong person but if you crumble 'oh you're weak'."

Lynne: "At the beginning I felt very inadequate for having to ask someone for help."

These assumptions appeared to motivate the participants in choosing to resist seeking help at this stage and appeared to be reflected in optimism about the extent of their mental health difficulties. However, the participants acknowledged that being resistant to their increasing mental health difficulties was only effective where their difficulties were manageable and therefore their resistance could be unsuccessful:

Sadie: "Most of the time I just ride through and I get over it. Unfortunately sometimes it just gets worse and worse."

This core category identified the participants' resistance and determination to continue coping with their increasing mental health difficulties without asking for help. It was also recognised though that at times, this was not always possible and that the participants' difficulties managing their increasing mental health difficulties got to such a degree that they reached a stage of crisis.

SUMMARY OF THEME: MOVING TOWARDS CRISIS

Moving towards crisis describes the participants' experiences of 'everything building up', to such an extent that for one participant, it felt as if there was no end in sight. The participants described a build of stress or distress associated with a variety of environmental factors that increased their psychological difficulties. Relationship issues, in particular, increased isolation and as the participants began to notice the psychological impact of this build up, they made efforts to resist their difficulties escalating. However, it was recognised that at times, 'working through' these difficulties was unsuccessful and that urgent help was then required. All of the participants recognised the stage at which they required help, which they identified as the breaking point. This is illustrated in the following theme (REACHING BREAKING POINT).

3.3 THEME TWO: REACHING BREAKING POINT (CRISIS)

Having moved towards crisis and their experience of that process, the participants then described their experiences of reaching a stage of crisis. Five core categories were identified that characterised their understanding of crisis; HELPLESSNESS, LOSS OF CONTROL, ISOLATION, HOPELESSNESS and IMPACT ON OTHERS. The participants described their experience of crisis in terms of reaching breaking point, which represented their experience of 'everything building up' to a point that became overwhelming and unmanageable:

Lynne: "Everything just came to a head. I think at that point I didn't go into work cos I realized I'd lost the plot. Everything just got on top of me. To use the word crisis, I was at breaking point."

The participants described a sense of feeling alone at the point of experiencing a crisis. The reasons that the participants found themselves coping alone have been captured in the following core category.

CORE CATEGORY ONE: ISOLATION

The participants described a sense of isolation in their crisis experience. This appeared to be related to thinking other people did not understand what they were experiencing, therefore leading them to conceal their thoughts and feelings from others for a number of different reasons. This then meant having no one to turn to for support, which promoted a sense of feeling disconnected from other people and the world around them. From the participants' responses, feeling isolated prior to reaching breaking point (crisis) or being an individual, who is typically avoidant of social contact, appeared to increase the likelihood of experiencing a crisis. There was one category, Coping alone and two subcategories, **having no one to turn to** and **disconnected from others**.

Category One: Coping alone

Coping alone was characterised by the participants feeling that others either were not able to understand their experiences (e.g. because of a lack of personal experience of mental health problems) or chose not to become involved. This appeared to leave the participants vulnerable to experiencing crisis on their own although many participants identified that they chose to conceal the extent of their coping difficulties. This was linked not only to perceptions about disclosing mental health problems and the reactions from mental health professionals, families or society (e.g. judgment) but also a wish to protect families from learning about the extent of their difficulties. The participants found themselves feeling alone and isolated, which appeared to make it more difficult to cope and became a central feature of their crisis experience.

Subcategory One: **Having no one to turn to**

This subcategory was characterised by the participants thinking that other people did not understand what they were experiencing, leading up to or just at this point of crisis:

Dai: "It feels like nobody can understand what I'm going through"

Thinking that other people could not understand their crisis experience appeared to manifest in assumptions that mental health difficulties are more difficult to discern because they might not always be evident (i.e. internal). There was also a belief that understanding is best achieved through personal experience and therefore, mental health professionals or other service users may be best placed to provide help because they are more likely to have experience of significant mental health and coping difficulties. The consequence of this thinking appeared to lead the participants to make decisions to conceal or mask their mental health difficulties, to such an extent that for one participant he changed his appearance in order to remain inconspicuous to others. In addition to thinking that other people would not understand their situation and thus provide suitable help, hiding thoughts and feelings from other people (including family members and work colleagues) seemed to make it difficult for the participants to access support and created a sense that they had no-one to turn to:

Gwyneth: "You feel as if you're on your own when you're not and it's hard to cope with that."

Gwyneth chose not to discuss the full extent of her experiences of depression with her family as she discovered that they were better able to cope as a family by not talking about her mental health difficulties. This seemed to be related to her family's struggle to accept her mental health problems and created a further sense of isolation for her. In turn, this made it difficult for her to find support when she most needed it and contributed towards her experience of crisis.

Having no one to turn to for support seemed to be interpreted by the participants as evidence of rejection or abandonment or necessary to avoid becoming a burden. The experience of coping alone in a crisis appeared to create a sense of disconnection from other people and the world around them, which the following subcategory identifies.

Subcategory Two: **Disconnected from others**

The participants described a sense of detachment, as if feeling disconnected from other people and the world around them, at the point of crisis:

Alun: "There's all these people with their cars, driving along. They seem really busy and I thought I can't handle that. It was alien to me, it was like I was outside looking in to something I didn't belong to."

Given that the participants felt that formal systems of support might come with unwanted consequences (e.g. compulsory hospitalisation) and for some, family support was unavailable (e.g. family members not being understanding of the participants' mental health difficulties), this appeared to create a scenario where the participants then found themselves in an isolated position. For Alun, his uncertainty about the reactions of others towards his mental health difficulties created his sense of disconnection, through his assumptions that his distressing experiences were unique and that others would not understand the extent of his difficulties. The experience for participants of isolation and disconnection at the point of crisis appeared to increase their sense of helplessness and hopelessness. The following core category identifies helplessness as described by the participants.

CORE CATEGORY TWO: HELPLESSNESS

Helplessness was characterised by the participants' inability to cope with their mental health difficulties. The participants reported firstly experiencing an inability to function, as a result of their increasing mental health difficulties beyond their capacity to cope. As their ability to function diminished, they reported becoming unable to cope on their own. For the participants, reaching a point of helplessness also appeared to contribute to experiences of anxiety and depressed thinking.

Within this core category there were two categories, Inability to function and Inability to cope.

Category One: Inability to Function

Inability to function was characterised by the impact of the participants' increasing mental health difficulties on their mind (e.g. confusion) and their body (e.g. physical exhaustion), to such an extent that they described becoming unable to function at the point of crisis. The crisis experience for the participants appeared to be so debilitating that it impacted upon their ability to focus their mind and carry out everyday tasks. As their mental health difficulties increased and their ability to cope diminished, the impact on their mind appeared to be significant and was interpreted by many of the participants as a shutdown of their brain:

Anwen: "It is a shut down, a little blip in the computer system, bang, gone and all that data's gone then for a couple of days. It's almost like you wake up out of it 3 to 4 days later and 'what the hell happened'? I think your brain does literally just shut down and do the vital things."

This suggests that at a point of crisis, service users are likely to be at an elevated risk of harm (either to themselves or others), particularly given that the experience of crisis appeared to create a sense of confusion, making it difficult for the participants to carry out everyday, personal tasks:

Gwyneth: "It's a mixture of confusion, not understanding just simple things, not being able to do simple things and then just letting yourself go personally, your personal everyday things I couldn't get right."

The impact of being unable to function and therefore losing everyday skills appeared to lead to several 'effects' (such as anxiety), which characterises the following category.

Category Two: Inability to cope

Being unable to function appeared to lead to an inability to cope, characterised by experiences of anxiety, depressed thinking (such as critical thinking and thoughts of self-harm) and an inability to manage mental health difficulties:

Lynne: "I was in crisis because I was feeling suicidal, I wasn't dealing with anything, I was depressed, anxious and I was seeing that as the meaning for a crisis."

Several of the participants indicated that they had experienced a sense of failure that appeared to arise from their experience of being in this position, as if they felt responsible for reaching a point of crisis. This sense of failure seemed to contribute to a feeling of uselessness:

Ceri: "Everything's crumbled and you feel like a total failure...I feel really, really guilty, really useless."

The participants who described a sense of failure had presented with a history or present diagnosis of depression, which suggests that perhaps they took from their experience of crisis, a meaning of a failing on their part to successfully overcome their increasing mental health difficulties. These participants also described either having a poor perception of formal systems of support (based on earlier experiences) or were unaware of suitable support (e.g. CRHT). In comparison, one of the participants who had described having a clear understanding of who to contact and where in the event of a crisis, did not allude to her meaning of crisis as a sense of failure. Perhaps, this suggests that having a clear understanding of the role and accessibility of formal systems of support reduces the likelihood that service users are to internalise a sense of failure. As the participants experienced a sense of helplessness upon reaching a point of crisis, their overall sense of control appeared to be drastically diminished. The following core category was considered closely related with HELPLESSNESS and

describes the process of losing control at a point of crisis, as described by the participants.

CORE CATEGORY THREE: LOSS OF CONTROL

Loss of control is characterised by the speed of onset of a crisis and the participants' inability to anticipate a crisis occurring. There were a number of triggers identified by the participants that contributed to their sense of a loss of control. Their diminishing control over their ability to cope with their mental health difficulties, further propelled the participants into a position of helplessness. This appeared to help create a vicious cycle of helplessness and loss of control. The categories that identify their experiences of loss of control are Rate of reaching breaking point and Losing control.

Category One: Rate of reaching breaking point

Rate of reaching breaking point describes the participants' experiences of the speed at which their crisis occurred. There was a sense that their crisis experiences were difficult to predict, which meant that following the build up to crisis, their ability to cope could change in an instant:

Sadie: "It's just all of a sudden it builds up and there's a switch and bang, that's it."

The sudden experience of a crisis appeared to reinforce the participants' sense of helplessness. They described different meanings that they attached to their experiences of crisis (e.g. that a crisis represented a loss of control, an inability to cope or feeling powerless to the interventions of the police or CRHT services), which reflects the uncharacterisable (i.e. one size does not fit all) experience that a crisis appeared to present. As Anwen described, a crisis is unique to the individual and a loss of control may occur at different stages, for different people:

Anwen: "People snap (experience a crisis through loss of control) further up the ladder and then other people snap further down the ladder. I think it's (crisis) just a unique thing to people."

Reaching a point of crisis for the participants meant losing the ability to control their behaviour and their emotions. There were a number of triggers described that enabled this process to occur and the participants also described their experiences of losing control, which offers a unique insight into the meaning they attached to their experiences.

Category Two: Losing Control

Losing control is characterised by fear (of the experience of losing control) and of becoming a different person, through behaviour uncharacteristic to the participants but influenced by their inability to cope with their mental health difficulties. The participants described different triggers they felt were responsible for their sense of a loss of control. These triggers included being under the influence of alcohol, experiencing bullying, rejection and family relationship difficulties. Distressing thoughts or symptoms of mental illness were also described as triggers. As Rebecca described, she understood her experience of crisis to have been triggered by alcohol that diminished her control over difficult emotions, built up over a period of time:

Rebecca: "I would have never gone and smashed up windows and I think by having alcohol, that's what I did. I think the drink can actually just push you over the edge, make you do things you shouldn't do really."

The experiences of losing control described by some of the participants embodied a sense of fear about seeing themselves differently or about being unable to control their behaviour at a stage of crisis. The changes in the behaviour of the participants were either identified by themselves, after a crisis event (e.g. engaging in destructive behaviour) or recognised by the members of their family. One of the participants described feeling ashamed about her

destructive behaviour after her crisis event whilst another participant reflected upon her experience of crisis (being admitted into a psychiatric hospital) and described feeling responsible for her behaviour in light of her having a mental illness.

For two of the participants, losing control was likened to the imagined sensory experience of 'freefalling'. This metaphor seemed to epitomise the experiences of losing control for the participants and further reflected their sense of helplessness. For Ceri, her meaning of crisis was characterised as a 'pit' that she made concerted efforts to avoid although acknowledged that losing control was a signal to her that she had begun to fall into the 'pit'.

Ceri: "Not being in control I guess is the falling bit. It's like you don't know when the end is going to be and there's nothing to cling on to."

At the point of crisis, the participants experienced a sense of isolation, helplessness and loss of control, all of which diminished their sense of hope. The following core category identifies their responses that reflected this sense of hopelessness.

CORE CATEGORY FOUR: HOPELESSNESS

The participants described a sense of hopelessness, which appeared to manifest from being unable to cope, contributing to their sense of a loss of control. Additionally, having no one to turn to emphasised their sense of disconnection and meant that for the majority of the participants, self-harming or suicide was a viable option and defined their sense of hopelessness. Within this core category there is one category, Reaching a Decision to Want to Die and two subcategories, **despair** and **wanting to die**.

Category One: Reaching a Decision to Want to Die

The participants talked about moving from a position of ambivalence over whether they lived or died, to a position of making and planning a decision to die. Their descriptions gave a sense of desperation, as if finding themselves at a point where they felt all hope had been lost and their options were limited.

Subcategory One: **Despair**

Despair describes the stage at which the participants experienced ambivalence about living, which seemed to stem from their inability to resolve their mental health difficulties. For Anwen, her sense of hopelessness was captured by her ambivalence over whether she lived or she died:

Anwen: "It got to the point where I wouldn't care if I'd been hit by a truck."

Despair for others, such as for Dai, was embodied within a sense of helplessness or an expectation that they would have to continue to deal with the problem they were experiencing on their own, as either help might result in a negative consequence (e.g. hospitalisation or displaying a sign of weakness) or would not be available:

Dai: "I was thinking to myself, no one's really going to help to solve the problem or get me to cope with the problem."

For some of the participants, their ambivalence towards living extended into a determination to die, as they became unable to tolerate their experience of significant psychological distress associated with their experience of crisis. The following subcategory identifies the responses by participants that described a stage they reached where they experienced a desire to end their lives.

Subcategory Two: **Wanting to die**

Wanting to die is characterised by a loss of hope, to such an extent that the participants felt that they needed to end their lives. The need to die appeared to be driven by going beyond a threshold of tolerance (i.e. being unable to tolerate further psychological distress) and then wishing for a way out of the despair. Being in a position of isolation by not wishing to disclose the full extent of their mental health difficulties meant that the participants' options for escape from their despair were limited. There was also a sense that feeling disconnected from other people influenced their thinking:

Lynne: *"You're just not connected with anybody and I think that's why some people end up maybe committing suicide."*

There was a real sense of determination in the responses of the participants that illustrated the depth of their despair at the point of crisis:

Sadie: *"I wanted to end my life basically. I felt I needed to hurt myself and end my life and it is at the time a need, it's real. You need to do it, same as you need to feed your children."*

Whilst all of the participants talked of having had thoughts of wanting to harm or kill themselves, two of the participants described the reasons that prevented them from committing suicide. These reasons included the consideration of the impact that it would have had on a family member. What prevented another participant from committing suicide was the fact that she felt she would be unsuccessful and as such, her inability to commit suicide became a point of self-criticism for her. Both of these participants had described feeling a sense of personal failure at reaching a point of crisis and perhaps their evaluations were indicative of their state of mind at a stage of crisis. This offers an insight into the experience of crisis for some individuals who perhaps neglect to comprehend the social factors (i.e. relationship issues, difficult living circumstances) present at the stage of crisis but rather internalise a sense of responsibility for causing the

crisis to occur. Participants not only talked about the impact for them on reaching a crisis point but also the impact on those around them. The following core category presents those responses.

CORE CATEGORY FIVE: IMPACT ON OTHERS

The experience of crisis for the participants appeared to have an impact on others. For the participants, the inability to function meant that their roles (such as job role or parental role) were compromised. The participants described how family members became invariably involved in their crisis experiences, such as intervening to prevent a suicide attempt, or becoming concerned about the welfare of the participants. Family members took on additional roles, such as children adopting the parental role by carrying out practical jobs or looking after siblings at home. There was a sense for Anwen, that a crisis was defined by the impact that it created for her family:

Anwen: "I knew it was a crisis when it started affecting the people around me. It wasn't just me anymore, it was my children and my parents."

Before moving on to the next theme, a summary of the theme REACHING BREAKING POINT (CRISIS) will be provided.

SUMMARY OF THEME: REACHING BREAKING POINT (CRISIS)

This theme identified the participants' responses relating to their descriptions, their understanding and meaning of a crisis. Participants defined this stage as reaching breaking point, a stage where they became unable to manage their mental health difficulties and as a result experienced a loss of control over what was happening to them. This loss of control and inability to cope and function appeared sudden and was difficult to anticipate. A cyclical process of losing control and being unable to cope was described, which was being reinforced by feeling isolated and disconnected from other people. Whilst some of the participants described themselves as isolated prior to reaching breaking point,

others talked about choosing to disconnect. Participants spoke about deliberate ways to mask their feelings whilst others described feeling out of reach of others because they perceived other people to lack understanding or concern. The impact of feeling disconnected, helpless and without control led to a sense of hopelessness, to such an extent that for some, committing suicide was a viable option. The impact of these processes on others was also described.

The next theme describes the stage at which participants talked about recognising the need to seek help. This theme also includes the participants' descriptions of their experiences of services' interventions.

3.4 THEME THREE: CONTACT WITH SERVICES

This theme incorporates three core categories ACCESSING HELP, BEING IN A POWERLESS POSITION and RECEIVING THE RIGHT SUPPORT. This theme captures the responses of participants that described the stage at which they accessed help from various sources (e.g. GP, disclosing to a family member). ACCESSING HELP is defined by the process of recognising that help is required and then asking for help. BEING IN A POWERLESS POSITION describes the situation some of the participants talked about in which they found themselves either having been arrested by the police or detained within a psychiatric hospital. Those participants who described these experiences provided responses that seemed to speak of a power imbalance between the participants themselves and the services. RECEIVING THE RIGHT SUPPORT describes the participants' positive experiences of receiving help.

CORE CATEGORY ONE: ACCESSING HELP

The participants described reaching a stage where they recognised that they needed help and how they made the decision to access help. They talked about the process of seeking help, some of the difficulties they encountered and the relief of getting CRHT support. Finding where to access help was relatively easy for some of the participants whilst for others, accessing support was more

difficult, based on either service criteria or services being unable to accommodate them. Those who described accessing help without much difficulty talked about having an understanding and the knowledge of who to contact, based on previous experience of making contact with local CRHT services. The participants described different forms of asking for help, which included speaking to family members for the first time about their feelings and current crisis experience and receiving feedback from family members about their behavior. Asking for help also seemed to reflect active measures taken by the participants in order to keep themselves safe:

Ceri: "I wanted to be under the crisis team cos I knew I'd gotten to the point where I couldn't cope and couldn't keep myself safe and I wanted to keep myself safe."

Accessing help seemed to signify a significant point for the participants. Despite their best efforts in resisting asking for help and making the decision to work through their difficulties, reaching breaking point (crisis) inevitably placed them in a position where without help, they would likely be unable to recover on their own:

Gwyneth: "I was quite at a state of crisis I couldn't sort of pull myself out of it... I just turned to the team to take over then if you like and then that sort of relieved how I felt."

Whilst the majority of the participants described their experiences of making contact with services (e.g. police, ambulance and CRHT services) as positive, there were stories that were shared that reported negative experiences. The following core category describes the stories of some of the participants who experienced compulsory intervention (which included police arrest and/or hospital admission).

CORE CATEGORY TWO: BEING IN A POWERLESS POSITION

This core category identifies the responses of participants that related to a sense of feeling powerless at the point at which services intervened. There is one category, Perceived Treatment by Services and two subcategories, **viewed as the patient** and **being done to**.

Category One: Perceived Treatment by Services

This category describes how the participants felt services lacked understanding about the situation in which they intervened and how this led the participants to experience being perceived as a mental health patient rather than as a human being. The participants described their experiences of encountering services at times of crisis and how they felt forced into a powerless position. This position was defined by the experiences of having their personal rights taken away without being informed what the processes or procedures were. Some of the participants described how they attempted to challenge this process.

Subcategory One: **Viewed as the patient**

Viewed as the patient is characterised by the participants' experiences of feeling judged by intervening professionals. The participants described their experiences of encountering services (e.g. Police, Ambulance Services and their local CRHT team) and how they perceived these services to lack understanding in relation to their situation. Viewed as the patient symbolises a power differential the participants identified, that appeared to occur between themselves and those within a professional position. For Sadie, this seemed to amount to a sense of being on opposing sides and captured her experience of a battle with police and ambulance services at a point of crisis:

Sadie: "At the end of the day it's still them vs. me. Them saying I'm ill and me saying I'm not. Whether they sit down and say it or whether they shout it

through the windows so everyone can hear, it makes no difference. They still think I'm ill and I don't."

There was a real sense of powerlessness in the responses of the participants who described experiences of encountering services in this way. The descriptions of the exchanges made with intervening services appeared to suggest that the participants identified themselves more as a patient receiving services rather than how they wished to be treated; as an individual in need of urgent support:

Lynne: "They (CRHT team) didn't know anything I felt they should have for me to feel more like a human being, I felt like a mental health patient. Which I am but I didn't want to feel like it. I was just somebody who was at the time, suffering from a mental illness."

The participants also described their experiences of receiving compulsory interventions, following their contact with services. Their responses are captured in the following subcategory.

Subcategory Two: **Being done to**

Being done to is characterised by having personal rights taken away without being given enough information about the process:

Lynne: "Everything was taken away (personal rights) without me having much knowledge of what was going on really."

The participants described how they felt the actions of services reflected a lack of understanding about how to support someone experiencing significant mental health problems. Being done to also characterises the experience of fear that was described in relation to a perception of the power mental health services can exert. One example of this was described by several of the participants as a fear of being hospitalised. Those who described this fear had in fact experienced hospitalisation previously, following a crisis. For Rhys, his meaning of crisis was

related to a fear he held about receiving hospital care indefinitely and was shaped by his previous admissions in which he described an experience of being detained without having enough information to understand the process:

Rhys: *“What a crisis means to me...is you could end up never getting out of the hospital.”*

This suggests that the experiences of making contact with services for service users can have a significant impact on how they view formal systems of support and what decisions they make to ask for help in future circumstances of crisis. In this instance, several participants who described their experiences of being in a powerless position also talked about a reluctance to ask for help during the build up to crisis, which meant that at the point at which services intervened, they were in a state of crisis and less able to challenge the views of the professionals. Understanding more about what provides a positive experience of crisis support for service users may aid service providers in encouraging service users to access help sooner. The following core category looks at the responses from participants that described positive experiences of receiving help, in particular from local CRHT services.

CORE CATEGORY THREE: RECEIVING THE RIGHT SUPPORT

This core category identifies the participants' positive experiences of receiving help from formal and informal systems of support. The majority of participants described how their experiences were mediated by being understood, being listened to and having their experiences validated, all of which meant that they felt a sense of acceptance. Reconnection was defined by these experiences and characterises outcomes. Within this core category there were two categories, Positive Experiences of Support and Outcomes.

Category One: Positive Experiences of Support

Positive experiences of support describes the experiences of participants receiving (informal or formal) support that was more likely to lead to better outcomes and result in crisis resolution. The system of support described by the participants included CRHT services, family or other mental health professionals. Some of the participants talked about their positive experiences in terms of validation. For many of the participants, this meant that they thought other people understood their experience, took them seriously and treated them like a person; providing them with an open and respectful space in which to talk about their mental health difficulties. Receiving validation also meant being listened to without judgment and learning about the individual in crisis. Where service providers met these criteria, the participants felt as if they were being treated like a human being and not as a patient:

Lynne: "They got to know me and that was more personal. I felt more like a human being."

Validation offered by service providers was more likely then to lead to the formation of meaningful relationships for the participants. Feeling validated not only appeared to enable the participants to feel like a human being but also meant that they did not need to communicate their distress through self-injury. Validation therefore, appeared to provide psychological containment:

Ceri: "If I can tell someone how bad I feel and they say 'yes, I can see that you're feeling anxious and I understand it', you don't need to hurt yourself to show it because they are listening."

The participants also talked about consistency of CRHT staff and how that contributed to their sense of feeling accepted. Having the same members of staff attending their homes meant that the staff got to learn about their circumstances and this appeared to strengthen the therapeutic relationship for the participants. Furthermore, by providing encouragement, CRHT staff were more likely to

reinforce the participants' feelings of acceptance. Being motivated by the CRHT team to engage in activities and challenge their negative thinking also seemed to enable the participants to make steps towards recovery and develop their resilience to cope.

Category Two: Outcomes

The participants described a process of reconnection, which characterises outcomes and derived from their positive experiences of receiving support. Feeling understood, accepted and supported, enabled the participants to regain their control and ability to cope with their mental health difficulties. The outcome of feeling more in control of their mental health difficulties was that the participants began to experience a sense of regained strength and a feeling of relief.

Practical support was described as useful, the outcome of which was that it enabled the participants to get back to a level of functioning of being able to continue with their daily routines and thus empowered the participants to take control over their lives again. Rebecca described how her experience of feeling understood and validated enabled her to begin to regain a sense of herself and the strength to move towards a position of recovery:

Rebecca: "She actually sat down and her first words were 'you shouldn't be in a place like this'... and I said 'I know' and we just talked about my life and my husband... I don't think for one minute she thought I was going to get sectioned but she must have thought, she needs help... from this I felt as if I was getting a little bit back to normal...I felt as if I was getting that bit of strength back."

A summary of the theme CONTACT WITH SERVICES will be provided before looking at the next theme (AFTER CRISIS).

SUMMARY OF THEME: CONTACT WITH SERVICES

This theme described the journey for participants, from experiencing a crisis to recognising that help was required. Making contact with services appeared to be a positive experience for the participants where they felt validated by the systems of support they encountered. However, negative experiences of contact with services, described by the participants, were characterised by feelings of powerlessness. Reconnection meant being heard, understood, validated and accepted by other people (e.g. services) and lead to positive outcomes, such as regained strength and control in their ability to cope. There was a stage described by participants that followed their experience of crisis and that defined the process of moving out of crisis and towards recovery. This stage was identified by the following theme and describes the participants' motivations to build resilience.

3.5 THEME FOUR: AFTER CRISIS

After crisis describes the participants' thoughts about their future after crisis as well as their reflections on their experiences of crisis. This theme has one core category BUILDING RESLIENCE, one category Moving Forward and two subcategories, **Learning to Cope** and **Towards the Future**.

CORE CATEGORY ONE: BUILDING RESILIENCE

The participants talked about taking steps to recovery, having activities in their lives and working towards regaining their sense of themselves again. The participants also talked about how they were learning or had learnt to cope and some of the participants acknowledged the progress that they had made.

Category One: Moving Forward

Moving forward describes the participants' journey of recovery following a crisis and is defined by **learning to cope** and **towards the future**.

Subcategory One: **Learning to Cope**

Learning to cope was described as a process over time. It involved confronting traumatic memories or experiences, using positive self-talk as a form of motivation to encourage participation in recovery-oriented activities (e.g. going out in the community and engaging in social activities with other people) and reflecting on what had been learned (i.e. what the participants had learned about themselves, such as isolation or avoidance acting as likely maintaining factors).

Reflecting on the crisis experience meant considering what to do to prevent a future crisis from occurring (i.e. how to cope, what signs to look out for, how to manage psychological difficulties and who to contact for help). Whether the participants had experienced multiple crises in the past or had only one experience of crisis, they all identified that they had reflected on what they had experienced and how they might manage increasing mental health and coping difficulties in the future. The difference however, seemed to lie in their decision about when to ask for help in the future. This was reflected in Anwen's response, who suggested that learning to cope with her symptoms of depression was critical for her because she felt that she would be unable to depend on other people for support:

Anwen: "It's something that you learn through the years, you learn to manage it a little bit yourself, you can't just rely on other people. It's something you learn to cope with."

Learning to cope, therefore, meant making sense of the crisis experience and learning how to manage mental health difficulties by reflecting on previous crisis experience(s), so as to avoid a crisis in the future.

Subcategory Two: **Towards the Future**

The participants also talked about rebuilding their lives after crisis and taking steps towards their recovery, which included planning events in the future.

Rebecca described a sense of self-assurance that she would not be experiencing a crisis in the future and a motivation to think positively for her future. The other participants, who described their actions to take steps forward, echoed her responses. These steps included talking to other people about their feelings as well as making efforts to reintegrate back into society. The participants also indicated that they had acknowledged the progress that they had made or were making. Ceri recognized that her most recent experience of crisis was shorter in duration, which she interpreted as her becoming more able to cope with the stresses and distress associated with everyday life. The acknowledgement of progress made by the participants appeared to suggest a sense of resilience in finding their ability to cope again:

Rebecca: "I think I've passed that now. I won't be calling on that crisis team again I know I won't be... I'm just trying to think, not negative, just trying to go forward."

Ceri: "I think that it was shorter so I guess that's positive. Makes me feel like I'm much better or much more able to cope with life and everything than I was 3-5 years ago."

Towards the future reflects the impact of the crisis experiences on the participants and their resilience in taking steps forward and acknowledging their progress in doing so. The participants identified a number of coping strategies to help them with this, which will be discussed in the following theme (WHAT HELPS), after a summary of the current theme.

SUMMARY OF THEME: AFTER CRISIS

After crisis was characterised by the process of building resilience. This was defined by the participants' motivations to learn from their crisis experiences and understand how to manage in the event of increasing psychological and coping difficulties in the future. The period after crisis also involved the participants focusing their efforts on getting on with or rebuilding their lives.

Some of the participants reflected on their behaviour at the time of crisis in order to make sense of the events that took place during that period. This seemed to help them develop their awareness of the triggers and signs associated with their experience of crisis, in order to support them in avoiding a relapse. The following and final theme identifies methods of coping from the perspective of service users in crisis.

3.6 THEME FIVE: WHAT HELPS

What helps is characterised by effective ways to reduce psychological distress and increase psychological wellbeing, in service users experiencing a crisis. This theme has one core category WAYS OF COPING, three categories, Time out, Connecting with Others and Methods of Coping.

CORE CATEGORY ONE: WAYS OF COPING

Category One: Time Out

Time out identifies that crises can be context-specific and time away from the context in which the crisis occurred (e.g. the home context) was reported to have had an immediate effect of improving wellbeing. Gwyneth's experience of crisis appeared to be precipitated by a breakdown in her relationship with her son who, over the years of witnessing her experience depression and in terms of his current age and circumstances, found it difficult to continue to support her. Gwyneth described feeling isolated and subsequently left alone to manage her symptoms of depression, which worsened until the point at which she felt she could no longer cope nor ask for support from her son and so contacted her GP. Having time out from her relationship with her son and the home context (within a hospital and day hospital context) provided her with the respite that she needed to manage her symptoms and work towards her recovery:

Gwyneth: "I knew then that I'd come to the end of reaching out and I really needed help. Hospital help then if you like, just to get away from the pressure of home."

The participants talked about having time out of the situation they were in during their crisis experience, in order to rest, recover, make sense of what had happened and manage their negative thoughts and mental health difficulties more effectively. Spending time away from their living situations was not only valued but having somewhere safe to rest, away from their responsibilities and everyday life stressors, was enough to foster recovery. Being taken out of the situation seemed to enable the participants to work through their mental health difficulties in order to reach a stage where they felt able to cope:

Anwen: "Taking me out of the situation and putting me somewhere totally different and I'll work through it."

Time out from the crisis situation for some of the participants meant talking about their experiences with other people (such as other service users in crisis), in a crisis house or crisis day hospital. Talking to other people about what they were thinking and feeling seemed particularly important for the majority of the participants and appeared to represent a deeper meaning for the participants; connecting with other people on a level at which they shared an understanding about their crisis experience.

Category Two: Connecting with others

Connecting with others is characterised by being around other people (who have had similar experiences or have knowledge about crisis) and sharing crisis stories. This meant talking to other service users who had experienced a crisis. Those participants who identified finding it difficult talking about their difficulties with other service users, described their process of connecting with others as being oriented around mental health care professionals (e.g. a Psychologist).

Being around other people that they felt comfortable with and thought were understanding, invited the participants to feel able to share their crisis experience, although, often just knowing that someone was there seemed to be enough:

Anwen: "I think it's important that there are people there, even if they don't say anything, even if they don't do anything, they're there."

Connecting with others is more than just being around other people. It speaks to a deeper, more emotional connection that seemed to exist between the participants in crisis and their peers or systems of support. This connection seemed to be facilitated by the listener showing understanding towards the participants and without judgement. Lynne described her difficulties connecting with people, which she attributed to her sense of abandonment that she had experienced at different stages throughout her life. Thinking that someone understood her and her experience was enough for her to feel connected and enabled her to move forward:

Lynne: "I'm in crisis, I need to talk about it. I look forward to seeing my therapist. I'm amazed by how much I get out of seeing her. You can say what's in your head and somebody that actually wants to listen. I think it's somebody listening that understands and who doesn't judge you. I wouldn't be able to cope if I didn't have that."

Talking about their coping difficulties leading up to a crisis was reported as difficult by the participants, as it meant placing themselves in vulnerable positions. The participants held beliefs about disclosure that impacted upon their decision to ask for help. At a stage of crisis however, where the participants recognised that they needed help, talking to other people became paramount. For Ceri, talking to members of the CRHT team, provided her with an avenue of neutral support where she could connect, without having to worry about the emotional impact upon the listener:

Ceri: "Having the crisis team meant that there was somebody to talk to who I could talk to openly, without feeling like I was upsetting them or letting them down."

When asked what advice participants would give to someone experiencing crisis, asking for help and talking to someone were offered as suggestions. Talking to a GP as a first contact was recommended although accessing any forms of help with someone who would likely understand was considered important.

In addition to finding a connection with others, the participants also valued several, specific methods of coping. These they had learned from their system of support and some they had developed from their own experience of managing their mental health difficulties. These methods of coping included relying on medication, finding ways to regain control or adopting strategies that placed them more in control of their distressing thoughts and symptoms of their mental illness.

Category Three: Methods of Coping

Methods of coping reflects the participants' will to regain control of their escalating mental health difficulties, using a variety of methods. Regaining control was achieved for one of the participants through challenging the symptoms of his mental illness (e.g. auditory hallucinations). Self-injurious behaviour was described as a further form of regaining control over negative thoughts and unbearable distress, whereas keeping busy (e.g. engaging in enjoyable hobbies or recreational activities, such as listening to music or driving) served the function of providing suitable distraction from negative thoughts and symptoms of mental illness. Medication was also considered an important treatment method for managing symptoms of mental illness. Following a crisis, control was important for the participants to restore and they seemed to value formal support that empowered them to control to some extent, the treatment that they received:

Ceri: "For me, being told what to do doesn't work...I have to feel like I'm in control. This time it was particularly helpful to be able to say I'd like this to happen and it did happen."

Despite describing a number of different ways of coping, some of these strategies appeared to be more effective in the short-term (e.g. self-injurious behaviour), given that many of the participants had employed them over the years but had nonetheless made contact with crisis services at different intervals. Where these coping strategies perhaps became ineffective were at points where they were unable to reduce the building stress and distress associated with a variety of environmental factors. It is at these points that the participants described reaching breaking point (crisis). Context seemed relevant here and from their descriptions of their crisis experiences and what support they found beneficial, it seemed more likely that a crisis might be avoided in environments where they felt supported, understood, accepted and safe.

SUMMARY OF THEME: WHAT HELPS

This theme identified the participants' ways of coping with their mental health difficulties, both in order to avoid a crisis, during or after an experience of crisis (e.g. as a form of resilience against further potential crisis experiences). Sharing their crisis stories with other people that would understand their experience was highly valued, as was having time out from the context in which the crisis occurred. Regaining a sense of control following a crisis seemed important as were finding different ways to decentre from negative thoughts and symptoms of their mental illness. These coping strategies appeared to offer the participants ways to manage with stress or distress associated with everyday living and to some extent, their symptoms of mental illness. However, environments that fostered acceptance, understanding and safety were considered more likely to prevent a crisis from occurring.

A summary of the results will now be presented.

3.7 SUMMARY OF FINDINGS

Five themes were identified from the responses by participants, which described the development of crisis, the experience of reaching a stage of crisis and the stages of accessing help and moving out of a crisis and towards recovery. Different ways of coping prior to and during a crisis were also described by participants and punctuated throughout the theory.

Figure 1. illustrates the Constructivist Grounded Theory of the process of disconnection and reconnection following a crisis. The theory offers an understanding of crisis from the perspective of service users. The theory suggests that the participants experienced a crisis when their resources to cope with increasing stress, distress or their existing mental health difficulties were diminished. The impact of significant life events or stress associated with the everyday life context contributed to an increase in their psychological distress. The theory postulates that the participants' perceptions associated with help-seeking behaviour (such as stigma towards mental health problems or fear of hospitalisation) seemed to increase their resistance to accessing mental health services. They described masking the full extent of their mental health and coping difficulties because of these perceptions, resulting in an experience of isolation and disconnection from other people. Where they became unable to manage their mental health difficulties on their own, they experienced breaking point (crisis).

A crisis was characterised by an inability to cope and function, which contributed to a loss of control and maintained a sense of helplessness. Isolation and disconnection were defined by the participants' perceptions that other people were not understanding of their mental health problems and increased their sense of helplessness. The theory suggests that the combining experience of isolation, helplessness and loss of control emphasised a further sense of disconnection, all resulting in a sense of hopelessness, such that suicide or self-harm became viable options to escape from their experience; all of which had a significant impact on other people around them.

Reconnection for the participants meant being understood by other people (e.g. other service users or professionals) and having their experiences heard and validated, which contributed towards their sense of feeling accepted (i.e. being seen and treated as a human being and not as a patient). Feeling empowered (such as being involved in care and treatment planning) or receiving encouragement, enabled the participants to regain their sense of control over their lives and their mental health difficulties. In contrast, where the participants perceived other people (e.g. services) to lack understanding about their situation, behaviour and experience, they described a sense of powerlessness.

The theory offers that the participants built their resilience towards further crises by reflecting on their crisis experiences and through learning to cope with their mental health difficulties (e.g. what to do in the event of escalating mental health difficulties). Several strategies such as engaging in activities to keep busy and having time out (e.g. time spent in an environment away from the home context) further enabled the participants to regain their sense of control over their mental health difficulties.

The following chapter will discuss these findings in relation to the existing literature, consider the limitations of the study and the implications for current practice, before discussing recommendations for CRHT services.

CHAPTER FOUR DISCUSSION

4.1. OVERVIEW

This chapter will discuss the findings from this study and consider them alongside existing, relevant research, in order to draw comparisons and identify gaps that this study addresses. The implications for CRHT service implementation and delivery will be considered as well as the methodological strengths and limitations of the study. Recommendations for further research will also be outlined.

4.2 RESEARCH FINDINGS AND THE EXISTING LITERATURE

The main purpose of this study was to explore service users' constructions of crisis in order to develop our understanding about their experiences and consider the implications for service delivery, at the level of the formal and informal systems surrounding the individual. The study also aimed to consider how these aid the resolution of crises. Five key themes were identified from the analysis: 'Moving towards crisis', 'Reaching breaking point (Crisis)', 'Contact with services', 'After crisis' and 'What helps'. The main findings will be discussed below in sections as each theme is presented and specific results will be linked to the existing literature. A summary of the Constructivist Grounded Theory will then be presented by comparing it to existing theories and our current understanding of crisis.

For ease of reading and consistency, the **THEMES** will be presented in bold capitals, the CORE CATEGORIES in capitals, the Categories in underline and the **subcategories** in bold, lower case.

4.2.1 THEME ONE: MOVING TOWARDS CRISIS

This theme captured the experiences of the study participants who considered themselves to be on the verge of experiencing a crisis. The contributory events to crisis that were captured in the findings were varied and included relationship issues, loss, stress associated with work, difficulties with finances and loss of housing. These findings support Rosen's (1997) description of a situational crisis and have been illustrated elsewhere (Borg *et al*, 2011). However, what has not been documented as far as the author is aware is the relationship between a build up to crisis, the sense of difficulties becoming apparent and then efforts to prevent a crisis from occurring and resisting contacting for external help.

This theme provides personal meaning to the process of building towards crisis that is not only integral to the framework of CRHT (Karlsson *et al*, 2008) but also offers an insight into what might lead to a crisis and the interactions between the causes of crisis and the personal significance of those causes. Whilst the process of the build up included a variety of environmental events, the interactions between these events and the experiences and meaning of having a mental illness for an individual suggest an association. Whilst other theories have suggested either a situation or force causing alterations in normal functioning (Caplan, 1964) or strengths and weakness in social support systems (Bridgett & Polak, 2008) what is less known is the meaning of the impact of these factors on an individual and why these factors might lead to a crisis.

The core categories in this theme support the theoretical views of Rosen (1997) in terms of a stage of mounting tension, however, they offer an insight into the personal meaning of this experience. Within the current study, the personal meaning to the participants of resisting making contact with services at this stage, included avoiding a sense of personal failure and abiding by personal rules for living (e.g. by getting on with things). They also alluded to the threat of being admitted compulsorily into a psychiatric establishment, which has been evidenced elsewhere (e.g. Bristol MIND, 2004), or showing a sign of weakness within a society that they perceived values strength. Public stigma is associated

with attitudes towards mental health services and help-seeking behaviour (Vogel *et al*, 2009). As one of the participants suggested, the experience of crisis for any individual is unique. Therefore, moving away from attempts to establish causal factors and more towards the personal significance of these causal factors on an individual with mental health difficulties might provide a clearer understanding of their experience.

The core category TRYING TO COPE WITHOUT SEEKING SUPPORT was closely aligned to another core category (ISOLATION) in that it described the participants wanting to be seen as 'capable'. This core category also speaks to broader issues of service users' experiences of marginalisation and discrimination, issues that can impact upon how accepted service users feel within society (Mental Health Foundation, 2000). The core category ISOLATION was linked to this theme in that showing to other people their capabilities of managing their mental health difficulties without support invariably meant the participants were left to cope on their own.

Many of the service users who participated in the current study described having experienced multiple crises yet despite their awareness of signs, there was a sense that they were unable to prevent a crisis from occurring. One explanation relates more to the experience of losing control of their ability to cope, which was described as sudden and has been evidenced elsewhere (Borg *et al*, 2011). Another explanation may well be related to their decision to 'work through' their mental health difficulties. There was also an indication that for several of the study participants, a crisis was considered to be more of a problem for people around them (e.g. family members, services) than for themselves. This would suggest a dichotomous relationship between the meaning of a crisis for service users and the definition of crisis understood by mental health services and appears to relate to how well services understand the experiences of service users in crisis (Lyons *et al*, 2009). What the current findings suggest is that the occurrence of a crisis for an individual is based upon the personal significance of the events they consider to be contributory to a build up. In addition, their sense of how to manage increasing difficulties with coping with mental health

problems as well as the personal meaning of experiencing mental health problems, will determine the meaning of their experience of crisis. The following theme discusses this meaning in more detail.

4.2.2 **THEME TWO: REACHING BREAKING POINT (CRISIS)**

Whereas in the existing literature, service users have defined a crisis as a feeling, a loss of control and an inability to cope (e.g. Bristol Mind, 2004) such that their mental or emotional state requires immediate help (MIND, 2011), there has yet been an exploration into the relationships between these experiences.

Breaking point was characterised by a cyclical process of a loss of control and a sense of helplessness. Lyons *et al* (2009) found an association between loss of control, being unable to cope and being alone that led to service users experiencing a sense of desperation and the current findings support this process. This process appeared to be associated with a period of confusion and lack of understanding for the participants, which supports existing evidence that describes this phenomenon (Borg *et al*, 2011). Reaching breaking point was described as sudden and the descriptive accounts of losing complete control were vivid examples of the impact of crisis. They also suggest important considerations for interventions that might in some ways mirror the experience of crisis by failing to empower or reinstate a sense of control in service users. Service providers, therefore, should consider the value service users place in having choice and control over their treatment (MIND, 2011; Iqbal & Moiser-Nagaür, 2013).

HELPLESSNESS was closely related to LOSS OF CONTROL and was defined as a stage at which service users lost their ability to manage their mental health difficulties on their own. For many, this stage and the sense of a loss of control was beset by fear; a fear of being admitted into hospital or fear associated with further losses of control and supports existing evidence (e.g. Bristol MIND, 2004). The stages of being unable to function, the 'effects' of crisis and the experiences of what it was like being unable to cope, signify the extent of

helplessness and subsequent distress service users experience during crisis (e.g. MIND, 2011). The descriptive accounts of becoming unable to function support Caplan's (1964) view of a crisis disrupting an individual's homeostasis. In the current findings however, the personal meanings of this experience are more evident and the participants described a 'shutdown' of the mind. This appeared to be to such an extent that experiences of disorientation during crisis were described (e.g. forgetting aspects of their experience or 'coming out' of crisis several days later.)

The findings suggest that in addition to experiencing a loss of control and helplessness at a stage of crisis, service users cope with their mental health difficulties on their own, due to a variety of different reasons. The process of being in this position starts with a perception that other people do not have a good enough understanding of what someone experiences during crisis (e.g. Bristol MIND, 2004). What the findings seemed to suggest was that for someone to qualify as having a good enough understanding from service users' perspective, they would either need to have a level of professional expertise or have experienced mental health difficulties themselves.

Agar-Jacomb & Read (2009) identified the needs of service users in crisis, which included contact with other service users. This finding is also supported by MIND (2011) but little further evidence exists that suggests why this might be the case. The findings from the current study offer several explanations. Firstly, several of the participants talked about societal perceptions of mental illness that influenced their decision not to disclose the full extent of their mental health difficulties to other people. Secondly, the findings echoed those from the study conducted by Bristol MIND (2004) and suggest that receiving unhelpful, misguided advice from other people, including family members, could lead to a perception that other people either do not care or do not have an interest in becoming involved. In turn, this might lead service users to conceal their mental health difficulties from other people and to feel that they have no one to turn to for support (Lyons *et al*, 2009).

The participants described their reasons for choosing to conceal their mental health difficulties from other people, which included protecting family members from the emotional pain of discovering the extent to which they experience a sense of hopelessness and thoughts of wanting to self-injure. Other reasons that were described, included wanting to avoid discrimination and the stigma associated with mental illness in society, by masking feelings and presenting an appearance of psychological composure.

The language used described a dialectic between strength and weakness, where asking for help was considered a sign of weakness or inadequacy and recovery from crisis was described in terms of regaining strength. The current findings suggested that having no one to turn to created a sense detachment and disconnection from other people and from the world, which were either part of the experience of crisis or created through deliberate means of isolation and might suggest why connecting with others is considered a need for service users in crisis (Agar-Jacomb & Read, 2009).

HOPELESSNESS described a process of moving from being initially ambivalent towards living, to a position of wanting to die. **Wanting to die** described a determination and need to die and exemplifies the level of despair that service users can experience by reaching a stage of crisis (e.g. Lyons *et al*, 2009). In addition to experiencing a need to die, the findings also revealed a difficulty the participants experienced in committing to self-injurious behaviour because of either the impact on other people or because of a belief that any attempt would be deemed to fail.

In terms of the impact on others, the findings suggest that as well as having a significant impact on service users, a crisis can affect the people around them. These groups of people included family members and those affected by service users' inability to carry out work responsibilities effectively. The impact on family included a change in roles within the family, as children became involved in caring roles as well as becoming directly involved in resolving crises or contacting services for help. Khalifeh *et al* (2009) conducted a study exploring

the impact of crisis on mothers and found that the participants' experiences of crisis pushed care giving responsibilities on to their children. Crisis Houses have been found to be beneficial in ameliorating the impact of crisis on children, by providing an alternative to home or hospital treatment (Khalifeh *et al*, 2009) and there are mixed views between service users on the benefits of children attending Crisis Houses with their parents (Johnson *et al*, 2004). The current findings raised issues about the potential impact of multiple crisis episodes on children, at various developmental stages. In terms of the shifting of roles within families, role adaptations of children during periods of crisis are unlikely to affect their perception of parenting (Aldridge, 2006) however, it has been recognized that CRHT interventions for families should consider acceptable and accessible means of providing help that addresses families' unmet needs (Khalifeh *et al*, 2009).

4.2.3 **THEME THREE: CONTACT WITH SERVICES**

This theme described the process of making contact with services, which included primary care services, CRHT teams, Police and Ambulance services. This theme relates to the way CRHT services are structured in meeting the needs of individuals in crisis. The experiences of service users accessing help were deemed positive if they were met with an understanding other who enabled them to share their experience and empowered them to become actively involved in the care they received (e.g. National Audit Office, 2008). Supporting the existing evidence, the current findings also suggest that service users are far more likely to respond to interventions where they are met with consistency of staffing (Iqbal & Moiser-Nagaür, 2013; Taylor *et al*, 2012) and encouraged to engage in meaningful activities as well as encouraged to challenge their negative thinking (Goldsack *et al*, 2005).

'Understanding' is a concept that runs throughout the constructivist grounded theory and having an 'understanding other' appears to be a fundamental need to service users experiencing a crisis (Agar-Jacomb & Read, 2009; Middleton *et al*, 2011). Interestingly, the meaning of an 'understanding other' from the

perspective of the participants was an individual with experience, either achieved through a level of professional expertise or personal experience of crisis or similar mental health difficulties. Service users in the current study valued their experiences being validated by the mental healthcare professionals they came into contact with, which facilitated their sense of reconnection. The participants were particularly vulnerable at the point of making contact with CRHT services and so it is not surprising that they seemed to develop strong attachments to 'understanding' professionals providing acute mental health support (Seager, 2006). Distinctions between being seen as a mental health patient and being understood as a person were evident within the findings and have been evidenced elsewhere (Hopkins & Niemiec, 2007; Winness *et al*, 2010). Therefore, by acknowledging that service users are experts of their experience could elevate their sense of themselves from a mental health patient to a person being treated for an illness. In terms of a model of recovery and with reference to the current findings, promoting personal growth is achieved by recognising service users on their own terms in a non-judgmental way and acknowledging their struggles and the work they put in to manage those struggles (Eriksen *et al*, 2012).

This theme also identified that in the majority of cases, service users were recognising the need for help although in some instances this help was not being offered. Winness *et al* (2010) found an emerging theme relating to issues of access and availability within their systematic review and suggested that flexible services are more likely to achieve positive outcomes. Certainly, the existing evidence suggests that service users value accessible and available services (Hopkins & Niemiec, 2007; MIND, 2011; Iqbal & Moiser-Nagaür, 2013).

Improving links between service providers and service users that take into account the sensitivity of sharing their experience with other people, might circumvent an individual's mental health difficulties increasing to such a degree that they reach a stage of crisis. The implementation of the Mental Health (Wales) Measure 2010 (Welsh Assembly Government, 2010) might offset the number of people reaching crisis by providing accessible, local support services

for people with severe, enduring but stable mental health difficulties. This is certainly an area for future research, in evaluating what impact these local support services have on the figures of people accessing CRHT in Wales.

One of the guiding principles of the CRHT service model is to actively involve service users in their care and treatment (Department of Health, 2001). However, the current findings suggested that for some of the participants, their experience of contact with services were associated with feeling powerless. The findings highlight the importance of understanding the service user experience in mental health services (Karlsson *et al*, 2008) and how to consider ways that service users can be supported in moving beyond a position where they feel helpless and without a sense of control, to a position where they can regain their sense of control (MIND, 2011).

The current findings show that providing service users with information about their treatment is likely to lead to positive outcomes and echoes existing evidence (Taylor *et al*, 2012). Iqbal & Moiser-Nagaür (2013) found that service users felt empowered by being actively involved in decisions oriented around their care needs. They recommended providing further information to service users on their medication, follow-up care and routes to contact services in the future. Service providers that fail to offer as much information as is necessary for service users to have a good understanding about the processes of receiving help are, in many ways, mirroring the experience of crisis that is characterised by a lack of understanding and a sense of powerlessness at being seen and treated like a mental health patient (Hopkins & Niemiec, 2007). Therefore, service providers should prioritise improving systems of communication to service users and their carers so that they feel adequately informed about the treatment they receive.

4.2.4 **THEME FOUR: AFTER CRISIS**

This theme relates to two other guiding principles underpinning the CRHT model; resilience and learning to cope (Department of Health, 2001). The

participants reflected on their experiences of crisis and in particular, on their experiences of losing control and on their intentions to commit suicide. The experience of reaching a stage of crisis appeared to galvanise several of the study participants into taking action; either to ensure another crisis does not occur in the future or to increase efforts to integrate back into society. There were also opportunities to learn from the experience of crisis in order to recognise signs of a future crisis approaching. Talking in itself was considered a step forwards and any progress that had been made since their experience of crisis was acknowledged.

These reflections appeared to form part of an important process of recovery and the participants that were involved in the focus group discussed the process of returning to a sense of normality following a crisis. Defining the parameters of normality appeared a somewhat ambiguous task and therefore, it was decided that 'achieving normality', in the concrete sense, was more appropriate to their experiences. This meant getting back to the lives they led before their crisis occurred, which could include returning to familiar environments, roles or responsibilities. Similarly, Borg & Davidson (2008) conceptualise recovery as a social process as well as an integrated part of service users' daily lives. Therefore, service providers should consider interventions that are embedded within the social environments of service users and enable service users to be reinstated into familiar roles.

Whilst the participants in the current study spoke about receiving encouragement from formal support systems, hope did not emerge as one might expect, in the context of recovery. Supporting and engaging service users' capacity towards recovery is a critical role for mental health professionals (Borg & Kristiansen, 2004) and promoting hope and optimism for the future is an important aspect of that process (Bonney & Stickley, 2008). The period after crisis presents an opportunity for formal support systems (i.e. CRHT teams) to validate service users' progress, recognise their intentions to 'work through' mental health difficulties and the struggles of doing so and promote personal growth by highlighting their resilience in making steps towards regaining

control over their lives. These are important considerations for CRHT service planning and delivery in continuing to work towards improvements based on the needs of service users in crisis.

4.2.5 **THEME FIVE: WHAT HELPS**

This theme relates to ways of coping, either before a stage of crisis (i.e. strategies to cope with the management of mental health difficulties) or during. The findings from the current study substantiate existing findings, relating to the value service users hold towards making contact with other people (Agar-Jacomb & Read, 2009), sharing their experiences with others (MIND, 2011), using methods of distraction and keeping busy in order to regain a sense of control (Mental Health Foundation, 1996), using medication (Mental Health Foundation, 2000; Bristol MIND, 2004) and having time out from the crisis 'situation' (Agar-Jacomb & Read, 2009).

Being around other people and sharing their experience was valued highly by the participants, provided that those people they connected with were understanding and showed an interest in listening, as evidenced by Agar-Jacomb & Read, 2009. Being around other people appeared to be a useful way to distract from thinking negatively and critically about the self as well as providing safety from opportunities to self-harm. Interestingly, the coping strategies described by the participants were all active whereas in other research findings, more passive forms of coping, such as relaxation and meditation, have been preferred (Bristol MIND, 2004). These variations in coping strategies emphasise the importance of understanding the individual in crisis and what methods of coping are likely to successfully promote resilience in that individual.

Trying to regain control was considered important and was described in different forms. Self-injury provided one mechanism of taking control whilst listening to music, challenging symptoms of mental illness (e.g. auditory hallucinations), engaging in hobbies and driving were also useful ways to cope with mental health difficulties at a level that was manageable. These findings

support Faulkner & Layzell's (2000) report into the strategies endorsed by service users in times of mental distress and suggest 'taking control' as an important characteristic of crisis recovery.

This theme adds to the existing literature on what service users find helpful in terms of being able to effectively cope with periods of acute distress, either in order to avoid a crisis from occurring or having reached a stage of crisis. What seems particularly significant from the findings of the current study is that finding an 'understanding other' to talk to and share experiences with is critical.

4.3 COMPARING THE CONSTRUCTIVIST GROUNDED THEORY WITH THE CURRENT UNDERSTANDING OF CRISIS

Our current understanding of crisis based on theoretical conceptualisations, broadly covers how an individual experiences crisis (Caplan, 1964; Rosen, 1997), crisis as seen from a social systems perspective (Bridgett & Polak, 2003a) and crisis as defined operationally (Department of Health, 2001). Experiences of crisis from the service user perspective are beginning to emerge and constitute an important foundation for CRHT development and implementation. In an effort to address the need for an understanding of service users' theories of crisis (Winness *et al*, 2010), what the constructivist grounded theory presented here offers is a theoretical understanding of crisis from the perspective of service users. Furthermore, having been conducted in line with quality guidelines to address issues of reliability and validity (Elliott *et al*, 1999), this study provides findings that can be considered with confidence.

Based on Caplan's (1964) original theory of crisis, Rosen (1997) defined a crisis in stages, where the initial stage of increasing tension leads to problem solving responses in an effort to maintain a state of equilibrium. Within the constructivist grounded theory, this was conceptualized as **MOVING TOWARDS CRISIS** and the problem solving responses described by service users, signified a determination on their part to manage their mental health difficulties on their

own. Contacting services would mean either a sign of failure or weakness or might jeopardise their intentions to avoid hospital admission.

REACHING BREAKING POINT (CRISIS) was understood by service users to represent their meaning of a crisis. Supporting existing descriptions of the experience of crisis (e.g. Bristol MIND, 2004; MIND, 2011), the constructivist grounded theory supposes that an individual's inability to cope is reinforced by their sense of a loss of control over managing their mental health difficulties. Experiences of anxiety and changes in mood and behaviour were evidenced in this study and support Rosen's (1997) description of crisis. There was also evidence of difficult social circumstances that precipitated crisis (e.g. bullying at work, relationship difficulties, lack of social support) that supports a social systems perspective of crisis (Bridgett & Polak, 2003a).

However, where the constructivist grounded theory presented here differs is in the consideration of the psychological impact of coping alone and the interactions between different processes. Experiences of disconnection, abandonment and burdening others were evidenced in the findings of the current study and contributed towards both the cyclical process of helplessness and loss of control, in addition to a sense of hopelessness. Whilst the service users in the current study defined crisis in various ways unique to their understanding of it, what connected their constructions of crisis were the relationships and interactions between these processes.

The findings support the understanding that at the point of crisis, service users are at risk of harm to themselves or others (Lyons *et al*, 2009; Minghella *et al*, 1998). Furthermore, the current study distinguishes between ambivalence towards living and serious intentions towards suicide. From a CRHT service perspective, understanding the different levels of risk associated with a crisis is critical in making a judgment towards appropriate interventions. Several responses from the participants suggested that despite efforts to make contact with services to request help, service users were declined help based on service criteria. The constructivist grounded theory suggests that failing to recognise the

needs of service users in crisis (such as the need to talk to and be accepted by an understanding other) may only exacerbate the situation and prolong the distress associated with crisis. The needs of service users in crisis have been evidenced elsewhere and support this theoretical assumption (Agar-Jacomb & Read, 2009). Furthermore, the current findings suggest that the experience of having their needs unmet may result in service users experiencing a position of powerlessness.

Whereas Rosen (1997) described crisis resolution as an adaptation to new circumstances resulting in a stable state, the constructivist grounded theory offers personal accounts from service users that describe what helps in resolving crisis, such as feeling reconnected with other people. **AFTER CRISIS** and **WHAT HELPS** define the experiences of service users moving past their experience of crisis and consider the ways that are most effective in coping before or at a stage of crisis. What seems fundamental in aiding resolution is providing service users the opportunities to talk to someone who is likely to understand and validate their experience (Agar-Jacomb & Read, 2009) as well as finding ways to reinstate a sense of control so that service users feel empowered to make choices about the directions of travel towards recovery (MIND, 2011). It has been suggested that a state of crisis can last several weeks or months (Rosen, 1997) therefore, the theme **AFTER CRISIS** does not reflect a particular timeframe but rather constitutes service users' reflections on their experiences of crisis and their efforts to build their resilience to a crisis should one approach in the future.

The implications of the findings on CRHT service implementation and delivery will now be considered.

4.4. IMPLICATIONS OF FINDINGS TO CRHT SERVICE IMPLEMENTATION AND DELIVERY

Relating these findings to the CRHT criteria outlined by the Mental Health Policy Implementation Guide (Department of Health, 2001) shows that current policy only defines crisis by the severity of acute mental health problems. These

findings offer an explanation to how mental health problems might become acute to such a degree that CRHT is required. Winness *et al* (2010) suggested a need to understand service users' theories of crisis in order to cultivate service response strategies that are most effective to the needs of service users at times of crisis. What the constructivist grounded theory presented here suggests are multiple processes that might warrant separate attention.

Supported by the systematic review, the findings suggest that the experiences of service users receiving CRHT are on the whole, positive. At a service delivery level, the formal systems of support in place appear to be meeting the needs of service users. At a planning and implementation level, consideration might go towards improving the access and availability of suitable systems of support for service users moving towards a crisis. At the pre-crisis stage, formal systems of support that recognise the difficulties for service users talking to other people about their mental health difficulties (Bristol MIND, 2004) might empower them to access channels of support on their own terms.

Other ways that might be considered to empower service users include improving communication about what CRHT can offer. From the current findings, there were a number of participants who were unaware of CRHT not least what the service could offer. As the majority of study participants indicated that their first port of call in a psychiatric emergency would be to talk to their GP, this suggests improvements in the way information is communicated between primary care services and CRHT services, as service users have indicated they value a smooth transition (Hannigan, 2010). The primary care support services that have been implemented as part of the Mental Health (Wales) Measure 2010 might provide some stability to service users aware of a crisis approaching and in need of support to alleviate their mental health difficulties.

There is some evidence from the findings of the current study that supports existing evidence, suggesting that service users might not be being given enough information about the processes and procedures involved at the intervention and treatment stage, following contact with acute mental health services

(National Audit Office, 2008). The evidence suggests that this can contribute to a sense of powerlessness and might impact on service users' decisions to make contact for help in the future. Evaluating the process of service users making first contact with mental health services, either at the pre-crisis stage or during a crisis, would be a useful step in considering improvements in the way information is shared with service users.

The findings here also suggest that crises are resolved through being listened to and understood, connecting with other people and having control restored. The evidence from the current findings show that whilst informal systems of support (e.g. friends and family) are valued and for some, can imbue a sense of acceptance, service users on the whole, would prefer to talk with someone with either professional or personal experience. The implications for service providers are to consider how families and carers might take more of an ownership of this key role. Providing training to families and carers about the stages of crisis and the experiences of crisis from the perspectives of service users could develop this role. This is in view of the evidence for social systems interventions (Bridgett & Polak, 2003b).

Time out from the crisis 'situation' was also highly valued, which for several of the participants meant time away from the home environment. Of course, this has implications for home treatment and raises questions about suitable residential alternatives. Johnson *et al* (2010) consider the comparison of cost-effectiveness between residential alternatives and hospital admission in order to assess the suitability of residential alternatives within local acute care pathways. They argue that residential alternatives such as Crisis Houses do cost less although might offer less in terms of clinical improvement. They suggest that by offering a wider range of acute interventions, the Crisis House model may thrive.

In Wales, the first Crisis House was established in 2006 and as far as the author is aware, is the only Crisis House in existence in Wales (Gofal Cymru, n.d.). In an evaluation of the service, the feedback from service users was positive and the majority of service users returned home following their admission to the Crisis

House, in comparison to a small percentage who required hospital admission (Gofal Cymru, n.d.). Crisis Houses offer a viable alternative to hospital admission and also the opportunity for service users to have time out to rest, recover and reflect upon their crisis experiences (Johnson *et al*, 2004), all of which form part of the process of building resilience.

4.4.1 *Implications for clinical practice*

The implications will be considered within the clinical cycle framework of assessment, formulation, intervention and evaluation. The findings and existing evidence (e.g. Bristol MIND, 2004) suggest that service users are presenting to crisis services having reached a sense of hopelessness to such an extent that for some, they have given considerable thought to ending their lives. Mental health service providers should therefore consider routinely assessing for hopelessness and indicators of risk of self-harm at the point of initial assessment. The findings also suggest a number of predisposing factors, such as isolation and limited social support and maintaining factors, such as limited control over their increasing mental health difficulties, poor relationships with service providers and inadequate living conditions.

In line with evidence that suggests service providers should intervene before a crisis escalates (Taylor *et al*, 2012), these predisposing and maintaining factors should be considered in order to formulate the risk an individual presents with and their vulnerability to experiencing a crisis. Using a formulation-based approach would serve to align with the current drive in mental health service provision in promoting psychological health and well-being (British Psychological Society, 2009).

In terms of intervention, service providers should consider interventions based on the experiences of service users (i.e. addressing helplessness and loss of control) and evaluate specifically targeted areas (i.e. interventions that enable service users to regain control over their difficulties) to assess the success of these interventions in aiding the resolution of crises (Hopkins & Niemiec, 2006).

4.5 STRENGTHS AND LIMITATIONS OF THE CURRENT STUDY

The current study explored service users' experiences of crisis to reach a closer understanding of their experience and consider the implications for CRHT service implementation and delivery. There is an emerging evidence base for service users' experiences of crisis, however, this study is the first in offering a theory of crisis from the perspectives of service users.

Participants in this study were recruited across three separate Crisis Services in South Wales. Limitations of the study include the ethnic diversity of the sample, given that all of the nine participants that took part were of the same ethnicity. Whilst the ages of the participants varied and offered a relatively even spread across the spectrum of working age adults, there were more females (n=6) in the study than males (n=3), suggesting an over representation of females. The diagnoses of the participants varied, as did the number of contacts made with the local CRHT teams. This latter point highlights a limitation of the study in that there was a dichotomy between participants who had experienced a crisis for the first time and participants who presented with a history of crisis experiences.

The experience of 'moving towards crisis' between these two groups of service users was qualitatively different in several cases (e.g. in terms of recognising signs of a crisis approaching based on previous experience) although the processes involved were similar (i.e. the build up to crisis and the efforts to 'work through' their mental health difficulties). Several of the participants talked about their experience of crisis within the context of being arrested and/or being admitted compulsorily into a psychiatric hospital, which suggests a limitation in the fact that the entry into CRHT was different amongst the participants.

Whilst there were some differences in how the participants interpreted their personal experiences of crisis, it was difficult to determine if this was influenced by their specific diagnosis or by their personal circumstances, relationships, life story or types and frequency of crisis experiences they had. The findings suggest that their interpretations were influenced by all of these things and the themes,

categories and subcategories captured their understanding of crisis. However, it may be useful for service providers to learn if specific diagnoses influence how service users interpret, experience and cope with a crisis and in that instance, this might represent a further limitation of the current study.

Difficulties with recruitment were encountered, which might highlight limitations with the methodology. However, upon receiving feedback from service users who took part and service users who showed an interest in taking part but eventually did not do, one of the reasons appeared to be related to the fact that talking about crisis has the potential of bringing up experiences that some people would rather forget. Also, there were a number of people who wished to take part but felt unwell at the time the interviews were conducted and were unable to reschedule because of their availability. It raises an issue about the impact on service users of taking part in research that requires them to discuss often distressing experiences. The service users that did take part did so voluntarily and all commented that they were keen on being involved, so as to help other people in crisis understand what the experience is like.

The application of a constructivist grounded theory approach (Charmaz, 2006) and the measures to ensure reliability and validity of the data were strengths of the study. This methodology promotes transparency about the researcher's epistemological position and fits with the phenomenon that was being explored. The high level of reflexivity was supported by regular supervision in addition to memo and journal writing and contrasts with the existing literature on service users' experiences of CRHT that fail to address this adequately.

The use of triangulation from different sources (i.e. regular use of supervision and a focus group) supported the validity of the findings, where the emergent analysis was presented within supervision at different stages and the grounded theory discussed with a sample of the participants. This conformed to good qualitative practice as recommended by Elliott *et al* (1999) and ensured that the emergent analysis was grounded in the data throughout the research process.

Finally, a thorough review of the relevant literature was conducted in this study. This review explored the experiences of service users, using crisis services and followed on from a comprehensive review of the literature by Winness *et al* (2010). Whilst Winness *et al* (2010) included both quantitative and qualitative studies, the systematic review in the current study focused only on qualitative studies. This meant applying a focus to the richness of the experiences of service users in crisis, rather than considering outcomes. The review provides an up-to-date account of service users' experience of using crisis services and considers the evidence with respect to the quality of the studies.

4.6 RECOMMENDATIONS FOR FUTURE RESEARCH

The systematic review identified issues of quality in many of the papers, one of which included reflexivity. If we are to expand our knowledge about the service user experience it is critical that we understand the position of the researcher(s) in order to make judgments about the data that are presented (Elliott *et al*, 1999). One of the collective strengths of the studies included in the review was the inclusion of service users in the research process. The current study identified that service users have an interest in taking in research and further research should consider incorporating methodologies that involve service users in the process.

Based on the findings of the current study, further research might consider the relationship between the individual moving towards crisis and the reasons for choosing to resist contacting services. Furthermore, how can services adapt so as to respect the sensitivity of certain groups of service users asking for help? The findings identified several potential reasons for this resistance, however, these findings are not conclusive enough to suggest a causal link and represent a homogenous sample in terms of ethnic diversity.

There are further opportunities to assess the 'fit' of the constructivist grounded theory presented here with the experiences of service users from a range of diverse social and ethnic backgrounds. It would also be useful to consider how

the theory might embed itself into current practices or if it signals the need for a paradigm shift in the way CRHT services are structured to best meet the needs of service users.

4.7 CONCLUSIONS

There is an emerging evidence base that supports the views of service users in crisis and their experience of using crisis services. Whilst existing research has explored the experiences of crisis and the needs of service users, from their own perspectives, this study complements this research by offering a *theory* of crisis based on the experiences of service users.

The current study explored participants' constructions of crisis and their ways of coping, both in order to avoid a crisis or ways to alleviate distress during a crisis. Nine participants that constituted a service user sample were recruited for the study across three separate crisis services in South Wales. A focus group (involving a sample of the participants) was facilitated following the analysis of the data, to triangulate the findings and enhance their validity.

The study identified a process of crisis development and resolution and demonstrated a relationship between service users moving towards crisis and reaching a stage of crisis. The interactions between becoming unable to cope and losing control were identified as a cyclical process that influenced and were influenced by participants perceiving that they were coping alone. Hopelessness was experienced as a consequence of the interactions between these processes. The study also identified the impact of crisis on others, the experiences of making contact with services at a stage of crisis and considered what helps service users to cope. The study also highlighted a phase of building resilience.

The study provided a comprehensive review of service users' experiences of using crisis services, paying particular attention to the quality of the evidence. It is hoped that this review and the current findings will address a gap in the literature and prompt further research to consider the ways CRHT services

structure themselves to address the needs of service users (and families) in crisis.

REFERENCES

- Agar-Jacomb, K. & Read, J. (2009). Mental health crisis services: what do service users need when in crisis? *Journal of Mental Health, 18*, 99-110.
- Aldridge, J. (2006). The experiences of children living with and caring for parents with mental illness. *Child Abuse Review, 15*, 79-88.
- Allen, M.H. (1996). Definitive treatment in the psychiatric emergency service. *Psychiatric Quarterly, 67*, 247-62.
- Ampélas, J.F., Robin, M., Caria, A., Basbous, I., Rakowski, F., Mallat, V. et al (2005). Patient and their relatives' satisfaction regarding a home-based crisis intervention provided by a mobile crisis team. *L'Encéphale, 31*, 127-141.
- Annells, M. (1996). Grounded theory method: philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research, 6*, 379-393.
- Barker, V., Taylor, M., Kader, I., Stewart, K. & Le Fevre, P. (2011). Impact of crisis resolution and home treatment services on user experience and admission to psychiatric hospital. *The Psychiatrist, 35*, 106-110.
- Barker, C., Pistrang, N. & Elliott, R. (2002). *Research methods in clinical psychology. An introduction for students and practitioners*. Chichester: John Wiley and Sons.
- Baronet, A. & Gerber, G.J. (1997). Client satisfaction in a community crisis center. *Evaluation and Program Planning, 20*, 443-453.
- Bonney, S. & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of Psychiatric and Mental Health Nursing, 15*, 140-153.
- Borg, M. & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health, 17*, 129-140.
- Borg, M., Karlsson, B., Lofthus, A.M. & Davidson, L. (2011). "Hitting the wall": lived experiences of mental health crises, *International Journal of Qualitative Studies on Health Well-Being, 6*, 1-9.
- Borg, M. & Kristiansen, K. (2004). Recovery-oriented professionals: helping relationships in mental health services. *Journal of Mental Health, 13*, 493-505.
- 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.

Bristol MIND (2004). *Crisis...what crisis? The experiences of being in a crisis in Bristol*. Bristol: Author.

British Psychological Society (2009). *Psychological health and well-being: a new ethos for mental health*. Leicester: Author.

Burns, T. (2000). Psychiatric home treatment. *BMJ*, 321, 177.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.

Charmaz, K. (2006). *Constructing grounded theory. A practical guide through qualitative analysis*. London: Sage Publications.

Chisholm, A. & Ford, R. (2004). *Transforming mental health care. Assertive outreach and crisis resolution in practice*. London: The Sainsbury Centre for Mental Health.

Department of Health (1999). *National service framework for mental health*. London: Author.

Department of Health (2000). *The NHS Plan: A Plan for Investment, A Plan for Reform*. London: Author.

Department of Health (2001). *The Mental Health Policy Implementation Guide: Crisis Resolution/Home Treatment Teams*. London: Author.

Department of Health (2003). *Personality disorder: no longer a diagnosis of exclusion*. London: Author.

Elliott, R., Fischer, C.T., Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields, *British Journal of Clinical Psychology*, 38, 215-229.

Eriksen, K.A., Sundfor, B., Karlsson, B., Rahlom, M. & Arman, M. (2012). Recognition as a valued human being: perspectives of mental health service users. *Nursing Ethics*, 19, 357-368.

Faulkner, A. (1997). *Knowing our own minds. A survey of how people in emotional distress take control of their lives*. London: The Mental Health Foundation.

Faulkner, A. & Layzell, S. (2000). *Strategies for living. A report of user-led research into people's strategies for living with mental distress*. London: The Mental Health Foundation.

Gilburt, H., Slade, M., Rose, D., Lloyd-Evans, B., Johnson, S. & Osborn, D.P.J. (2010). Service users' experiences of residential alternatives to standard acute wards:

qualitative study of similarities and differences, *The British Journal of Psychiatry*, 197, 26-31.

Glaser, B.G. & Strauss, A.L. (1967). *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine Publishing Company.

Glover, G. and Barnes, D. and Wistow, R. and Bradley, S. (2004) 'Mental health service provision for working age adults in England 2003', Technical Report. Durham University, Centre for Public Mental Health, Durham.

Gofal Cymru (n.d.). The community crisis house model. An evaluation of Wales' first crisis house. Retrieved 7 June 2013 from www.gofal.org.uk/uploads/Policy_documents/Gofal_reports/crisis-house-english.pdf

Goldsack, S., Reet, M., Lapsley, H. & Gingell, M. (2005). Experiencing a recovery-oriented acute mental health service: home based treatment from the perspectives of service users, their families and mental health professionals. New Zealand: Mental Health Commission.

Hannigan, B. (2010). Mental health services in transition: examining community crisis resolution and home treatment care. Final report to the Research Capacity Building Collaboration Wales for Nursing and Allied Health Professionals (rcbcwales).

Hannigan, B. (2012). Connections and consequences in complex systems: insights from a case study of the emergence and local impact of crisis resolution and home treatment services, *Social Science & Medicine*, 1-8.

Hogan, K. (2000). Treatment at home is nationwide and successful. *BMJ*, 321, 178.

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.

Hoult, J. (2006). Setting the scene. In McGlynn, P. (Ed.) *Crisis resolution and home treatment. A practical guide*. London: The Sainsbury Centre for Mental Health.

Hubbeling, D. & Bertram, R. (2012). Crisis resolution teams in the UK and elsewhere. *Journal of Mental Health*, 21, 285-295.

Iqbal, N. & Moiser-Nagaür, C. (2013). Service user evaluation for a crisis resolution and home treatment team. *Clinical Psychology Forum*, 245, 20-24.

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

Johnson, S., Bingham, C., Billings, J., Pilling, S., Morant, N., Bebbington, P. *et al* (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., Lloyd-Evans, B., Howard, L., Osborn, D.P.J. & Slade, M. (2010). Where next with residential alternatives to admission? *The British Journal of Psychiatry*, 197, s52-s54.

Johnson, S. & Needle, J. (2008). Introduction. In Johnson, S., Needle, J., Bindman, J.P., Thornicroft, G. (Eds.) *Crisis resolution and home treatment in mental health*. Cambridge: Cambridge University Press.

Johnson, S., Nolan, F., Hoult, J., White, I.R., Bebbington, P., Sandor, A. *et al* (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. *et al* (2005b). Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *British Medical Journal*, 331, 1-5.

Johnson, S. & Thornicroft, G. (2008). The development of crisis resolution and home treatment teams. In Johnson, S., Needle, J., Bindman, J.P., Thornicroft, G. (Eds.) *Crisis resolution and home treatment in mental health*. Cambridge: Cambridge University Press.

Jones, R. & Jordan, S. (2010). The implementation of crisis resolution home treatment teams in Wales: results of the national survey 2007-2008. *The Open Nursing Journal*, 4, 9-19.

Jones, R. & Robinson, B. (2008). *A national survey of crisis resolution home treatment teams in Wales*. Retrieved 5 November 2013 from <http://www.wales.nhs.uk/sites3/Documents/776/A%20National%20Survey%20of%20CRHT%20Teams%20in%20Wales.pdf>

Kalucy, R., Thomas, L., Lia, B., Slattery, T., Norris, D. (2004). Managing increased demand for mental health services in a public hospital emergency department: a trial of 'hospital-in-the-home' for mental health consumers. *International Journal of Mental Health Nursing*, 13, 275-281.

Keown, P., Tacchi, M.J., Niemiec, S. & Hughes, J. (2007). Changes to mental healthcare for working age adults: impact of a crisis team and an assertive outreach team. *Psychiatric Bulletin*, 31, 288-292.

Karlsson, B., Borg, M. & Kim, H.S. (2008). From good intentions to real life: introducing crisis resolution teams in Norway. *Nursing Inquiry*, 15, 206-215.

Khalifeh, H., Murgatroyd, C., Freeman, M., Johnson, S. & Killaspy, H. (2009). Home treatment as an alternative to hospital admission for mothers in a mental health crisis: a qualitative study, *Psychiatric Services*, 60, 634-639.

Khan, I. & Pillay, K. (2003). Users' attitudes towards home and hospital treatment: a comparative study between South Asian and white residents of the British Isles. *Journal of Psychiatric and Mental Health Nursing*, 10, 137-146.

Law, M., Stewart, D., Letts, L., Pollock, N., Bosch, J. & Westmorland, M. (1998). Guidelines for critical review of qualitative studies. Based on guidelines for critical form-qualitative studies. Retrieved on 12 February 2013 from <http://www.musallamusf.com/resources/Qualitative-Lit-Analysis-pdf.pdf>

Lazarus, R.S., & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer Publishing Company.

Lyons, C., Hopley, P. & Horrocks, J. (2009). Mental health crisis and respite services: service user and carer aspirations, *Journal of Psychiatric and Mental Health Nursing*, 16, 424-433.

McNamee, S. (2004). *Relational bridges between constructionism and constructivism*. Retrieved 10 May 2013 from http://www.taosinstitute.net/Websites/taos/Images/ResourcesManuscripts/McNamee%20-Relational_Bridges_Between_Constructionism_and_Constructivism.pdf

Mental Health Foundation (2002). *Being there in a crisis*. Sainsburys Centre for Mental Health and Mental Health Foundation.

Middleton, H., Shaw, R., Collier, R., Purser, A. & Ferguson, B. (2011). The dodo bird verdict and the elephant in the room: a service user-led investigation of crisis resolution and home treatment, *Health Sociology Review*, 20, 147-156.

Mills, J., Bonner, A. & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5, 25-35.

MIND (2011). *Listening to experience. An independent inquiry into acute and crisis mental healthcare*. London: Author.

Minghella, E., Ford, R., Freeman, T., Hault, J., McGlynn, P. & O'Halloran, P. (1998). *Open all hours. 24-hour response for people with mental health emergencies*. London: The Sainsbury Centre for Mental Health.

Murphy, S., Irving, C.B., Adams, C.E. & Driver, R. (2012). Crisis intervention for people with severe mental illness. *Cochrane Database for Systematic Reviews*, 5.

National Audit Office (2008). *Crisis resolution and home treatment: the service user and carer experience*. London: The Stationery Office.

National Audit Office (2007). *Helping people through mental health crisis: the role of crisis resolution and home treatment services*. London: The Stationery Office.

Onyett, S. Linde, K. Glover, G. Floyd, S. Bradley, S. & Middleton, H. (2006) *A National Survey of Crisis Resolution Teams in England*. London: Care Services Improvement Partnership.

Osborn, D.P.J., Lloyd-Evans, B., Johnson, S., Gilbert, H., Byford, S., Leese, M. et al (2010). Residential alternatives to acute in-patient care in England: satisfaction, ward atmosphere and service user experiences. *The British Journal of Psychiatry*, 197, s41-s45.

Pearce, W. B. (2009) Communication and social construction: Claiming our birthright (pp. 33-56) In Wendy Leeds-Hurwitz and Gloria Galanes (Eds). (2009) *Socially Constructing Communication*. Cresskill, N. J.: Hampton Press.

Robin, M., Bronchard, M. & Kannas, S. (2008). Ambulatory care provision versus first admission to psychiatric hospital: 5 years follow up. *Social Psychiatry and Psychiatric Epidemiology*, 43, 498-506.

Rose, D. (2001). *Users' voices. The perspectives of mental health service users on community and hospital care*. London: The Sainsbury Centre for Mental Health.

Rosen, A. (1997). Crisis management in the community. *MJA Practice Essentials*, 167, 1-15.

Ruggeri, M., Salvi, G., Perwanger, V., Phelan, M., Pelligrini, N., Parabiaghi, A. (2006). Satisfaction with community and hospital-based emergency services amongst severely mentally ill service user. *Social Psychiatry and Psychiatric Epidemiology*, 41, 302-309.

Seager, M. (2006). The Concept of 'Psychological Safety' - A psychoanalytically informed contribution towards 'safe, sound and supportive' mental health services". *Psychoanalytic Psychotherapy*, 20, 266-280.

Scott, R. (2000). Evaluation of a mobile crisis program: effectiveness, efficiency and consumer satisfaction. *Psychiatric Services*, 51, 1153-1156.

Sjolie, H., Karlsson, B. & Kim, H.S. (2010). Crisis resolution and home treatment: structure, process, and outcome – a literature review. *Journal of Psychiatric and Mental Health Nursing*, 17, 881-892.

Smyth, M. (2003). Crisis resolution/home treatment and in-patient care. *Psychiatric Bulletin*, 27, 44-47.

Smyth, M. G. & Hoult, J. (2000) The home treatment enigma. *British Medical Journal*, 320, 305-309.

Spencer, L., Ritchie, J., Lewis, J. & Dillon, L. (2003). *Quality in qualitative evaluation: a framework for assessing research evidence*. London: Crown Copyright

Strauss, A. L. and Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, 2nd Edition. London: Sage.

Taylor, S., Abbott, S. & Hardy, S. (2012). The Inform Project: a service user-led research endeavour, *Archives of Psychiatric Nursing*, 26, 448-456.

Tracy, S.J. (2010). Qualitative quality: eight “big-tent” criteria for excellent qualitative research, *Qualitative Inquiry*, 16, 837-851.

The Sainsbury Centre for Mental Health (2001). *Crisis resolution*. London: Author.

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J., & Walsh, S. (1997). Standards for research projects and thesis involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum*, 108, 3-7.

Weich, S., Griffith, L., Commander, M., Bradby, H., Sashidharan, S.P., Pemberton, S. *et al* (2012). Experiences of acute mental health care in an ethnically diverse inner city: qualitative interview study, *Social Psychiatry Psychiatric Epidemiology*, 47, 119-128.

Welsh Assembly Government (2010). *Mental Health (Wales) Measure 2010*, Cardiff, Wales: Author.

Welsh Assembly Government (2005) *Policy Implementation Guidance on the development of Crisis Resolution/Home Treatment (CR/HT) services in Wales*. Cardiff: Author.

Willig, C. (2008). *Introducing qualitative research in psychology*. Berkshire: Open University Press.

Winness, M.G., Borg, M. & Kim, H.S. (2010). Service users' experiences with help and support from crisis resolution teams. A literature review. *Journal of Mental Health*, 19, 75-87.

Wolkon, G. (1972). Crisis theory, the application for treatment, and dependency. *Comprehensive Psychiatry*, 13, 459 – 464.

Woodbridge, K. (2006). The role of values in a crisis. In McGlynn, P. (Ed.) *Crisis resolution and home treatment. A practical guide*. London: The Sainsbury Centre for Mental Health.

Vogel, D.L., Wade, N.G. & Hawke, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, 53, 325-337.

APPENDIX I: SUMMARY OF SYSTEMATIC REVIEW PROCEDURE

Table 1. *Summary of Systematic Review Procedure*

<i>Search conducted 5.11.12</i>		<i>No. of articles generated</i>	<i>No. of articles relevant to review</i>
Databases searched:	PsychInfo	62	41
	Embase		
	Medline	376	60
	Psycharticles		
	Cardiff Full Text Journals		
	CINAHL	32	0
	ISI	510	32
	SCOPUS	153	3
Total		1133	136

Search terms:
 crisis resolution OR crisis assessment OR intensive home treatment OR home treatment
 AND
 user experiences OR user perspective OR client attitudes OR subjective experiences OR patient satisfaction OR consumer satisfaction

Additional key words used: experience*, view*, perspective*, features, indicators, signs, difficulties, issues, warning signs, living, symptoms, risk factors, clues, impact, mental health, mental health crisis, cris*, support, service*, acute, psychiatric, hospital, admission, section*, screening, primary care, assessment, intervention, resolution.

Limits applied: 1990 – Current.
 Articles in the English Language

↓

Initial review: titles (and abstracts where relevant) manually reviewed (1133). 136 articles relevant to review question and that met inclusion criteria, retained based on initial review of title or abstract.

↓

Second review: Titles, abstracts and full texts manually reviewed (136). Articles were initially excluded if:

- i) related crisis to accidents, catastrophic disasters, medical crises or substance use
- ii) duplicate articles
- iii) child, adolescent or older adult studies
- iv) carers' or providers' views of crisis

Full texts were then manually reviewed (57). Articles were further excluded based on:

- v) no primary data (9)
- vi) quantitative studies (e.g. outcomes) (33)
- vii) not relevant to the review question (i.e. article on service users' experiences of crisis BUT not on experiences of using crisis services) (1)

↓

Number of relevant articles: 14

→

Manual review of key journals, third sector policy and reports (e.g. MIND), reference lists from key articles, Google and Google Scholar. 2 additional articles identified however, they could not be retrieved and were not included. No additional articles found after second search (28.4.13)

↓

Number of articles remaining : 14
 Retained for systematic review

APPENDIX II: FRAMEWORK FOR CRITICAL APPRAISAL PROCESS OF SYSTEMATIC REVIEW

- *Aims / Purposes*
Were these clearly stated that helped determine whether the topic was relevant, timely and interesting and if a qualitative inquiry was appropriate.
- *Literature review*
Did the study consider relevant literature congruent with the research question? Did the authors identify gaps in the literature that would support their rationale for conducting the research?
- *Study design*
Is the design appropriate to the research question and therefore defensible?
- *Methods*
Are the methods that have been designed to generate data adequately described? Are they appropriate to the research question and therefore likely to generate data that the study aims to generate? Is there evidence of transparency about the methods?
- *Sampling*
Is the sample representative, for example, of gender, race, ethnicity, religion, age and is this demographic information provided? How were participants selected and is the procedure adequately described and appropriate with respect to adequate coverage (e.g. accessing participants from one CRHT service as opposed to many)? How did the sample relate to the population of interest? Did the study address non-participation?
- *Research Governance*
Have the researchers sought ethical approval for the study (where appropriate) and is there evidence that informed consent has been addressed and obtained?
- *Data Collection*
Is there sufficient information explaining the process of data collection (e.g. site of data collection, discussion of who collected data, methods of

collection)? Are the assumptions of researchers as well as their relationships with participants clearly outlined? Are there enough data for claims to be credible? Can the data collection process be considered rigorous (e.g. processes taken to ensure the accuracy of transcriptions)?

- *Analysis*

Is there sufficient information provided on the approach to and analysis of the data (e.g. the process of transforming data into codes and themes)? Are the connections between data and interpretations clear (i.e. the themes reflective of the data? Have the themes been labeled?

- *Reflexivity / Trustworthiness*

Within the qualitative literature, reflexivity reflects the authenticity and genuineness of the study (Tracy, 2010) and an understanding from the researcher(s) of their position(s) within the research process (Elliott *et al*, 1999). How credible are the findings (e.g. evidence of triangulation? Have the researchers accounted for their own biases and subjective values that may affect their interpretations and conveyance of the findings? Have quotes been used and if so, effectively?)

- *Discussions / Conclusions*

Does the study bring together the literature, research questions, findings and interpretations in a meaningful way? How coherent is the reporting of the findings? Have the researchers considered any limitations of the study and if so, what likely impact this had on the generalisability of the findings? Did the findings contribute to future research or provide a useful step forward in service development or approach?

APPENDIX III: EMAIL FROM AUTHOR OF RELEVANT RESEARCH

From: <XXXXXXXX>
Date: 8 January 2013 09:22:25 GMT
To: <XXXXXXXXXX>
Subject: RE: CR/HT user experiences

Dear XXXXX.

Good to hear that you found some material of interest.

The abstract you mention was made for a presentation at a conference in 2011, so the paper is still in progress.

At the moment it seems like it will not be finished this year, because I have decided to work on two other papers.

Keep in touch.

Best,
XXXXXX

From: XXXXXX [mailto:XXXXXXXXXX] **Sent:** 5. January 2013 16:05 **To:** XXXXXXXX **Subject:** Re: CR/HT user experiences

Hi XXXXXX

Thank you for your previous email-your advice to search the authors you recommended was fruitful. I have recently come across an article that you are a co-author of, titled 'Mental Health Crisis - experiences and strategies in everyday life' which seems very relevant to my study. I have tried to obtain a copy of the article via the University that I am training at but they have only been able to access the abstract. I was wondering if you have a copy of the full article that you would be able to send me?

Kind Regards

XXXXXX
Trainee Clinical Psychologist
XXXXXXXXXX

APPENDIX IV: CARRS (CHAIR OF THE CARDIFF AND VALE RESEARCH AND REVIEW SERVICE) APPROVAL FOR THE SCIENTIFIC QUALITY OF THE PROPOSAL



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Ysbyty Athrofaol Cymru
University Hospital of Wales

Heath Park,
Cardiff, CF14 4XW
Phone 029 2074 7747
Fax 029 2074 3838
Minicom 029 2074 3632

Parc Y Mynydd Bychan,
Caerdydd, CF14 4XW
Ffôn 029 2074 7747
Ffacs 029 2074 3838
Minicom 029 2074 3632

Eich cyf/Your ref
Ein cyf/Our ref
Welsh Health Telephone Network 1872
Direct line/Llinell uniongyrchol

Tel: 029 20746986
Fax: 029 20745311
CAV_Research.Development@wales.nhs.uk

From: Professor JI Bisson
R&D Director
R&D Office, 2nd floor TB2
University Hospital of Wales
Cardiff
CF14 4XW

28 May 2012

Mr Ross Watson
South Wales Doctoral Programme in Clinical Psychology
1st floor, Archway House
77 Ty Gas Avenue
Llanishen
Cardiff
CF14 5DX

Dear Mr Ross Watson

Cardiff and Vale UHB Ref: 12/MEH/5389
Title: People's Constructions Of Crisis And Ways Of Coping

Thank you for your recent correspondence addressing the points raised about the above project and supplying the following revised documents:

Document	Version	Date
Protocol	6.0	18/05/12

Your response and revised documents were reviewed by the Chair of the Cardiff and Vale Research Review Service (CaRRS).

The Panel is now satisfied with the scientific quality of your proposal.

You may now apply for review by an NHS Research Ethics Committee and for NHS R&D governance review. Please follow the application instructions below:

For NHS REC review:

- Contact the Cardiff & Vale UHB R&D Office to obtain the sponsor's representative signatures needed prior to your submission to the NHS Research Ethics Committee (on your NHS REC form). Please see the enclosed information sheet for details of how to obtain a sponsor's signature.

For NHS R&D governance review:

- Contact the Cardiff & Vale UHB R&D office to obtain the sponsor's representative signature needed on the IRAS NHS R&D form prior to your submission to the National Institute for Social Care and Health Research – Permissions Coordinating Unit (NISCHR PCU).
- Once this signature is in place you should submit the IRAS NHS R&D form and Site Specific Information (SSI) form and all supporting study documentation to NISCHR PCU who will coordinate completion of governance checks prior to R&D permission being granted.

The following signatures/authorisations must be obtained in Q23 the SSI form prior to submission to NISCHR PCU:

- Professor Nick Craddock, RD Lead for Mental Health

Final R&D permission to begin your study in Cardiff & Vale UHB will be issued following completion of the governance review by Cardiff and Vale UHB and NISCHR PCU.

YOU SHOULD NOT BEGIN YOUR PROJECT BEFORE RECEIVING WRITTEN CONFIRMATION OF NHS R&D PERMISSION TO BEGIN.

If you require any further information or assistance, please do not hesitate to contact the staff in the R&D Office.

Yours sincerely,



**Professor Jonathan I Bisson
Chair of the Cardiff and Vale Research Review Service (CaRRS)**

**CC R&D Lead, Professor N Craddock
Dr Andrew Vidgen, Academic Supervisor**

Enc. Sponsor signature guidance

Link: 'Gaining NHS research permission from Cardiff and Vale UHB – Guidance for researchers' <http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/180875>

APPENDIX V: CARDIFF AND VALE LOCAL HEALTH BOARD RESEARCH AND DEVELOPMENT APPROVAL



**GIG
CYMRU
NHS
WALES**

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

**Ysbyty Athrofaol Cymru
University Hospital of Wales**

Heath Park,
Cardiff, CF14 4XW
Phone 029 2074 7747
Fax 029 2074 3838
Minicom 029 2074 3632

Parc Y Mynydd Bychan,
Caerdydd, CF14 4XW
Ffôn 029 2074 7747
Ffacs 029 2074 3838
Minicom 029 2074 3632

Eich cyf/Your ref
Ein cyf/Our ref
Welsh Health Telephone Network 1872
Direct line/Llinell uniongyrchol

Tel: 029 20746986
Fax: 029 20745311
CAV_Research.Development@wales.nhs.uk

From: Professor JI Bisson
R&D Director
R&D Office, 2nd Floor TB2
University Hospital of Wales
Cardiff
CF14 4XW

25 September 2012

Mr Ross Watson
South Wales Doctoral Programme in Clinical Psychology
11th Floor, Tower Building
70 Park Place
Cardiff
CF10 3AT

Dear Mr Watson

**Cardiff and Vale UHB Ref : 12/MEH/5389 : People's Understanding Of Crisis
And Ways Of Coping**

NISCHR PCU Ref: 100170

The above project was forwarded to Cardiff and Vale University Health Board R&D Office by the NISCHR Permissions Coordinating Unit. A Governance Review has now been completed on the project.

Documents approved for use in this study are:

Document	Version	Date
NHS R&D Form	3.4	Received 1 August 2012
SSI Form	3.4	Received 1 August 2012
Research Proposal	7.0	20 July 2012
Flow Chart of Initial Participant Recruitment Phase	3.0	30 July 2012
Participant Information Sheet	5.0	3 September 2012
Questionnaire: Semi Structured Interview Schedule	2.0	27 March 2012
Letter of Invitation to Participant	1.0	3 September 2012
Letter of Invitation: Focus Group	1.0	29 August 2012
Reply Slip: Focus Group	1.0	3 September 2012
Reply Slip: Initial Interview	1.0	3 September 2012
Participant Consent Form: Focus Group	1.0	3 September 2012

Page 1 of 2

Version 1.0. 09.06.10



Participant Consent Form: Initial Interview	5.0	3 September 2012
---	-----	------------------

I am pleased to inform you that the UHB has no objection to your proposal. Please accept this letter as confirmation of sponsorship by Cardiff and Vale University Local Health Board under the Research Governance Framework for Health and Social Care, and permission for the project to begin within this UHB.

May I take this opportunity to wish you success with the project and remind you that as Principal Investigator you are required to:

- Inform the R&D Office if this project has not opened within 12 months of the date of this letter. Failure to do so may invalidate R&D approval.
- Inform NISCHR PCU and the UHB R&D Office if any external or additional funding is awarded for this project in the future
- Contact the R&D Office for Sponsor representative's signature prior to submission of any substantial amendments to NISCHR PCU
- Ensure that all study amendments are favourably reviewed by the R&D Office prior to implementation
- Ensure NISCHR PCU is notified of the study's closure
- Ensure that the study is conducted in accordance with all relevant policies, procedures and legislation
- Provide information on the project to the UHB R&D Office as requested from time to time, to include participant recruitment figures

Yours sincerely,



Professor Jonathan I Bisson
R&D Director

CC R&D Lead Prof Nick Craddock

APPENDIX VI: DYFED POWYS RESEARCH ETHICS COMMITTEE
APPROVAL

Part of the research infrastructure for Wales (funded by the National Institute for Social Care and Health Research, Welsh Government).
Yn rhan o seilwaith ymchwil Cymru a ariannir gan y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd, Llywodraeth Cymru.



Dyfed Powys Research Ethics Committee

Postal address: PO Box 108
Building 1
St David's Park
Carmarthen SA31 3WY
(for sat nav SA31 3HB)

Telephone : 01267 225045
Fax : 01267 225226
E-mail : sue.byng@wales.nhs.uk
Website : www.nres.nhs.uk

Mr Ross Watson
Trainee Clinical Psychologist
South Wales Doctoral Programme in Clinical Psychology
Cardiff University
11 Floor
Tower Building
70 Park Place
Cardiff CF10 3AT

30 August 2012

Dear Mr Watson

Study title: **Constructions of crisis and ways of coping: a constructivist grounded theory of clients' experiences of crisis**
REC reference: **12/WA/0248**

The Research Ethics Committee reviewed the above application at the meeting held on 28 August 2012. Thank you for attending to discuss the study.

Ethical opinion

Mr Watson confirmed that the type of clients included in the study would be people known to the CMHT team and those signposted via their GP or community care. Mr Watson explained that if participants experienced distress during interviews they could stop or withdraw from the interview. Mr Watson confirmed that Mr Andrew Vidgen, his academic supervisor and a Clinical Psychologist, could make himself available within 24 hours. Another Clinical Psychologist would also be available. Mr Frude commented that Mr Watson was in his final year of training and had been on various placements for two years and had considerable clinical skills himself to help distressed participants.

Mr Watson confirmed he had no involvement with the recruitment process until responses were received from potential participants to the invitation to take part in the research. The Committee suggested that as the initial contact was being made by the care team a short introductory letter be sent enclosing the Information Sheet and reply slip. The Committee informed Mr Watson that if he intended increasing numbers for the study he would have to submit a Notice of Substantial Amendment to the Committee in future.

Mr Watson confirmed he would adhere to the Health Board's lone worker policy when visiting participants' homes in order to carry out the research.

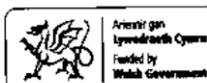
The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.



GIG
CYMRU
NHS
WALLES
Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Cynhelir Cydweithrediad Gwyddor Iechyd Academaidd y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd gan Fwrdd Addysgu Iechyd Powys

The National Institute for Social Care and Health Research Academic Health Science Collaboration is hosted by Powys Teaching Health Board



Part of the research infrastructure for Wales funded by the National Institute for Social Care and Health Research, Welsh Government.
Yn rhan o seilwaith ymchwil Cymru a arhannir gan y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd, Llywodraeth Cymru



Gwasanaeth
Moeseg
Ymchwil
RES
Research
Ethics
Service

Mr Ross Watson
Trainee Clinical Psychologist
Cardiff and Vale University Health Board
South Wales Doctoral Programme in Clinical Psychology
11th Floor
Tower Building
70 Park Place
Cardiff CF10 3AT

Dyfed Powys Research Ethics Committee

Postal address: PO Box 108
Building 1
St David's Park
Carmarthen SA31 3WY
(for sat nav SA31 3HB)

Telephone : 01267 225045
Fax : 01267 225226
E-mail : sue.byng@wales.nhs.uk
Website : www.nres.nhs.uk

7 September 2012

Dear Mr Watson

Full title of study: **Constructions of crisis and ways of coping: a constructivist grounded theory of clients' experiences of crisis**
REC reference number: **12/WA/0248**

Thank you for your email of 5 September 2012. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 30 August 2012. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	Version	Date
Covering Letter		05 September 2012
Letter of invitation to participant	1	03 September 2012
Letter of invitation: Focus Group	1	29 August 2012
Reply slip: Focus Group	1	03 September 2012
Reply slip: Initial Interview	1	03 September 2012
Participant Consent Form: Focus Group	5	03 September 2012
Participant Consent Form: Initial Interview	1	03 September 2012
Participant Information Sheet	5	03 September 2012

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/WA/0248 **Please quote this number on all correspondence**

Yours sincerely

Mrs Sue Byng
Committee Co-ordinator

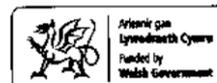
Copy to: Professor Jonathon Bisson, Cardiff and Vale UHB R&D Office



GIG
Llywodraeth Cymru
NHS
Wales
Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Cyfeirir Cydweithrediad Gwyddor Iechyd Academaidd y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd gan Fwrdd Addysgu Iechyd Powys

The National Institute for Social Care and Health Research Academic Health Science Collaboration is hosted by Powys Teaching Health Board



Arianir gan
Llywodraeth Cymru
Funded by
Welsh Government

APPENDIX VII: PARTICIPANT INFORMATION SHEET (VERSION FIVE)

PARTICIPANT INFORMATION SHEET [Version 5. 03.09.2012]

People's understanding of crisis and ways of coping

We would like to invite you to take part in our research study. The research study is being carried out by Ross Watson, Trainee Clinical Psychologist and is being supervised by Dr Andrew Vidgen (Clinical Psychologist, South Wales Doctoral Programme in Clinical Psychology) and Dr Ella Rafferty (Clinical Psychologist, Crisis Services, Cardiff and Vale UHB). The research study is interested in people's understanding of their crisis experiences.

Before you decide whether you would like to take part, we would like you to understand why the research is being carried out and what would be involved for you, if you were to agree to take part. **We would be happy to go through this information sheet with you and answer any questions you may have.** This would likely take about 10 minutes. Talking to others about the research study may also help you decide whether or not to take part.

What is the purpose of the study?

Little is known about people's own understanding of crisis and their ways of coping with a crisis. The purpose of the research study is to gain a better understanding of what is happening for people at various stages of crisis, particularly:

Leading up to a crisis and at the point that the crisis begins
During the crisis
Recovering from a crisis

Why have I been invited?

We are interested in talking to people who have had a first-hand experience of a crisis. You have been identified by the Crisis Resolution Home Treatment Team. In order to preserve your anonymity and for purposes of confidentiality, we will not be involved in contacting you until you have consented to take part. The Crisis Resolution Team that was involved in your care was informed about the research study and contacted you independently. We are looking to talk to up to 12 people about their experiences.

Do I have to take part in the research study?

It is up to you to decide if you would like to take part in the research study. Participation is entirely voluntary. We can go through the information sheet with you and provide more information about the study. If you agree to take part, we will ask you to sign a consent form. If you wish to take part, you are free to withdraw at any time without having to give a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

If you decide to take part, you will be invited to attend one interview, which will be carried out by the researcher, Ross Watson. The interview will take place either within a consultation room at the North or South Crisis Team base, or if you would prefer, at your home. It will be arranged so that it is convenient for you to attend. It is anticipated that the interview will last for 60 minutes. During the interview, the

researcher Ross Watson will ask you questions about your experience of crisis. **If you decide during the interview, that you no longer wish to take part, the interview will be stopped and you will be free to withdraw, without having to give a reason.**

The interview will be recorded using an audio-recording device. Once the interview has finished, your participation at this stage will be complete. The researcher will then analyse the information provided by you and other participants.

After the information has been analysed, the researcher will feed back the findings to staff members of the Crisis Resolution Team who have been involved in the research study. You do not have to take part in this discussion.

We would like you to take part in a focus group (second stage), which will be set up for participants only, to discuss the findings. This will be held after all of the interviews have been completed. You will be sent a separate consent form and an invitation to this second stage, giving details of where the focus group will be held and the time. The focus group will be held in a suitable room at one of the Crisis Resolution Team bases and will be looking at the themes that the researcher has drawn from the all of the interview transcripts. The focus group will last for 60 minutes and notes of the discussions will be taken. You do not have to decide now, if you would like to take part in this stage. You can also decide to withdraw from the focus group, if you initially volunteer to take part.

What are the possible advantages of taking part?

You will be contributing to an area of research where currently, there is a gap in our understanding about the experiences of crisis. It is hoped that client accounts will provide a clearer picture for clients and mental health services of what the individual at the centre of a crisis experiences. It is hoped that the findings will help teams consider how their service can then best meet the needs of their clients.

The researcher intends to publish the study findings in a scientific journal. This will have implications for services supporting individuals in crisis, in considering how their service is delivered to best support the needs of people in a crisis and those recovering from a crisis.

What are the possible disadvantages of taking part?

Before participating, you should consider whether you would be happy to talk about your crisis experience. There are no known risks involved in taking part in this research study but if you decide to withdraw from the study, you may do so without reason, at any stage. Talking about your experiences of crisis may cause distress. If you feel distressed during any part of the interview and no longer wish to carry on with the interview, the interview will be stopped immediately. If at this point you felt that you no longer wished to take part in the study, your data would be destroyed.

If you decide to take part in the focus group, talking about the themes with the other participants may cause distress. If you feel distressed during any part of the focus group you will be able to leave immediately. If at this point you feel that you no longer wish for your information to be included in the study, your data would be destroyed.

If during the interview or focus group discussion, you feel concerned about anything, you would be able to contact Dr. Andrew Vidgen or Dr Ella Rafferty, to discuss this with them. Dr Andrew Vidgen or Dr Ella Rafferty could make himself or herself available to speak with you in 24 hours.

Will my taking part in the research study be kept confidential?

Your participation in the research study and your interview will be kept strictly confidential. The results will be written up and direct quotations will be used which will mean that your anonymity cannot be guaranteed. However, all steps will be taken to preserve your anonymity. All the names of participants will be changed on the transcripts so that you will not be identifiable from the data and the transcripts and audio-recordings of the interview will both be kept within a securely locked cabinet, which the researcher will have sole access to.

Only in the event that you disclose information that presents risk to yourself or others, or information about the crisis service that discloses professional standards, will confidentiality be broken. This is in keeping with professional codes of conduct and duty of care. In these circumstances, we will only inform those professionals whose care you currently fall under. **You will be informed first of this.**

If you would like more information about this or if you have any concerns, please either contact the researcher using the details below, or you may speak with the member of the Crisis Resolution Team that contacted you to tell you about this study.

What will you do with my answers to the interview questions?

Participants will get the opportunity to discuss the themes drawn out from the interview transcripts, in a focus group and consider whether they fit with their experiences.

The research study will be written up as a doctoral dissertation and then submitted as part fulfilment of the researcher's Doctorate in Clinical Psychology.

What if I have a problem with the study?

Please either contact the researcher or the member of the Crisis Resolution Team that identified you as a participant, if you have concerns about any aspect of this research study. They will do their best to answer your questions. Contact details of the Dyfed Powys Research Ethics Committee can also be made available to you, if you wish to complain formally. These details can be obtained from the Crisis Resolution Team known to you.

Has the study been ethically approved?

All research in the NHS is looked at by a Research Ethics Committee, to protect your interests. The Dyfed Powys Research Ethics Committee has reviewed and approved this research study, taking into consideration the rights, safety and wellbeing of the participants to be involved.

Further information

If you would like any further information about the research study, please do not hesitate to contact the member of the Crisis Resolution Team that contacted you to tell you about this study. They will be able to liaise with the researcher, in providing more information for you. Alternatively, you may contact the researcher directly, either by email (Ross.Watson@wales.nhs.uk), or by contacting the South Wales Doctoral Programme in Clinical Psychology on 02920 870545.

If you do not wish to take part in this research study, you will not be contacted again. Thank you for taking the time to read this information sheet.

Ross Watson
Trainee Clinical Psychologist

PARTICIPANT CONSENT FORM - INTERVIEW
[VERSION 5 03.09.2012]

Title of Project: People's understanding of crisis and ways of coping

(Please tick and initial the box next to each statement below)

- I confirm that I have read and understand the information sheet dated (version.....) for the above psychological study. I have had the opportunity to consider the information and ask questions, which have been answered satisfactorily.
- I understand that I am free to ask further questions, at any time and can contact Dr Andrew Vidgen at the South Wales Doctoral Programme in Clinical Psychology Training, should I wish to.
- I understand that my participation in this research study is entirely voluntary and that I may withdraw at any point during the study, without giving a reason and without affecting the standard of care I receive.
- I understand that my participation in this research study means that I will be interviewed which will take 60 minutes of my time. The interview will be audio-taped and I understand that I can request that it is turned off at any time during the interview.
- I understand that my information will be kept confidential, accessed only by the researcher. The information will be kept for 5 years before it is destroyed, as per policy guidelines. I understand that I can access my information and/or ask for it to be destroyed, at any time.
- I understand that extracts from the interview transcripts will be used to include in the final report and that steps will be taken to ensure my anonymity. I give permission to include extracts from my interview transcript.
- I agree to take part in the initial interview phase, of the above study.

I, _____ (NAME) consent to participate in the above psychological study which will be carried out by Ross Watson, South Wales Doctoral Programme in Clinical Psychology, Cardiff University, under the supervision of Dr Andrew Vidgen and Dr Ella Rafferty.

Signed (participant):

Date:

1 copy for participants; 1 copy for researcher

APPENDIX IX: REPLY SLIP FOR INTERVIEW (VERSION ONE)

REPLY SLIP - INTERVIEW
[VERSION 1. 03.09.2012]

Title of Project: People's understanding of crisis and ways of coping

(Please tick the box next to the statement below that applies to you)

- Yes, I am interested in taking part in this study. Please contact me on
..... to
arrange an interview.
- Yes, I am interested in taking part in this study. I will contact you to arrange
an interview.
- No, I would not like to take part in this study.

APPENDIX X: PARTICIPANT CONSENT FORM FOR FOCUS GROUP
(VERSION ONE)

PARTICIPANT CONSENT FORM - FOCUS GROUP
[VERSION 1. 03.09.2012]

Title of Project: People's understanding of crisis and ways of coping

(Please tick and initial the box next to each statement below)

- I confirm that I have read and understand the information sheet
dated (version.....) for the above psychological study. I
have had the opportunity to consider the information relating to the focus
group and ask questions, which have been answered satisfactorily.
- I understand that I am free to ask further questions, at any time and
can contact Dr Andrew Vidgen at the South Wales Doctoral Programme in
Clinical Psychology Training, or Dr Ella Rafferty, should I wish to.
- I understand that my participation in the focus group is entirely voluntary and
that I may withdraw at any point during the focus group, without giving a
reason and without affecting the standard of care I receive.
- I understand that my participation in the focus group means that I will be
involved in the group with other participants from the research study. I
understand that the focus group will take 60 minutes of my time. Written notes
will be taken of the discussions and I understand that I can request to see the
notes or receive a copy of the notes taken.
- I understand that any information I contribute to the focus group will be kept
confidential, accessed only by the researcher. The information will be kept for

5 years before it is destroyed, as per policy guidelines. I understand that I can access my information and/or ask for it to be destroyed, at any time.

- I understand that extracts taken from the focus group discussions may be used in the final report and that steps will be taken to ensure my anonymity. I give permission to include extracts from any contributions I make to the discussions within the focus group.
- I agree to take part in the focus group, for the above study.

I, _____ (NAME) consent to participate in the focus group for the above psychological study which will be carried out by Ross Watson, South Wales Doctoral Programme in Clinical Psychology, Cardiff University, under the supervision of Dr Andrew Vidgen and Dr Ella Rafferty.

Signed (participant):

Date:

1 copy for participants; 1 copy for researcher

APPENDIX XI: REPLY SLIP FOR FOCUS GROUP (VERSION ONE)

**REPLY SLIP - FOCUS GROUP
[VERSION 1. 03.09.2012]**

Title of Project: People's understanding of crisis and ways of coping

(Please tick the box next to the statement below that applies to you)

- Yes, I am interested in taking part in the focus group.
- No, I would not like to take part in the focus group.

APPENDIX XII: LETTER OF INVITATION TO PARTICIPANTS TO
TAKE PART IN THE STUDY (VERSION ONE)

People's understanding of crisis and ways of coping
[Version 1 03.09.12]

You are invited to take part in a research study that is interested in people's understanding of crisis and ways of coping. This research study is being carried out by Ross Watson, who is a Trainee Clinical Psychologist and is being supervised by Dr Andrew Vidgen (Clinical Psychologist, South Wales Doctoral Programme in Clinical Psychology) and Dr Ella Rafferty (Clinical Psychologist, Crisis Services, Cardiff and Vale UHB).

The researcher is interested in talking to people who have been discharged from our service and have an experience of crisis, which is why you have been contacted. Please find enclosed an information sheet that provides details about the study and ways to get in touch, if you decide that you would like to take part.

If you decide that you would like to take part, please could you complete the reply slip also enclosed and return this to the address given above. You will be able to ask any questions about the study and the details of how to do this are provided on the information sheet.

If you decide to take part, you may either contact the researcher to organise an interview, or provide contact details on the reply slip for the researcher to contact you. You will be asked to sign a consent form at the interview, which the researcher will go through with you. This is to make sure that you are happy to take part in the study, to check that you understand the information given on the information sheet and to answer any further questions you may have about the study.

If you do not wish to take part in this research study, you will not be contacted again and you do not need to reply to this letter. This will not affect the standard of care you receive.

Thank you for your time

APPENDIX XIII: LETTER OF INVITATION TO PARTICIPANTS TO ATTEND THE FOCUS GROUP (VERSION ONE)

**People's understanding of crisis and ways of coping
[Version 1 03.09.12]**

Dear

Thank you for taking part in the above psychological study. The interviews formed the first stage of this research study. I would like to invite you to attend a focus group, which forms the second stage of this study. The focus group will be carried out by Ross Watson, Trainee Clinical Psychologist and will be supervised by Dr Andrew Vidgen (Clinical Psychologist, South Wales Doctoral Programme in Clinical Psychology) and Dr Ella Rafferty (Clinical Psychologist, Crisis Services, Cardiff and Vale UHB).

The focus group has been set up to provide an opportunity for participants to discuss the themes that have been drawn out from the interview transcripts and to see if the themes match with people's experiences. The information sheet that was given to you when you were contacted to see if you would be interested in taking part in this study, has details about what is involved if you decide to take part in the focus group. The information sheet is enclosed with this letter and provides details of how to get in touch if you would like any further information about taking part in the focus group.

It is up to you to decide if you would like to take part in the focus group and participation is entirely voluntary. If you do wish to take part, please could you return the reply slip that is enclosed with this letter. You will be asked to complete and sign a consent form when you arrive to attend the focus group. This is to make sure that you are happy to take part in the focus group.

The focus group will take place onat.....and will be held at.....

The focus group will last 60 minutes. If you require directions of how to get to.....

please could you contact.....

If you do not wish to take part in the focus group, you will not be contacted again and you do not need to reply to this letter. If you do not wish to take part in the focus group this will not affect the standard of care you receive.

Thank you for your time and for taking part in the study.

Kind Regards

Ross Watson
Trainee Clinical Psychologist

APPENDIX XIV: LETTER TO PARTICIPANT OFFERING AN
APPOINTMENT (UPON HER REQUEST)

1st March 2013

People's understanding of crisis and ways of coping

Dear XXXXX,

Thank you for your interest in the above psychological study and for returning the reply slip. If you have any questions or concerns about participating in the study, please do not hesitate to contact me, either by email (XXXXX) or by telephone (XXXXXX).

I would like to offer you the following date and time to meet for the interview:

XXXXXXX

The interview will take place at the **XXXXX**, based within **XXXX** at the **XXXXXXXX**. It is anticipated that the interview will last for 60 minutes. I will ask you to complete a consent form before we begin the interview and you will also get a chance to ask any questions or share any concerns before we start.

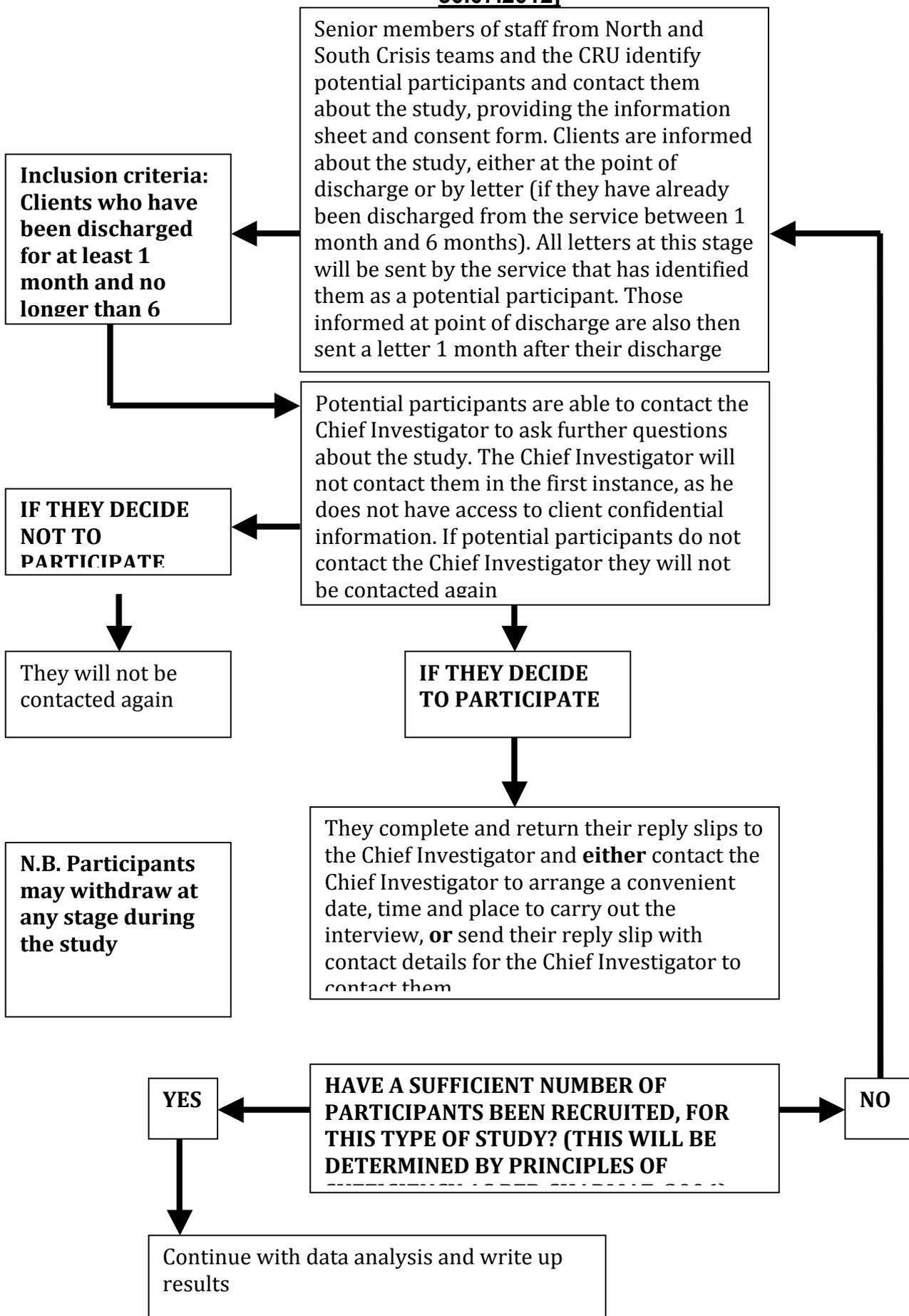
If you require any help with directions, please contact XXXX directly on XXXXXX. If you are unable to attend the interview or it is inconvenient for you to attend, please could you contact me on XXXXX. If you wish to rearrange the appointment, I will then be in contact shortly.

Thank you again for your interest in the study and I look forward to meeting with you.

Kind Regards

XXXXX
Trainee Clinical Psychologist

**Flowchart of Initial Participant Recruitment Phase [Version 3
30.07.2012]**



Semi-structured interview schedule [Version 2 27.3.12]

Role of Facilitator:

- Welcome the participant and thank them for agreeing to participate
 - Give an opportunity to the participant to ask any questions if they have any
 - Explain the predicted length of the interview reiterating their right to stop the interview and withdraw at any time, if they wish
 - Tell the participant that you will be timekeeping and intermittently referring to the interview sheet during the interview
 - Offer another information sheet to participants and signpost them to contacts for support and the procedure for withdrawing at a later stage, if they wish
 - Talk to the participant about the focus group, answer any questions they may have about it and signpost them to the information sheet. Advise them that an initiation letter, inviting them to attend the focus group will be sent out following the completion of all of the interviews
 - Ask the participant to sign the consent form
 - Start the interview if the participant is ready to proceed
 - Once the interview is complete, thank the participant for coming and for taking part and ask them how they found the interview and if they have any questions
-
- How do you understand what happened?
(Prompt if appropriate) What happened next?
 - What was going on around you, at the time?
 - What were the reactions of people around you?
 - What happened when you met with the crisis team?
 - What did you need?
 - What was helpful about their involvement?
 - What helped you the most to recover?
 - What advice would you give to someone who was going through a similar crisis experience?
 - Are there any questions that you would have liked to have been asked? /
Are there questions that I should ask other participants?

Changes made following Interviews 1 & 2. [The questions shown in black type are those that were introduced at this stage. The questions shown in grey type are those from the original schedule and a sample of these questions were asked to provide a temporal framework]

- How do you understand what happened?
(Prompt if appropriate) What happened next?
- What was going on around you, at the time?
- Was there a point at which it became unmanageable?
- What were the reactions of people around you?
- What happened when you met with the crisis team?
- What did you need?
- What was helpful about their involvement?
- What helped you the most to recover?
- How have you learned to handle a crisis?
- What advice would you give to someone who was going through a similar crisis experience?
- Are there any questions that you would have liked to have been asked? / Are there questions that I should ask other participants?
- Is there anything else you think I should know to understand better?

Changes made between Interviews 3, 4 & 5. [The questions shown in black type are those that were introduced at this stage. The questions shown in grey type are those from the original schedule and a sample of these questions were asked to provide a temporal framework]

- How do you understand what happened?
(Prompt if appropriate) What happened next?
- What was going on around you, at the time?
- How aware were you of a crisis approaching? How will you recognise if a crisis is approaching in the future?
- Was there a point at which it became unmanageable?

- What were the reactions of people around you?
- How important is the role of family or friend support in helping you cope with a crisis?
- How did the crisis team make a difference to how you were feeling?
- Did the circumstances change how you viewed helping professionals in their role? If so, in what ways?
- What did you need?
- What was helpful about their involvement?
- What helped you the most to recover?
- How have you learned to handle a crisis?
- What advice would you give to someone who was going through a similar crisis experience?
- Are there any questions that you would have liked to have been asked? / Are there questions that I should ask other participants?
- Is there anything else you think I should know to understand better?

Changes made between Interviews 6, 7, 8 & 9. [The questions shown in black type are those that were introduced at this stage. The questions shown in grey type are those from the original schedule and a sample of these questions were asked to provide a temporal framework]

- How do you understand what happened?
(Prompt if appropriate) What happened next?
- What was going on around you, at the time?
- How aware were you of a crisis approaching? How will you recognise if a crisis is approaching in the future?
- Was there a point at which it became unmanageable?
- What does a crisis mean to you?
- How did you communicate what you were thinking/feeling/experiencing?
- What were the reactions of people around you?

- What impact does a crisis have on people's relationships with others?
- How important was it for you to have people understand what you were going through?
- How able did you feel others were at understanding what you went through when you experienced a crisis?
- How important is the role of family or friend support in helping you cope with a crisis?
- How did the crisis team make a difference to how you were feeling?
- Did the circumstances change how you viewed helping professionals in their role? If so, in what ways?
- What did you need?
- What was helpful about their involvement?
- What helped you the most to recover?
- How have you learned to handle a crisis?
- What advice would you give to someone who was going through a similar crisis experience?
- Are there any questions that you would have liked to have been asked? / Are there questions that I should ask other participants?
- Is there anything else you think I should know to understand better?

Extract of interview transcriptsExtract 1

Researcher: Is that the breakdown point, the crisis?

Anwen: Not always the breakdown point but yeah, yeah it is getting to that stage yeah, that's when I would seriously consider I need some help because this is a crisis, because this is big and bad and ugly and real and its not just the person that suffers, its everybody around them. Families, I mean my mother and father are brilliant but they're getting on a bit now and it's a crisis for them really, it affects the whole structure of the family

Researcher: So it doesn't just impact on yourself?

Anwen: Yeah on everybody around me

Researcher: When you think about that moment before you made contact with crisis services, what sort of things were going through you're mind or what sort of things were you feeling?

Anwen: Despair. Just not really wanting to go to be honest. It got to the point where I wouldn't care if id were hit by a truck and it's not a selfish thing, it's a reality thing of the illness. It's a very selfish illness really. In society today, if you're like that and everything is evolving around you that then you're selfish. But the illness itself is very selfish, it doesn't just affect you, it affects everybody around you. As in they've got to pull together, no body really knows how to deal with it, it's a very taboo kind if thing, but when you get to that, me personally, I knew it was a crisis when it started affecting the people around me. It wasn't just me anymore, it was my children, my parents, its just being aware, sometimes its not possible though, sometimes it does just come up and bite you.

Researcher: What did you notice that was happening to other members of your family?

Anwen: My daughter had to take on a bigger role, fourteen year old daughter had to do a lot more to look after the two younger girls. That affected her because she didn't want to leave me in the house on my own with the two younger kids because I was falling asleep, just no energy and then it affected my mother and father because they were, they were trying to sort out everything as well. So by looking after the children, making sure everything was ok, making sure that they got shopping in. so even things like that you don't do when you're like that. So it does affect them

Researcher: Right, I was just thinking about a crisis itself. When you think about a crisis, what does it mean to?

Anwen: A crisis to me is when I've lost control. I think that's the biggest issue, is losing that control. You're every day things that you usually have control to a certain extent and you usually control over it. you lose that

Extract 2

Researcher: Did it feel like a build up events?

Lynne: Yeah, everything just came to a head. I think at that point I didn't go into work cos I realized id lost the plot because there's no way I would have spoken to a customer in that way at all. It came to a head and there was a lot of things, I knew I was going to lose my job because I'd gone sick and they were starting to get annoyed. I did lose my job, ill health dismissal, didn't have a job didn't have a house, had no money and nowhere to live.

Researcher: Right, ok. Did it feel like there was a breaking point cos someone else had mentioned about seeing crisis as a breaking point. Does that fit with your experience?

Lynne: Yes, it does, it became unmanageable, everything just got on top of me, with hindsight I should have dealt with it better. But I think the reason I didn't deal with it is because you're not thinking, if you're in a normal state of mind, whatever normal is you're not thinking of suicide. I would never thought of suicide before; it never would have entered my head. But other than that, I would say it would never have occurred to me to commit suicide. So I realised that, to use the word crisis, I was at breaking point, I had come to the end of whatever there was, I couldn't deal with anything and I thought to myself suicide was the only way out because I had nothing left and I don't have any friends or anything so I just thoughts that's it and I was living in place where I didn't really know anybody.

Extract 3

Researcher: What did you feel needed when things reached a breaking point?

Alun: Well that's a good question really. I just wanted to get back to normal. I needed some sort of normality, getting up in the morning, not forgetting to put my socks on, looking in the mirror, having a shave, having a shower and feeling fresh again, not crying and everything got sick of what I was doing really. I had everything I needed support wise.

Researcher: And what did you need support wise?

Alun: Well when I was crying, my wife, we haven't got on very well but she saw I was down so she always give me support and put her arms round me and my sons girlfriend, I knew I had different health teams saying if you need to phone us up, phone us up so I had everything I needed on that side. But inside I just wanted to get back to normal again, I didn't know what was doing it, and it was frightening me to death, if someone had said so and so died a few weeks ago delayed reaction but nothing had happened that I could put my finger on or any of us could and all I wanted was to get back to normal.

Researcher: That's interesting. I just wanted to ask you Alun, how important was it for you to understand what was going on and for other people to understand what was going on?

Alun: The other people understood because my wife was straight on the Internet, which could be a good thing and a bad thing really. She was looking into what could have caused it. But it was important for me to have supportive people but myself I couldn't understand it, I could not understand, why it happened and what was happening.

Researcher: How did that make you feel?

Alun: Useless. I felt useless, I still do. I'd love to say to my wife lets go shopping or lets go somewhere. But we took the dog out yesterday but I couldn't do that before, but going out places outside is the problem, but I'd still like to say come on, get the fence painted today and this done and that done, you know just do things you do now. But I still cant at the moment and that frustrates me. I can't understand why I can't do a lot of things when I want to in a way. It was still alien.

Researcher: How able do you feel others are at understanding what you go through when you experience a crisis?

Alun: Ok. The people around were the only ones who I care about who cares about me, I don't care about what people in work think, I couldn't care a less, they all know what's wrong now cos I told my mate to tell them. My sons girlfriends mother went through it, she came here, she was actually sectioned at one time so she'd seen it, my son had been bit depressed and had problems so he was very understanding and my wife was understanding, my mother was understanding cos they'd been through it and they're the only people I'd been seeing really and it wasn't until I came here and saw people here and met people here that I realized there's a lot of people who get these problems and the people here were a great help.

Reflective Journal

22.1.13 (One interview had been conducted). This reflective note was written after my Clinical Supervisor had spoken to a client about the study and the client had told her that she felt she would be unable to participate in such a study because she wished to forget her crisis experience.

What must the experience be like for clients who are considering taking part, knowing that they will be asked about an event or series of events they may wish to forget. Some people may view their participation as a way to help others. Some may view their participation as a form of self-healing - to enable themselves to reflect on their crisis experience. How does that impact on or change my position as a researcher, as a listener? How will it impact on what we create during the interview process bearing in mind the agenda of the research project?

24.4.13. (Five interviews had been conducted). This reflective note was written during the initial and focused coding process.

As I have been going through the coding process I have been struck by two observations. The first is that I'm wondering if there's a parallel process occurring between what I'm finding in the data and what I'm experiencing with regards to recruitment. What seems to be coming from the data is that those who have experienced a mental health crisis feel other people around them (including family in some instances), do not understand what they are going through or have been through. This has meant that for some of the participants, they have reported choosing not to tell other people, even services in one instance. With regards to recruitment, what I have found is a fairly low response rate. Is this to do with not wanting to share their story with someone who they feel might not understand? It might be worth checking this out with future participants.

I have found myself drawn to themes of understanding, acceptance, power and control. This has extended to an interest in literature that explores these themes. However, that said, having recently purchased a book that explores power, resistance and liberation in therapy for example, I am aware that my reading and interest may well be influencing the resonance of these themes with me. There's something quite powerful in owning your own story and choosing who to share it with; someone who will accept and understand. I'm beginning to wonder if the participant's constructions of crisis are in fact encapsulated by these four themes.

28.4.13

I find myself drawn to an idea about connection – feeling disconnected to others and to the world at the point of crisis. Feeling disconnected and feeling connected were two focussed codes that came out of the data from the first interview but they appear to resonate with the data from the other interviews.

30.4.13. This reflective note was written shortly after conducting Interview 7.

I definitely noticed similar themes and a central theme of feeling disconnected at the point of crisis. The term breakdown was used again, paired with the feeling of despair. When I asked the participant if they felt there was a sense of feeling disconnected to others and the world at the point of crisis she agreed and it seemed to resonate with her. She also agreed that there might be a connection between feeling understood and feeling accepted. She talked about the impact of a crisis on her family, on the family structure and the physical impact (not being able to do anything physically). She talked about losing control, which echoed what previous participants had said. There was a strong sense of feeling stigmatized in her narrative-she talking about social stigma and the government not appreciating mental health difficulties, before the interview had even begun.

If a crisis is about feeling disconnected, I need to go through the codes again and see what leads someone to feel disconnected. Reconnecting seems to be about 'getting the right support'-feeling heard, understood, accepted, practical support etc.

The time before a crisis seems to be about self and family at the moment that can lead to someone feeling disconnected.

I was struck in the interview that I had begun to listen out for specific aspects of her story and wishing to explore some of the key ideas that have come out of the data. In comparison to the previous interview in which I felt like I was put in the expert position, I felt very much like an observer in this interview and the theme of expertise in experience came up. She made it clear at the beginning that she perceives people's experiences as unique which she alluded to being one reason why it might be difficult for other people to understand what someone in crisis is going through.

Notes taken during an initial coding and review of a transcript (Interview 5) -

23.4.13. These notes were written adopting a style suggested by Charmaz (2006).

Sense of feeling isolated and alone where no-one understands and therefore, doesn't want to know. *'Like a tunnel and you're going through it'*. Accompanied by a sense of helplessness.

Acceptance is a central theme in her narrative about crisis. Feeling accepted by other people through being understood, kids not making fun of her etc. And accepting the loss of a caring role, the loss of a role as mother. Accepting that her son wanted to live his own life which meant for her she was left on her own. Acceptance means being psychologically held in mind.

Experiencing a crisis and looking round at people around her, family members but she can't reach out to them because they don't care and they don't understand. She'll be a burden to them therefore she has to learn to live with the illness and reach out to familiar sources of help (professionals) when she really needs it. Of course, this then means that her family and neighbours see her as a psychiatric patient and unwell and so she feels stigmatized and ostracized all because people don't want to know, they've got their own lives and so she carries on, on her own, learning to live with it until the point where she can't cope and she needs to reach out to talk to someone who understands her.

There's no one she can talk to so she's going to breakdown. She's reached the end of reaching out and now needs to get away from the pressure of being at home. She needs to get away immediately.

Wanting to talk, trying to talk, to get it out there, but other people might be afraid of her and so she feels separate from others, as if she's different but she's not and it's insulting.

Crisis - One minute it's there and the next it's gone. Disappears - no longer there, as if it wasn't there. Leaving no trace. Something about the word disappears - as if when she is in crisis she reappears to the world (i.e. she finds people who want to know and want to listen) but as soon as the crisis disappears she disappears with it, back to being a lonely person, disconnected from the world and not being understood. In a strange way it connects her to others and makes her feel connected.

After receiving help she finds a new lease of life, she feels resilient and can cope with anything. Keeping herself busy allows her to avoid becoming unwell again and feeling well means she is better able to communicate to others. Illness makes her feel invisible to other people where she copes with her illness alone and finds it hard to speak to people about this.

Themes:

Isolation

Invisibility

Difference

Us vs. them

Feeling ostracized

Acceptance

Connection

What was needed at the time of crisis:

Time to recover

Having others around who share similar experiences (understanding)

Thinking outside of self which is helped by socializing with others

APPENDIX XIX:

EXAMPLE OF MEMO WRITING

Defining Hell. Memo. 13.4.13. This Memo was written about what crisis meant for Participant 1.

The concepts that seemed to come out of what participant 1 was talking about when he was describing hell were:

Making a decision based on symptoms

- Seeing symptoms as dangerous
- Believing symptoms
- Making a decision to die / deciding to die

Feeling disempowered

- Difficult to imagine
- Losing sleep
- Being taken over by experiences
- Reliving the abuse
- Becoming stressed / feeling distressed
- Repeating the process
- Being transported to a different world

Being proactive

- Staying focused
- Going with it
- Working through it
- Stopping thoughts
- Getting away from it

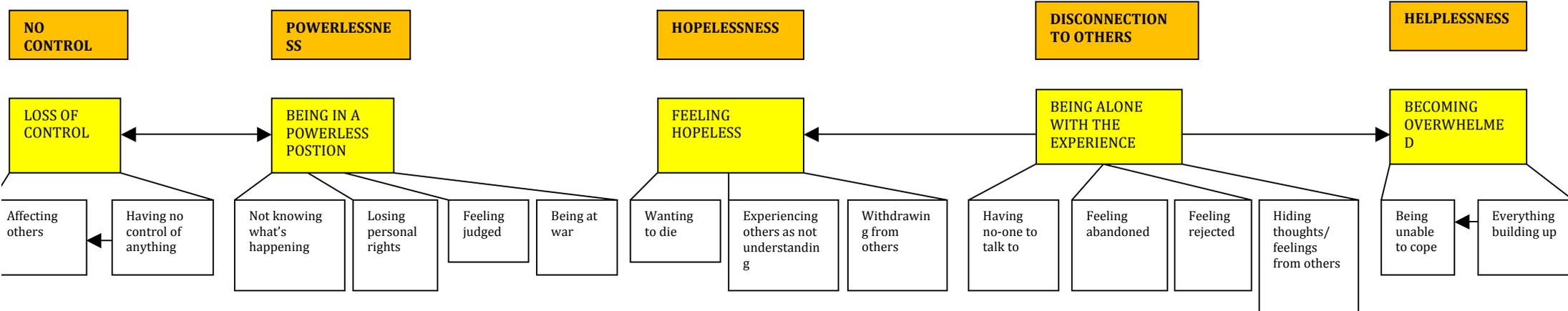
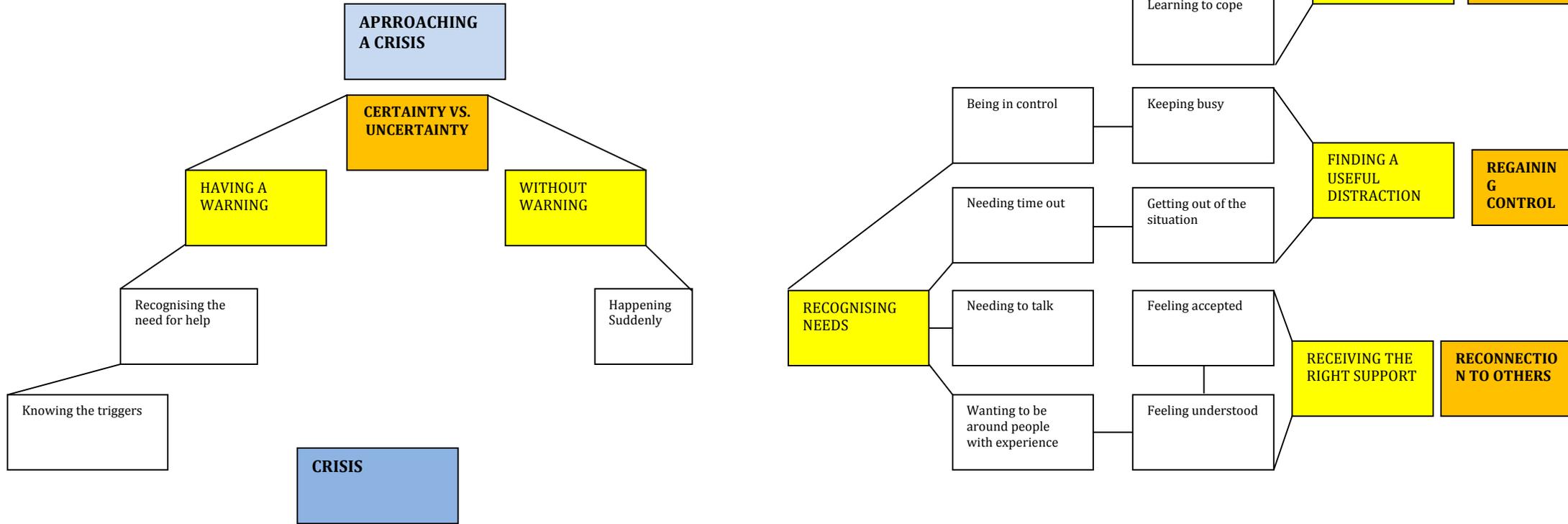
Feeling alone with the experience

- Receiving hassle with others unaware (others not knowing)
- Others disbelieving
- Feeling alone and without help
- Blanking others out
- Accepting solitariness
- Speaking inwardly
- Wanting a new experience
- Wanting to be loved

The experience of hell seems to relate to a state of mind that is difficult to imagine and therefore perhaps difficult to understand or feel understood, where life-saving decisions are made based on symptoms. Uncertainty over whether these symptoms feel real or not for the person only strengthens the experience for that person of feeling disempowered and alone with the experience. In turn, feeling alone with the experience means not feeling understood, accepted or loved by others and speaks to the loss of relationships with others, to the point of feeling separate from others and the world, as if transported to a different world, where negative, traumatic experiences are relived and repeated and any sense of having control or feeling empowered are lost, lost to those experiences that are being relived and replayed. Conversations become inward, with the self and as a result others are blanked out. Accepting solitariness seems one option although precludes the opportunity to attain the underlying need to be loved. The only escape seems to lie with trying to be proactive, rather than fighting the symptoms that might incur a battle, it is more about going with it but staying focussed and taking moments to get away from it, searching for a new experience and allowing oneself some moments of respite.

APPENDIX XX:

BUILDING THE GROUNDED THEORY (FIRST CONCEPTUALISATION)



SECOND CONCEPTUALISATION

APPROACHING A CRISIS

GETTING TO THE EDGE

BUILD UP

- Psychological
- Combination of environmental events

BECOMING UNMANAGEABLE

- Signalling a problem

LIVING NEAR THE EDGE OF CRISIS

- Defiance (Not giving in)

REACHING A CRITICAL POINT

HELPLESSNESS

UNABLE TO COPE

- Overwhelmed
- Responsibility
- Understanding
- Not functioning
- Environmental stress

AT A DISADVANTAGE

- Having a mental illness

DISCONNECTED

BEING ALONE WITH THE EXPERIENCE

- Invisible
- No-one to turn to
- Not understood
- Separate from the world
- Hidden thoughts/ feelings

HOPELESSNESS

REACHING A POINT OF HOPELESSNESS

- Trapped
- Limited Options
- Despair

COMMUNICATING DISTRESS

- Causing harm to self
- Cry for help

IMPACT ON OTHERS

AFFECTING OTHERS

- Others
- Family

LOSS OF CONTROL

SUDDEN BUILD UP

- Unpredictable
- Detached from reality

BEING PUSHED OVER THE EDGE

- Psychological Triggers
- External triggers

LOST ALL CONTROL

- Taking action
- Freefalling

POWERLESSNESS

BEING IN A POWERLESS POSITION

- Being done to
- Reacting
- Being seen as the patient
- Lack of understanding

ACCESSING HELP

TIME TO SEEK HELP

- Recognising the need for help

COMPULSORY INTERVENTION

COMING OUT OF CRISIS

WAYS OF COPING

COMMUNICATION

- Sharing experience with understanding others

STAYING CONNECTED

- Being with people

TREATMENT

- Medication

TIME

- Control over time
- Time out

CONTROL

- Care Planning
- Taking control of symptoms
- Controlling thoughts

POSITIVE EXPERIENCE OF CRHTT SUPPORT

ACCEPTANCE

- Validation
- Consistency
- Treated as a person

HELP AT HOME

- Practical support

OUTCOMES

- Coping
- Hope
- Control

BUILDING RESILIENCE

MOVING FORWARD

- Future
- Cognitive strategies
- Coping
- Remaining hopeful

APPENDIX XXI: LIST OF THEMES, CORE CATEGORIES, CATEGORIES,
SUBCATEGORIES

MOVING TOWARDS CRISIS (THEME)

- TRYING TO COPE WITHOUT SEEKING SUPPORT (Core Category)
- NOTICING SIGNS OF INCREASING DIFFICULTIES (Core Category)
- THE BUILD UP TO CRISIS (Core category)

REACHING BREAKING POINT (CRISIS) (THEME)

- ISOLATION (Core Category)
 - Coping alone (Category)
 - Disconnected from others (Subcategory)
 - Having no one to turn to (Subcategory)
- HELPLESSNESS (CORE CATEGORY)
 - Inability to cope (Category)
 - Inability to function (Category)
- LOSS OF CONTROL (Core Category)
 - Losing control (Category)
 - Rate of reaching breaking point (Category)
- HOPELESSNESS (CORE CATEGORY)
 - Reaching a decision to want to die (Category)
 - Wanting to die (Subcategory)
 - Despair (Subcategory)
- IMPACT ON OTHERS (Core Category)

CONTACT WITH SERVICES (THEME)

- RECEIVING THE RIGHT SUPPORT (CORE CATEGORY)
 - Outcomes (Category)
 - Positive Experiences of Support (Category)
- BEING IN A POWERLESS POSITION (Core Category)
 - Perceived Treatment by Services (Category)
 - Being done to (Subcategory)
 - Viewed as the patient (Subcategory)
- ACCESSING HELP (CORE CATEGORY)

AFTER CRISIS (THEME)

- BUILDING RESILIENCE (Core Category)
 - Moving Forward (Category)
 - Towards the future (Subcategory)
 - Learning to cope (Subcategory)

WHAT HELPS (THEME)

- WAYS OF COPING (CORE CATEGORY)
 - Methods of Coping (Category)
 - Connecting with Others (Category)
 - Time out (Category)

The Focus Group took place at a Crisis Recovery Unit in a consultation room and lasted for approximately 60 minutes. Four of the participants (three males and one female) that had taken part in the interview stage attended the Focus Group.

PROCEDURE

The participants were welcomed and offered to ask any questions. Each participant was then asked to sign a consent form and reminded of their right to withdraw at any point without having to give a reason.

The Focus Group was not audio-recorded. Instead, contemporaneous notes were taken during the Focus Group and reflections were written down directly after the group, to enhance the richness of the notes.

The themes, core categories, categories and subcategories were presented to the group in turn. As these were being presented, a description of the Constructivist Grounded Theory was presented as it was unfolding, both orally and in written form to enhance their understanding. Following this process, a summary of the theory was given orally and discussed with the participants who attended the group, to check the validity of the theory against their experiences.

SUMMARY

Overall, the participants agreed with the theory and with the themes, core categories, categories and subcategories. One of the participants felt that in her experience, she did not recognise there being a stage where coping with her mental health difficulties became unmanageable. She described how she felt in her experience it was sudden and unexpected. She did, however, recognise a build up to her experience of crisis. The other participants in the group however, agreed that there was a stage at which they recognized signs of finding it harder to cope. It was agreed in the group that the core category that described noticing signs of coping difficulties would remain in the theory, given also that other participants who had talked about this had not attended the group.

The participants asked that within the core category that identifies their descriptions of ways of coping, the category that captures participants' responses relating to *taking control* be changed to *trying to take control*. This change emphasises the difficulty they described in trying to regain control following a crisis. It also highlights the impact of a crisis on someone's control over their ability to cope.

The Focus Group also all agreed that the category that captures participants' responses relating to experiencing anxiety following a crisis, remain in the theory. This was particularly salient as only a few of the participants had talked about these experiences during the interview stage, which therefore questioned the significance of this phenomenon.

REFLECTIONS

The group spoke openly about their experiences and one of the participants said that he had found the group an enjoyable experience. It made me think about one aspect of the Constructivist Grounded Theory that highlights sharing experiences with others who have an understanding of mental health difficulties or of crisis. Participants who had initially said that they found attending groups unsettling and anxiety-provoking had attended and more interestingly, were actively involved in group discussions.