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**CRISIS RESOLUTION AND COMMUNITY
MENTAL HEALTH: AN ETHNOGRAPHY OF TWO
TEAMS.**

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A Thesis Submitted to the University of Durham
for the Degree of Doctor of Philosophy.

By George Anderson.

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2006.



01 JUN 2006

ABSTRACT.

“Crisis Resolution” teams are a growing element of community mental health services in the England. The Department of Health intended to have 335 services established by the end of 2004 and had in fact achieved a total of 343 by mid 2005. This study focuses on two such crisis teams operating in the north east of England and aims to describe important features of their routine work. Using a fusion of observation and discourse analysis (the latter based on audio recordings made during team meetings and interviews with team members), areas such as multidisciplinary team working, expertise, user involvement and the understanding of mental health crisis itself are subjected to scrutiny, discussion and analysis. The study was funded as an ESRC CASE studentship.

A variety of professional expertise comes into play in the formation of any multidisciplinary community mental health team. How these disciplines interact when delivering crisis resolution is a key focus of the study in hand. Both teams are made up of the same professional disciplines; medicine, nursing, and social work. In addition, support workers are present in both teams. This research examines the interaction of these disciplines and roles, the possibility and actuality of conflict between them and the various ways in which individuals work together to *create a team*.

While Department of Health guidelines deliver a referral criteria with a definition of the constituents of a mental health crisis, this definition is general and cannot describe the numerous interpersonal processes involved in accepting a referral. Hence, the nature of mental health crisis itself is debatable. The study examines a variety of ways in which “crisis” is constructed and understood. Also, the practice of crisis resolution does not simply involve the work of mental health professionals; it also involves the input of the mental health service users themselves. “User involvement” is a phrase that commonly appears in contemporary Health Service literature. This study seeks to describe what this phrase actually means in the day to day delivery of the service.

Statement of Originality.

I wish to clarify that this thesis is my own work. The data presented are original and were collected by me over a 16 month period between March 2003 and August 2004.

All names of people and places have been changed.

Acknowledgements.

For their support, criticism and patience, I would like to thank my supervisory team: Mr Robin Williams, Dr Roger Paxton and Professor John Carpenter. I would also like to thank Dr Ali Zaatar for his invaluable assistance in the early stages of the project.

Special thanks are due to all the crisis team members for allowing me an insight into their working world and without whom this project would have gone nowhere. Equally, I would like to thank the service users and carers who participated in this study, allowing me to observe them at a particularly difficult time in their lives. Their courage will always command my greatest respect.

Thanks are due to the School of Applied Social Sciences and the University of Durham as a whole. Also, the Mental Health NHS Trust with whom I worked (anonymised for the purpose of employee and service user confidentiality) is owed my appreciation.

Finally, I would like to thank family and friends who have supported me over the last three years. In the words of Roy Harper, “they are who they think they are!”

Contents.

Abstract.....	i
Statement of Originality.....	ii
Acknowledgements.....	iv
Chapter One: Introduction.....	1
1) General Overview.....	1
2) Background and Motivations.....	2
3) The Structure of this Thesis.....	3
4) Crisis Resolution Services.....	4
5) Crisis Theory.....	9
6) An Empirical Study of Two Crisis Teams.....	15
7) Key Activities.....	18
8) Summary.....	19
Chapter Two: Background and Methodology.....	20
1) Introduction.....	20
2) The Methods Employed in this Study.....	26
3) Analysis.....	32
4) Ethics.....	40
5) Access and Field Relations.....	44
6) Reflection and Concluding Remarks.....	52
Chapter Three: Understanding “Crisis”.....	55
1) Introduction.....	55
2) Crisis as Understood by Team Members.....	58

3) Handover Discussions.....	60
4) Assessment and Treatment.....	79
5) Conclusion: The Multifaceted Nature of Crisis.....	91
Chapter Four: Teamworking.....	94
1) Introduction: Multidisciplinary Teamworking and its Significance.....	94
2) Defining “Teams”: A Dramaturgical Model.....	100
3) The Official Frontstage.....	108
4) The Unofficial Frontstage.....	114
5) The Official Backstage.....	118
6) The Unofficial Backstage.....	125
7) Teams, Hierarchy and Leadership.....	130
8) Conclusion: The Negotiated Nature of Teamworking.....	134
Chapter Five: User Involvement.....	137
1) Introduction.....	137
2) The PIG on User Involvement.....	140
3) Team Members’ Descriptions of User Involvement.....	143
4) Conflict and Collaboration in Crisis Resolution: Three Cases.....	150
5) Conclusion: Audience Participation on the Official Frontstage.....	168
Chapter Six: Expertise.....	170
1) Introduction.....	170
2) The Expertise in the Teams Observed.....	172
3) Team Members’ Descriptions of their Expertise.....	183
4) Utilising Expertise in Home Treatment.....	197
5) Conclusion: The Significance and Insignificance of Professional Disciplines.....	209
Chapter Seven: Discussion.....	211
1) Introduction.....	211

2) The Central Findings of this Study.....	213
3) Crisis Resolution: Part of a “Third Way” in Mental Health?.....	221
4) The Limitations of this Research.....	224
5) Some Implications for Policy and Practice.....	228
6) Conclusion.....	232
Bibliography.....	236
Appendices.....	243
Appendix I: A Tree Diagram.....	244
Appendix II: Project Documents.....	246
Appendix III: The Mental Health Policy Implementation Guide: Crisis Resolution/Home Treatment Teams.....	<i>Following 262</i>

Chapter One: Introduction.

1) General Overview.

‘Crisis resolution’ is one of several new mental health services introduced throughout England in 2001. This particular community-based service is designed to offer short-term and intensive intervention with individuals experiencing a “mental health crisis”. Crisis resolution services merit study because they are new. They are also complex in that they involve the bringing together of several distinct specialist skills into one particular mode of delivery and they are designed to treat specific individuals in specific circumstances. Who these individuals are and what these particular circumstances are is a central focus of this thesis. In short, one of the questions I seek to answer is: *what is a crisis from the standpoint of crisis resolution services?*

Crisis resolution team members come from an array of backgrounds. Psychiatrists, psychiatric nurses, social workers and support workers have designated roles within the teams in relation to their expertise. They are also required to work in unison as a team with specific working agendas. The purpose of a crisis resolution team is to treat people experiencing crisis at home, so that if at all possible they do not have to be admitted to psychiatric hospital. How team members accomplish this, in particular how they ‘work as a team’ is a particular interest of this study. Do teams involve and empower service users? If they do, then how do they do it? If they do not, then how do they fail?

I attempt to answer these questions through an empirical study of two crisis teams. Two and a half months was spent with each team over an 18 month period, and using data gathered from official documents, fieldnotes, interviews and recordings, I seek to describe the process of crisis resolution as I witnessed it.

In this introductory chapter, I describe the structure of this thesis. I consider the origins of crisis resolution services, how they are described in current service literature and their



significance in relation to mental health service reform. I then present the “crisis theory” on which current practice may or may not be loosely based. I proceed to describe the two teams studied and key activities in which they engaged. The next section explains my background and motivation for conducting this study.

2) Background and Motivations.

In this section, I describe my motivation for undertaking this study in the context of my background and prior understanding. I have always been fascinated by perceptions of mental health and illness which pervade our society. It would seem that, as our lives have grown ever more complex, so have the variety of ways in which we pathologise one another. The “mad” of past history can now invite dozens of diagnostic labels (Porter 1987, Hacking 1998). As we construct new understandings of those who are apparently unable to function in a way deemed ‘appropriate’, so do we introduce new ways in which to address these problems. In the recent past (until around half a century ago), this was done through overt social exclusion in the form of institutionalisation (Foucault 1961). Over the last few decades, however, policy makers have instigated a move to “community care”; those deemed mentally ill or incapacitated being treated in their homes, in day-centres, and in various forms of supported accommodation.

Prior to embarking on this project, I worked for eighteen months as a research assistant in a specialist mental health unit; a “democratic therapeutic community”. This was a residential service for people diagnosed as having a “severe personality disorder”, a condition often deemed “untreatable” by contemporary mainstream psychiatry. Independent of these technical terms, however, I encountered a diversity of people with a complex variety of reasons for their current status as residents of the unit. Though the place was a source of fascination, inspiration and learning for me, the requirements of my position meant that I was greatly restricted in the type of research I could conduct. Much of the time was spent administering projects devised by senior health service researchers, which were largely statistical studies of clinical effectiveness. My academic background

was chiefly in qualitative research, and so I began to seek out opportunities to utilise these skills and develop them further.

Since my introduction to the mental health services had been in a highly specialised unit utilising an unconventional (albeit well-established) approach to treatment, it seemed appropriate to acquaint myself with a community-based service with a different approach. It remained, however, my wish to research a specialist service; preferably one which was relatively new. When a CASE studentship for an ethnographic study of crisis resolution teams was offered to me, I swiftly accepted.

3) The Structure of this Thesis.

There are four central topics of this thesis; crisis, teamworking, expertise and user involvement. These central areas are covered both for their contemporary relevance and because they emerged in my initial assumptions about the nature of crisis work. These assumptions are discussed in chapter two where I explain further the background to this project and the research methods employed in its delivery. I present a “natural history” of the project, from its original formulation and my initial involvement to its practical execution and my time in the field.

As previously stated, crisis resolution is a ‘specialist’ service, focussing on specific needs. In chapter three, I consider how these needs are identified and thus how a crisis is defined. Drawing on data from interviews, recordings of team meetings and fieldnotes taken during assessments and home visits, I identify an array of factors that may be deemed as constitutive of crisis and also consider how and when a crisis is excluded.

In chapter four, I consider teamworking in crisis resolution services. What is teamwork and how is it achieved? I examine how this work is accomplished in various activities. I also consider team structure and hierarchy, drawing on a range of data from fieldnotes and recordings.

Chapter five focuses on user involvement; that is the extent to which service users are involved in the planning and execution of their own treatment and how this is achieved. I consider the importance of user involvement in contemporary mental health services. I then describe the intricacies of user involvement in the two teams observed. In three case studies of service users, I explain how the extent of such involvement is negotiated between professionals and service users.

In chapter six, I consider professional expertise. I describe the array of expertise present in the two teams studied and how these are applied in the delivery of crisis resolution. Using data from interviews and fieldnotes, I consider where there may be areas of tension between professional disciplines and how consensus in approach is accomplished.

In chapter seven, I discuss the findings of this study and its broader relevance. I consider the implications for policy and practice, the limitations of my research and suggest further areas of investigation. Following this, I speculate as to how crisis resolution services may evolve.

Before proceeding to describe the practice of crisis resolution, it is necessary to present an overview of the services themselves.

4) Crisis Resolution Services.

4.1. Origins.

Fennel (1999:104) described a significant event in the recent evolution of mental health services in the United Kingdom:

In July 1998 the Secretary of State for Health, Frank Dobson, declared that community care had failed. He wanted 'a third way' in mental health. The third way would steer a path between reliance on putting all mentally ill people in institutions-

‘out of sight- out of mind’ and community care where people with mental health problems could be ‘left off the books’ thereby putting themselves and others at risk.

In the wake of Dobson’s statement, the Department of Health invested in new mental health services; services which would evolve over time and have a more ‘specialist’ remit than existing community mental health teams and psychiatric hospitals. These services would be geared towards specific mental health needs, be they the early stages of psychotic illness (early intervention for psychosis services), failure or reluctance to engage with services (assertive outreach teams) and acute psychiatric crises (crisis resolution and home treatment services).

The last of these- crisis resolution services- originated in Australia in the 1980s and were introduced in Britain around the millennium. Raphael (2000) described how Australian researchers (Maddison and Walker 1967) pioneered empirical research that tested Caplan’s model of crisis intervention (see section 5 below). Also, in Australia, Szmukler (1987) considered how Caplan’s “crisis theory” might be applicable to community-based psychiatry. He concluded that though this model could not be fully transplanted into the daily reality of community work, certain elements of it could be useful; in particular, that a person’s “crisis” could act as a catalyst for long-term behaviour change. Rosen (1997) conducted further research into Australian crisis teams, concluding that these specialist services could not “provide the entire range of crisis interventions required in our society” (44) and suggesting that other services, families and communities should also play a part. He also asserted that while a crisis in itself is not a mental illness, it can precipitate or be a consequence of such and that 24-hour “crisis response services” (44) are a necessity. This Australian research has been influential in the setting up of crisis resolution services in England.

Dean and Gadd (1990) pioneered home treatment in Birmingham in the late 1980s. Their study concluded that the 24 hour availability of home treatment was an effective means of reducing hospital admissions. It was also more likely to deliver effective treatment

than hospital alone, since social rather than medical factors would be more easily identifiable and addressable by professionals if the person was seen at home.

In 1999, the government introduced The National Service Framework for Mental health (1999) to begin deliver its pledge of investment and reform in relation to mental health services. The Framework stated the need for community mental health services which would operate 24 hours a day and be available quickly to those in greatest need. It noted that three in four mental health authorities did not yet provide access to a 24 hour community mental team and that “few authorities have specific crisis resolution teams” (54). This belief that more 24-hour community based teams were needed was based on the acknowledgment that psychiatric emergencies could occur at any time but did not always require hospitalisation. Also, the burden, in terms of time and cost, of psychiatric emergencies on other services, such as accident and emergency departments, psychiatric hospitals and the police might be relieved by the implementation of 24-hour community-based services.

The Framework (54) described briefly the role that crisis resolution services would play in the future:

Community-based assessment and treatment may be effective alternatives to hospital admission, with crisis resolution and sustained home care for people with serious mental illnesses. This can be delivered either by members of the community mental health team, or a specialised home treatment or crisis resolution team. It may involve intensive work with a single service user over a period of several days. Staff should be skilled in risk assessment and management, and will need supervision and support.

It would seem that, at this early stage, the Department of Health expected crisis resolution to be carried out by both established community mental health teams and the few fledgling crisis resolution services that existed at this time. Though this remains, in part, the case, the emphasis has shifted with the Department pledging in 2001 that all mental

health trusts should have distinct crisis resolution services. In that year, the Mental Health Policy Implementation Guide was published by the Department of Health. This important document defines what a crisis service should be and how such a service should work.

4.2. The PIG

The Policy Implementation Guide (or P.I.G) (Department of Health, 2001) was produced by service managers, mental health professionals and Department of Health officials. Its purpose was to describe how the new specialist services referred to in the National Service Framework would be established and how they would operate. It was defined as a “work in progress” (4), hence open to revision and it acknowledged the differing needs of different localities. However, the PIG is quite precise in defining the particulars of these new services.

According to the description put forward by the PIG, a crisis resolution team should be available at all times (24 hours a day, 365 days a year) as a service for those who may be experiencing a mental health crisis. It is the team’s job to intervene, assess and potentially “treat” such individuals. They were expected to have a “gate-keeping” role; a person will not be admitted to hospital without first being seen by a team whose primary function is to treat people at home. Crisis resolution teams are also multi-disciplinary in that team members will come from a range of both health (psychiatry, psychology, occupational therapy and nursing) and social work backgrounds. Multi-disciplinary teams bring with them the potential for a diversity of treatment methods, depending upon the nature of the crisis in hand.

The PIG is the most significant official document to be considered in this thesis (see appendix III). In subsequent chapters, I discuss segments of this guide in detail. Here, I present a general description of the section of this document which specifically covers crisis resolution services (12-25).

The PIG asks, and subsequently attempts to answer three essential questions: Who is the (crisis resolution) service for? What is the service intended to achieve? What does the service do? The first section (“Who is the service for?”) is very short and presents a broad definition of the people a team can expect to treat, followed by a more focussed set of exclusion criteria (see chapter three). The focus of this section, then, tells us more about who is *not* to be treated by crisis teams rather than who is entitled to the service.

The following section (“What is the service intended to achieve?”) states the importance of home-based treatment in relation to the preferences of service users. It then presents a list of what a crisis resolution team should be able to do, and a list of “principles of care” (see chapter five). In describing what the service does, the PIG presents a table which summarises four stages of crisis resolution: assessment, planning, intervention and resolution. There are five essential features of a crisis resolution team according to this description:

- 1) 24 hour availability.
- 2) Multidisciplinary teamworking and a multidisciplinary approach to mental health crisis.
- 3) “Gate-keeping role”: keeping people out of hospital, functioning as an alternative to hospital, and referring forward to other services.
- 4) Short-term intensive involvement: continued involvement until the “crisis is resolved”.
- 5) User and carer involvement and collaboration in treatment planning.

Not all of these features are exclusive to crisis resolution teams. Multidisciplinary teamworking and user and carer involvement are advocated throughout contemporary mental health services and are indeed mentioned frequently in the National Service Framework. They are also terms for which little detailed description is provided in these policy documents and are therefore subject to a variety of interpretations within relevant professional communities. Subsequent chapters seek to demystify these terms through an examination of processes in professional practice. The 24 hour availability of community

care is more or less specific to crisis resolution. Other teams which may be available 24 hours will at least have a crisis resolution function, even if this is not their sole function.

The “gate-keeping role” role is also significant to these services in this context, since an important function of a crisis resolution team is to reduce bed-occupancy in psychiatric hospitals. Once the involvement of the team has concluded, it is likely to refer a person to another mental health service, such as a CMHT.

Short-term intensive involvement, until the “crisis is resolved”, is perhaps *the* essential factor in crisis resolution. However, this statement appears as a possible contradiction without an understanding of mental health crisis itself. If the team is focussed on short-term involvement, but at the same time will stay involved with a person until the crisis is resolved, it is to be assumed that a crisis is a short-term state, at least if intensively addressed. (See chapter three).

The PIG presents a set of requirements with which crisis teams are expected to comply. These guidelines are important in distinguishing crisis resolution teams from other similar services such as assertive outreach teams (which intervene when individuals deemed in need cannot or will not make contact with services), but they are not intended to address in any great depth either the theoretical basis for the creation of these services, nor describe the intricacies involved in accomplishing teamwork, making decisions, and defining cases inherent in the practice of crisis work. As this thesis proceeds, these intricacies will receive due attention. Nevertheless, in the next section I provide an initial consideration of the conceptual basis on which these various uses of “crisis” rest.

5) Crisis theory.

In this section, I consider “crisis” as a theoretical phenomenon. I describe how notions of “crisis” have changed over time and then examine the original “crisis theory” put forward by Gerald Caplan (1964).

Though not cited in any contemporary service literature, an understanding of “crisis theory” is important to this study. It is important both in the context of the evolution of crisis services and the theoretical rationale for the creation of such services in the first instance. Though this theory is now half a century old, it retains a degree of its original relevance. The fact that it is rarely cited in the context of current service planning may suggest that, rather than being a discredited theory, it is so well established it attracts little discussion; a truism as opposed to a theory. Whether the teams themselves define crisis in such terms is a matter this study seeks to address.

Hacking (1998) described what he called “transient mental illness”, specific forms of mental illness that exist only in specific places at specific times. To illustrate this, Hacking tells the story of a 19th century Frenchman, Albert Dadas, a “mad traveller” with an apparent compulsion to travel which eventually led to his diagnosis of “hysterical fugue”. Such a diagnosis is now defunct. Hacking explains how a combination of cultural conditions reflected in the psychiatric discourse of nineteenth century France led to this specific framing of Dadas’ case. He then applies this to psychiatric discourse as a whole. The knowledge and culture of any time and in any place will produce certain psychiatric diagnoses. As knowledge expands and changes with culture, so will the diagnosis given to a particular presentation. The notion of a mental health crisis is no exception to this rule. As this section proceeds, I shall define three key stages in the development of crisis theory.

- 1) Crisis understood as a reaction to a traumatic event;
- 2) Crisis understood as an “inner-world collapse”; and
- 3) Crisis understood as a “psychiatric” event.

These three stages are not mutually exclusive. It is simply a matter of where the emphasis was at a specific time. Indeed, the emphases of stages one and two are not denied by stage three; rather, they have come to be seen as examples of the many ways in which a psychiatric crisis may manifest. In order to illustrate the development of these stages, I now present a summary of “crisis theory”.

“Crisis theory”, as an object of attention for academic psychology, originated in the mid-twentieth century; around the time that community treatment for those deemed mentally unwell was becoming an influential idea. As the focus of treatment shifted from the context of the institution to the outside world, new ways of considering mental illness became significant. Caplan (1964) defined a crisis as a state of being in which an individual’s usual methods of coping with a problem are no longer effective, an idea which he adapted from the earlier work by Lindemann (1944). Lindemann

...studied bereavement reactions of the survivors of those killed in the Coconut Grove night club fire and developed the fundamentals of “crisis theory” as a conceptual framework for preventative psychiatry. He felt that the possible psychopathological sequelae of unhealthy coping with the crisis of bereavement could be prevented by clergymen and other community caretakers helping the bereaved to mourn adequately, and he began to develop techniques of preventive intervention in order to achieve this. (Caplan. 1964:10.)

Lindemann’s ideas were developed in the context of people’s responses to a traumatic experience, a fire in a Chicago nightclub. Removing the language of psychology so prevalent in the texts of Caplan, one may define Lindemann’s idea of crisis as the point when an individual presents themselves as engaged in a specific socially acceptable process (grieving) in a socially deviant manner (“unhealthy coping”). In short, Lindemann is the protagonist of stage one in the development of crisis theory. Caplan adapted this idea and applied it to a more general idea of individual psychology (stage two). He shifted the emphasis from crisis as a reaction to a traumatic event and attempted to describe crisis more intricately as a process and an inner mental state.

Caplan prefaced this idea of crisis by defining a “problem”; that which upsets “equilibrium”. Equilibrium is basically an individual’s apparent psychological and social stability; “the normal consistency of pattern” (38). This is the behaviour deemed as regular by the person’s peers. The upsetting of equilibrium may occur frequently in an

individual's life, and the individual may have developed a ready set of "coping mechanisms" in order to contain it. "Coping mechanisms" may be manifest in a wide variety of behaviours, some observable to the person's peers, others not. It is when a problem is of such a severity that these pre-established coping mechanisms are ineffective that a crisis emerges.

To illustrate this we may consider the example of an individual who suffers rejection in a personal relationship. This may strain an individual's previously "consistent" state of mind. However, after a period of time, the individual may develop methods of coping with this upset, through social support networks, introspection and finally wisdom. These methods are again employed when a subsequent personal relationship breaks down. Hence, the coping mechanisms become part of the "pattern". Then a close family member dies. The individual has not previously experienced a problem of this magnitude. Whereas it is essentially similar to the breakdown of a personal relationship, the coping mechanisms developed and employed in such circumstances may not be potent enough to be truly effective in re-establishing stability. It may be that the deceased family member was a key part of the very social network which was previously employed when a problem emerged. The person may hence be "at a loss". They do not have the social and psychological resources necessary to cope with the problem. The individual is thus in a state of "crisis".

Caplan defined four phases in the development of such crises, the first being when "the initial rise in tension from the impact of the stimulus calls forth the habitual problem-solving responses of homeostasis". In terms of the example described above, this is when the individual instinctively employs the coping mechanisms used in dealing with relationship breakdown in response to the death of the relative. The second phase is when the "lack of success and continuation of stimulus" causes further tension. Try as they might, the individual's usual coping mechanisms simply do not diminish the impact of the relative's death. The third phase involves further efforts to deal with the problem. An individual may try to bring the current problem within the range of their previous experience and develop new, even "novel" ways of coping with it. This may be to an

extent achieved by breaking the problem up; certain aspects which cannot currently be dealt with are placed to one side. "There may be active resignation and giving up certain aspects of the goals as unattainable" (40-41). Hence, the individual is now no longer concerned with "solving" the problem, but rather with "living with" it. The person may no longer look to "get over" the relative's death, but to accept that the pain will be constant for the foreseeable future. With this new acceptance, the problem will be not solved but integrated into the individual's life and hence diminish to a conceivably manageable extent.

In employing new methods of coping with a problem in the way described above, the individual may avoid going into full-blown "crisis". Caplan's fourth phase in the development of crisis is when the third phase fails to either solve or diminish the individual's problem. The problem does not become integrated over time; on the contrary, it seems to become more prevalent in their lives. The deceased relative does not come back and further aspects of their loss become more and more apparent. By this time, the individual's coping mechanisms are exhausted. This is when a problem truly becomes a "crisis". The fact that the individual has been exhaustively attempting to resolve the problem and has failed only serves to intensify their current situation.

The example of employing coping mechanisms previously used in relationship breakdown when attempting to deal with bereavement is simple and fairly obvious. In relation to a broader spectrum of experience, "crisis theory" can be applied to any situation in which an individual enters new mental territory; they have an experience which is profoundly different from their previous experience. In short, to be "in crisis" is to react to a life-changing event in a negative, destructive way. It may be a reaction to a positive event, such as a move associated with a job promotion, or a far more complex set of circumstances such as the sudden onset of illness and related factors. In short, "crisis theory" is inextricably linked to life-events and crisis in itself becomes a life event.

The PIG does not openly reject Caplan's model of crisis. Rather, it approaches the notion of crisis in more practical terms. The PIG (2001:11) notes that the service is for

individuals “with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder) with an acute psychiatric crisis of such severity that without the intervention of a crisis resolution/home treatment team, hospitalisation would be necessary”. The nature of such “psychiatric crisis” is elusive; the preceding list of psychiatric diagnoses, however, implies a fundamentally medical and diagnostic framework. According to the PIG, a “crisis” may occur when a pre-established “severe mental illness” increases in severity. This is the third stage of how crisis is understood.

In this thesis, I attempt to describe what I have called stage three of crisis theory in terms more applicable to this ethnographic study of crisis resolution than the original texts, since these texts were primarily focussed on individual psychology. “Crisis”, in relation to crisis resolution services, is a *psychiatricisation* of the concept. This psychiatricisation of crisis is better considered as a process rather than a fixed idea. It is discursively constructed by team members, utilising a specific body of knowledge which is owned by them as crisis workers. Sharrock (1974:45) explained:

The use of such notions as ‘culture’, ‘perspective’, ‘ideology’ and ‘world view’ has not only been intended to convey the idea that members’ activities are to be construed by reference to some corpus of knowledge but also that the corpus of knowledge itself must be viewed in some way associated with the collectivity in which actors have membership. The problem for sociologists has not, then, been that of finding a relationship between member’s knowledge and activities but, instead, that of interpreting the relationship between a collectivity’s corpus of knowledge and the activities of its members.

Knowledge, then, will shape and influence a group’s activities and these activities will add to the development and perpetuation of the initial knowledge base. It is not only the case that crisis teams are based on the notion of psychiatric crisis; it is also through their activities that crisis is defined as psychiatric. The collectivities (the crisis teams) are made up of professionals (psychiatrists, psychiatric nurses, and social workers) who may share a similar knowledge base. Though there are likely to be significant differences between

these disciplines, each may possess a particular knowledge of that which is defined by them as “psychiatric”. The nature of the “psychiatric”, then, is a recurrent theme throughout this study: I consider how “crisis” and its psychiatricisation may be observable to others.

6) An Empirical Study of Two Crisis Teams.

6.1. Introducing the Teams.

In this section, I introduce the two teams studied. I describe their professional make-up and their general structures of working. I also describe the initial impressions I was given as to the organisation of these teams before beginning research. I was given these impressions both by my supervisory team and the team leaders who I met prior to my time in the field. Subsequent chapters discuss more subtle factors in the teams’ organisation, as well as the distinctions apparent between the two. Here, a general description of the teams is put forward in order to establish a foundation for future discussions.

I shall refer to the first team studied as the Churchfield team. This team operated in a semi-rural area, covering several small towns. The second team studied I have called the Newchester team; it covered a large city and surrounding towns.

6.2. The Churchfield Team.

During the first period of study with the Churchfield team, twelve members were nurses (including the team leader), four were social workers, two were support workers and one (part-time member) was a psychiatrist. There were also two secretaries. The structure of the first team studied changed minimally over the sixteen months during which the research took place. When research began in 2003, one of the nurses was on maternity leave. In 2004, one of the support workers had left to undergo formal training as a nurse, a social worker was on maternity leave, and a second consultant psychiatrist had joined

the team on a part-time basis. The previous team leader (Charlie¹) had left and had been replaced by another senior nurse (Gemma) from outside the team.

The Churchfield team was not a 24 hour service. They operated from 9am to 9pm (two shifts: 9am-5pm and 1pm to 9pm) on weekdays and 10am to 6pm (one shift) at weekends and on bank holidays. They planned to become a 24 hour service and adopt the model presented in the PIG. However, they retained these limited hours throughout the period of research. Despite these limitations, the Churchfield team functioned as a crisis team. They saw people who they deemed “in crisis” and were involved intensively in their treatment over a short period of time.

6.3. The Newchester Team.

The Newchester team consisted of fifteen nurses, including the lead nurse and the team leader. During the first period of research, its members also included two social workers, two support workers and six psychiatrists. Three of the psychiatrists were SHOs (senior house officers). These were newly qualified psychiatrists and so occupied the lowest level in the medical hierarchy. They had duties outside of the team and were expected to engage in various services before focusing their career on a specific area of psychiatry. They were changed on a six-monthly basis. Another psychiatrist was an SPR (senior psychiatric registrar) who was higher up in the professional hierarchy than the SHOs. Though his interests were more specialised, he did not as yet have the experience and expertise necessary to become a consultant psychiatrist. The remaining two psychiatrists were consultants and highest in the professional hierarchy. They were highly experienced practitioners with expertise in specific areas. They also had a managerial and supervisory role in relation to the other psychiatrists.

During the second period, an additional social worker and additional support worker had been recruited and one of the nurses had been replaced. It had also previously featured an occupational therapist and, during the first period of study, was seeking to recruit another.

¹ Names have been changed.

Ultimately, however, they did not recruit such a professional, but instead established closer links with a local occupational therapy service.

The Newchester team provided a twenty-four hour service and therefore had more members due to the number of shifts to be covered (three: 9am to 5pm, 1pm to 9pm and 9pm to 9am). The psychiatrists, secretaries, and team leader were usually present only for the day shift on week days. On evenings, weekends, and bank holidays, a smaller number of workers (nurses, support workers and social workers) would be present, though there would occasionally be a psychiatrist. The night shift was covered by two nurses.

6.4. The Two Teams and the PIG

The practices of the Newchester team were very much in line with those put forward in the PIG. They were a 24 hour service, engaged in short-term intensive intervention and were a multidisciplinary team. They also successfully attained a “gate-keeping” role; if a local GP thought a person was in a need of hospitalisation, they had to refer them to the crisis team first. The Churchfield team was aspiring to emulate this service. Though they were a multidisciplinary team engaged in intensive short-term intervention, their limited hours of working meant it was not possible for them to attain a “gate-keeping” role; a person who would otherwise be referred to the team would be hospitalised if they presented outside of the team’s hours of working. From the outset, it was hence debatable as to whether the Churchfield team was a crisis resolution team at all. However, the commonalities of practice between the two teams suggest that both teams “did crisis resolution” as their primary activity, even though Churchfield was not currently working to the model defined by the PIG.

7) Key activities.

In this section, I describe the key activities of the two teams studied. These activities were central to the research, and examples of each are discussed in the following chapters. A consideration of the formal structures of key activities in which the teams engaged is important because it is in this work that the main body of crisis resolution is convoluted. Here, I describe three routine observable activities of the teams.

7.1. Handovers.

I begin by considering handovers, the meetings in which the team's daily activities are ordered and discussed. It is where team members receive information on new referrals, discuss impending home visits and report on the progress of particular service users. In short, it is where the daily practice of crisis resolution is structured. Since new referrals can arrive at any time, however, the extent to which such structuring is possible is limited.

In general terms, the handover was for me as a researcher a vast source of information on both current cases and team dynamics. In subsequent chapters, transcripts from handovers which I recorded are cited at length.

7.2. Assessments.

Assessments are the first encounter between team members and service users. It is where information is gathered on the person's presenting problem and the team member or members decide upon the person's suitability for treatment. Assessments frequently take place in accident and emergency departments, often the initial "port-of-call" for a person experiencing acute mental distress. On occasion, assessments may be conducted in a GP's surgery, a police station, or in the person's home, depending upon the circumstances of their referral.

Though no manual or “script” is deployed in assessments, the team member will always seek specific information from the service user, such as their psychiatric/medical history, domestic circumstances and presenting problem. Subsequent chapters provide a detailed discussion of fieldnotes taken during assessments, since they are essential to the workings of crisis resolution services.

7.3. Home Visits.

Home visits are when established service-users (those who have already been assessed and deemed suitable for treatment by the team) are visited by team members for treatment. This “treatment” may take the form of a discussion between team members and service users, and at times their carers. It may also take the form of a medical review, where reactions to medications may be measured and new medications prescribed. Subsequent chapters present examples of home visits, as they are, once again, a routine activity in crisis resolution.

Data drawn from the observation and recording of these three activities are subjected to frequent discussion throughout this thesis. Each offers a rich array of information about the practical accomplishment of crisis resolution. Though informal activities are also important, it is in these formally sanctioned activities that the practical accomplishment of crisis resolution is most apparent.

8) Summary.

In this introductory chapter, I have gone some way to explaining the context of this study as a whole. I have described crisis resolution as it appears on paper (in policy documents) and I have also explained some of the socio-political circumstances in which crisis resolution services emerged. However, the context of this study and the nature of these services are realized to a fuller extent in the proceeding chapters. In general terms, this study is an investigation into crisis resolution, examining what these services do and how they do it.

Chapter Two: Background and Methodology.

1) Introduction.

1.1. Chapter Overview.

In this chapter, I describe the background to this study of crisis services and the methodologies employed in its execution. Following the recommendations of Silverman (2000:236), this chapter describes the evolution of this project, a *natural history* of the research. I begin by outlining the intentions of the study, the choice of methodologies employed, and my ethical stance. Following this, I describe how I negotiated access to the settings, the progress of the research and my relationship with the subjects that I studied. Finally, I reflect on the study as a whole; its foundation and practical execution.

1.2. The Objectives of this Research.

The following list summarises briefly the objectives of this study:

- to consider and describe how a “crisis” is identified, recognised and co-constructed in the discursive work of team members;
- to describe the processes through which team work is accomplished in these crisis services;
- to consider and describe the relationship between professionals (team members) and service users; and

- to understand the contribution of different forms of expertise (e.g. psychiatry and social work) to the accomplishment of team work and delivery of treatment to service users.

In more general teams, my intention was to describe the day-to-day workings of crisis services. Such descriptions of routine work necessarily require observation of what real people do in real circumstances (in particular how team members interact both with each other and with service users), how different types of cases are discussed and framed, how important decisions are made and by whom, and what exactly is deemed important and why. Essentially, my aim was to *find out how members of crisis resolution teams accomplish their work*.

The consideration of how an institution (or more precisely, its collective membership) works has a long tradition in sociology. It originated in the 1930s in Chicago. The sociologists at this institution were known as the Chicago School. Its chief protagonist was Everett Hughes who held a position there from 1938 to 1961. Hughes was greatly influential in the development of field research. He described an “inquiring attitude” necessary for such research which is defined by Fielding (2005:Paragraph 4. 2²):

Its first element emphasized comparing social events to those in other times and contexts. Second, he insisted on the mutual enrichment of the empirical and the theoretical, on being able to see analytic enrichment in apparent social trivia. Third, Hughes rejected disciplinary boundaries as arbitrary. Last, he valued a free sociological imagination as opposed to narrow hypothesis-testing and recognized the need for eclectic methods and constant methodological innovation.

The first element of Hughes’ “attitude” states the necessity for comparison between one’s own findings and those of other studies which may be similar: for example, there may be

² As this paper appears on-line, the pages are not numbered in the original text. However, if saved as a word document, text size 12, the quotation appears on these pages. I have hence cited both section and (imposed) page numbers.

commonalities between the practical realities of crisis work and general medical or social work, even police work. The second element shows how the apparently banal and trivial may be reflective of something significant: for example, an “off-the-cuff” remark made by a nurse directed at a consultant psychiatrist may reflect a significant difference between the two disciplines. Both the third and fourth element is reflected in the evolution of research methods since Hughes’ time: for example, this study is a fusion of methods; ethnography and discourse analysis. It is not exclusively bound in one or the other.

Hughes’ “inquiring attitude” has been applied to many studies since its initial conception. In relation to public services, Becker *et al* (1961) looked at medical schools, Goffman (1961) at psychiatric hospitals, while de Montigny (1995) and Housley (2003) looked at social work teams. Sinclair (1997) conducted a further ethnography of medical training (see section 3.1. below).

Describing the intricacies involved in the practical execution of crisis work is not only interesting for its own sake as a contribution to an academic field, but may also provide information potentially useful in subsequent service development. For example, Goffman’s *Asylums* (1961), alongside the other work of contemporaries such as Caplan, Laing and Scott served to challenge the psychiatric establishment of the time, ultimately contributing to subsequent humanitarian reforms. Later in the same decade, Cicourel’s (1968) ethnography of police engaged in juvenile justice served to uncover institutional racism in the police force in two American cities. These two examples serve to demonstrate the potential value of ethnographic research in a context broader than academia alone.

1.3. Initial Assumptions.

Before beginning fieldwork, I read official documents (Department of Health 1999 and 2001) and some of the limited academic literature (Thompson 1991, Mitchell 1993) on crisis services. In response to this material, I developed some tentative initial assumptions about what I wanted to observe. These were that:

- the “crises” that the teams strive to “resolve” are likely to be recognised in a service user’s reportage that they “cannot cope” to the extent that they would otherwise require hospitalisation:
- a crisis could be ‘psycho-social’, ‘psychiatric’, or both:
- should the service user pose a significant risk to themselves or others, this would not necessarily constitute a crisis and a mental health section (involuntary hospitalisation) would be used in place of a crisis team:
- “teamworking” is chiefly accomplished through mutual support:
- the teams would involve service users in most, if not all, of the design of the care plan and that care plans would not be compulsorily imposed:
- team members would, for the most part, have clearly defined roles in relation to their expertise at the point of care delivery whilst these roles may be of less significance in “backstage” team discussions; and
- disagreements may take place between professionals of different disciplines, e.g. psychiatrists and social workers, regarding treatment and the nature of the crisis in hand.

As an observer, I had to enter the field without being heavily driven by assumptions. Those which I inevitably did have would be constantly challenged. I was to *research the underlying logic of routine practice*, not to evaluate the effectiveness of that practice. However, no research can be completely value-free. As a social scientist, I had my own predispositions, some of which I only became conscious of during the research, others when reflecting on my experiences once research had concluded, and some of which I had from the beginning. These predispositions will emerge as this chapter commences. From the outset of the research, I considered three questions as centrally important:

- how do team members *act* with one another;
- how do they *act* with service users; and
- how do they *act* with me?

In considering these questions, a fusion of methods seemed appropriate. The data would be gathered by more than one means (fieldnotes and recordings) and analysed in more than one way (described in sections 2 and 3). Considerations of how team members acted with one another would form the greater part of the study and data on this would be gathered from both fieldnotes and recorded meeting. How they acted with service users would be covered by fieldnotes alone. It would have been ethically and practically difficult to make recordings of their visits to service users (see section 4). How they acted with me would be apparent in recorded interviews and as I went about the routine fieldwork in their company. This last factor was of less importance to the overall understanding of crisis resolution, but would provide insight into how team members would present to outsiders who were not fellow mental health professionals or service users.

1.4. A CASE Studentship.

I conducted the project as a holder of an ESRC CASE³ studentship. I was registered as a PhD student at the university and acquired an honorary contract with the mental health trust which was the non-academic partner in the studentship. The two teams studied were part of the trust. As required by the ESRC, the outlines of the research project had been designed by one of my supervisors and agreed with the trust before the studentship was awarded and advertised. The research methods initially proposed were discourse analysis and an ethnography of one team. In the event, I studied two teams in order to compare their operation.

There were various benefits that accompanied the holding of a CASE studentship (besides the obvious benefit of full funding). The team leaders knew of the proposed study and had agreed in principle to provide access and support. Also, particular aims, objectives and methods had been devised. This no doubt saved me a lot of time in planning the study. A topic, a field, and the methods to be employed in exploring that field existed before the empirical work began. Unlike many PhD students, who may spend long months refining their topic of choice and finding an appropriate field and method, my direction was reasonably clear from the outset. This is not to say that every aspect of the original research proposal had to be followed precisely to the letter. Indeed, as this chapter subsequently describes, there were certain changes in direction throughout the execution of this project. Some of these changes were instigated by my supervisory team (who devised the original research proposal), some by the teams themselves, and others by me as the investigator.

Along with the benefits described above, the holding of a CASE studentship is accompanied by particular pressures. I was not only accountable to my department at the University, but also to the Mental Health Trust. Since the fundamentals of the project had already been designed, I was not in a position to change them. Of course, in my applying for and acceptance of the studentship, I had demonstrated my broad agreement with and

³ Collaborative Award in Science and Engineering.

approval of the study's design as well as my interest in mental health services. However, there were times, particularly early on, when I felt more like a research assistant on someone else's project than a student producing a piece of original research. This changed as the project progressed and I collected data which I could call my own.

1.5. The Observation Periods.

The data collection stage of the research covered a total of 16 months between March 2003 and July 2004. Over this period, I spent a total of two and half months with each team. I spent an initial fortnight with each team for orientation purposes. I would take notes and ask questions, but the main purpose of my visits at this time was to become acquainted with the teams and their working structures.

Following these initial orientation periods, after a short break from the field, I spent a full month with each team. I accompanied them on visits, and recorded team meetings. Having completed these observation periods with each team, I spent several months analysing the data and discussing my observations with my supervisory team in order to give a clearer focus to my observations in a second period of fieldwork. In short, the purpose of the first observation period was to *see what was going on* and hence everything was potentially significant while in the second period, I was focussed on attaining an understanding of specific areas.

2) The Methods Employed in this Study.

2.1. Engaged Observation.

In order to attain as full an understanding as possible of the workings of crisis services, I adopted the role of an overt observer. As I was not trained in crisis work or indeed as a mental health professional, such a role could only be, for the most part, that of a non-participant. However, as I was observing the teams in their day-to-day activities, asking questions and contributing to discussions where appropriate, I could not be said to be in a

wholly detached or distant position. Hence, I was, to a limited degree, a participant in some of the practices I was observing. Though I could not be said to be “doing” crisis resolution with the teams, there were occasions when I would contribute to team discussions, particularly if a service user whom I had met was being discussed. Sometimes, I volunteered comments; often, I was invited to comment by team members I had accompanied on home visits. Also, I was able to participate in a lot of team banter: during tea breaks, lunch breaks and quieter periods, I was able to engage more fully with team members. This also applied during shared car journeys with team members to and from visits to service users.

I discussed my research and its purpose with service users and carers, but could not participate in their actual treatment. Most service users seemed to recognise this, but there were occasions when they asked for my opinion of them or their situation. I was asked by one user if I thought her “pathetic”; unable to suppress my natural response, I said “no, not at all”. In short, though not able to do everything that a team member would do, I considered myself an *engaged* observer. I was fully engaged with the groups I observed, though not able to fully emulate their behaviour.

Becker and his colleagues (1961: 25-26), though claiming to be participant observers, approached their research with medical students in a similarly engaged, yet at the same time detached way.

We observed the participants in the daily activities of the school- which is to say we were not hidden; our presence was known to everyone involved, to the students, their teachers and their patients. Participating in the ordinary routine, we did so in the ‘pseudo-role’ of student. Not that we posed as students, for we made it clear to everyone that we were not students; but rather it was the students we participated with... We went with the students wherever they went in the course of the day.

In that Becker and his colleagues “were not hidden”, and in that they accompanied the students in their daily activities (which is not the same as actually *doing* the students’

work), their roles in the medical school had similarities with mine in the crisis team. I was also “in the ‘pseudo-role’ of a student. Although I *was* of course a student, I was not of their usual student type. The teams frequently accommodated medical, nursing and social work students who were similarly *engaged observers*, though concerned with learning to emulate the observed rather than catalogue their observations in the same way or for the same purpose as me. In practical terms, however, my role was essentially the same as these students in that I would observe, accompany, and ask questions.

“Engaged observation” does not carry the same level of detachment as non-participant observation. The engaged observer can “get involved” with those observed to the extent necessary. Participant observation was not possible, nor was the associated risk of “going native” and losing my objectivity (insofar as one can be said to be objective).

2.2. *Ethnographic Fieldnotes.*

Throughout the observation periods, I took detailed notes. There is little in the way of published material into *how to write* ethnographic fieldnotes as Emerson *et al* (1995) have remarked, but certain conventions do apply. An important convention is writing-up as quickly as possible. I would write rough notes and memory triggers while at the team base which I would write-up as a narrative once I had left the field. This was often an arduous but always a necessary task, though it also served as a release. Emerson *et al* (1995:42) described the dual-edged nature of writing-up:

...beginning ethnographers should not be surprised to experience deep ambivalence in writing fieldnotes. On the one hand, after a long, exciting, or draining stint in the field, writing up notes may seem a humdrum, extra burden; on the other hand, writing fieldnotes may bring expressive release and reflective insight.

Writing-up quickly was important for two reasons: memory was fresher and reflection would be provoked immediately. Short-hand memory triggers can easily lose their meaning over time. Reflection is, however, continuous and immediate reflections can be

contrasted with those which occur at a later time, thus providing an invaluable insight into the development of analysis. Also, the style of writing may develop over time, as the researcher discovers and refines the technique most effective to them. In immediate writing up, one has the freedom to experiment. Emerson *et al* (1995:44) described this process:

Under most circumstances, a researcher writes fieldnotes immediately for herself as a future reader. This absence of an actual reader allows the researcher to write in relaxed and shifting styles, moving from stance to stance, from audience to audience without worrying (at that point) about consistency or coherence.

In writing up, I experimented with two different approaches. I began by describing events in the past tense: “Paul and I went to visit K” etc. However, shortly after research had begun, I found a more effective means was to write in the present tense: “Paul and I go to visit K” etc. I found writing in the present tense more helpful as it gave me no choice but to construct a detailed, linear narrative. In short, I found that the past tense allowed for certain facts to be omitted, as I was writing as one remembering events. Writing in the present tense allowed events to be not merely remembered, but re-lived.

2.3. Recordings.

During the fieldwork, I recorded a number of team meetings, chiefly ‘handovers’, where currently engaged service users and new referrals were discussed. These recordings complemented and enhanced my fieldnotes. Since I was writing notes based on the short hand and memory triggers I had scribbled at the time, these notes could not be relied upon to capture, word for word, what a person said, particularly if they were speaking on a subject at great length

Through the analysis of recordings of team meetings, I was able to uncover the intricacies of team practices in a way that fieldnotes alone could not. In observing the communicative practices of team members, the ethnographer is able to attain an

awareness of the more subtle processes of *performing as a team*, how power relationships are played out, how hierarchies are established and maintained. An understanding of how relevant narratives are constructed (see section 3.2.) also provides insight into the process employed in the ordering of facts and ideas and hence can be used to reveal the areas that the subjects deem important. In studying these recorded interactions, one is also studying how other team members receive those facts and ideas. In general terms, through recording team members in negotiation, I was able to describe both the intricacies and significance of such negotiation. For example, if a psychiatrist contradicted a nurse, the nurse's reaction may have been either accepting or defensive. If I had the exact words spoken in front of me to analyse, such an occurrence could be described more accurately, its potential significance easier to grasp.

2.4. Interviews.

In addition to observing and recording what people said and did in the course of their everyday work, in Newchester I interviewed the team leader, a consultant psychiatrist, SHO, nurse and social worker. In Churchfield, I interviewed the team leader, two nurses and a social worker. The choice of interviewees reflected the professional composition of each team (see chapters one and six). In Newchester, there were at least five psychiatrists at different levels of the professional hierarchy at any one time, while in Churchfield, the psychiatrist was part-time and his role in influencing team practice as a whole was limited; rather, he was called upon when another team member deemed a medical review necessary. He did not appear to instigate such reviews himself. As stated above, all the interviews were conducted towards the end of my time in the field. This enabled me to formulate the most appropriate questions, based upon what I had observed. Hence, the interview data I hoped to gather was essentially complementary to the fieldnotes and recordings I had already made. This is not to say that the interviews were unimportant. Indeed, they gave me the opportunity to test my assumptions. The general approach to interviewing adopted in this study hence merits consideration.

Kvale (1996) defined two distinct approaches to qualitative interviewing: *travelling* and *mining*. My approach was closer to that of the traveller. The “mining” approach may be more appropriate for a primarily interview-based study, or a psychological, rather than sociological approach. I was not looking to “read between the lines” and attribute psychological motivations to the person’s statements. Rather, I wished to collaboratively explore the person’s world in the context of their professional position. As Kvale (4) explained:

The...*traveller metaphor* understands the interviewer as a traveller on a journey that leads to a tale to be told upon returning home. The interviewer-traveller wanders through the landscape and enters into conversations with the people encountered. The traveller explores the many domains of the country, as unknown territory or with maps, roaming freely around the territory. The traveller may also deliberately seek specific sites or topics by following a *method* with the original Greek meaning of “a route that leads to a goal”. The interviewer wanders along with the local inhabitants, asks questions that lead the subjects to tell their own stories of the lived world, and converses with them in the original Latin meaning of *conversation* as “wandering together with”. (*Original emphasis.*)

Metaphor aside, the initial questions I asked related to phenomena I deemed important. My interviews were semi-structured: I had a number of questions I wanted to ask, but would follow-up any subsequent points that emerged in the narrative. To return to Kvale’s metaphors, one could say that I had already compiled a “guide book”, but it was roughly sketched and did not recommend keeping to the beaten track. It did, however, recommend a “goal”. This was to gather information on how the person described their role within the team, what they understood a “crisis” to be, how they viewed topics such as teamworking and user involvement, and indeed the treatment methods they deemed important. I began each interview by asking the person about their professional background and how they came to be involved in crisis resolution. In this way, I instigated the telling of a personal story. This proved an effective technique in encouraging the interviewees to talk at length. A good semi-structured or unstructured

interview involves minimal intervention on the part of the interviewer and questions which invite an open-ended answer. Indeed, it was often the case that I did not need to ask all the questions I had planned. For example, it was not always necessary to ask directly about the person's role within the team as they would often describe this without prompting once having described their background and training.

My interviews were intended to be collaborative. I was not intending to "catch anyone out" or provoke argument. I was questioning people as authorities on their own subjects; themselves, their positions in the team, and indeed the professional practices in which they engaged. This is not to say I took everything I was told at face value. In the analysis of all my project data (described in section 3.2. below), it was my intention to examine emergent themes.

3) Analysis.

3.1. The Dramaturgical Model.

The origins of the dramaturgical model are to be found in the early work of Erving Goffman. It is important to note that this model is an analytic framework, not a research method. It is a potent tool with which to consider the nature of face-to-face interaction in general, and has been used by many others to study such interactions within formal institutions. The dramaturgical, or theatrical model considers the social world of an organisation as operating on four distinct "stages"; official frontstage, official backstage, unofficial frontstage and unofficial backstage. Members of this organisation, in this case members of the crisis teams, are hence "performers". This model is applied in detail in chapter four. Here, I consider the rationale for applying such a model to the analysis of my data and answer some of the criticisms which may be directed at its usage.

Travers (2001:54) assessed the validity of the dramaturgical model:

Although ideas and concepts from Goffman are often employed in qualitative studies, relatively few people have used this perspective systematically in analysing social settings...a relatively simple idea, which Goffman never claims is more than a useful metaphor, can be used to reveal something interesting about institutions.

Sinclair's (1997) study of training doctors is an example of the systematic application of this model. His study also demonstrated how the application of this model can provide significant insight into the process undergone by medical students as their training progresses. The activities which take place on each "stage" change throughout the course of medical training. For example, for preclinical students, the activities performed on the unofficial frontstage include sports and theatrical productions, while the unofficial backstage is defined as preparation for such activities and time in the student bar (16). When they become clinical students, however, the unofficial frontstage and backstage are no longer distinct: they are both confined to the student bar (227). This demonstrates how the world of the trainee doctor will change significantly as they advance in their careers.

In identifying and placing activities on distinct "stages", Sinclair was able to show the significance of each activity in the process of medical training as a whole. He offers a powerful insight into the world of the medical student, encapsulating what the students *do* in particular circumstances and indeed how they perform to particular audiences. On the official frontstage, they are performing to both their teachers and their patients. On the unofficial frontstage, they are performing to any who would care to see them. On the official backstage, they are performing to one another, but planning specifically for frontstage activity. Finally, on the unofficial backstage, they are performing to one another for their own entertainment.

In this study, I applied the theatrical metaphor to the crisis teams in order to explore the different aspects of the ways in which they jointly accomplished "being a team". It was also a potent tool in examining the relationships between performers (team members) and their audiences (service users, carers, visitors, other team members etc). The different stages upon which teamwork is accomplished would be seen by different audiences; for

example, visitors to the team base and service users visited in their homes would experience different performances (see chapters four and five).

This approach has been subject to a variety of critical comments. It may be seen as limited as to what it can explain about social life, and the overall usefulness of adopting this view may be questionable. Sennett (1977:36) criticised Goffman's work:

Here there is a picture of society in which there are scenes but no plot...In Goffman's world, people behave but they do not have experience.

Sennett may have over-estimated the intentions of Goffman and those adapting his model. It was not intended to present an all-encompassing picture of social life; it is merely a means through which to understand certain aspects of it. The dramaturgical model is primarily concerned with interactions and relationships *as they are performed*, within specific social contexts. It does not pretend to provide the key to understanding the deep-seated socio-political or even historical motivations of social actors. Sennett's claim that there is "no plot" is also contestable. A "plot", understood as a *process where events unfold* may be inferred through the application of the dramaturgical model, as Sinclair demonstrates. Noting how social actors will move from stage to stage depending on their audience (as I have done), is not possible without the consideration of *unfolding events*. In short, the dramaturgical model is not imposed for its own sake.

Manning (1992:53-54) summarised many of the existing criticisms of dramaturgical analysis when he wrote that:

The thrust of...critiques is that Goffman's dramaturgical perspective over-extends the notion of acting or performing, that it offers an inadequate account of the intentions of actors and that it imposes its solution onto the phenomena it purports to explain.

The dramaturgical model is not a “solution”, but an analytic tool. It is a means to explanations, not an explanation itself. It is not so much imposed on individuals as it is on social settings. To attempt to describe the intentions of actors in any immense detail would be to “impose a solution” on observed social action. This links to a further criticism of the theatrical metaphor (MacIntyre 1981); that it denies social actors their authenticity as human beings. Even if this were the case, this is a somewhat romantic view in the first instance and provokes debate far beyond the scope of this thesis. However, this criticism is to be taken seriously as it is one which research subjects themselves may hold. People may resent the implication that they are “acting” when going about the serious business of their everyday lives. However, a potent response to such criticism may be taken from Goffman’s (1974:246) own reflection:

The claim that all the world’s a stage is sufficiently commonplace for readers to be familiar with its limitations and tolerant of its presentation, knowing that at any time they will be easily able to demonstrate to themselves that it is not to be taken too seriously. An action staged in a theatre is a relatively contrived illusion and an admitted one; unlike ordinary life, nothing real or actual can happen to the performed characters- although at another level of course something real and actual can happen to the performances qua professionals whose everyday job is to put on theatrical performances.

In general terms, the premise of the dramaturgical model is that social action, “performance”, is influenced by its intended recipients, “the audience”. To suggest that people are “acting” in this way is not to criticise them, to suggest that they are superficial beings, or simply “pretending”. As I write this chapter, I have an audience in mind, and am hence “acting” as a research student writing a thesis. This is not to imply that this is not a “real” process.

3.2. *Discourse Analysis.*

The dramaturgical model is a potent analytical tool in considering crisis services as a whole. However, in order to examine the intricacies of the day-to-workings of crisis resolution, I focus on discourse. I consider how mental health professionals formulate their understanding of the situations presented to them through both discussions with colleagues and service users. Discourse analysis is concerned with *how* an idea is expressed (how something is said) and the significance of its expression in a given context (why this is said now). Potter (1997:146) summarised this approach:

Discourse analysis emphasizes the way versions of the world, of society, events and inner psychological worlds are produced in discourse. On the one hand, this leads to concern with participants' constructions and how they are accomplished and undermined; and, on the other, it leads to recognition of the constructed and contingent nature of researchers' own versions of the world.

The use of discourse analysis is based on the premise that, through discourse, social actors construct and negotiate shared meanings. The purpose of the analysis of Potter and his colleagues is to describe *how this is done*.

For example, Opie (1997) studied narrative construction in two multi-disciplinary teams working in different areas of the New Zealand health service; the first on a quadriplegic ward, the second on a medium secure psychiatric unit. Though the findings relating to the team working on the quadriplegic ward are potentially of relevance in the study of crisis teams, for reasons of space and in order to avoid unnecessary repetition, I concentrate here on those relating to the team on the psychiatric ward. Despite the differences in approach that exist between a hospital based and a community based mental health team, a common vocabulary remains.

Part of Opie's paper covered the discussion of a particular patient (Pat) by a psychotherapist (Miles). Miles reported back to the team from a meeting with Pat's legal

guardians. He went through the facts of the case, covering Pat's psychiatric history and his current difficulties. He described the meeting's progress in a factual, ordered way. However, prior to Miles' presentation, Opie has learnt that Pat's guardians were not easy company to keep. In order to demonstrate the range of complex conclusions that can be drawn from a relatively simple narrative construction, it is necessary to quote Opie (Section 3.37.17-18⁴) at some length.

In order to open this narrative of 'difficult relatives' (a common enough narrative in human services) to scrutiny and revision, Miles engages on several occasions in some complex work, the process of which reflects his disciplinary orientation, in his delineation of the relevant 'facts', his placing these in different and increasingly intricate relationships to each other as more become available, and his seeking to avoid moral strictures. Further, I would argue that the detailed way in which he goes about his narration can be read as demonstrating a method of narrative construction in which interpretation and closure are suspended for as long as possible in order to encourage the team to identify the problematic issues and to collectively bring these to a provisional point to allow the team to identify a course of action.

In simpler terms, Opie is here arguing that, in placing fact upon fact before putting forward any conclusions of his own, Miles is asking for other team members to present their views on the situation described. This reflects something that may be related to a broader practice present within the discipline of psychotherapy: listening to others before making conclusions. In general terms, Opie's paper described how the narratives constructed by team members reflected broader issues of team practices and working relationships.

In the original research design, it was suggested that I use the conventions of conversation analysis in the transcriptions of my recordings. This would have involved the application of an intricate system of transcription symbols to capture the timing of

⁴ As this paper appears on-line, the pages are not numbered in the original text. However, if saved as a word document, text size 12, the quotation appears on these pages. I have hence cited both section and (imposed) page numbers.

pauses (usually to the tenth of a second), changes in pitch, and the speed of the talk itself. This method has been applied to previous studies of discourse in a professional context (Drew and Heritage 1992). The aims of discourse analysis and conversation analysis are very similar; indeed, the terms may sometimes appear as synonymous. They seek to describe the intricacies of talk, the nature of the language employed, and indeed the *function* of the language employed in the given context.

Though I remained concerned with the teams' discursive practices throughout the study, I decided early on in the analytic process that the application of "full-on" conversation analysis was not appropriate to the data I had or my principle aims. The focus of conversation analysis is often concerned with the rules of conversation itself, the significance of pauses and of shifts in pitch and tone, what Lynch (1993:215) called "an overbearingly fetishist concern with certain structural features of ordinary conversation". I did not deem this focus to be sufficiently relevant to the study's intent and purpose to merit the rigorous application of the conventions necessary to show this in transcription. I was working with large quantities of recorded data which I wished to consider thematically, and as narratives as well as interactions. Indeed, in the interviews, I was fundamentally more interested in the content of the answers and the emergent themes therein than the interplay between questions and answers. In the recorded meetings, interactions were of greater importance. However, these recordings contained long in-depth discussions of particular cases. The timing of every pause and the noting of every minor change in pitch would have been time consuming and unnecessary when commenting on the given case as a whole. Had I been working with smaller portions of data, for example telephone exchanges between team members and service users in arranging home visits (which I was not permitted to record nor given the resources with which to do so), such things would clearly have been more significant and the conventions of conversation analysis hence appropriately utilised.

3.3. Thematic Analysis, Coding and NVIVO.

Once my time in the field had concluded, I had in my possession a vast amount of written text. In order to make the task of data analysis manageable, I undertook initial thematic analysis with the aid of a computer programme designed specifically for such a purpose: NVIVO (2002). With NVIVO, I was able to read through my data in a linear fashion, using the programme's "coder" to assign "codes" to each segment of data. These codes, or "nodes" as they are called in the programme, would then be displayed in the margins. Once I had assigned a "node", I could recall it upon encountering further data to which it was appropriate. Once I had coded a substantial body of work, the programme was able to generate "coding reports": each segment of data to which I had assigned a specific "node" would be recalled into a single document in a matter of seconds. I was thus able to quickly ascertain how many examples of specific phenomena (e.g. handovers, mental health assessments etc) and concepts (e.g. teamworking, user involvement) I had documented and where it appeared in the data as a whole. At this stage, my coding was very general: I had coded large segments with key themes and concepts. However, as the analysis progressed, I was able to embark upon more detailed coding of segments of data. For example, if I had a node called "K", which encompassed all the data I had on a service user called K, I could further code these segments to encompass different aspects of K's case, e.g. K's psychiatric diagnosis, nurses' views of K, K's description of his current circumstances.

NVIVO offers the researcher the ability to assign three different types of "node" to their data: free nodes, tree nodes and case nodes. All nodes are free at first. Free nodes have no immediate relationship with other nodes, hence their name. They are not attached to anything. When they are attached, they become "tree nodes"; these may be hierarchal, having a key concept at the root (e.g. crisis) with various branches growing from it (e.g. domestic crisis, psychiatric crisis), and yet further branches growing from these branches (e.g. housing crisis, marital crisis, depression, schizophrenia). An example of a tree node appears in appendix I. Tree nodes basically function as a tool with which to relate themes and they relate specifically to concepts. As referred to above, I was coding both concepts

and cases. With case nodes, a specific phenomena was, as the name suggests, “cased”; this could be a service user, a team member, or even a specific interaction such as a handover. Each case, however, would be sub-coded with emergent concepts. Hence, cases and concepts could be interrelated very swiftly and efficiently. This was invaluable when choosing which data to use in the final thesis. Cases rich in recurrent themes and encompassing examples of a variety of significant phenomena would hence serve as effective illustrations of the teams’ work as a whole. This is not to say that atypical cases would be discarded. On the contrary, their atypical nature made them potent subjects for inclusion. To find a case “unusual” serves to emphasise the typicality of other cases; what Silverman (1993:44), adapted from Becker and Greer (1960), calls “deviant case analysis”.

The type of thematic analysis described above was applied to both fieldnotes and transcripts. Though learning NVIVO takes time and concentration, it substantially reduces the time taken to find the appropriate data in the long-term. However, it is merely a tool and does not do the analysis itself, but simply orders it.

4) Ethics.

4.1. Ethical Concerns.

When conducting good research, it is important that the potential benefits to services outweigh the potential risks to service users. As with any study that involves human subjects an array of ethical concerns was apparent in the project in hand. As this was a qualitative study, most of these concerns were based primarily on the researcher’s relationship with the people observed, recorded and interviewed. As I was studying two distinct groups, team members and service users, the nature of this relationship and related concerns varied depending on whom I was observing.

My observer status placed me in a position of power, particularly since I was, at least initially, also in a position of relative anonymity. Since I was to be a stranger, overtly

watching what team members were doing, there existed the potential for my purpose to be confused with that of an outside inspection. There were instances throughout the research period where this was in evidence (see section 5, below). The behaviour of team members would inevitably be to an extent influenced by my presence, but this could be minimised if I could clarify my purpose of producing research.

I would be visiting service users and their carers in the company of team members, whether they be arranging, delivering, or assessing the person's suitability for home treatment. It was hence inevitable that there would be occasions when I would be regarded as a team member by users and carers if my role as observer were not clearly explained. Were I to be regarded as being directly involved in the person's treatment, they would be more likely to co-operate in the study and agree to my presence, since refusal would have implications to their hopeful recovery. From the outset, I knew it was very important that this not be the case. I resolved to state, both in the information letter and verbally upon our first meeting, that agreeing to participate in the study, to my presence and subsequent writing-up of the encounter, would not affect their treatment (see section 4.2. below). I also knew, however, that there was no perfect solution to this problem.

As my presence was likely to affect the behaviour of team members whether or not they understood my role as researcher, such would also be the case with service users. Added to this was the fact that I was observing people at their most vulnerable. The interaction between professional and service user was hence likely to be influenced by a researcher's presence, and this would potentially affect the person's treatment, albeit, one hopes, minimally. Team members would be conscious of the need to create a "good impression" for both the service user and the researcher whose observations would potentially be read by those who could act upon them. Likewise, some service users may be anxious to create the impression of being co-operative in treatment by also being co-operative in research. However, if my intent and purpose could be clearly explained, my influence upon the situation would not be so great as to detract from the integrity of my observations.

4.2. *Obtaining Ethical Approval.*

With the help of my supervisors, I drafted protocols, information letters, consent forms and filled in an application form for the local NHS research ethics committee. This form was far from simple. Justifiably, a health trust is protective of its patients. Ethics committees exist to ensure that researchers will not breach a person's rights. However, such committees produce standardised forms and have standard procedures. This means that one wishing to conduct an observation-based study will go through the same procedure as one wishing to test out a new medicine.

In the first instance, I concentrated on the matter of obtaining informed consent from service users, as they were the vulnerable group. Hammersley and Atkinson (1995:268) referred to the importance of ethical considerations when researching such groups:

...being researched can sometimes create anxiety or worsen it, and where people are already in stressful situations research may be judged to be unethical on these grounds alone.

People experiencing a mental health crisis will inevitably prioritise factors and choices in their lives other than whether or not to participate in research. It was hence possible that some users would be indifferent to my presence in the first instance and thus consent to participate. Conscious of this possibility, and the need for truly *informed consent*, I made it clear to the ethics committee that I would offer service users both a twenty four hour period in which to decide, and the option of withdrawing consent at a later time. Once I had designed information letters, consent forms, and completed the application, I sent these to the ethics committee and awaited their response.

The ethics committee did not give my project their immediate seal of approval. However, they implied that with a few alterations and additional information, the project could proceed without substantial redesign. The committee's primary concern was that I had

not defined a process of obtaining consent from team members themselves. Admittedly, it had only vaguely occurred to me that I may need to do this. I had assumed that the teams had already agreed to participate since the research was devised in collaboration with the mental health trust. Also, the culture of health research ethics has only recently shifted to consider the implications for professionals as well as service users in participating in research. In my previous position as a research assistant in a specialist mental health unit, staff were not asked to sign consent forms if we wished to research them. However, I did not object in principle to devising a consent form for team members (I had already designed an information letter specifically for them), so I went about this task swiftly before resubmitting the application. But the requirement for team members to give signed consent had implications. Were even one team member to refuse consent, I would be unable to document any instance in which they were involved. If they were present in a handover, I could not record it, even in note form. Thankfully, no team members overtly objected to my presence, but there were occasions (described in section 6.1. below) in which I was refused requests to record meetings and to accompany them on visits to service users.

In their reply to my second application, the ethics committee granted approval. The whole process had taken around six months. It had been a frustrating wait, but I understood most of the committee's reasoning. The set of protocols, information letters and consent forms are catalogued in appendix II. Bowling (2002:158) defended the role of research ethics committees in health-based research:

Investigators frequently complain about the time and expense involved in ethical committee submissions...However, individuals need protection in relation to their privacy and protection from manipulation by the research; also required is the protection of the aura of trust on which society and the community depends; and the good reputation of research requires preservation.

While I essentially agree with Bowling in that, if a protocol agreed by an ethics committee is followed, the attainment of ethical approval will serve to protect the

researcher in the event of any conflict in the field, she speaks as though all research projects carry the same ethical implications. There is a difference between investigating the affects of a new medicine and wishing to observe home treatment. Once a tablet has been taken, it can only be digested or vomited out. An observer can simply be asked to leave, consent withdrawn and data destroyed. Indeed, as described below in section 5.2., ethical guidelines which are disproportionately stringent to the intentions of the researcher may be counter-productive to both researcher and researched. A debate in the *British Medical Journal* (31 July 2004) demonstrates that this view is shared by many health service researchers. Two researchers (Jones and Bamford, pp280-281) reported on how an apparently minor protocol deviation (the introduction of qualitative interviewing into a questionnaire based study) was analogised by an ethics committee as akin to giving the wrong drug to a cancer patient. While I experienced nothing so extreme, such incidents demonstrate the degree of rigour and clarity required in applications to NHS research ethics committees for approval to be obtained, whatever the nature of the study.

5) Access and Field Relations.

5.1. Meeting the Teams.

A consideration of access is essential to this chapter. Both the difficulties encountered and the kind assistance offered in this process was reflected throughout the research period. The influence of first impressions, both my own of the teams and the teams of me, cannot be underestimated. It is hence necessary to describe this process in some detail. It is important to note that the process of access gaining does not end once one's presence has been permitted and research is underway; rather, it is a continuous process throughout any observation-based study. As observed by Hammersley and Atkinson (1995:54):

The problem of obtaining access to the data one needs looms large in ethnography. It is often at its most acute in initial negotiations to enter the setting and during the 'first days in the field'; but the problem persists, to one degree or another, throughout the data collection process.

This section concentrates on the process of initially gaining access to the two teams as a whole. Section 5.2. describes this process in relation to users and carers, and section 5.3 describes the ongoing process of gaining access as the research continued.

Since the research had been proposed by the mental health NHS trust in collaboration with the university before I was enrolled to conduct it, both teams were loosely aware that a student may wish to observe them at some point in the near future. I say “loosely” aware as it was not possible in retrospect to ascertain the extent to which the project had been ingrained in team member’s individual awareness before my first contact with them. This was in part because there remained matters to attend to on my recruitment before the research could proceed; the ethics committee and criminal records bureau check, the outcome of which could potentially lead to the project requiring substantial review, or even prevent it from proceeding at all. Also, while it became clear early on that both team leaders were aware of what I intended to do, other team members remained uncertain. Also, though the staff-turnover in both teams appeared to be low, some had joined the services in the period between the initial proposal being put forward and the details finalised. However, whatever the extent of the teams’ awareness of the project, it was only polite to introduce myself and explain my intentions.

I spent the first three months of the study, for the most part, perusing appropriate literature and working towards obtaining ethical approval. I was able, however, to meet both team leaders during this time. I travelled to the Newchester team’s base in order to “sit in” on the discussion of a research project already in progress (a Delphi-based study on the experience of service users with a view to generating a standardised questionnaire). As well as the opportunity to meet the team leader and other team members, this visit would give me an idea of any difficulties I may be hampered by, approaches which may be helpful, and some of what I could expect to encounter in the field. A week or so prior to this meeting, I had sent an e-mail to the team leader, introducing myself and explaining my intentions. He had not replied. When he greeted me at the team base, however, he assured me that he had intended to do so in due course.

In the leader's office, besides him and me, were the two researchers whose project was to be discussed, the research manager of the mental health NHS trust, and a consultant psychiatrist from the Newchester team. I listened to those present describe the project's progress. They described how those users who had taken part in the study had been very complimentary of the service, but that of those invited to participate, only a small percentage had responded. They proceeded to describe the means through which they hoped to engage service users and put them at ease. One of the lead researchers was a representative of a local service users' organisation and it was members of that organisation who were conducting interviews with participants. At this point, I felt slightly uneasy. As a postgraduate student who was not part of such an organisation, whose intention was to "sit in" and observe, and whose active participation in the meetings between professionals and service users would be minimal, would service users feel comfortable enough to agree to my presence? This question further intensified the realisation that clear and concise information was a necessity in this project, and that it was likely that there would be times when users would not agree to my presence. I would, after all, be a stranger visiting them at an extremely difficult time in their lives without the team member's ability to offer support. Why should they participate?

The consultant psychiatrist entered the meeting once it was already underway. The research manager, who had been assisting greatly in planning of the project, introduced me and explained the reason for my presence. He greeted me with a nod and a "hello" but said nothing else. This was not a meeting about my project. I had hoped, however, that I would be asked more questions. Once the meeting had concluded, I left the team base with the research manager. I was glad to have met the team leader and psychiatrist and to have learnt of the other research project. I was, however, a little disappointed not to have had the opportunity to discuss my own in any depth. In retrospect, it was perhaps wise not to give too much away at this early stage. At least now, they knew who I was.

My next encounter with members of the Newchester team coincided with my first with the Churchfield team leader. Around a month after my visit to the Newchester team base,

I attended a meeting of practitioners, managers and researchers of crisis resolution in the region, in the company of two members of my supervisory team. On the train to the meeting venue, I was introduced to Charlie, who was then the leader of the Churchfield team. He was friendly and held an expression of genuine interest in my intentions.

At the meeting itself, representatives of the services described their operations and how close they were to conforming to the PIG. There was a slot on the agenda for my project; when it came, my main academic supervisor and I described what I intended to do. The consultant psychiatrist from the Newchester team who I had met previously enquired as to what “results” would be presented on the project’s completion. My supervisor replied that the research was “purely descriptive”; I would not be seeking to “measure” or “assess” anything.

On the return journey, my supervisor and I continued to describe the project to Charlie, who subsequently gave me his e-mail address. Early in my second term, I contacted him with the intention of arranging a visit to the team base where I might address the team as a whole, or at least those members present at that time. Charlie not only agreed to this, but would also pick me up from Churchfield train station and drive me to the base. We arranged a date when there would be a business meeting and a slot on the agenda was arranged.

By the time the meeting took place, I had drafted an information letter for team members and was thus able to describe the project with greater lucidity than before. I explained that I would essentially be an observer, my role similar to that of a nursing or social work student on placement with them. Inevitably, I was asked what I hoped to find out. One of the social workers, Paul, asked me about my “hypothesis”. I explained that it was my primary intention to generate rather than test theory in the first instance. On my first placement, I would ascertain what was important; on my second placement I would investigate these areas further. He seemed to accept this and indeed spoke to me further after the meeting was over. My slot concluded with Charlie stating that he thought the project was a “great idea” and should be supported. No objections were raised. This

meeting contrasted with my first with the Newchester team, which took place some months later.

When I first addressed members of the Newchester team, the first observation period in Churchfield had concluded. I hoped that by describing this period, I would win the confidence of team members. The meeting had been arranged, once again, via e-mail contact with the team leader. I was allowed inside the main room once the afternoon handover had concluded and team members were still assembled. I introduced myself to the ten or so members present; they gave their names and professional titles. I explained my wish to observe and accompany team members, both at the base and on home visits. A nurse raised concerns about my potential presence at mental health assessments. His concern was that, when a person is being assessed, they expect those around them to be contributors in some way. The presence of an observer could hence be problematic. I explained that my accompanying could be considered on a case to case basis. I had no more definitive answer. The team leader asked me how many service users I wished to visit. Though I couldn't help but wonder if he was missing the point somewhat as I was not looking for a sample, I said I suspected around three a week, totalling twenty-four throughout the whole research period. A medical student was also present. With a bemused frown she asked me "why?" The consultant psychiatrist, with a light-hearted smile, repeated her question. I smiled and replied that I wanted to understand "how it worked", not the "why or whether or not". I think that they accepted this, and did not seem too troubled. Once the discussion had ended, the team returned to work. I did not feel that I had licence to hang around. A month or so after this meeting, I arranged my "start date" with the team leader for the orientation period.

There was a clear contrast between the responses I got during initial meetings with the two teams. My first impression was that the Churchfield team were supportive, while the Newchester team, though not hostile, were essentially indifferent. However, as the research progressed, these first impressions were replaced by others, as I explain in section 6, below.

5.2. Meeting Service Users and Carers.

I found that in order to meet service users and carers, I needed to have the confidence of the team member I would be accompanying when visiting them. There were times when my requests were turned down; sometimes, the team members deemed the service user too dangerous (as in the case with those with a history of violent behaviour, and in more than one instance, hostage taking) or too vulnerable (some service users were seen only by members of their own gender as they were distrustful of those of the opposite for various reasons). As the reasons for refusal were always given, I did not deem it necessary to question team members on this and respected their wishes.

Where possible, a team member would request to the service user by telephone that I accompany them on the planned visit. At other times, I would simply “turn up”, but offer to leave once I had explained myself. This often occurred in Newchester, where team members would do several home visits sequentially, and would not have time to telephone prior to our arrival. As it happened, I was never asked to leave by a service user. On a few occasions, my presence was refused over the phone, and one service user agreed to my presence on several encounters but subsequently withdrew their consent. In accordance with the procedures I had agreed with the ethics committee, I destroyed all the data I had relating to them.

The process of obtaining informed consent from service users was, at times, uncomfortably simple. I explained my intentions, that their anonymity would be protected; I gave them the information letter and consent form, told them they could withdraw at any time, and that they did not have to decide whether or not to participate immediately. I also gave them the opportunity to ask me further questions. However, the reaction I got, almost universally, was an offer to sign the consent form immediately. My first reaction was to ask if they were sure of their wish to consent, which in retrospect I feel was somewhat condescending, but after the experience of obtaining ethical approval, I felt I had to “protect” myself and them from potential problems in the future. One service user adamantly told me she had “nothing to hide” as she signed the consent form; another that

he'd "trained many a doctor". It is possible to infer from this that some services users are accustomed to being observed; this may make them more acceptant of such, as seemed to be the case with those I met, or it may just as likely mean that they resent it more than most, though I did not encounter such resentment in the course of this study. It also seemed that, in rigidly following protocols in which I gave the service users multiple opportunities to refuse participation, I was creating an impression that participating in the project carried far more serious implications than was actually the case. I would write about my encounters with users for a limited audience and their identities would be, in any case, well disguised. Though I do not dispute the need for truly informed consent in studies such as this, my contention is that an overly tentative approach to obtaining consent may give the impression that the researcher is hiding something from the "subject".

In general terms, the difficulties I had in gaining access to users and carers were, by and large, related to the teams' anxieties. This was, to some extent, to be expected as it was chiefly their actions which were under observation. There were times when these anxieties reflected those of the service users in question, others when it seemed that team members somehow knew that a service user would not agree to my presence. So sure were they of this, consultation was not deemed necessary.

5.3. Team Members' Reservations.

In this section, I describe a significant occurrence in the evolution of my relationship with the two teams, reflecting some team members' reservations regarding my research. This incident serves to illustrate how gaining access is a continuous process that does not end once one is established in the field. Trust between the observer and the observed may require continuous maintenance.

During the first observation period with the Newchester team, a documentary was screened by the BBC in which an undercover reporter had trained as a police officer and, with the aid of a hidden video camera, exposed severe levels of racism amongst other

trainees. This led to comments from team members. On several separate occasions over the subsequent week, I was asked by different team members if I had a hidden camera or if they were going to appear on *Panorama*. I took these questions to be asked in good humour; the enquiring team members were, after all, playing to an audience of those others present. However, the situation as a whole reflected a more serious potentiality; that there may be a hidden agenda to my study.

A nurse jokingly remarked that “we’re gonna be on television, saying let’s hope so-and-so hurts herself so she can be sectioned and taken out of our care!” Thankfully, I had heard no comments like this employed in seriousness. However, this tongue-in-cheek statement was an example of how behaviour may be affected by the presence of an observer; whether such things be said or not, the team would try not to say them in front of me. I was hence potentially observing a practice more defensive than would otherwise be the case. The same nurse later asked me, this time in the kitchen when no other team members were present, “what do think about all this hidden camera stuff?” I replied that “you could never get away with it these days in academic research”. He accepted this in good humour. I don’t think that he doubted my motivation, but wanted to check on my moral stance, to which I was able to elude.

In general, I did not take the teams’ professed suspicions too seriously. However, shortly after the exchanges described above, I was refused permission to record a team business meeting. There were no objections to my physical presence; but several team members objected to the presence of my mini-disc recorder, which I subsequently buried in my rucksack. I could not be sure if these objections were directly related to the BBC documentary as they were not explained. The team members were under no obligation to justify their objections, and I did not get the opportunity to ask. Indeed asking was difficult as I feared it would seem like pestering on my part, further fuelling any resentment they may have had at being observed. When I left the field on this occasion, I possessed no audio recordings. After consulting my supervisors, we arranged a meeting between two senior team members, the trust representative on my supervisory team and

me. At this meeting, I found that I had been wrong in my suspicions that team members' objections to my recording that meeting had been related to the BBC documentary.

The consultant psychiatrist explained that the objections to me recording the meeting in question were to do with the meeting itself: "We don't have these business meetings very often, so when we do, people want to vent spleen." The objections now made sense to me; people are seldom happy to be recorded when expressing intense emotion, regardless of the context. Also, they may have feared that to be "on record" being fiercely critical of trust policy could be used against them in future. In short, the preservation of discourse in audio recording may make such discourse seem somehow more "official" in the bureaucratic sense of the term. Returning to the meeting, the team leader and consultant psychiatrist agreed to discuss my recording of meetings with the rest of the team in the hope, in the second observation period, I could make the recordings I needed. When the second period came, I encountered no further objections.

In general terms, gaining access, though an issue most evident at the beginning, is an ongoing process throughout a research project. Though general access may be granted initially, access to particular areas is subject to a process of continuing negotiation. That described above is an extreme case; I did not have to involve my supervisors in any further negotiations with the teams. It illustrates, however, how the acceptance of one's presence is not necessarily acceptance of all the aspects of one's research.

6) Reflection and Concluding Remarks.

In this chapter, I have attempted explain my choice of methods, the process of analysis, and provide a description of the research process itself, thus providing a context for the subsequent analytic chapters. In this final section, I reflect on the research process as a whole and consider how some of my initial suppositions were proved wrong. My initial impressions of both teams studied were not significant predictive factors in my overall relationship with each of them. Ultimately, I encountered indifference in Churchfield as much as I was offered assistance in Newchester. On the whole, despite an inevitable

degree of reservation, both teams were very supportive of my research. It is true that it is difficult for the lay person to become fully immersed in the “unofficial backstage” of the mental health team under any circumstances, at least not immediately. Both teams studied were conscious of this and were thus somewhat defensive, though they exhibited their defensiveness in different ways.

I consider that had I studied Churchfield alone, I may not have experienced the model of practice they aspired to attain. Had I only studied Newchester, I may have attained a lesser understanding of the model itself, having no contrasting service model on which to reflect. The study of either team alone would certainly have been a worthwhile project. However, in studying both teams, I was able to attain a deeper understanding of several things; how mental health services are changing, how demographic factors may or may not influence practice, and indeed if different understandings of mental health crisis existed between and within the two teams. It was not the case, however, that I began research assuming that Newchester “did it properly” and that Churchfield should indeed aspire to emulate them. Neither did I take sides as a preservationist, believing that Churchfield should maintain their current model of working and resist attempts to make them into a carbon copy of another team.

My initial fears of service users refusing to participate were, while not without foundation, for the most part, misplaced. I feared that since participation was of no immediate benefit to them, they would not want to be involved. This fear was based on a generalised notion of how people behave when in mental distress. I realised that I had condescendingly expected service users to be selfish and concerned only for their own immediate welfare. I do not believe that I alone am guilty of harbouring such an expectation, and that such an expectation will, on occasion, be fulfilled. However, my experience of service users suggests the contrary. Some people are happy to help for the sake of helping, no matter how distressed they might be at the time. Also, service users understood that research can influence practice, and thus saw me as potentially giving voice to their opinions. If the research was not of immediate benefit to them, they saw how it could be beneficial to future service users.

My stance was influenced by my position as a social scientist. It would, however, be foolish and counter-productive to pretend that I have no other personal values that have influenced my work. My personal values may have at times given me a prejudicial view of certain aspects of their practice. I would find myself angry at attempts to “medicalise” a person’s predicament and label them with psychiatric diagnoses. As the research progressed, however, I was able to take a more distant, yet balanced view. This was invaluable in order to achieve a thorough understanding of what my data was telling me. If I resisted the temptation to “take sides” in the first instance, it was easier to understand both sides of an argument.

Chapter Three: Understanding “Crisis”.

1) Introduction.

1.1. Chapter overview: Crisis as a Discursive Construction.

In this chapter, I examine the notion of “crisis”. I consider how crisis is ‘constructed’, by which I mean how it is identified, understood and treated by the mental health crisis teams studied. I describe how people experiencing mental distress are brought to the attention of the services and how the services subsequently work with them. Four specific “cases” are used both as examples of crisis work in themselves and as pointers to more general findings. Finally, I consider whether there exists a particular set of criteria which is commonly agreed to constitute a mental health crisis.

I adopt a fundamentally discourse analytic approach to the construction of crisis in order to consider how mental health professionals formulate their understanding of the situations presented to them through both discussions with colleagues and service users. From this perspective, the categorisation of an event as a “mental health crisis” is a discursive accomplishment of mental health professionals. de Montigny’s (1995:82) use of this perspective to inform his study of social workers working in child protection was made clear by his assertion that

...what is counted as child abuse and neglect arises from methods for making sense which are inextricably linked to an institutional apparatus. Untoward occasions of hitting, slapping, punching or stabbing between parents and children are worked- and become visible- through the work of social workers, psychologists, pediatricians, public health nurses and teachers, not just as remarkable but as properly warranting their interventions.

The premise for this chapter is similar to that described above. Social workers, psychiatrists, psychiatric nurses and support workers discursively construct certain events which they confront as visible and accountable “crises”, or more exactly “acute psychiatric crises”. In the particular context of this research, an important institutional resource for such an accomplishment is an officially sanctioned working definition of “crisis”. This is to be found in the Department of Health’s (2001) Policy Implementation Guide.

1.2. The Department of Health Definition of “Crisis”.

The Department of Health’s Policy Implementation Guide (PIG) on crisis resolution and home treatment teams is an essential frame of reference for understanding what crisis means in the current research context. It begins by stating who the service is for:

Commonly adults (16 to 65 years old) with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorders) with an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary. (12.)

While this sentence effectively refers to what a crisis team is supposed to *do* (keep people out of hospital), it says very little about what such an “acute psychiatric crisis” actually *is*. How do those with relevant authority decide when hospitalisation is necessary? What can this list of “disorders” tell us about how a crisis is identified? In fact it assumes a prior understanding of the constituents of a mental health crisis. This prior understanding is that of the mental health professional, not that of the service user or indeed of the layperson.

The PIG goes on to define those circumstances that would not be properly categorised as an “acute psychiatric crisis” when they declare the service is **not** usually appropriate for individuals with:

- Mild anxiety disorders
- Primary diagnosis of alcohol or other substance misuse
- Brain damage or other organic disorders including dementia
- Learning disabilities
- Exclusive diagnosis of personality disorder
- Recent history of self harm but not suffering from a psychotic illness or severe depressive illness
- Crisis related solely to relationship issues (Section 3.1.)

Once again, these exclusions are those of the mental health professional. One assumes that an individual “in crisis” must be presenting themselves in a particular way for such a definition to be attached. The reference to “self harm” without the presence of psychotic or severe depressive “illness” implies a medicalised notion of “crisis”. Presumably, if “self harm” was identifiably a *symptom* rather than merely a *behaviour*, it may indeed be indicative of crisis. However, this is not to say that alcohol, substance misuse, personality and “relationship issues” do not have their part to play. They are only excluded when they are the “primary diagnosis”, “exclusive diagnosis” or sole factor in the “crisis”. Hence, the PIG seems to hint that, whatever the individual’s circumstances, there must be a medical element to their presentation in order for their “crisis” to qualify as “psychiatric” and thus appropriate for the team’s intervention. In short, while the PIG does not describe “severe mental illness” beyond a list of diagnostic terms, it presents the above list of those presentations which it does not classify as such.

In general terms, the definition of crisis contained within the PIG is limited. Though the phrase “severe mental illness” is reiterated on several occasions, the lack of definition insinuates that the intended readers of the document (mental health professionals and service managers) have a prior understanding of what the term means. The purpose of the exclusion criteria is to ration the service; theoretically, it is to be accessed only by those diagnosable as experiencing “severe mental illness”. Whether such rationing serves as a meaningful guideline in day to day practice is considered as this chapter proceeds. Despite the few direct references to the nature of “crisis”, certain aspects are implied in

the description of what the service is intended to do and hence the needs of the people for whom the service is deemed necessary. If a person is experiencing an “acute psychiatric crisis”, they need a “rapid response following referral”, “intensive intervention and support in the early stages” (12) and an “ongoing risk and needs assessment” (14). This implies an intensive intervention, which in turn implies the presence of intense mental distress upon which such an intervention is focussed. A “crisis” may be a relentless experience; its management at the hands of mental health professionals equally relentless.

Though the PIG defines a “crisis” in terms of both “illness” and “needs”, it does not describe the many presentations which a crisis team may deem as constitutive of such. In this chapter, I describe some of these presentations as encountered during my time in the field and how the teams discuss them. I begin by considering team members’ views on the constituents of “crisis”.

2) Crisis as Understood by Team Members.

Towards the end of the observation periods in each setting, I conducted interviews with several members of both teams. Though the interviews were unstructured (see chapter two), there were certain key areas that I wished to cover. Crisis was one such area. I asked each team member how they would define a crisis. The following quotation comes from an interview with a nurse from the Churchfield team.

I think that for whatever reason this person is unable to cope and they have reached their threshold, and I think we all have different thresholds and I think that when they reach that they’re defined as being in that crisis situation.

The nurse’s understanding of a crisis parallels Caplan’s definition; the essential factor being an inability to cope. She says that the person is “defined” as being in a crisis situation, but she does not say who has made this definition. She talks of different “thresholds” which, when reached, result in crisis. Crisis is hence relative from one case to the next. Essentially, the nurse has put forward a broad definition of crisis,

encompassing an unlimited array of possible situations. However, a social worker from the Newchester team had a different view:

It doesn't need to be too sharp focussed but I do like to...for instance, here I think it is important to focus in on psychiatric crisis, otherwise we'd be <going> off in all sorts of areas that we're not particularly well set up to deal with. I think if the team was differently constituted I think we'd be much more open-ended about it, but it's not.

A key issue here is the professional constitution of the team. Although the speaker is a social worker, the team of which he is a member is made up predominantly of nurses and psychiatrists (see chapter six). The crises to which the team responds are hence predominantly psychiatric. This explains the team's apparent reluctance to treat a man who had been threatened by his neighbours (see section 4.4.). A social work team may have taken a different view. The crises that the teams construct reflect the professional standpoints, or predispositions, of their constituent members. In the case of the Newchester team, this means psychiatric crisis, as implied in the PIG, is the main focus of their work. An SHO from the Newchester team put forward her definition of a psychiatric crisis:

Psychiatric crisis, first thing that comes to mind is rapid deterioration of mental state in terms of somebody either in first episode of psychosis or depression or any other severe mental illness or person with long history who relapses due to various circumstances and requires more...Basically malfunctioning, is not able to function the way he normally does for...because of the symptoms. That's the psychiatric crisis in my head, the definition.

This is, fundamentally, a medicalised and mechanistic definition of crisis. It is restricted to people with particular psychiatric conditions: "malfunction" insinuates the existence of "regular function" and hence health. It is a definition inextricably linked to an idea of mental illness and is much more narrowly focussed than the nurse from the Churchfield

team's assertion of a crisis as being an inability to cope. However, this definition is no less a potent construction of crisis; it is simply different. An inability to cope can be indicative of mental illness and visa versa. In combining these two definitions, a more holistic notion of crisis emerges. This definition, however, remains relative to the situation in hand and the teams' constructions of crisis in their discussions. In the next section of this chapter I go on to consider these situational relevances.

3) Handover Discussions.

3.1. Reaching Handover.

No person is referred to a crisis service without being accompanied by varying quantities of background information. Such information is given to the team by the referring agency (such as the GP) at the time of the initial referral. If the referral is deemed appropriate, the person will be seen, or at least contacted by the team as soon as possible within 24 hours. The most important information that the team requests from the referrer will be the 'current presentation' of the service user; why the referrer thinks the person in question needs to be seen by the service. The referrer will also be asked whether or not the person has a psychiatric history and, if so, the nature of this history (diagnoses, previous contact with mental health services etc). Aside from this, the team will request demographic information and information on the person's current social and domestic circumstances. This information serves to both prepare team members for a possible meeting with that person and to ascertain the appropriateness of the referral.

Most referrals come from general practitioners, requesting that the team become involved with a person's care. The GPs will request the person be assessed by team members and considered for treatment by the service. It is usually the case that in referrals from accident and emergency departments, less background information is accepted as sufficient. This may be because the assessment will be conducted in the relatively secure environment of the hospital ward rather than in the person's home. As much of this initial assessment involves the measurement of risk, including potential risks to the safety of

mental health professionals, it is safer to conduct such an assessment in a place where assistance can be swiftly acquired.

New referrals will first be presented to the team in a handover discussion. They will be presented by the triage staff member (in Newchester) or co-ordinator (in Churchfield). Prior to this, the triage staff member or co-ordinator will have spoken to the referrer on the telephone and recorded the person's details. The referral may then have been discussed informally with any other team member in the vicinity. However, it is in the handover where the details of the person's presenting problem are formally described to the team, or at least those members currently present. Depending on the time of day the initial referral is received, it may be that the person has already been visited by team members and indeed "assessed"; that is, been subjected to a mental health assessment. For instance, a person referred around 9am will be discussed in the morning handover before the initial contact (by telephone or home visit). However, if they are referred at 10am, they may well be visited and assessed before the next handover at 1pm.

3.2. Case 1: Postnatal Depression?

Handovers are interactions- collaborative discourses in the construction of 'crisis'- as well as exchanges of information. The following transcript comes from a handover recorded early in the second observation period with the Newchester team:

Triage: Did you mention (person's name)?

Nurse 1: Yeah. J was a girl who was referred to us...who was referred by the GP. A <familiar> presentation. She presented at A and E after a night of er drinking. Er... when she got to A and E she expressed some suicide ideation but more worryingly she had expressed the desires to shake her ten week old baby to death.

Here, Nurse 1 provides a brief summary of the circumstances of the person's referral and their "presentation". He does this at the instigation of the triage staff member. The

instigating question is significant; it suggests that information has been exchanged between Nurse 1 and the triage staff member prior to the handover commencing. The question is hence not to be taken literally. It is likely that the triage staff member is well aware that the person has been mentioned to him, and perhaps to other team members, at an informal level by Nurse 1. He is essentially formulating a request that the information be shared with the others present as a request for the clarification that a previous exchange has taken place. It is hence a request put forward as a question; a question which can be answered with a “yes” or with a “no”. It is his role to “manage” the giving of information, while it is the role of Nurse 1 to actually give it. On the surface, these roles are transcended and a more collaborative relationship is established. However, the exchange takes place within the pre-established framework of a handover. The triage staff member is using his authority as the manager of information to provide a cue for Nurse 1 to demonstrate his own authority in the case. In short, “Did you mention...?” may also mean “tell us about...”

From Nurse 1’s response to the initial question, it appears that the circumstances of the referral are unusual; J is described and having been referred by the GP and yet she presented at A and E. This could suggest that she was already established as a case for the crisis team. Her subsequent presentation at A and E may have served to re-prioritize her as a case for immediate and detailed discussion, followed by subsequent action. In short, she may have demonstrated that her needs are not currently being met and that hence requires more intensive involvement from the team. Indeed, it is often the case that established clients with a clear care plan are discussed only briefly when a visit is planned. This will only change once the person is deemed fit for discharge or what team members often call an “adverse event”, such as an act of self harm, takes place. An “adverse event” is an unexpected occurrence relating to a particular service user which is demonstrative of an increase in risk, need, or both.

Though the urgency with which service-users’ problems are attended to by team members may fluctuate throughout the period of the teams’ involvement, it is more likely that, in this case, the person, J, is a new referral. This is implied by the fact that hers is the

first case to be discussed in this handover. Were she already subject to the team's involvement, her case would have been discussed at a later point. It is a rule of the handover that new referrals are discussed first, established cases second. Hence, it is likely that J's GP was informed of her presentation at A and E and passed on this information to the crisis team.

Nurse 1 goes on to summarise the desires that the person expressed. "Suicide ideation" is a term frequently used by both teams. It is sometimes used to summarise whole cases and, as is the case above, to summarise information given by the service user. However, service users do not approach mental health professionals and say "I wish to express suicide ideation." It is hence a term seemingly employed, at least in part, for the sake of professionalism: "She said she was thinking of killing herself" will not be used when "she expressed some suicide ideation" will suffice. It is also a means through which J's possibly ambiguous words are generalised through the use of a technical term. An expression of suicide ideation could mean a serious threat to take one's own life, or simply an expression of exasperation. If it is unclear as to the interpretation intended by J, "suicide ideation" functions as a broad technical term; perhaps she was serious, perhaps she was not. However, it is clear here that risk to others is deemed a great concern alongside the risk to self, particularly when the other is particularly vulnerable; in this case, a ten week old baby. The apparent threat to her baby's life is greeted with a request for repetition.

Consultant 1: She what?

Nurse 1: Threat- verbalising these desires to shake her baby, really quite violently out of frustration erm...(pause) Consultant Y saw her at home. She's in the company of her husband and her Mother-in-law. Er... she's presenting with symptoms of acute anxiety. As I say, these thoughts of shaking the baby or of killing herself. She er disclosed that she'd been over to one of the local fly-over bridges a couple of times with the little one. It was simply the fact that the baby was there which had stopped her from jumping...Erm....feelings of guilt

regarding these thoughts of harming the child and guilt at being a p-poor Mother. She's not sleeping. She's lying in bed kind of ruminating over these thoughts of not being able to cope with the baby. She's not bonding with it, she wants nothing to do with it. Mother-in-law's basically looking after the baby 24-7. Er...and basically said well if you take it away now it wouldn't bother me basically.

At the request of the Consultant, Nurse 1 re-iterates that the woman has said she feels like violently shaking her baby. However, it seems that he has almost softened the tone; she wants to shake her baby "really quite violently out of frustration". He does not re-iterate that she has expressed the wish to actually kill her baby. The word "threatening" was started, but in the end he uses the less malignant expression, "verbalising." What one may infer from this "toning down" of the language is presently unclear, but one interpretation is that Nurse 1 is trying to avoid imposing premature judgement on the person and to avoid provoking the team to do the same. This may in part reflect the apparently "caring" rather than "punitive" nature of the service. Nurse 1 has chosen to use one word in place of another. "Threatening" has an implication different to that of the word "verbalising". If the person has made "threats", they are seen to be demanding something from another in order that these threats are not carried out. This is clearly not the impression that Nurse 1 wishes to create here. The woman is merely *reporting* that she has these desires. This is not the same as threatening to act upon them. This has implications regarding how the team will treat the case, which become clearer as the handover continues.

Nurse 1 continues. It seems that he is wishing to "tell the case", giving as much detail as possible, before getting into a discussion with those other team members present. After a short pause, Nurse 1 states that the woman has been seen by a consultant, who evidently has passed details of the visit onto the team. (It is not clear from the recording as to whether the consultant in question is a member of the same team, as the name is inaudible.) The order in which these details are given may be of further significance: current domestic situation followed by what may be a provisional medical diagnosis (acute anxiety) and then further details of the presenting problem. The narrative begins as an initial summary of the person's recent presentation, which is essentially a

description how the person has now come to the team's attention. It then evolves into the clarification of background details. These are followed by a further illustration of the presenting problem that uses examples of the person's actual behaviour, or at least how it has been reported. She is standing on top of fly-over bridges; she is lying in bed ridden with guilt. She has expressed apparent indifference towards her baby. The baby, however, is in the care of her Mother-in-law and this information proves to be significant. The discussion continues:

SHO 1: How old is the baby?

Nurse 1: Ten weeks.

SHO 2: Ten weeks?

Nurse 1: Ten weeks.

SHO 2: How did it get to referral stage?

Nurse 1: She'd gone to er A and E. She'd...it seems that there's been a erm gradual deterioration in her mood over kind of the past 3 or 4 weeks. She used to work in a pub. <She had> her leaving do and she kind of got it into her head oh right if I actually go out perhaps I can snap myself out of this, got out <<unintelligible>> on the hoy basically, drank four <<unintelligible>> of beer and then it just hitched up, an alcohol induced crisis for want of a better word, at A and E. Then obviously <<unintelligible>> to us. They sent her home with 5 milligrammes of diazepam and she'd slept when we picked up the referral later on in the day. Erm...she describes having panic attacks when she goes out. She doesn't actually go out anymore. She's isolating herself. She won't see her friends who come in or call her. She feels marginally better when she's inside the house but not much. Erm...she'd been previously prescribed fluoxetine by the GP. That had been stopped because she'd suffered a- what appeared to be a seizure during

the night. Er so the GP subsequently stopped it. She's also been prescribed diazepam, which the GP had stopped and propranolol for panic attacks again which the GP had stopped er...

(Pause.)

The focus of attention in the above exchange seems to be initially on the baby. The SHO's question indicates that the age of the baby may be clinically significant; a very young baby may be indicative that J is suffering from a form of post-partum mental illness. Hence, the SHO may be in fact asking when the woman had the baby as this is likely to give an indication as to how long it has taken for the current situation to emerge. The presenting problem so far appears to be inextricably linked to the ten week old baby. However, Nurse 1 has already stated the age of the baby earlier in his narrative. It is possible that this fact was not initially registered since the sentence in which it appeared also described the woman's desires to shake the baby to death. These desires hence appear to be the over-riding factor in the case, since there are implications regarding the management of risk. This is further suggested by the fact that the second SHO also asks for information to be repeated: "How did it get to the referral stage?" This is a request for information as to how J has come to the attention of the service; why did the GP deem the involvement of a crisis resolution service in J's care as an appropriate course of action? In his reply to this, Nurse 1 uses the word "crisis" for the first time in relation to the case.

Nurse 1 summarises the circumstances which led to the woman's presentation at A and E:

a gradual deterioration in her mood over the past 3 or 4 weeks", an attempt to "snap out of it" by going out and drinking, culminating in an "alcohol induced crisis, for want of a better word.

Thus, the "referral stage" is shown to be synonymous with the point of crisis. Following this, Nurse 1 volunteers (in that he has not been directly asked) further information; what happened at A and E and afterwards. He describes the short-term measure adopted by A

and E: diazepam to help her sleep. He describes other recent symptoms of mental distress (panic attacks) and relates this to the medications she has recently been prescribed. He also gives further information on the woman's support network: she is "isolating herself" and not seeing her friends. All these factors contribute to the accountable description of her state as that of a crisis, by virtue of their inclusion in this discussion. It may also be that the nurse is listing the reasons why the team need to see her, and this, in turn, is synonymous with crisis. SHO 2 asks for further information on the precipitant factors:

SHO 2: Has she been drinking a lot? Was this just a one-off?

Nurse 1: No. She says she's been drinking a couple of glasses of lager per night to help her sleep. But certainly it didn't seem anything more than that. No other symptoms, no other symptoms, no other <risks> of drug use. Erm...

Triage: <<Unintelligible>> the Father?

Nurse 1: The Father says there's 3 other kids, they've been over, basically all the kind of the immediate family inside are pulling together to provide 24 hour support for her and for him. He's took time off work. 3 other kids. The eldest one, 14, they say they're having a bit of a problem with. But it just really sounds like a 14 year old lad with a bit of lip. Y'know. He's testing the boundaries out with his parents. I don't think there's significant behavioural problems with him. It just felt like... Well, one time it felt like post-natal depression, erm, but then again...

Nurse 2: Sounds like it.

Nurse 1: Yeah. Yeah. Erm... She has been starting-

SHO 1: Any past history?

Nurse 1: No. No.

SHO 2 is asking if “drinking” is a longer term factor in this woman’s crisis. Drinking has already been established as an immediate factor in the referral to the crisis team, but there may be different implications if there is a background of substance misuse over a longer period of time. Nurse 1 reports that there are “no other symptoms” or “risks of drug abuse”. From this, one may take it that alcohol and drugs are not deemed significant factors in this case, at least in terms of the knowledge the team has currently. Hence, although not apparently significant to this particular case, drug and alcohol “misuse” are shown to be important factors in the constituents of crisis.

The triage staff member asks Nurse 1 for further information on the woman’s family. He replies by detailing the family support the woman currently has; “24 hour support” from her husband and 3 other children. He goes on to expand on the family factors: a possible problem with the eldest son, dismissed by Nurse 1 as sounding like “a lad with a bit of lip”. He doesn’t think there are “significant behavioural problems with him.” What is meant by “significant” here is worth noting; the son’s behaviour is not deemed “significant” to the woman’s current predicament and involvement with the team. He then contrasts the son’s behaviour with a possible diagnosis, or more specifically what at one time “felt” like a diagnosis: post-natal depression. “But then again...” Before Nurse 1 can complete his sentence, he is interrupted by Nurse 2. Nurse 2 puts forward his own conclusion on the facts he has been presented with; it “sounds like” post-natal depression, though it appears that Nurse 1 was about to put forward an alternative explanation. He is about to give more information, when he is interrupted again by the SHO. “Any past history?” in itself is a vague question, but as it appears here and that it is asked by an SHO suggests that she is asking for a specific *type* of history, which can only be a psychiatric one. It is not clear, however, if she is asking for a broad psychiatric history or simply whether the woman has previously suffered from post-natal depression. Whatever the case, Nurse 1 clarifies that no past history exists. The SHO proceeds to ask a further question:

SHO 1: And er planned baby?

(Pause.)

Nurse 1: We'll make them aware that we probably need to speak to social services regarding the issues with the child. Mother-in-law's took the little one plus the other 3 kids back to her house for the next couple of days. Er...they only live round the corner so J's said that she's going to the house and coming back so she's still having some contact with the kid but Mum's supervising everything. Hubby's took the next 4 or 5 days off to be with her. Spoke with the on-call SPR last night and got a kind of 5 milligrammes diazepam TDS to help her sleep. Hubby reports that the first 5 milligrammes took the wind out of her sails and she slept for about 5 hours. Got up again at about 5, 6 in the morning? Thoughts of leaving the house but again took another 5 milligrammes <<unintelligible>> goes down. Hubby's kind of locked the door.

The SHO's question is not answered. It is possible that the answer is not known by Nurse 1, perhaps the answer is not deemed as important to the case by those others present. To the SHO, whether the baby was planned or not is clearly significant; one assumes that it could be deemed as a factor in the woman's relationship with the baby and subsequent referral to the team. However, no one asks the SHO why she has asked the question, and Nurse 1 continues by putting forward a possible plan of action. A representative of the team will tell the family that they "may have to speak to social services". This possibility is to be raised with the family before it is carried out, if indeed it is carried out at all. In short, Nurse 1 is uncertain whether another service needs to be involved. He goes on to describe further the current domestic circumstances, not only of the woman at the centre of the case, but also her family. Since the family has now been introduced to the narrative, they are now given as much attention as the mother and baby. "Hubby's kind of locked the door" to prevent her from leaving the house, presumably fearing that should she do so, she will again visit fly-over bridges. The Team leader now interjects:

Team leader: Has she ever harmed the child?

Nurse 1: No. It's just thoughts. It's just thoughts. She recognised that-

Team leader: I wouldn't contact social services. It's probably part of her illness.

Nurse 1: Yeah.

Team leader: And let's treat that.

Nurse 2: Just monitor her.

SHO 1: Play safe.

(Pause.)

Nurse 1: So basically we give her home based treatment?

Team leader: It's grabbing a-hold...

Nurse 1: Yeah. Erm...She's down for a medical review today.

Consultant 2: Yeah. Good. Excellent.

Here, there is a move in the discussion from deliberation to candidate decision. This happens when the team leader asks whether J has ever harmed the child. The Team leader's question is central to the planning of the treatment to be offered. It is also demonstrative of how the planning of treatment is inextricably linked with risk. When he hears that she hasn't harmed her child, and that the professed desires to do so are just thoughts, he advises against involving another service, and centres the treatment to be offered on the woman alone. The two nurses and the SHO demonstrate that they are in agreement with him. They do this by adding suggestions that seem to compliment his

own. The team will treat her “illness” in contrast to her domestic situation; they will “play safe” and “just monitor” her. The team leader thus shifts the emphasis from the woman’s relationship with her baby to the woman’s psychiatric condition alone. The “crisis” that the team are agreeing to treat is hence primarily a mental health crisis. This is not to say that the familial element is not acknowledged; the preceding exchange demonstrates that this requires continued observation. The subsequent plan is to simply give her home based treatment with a “medical review” as the immediate action. Her medication is to be reviewed, with the potential for the dosage to be increased or decreased, and for new medications to be prescribed and old medications stopped. That such a course of action is imminent further demonstrates the psychiatric emphasis upon which this case now rests. It may therefore be “grabbing a-hold” of the psychiatric element, indicating that the potential risk to the baby will diminish as the mother’s mental health improves. A Consultant then concludes the case by agreeing with the plan of action.

There are several emergent factors in the above case. Substance misuse is hinted at, but not deemed significant. Family factors are very important, regarding both the woman’s support network and the risk the woman may pose to her young baby. Indeed, family factors can be both positive and negative. Risk is central to the team’s intervention, but this is not to say that it is the key constituent of this “crisis” in terms of the woman’s own experience. Though the discussion concludes with reference to the woman’s “illness”, the psychiatric factor is, on the whole, discussed fairly minimally. However, prior to its introduction, the participants consider the characterisation of crisis from a broader framework, one which relates to “life events”. Their consideration of the case thus accords with Caplan’s (1964) earlier definition of crisis focussed on life events as a key constituent. Giving birth, though often cause for celebration, is a life event that can precipitate crisis, psychiatric or otherwise. (See chapter one.)

3.3. Crisis as a "Life Event."

The above case is an example of several occasions when the birth of child was a factor in the "crisis" the teams' sought to manage, contain and indeed "resolve". During the second observation period with the Newchester team, I accompanied a SHO on a home visit. The woman I met had given birth to her first baby two days before, and had subsequently experienced an apparent psychotic breakdown. She was living with her parents and the father of the baby, with whom, by all accounts, she had a positive relationship. She did, however, appear very distressed. Her manner was frantic. She was not sleeping well. Her voice was barely audible and her utterances made little tangible sense. At one point, she appeared to be stating that she was protecting her baby from a poster of the local football team which adorned the wall. She had no history of mental illness.

After taking blood from the woman, discussing medication with her and her parents and arranging a subsequent visit for the following day, we left and made our way to the SHO's car. On the proceeding journey, I asked for her opinion on the case:

Having a baby can be one of the most traumatic experiences of a woman's life. Cases like these are not uncommon.

Postnatal mental illness including depression and psychosis is recognised as a common affliction (Cohen 1994:298-299), but does not always lead to the intervention of mental health crisis services. In the cases described above, however, there are additional factors. It is not simply that these cases are more "severe" than most. In the handover discussion, there were the additional factors of risk, the possibility of substance misuse (though this was rejected), and negative reactions to previous treatments. With the young woman I visited with the SHO, it was also her first known episode of apparent mental illness; one life event exacerbated by another. In short, it appears that there is no single factor in a "crisis".

3.4. Case 2: Crisis Prevention.

It was sometimes the case that crisis prevention was practised by the teams, particularly in the Churchfield team, who had a greater role in the aftercare of people who had just left psychiatric hospital. The following transcript comes from a handover recorded at the beginning of the second observation period with the Churchfield team:

Nurse 1: Saw him on the ward yesterday. It was just a very long session, bearing in mind that he's just been in hospital and we're gonna keep it to a bare minimum, what we would be doing. Here and now stuff, every question that I asked, but y'know, his life story. It's obviously what he thought he needed to do. I have agreed to take him onto case load, but it will be very short term. There's referral to B K and I believe there's an appointment for next week so it's all about this weekend. The major problem is he's gonna be discharged from hospital today. He has got plans in place but this weekend is a particularly bad time. First weekend at home...The risks there are major alcohol problems, but he has been abstinent for 18 months but prior to that, gave up the antabuse and had a week's relapse drinking. From what I can gather, he does use cannabis still, on a regular basis. There is a history of substance misuse but there's no mention of that happening now. And risk to himself is mainly risk of self-harm. But the information is mainly from him. It didn't appear that frequent or that dangerous what he was doing. It was sort of his way of dealing with things and it was very controlled. There was one suicide attempt he mentioned erm and was found hanging by a stranger. The difficulty I do have is from the documentation I've gotten from the ward is the risk history sheet...isn't very good at all so I will query that with the medical staff 'cos there's things ticked that I have no understanding as to why they're ticked, it's not confirmed why. And just for my stupidity, if someone is an informal patient in hospital, they wouldn't be subject to supervised discharge?

Team leader: No.

After a brief description of her meeting with the person, “a very long session”, Nurse 1 states that the team will provide minimal input in this case. She professes to have asked him questions about his current needs, “here and now stuff”, but reports that he gave an apparently detailed history in response. This is demonstrative of the role of the crisis team to provide short-term intervention, treating immediate problems. The person’s response to the team member’s questions has apparently conflicted with this role. She emphasises that he will be on the team’s “caseload, but it will be very short term”. The potential for crisis is at the coming weekend. It is not stated how long the man has been in hospital. Since this is his “first weekend at home”, one assumes he has been there for a significant length of time from the viewpoint of Nurse 1.

Nurse 1 goes on to narrate a past history of self-harm and substance misuse. She states that there is no apparent danger of a relapse in terms of this substance misuse, but there remains a risk of self-harm. The “self-harm” in question is thus deemed distinct from substance misuse alone. This is further apparent in her mention of a suicide attempt, though the point in the past history at which this occurred is not made clear. However, all this background information is not the only factor in the potential crisis. It is clear that an integral factor in the nurse’s concern is a lack of information; “the information is mainly from him”.

It is not clear from the nurse’s question about “supervised discharge”⁵ whether the mistake is that the man was not an informal patient, or that he should not be subject to supervised discharge. The team leader, however, provided a definite response. The discussion continues.

Nurse 1: ‘Cos they’ve ticked that.

Team leader: They’ve ticked the wrong box.

⁵ “Supervised discharge” usually occurs when a Mental Health Section has been lifted and a person is released from hospital. It is where a person’s behaviour is closely monitored by mental health professionals in order to assist in a person’s resettlement into the community and ensure that they are no longer a danger to themselves or others. Since the person referred to here was an “informal patient”, he was not detained under a Mental Health Section.

Nurse 1: And y'know, I was thinking that definitely isn't right. I'll chase that up just so we've got some sort of current stuff.

Team leader: Is it the SHO who's done?

Nurse 1: I'm guessing the duty SHO. I couldn't actually make out the signature as to who it was. (Pause.) That's very cute, isn't it?

Social worker: At least they filled it in! Well, they tried.

Nurse 1: Risk to self and others. Tick! (*Giggles.*)

Social worker: Bless!

The obvious implication of the above is that the team views the information given to them by the ward staff as inadequate. The need for "current stuff" re-emphasises the crisis team's purpose to manage the situation immediately presented. It is not their role to provide talking therapies for childhood traumas. A crisis is an immediate problem; crisis teams work with the "here and now". This is not to say that personal history is not relevant to determining the nature of the current crisis; this becomes apparent as the discussion continues.

Nurse 1: Well, they tried and I've got it, but as I say, I will chase it up as to what's what. He needs to go on the board.

Nurse 2: They probably mean supervised as in that we're gonna see him.

Nurse 1: Well <<unintelligible>> from the history. And I know he has had admission to the X wing, but as far as I can gather from the information it's

always been informal...And I'm gonna ring him tomorrow afternoon...It was very sad as well.

Student nurse: Oh yeah. He was crying. There's loads of underlying problems.

Nurse 1: He's got a significant history-

Student nurse: But it's all through to drinking. The family, y'know fallen out with him when he was drinking.

Nurse 1: Well, *(goes on to describe the man's "significant history", the inclusion of which could compromise his anonymity and is not necessary for the purpose of this discussion.)*

Nurse 1 re-iterates her intention to gather more information on the person's current situation: "what's what." This information is not to come from the person himself, but from the hospital staff who were, until recently, responsible for his care. This relates back to the factors surrounding referral to a crisis team. People experiencing acute mental distress which may be definable by professionals as a "psychiatric crisis" cannot self-refer. Though service users, their families and carers, will very often bring their problems to the attention of the health professionals, the crisis is discursively constructed by the referring body and the responding crisis team. The person referred is, to a certain extent, a collaborator in this process, in that they have drawn attention to themselves, but the way in which the crisis is framed and, by implication, subsequently treated is, for the most part, decided by professionals. (See chapter five.)

After putting forward a plan of action, "I'm gonna ring him tomorrow afternoon", Nurse 1 makes a general comment on her meeting with the person; "it was very sad as well." The student nurse, who was evidently also present, complements this comment and adds a second assessment: "loads of underlying problems". Nurse 1's reply not only refers to the person's "significant history", but to the significance *of* history. Before she can

elaborate, she is interrupted by the student nurse. The student nurse states that “drinking” is the over-riding factor, but Nurse 1 then contradicts her, giving a detailed family history. This history is self-evidently distressing, the circumstances extremely rare, and are demonstrative of Nurse 1’s view that “drinking” is not the sole factor in the man’s history which have precipitated the current potential for “crisis”.

The following exchange concludes the discussion.

Nurse 3: Are you working with (Nurse 1), (Student nurse) on him?

Student nurse: Yeah, ‘cos he’s going soon. *(Cackles.)*

Team leader: That’s what you think!

Nurse 3: And what are the risks for him?

Nurse 1: I’d say self-harm...and substance misuse.

Nurse 4: Well, that’s a type of self-harm.

Team leader: But it’s risk of relapse more than anything.

Nurse 1: It is, yes.

Team leader: That’s what he’s on the antabuse for.

Nurse 1: There’s something about controlling anger as well. There is a brief quote about him punching his ex-wife. He was arrested for that. *(Pause.)* I think that, in reality, we could’ve just been two cardboard cut-outs.

Student nurse: *Cackles.*

The student nurse was nearing the end of her placement with the team when the above exchange took place, hence her reference to the person “going soon.” However, the team leader suggests that he (service user) may in fact, be on the caseload for some time. In saying “that’s what you think”, she appears to be using her role and by implication greater experience to add an element of uncertainty to the case; an uncertainty she deems not adequately appreciated by the student nurse. The outcome of a crisis or, in this case, more specifically, the potential for a crisis is never a foregone conclusion. The intervention of a crisis team, one assumes, serves to an extent to diminish the uncertainty.

Nurse 3 asks for a list of specific risks which is given by Nurse 1 and the team leader. Nurse 4 then appears to question the distinction between self-harm and substance misuse; in her view, they are different “types” of essentially the same thing. However, the team leader provides the conclusive statement that “it’s risk of relapse more than anything”. Here, the risk in itself is not necessarily a crisis, but if the person was to “relapse”, the situation would be considered as such. Almost as a post-script, Nurse 1 adds a hitherto unmentioned history of aggression; “something about controlling anger.” Referring to the history as a predictor of a possible future, she adds another “risk” factor to the case. Again, this in itself is not a crisis, but a crisis would ensue if this possible future became an actuality. Ending the discussion, Nurse 1 provides a further reflection on her meeting with the person, suggesting that she and the student nurse had been an outlet for the man’s own story (*implied readers*). This seems the likely meaning of her reference to “cardboard cut-outs” and it relates to her earlier comments about the man telling his “life story.” Whatever the case, this comment takes the discussion away from “risk” and provides a closing comment about her experience of the person discussed.

3.5. Summary: Past Behaviour as a Predictor of Future Behaviour and Lack of Knowledge.

There are several factors in this potential crisis. The main precipitating factor is that the man has just left hospital. Exactly how long he was in hospital is not made clear. A

history of substance misuse is equated with the possibility of relapse. This is further exacerbated by his reintroduction to the outside world. As in the previous handover discussion, medication is covered briefly (antabuse), but it is not the subject of any actual debate. Unusually, medication does not appear to be a significant issue in this case. Also, there is no mention of mental illness or indeed any medical diagnosis. However, an overriding factor is the lack of knowledge the team has about the man in question. The team members do not deem the risks in the case to have been adequately explained to them. Hence, there exists the potential for a crisis hitherto unforeseen.

In the above case, there is no immediately visible and reportable crisis. Instead, it would seem that the team (and indeed, prior to this meeting, the referring hospital staff) have constructed a notion of an “immanent crisis”. This “potential crisis” is deemed as possible by the interaction between the person’s current circumstances, presentation and previous behaviour. The team thus possess a frame of reference from which to predict a possible future.

It is important to note that, while the above case illustrates what I have called a potential crisis, all crises carry the possibility that they will lead to an even bigger crisis. This is why notions of risk play a significant part in the work of these teams. If the woman described in the previous case went on to physically harm her baby, the situation would have been much more catastrophic. Likewise, if the man discussed above relapsed and harmed himself and others, the situation would evolve into a greater disaster. In other words, a crisis is not a fixed state, but a process which can either lead to crisis resolution or a bigger crisis.

4) Assessment and Treatment.

4.1. Case 3: “Totally Inappropriate.”

Similar information to that gathered in “referral” and discussed in a “handover” is also extracted in “assessments”. In this final type of interaction sequence, team members

allow the person in question to give their own account of their current problem and it can hence be argued that this gives the team member a more authentic understanding of the situation with which they are confronted. However, the information gathered also provides team members with a further justification for action, such as whether or not to treat the person, and to judge the appropriateness of the initial referral. The following fieldnote comes from an assessment attended during the first observation period with the Churchfield team. I accompanied a social worker on the initial assessment of a young woman referred to the team by her GP, apparently suicidal.

Lilly goes on to refer to the knowledge of C that she already had. "I understand that you got really depressed in 2001. What was that like?"

"I can't remember."

The referring GP has evidently passed on knowledge of the 2001 depression to the team. Lilly's question demonstrates the relevance of a person's history in ascertaining the nature of the current situation. As demonstrated in the preceding case, it is often that knowledge of previous times in which the circumstances were similar to the present (which I shall subsequently refer to as "previous episodes") is a useful tool in working with the presenting problem. C was depressed in 2001 and is apparently depressed two years later. There has evidently been a period between these times in which she hasn't been depressed. She has hence survived a previous depression. What this depression was like, and how C recovered from it, is of great interest to Lilly. If the factors which have lifted the previous depression can be identified, they can be employed to potentially speed-up recovery on this occasion. Unfortunately for Lilly, this information is not forthcoming, as C claims to be unable to remember the previous episode. Lilly subsequently resorts to a different tactic:

Lilly goes onto ask for further details about C's mood.

"What's going on at the moment, then?"

C says she doesn't sleep well, and usually stays in bed until the afternoon. She also says that she eats very little.

Lilly proceeds by asking about how C feels on a day to day basis.

"Awful. I just can't cope."

"With what?"

"Life."

Lilly has shifted the emphasis from the past to the present. She is seeking details of C's current mental state and contributory factors. The question is broad and can be seen to provide C with the opportunity to frame her answer in a way that suits her. C delivers a list of symptoms; essentially problems with eating and sleeping. From this, it appears that C is treating the discussion as essentially medical. Although Lilly had introduced herself as a mental health social worker, C presents her current problem in much the same way as might be appropriate to offer to her GP. She does not, at this stage, volunteer any precipitating factors. Lilly subsequently appears to change her tactic again, by asking how C actually *feels*. C's answer is very much suited to the *Caplanesque* definition of crisis: an inability to cope. In asking what C cannot cope with, Lilly appears to be asking for further information on factors relevant to the current episode. The answer C gives carries no specific information of particular events. Lilly once again shifts the emphasis:

Lilly asks her about what medication she is currently taking. She replies that she's on cetalipram "at the mo".

"How long have you been taking those?"

"Two weeks".

"Have you been on any thing before?"

"Something beginning with F."

"Fluoxetine?"

C gets up and moves to a ledge behind the sofa. From it, she takes two packets of pills.

“Yes. That’s them.”

She takes the pills back to her chair with her and curls up again.

Lilly’s question on medication may serve a dual purpose. Firstly, she is ascertaining that C is indeed taking medication and hence has this type of “support”. Secondly, knowledge of which specific medication may provide an indication as to C’s current mental state; what effect is the medication having? This is further apparent in Lilly’s asking how long C has been taking the medicine: is it working yet? She asks what medication C had taken before: does C have prior knowledge of how antidepressants work? It may be that, in showing Lilly her medication, C is simply clarifying the matter. It may also be that she is being defensive: this is my medication. I am not lying. Lilly, however, does not discuss medication further, and asks directly about precipitant factors:

Lilly goes onto ask about the events leading up to the depression. C says that when she about fifteen, a friend of hers, who was “like a brother” hung himself in prison. She lost her grandfather at around the same time.

The factors volunteered by C are fundamentally about relationships and bereavement. This is a frequently occurring factor in “crisis”, both as originally defined by Caplan and in the instances observed in this study.

Lilly asks C what she does with herself these days. She is not currently working. What would she like to do? She would like to do bar work but is uncomfortable around more than three people at a time. She currently lives with her Mother and sister and has a boyfriend who she sees most days. She says she has three horses, one of them in a field nearby. As C describes this, her speech becomes more

animated, though her bodily demeanour remains unchanged. Lilly continues to take notes.

Lilly has asked C to describe her current circumstances and C has described these. The exchange is straight-forward. Lilly is also seeking knowledge she can use for the assessment: are there any risks not previously identified? Is there anything happening in C's life at the moment which is contributing to her current presentation? This contrasts with Lilly's previous question on precipitant factors. Now that these past events have become known to her, Lilly returns the focus to the present situation. She then asks a key question in the assessment of C's potential risk to herself:

“Suicidal thoughts then? Tell me about those.” Lilly raises her voice as she says this, and looks C in the eyes with a wide, anticipatory smile. “Sometimes” replies C. Lilly goes onto explain that there are different types of suicidal thoughts; the type where the person “really wants to be dead” and the type where the person simply wants to “get away”. C says that she doesn't think she actually wants to die, but describes an incident in the bathroom where she thought about cutting herself, but she didn't act upon it.

Lilly goes on.

“I don't think you're in what we would call a crisis. You know, sometimes you think ‘this person's really ill’ or ‘they should be in Captain Cooke's hospital’...”

“I'm not going there.”

“Well I'm not going to take you there.”

Lilly's facial animations here may be serving to acknowledge to C that this is a sensitive question. “Suicidal thoughts” were what the referring GP had initially reported to the team. Lilly has not yet broached the subject with C. The questions she has asked C previously could be asked in many situations. A question on suicidal thoughts from a

relative stranger could rarely be asked in a situation other than a mental health assessment. C's answer, once again, contains little information. Lilly responds to this by sharing her own knowledge with C. Indeed, for the remainder of the encounter, Lilly is in an educative role.

In response to C's report on wanting to cut herself but not doing so, Lilly puts forward a tentative conclusion: "I don't think you're in what we would call a crisis". She then begins to explain to C what she means by this. Someone in crisis is apparently "really ill" or "should be in hospital." On C's assertion that she is not going to hospital, Lilly responds with what is partly a reassurance, but may in fact be something more. She will not take C to hospital because she is not in crisis. Even if she had deemed C to be in crisis, she would offer C home based treatment from the team as the preferable option. However, although C is not deemed to be in crisis, Lilly offers to arrange home based treatment of a different kind:

She goes on to ask if C would like to be visited by a CPN, perhaps on a weekly or fortnightly basis.

"What's a CPN?"

"I apologise. Community Psychiatric Nurse."

C says she doesn't want to see a CPN at the moment. Lilly offers to send her some leaflets on depression and healthy sleeping. C accepts.

On the rejection of her offer to arrange a CPN for C, Lilly offers her information. Although it is now clear that the team will not plan to see C again, Lilly will nonetheless assist her in her current situation. The PIG asserts that "learning from the crisis" is an important principle of care in crisis resolution. Despite Lilly's insistence that C is not in crisis, this offer of leaflets is an example of the application of a broader educative principle. Once C had accepted Lilly's offer, the assessment concluded:

As we make our way back to Lilly's car, she says "well, that was a totally inappropriate referral". She goes on to explain that there was no suicide risk and that C just needed to "grow up". The GP had "panicked" and referred needlessly.

4.2. Summary: Why was C not in Crisis?

Lilly's assertion that there was no suicide risk is undoubtedly the major factor in her conclusion that C is not in crisis. The crisis was perhaps that of the GP. Confronted with the possibility of suicide, they have contacted the crisis team. To Lilly, the GP has equated the expression of suicidal thoughts with the risk of actual suicide "inappropriately." But why is there no risk of suicide? It is unlikely that C's own description (that she had thoughts and didn't act on them) is the only factor in Lilly's conclusion. Aside from suicidal thoughts, there are other factors in the case which equate with the possibility of crisis; bereavement and a previous depression. However, both of these occurred two years prior to this referral. Though they are precipitating factors, they cannot be said to be immediate.

There are other factors excluding C from being in crisis. Lilly says that C needs to "grow up." Her age is thus also a significant factor. Had an older person presented in the same way, the response may have been different. Indeed, at times, Lilly seemed to speak to C as if she were a young child. C reported an apparently strong support network. Though she said she cannot cope, she also refused help any more intensive than the delivery of leaflets. The combination of all these factors has led Lilly to conclude that this was an inappropriate referral. As in the construction of crisis, there are numerous factors in play when 'crisis' is rejected as an appropriate attribution of personal situations.

4.3. Case 4: "I Want to Move."

P was a man in his thirties with a long-standing diagnosis of paranoid schizophrenia. I saw P on several occasions throughout the initial observation period with the Newchester

team. (See chapters five and six.) I first met him in a specialist unit where he had gone for “a period of respite”. I had accompanied Alex, a nurse, on this visit. The following fieldnote describes this meeting.

“Can I have some more sleeping pills?”

Alex looks at P’s notes, which he has on his knee. He tells P that he already has a lot of sleeping pills, and should stick with what he’s got.

“I’m worried that I’m going to run out. I’ve only got enough of the yellow ones left for a couple of days.”

Alex explains that the yellow ones are temazepam, and that they are only for short-term use. He says that one of the psychiatrists, “probably Dr. H” will make sure he doesn’t run out completely and get him another prescription. P says that the pills are helping and that he likes the unit.

As demonstrated in the previous examples, the discussion of psychotropic medication often features in both team discussions of cases and in meetings with service users. Unusually, the above discussion is initiated by the service user and not the mental health professional. Alex responds to P’s anxieties that he is “going to run out” with information about the pills themselves. Again, this seems to be a consistent feature of home based treatment and may be characterised as educating and hence *empowering* such users. Alex continues, however, by offering P reassurance. To do this, he refers to the expertise of a colleague who will repeat the prescription of temazepam when necessary. Alex is also demonstrating the limits of his power as a nurse, but assuring P that he is part of a team who together will ensure he receives appropriate care.

Alex continues by asking a broader question about P’s general state:

“Good. How’ve you been then, generally?” asks Alex.

“I’m sleeping better, but I’m worried about going home today.”

“Why’s that?”

“It’s where I live. I can’t sleep. There’s young-uns, it’s just young-uns, ya know, being loud.” He goes on to explain how teenagers hang around near his house on certain nights, drinking alcohol and making noise.

“Have they ever threatened you directly?”

“No. But it still scares me. I want to move.” He says he’s taken his case to the housing department of the city council. He asks if Alex can “put in a good word” for him. He smiles and says this in a nervous laugh, turning to make eye contact with me and then with Alex. Alex says he’s not sure how these things work, but it’s possible that someone in the team will be able to help. P re-emphasises how unpleasant his experiences are.

P’s worries are also the reason for his period of respite. The problem he has presented on this occasion is centred on the place he lives and how this has affected his ability to sleep. An inability to sleep appears to be a common factor in cases referred to the crisis teams and is indeed a factor in the previous cases covered.

Although P has not been directly threatened, his fear of the teenagers outside his house has led him to the point where the team has intervened. His nervous laugh and brief eye-contact may be read as embarrassment at asking a question about what the team can do for him. He does not ask if Alex *will* “put in a good word”; he asks if Alex *can* do this, if Alex is *able* to do this. This is a question about the propriety of a possible action rather than a request for its accomplishment. To a certain extent, the team has already demonstrated the professional legitimacy of his condition by arranging this period of respite for him. However, arranging a period of respite is more tangibly centred on a

person's immediate mental well-being than assisting in arranging new housing. (This is a long term process, likely to out-live the crisis.) P's apparent embarrassment suggests that he is aware that he is asking a mental health professional to do something outside of their regular line of duty. In reply, Alex once again draws on the expertise of other team members who may be able to help him in this area.

Alex responds to P's description of his circumstances:

“Well, I wouldn't like it myself and I don't have schizophrenia.” I'm surprised that Alex says this. P does not appear to react. He seems to stare. I notice how glazed his eyes are.

There is a short pause. Alex continues “so, the main thing at the moment is your worry about going home?” P nods and croaks a “yes”.

On reflection, Alex's initial comment surprised me in that he had so swiftly shifted the focus of the discussion from P's domestic circumstances to a pre-established diagnosis. Though Alex comment serves, to an extent, to empathise with P's situation, this empathy is complicated by Alex reminding P that he is not the same as him. P's response, or lack thereof, to this comment is interesting. He appears to adopt, purposefully or not, what I shall call a *medicated* expression. Intentionally or not, Alex appears to have asserted a power-relationship; mental health professional to service-user. (See chapter five.) The ensuing short pause may have been an awkward silence. Alex breaks this by checking with P that he has understood P's original worries. He then concludes by suggesting a plan of action:

“Okay, well you know you're going to have to go home eventually, but Craig did say you stay here another night if you need to”. P nods again. “I think it's been helpful, you staying here, so I think you need a bit more time before you go home. We will visit you when you go back home and Dr H will come round to sort your

medication.” Once again, P reacts by nodding and saying “yes” while seemingly staring straight ahead.

“Well, I’ll talk to Craig, just to confirm that you can stay, and I’ll phone your Mum to tell her what we’re doing. If we come and visit you tomorrow afternoon, and we’ll take you home?”

“Okay”, says P.

Once again, Alex refers to “Dr H”, the psychiatrist who will “sort” P’s medication. He also acts on P’s concerns about going home, agreeing to phone his Mother to explain that P will stay in the unit another night. Alex is hence acting as a link between P, his current situation, and his mother’s understanding of that situation. Indeed, in the PIG, it is stated that another important principle of care is “active involvement of the service user, family and carers”. This was previously illustrated in the first handover discussion described above.

4.4. Summary: Housing as a Mental Health Issue.

The central factors in the case of P are housing and mental illness. The problems he is having at home have caused deterioration in his mental state, adding sleep difficulty and worry to his schizophrenia. This is illustrated by Alex’s comment; teenagers making noise outside your house is bad enough. It is even worse when you have schizophrenia. P, however, views it slightly differently. While housing is still the main problem for him, he has the added fear of running out of sleeping pills. Hence, the crisis is constructed differently by service user and mental health professional in this example. This is often this case is crisis resolution (see chapter five) and demonstrates further the variety of factors in the construction of crisis.

There were further occasions in which housing was a central problem. During the first observation period with the Newchester team, a case recurrently emerged in handover

discussions. A man with five children was being threatened by neighbours. On one occasion, neighbours had threatened to put a petrol bomb through his letterbox. He had applied to the council to be moved with his family to a larger house in another area. However, rent arrears had diminished his eligibility for such a move.

When this case was discussed, the team leader asked “how much of this is a psychiatric crisis?” to which a nurse replied “very little”. The discussion continued and it was agreed that the man was so depressed by the situation (he had threatened to kill himself), he needed to be seen by the team. However, the team leader stated firmly that “we’re not going to be able to sort out his social problems.” When his case was next discussed, it was reported that his wife had phoned the team, reporting “suicidal behaviour.” The team leader then said “we’ve made it clear that we’re not gonna sort it out. We can’t sort it out.” However, the team decided to increase the frequency of home visits to one a day. They would work intensively with the suicidal behaviour, but were not going to “sort out” the housing. When I next heard his case discussed, he was staying, with his family, in a bed and breakfast, paid for by his sister. A nurse said “we need to think about getting out soon. He’s been prioritised for housing as much as he’s gonna be.” The implication here is that the man’s support network, his family, are assisting with the main problem (his housing) and the team can hence begin to withdraw from care. The team “need to think about getting out soon”, “getting out” meaning in this context discharging the person from their care. It was further demonstrative of the team’s general reluctance to take on this case.

It is significant that there was no reluctance on the part of the team to treat P, but in the case of the man threatened by his neighbours, the team leader was initially uncertain as to the appropriateness of their involvement. Teenagers making a noise outside may be distressing, but the threat of a petrol bomb through the letterbox instigates a more profound dread. So why were the team more reluctant to get involved in this case? The man who had been threatened had no known history of mental illness. P was known to have suffered periodic bouts of schizophrenia for much of his adult life. P’s crisis hence carried a more obvious psychiatric element. His crisis hence fitted better with the

descriptions put forward in the FIG. Also, his case further illustrates the relevance of past history in treating the “here and now”. However, the woman who had suffered an apparent psychotic breakdown after giving birth had no history of mental illness. Indeed, part of her crisis was the fact that this was the first occasion she had come to the attention of mental health services. This is where there is a distinction between psychosis (which is, by definition, difficult to understand and is exhibited in apparently irrational behaviour) and suicidal behaviour in response to an impossible situation. There is also the possibility that the team see this man as manipulative: he wants the mental health team to assist him in a housing matter. In order to strengthen his case, he is exhibiting suicidal behaviour. He is no doubt experiencing a crisis, but mental health is deemed a secondary factor. Though P asked Alex to put in a good word for his housing application, he did not push the matter in the same way. His history of schizophrenia enabled the team to construct his crisis in a way suited to their prescribed function.

5) Conclusion: The Multifaceted nature of “Crisis”.

There is a short answer to the question of what a crisis is: it is a presentation deemed by the crisis team as meriting their professional and specialised intervention. However, this leaves us in the position from which we started, since such presentations have an array of constituents. Crisis is multifaceted; a number of different factors contribute to its overall construction. It is relative to the professional affiliations of crisis team members; it is also relative in terms of the combination of constituents in each individual subject to the teams’ attention. In this chapter, I have identified some of these constituents: inability to cope, “mental illness”, risk to self and others, and related issues of life events, substance misuse, self-harm, difficulties in eating and sleeping, domestic and social circumstances, isolation. None of these factors alone appears to constitute a crisis; it is when a variety exist in the case of one individual that the team regard the person as meriting their attention.

The consideration of previous behaviour often significant in a crisis is a factor in many services whose role is to contain and manage social deviance. Cicourel (1968) observed

police officers from two American cities whose focus was on juvenile offenders. He found that an important factor in the officers' decisions as to whether to charge, caution or discharge a juvenile was how they interpreted

his (sic) past activities as revealed on the summary file card, whom he (sic) asks for advice or information about the youth from other officers, the kind of behavioral performance enacted by the juvenile during the interrogation procedures, and the parental responsiveness or lack of interest evaluated by the officer. (202.)

Crisis teams make decisions on a similar basis. Past behaviour in terms of referral information, information from other team members and other mental health professionals, a person's presentation in assessments and home visits and social and domestic circumstances are all factors that come in play when a crisis is identified, managed, and (perhaps) resolved. However, there are no universal factors in a crisis, there are just certain commonalities. Like Wittgenstein's (1972:67) rope, there is no continuous single thread that runs throughout, but only a series of overlapping threads linked together in and through its course. Though "severe mental illness" is a commonly occurring facet, and is indeed the facet emphasised most strongly by the PIG, there are occasions when it is not apparent.

To the teams studied, and indeed the P.I.G, crisis is a temporary state; it is present in the "here and now". It is also a state which requires management; it has the potential to evolve into a crisis of greater severity. Psychoanalyst Barry Richards (1989:1) described this state further:

...a 'crisis' is not simply a state of imminent mental collapse but is a psychic configuration in which something continually needs to be done, and is being done, in order to ward off a collapse; an immanence rather than imminence.

Though Richards is discussing the internal defence mechanisms employed by individuals in a state of "imminent mental collapse", this definition also fits the work of the crisis

teams in their construction and subsequent treatment of crisis. In their day to day work, they are doing something which “continually needs to be done.” A crisis is constructed when it is deemed by team members that both an individual’s internal and external world have become difficult to bear, if not unbearable. The constituents of both these worlds in terms of the definitions put forward by the teams and service users are what this chapter has sought to present.

Chapter Four: Teamworking.

1) Introduction: Multidisciplinary Teamworking and its Significance.

1.1. Chapter Overview.

This chapter seeks to demystify the term “multidisciplinary teamworking”. It begins from the premise that team working is an achievement; that it does not exist by organizational fiat but in and through a variety of practices through which the work of a crisis resolution team is accomplished under specific circumstances. I shall consider the role of key interactions such as “handovers” in the accomplishment of teamwork. I use a dramaturgical model to describe teams, considering how team members “perform” to each other and to outsiders, recreating and asserting team processes. As much of a team member’s work is conducted outside the direct presence of others, I will also describe how this work is accomplished and subsequently shared with others.

I will suggest that there are also many “unofficial” aspects of team working, such as humour, play and leisure activities, all of which may be considered as devices “used by individuals for coping with uncertainty, exploring ambiguous situations, releasing tensions or distancing unpleasantness” (Linstead 1988:123). I will argue that these are integral to teamworking and present examples of how humour is employed by team members in various aspects of their work. Following this, I examine hierarchy and leadership within the two teams studied. Finally, I consider how these all of these factors are related, and consider how a team becomes a team on a variety of levels. I begin, however, by presenting a more general definition of multidisciplinary teams.

1.2. Definitions.

It is generally understood that crisis resolution teams are multidisciplinary; that is, they are made up of a number of individuals from a variety of disciplines within the field of

mental health care. Nurses, social workers, support workers and psychiatrists come together in co-operation in order to achieve a common end. Multidisciplinary teams are common throughout the National Health Service. The rationale for the existence of a multidisciplinary team is that each discipline is able to offer an interpretation of the situation observed and suggest strategies to achieve specific goals. A multidisciplinary team can hence conduct *multidisciplinary* assessments and compile *multidisciplinary* casenotes. The PIG states that a crisis resolution team should be able to “provide immediate *multidisciplinary*, community based treatment” (12 *Italics my own*). It states that, in the planning of home-based treatment, a crisis resolution service should adopt a “team approach” and engage in “team decision making”. It does not, however, provide a description of multidisciplinary teamworking. Thus, by implication, the PIG presupposes the meaning of “team” and “teamworking”. It also assumes that roles within a team are clearly defined, with all those fulfilling them united in a common purpose. However, to assume that the nurses do the nursing, the social workers the social work, the support workers the support work and the psychiatrists psychiatry is to misunderstand the nature of these teams; flexibility in terms of professional role and duties are important to their functioning. To achieve this end requires both co-operation and an understanding of the ultimate purpose of the team’s work.

In fact, “Multidisciplinary teamworking” is a somewhat problematic phrase. It regularly appears in industrial self-promotional literature: “*we are/have a multidisciplinary team*”. An example of this is in the National Service Framework for Mental Health (Department of Health 1999) in which the phrase “multidisciplinary team” appears on four occasions (41, 133, 133, 135), yet on none of these occasions does it describe *what such teams are*. The actual meaning of teamworking may hence seem elusive, particularly if prefaced with “multidisciplinary”. However, good definitions of multidisciplinary teams do exist. Onyett (2003:3) described the contrasting definitions of Ovretveit (1993:9) and Opie (1997:263). Ovretveit’s definition was broad: “a group of practitioners with different professional training, employed by more than one agency, who meet regularly to coordinate their work providing services to one or more clients in a defined area”. This definition is problematic. There is no specific reason why members of a multidisciplinary

team should be employed by more than one agency; though such may sometimes be the case, it should not be regarded as a prerequisite. Opie limited this definition further when she stated that what Ovretveit had defined was merely “inter-disciplinary working”: the practitioners may be meeting regularly, but may still work primarily within their own field. This is not the same as consistently working together. To Opie, it was necessary for professionals to “work parallel to each other, their primary objective being that of coordination”. Working parallel may be understood as working with the same things at the same time. This relates back to the rationale for the existence of a multidisciplinary team, defined above.

By virtue of the fact that the teams comprise of a number of individuals sharing information, one assumes that crisis resolution cannot be conducted (or achieved) by one person alone. Even when a lone team member is visiting a service user, they do so with the knowledge and consultation of the team as a whole, as I shall demonstrate below. Hence, crisis resolution is a “team” activity. However, as previously mentioned, these definitions are no more than simplified and generalised descriptions. Any analysis of the complexities of teamworking, in terms of this or any group of people professing to be a team, must consider *how* a team works.

1.3. Organizationally Recognised Teams.

Teams are often part of larger organizations, as is the case with the two teams studied. Shea and Guzzo (1987:327) defined a team as:

...three or more people employed by an organization who see themselves as a group, are seen by others in the organization as a group and who depend on each other for resources...to accomplish a task or set of tasks.

Organizations differ from teams in that members will not necessarily work together. A team often operates in the service of an organization. In the given context, a mental health NHS Trust is the employing organization which recognises certain groups within itself as

crisis teams. Both the organization and the team share the purpose of providing mental health care. Whereas the organization provides a vast array of different types of care, the teams in question provide a specific service of crisis resolution. While all community mental teams carry out crisis resolution, these teams are put together by the organization to carry out this function alone. Strauss *et al* (1985:266) stated that

Teamwork...is carried out within a *thick context of organizational possibilities, constraints and contingencies...within a larger matrix of linked organizations or organizational settings.* (Original emphasis.)

Hence, the intent and purpose of crisis teams is organizationally prescribed. The actual *carrying out* of this intent and purpose is dependent on the people who constitute these bodies and make them into teams. The mental health trust and the crisis team are dependent on each other for service delivery and resources. The identification of such resources is important to the description and practice of teamwork. Such resources include emotional support in stressful work, medicines and prescriptions, and expertise, such as medical knowledge and psycho-social intervention skills (see chapter six). However, the means through which some of these resources are shared may be more subtle. Clinical supervision is given to team members and the business meeting functions as an official forum where team members can arrange and discuss support in their work. However, it may also be that team members are dependent on the support of the team as a whole when engaging in all aspects of their work.

1.4. Teamworking as an Accomplishment.

An understanding of how team working is carried out- how teams work- is integral to the study of crisis resolution. Department of Health guidelines (2001) state the goal of crisis resolution is to be accomplished by a team; there is not one psychiatrist or social worker alone working towards this end. As crisis resolution is an accomplishment, so is the teamworking through which it is delivered. The two are hence inextricably linked.

Griffiths (1997) studied group identity in two community mental health teams, chiefly in terms of the relationship between the teams' psychiatrists and the other professionals (nurses and social workers). For Griffiths

Teamworking is...an ongoing practical accomplishment: it emerges out of the everyday interactions and micro-political struggles of those charged with making joint work a reality. (60.)

Griffiths thus concluded that there are two aspects to the accomplishment of teamwork; "everyday interactions" and "micro-political struggles". Hence, teamwork is accomplished through both conflict and co-operation. Without co-operation, team members at odds would fail to work effectively as a team. Without a degree of conflict, there would be no debate and service users may find their choices restricted by a stagnant and dogmatic service. In short, for the accomplishment of teamwork and "joint working" to become a reality, the micro-processes within the teams must constantly evolve.

Three dimensions of a team were defined by Ovretveit: structure, process and integration. These are described by Onyett (2003:3) in the following quotation:

Structure refers to the composition of a team and how it is managed. *Process* describes how the team receives referrals and works with service users over time. *Integration* refers to the 'closeness' of working between members. (Original emphasis.)

These concepts of "structure", "process" and "integration" demonstrate further that a team does not exist simply by virtue of its organizational recognition. A team becomes such in and through the accomplishment of these three elements. In each team, the *structure* is similar; each is composed of social workers, nurses, support workers, psychiatrists and led by a senior nurse. (See chapter six.) The *process*, however, differs between the two. In an organizational sense, the hours of working are different, though the referrals will come from the same agencies (accident and emergency departments,

general practitioners etc). However, there may also be more subtle elements to the *process*, which are addressed as this chapter proceeds.

Integration is the most significant area in relation to the study of teamworking. It is how this “‘closeness’ of working between members” manifests in the day-to-day running of the crisis teams. A team is a collection of individuals who *integrate* to become a team. However, such integration is subtle in that the team engage in a variety of different tasks and different sub-teams are composed for each one at each time. The establishment of a team is hence not *fixed*, but is constantly re-accomplished by the day to day actions of its members. An important way in which teams maintain themselves as such is through their *authorship* of their work. Teams are the authors of the knowledge that they generate in relation to the cases they describe. For Opie (1997: Section 4.4.:21⁶)

The team narrative is the result of a recursive and interactive process which enables the team to explore the possibilities and constraints made available to the team through its different constituent knowledge bases.

The team narrative is integral to the accomplishment of teamwork. It is a collaborative effort on the part of team members to construct a framework within which they can continue to conduct their work. The construction of this narrative is the combined effort of “different constituent knowledge bases” and the multidisciplinary element of teamworking may offer a series of alternative endings and sub-plots to the story of which the teams are authors. On the one hand, this may complicate matters and make decisions difficult, but the desired outcome is the attainment of a rich array of detail on the case and hence a variety of possibilities for action.

The discussion of cases, particularly in handovers (see section 5.2. below), is a central activity of mental health teams generally. Individual team members do not receive the

¹ As this paper appears on-line, the pages are not numbered in the original text. However, if saved as a word document, text size 12, the quotation appears on this page. I have hence cited both section and (imposed) page number.

relevant information, make a decision as to the action required and conduct such action on a lone basis. Instead, team members work collaboratively to construct a narrative around the case. *How* team members pass on and discuss information and decide upon a particular course of action is thus central to any consideration of the accomplishment of teamworking. Agreements and disagreements, the usage of contrasting professional terminologies, and the whole interactive process leading to the final decision, who makes this decision and who accepts it, are all factors in team narratives.

2) Defining “Teams”: A Dramaturgical Model.

2.1. The Theatrical Metaphor: “Performances”, “Teams” and “Regions”.

In the dramaturgical tradition of sociological analysis (Ball 1967, Harper 1987, Sinclair 1997), co-operative “teamwork” has been understood as ‘performative’ in character. This particular tradition is derived from the work of Erving Goffman (see chapter two). It is, at least in part, through co-operation in performing that a collection of individuals become a team. Goffman (1974:26-27) defined a performance in the following terms:

A ‘performance’ may be defined as all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants. Taking a particular participant and his performances as a basic point of reference, we may refer to those who contribute the other performances as the audience, observers, or co-participants.

A performance is hence not a solitary act; it is dependent on its audience, who by virtue of their presence at the performance and receipt of it are co-participants. This is particularly relevant in terms of the accomplishment of teamwork.

In the first chapter of *The Presentation of the Self in Everyday Life* (1959, 1974), Goffman defined the multifaceted and often interrelated aspects of “performances”: belief in the part one is playing, front, dramatic realization, idealization, maintenance of

expressive control, misrepresentation, mystification and reality and contrivance. The “belief in the part one is playing” is essentially a two way process; the character portrayed is to be “believed” by both the performer and the audience (1974:28). It may hence be said to be the *foundation* for all performances in everyday life. “Front” is defined as “the expressive equipment of a standard kind intentionally or unwittingly employed by the individual during his (*sic*) performance” (32). In other words, “front” is the employment of expressive “props” or “costumes” by the performer. It may be manifest in such things as facial expression, gesticulation, and the wearing of suits and ties. “Dramatic realisation” is essentially *how the performer makes the performance interesting and engaging to the audience*. “(I)f the individual’s activity is to become significant to others, he must mobilize his activity so that it will express *during the interaction* what he wishes to convey.” (40. Original emphasis.) It is hence the “dramatisation” of the performance and is inextricably linked to “belief in the part one is playing” and “front”. For example, one engaged in intense discussion, “believing” in the importance of their contribution, may employ a “front” (perhaps wide-eyed, rapidly gesticulated) in order convey such intensity for the “dramatic realisation” of such importance.

Goffman continued with a definition of “idealization”; this is essentially the performer’s presentation of “an idealized view of the situation” (44.) Such “idealization” reflects the values of the society in question. In relation to this study, a team member may present “an idealized view” of their (arguably) therapeutic relationship with the service user; they perform as professionals delivering a service for the benefit of the user in question. “Idealization”, however, requires at least a degree of continual and focussed effort, in much the same way as “belief”, “front”, and “dramatic realisation”. Goffman thus proceeded to describe at length the “maintenance of expressive control”:

...we must be prepared to see that the impression of reality fostered by a performance is a delicate, fragile thing that can be shattered by very minor mishaps. (63.)



An example of the application of such “maintenance” would be when a mental health professional momentarily forgets the boundaries of the therapeutic relationship and lapses into being either too friendly or too authoritarian. On such an occasion, it would be necessary for them to re-emphasise the “belief in the part one is playing” and to re-articulate the appropriate “front”, “dramatic realisation” and “idealization”.

It is also the case that the “maintenance of expressive control” is employed in order to avoid misunderstanding of what the performer is trying to convey. For example, a team member may wish to review a service user’s medication, and the service user may interpret this as an attempt to sedate them and make them easier to control rather than to improve their mental health. Whether this would be an apt interpretation of such an expressed wish is not the point here; the point is rather that it would not be the *intended* or desired interpretation on the part of the performer. As performers may be potentially misunderstood, they may also choose to mislead. Hence, Goffman proceeded to talk of “misrepresentation” (65). An example of this is again to be found in the afore-defined scenario, only this time the team member *does* wish to sedate and control but frames this wish as a desire to improve well-being, employing the performance devises previously described.

The hypothetical scenario described above demonstrates a certain power-relationship between the performer and the audience. For the creation of such a relationship, a performance will in some cases involve a certain distancing between the performer and the audience. Such distancing may result in a sense of mystery and awe regarding the performer on the part of the audience. Goffman called this distancing “mystification” (74). Examples of this are not confined to interactions between team members and service users (where they are perhaps most obvious), but may also be found in those between senior and regular team members. A consultant psychiatrist may adopt a certain “front” etc in order to simultaneously distance themselves from and command the respect of an SHO. The performer may do this through the withholding of personal information and the wearing of more elaborate and expensive clothing, while at the same time imparting their greater knowledge of the shared subject to the audience. This “mystification” may often

be, at least in part, contrived. The performer is a “mystery” since their “reality” is not known to the audience. This links to the final aspects of performance identified by Goffman: “reality and contrivance”.

The phrase “reality and contrivance” encompasses the contrast between the performer’s identity as understood by the performer themselves, the supposed “real” person, and the “contrived” projection of an idealized, possibly simplified and potentially mystifying performer identity to an applicable audience. As Goffman himself stated:

In our own Anglo-American culture there seem to be two commonsense models according to which we formulate our conceptions of behaviour: the real, sincere, or honest performance; and the false one that thorough fabricators assemble for us, whether meant to be taken unseriously, as in the work of stage actors, or seriously as in the work of confidence men. (76-77.)

Hence, “reality and contrivance” need not be simply synonymous with sincerity and insincerity. A “contrived” performance may simply be one in which one’s talents are flaunted and one’s flaws kept hidden, such as in a job interview. It may also be an “over-performance” where the performer exaggerates their “real” identity. This may be done humorously to the audience’s knowledge (such as in self-deprecating banter), or seriously in an attempt to impress (such as in the advertising or “selling” of a service to which the performer is attached).

All these interrelated aspects of performances may appear as constitutive of a relationship between a performer and an audience. However, a performance can be given by a collective as well as an individual. In the second chapter of *The Presentation of the Self in Everyday life*, Goffman looked at the role of performances in the making of teams:

...we often find that the personal front of the performer is employed not so much because it allows him to present himself as he would like to appear but because his appearance and manner can do something for a scene of wider scope. (83.)

A team member will perform as part of a team; thus accomplishing “something for a scene of wider scope”. Performances and teams are thus inextricably linked. In the context of teams, then, performances are negotiated by members. They are given to convey not merely an individualised “self”, but that “self” in the context of that of which the performer is a part. An understanding of performance is hence integral to an understanding of teams.

Manning (1992:42) further summarised Goffman’s approach to understanding teams. Teams “share both risk and discreditable information in a manner comparable to a secret society...They perform in “front regions” –spaces from which they are seen by different publics.” A team is thus a distinct group of people who form a specialist, potentially closed, *micro-society*. They may perform collectively to these different publics, or alone representing this *micro-society*. Hence, on the one hand, there are the different publics who the team and its members perform to as a collective distinct from that audience. On the other, as stated above, they perform to each other. As Manning, citing Goffman, continued:

Teams rehearse, relax and retreat to “back regions” –areas where front-region performances are “knowingly contradicted as a matter of course.” (Goffman 1959:110-14.)

Goffman (1974:109) defined a “region” as “any place that is bounded to some degree by barriers to perception.” In the context of crisis teams, there are areas where team members work with one another (back regions) and areas where they work, often alone, with service users and, sometimes, as presenters, sellers, and advertisers of their services to other professionals or even the general public (front reasons). Front region and back region performances are distinct by virtue of the different audience and co-participants. If the audience/co-participant is not a team member, the performance to which they will be party is likely to polite and stylised. If the audience/co-participant is recognised by the

performer as a team member, the performance may be less stylised, but by no means less structured as a rule.

The world in which team members operate was likened by Goffman to a “stage”. “Front-stage” and “back-stage” are thus effectively synonymous with the aforementioned front and back “regions”. As previously stated, there are various aspects of “being a team”. There is the officially sanctioned “teamwork” and the unofficial day-to-day interactions between team members. This dramaturgical model of official and unofficial frontstage and backstage in the social world was adapted by Sinclair (1997:16) in his study of training doctors. Sinclair devised a table presenting the aspects of the trainee doctors’ work which constituted each different “stage”. Here, I apply a similar table in relation to crisis resolution teams, summarised in the table below (*Fig. 1*). The nature of each “stage” is explicated as the chapter continues.

2.2. Teams Within a Team.

As there are different aspects of teamworking, there are also different types of a team. Membership of a particular team depends on the type of activity undertaken. A majority of team members are involved in all four teams at different times, yet the different teams will exist simultaneously. Hence, there is a formation of official frontstage, official backstage, unofficial frontstage and unofficial backstage teams. A simple example of this is the role of secretaries and receptionists within the two teams studied; together, they are an officially sanctioned backstage team.

Secretaries had no duties as clinicians, but were nonetheless important to the team’s functioning in a variety of ways. They also had a limited degree of dealings with service users directly, if one was to contact the team by telephone or, in the case of the Newchester team, visit the team base. Secretaries were therefore expected by the team members to have a degree of sensitivity regarding mental health issues. However, secretaries were not present in clinical discussions such as handovers. While they took notes in other meetings, they contributed only if administrative matters were discussed.

Here, the distinction between the organizationally instigated establishment of the team and the dramaturgical process in which teamwork is accomplished comes into play. Secretaries and receptionists are part of the organizational framework of a team, distinct from the clinicians. However, in carrying out their day-to-day duties to the rest of the team, they are important “stage hands”.

Figure 1 one overleaf summarises the teams’ activities on each “stage”.

Fig 1. The Official and Unofficial Frontstage and Backstage in Crisis Resolution.

	OFFICIAL.	UNOFFICIAL.
FRONTSTAGE.	<p>Assessments.</p> <p>Home visits.</p> <p>Working with Users and Carers (offering support and mental health education).</p> <p>Contacts <i>from</i> other professional agencies such as GPs for the purpose of incoming referral and essential case discussion.</p> <p>Contacts <i>to</i> other professional agencies for the purpose of outgoing referral and essential case discussion. (GPs, CMHTs, A+E, the Police.)</p>	<p>Contacts <i>from</i> other professional agencies such as GPs for purposes other than referral and essential case discussion.</p> <p>Contacts <i>to</i> other professional agencies for purposes other than referral and essential case discussion. (GPs, CMHTs, A+E, the Police.)</p> <p>Performing to visitors.</p>
BACKSTAGE.	<p>Team meetings and discussions.</p> <p>Handovers.</p> <p>Compiling case notes.</p> <p>Writing prescriptions.</p> <p>Training.</p>	<p>Humour and play.</p> <p>Leisure activities.</p> <p>Emotional support to troubled colleagues.</p>

3) The Official Frontstage.

3.1. Definition.

The official frontstage of crisis resolution is the observable and accountable practice (officially sanctioned by the mental health trust) of the crisis resolution team: resolving mental health crisis. Hence, initial assessments and the subsequent home treatment of people in acute mental distress take place on the official frontstage. This relates to a description of the crisis team's purpose stated in the PIG that the team should "ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible".

Also taking place on the official frontstage is the receiving, passing on and discussing of cases. This is where the team's relationship with other professional agencies is important. Referral is the official receipt of a person from another agency. Not all referrals are eventually taken on for home treatment, as described in chapter three. However, this is beside the point here. In the discussion between the referring agency and the receiving team member, the team is engaging in an officially sanctioned and hence official frontstage activity; an activity essential to its working as a crisis team. The same dynamic is in place when the team refer a person onwards, that is when the crisis is apparently resolved and another agency is to be responsible for the person's care.

To be discharged from the crisis team is often to be referred to another professional agency such as a CMHT, or for hospital admission. It is very rare for a person to have no further contact with mental health services immediately after the involvement of a crisis team. As stated in the PIG, a crisis team should "remain involved with the client until the crisis has resolved and the service user is linked to ongoing care."

3.2. *“Essential Case Discussion.”*

What I call “essential case discussion” is related to referral as an officially sanctioned activity of the team. It does not happen in every case, but on occasion the team may have cause to make contact with another agency familiar with the person in question. This can happen for a number of reasons: the team may wish to refer the person onward to another service, for example, a specialist drug and alcohol service. It is possible that the service in question may have reasons for not accepting this person (the person is perceived by them as a trouble-maker, for example, or that the service is at its maximum capacity and unable to accept new cases). Also, the team may wish for further information on a person from a service previously involved or currently involved in their care. They may want a more comprehensive medical history from a GP than that provided in the initial referral in order to ascertain an appropriate psychotropic medication compatible with a person’s physical condition. Most of these discussions take place on the telephone, so just one side of the process is observable. However, there are exceptions to this, an example of which is presented below.

The following fieldnote describes a visit to a service user in temporary respite accommodation that took place early in my first placement with the Newchester team.

We arrive outside a large Georgian building. Alex explains that this is a short-stay residential unit, where people may go for a “period of respite”. It does not have the ethos of a psychiatric hospital. Residents are supposed to cook for themselves etc. Medication is used at the unit, but it is not regimented in the same way as a conventional hospital. It is run by social services.

Alex goes on to describe the next person we are going to see. Again, he begins with name, age, gender. He goes onto to say that the person, P, suffers from paranoid schizophrenia. He had cut his arms a few days previously, but the cuts “were superficial” (whatever that means). He then explains that he needs to discuss P with the unit’s staff before we see him. P has now been in the unit for

the three nights that the unit staff agreed to accommodate him. Either an extension to his stay needs to be negotiated, or arrangements need to be made for taking him home.

We ring a doorbell and the door is opened for us by a large man. Alex says “Hi, I’m Alex and this is George. We’re here to see P”. “All right” says the man and steps back to let us in.

A small man with facial piercings answers Alex’s knock. “Hiya. How ya doin?” he says to Alex, familiarly.

“Alright. Just come to see P. This is George, a PhD student. George, this is Craig”.

Craig shakes my hand firmly and nods his head. “Alright George”.

“Alright. Good to meet you.” There is something very down-to-earth about this man.

“How’s he doin then?”

“Alright. He’s just very depressed I think. He’s been waiting for you.”

“I understand he’s at the end of his stay?”

“Yes, but if he needs another night, he needs another night.”

An interesting element in this friendly exchange is that Craig’s impression of P appears to contrast with that suggested in Alex’s earlier remarks. Alex framed P’s underlying problem as paranoid schizophrenia, while Craig thinks that he’s just “very depressed”. This is not to say that the two conditions cannot co-exist, rather that the emphasis is different. Craig, who has been party to P over the last two days, emphasizes his current

presentation of mood. Alex, who read his medical notes in the car before entering the unit, had spoken of P's psychiatric diagnosis. Craig thus gives Alex a potentially useful insight into P's current presentation.

Alex gave the impression that an extension to P's stay would have to be negotiated were we not to take P home. The statement "I understand he's at the end of his stay" is a question which does not look like a question. He is essentially asking Craig which course of action Craig thinks should be taken; is he to be taken home by the team today, or remain in the care of the residential service? Craig appears to have already decided that the latter course of action is appropriate; "if he needs another night, he needs another night." Hence, the negotiation occurs as a brief exchange, which takes place in P's absence.

What is essentially happening is that the needs of a particular service user are being discussed by two clinicians who are members of two different organizationally recognized teams. Although Alex and Craig are working together, they are representing their respective organizations. They are working collaboratively, in "partnership", in relation to the man discussed. They are performing to each other and to me, the observer. Hence, this conversation is both a front-stage performance, in that it is an essential case discussion, and a back-stage performance, in that it is in part a preparation, or rehearsal for the meeting with P. It is an example of *inter-disciplinary* teamworking. What is happening is not only essential case discussion, but the setting up of the officially sanctioned frontstage performance.

3.3. Frontstage Solitary Working: An Attempted Home Visit.

In 2003, I attended a home visit with one of the nurses in the Churchfield team. The following fieldnotes describes what happened.

A little later, I go out with James to see D. On the way to her house, I ask James about what he is likely to do at this visit. He asks me about what I have picked-up

from her, as he has not met her before. I explain that as a researcher, I can't really judge, but that she seemed anxious. I tell him that I thought she may have thought she was going to be sectioned. He says that, from what he knows of the case, it is likely that she will be handed over to the local CPN very quickly. "I know she's resisted this before, but things are different now."

We arrive at D's house and James knocks on the door. We wait. No answer. James knocks again.

"We've definitely got the right house?" I ask.

"Yeah."

He knocks for a third time. He looks a little frustrated. I stand behind him.

"Does this happen a lot?"

"Quite a lot. Yeah."

He knocks on the window this time. There is still no answer. He writes something on a card and puts it through the letter-box. We leave.

On the return journey, James asks me if I think we have any reason to be particularly concerned about D's absence (as I had been present at her assessment). I tell him of the worry she had expressed on Monday regarding her job and her driving license. James tells me that nothing has yet been clarified in relation to this. I ask him what he is going to do now. He says he hopes she'll phone later today and that another visit can be arranged either for this afternoon or the following day. I ask if he will feed-back the events of this morning to the team. He says he only does that if he thinks there are serious risks. On this occasion, he does not.

After the same outcome the following day, D was discharged from the care of the team.

What is interesting about this occurrence is that James did not inform the team of D's absence. Since her previous behaviour was known to him, her current behaviour was not deemed out of character. Her absence was not interpreted as indicating an increase in risk and hence it was unnecessary for other team members to be told. The case was thus to be discussed in the next handover.

One gets the impression that the attempted home visit to D was a very solitary experience for James. He seemed to ask me, though a mere observer, for advice: is there any reason to be concerned by D's absence. In doing this, he seemed to be both playing on the fact that I had met D before and making up for the absence of another team member, with whom he could have had an official backstage clinical discussion. However, though he was not able to physically perform as a team member to a service user, he was nonetheless representing the team and carrying out his official frontstage duty. He pushed a card through D's letter box, saying that the team had tried to see her and that she should contact them. In this way he creates the potential for the re-run of a missed performance.

3.4. Accomplishing Teamwork on the Official Frontstage.

Ironically, perhaps, it is the official frontstage of crisis work which looks least like teamworking. No more than two team members will visit at service user at the same time. Conversations regarding incoming and out-going referrals will usually take place between two individuals. As this is often done over the phone, only one of these individuals is a crisis team member. On occasion where face-to-face meetings are required for an interagency discussion of a case, it is possible that two team members will attend. Hence, the official frontstage of crisis resolution is essentially either solitary work or a partnership between two team members. It is in backstage activity where teamworking is most obvious. However, the performance of team membership does not depend upon the presence of other team members. All official frontstage work is carried out after a degree of discussion with all team members present in the most recent handover. This is where impressions and ideas are shared and decisions made. It is hence solitary in its execution, not in its planning. Lone team members performing on the

official frontstage are representatives of the team as a whole, and by virtue of this, are carrying the *will* of the team.

In general terms, home visits and essential case discussions are occasions when members are representing their teams in their official capacity. Official frontstage performances are given by particular team members on behalf of the teams as a whole. Though a less obvious factor in the accomplishment of team working than discussions taking place on the official backstage, the official backstage could not exist without the planning and carrying out of official frontstage work, for this is its key purpose.

4) The Unofficial Frontstage.

4.1. Definition.

The boundary between the official frontstage and the unofficial frontstage is complex. Sinclair (1997:16) defined the unofficial frontstage of medical training as those activities that “also fall within the institution, even though they are not part of the school’s official function to produce doctors”. He gives the examples of the school rugby team and amateur dramatics society. Neither crisis team indulged in unofficial frontstage activities as obvious as this. However, they did perform to outsiders as crisis team members without conducting their officially sanctioned purpose of resolving mental health crisis. It is in these activities that I think of the unofficial frontstage. The boundary is complex because team performances to outsiders, even when not directly engaged in resolving crisis, may relate to their work as a crisis team. Hence, promotional public performances, in which team members address conferences about their work, are not obvious unofficial frontstage activities in that they are directly related to their officially sanctioned purpose. Such performances are undoubtedly important to the team and its continuing existence in that they invite the support of other groups within the health service, whether they are funding bodies or primary care services with whom they have to work. However, they are not absolutely essential to the teams running on a day-to-day basis. A crisis team could

not function on a daily basis without people in crisis, but, with the right support and funding, could continue indefinitely without justifying themselves to other agencies.

To simplify, the unofficial frontstage is where the teams perform to a public other than service users and their informal carers. These frontstage performances may be “official” in the sense that they are organizationally sanctioned, but they are “unofficial” in the sense that they are not given *for* the regular purpose *to* the regular audience. In relation to Sinclair’s definition, these performances do “fall within the institution” if a crisis team is to be understood as an institution without walls. They are not directly, however, part of the teams “official function” to treat those experiencing mental health crises.

In this section, I concentrate on how team members present themselves to outsiders who are neither service users nor those directly involved in essential case discussion. I begin by examining how team members will perform to visitors.

4.2. Visitors.

During my time with the teams, I was present while they received various visitors; students (of medicine, nursing and social work), and members of other community mental health teams. The nature of the visitor and the purpose of the visit determined the “performance” that the visitor was given. Essentially, visitors may be divided into two types. While the purpose of all visitors is to observe and learn, some are there to participate more than scrutinise, others to scrutinise more than participate. Medical and nursing students, who fit the former description, are treated to a lighter side of the team dynamic with the team’s regular practitioners; nurses, social workers, support workers and junior doctors. Visitors from other mental health teams, those fitting the latter description, including those from other health service trusts seeking to set up their own crisis team, received a more formal promotion of the team from those higher in the team’s hierarchy.

Team promotion is an important part of the unofficial frontstage of teamworking. This was particularly evident on an occasion when the leader of the Newchester team received a visitor who wished to know more about crisis teams. I was sitting in the main room used by the team, where the white boards adorned the walls and the handovers took place. The team leader strode in, swiftly and steadily, back and neck straight with his hands on his hips, his visitor a couple of paces behind. Without turning to face his visitor, he spoke.

On these boards, we have sixty-five people, most of who would be in hospital if it wasn't for us.

This assertion was confidently expressed through a mixture of body language and precision of words and the delivery of words. However, this was not simply *his* performance. In referring to “we” and “us”, the credit is given to the team of which he is a part. In his role as leader, he is summarising the achievements of the whole team in a confident performance to an outside audience. The fact that he does not turn to face her as he makes the above assertion suggests that he is confident to the point of not feeling the need to use eye-contact to carry conviction.

4.3. Introductions.

How team members introduce themselves is a significant reflection of professional identity as both team members and members of particular disciplines. Introductions are presentations for the purpose of immediate impressions. In both teams, members would refer to each other by first names; in the larger Newchester team, as some first names were shared by more than one member, surnames or, more commonly, the first letter of the surname would be added, e.g. “I’ll ask John S what John B said”. However, in the Newchester team, the doctors were as likely to be referred to as and addressed by their surname and title as by their first name. They were also more likely to introduce themselves to service users as a doctor. Nurses, social workers and support workers would more often venture their first names before stating their role, if they indeed stated their role at all.

In the Newchester team, the SHOs (Senior House Officers) were replaced every six months. I therefore met a number of different SHOs over the course of the observation periods. When introducing themselves to me, two of them gave their names, swiftly adding “I’m one of the doctors”. This claim to professional status contrasted with the introductions given by other team members. On an occasion when a visitor was present at the start of the afternoon handover, all the team members introduced themselves. A nurse described himself as a “CAT⁷ clinician”, leaving his actual profession open to guess work. In doing this, he made his status as part of the crisis team more important than his status as a psychiatric nurse. He also left open the possibility that he may be a doctor or psychologist. He therefore limited the conclusions that the visitor could make as to his professional status. Hence, the nature of an introduction can reflect a person’s perception of their primary role, either as a team member, or as a member of a particular profession.

4.4. Accomplishing Teamwork on the Unofficial Frontstage.

In accommodating visitors, the team were performing to a different audience: students were not treated in the same way as service users. In their introductions, team members may perform as either part of the team, or as part of their professional discipline. However, “one of the doctors” is an introduction which still insinuates membership of a wider organization, in this case the crisis team. If the person said they were simply “a doctor”, they could just as easily be a GP who is not a team member.

Like the official frontstage, the unofficial frontstage is where team members project team membership onto an outside audience. Where it differs from the official frontstage is that these projections are not essential parts of the team’s day-to-day “officially sanctioned” practice. In terms of the accomplishment of teamworking, team members often have more resources available to them on the unofficial frontstage; the physical presence of other team members.

⁷ Crisis Assessment and Treatment.

5) The Official Backstage.

5.1. Definition.

Unlike the unofficial frontstage, the activities undertaken in the official backstage of crisis work are essential for the day-to-day running of the team. It is where the activities performed on the official frontstage are prepared, or even rehearsed. It is also where official paperwork is completed. The handovers conducted by the crisis teams on a daily basis form the bulk of such activity. The handover is where current and impending cases are discussed and decisions about them made. It may be that the team arrange to discharge a person from their care or prescribe a different medication for their condition. Since such decisions have far-reaching implications for a person's care, the handover is more than a rehearsal; it is where significant parts of the frontstage performance are *written*. It is also where the performers and the audience are one and the same and such roles will constantly fluctuate. In official business meetings, preparations for unofficial frontstage activities may also be planned. The team may discuss impending visitors, for example, and how best to accommodate them.

5.2. The Handover.

The organization of most handovers is essentially identical in each team. In both teams, new referrals are distinguished from current patients. New referrals are presented, usually by the team member who is in charge of new referrals that day. (This is the person who is the triage staff member or is the coordinator). Using the white board (that can be seen by all those present) and medical notes (seen only by the reader), the team member describes the case in hand. For new referrals, this process begins with details of the circumstances of the referral itself (who spoke to whom and when) and why the referrer views this person as a case for the crisis team. This links to the broader description of the person; age, gender, social circumstances, previous involvement with services and diagnosis if one has been given. The team will then discuss what they can offer this person along with any practical issues (where and when the visit will take place and who will go) that

emerge. This formula is employed when describing all cases, though details of the referral itself are not included in those already established. Once new referrals have been discussed, the team reviews current and established patients, whose details appear on a different board.

The detail provided on each case varies. New cases are always discussed in the most substantial detail possible with the information the team has available at that time. More complex established cases inevitably take up more discussion time as such discussion cannot be so easily abbreviated by professional terminology (see chapter three). Cases in which the person is to be contacted before the following handover are not necessarily discussed in great detail. It may be that the clinician who is dealing with the case is able to say “I’m seeing them this morning, nothing further to report since last time” (this being the last time the case was discussed). Also, if the person concerned is well known to many of those present, it is not necessary to reiterate background information in any great depth. If the case is established, but still relatively new and hence not known in any detail other than that provided on the board, it may again be described at greater length.

When describing cases, team members may be considered to be constructing a narrative. Often, such a narrative will include characters and knowledge of these characters’ background and attributes is important to its construction. Opie (1997:abstract) defined teamwork as “primarily a process of knowledge work and knowledge creation”. Teams are hence authors of collectively generated knowledge about service users (as mentioned in section 1.3.).The following is taken from a morning handover delivered by the Newchester team.

Triage: (Person’s name)...is someone who’s new to psychiatry.

Consultant: Oh mm.

Triage: GP, Registrar referred him yesterday. 22 year old single man living with his mother (*pause*) in a stable council estate? (*Cackle.*)

Consultant: Stable rather than unstable! (*Indecipherable due to people talking over each other and laughter.*) Maybe sort of (name of place).

Triage: Everybody owns their council house! (*Laughter.*)

Consultant: Parts of (name of place) are nice and stable!

What is happening here is more than simply the telling of a case. While the triage staff member is delivering facts in a recognisable and familiar way, the facts are being scrutinised at the very moment they are received. This scrutiny is apparent not only in the comments of the consultant and the laughter of those others present, but also in the triage staff member's delivery itself. The triage staff member is reading from the notes compiled by another team member and essentially mocking their phrasing. Such mockery seems to serve a dual purpose. Firstly, the notes are mocked for entertainment alone. To refer to a "stable council estate" is apparently irregular in this context and is hence delivered in such a way as to cause amusement. The pause before delivering the phrase, the raising of pitch that makes the phrase into a question, and the cackle once the phrase has been delivered are all combined to express both surprise and amusement. Not only is the audience audibly amused by this; the consultant contributes to enhance the performance. Secondly, such mockery distances those present from the authorship of an apparently bizarre and irregular phrase. However, an interpretation of the phrase's meaning is nevertheless offered by both triage and consultant for further entertainment. By the fact that no verbal resistance to this mockery or defence of the original phrase is offered, one assumes that the responsible team member is not physically present. However, mocking this team member's use of words serves to bring them to the performance in their absence.

In general terms, the triage staff member is presenting some initial facts on the case: the person's psychiatric history ("new to psychiatry"), the facts of the referral (GP, yesterday), age, sex and domestic circumstances. This delivery of facts by a single

performer (Triage) becomes a verbal interaction between two performers when one of the facts is questionable. The consultant joins the triage staff member on stage. The triage and consultant thus become something of a performing “double act”. The delivery continues.

Triage: He’s employed as an administrator in a care home, though he’s currently off sick with stress. Four year history depression and anxiety which dates from *(pause.) (Chuckle)* “lavving...lavving” university after his first term. He was prescribed fluoxetine at the outset although he did not find this useful. More recently he’s been referred on two occasions <towards> CMHT, which he did not attend. He’s very concerned about being involved with psychiatry by all accounts. On Sunday 20th of May a female friend stopped him from self-harming and informed his mother who insisted he attend the GP leading to CAT referral. Initial assessment he was acutely anxious, tense, sweating, tightness of the chest and poor eye contact, monosyllabic in his responses, frequently tearful. He did eventually start to relax. He spoke of the traumatic affect of his Father suddenly departing from the home when he was 13. He added that he has long-standing anxiety.

Consultant: *(Makes the noise of a gun being fired, placing two extended fingers against his temple and jerking his head back which each “shot”.)*

Triage: He described *(indecipherable due to gun-shot sound effects)* from work leading to an increase in already heavy drinking. He acknowledges that this may have contributed to his current low mood. He has suffered from poor sleep, decreased appetite and anadonia, all increased of late. During the interview, there were moments when he seemed particularly anxious at the prospect of meeting professionals. Depression. It’s mild depression and anxiety in a young man who’s increased his alcohol take after work stressors. Possibility of social phobia. Medical review, with offer of brief home-based treatment. Encouraged to disclose the situation to his mother. Query counsellor. I think his GP’s actually already trying to sort that out, some GP counselling.

Consultant: Right.

Triage: Carer's line and psycho-education re alcohol. There is a medical review.

Consultant: Well, I think we probably need to get him seen by the Professor of Anxiety at the University of the Anxious! (*Laughter.*)

The triage staff member continues to construct a linear narrative on the facts of the case. Many of the facts are delivered one on top of the other as "lists": the person is described as having appeared "acutely anxious" and "tense". The details of his presentation (sweating, tightness of the chest and poor eye contact etc) are then listed as if in order to substantiate this conclusion. He continues by listing that which the person himself described to the team, while the consultant, for reasons known only to himself, makes the noise of a gun being fired and puts his fingers to his temples. This was met by wry smiles from the audience. The consultant's gesture may be read as either a demonstration of wariness of this type of case, or that he is unpleasantly suggesting that the person being discussed is suicidal. However, in this context, the former is more likely. The person is to be referred for GP counselling (another service is already involved), the team is offering telephone contact (the carer's line) and psycho-social education. This suggests that this particular case is not deemed as severe enough for the team to become intensively involved. They have offered telephone contact, brief home-based treatment and a review of the person's current medication. However, this is more likely offered as a means of ensuring the person's condition does not deteriorate, rather than a response to an acute psychiatric crisis. (See chapter three.)

In general terms, the triage staff member is verbalizing medical notes by delivering them as coherent sentences, prefixed by returning the fact to the person. Rather than saying simply "poor sleep, decreased appetite" etc, Triage first reminds the audience that "he has suffered". That he mocks the note-compiler's handwriting ("lavving" instead of "leaving")

university) serves to further demonstrate that this is a process of verbalizing what has been written.

Triage goes on to summarize the case in three sentences, the first of which is simply one word: “Depression”, as if this encapsulates the case as a whole. He goes on to describe what is to be done: “medical review, with offer of brief home-based treatment”. In keeping with the pre-established “double-act”, the consultant then offers a joke alternative course of action, which is met with laughter. This is deemed as funny as it projects the person’s acute anxiety into a mock fantasy world in which anxiety itself is an important part; it has its own professor at its own university. In applying this fantasy world to the case discussed, the consultant distances those present from its obvious seriousness. This use of humour further suggests that the case is not considered by those present as particularly severe.

As the above demonstrates, handovers are more than simply a delivery of essential information; they are also team performances based around the construction of a “case” narrative. Those present are hence performing to each other as a team.

5.3. Backstage Solitary Working: Triage and Coordinator.

A significant factor in the lay-out of the team bases was the position of the triage staff member or coordinator and where they went about their business. In the Churchfield team, the coordinator took possession of a mobile phone and could hence remain in their pre-allocated seat. In the Newchester team base, there was a specific “triage room” with a landline in it. While the triage staff member was free to wander the team base, they would return to the triage room when business demanded.

The triage staff member and coordinator play an essential role in the day-to-day running of the crisis team. As no one team member is the triage or the coordinator all the time, though it may be an isolating role, it does not alienate the member in question. It is significant that consultants, doctors, and team leaders are not given, or do not take this

role. The experience of being in triage or coordinator is not viewed as a pleasant one. At various points during the observation period, I was party to numerous comments regarding the experience. A nurse in the Newchester team claimed it to be “absolute Bedlam when you’re on triage”, while another claimed that he had spent “nine hours on triage just being shouted at”, presumably by referrers unhappy at the amount of information asked of them (see chapter three). The quote which perhaps encompasses best the attitude towards being on triage comes again from a nurse in the Newchester team.

I came to see people, not to answer phones. The fact that I’m paid three times more than the average receptionist is neither here nor there.

The above statement is not merely a negative comment on being the triage staff member; it also reflects the nurse’s desire to “see people”. This is part of a broader team ethos which unites the team members in their dislike of the experience of being “on triage”.

While the triage staff member is the “stage-manager” of the official backstage, in the official frontstage it is the team members attending the assessments and home treatment visits: delivering crisis resolution. What happens on the official frontstage is reflected in other team activities.

5.4. Accomplishing Teamwork on the Official Backstage.

It is on the official backstage where what Sinclair (1997:96) called “official purpose teams” are most obvious. Official purpose teams are formed for the management of official work. Those present in the handover are an official purpose team planning official frontstage work. However, the triage staff member also has the official purpose of chairing the handover. This is done in collaboration with other team members. In each handover new referrals and established cases marked for attention are covered. Here, there is a marking system in place. A red dot next to a person’s name indicates increased risk, a blue square indicates the need for immediate discussion (though not necessarily

because of any perceived risk) and a green dot indicates decreased risk, which nonetheless requires discussion. These cases are “marked” by the team member most recently involved with the service user in question. The fact that these cases are “marked” allows all those present in the handover to see who is to be discussed. In short, the triage staff member, though they are the chair of the handover, is not alone in the planning of the handover.

In general terms, the official backstage of teamworking is carried out by official purpose teams. Official purpose teams are accomplished by a collaborative effort in the preparation of official frontstage and indeed official backstage work.

6) The Unofficial Backstage.

6.1. Definition.

If the official backstage is where official purpose teams operate, the unofficial backstage is where team members perform to one another with no officially sanctioned purpose. This is not to say that there is no essential purpose to the performances and interactions which take place here. In fact, it is on the unofficial backstage where relationships between team members are strengthened and re-intensified.

All teamworking involves the sharing of experience. Since the experience of solitary working is often shared after the event, solitary working and team working are not polarised. The official and unofficial stages of teamworking hence fuse. The unofficial backstage, where humour and play take place, is no exception to this rule.

In considering the types of humour, play and leisure activities in which team members may indulge, their official role as crisis workers is ever present to a greater or lesser degree. Hence, by virtue of the fact that on these occasions the team members are performing together to one another, the unofficial backstage is not “offstage”. The

unofficial backstage is an inevitable part of teamworking, though not officially sanctioned.

6.2. Workplace Discussion of Leisure Activities.

Sinclair (1997:5) explained how the leisure activities undertaken by medical students and junior doctors often relate to their professional world.

What is perhaps surprising is medical students' and junior doctors' own avid consumption of such theatrical accounts of their theatrical world- the television series 'Cardiac Arrest' and 'Casualty' seemed to be particular favourites during my fieldwork.

Both teams discussed 'Coronation Street', while the Newchester team also discussed 'Holby City'. Also, in the Newchester team, there was a discussion of the "reality TV" show, 'Big Brother' in which one member suggested they "spot the P.D." (an abbreviation for a person with an apparent "personality disorder"). The apparently chaotic behaviour of one of the 'housemates' was subsequently discussed.

What is interesting here is not merely the way in which soap operas and reality TV may reflect the work of the crisis team, but how the crisis team may apply their work to such television. It may be the case that the apparent unpredictability of soap opera characters and reality TV contestants may mirror that of the crisis team's client group. Onstage skills are hence applied offstage and then shared when team members return to the stage.

Some team members were conscious of how their leisure activities related to their work. In the Newchester team, a number of members played Poker together in their spare time. On the first discussion of the game that I was party to, a nurse noticed that I was writing in my notebook. He said "I see this is interesting for you!" He went onto explain that he and his colleagues "work with risk everyday" of their working lives, and that the Poker games seemed to reflect this. Poker games carry the risk of losing money and being

humiliated in front of other team members. This may either be read as thrill-seeking, an inability to let go of the risk factor offstage, or simply the need to work with a different type of risk.

6.3. *Humour and Characterisation.*

At 12:30pm on my first day with the Newchester team, I asked one of the nurses what people did for lunch. She replied “nothing. We’ve all got eating disorders.” She proceeded to eat a small salad from her lunch box. This theme seemed to recur on subsequent occasions. Three months later, another nurse told me “you’ll hear a lot of diet conversations”, which indeed I had done. He then described how he had eaten a cake and three peanuts the last time he had worked the night shift. The nurse who had first mentioned the eating disorders then interjected “I bet you broke the scales!”

What is interesting here is how the simple act of dieting is referred to as an “eating disorder” and that the nurse jokingly professes to have one. A common practice is hence pathologised as a “disorder” which apparently affects many members of the team. In crisis work, the behaviour of the person in crisis is constantly observed and then interpreted. Here, it would seem, albeit in a light-hearted way, that such observation and interpretation is applied by team members to their colleagues, and indeed to themselves.

Team members will *characterise* one another in humour. This will sometimes relate to professional disciplines. This occurred as the morning handover was about to start one day in Newchester. A moth had entered the building and was resting on one of the doors to the handover room. The consultant psychiatrist present said he was going to squash it. When a nurse told him not to, he said he’d “get a nurse to do it”. At this, the nurse professed that “Consultants are all mindless killers!” This is not merely the humorous characterisation by one team member by another, or even of one professional discipline by another; though it is both these things, it also reflects a perception of hierarchy in the team (the consultant will get a nurse to squash the moth) and a more general view about the team’s way of working. In saying that “Consultants are all mindless killers”, it may be

that the nurse is stating that consultants have a one-tracked attitude to their work, “dope” rather than help people and make people into psychiatric disorders.

6.4. Sharing and Support.

As I previously mentioned, the identification by team members of themselves as members of a crisis team is integral to teamworking. A team member’s acknowledgement that they, as an individual, is not a wholly independent and autonomous unit but a functional part of a functioning whole is, in my opinion, an important factor in accomplishing team work. An important constituent of such an accomplishment is the sharing of information, experience and indeed personality. Much of this is evident in the areas already covered in this chapter; sharing information and experience in handovers, characterising and expressing personality through humour and play. However, sharing is also evident in other areas.

In the team bases, many notices adorned the walls. In both teams, such notices gave information on Trust policies, procedures, and working with certain groups of people, or “client groups” (such as “alcohol misusers”). In the Churchfield team, however, there was something else. Humorous notices that reflected certain aspects of the team’s work appeared in various places, all of which could be seen by any team member or visitor who cared to look. One such notice caught my attention immediately. It showed a picture of a boat stationed at the side of a calm river. The caption read: “The boat is safe in the Port, but that is not what it was built for.” The analogy is obvious. Team members are comfortable in the safety of the team base, but their official frontstage work with service users, where such comfort and safety is not necessarily apparent, is their main purpose as a part of the service. This is an interesting example of how an aspect of the team’s work is displayed and shared. The fact that this poster is a prominent physical presence suggests it shows an established view of work held by the team, or least a view that the team are expected to hold.

It was sometimes the case that team members volunteered summaries of the behaviour expected of team members when relating to one another. I was told by a nurse in Newchester, for example, that “no one gets spoken about behind their back”. Also, I attended a meal with the Churchfield team after my first fortnight of observing them. The following fieldnote comes from this meal:

Joan and I talked. She said that, in the team, “we all look after each other. Because Paul’s new, I don’t think he understands that yet.” She went on to state that Paul was prone to making the odd condescending comment to other members. Whereas she saw this as meant in good humour, she was planning to “pick him up on it.”

A significant factor in the functioning of the teams is the camaraderie existing between team members. As the above shows, however, this sense of comradeship and belonging to the team is not given. In order to “get along” with fellow team members, certain pre-established team conventions must be learned and practiced. This was particularly evident in this discussion with an established team member about the behaviour of a relatively new team member: Paul. Joan is not simply telling me that team members “all look after each other”, though this in itself is essential knowledge, but that those who don’t observe this fact are likely to be challenged. This relates to the broader issue of integration, and its role in the creation of a team.

6.5. Accomplishing Teamwork on the Unofficial Backstage.

It is in the unofficial backstage that Ovretveit’s concept of *integration* is most apparent. It is where some of the most important teamwork is accomplished. It is here where team members become acquainted outside of their shared professional purpose. The use of humour and characterisation serve to both distance team members from the stresses of their day-to-day work, and to hold a mirror to it. It is also shared with other members, and it is through sharing that team members support each other. It hence perpetually renews what Ovretveit calls the ‘closeness’ of working together.

Humour, sharing and support in the unofficial backstage is also an important factor in maintaining hierarchy in the team. If a consultant psychiatrist and a support worker can share a joke, the professional distance between them is less apparent. A fuller discussion of hierarchy is now presented.

7) Teams, Hierarchy and Leadership.

7.1. Physical Manifestations of Hierarchy.

Hierarchy was reflected in the lay-out of the team bases. As stated in the introductory chapter, the consultants, lead nurse, psychiatric registrar and team leader all had individual offices, while the SHOs shared what was known as the “doctors’ room”. In the case of the consultants, registrar, leader and lead nurse, this was partly a perk of their position within the team as well as a separate space in which to carry out their managerial duties; in short, they were entitled to “shut themselves away” from the rest of the team. With the junior doctors, the reason for a separate office is less obvious. The “doctors’ room” did not function as a clinic or a place where medicine was stored, (a separate room, locked at all times when not in use, was provided for this purpose) but on the occasions when service users visited the team base, the doctors would receive them here. It was hence, in effect, a doctor’s surgery. This reflects how a professional discipline attained a perk associated with hierarchy. As there was no “social workers’ room” or “nurses room”, medicine may be regarded as a privileged discipline in this instance.

As with the lay-out of the team bases, the similarity between hierarchy and professional discipline is also apparent in dress. A further distinction, however, is evident here: gender. In both teams, the male doctors and team leaders usually wore shirts and ties, in contrast with the other team members who were clad in an array of casual clothes; some nurses and support workers had body-piercings and tattoos. Female doctors and the female leader of the Churchfield team dressed smartly, often in a blouse, skirt or trousers. Whereas this may have been reflective of a sense of status, it did not seem as visually obvious, or indeed “uniformed” as with their male counterparts.

An example of the significance of dress in team hierarchy and professional discipline occurred on a Bank Holiday Monday I spent with the Newchester team. The Bank Holiday working arrangement was essentially the same as that of a weekend: no doctors, leaders, or secretaries. On this occasion, however, a consultant psychiatrist was briefly present. His purpose was to discuss possible changes in medication and new prescriptions for people who had been seen over the long weekend. As usual, he was clad in shirt and tie. The nurse with whom he was in discussion said “I expected you to turn up in your civvies today”. The consultant reacted with a chuckle. This is, perhaps, demonstrative of the importance the consultant attaches to his clothing in relation to his role. His presence on that day was brief, unlike on a regular weekday. He dealt only with a small number of specific matters and did not attend any home visits or assessments, as he would normally. In wearing a suit and tie on a Bank Holiday, he is showing he is *being* a consultant psychiatrist.

7.2. Accountability to Team Leaders.

The relevance of hierarchy in the teams studied was particularly obvious in terms of members’ accountability to the team leaders. Leaders have a variety of different roles. They will instigate the protocols of crisis work; the members will on occasion wish to clarify that their work conforms to these protocols. Clarification is a two-way process: members sometimes “check things out” with leaders; leaders sometimes with team members. Indeed, in the early stages of my research, the team members I accompanied on visits to service users would clarify with their superiors that my presence was acceptable. When details of a service user and their recent behaviour was described in a handover, those higher in the hierarchy (consultants and team leaders) would request further information from the team members involved. For example, when the leader of the Churchfield team had returned from a short holiday, a case was described in the handover which concerned him so much that he requested a meeting later that day with the three team members involved. The following fieldnote describes this meeting.

“Right, start at the end” said Charlie.

The team defined the case as an “ongoing suicide risk assessment”. They were very quick to point out that the client in question would get emotionally charged when questioned or “challenged”. In general terms, the meeting appeared to be a dialogue between Charlie and the three other team members present.

In considering a possible course of action, Charlie suggested alcohol education. He proceeded to ask, however: “Is that our function as a crisis team?” He went on: “There’s obviously a psychological problem behind all this (the alcoholism) but we’re not going to be able to access it.” After further discussion along these lines, Paul said, “Thank you Doctor” to Charlie.

The meeting concluded by Charlie suggesting that in this case, the team may be “duty bound to withdraw” but the team agreed it was important to write-up a detailed risk assessment.

What is interesting here is how the leader exercises his authority over the other team members. He has not been in direct contact with the service user under discussion and all his information comes from the other team members. The person in question had problems with alcohol and other substances. That Charlie suggests alcohol education as a possible course of action is demonstrative of his role as a decision maker. He then puts a question to the team which almost contradicts his suggestion: is it the team’s function to arrange such education? He is decisive in stating that the underlying problems cannot be addressed by the team at this stage, and concludes that the team is “duty-bound to withdraw”. What appears to be happening is that the leader is making a decision based on the evidence of other team members and the experience and expertise that have made him team leader. The person will be referred to another service as he deems them not suitable at this stage for the service he leads. That Paul says “Thank you Doctor” once Charlie has put his decision towards them is also an interesting reflection of hierarchy and the

perception of different professional disciplines within that hierarchy. Charlie is not a doctor but a senior nurse, while Paul is a social worker. However, because Charlie is taking charge of the situation in such a way, Paul's reaction suggests that Charlie is behaving how Paul would expect a doctor to behave. Paul appears to be using the term "doctor" as a symbol of authority; its use hence suits the dynamic of the above discussion.

7.3. Senior Members as Team Representatives.

Another aspect of a crisis team's hierarchy is the responsibility of leadership. This is particularly evident when the leaders *perform* as leaders on behalf of the rest of the team. An example of this was described in section 4.2. where the team leader presented the white boards to the visitor. Another occurred towards the end of my second period with the Newchester team. An assessment which had taken place in a hospital was discussed in the morning handover by the two female SHOs who had attended. Their accounts centred on the behaviour of a male hospital consultant who had been rude to them and dismissive of their opinions of the person being assessed. The person in question had showed signs which suggested he was suffering from delirium tremens (DTs). In their words, he was experiencing "bizarre complex hallucinations", showed signs of "thought disorder" and they couldn't "get any history from him." They concluded that "we need to treat him empirically. This looks like DTs." The hospital consultant was apparently unconvinced by this conclusion, claiming the person may simply have been psychotic. He had also questioned the SHOs' clinical capabilities. When they reported this, the team's female consultant psychiatrist asked them if they thought this was because they were young women. The SHOs said that they felt this to be the case and went on to describe the man's abrupt and bullish manner. The consultant psychiatrist then said that she would phone the ward and confront the hospital consultant on his behaviour and attitude. She also commented that delirium tremens are an "under-diagnosed medical emergency". She proceeded to rise from her chair and stride swiftly from the room with a frown. Once she had opened the door, and was still able to hear them, this was greeted by cheers from the two SHOs.

Essentially, the consultant psychiatrist was demonstrating that she deemed the hospital consultant's behaviour to have been inappropriate and even unprofessional. That she concluded by adding a clinical opinion (that DTs are under-diagnosed) added to this display of authority with the aid of expert knowledge and hence power. She made it clear that she would use her position to do what the SHOs had found difficult to do: challenge the consultant. This is hierarchy as it is harnessed for teamworking; the exercise of power and authority for the benefit of the team as a whole. In this example, there are the additional factors of gender and professional discipline. A female consultant psychiatrist is demonstrating that she will perform on behalf of two female junior psychiatrists. If two male social workers had reported the same situation, the outcome *may* have been different.

7.4. The Relevance of Hierarchy in Accomplishing Teamwork.

In general terms, hierarchy can come into play on all four stages of teamworking. It is demonstrative of power relationships within the teams. It is imposed by the organization but maintained by the senior team members. It is given in what Ovretveit called *structure* and essential to what he called *process*. The leaders are in part the instigators of the accomplishment of teamwork, but that is not to say that it could not be accomplished in their absence. It is also not the case that other members serve as the "supporting cast" behind their seniors. Indeed, as in the example described above, it was the consultant psychiatrist, from the backstage, supporting the SHOs on the frontstage. In short, the hierarchy present within the teams is, for the most part, unchallenged.

8) Conclusion: The Negotiated Nature of Teamworking.

Through the application of the dramaturgical model, one can identify distinct levels of teamworking. The frontstage is where crisis teams perform to outsiders, the backstage where they perform to one another. The nature of teamworking is hence in part determined by its audiences. The official backstage is an intensive and collaborative rehearsal for the official frontstage performance. Most unofficial frontstage performances

are more spontaneous in nature. The unofficial backstage is integral to maintaining the momentum of the social actors. On the official frontstage, where team members visit service users, they are acting as team representatives. On the unofficial frontstage they are representatives to another audience. On the official backstage, the team may break down into smaller official purpose teams and perform to one another. On the unofficial backstage, they also perform to one another as support and entertainment. Hence, teamworking does not conform to a specific set of rules. Rather, it is negotiated depending upon context, purpose and audience.

Teamworking is subject to perpetual negotiation. Negotiation may be defined as a collaborative effort to decide what course of action is appropriate to a given situation. Strauss *et al* (1964, 1981:374) described negotiation in terms of the running of psychiatric institutions.

Negotiation is not “organized” as in the sense that it lays down permanent expectations for behaviour. Rather, expectations are perpetually negotiated as new situations arise. The bases for working together are continually reconstituted through negotiation....Negotiation is not chaotic. It follows patterns, in the sense that certain amounts, kinds, *and* participants of negotiation recur predictably.

The above connects negotiation to the dramaturgical model. Negotiation is not “organized” since it may take place in a multitude of situations arising on any of the four stages. Crisis work is often, by its very nature, unpredictable. Hence, on whatever stage a team member is performing, they may unexpectedly find themselves transferring to another stage and adjusting their performance accordingly, through negotiation. “Negotiation is not chaotic”, however, since certain structures do exist, such as regular handovers, team meetings, assessments and home visits. Hence, there is always a forum for negotiation, although the process and outcome of such can never be comfortably predicted.

Teamworking cannot be removed from the context in which it takes place. Though there may be a pre-existing organizational structure to the team, this is most often of limited relevance in terms of the day-to-day practicalities of teamworking. The roots of a tree do not possess overall control of how the branches will eventually grow. Housley (2003) conducted a study of a social work team and concluded that

In terms of 'team structure' the Team can be heard to be an interactional accomplishment that is praxiologically and methodologically achieved, rather than a contextual backdrop to which team members mystically slot into or simply find a role within. The Team can therefore be understood as a locally produced form of social organization that is interactionally sustained and reproduced. (119.)

A team cannot be merely a contextual backdrop to practice. Being a team is a practice itself. It is not only something that is accomplished by its members, it is also constantly re-accomplished. Its maintenance depends on it being constantly performed. In each stage, there exist different tasks, some of which are team tasks, others which are not. Teams are hence a group of individuals who create teamwork. The organizationally instigated existence of a team is merely the catalyst. Like crisis itself, teamworking is multifaceted. There is no one way to do it or define it.

Chapter Five: User Involvement.

1) Introduction.

1.1. The Importance of User Involvement.

Over the last two decades, “user involvement” has become a driving factor in health service reform. The principle that “users” should be involved in both the evolution of established mental health services and the development of new ones is frequently cited in official health service literature and that of the service user’s movement (Department of Health and Social Security 1989, 1990). However, there is little guidance on how user involvement is to be instigated or achieved in relation to specific services. Crisis resolution and home treatment is such a service. Also, while the above defines user involvement in terms of policy, the main purpose of this chapter is to describe user involvement in an operational sense; its practical application in the day-to-day operations of the crisis services.

This chapter examines the notion of “user involvement” in the two home treatment teams studied. I consider the extent to which recipients of the service provided by the teams are involved in the planning of the treatment they receive, occasions when their wishes may be over-ruled and the limits of user involvement in crisis resolution. I examine the descriptions put forward by team members when asked about “user involvement”. I then describe three specific “cases”, each covering different aspects of how collaboration is established, maintained, or replaced by conflict. Finally, I consider the distinction between “empowerment” and “involvement” and how these concepts are perpetuated in the discourse of professionals and the interaction between professionals and service users.

There are two dimensions to user involvement. Firstly, there is what I call involvement on the “official backstage” (see chapter four); this is where users are actively involved in the planning and running of the services. In the two teams studied, such involvement was

very limited. Secondly, users may be said to be involved in the “official frontstage” of crisis resolution and home treatment. This is where users are involved in a dialogue with the crisis team, contributing to the planning of their care. In this sense, home treatment may be regarded, at least in part, as a collaboration between the professionals and the service users. How such collaboration is evident in the discourse of home treatment is described in this chapter.

1.2. Contrasts between Crisis Teams and CMHTS.

When considering user involvement, it is important to note the contrasts between the ways in which such involvement is structured in crisis teams on the one hand and in regular community mental health teams (CMHTS) on the other. The National Service Framework for Mental Health (1999:41) puts forward the following aims for mental health service users:

All mental health service users on CPA should:

- receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk
- have a copy of a written care plan which:
 - includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator
 - advises their GP how they should respond if the service user needs additional help
 - is regularly reviewed by their care co-ordinator
 - ⁸ be able to access services 24 hours a day, 365 days a year.

The CPA (Care Programme Approach) was devised in order to optimise collaboration between professionals and service users. Certain aspects of this approach were evident in the two teams studied: in Newchester, the service was available 24 hours a day, 365 days

⁸ The use of the hyphen here is as in the original document. I am inclined to suspect this is a misprint and a further bullet-point would more appropriate in the given context.

a year and both services certainly strived to provide care that optimised engagement and reduced risk. As stated above, how such engagement is optimised is a major focus of this chapter. However, service users and team members did not, as a rule, work together to devise a formal written care plan. Perhaps this was due to the short-term, intensive nature of the service and the fact that the services were focussed on “crisis” and hence volatility. Since a crisis team’s involvement is most likely to last around three weeks, the relevance of a formal written care plan may be limited. If a person is being visited at least three times a week (at most three times a day) there exists ample opportunity to negotiate and re-negotiate the nature of the care provided. Finally, since the person is defined as being in a “crisis” situation, their needs may shift from day to day as the crisis either ‘lifts’ or ‘deepens’. In short, for a crisis team, the devising of a formal written care plan may be of limited effectiveness in most cases. Formal written care plans are perhaps more appropriate to regular community mental health teams, where involvement is more long-term and less intensive.

Another significant difference between crisis teams and CMHTs is the role of key worker. Carpenter *et al* (2004:329) conducted a study of users’ experiences of the Care Programme Approach. One of the findings was that designated key workers were an important factor in user satisfaction:

...almost all users in our study were able to give their (the key workers’) names, and report that they felt comfortable with them and considered that they were treated with respect.

Crisis teams do not allocate key workers. Though some users may see a specific team member more frequently than others, the 24 hour availability of the service (in Newchester) and the intensity of treatment mean that, by default, it is not possible for the same person to always be seen by a particular worker. A worker who has visited a user in the daytime may not be available if an evening visit is also required. Rather, cases are shared; all team members have access to a person’s file. Since the designation of key workers is not possible, case notes may be relied on to a greater extent than the workers’

experience of the service user. This has implications for user involvement. Collaboration cannot be established between the service user and one worker alone; rather, it must be perpetually renegotiated by the service user and a potential array of different workers. This may limit the user's capability to become truly involved in the implementation of their care.

Carpenter *et al* (2004:314) drew a distinction between "targeted" and "inclusive" services. A "targeted" service, as its name suggests, "targets" a particular type of service user: it is rationed to those presenting with severe mental illness. A crisis service is hence an example of a "targeted" service. (See chapter three.) An inclusive service will "include" on its caseload an array of service users with a diversity of presenting problems. A regular CMHT is hence more likely to be an "inclusive" service. The findings of Carpenter *et al* showed that service users professed less satisfaction with targeted services than with inclusive services. This may, in part, be due to the often greater severity of the problems with which targeted services are presented. A person "in crisis" may find it more difficult to engage than a person with a long-standing, "chronic" problem of which they may be more likely to have significant insight. In general terms, the nature of crisis work itself may limit the extent of user involvement.

2) The PIG on User Involvement.

In this section, I examine the Policy Implementation Guidelines (2001) in crisis resolution and home treatment and how "user involvement" and related factors are described, in general terms, therein.

Fundamentally, crisis resolution and home treatment teams act as an alternative to inpatient care. The PIG (2001:11-12) suggest that the establishment of these services is directly related to the needs and wishes of service users and that "active involvement of the service user, family and carers" is an important principle of care. They also suggest that such services are more "user friendly" than inpatient care.

People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care. The majority of service users and carers prefer community-based treatment, and research in the UK and elsewhere has shown that clinical and social outcomes achieved by community-based treatment are at least as good as those achieved in hospital.

The “least restrictive environment” for treatment need not necessarily be a person’s home. Indeed, certain “visits” may take place in short-term respite accommodation, rooms in GPs surgeries, and, in the case of the Newchester team, in a room in the team base itself. An initial mental health assessment will often take place in accident and emergency departments, and, on occasion, in police cells. In short, it is a mistake to consider community based treatment and home treatment as synonymous.

There are a variety of reasons why the “least restrictive environment” for treatment may not be a person’s home. Indeed, domestic factors may play a large part in the initial presenting problem (see chapter three). It may also be the case that there are others in the home, be they informal carers, family, or otherwise, whose presence is not necessarily conducive to crisis resolution. As easily as family members may support the person, they may also be a source of the person’s difficulties. It may also be the case that they are unable to cope with the individual’s behaviour.

There is potential for disagreement between the professional and the service user as to the most desirable type of treatment offered. Sometimes the service user wishes for a period away from home, even for hospitalisation. The existence of a crisis resolution/home treatment team does not necessarily lead to greater choice for the service user. In Newchester, all service users potentially requiring or wishing for hospitalisation are initially referred to the crisis team. The PIG says that “the majority of service users and carers prefer community-based treatment”. This may serve to justify the fact that this re-

allocation of services does not increase choice. Indeed, the existence of these new services is presented as a response to service users' preferences.

People experiencing a mental health crisis cannot refer themselves to the crisis team. Once treatment has been established, however, they are often given a telephone number to contact the team should the need arise while they remain on the team's caseload. Family and carers are also given this telephone number. Hence, the principle of user involvement is not confined to the setting up of the service (where it is apparently evident) and initial access (where it appears to be profoundly limited); it is also cited as important when a team's involvement has been established. The PIG continues (2001:15) to assert that, on a practical, day-to-day level:

- Empowering service users and respecting their independence is crucial
- Service user/family/carers must be involved in all decision making

Empowerment and independence are deemed as so important as these are seen to have been previously denied to service users and their families. The drive for a greater consideration of family factors has a long history, originating in the mid-twentieth century in the work of R.D. Laing (1964) and R.D. Scott (1969). Scott, in considering a broader spectrum of psychiatric intervention and care, defined the concept of the "treatment barrier". This is when an individual's treatment is hindered by the cultural view of mental illness. Such a hindrance may be created by both the individual in question and their peers. The professionals themselves may also inadvertently exacerbate it.

Besides the more obvious issue of social stigma surrounding mental health difficulties, there are also more complex factors surrounding the creation of the treatment barrier. Scott illustrated this with an example: "The hospital doctor is rung up and held totally responsible for a person who, because he is a mental patient, is assumed to be not responsible for his behaviour." (30) This has implications for all those involved in a

mental health crisis; the subject, their immediate peers such as family, and the professionals involved in care and treatment. Though Scott argued that the individual remains essentially autonomous, even while experiencing acute mental distress, he argues that a culturally learned response may well be acted out in such a situation. The individual may genuinely believe that they are not responsible for their actions, or even feign that they are not since they know such a view is likely to be accepted. In accepting this view, the significant peers will hence become key players in the cycle of destructive behaviour. But they will believe themselves to be helping through their acceptance. This, in turn, will put responsibility onto the professionals. It will be believed that they alone have the power to contain and improve the individual's condition. If the professionals play into this belief, it will establish the treatment barrier still further. Hence, Scott's argument was that mental health professionals should not only "treat" those deemed mentally unwell, but also facilitate the empowerment of such individuals.

In general terms, the PIG presents a broad, historically rooted view of user involvement. These guidelines are influential in the day-to-day operations of a crisis team. However, they cannot describe the more subtle process by which a collaborative relationship is established between professionals and service users. The nature of such a process depends not simply on the presenting problem and reciprocating expertise, but also on the individuals involved in the relationship and their interpretations of the situation.

3) Team Members' Descriptions of User Involvement.

3.1. Collaboration on the Official Backstage.

Definitions of user involvement vary between team members. The following transcript comes from an interview with a consultant psychiatrist from the Newchester team:

When we first started we had a service user development worker worked with us. Er, he was on the implementation group and erm worked with us all the way through developing the service. Then, for a short period of time actually was

around in the service, erm but subsequently left and wasn't replaced. And so we went to the service user organization of South West Pogsire and erm had a discussion about y'know should we, should we have someone on our service and if so how we're gonna fund it and what their role would be, all that kind of stuff. So the service user development worker from assertive outreach came and spent a week with us erm to see what we did and if she worked here what would her role be, that kind of stuff. And at the end of the week, she said she really wasn't convinced it would be a very good use of someone's time because so much, so much of the work was done out of here and erm what we can do we can identify problems and then get somebody to help us do it rather than have somebody there who may not be busy all the time and that was, that was our feeling as well at the time, I mean we don't have erm any strong feelings either way particularly.

The consultant is essentially telling a story that justifies the absence of service users in the team itself. (The PIG recommends the recruitment of service users as support workers in crisis teams.) In this story, a service user development worker has worked with the team as it began to develop and operate as a service. The reason why this worker left and was not subsequently replaced is not given. Instead, the consultant reports on the action that was taken on the part of the team after the worker's departure; a consultation with a user organization takes place, and a development worker is borrowed from another service. That this action was taken gives some clue as to why the first development worker was not simply replaced (one cannot speculate as to his reasons for leaving): the development workers' role was not clear.

The problem of the development workers' role in the day-to-day operation of the team is further apparent in the outcome of the second worker's placement. It was the service user development worker herself who decided that her long-term involvement was not appropriate. The team apparently had the same "feeling", though conversely didn't "have any *strong* feelings either way particularly." This apparent contradiction suggests that the consultant is distancing the team from the responsibility for accommodating the involvement of the development worker; the team did what they could, but it was

ultimately the decision of the development worker not to remain involved. This is not to say that the team has not genuinely attempted to accommodate user involvement of this kind. The team has consulted with a service user organization and a development worker with an established role in another, to a certain extent similar, service. In short, according to the consultant, the service user development worker has observed and made her own decision as to the degree of involvement possible in the team.

In the consultant's story, the team cannot be said to have prevented service users from being involved in the official backstage running of the service. However, it is not suggested that the development worker is a representative of all service users. Coupled with the team's apparent indifference to her presence, this leads one to speculate that the involvement of the development worker was little more than a token gesture. Indifference, however, is distinct from hostility. The consultant, apparently in common with the development worker and the rest of the team, acknowledges a role for such workers in identifying and working to solve "problems". The nature of these problems, however, is not made clear. By implication, such problems may emerge in terms of the team's relationship with service users; that the role in solving them is deemed as temporary and infrequent suggests both a certain complacency on the part of the team, and an acknowledgement of their own limits.

The consultant goes on to describe the implications of the membership of a development worker in the team:

Erm, I think erm sometimes, if we joke about erm, if we erm, we'd have to be politically more correct if we had service user development workers in our service. Erm, but that's a joke that we have, y'know. When we laugh, we're never laughing at people, we're just laughing at the situations that we find ourselves in...but erm...I can remember once we had someone visiting and I was met at the front door and as "for goodness sake, Sally, don't swear when you get in there!" (*Laughter.*) Erm...but that's not really-that's a bit silly really but erm that's, that's the situation that we're in currently.

The implication of the above is that a service user development worker would be offended by jokes and comments that would not offend other team members. This serves to distinguish such workers from the rest of the team; established team members, “us”, would have to change their behaviour in order to accommodate development workers, “them”, should such a scenario arise. For example, the consultant would not “swear”. However, this assertion is framed as a “joke” itself and hence not intended to insinuate such polarisation as an actuality. According to the consultant, it is situations that are humorous, not the people in these situations. This assertion is, however, problematic.

Early in the first observation period with the Newchester team, a case was discussed regarding a woman who was admitted to hospital. Her stay was thought to be short term as it had been instigated to allow her husband to go on holiday. The husband had apparently been under a substantial amount of stress as her principal carer. The situation invited the comment “it’s like going into kennels, isn’t it?” which was greeted with laughter. On initial consideration, this laughter may be, as the consultant says, related to the situation rather than the individual. Hospital admission may indeed be a dehumanising experience, particularly for those with mental health problems. The fact remains, however, that a person has been analogised with a dog. One can speculate as to whether a person going into hospital for the care of a physical ailment while their principal carer holidays would invite a similar comment; it possibly would, but such people are not already stigmatised in the same way. In short, laughter at a situation may be more politically “loaded” than it at first appears.

The consultant continued by describing some of the problems service users currently had with the crisis team:

There is a group of service users who aren’t very happy with the (crisis) team. They seem to all have similar problems in that they see us as being an obstacle to what they want which is often hospital admission and erm at the moment what we’re doing is erm getting together with those people, finding out what their

difficulties are and then making an evaluation of whether that's an accurate reflection of what happens or not. So I suppose we try and manage it. Y'know, you can't please everybody all the time.

As stated earlier, it is sometimes the case that service users want hospital admission rather than treatment at home. Though home treatment may to an extent grant a person greater autonomy than they would have in hospital, it is not always what the person wants. Hence, home-treatment is more a replacement than an alternative, and hence an "obstacle" to hospital admission. The consultant says that a dialogue between the team and the people concerned is taking place. It would seem that the team has the greater power in determining outcome of this dialogue, at least that is what the consultant appears to imply. The team will find out what the "difficulties" are and make an "evaluation of whether that's an accurate reflection of what happens or not". This suggests that the objections of the service users have to be "validated" by the professionals before they can be regarded as a view to action. The power balance between professionals and service users is hence one-sided in this instance. The consultant seems to imply that the user's voice is potentially not an "accurate reflection" of the situation. This serves to deny the service-user validity in their own experience; a common complaint in mental health services. Laurance (2003:73) defined this phenomena:

A diagnosis can become true just because it has been made. Once labelled "schizophrenic", a patient cannot object to or resist treatment –that would be evidence of their mental disorder. Branded as a mental patient, he or she is no longer a credible witness, even about his or her mind.

Thankfully, there is ample evidence in my data that this is not always the case, and that professionals, often do regard service users as "credible witnesses" to their experiences and, by implication, their minds, in home treatment discussions. However, Laurance's observation remains significant, particularly in the consideration of users' complaints.

In general terms, the Consultant's comments demonstrate that user involvement on the official backstage is very limited. She offers minimal justification for this, but also reports on how the team has strived to instigate further involvement. Her comments on the possible need for political correctness should a user join the team suggests the culture is not currently conducive to their involvement. If team members need to be more "politically correct" (i.e. use less emotive language and behave differently) in the presence of a user, their current language and behaviour may, by implication, have the potential to cause a degree of upset.

3.2. Collaboration on the Official Frontstage.

In contrast to the consultant from the Newchester team, a nurse from the Churchfield team framed user involvement as an official frontstage collaboration:

The person that we're treating is the expert on their problem. It's a difficult one to get people to come forward for the likes of user voice, user voice network... 'cos a lot of people will say... "we'd rather be well again", discharged from the team, and don't want to be reminded of the crisis they were in. Other people who've had a positive experience...want to give a little bit, they wanna share what's happened.

In contrast to the Newchester consultant, the nurse is granting the service user authority over their own experience. Service users are also "experts". Clearly, the nurse is suggesting that the relationship between professionals and service users is essentially collaborative; through the exchange of personal and professional knowledge, the presenting "problem" may be solved, or at least contained. However, the nurse goes on to refer to a separate organisation, the user voice network. The user voice network is a local service user support organisation that operates from the hospital in the grounds of which the team were located. That the nurse refers to this organisation so immediately in her answer to the question suggests that it is here, rather than in the crisis team, where user involvement is contained. In short, the nurse may be saying that involvement is the responsibility of the user voice network, rather than that of the team.

The nurse continues by referring to the role of family and carers:

We involve the family and the carers in the care because they know what works best for them, so it's simply asking questions and involving them, doing the care plan with them, something as simple as that.

Once again, the nurse is stating that authority in the crisis situation is not solely the property of professionals. This is perhaps obvious, though it is nonetheless stated. Essentially, it seems that the nurse is saying "we do not enforce our will on the people we are treating and their carers". In contrast to Laurance (2003:73), she is stating that the knowledge of service users and carers is not only credible, but also important in the implementation of home treatment.

The nurse goes on to voice her perception of the expectations of some service users:

Some people do have that expectation that we are experts, we come in and we make them better, but it's joint working and the people that you're working with have got to know that they've got to put the work in to get out of... But some do say "wave the magic wand, give me the magic pill."

The nurse is stating that there exists a certain cultural expectation that professionals "know best". This suggests that Scott's "treatment barrier" is alive and well in certain quarters. However, she goes on to assert that crisis work is "joint working". This joint working, however, may be for the most part confined to the official frontstage.

In general terms, the nurse frames user involvement in terms of the user's collaborative role in the implementation of home treatment. This collaboration exists in both the initial framing of the presenting problem and the subsequent action undertaken. This phenomenon is illustrated further in the cases presented below.

4) Conflict and Collaboration in Crisis Resolution: Three Cases.

4.1. Case 1: Involving Carers.

Towards the end of the first observation period with the Churchfield team, I accompanied a nurse on a home visit. This visit was also an assessment; the nurse was seeking to ascertain the most appropriate course of treatment for the individual concerned. C had been referred to the team earlier that morning by his GP. He had stated that he was drinking heavily and expressed suicidal thoughts. Laura, the nurse I was to accompany, had telephoned C and arranged an immediate visit at his brother's home. Once we had been shown in by C's sister-in-law, E, and introduced to C, Laura asked him what was happening:

C begins to tell his story. "Well, it began a few months back..."

C describes how he met an American woman over the internet and had gone over to America to visit her. He tells of a friend who was now living with a woman he had met in the same way. He had given up his job in order to make this visit and his expectations were high. The woman was "a nightmare, a horrible person". She had assaulted her children in front of C. Despite his telling her that he suffered from depression long before the visit, she had been insensitive towards him. She "didn't understand". C had had to stay on the woman's sofa for several days before he had been able to get a plane home. On his return, the heavy drinking had started.

E confirms that C is "in a bad way" and has been staying at her house as "he cannot stand his flat".

On initial consideration, it is perhaps to be expected that C be invited by Laura to "tell his story". Laura is seeking the information that will allow her to determine the best possible course of action. However, she has already been given general information by the GP.

The fact that she has invited C to explain the presenting problem suggests that he is indeed regarded as an authority on his experience. He is also, albeit unknowingly, given the opportunity to contradict the GP, though in this instance there is nothing to suggest that he does so. C frames his problem as reactive to a life event. Laura does not challenge him on this and does not interrupt his story. In short, C is given authority and autonomy in the verbal construction of his current difficulties. Though this may seem obvious, it is worth considering an alternative action that could have been undertaken by Laura. In her pre-established knowledge that C is drinking heavily and expressing suicidal thoughts, she could have asked directly about these factors without inviting C to provide initial context. Such an action would profoundly change the power balance in the exchange. It would reduce C's life experience to mere symptoms, making Laura the "expert" and C apparently helpless.

By virtue of its short-term involvement, a crisis team is limited insofar as it can treat the underlying "cause" of a person's crisis. Their purpose is to assist in the management of the most burdensome symptoms. Hence, by inviting C to talk about the "cause", Laura is not simply gathering clinical information. Rather, she is instigating C's collaboration in the assessment. C's story is then verified by his sister-in-law, who proceeds to impart additional information; that C is staying with her as he "cannot stand his flat". In doing this, she may be not only providing further verification of the seriousness of C's situation, but also she may be presenting herself to Laura (and indeed me) as a *carer*. She is prepared to assist C during this difficult time. The discussion continued:

"How much are you drinking now then?" Laura asks.

"About four litres of cider every day. And it's the nasty white stuff as well" replies C. E nods and lets out a chuckle in agreement.

C is sat on the sofa, slightly leaned forward, his knees together and his heels back, somewhat foetal. He rests his hands upon his knees, occasionally gesticulating. His head is usually bowed slightly, but he occasionally looks up at Laura or me and laughs nervously.

“Have you had problems with drinking in the past?”

“Yes.”

“What about drugs?”

“No.”

E corrects him. “Yes you have. Well, you used to do cannabis.”

“Yeah. Alright, but not for a while.”

Once again, E is acting as collaborator in C’s story. She both verifies the extent of his drinking with a gesture, and contradicts him when he professes to have had no problem with drugs. It is apparent here that E’s interpretation of Laura’s question is different from that of C. C professes no history of drug *problems*, while E’s contradiction refers to drug *use* that, perhaps to C, is not synonymous. Though E has contradicted him, she subsequently dilutes her contradiction: “well, you used to do cannabis”. Laura does not comment on the exchange between C and E and does not verbalise the possible significance of the information given. This is not to say that she necessarily deems a history of cannabis use as insignificant in relation to the presenting problem, as C suggests he does. More likely, she deems it unnecessary, perhaps inappropriate, to pursue this line of questioning further at this time. C does not deem his history of cannabis use as a key factor in his current predicament; Laura is willing to respect his opinion. She proceeds to report on the information given to her by C’s GP:

“Your GP tells me you’ve been having suicidal thoughts. Do you want to say anything about that?”

“Yeah. I get ‘em all the time. Especially when I’m drunk.” He rolls up his sleeve. There are many red scar-lines across his tattooed arms. “I admit they’re superficial” he tells us.

The way in which Laura frames her initial question is interesting. She is essentially asking C to verify what his GP has told her. This information has been initially imparted to the GP by C, by the GP to Laura, who is now asking C to reiterate it. On referring to C's GP as the source of this information, she is once again giving C the opportunity to contradict the GP if he so desires. She is also presenting as none-presumptuous; she is not taking the GPs information at face value since it is C, and not them, who is the authority on this subject. In asking if C *wants* to say anything on the subject, she is allowing him to express his response broadly. Had Laura asked C "are you having suicidal thoughts?" his choice of reply would be limited, the question almost interrogative. It could also mean that the information she received would be inadequate. Instead, she appears to allow C a certain freedom of expression. However, as it had already been established that Laura is the nurse and it ultimately her role to assist C once he has assisted her with information, his array of possible responses remains restricted. He can tell her he is not having suicidal thoughts, that he is having suicidal thoughts but will not talk about them, or, as he does, he can verify what the GP has said and give further information. Had he given either of the first two possible responses, the discussion would most likely become more difficult with Laura limited as to the assistance she could offer. Hence, C's response is a collaborative one. Laura continues by asking a question that is more direct:

"Do you have any plans?"

"No actual plans, no."

"Have you been like this before?" asks Laura.

"Yeah. I was really depressed a couple of years ago."

"What would you like us to do?"

Laura's first question is to ascertain the extent to which C is a risk to himself. It is necessarily a question inviting no more than a "yes" or "no" answer. Here, the power balance momentarily shifts; C *must* tell Laura whether or not he plans to commit suicide. The broader implications of this are discussed in section 6 below. C has shown himself to be co-operative and acceptant of, indeed grateful for, Laura's presence. She continues by asking another direct question; equally significant clinically though not requiring the

same urgency of response as the previous one. From C's reply that he was "really depressed a couple of years ago", Laura is able to ascertain that C is not in wholly uncharted territory mentally. Since he has previous experience and, by implication, knowledge, she is able to ask him what he would like the team to do for him now. If C had claimed to never have been depressed before, it is likely that Laura would have offered information about his condition and reassurance that he would ultimately recover. As it is, by implication C has recovered from depression before. In her question, Laura is asking C to apply his knowledge. His response has far reaching implications:

C looks down at the floor and grins broadly.

"Commit us."

He pauses.

"I can't see any other way."

There is another short silence.

"I don't think that's the answer" says Laura. "In hospital, they'd be a lot of other people with the same problems. Alcohol does get onto the wards and that would make it more difficult for you to stop drinking. I think we should consider a home detox."

C is apparently stating a preference that his personal freedom and autonomy be restricted. To him, a period in hospital is the only solution to his problem. The short pause which follows his stated preference may indicate the possibility of a dispreferred response emerging from Laura. She proceeds to tentatively contradict C; she does not *think* hospitalization is the answer. In this way, she offers a contradiction that does not impose authority. She then puts forward a reason for her rationale: hospital will not protect C from that which he desires to escape from. Also, if in hospital, the team would have no input into C's care and may thus be seen to have failed to help him. However, a home

detox allows the team input while preserving a degree of C's autonomy. Collaboration between C and the team can continue in a less "restrictive environment". C responds to this suggestion:

"Yeah. I've had a home detox before. I stopped drinking for several months at the end of it."

"Yeah, you did" E says over him.

"Okay. I'll see if I can sort that out for you."

"It's only since I got back from America that I've been drinking like this again" C reminds us.

C is volunteering further information on his personal history. He apparently accepts Laura's suggestion as this course of action has worked for him before. His sister-in-law again offers verification. Laura interprets this response as an agreement, and says that she will "see" if she can arrange for a home detox to take place. Her response suggests that there exists the potential that this course of action will not be possible. She needs to consult with other team members before treatment can begin. Now that a course of action has been agreed, C reiterates information that he has already given. However, this time, it is given in a direct statement which is also a presentation of his own perceived strengths: he is not usually such a heavy drinker; he is simply reacting to an adverse event. In this way, he presents a simple rationale for his behaviour, which also says "please don't think I'm weak". Laura then asks a question that draws further on C's strengths:

"How were things before you went to America?"

"Good. I'd been to college, I'm a qualified chef. I had a job, but I gave it up to go to America."

"Has there been anything else worrying you?"

"I've got a lot of debts, just with the bank."

"Well, we'll do the detox first and then maybe we can think about tackling the debts. Will E and your brother be able to support you if you go on a detox?"

"Yes."

“Yes. You’re welcome to stay for as long as you need to, but you know you’ll have to go back sometime” interjects E.

“How are you coping with all this, E?”

“It’s okay. He’s family.”

“I don’t fly off the handle when I’m drunk. I just pass out after a while.”

“And is your brother okay with you staying here?”

“Oh yeah. D’s great.”

Here, Laura is confirming that C’s current principal carers are willing and able to support C for the duration of his detox. In this way, she gives E the opportunity to object and hence invites her to take a more active role in the discussion. She then asks E how she is coping, temporarily shifting the focus of discussion from C to her. C proceeds to explain to Laura that his behaviour is not overly problematic to his brother and E. Laura then asks for the view of an absent party, C’s brother and E’s husband, D. C’s reply establishes that he has support at home which is more than adequate. Laura continues by elaborating on the workings of the home detox.

Laura says that it’s best for C to begin his detox the following Monday, so that more services are available at the beginning of the detox if he wants them. C now seems quite tearful. Laura gives him a card with the helpline number. Laura offers what I took to be some reassurance.

“Sometimes people have to scrape the bottom of the barrel before they can start to get better.” C nods.

Laura is concluding the discussion by offering information and advice. She is suggesting to C that, in his current state, he has the best opportunity for recovery. Since a collaborative and acceptant relationship has now been established, it appears that Laura expects this advice to be heeded, her suggestion taken seriously. Her final statement would most likely have been ineffective had it appeared towards the start of the discussion.

This case illustrates both how a collaborative relationship is established between a professional and a service user and how the carer is involved. Since E is present throughout the discussion and C has been, and indeed will be staying with her, she is treated as an equal partner in the planning of C's treatment. Hence, had E refused to allow C to stay with her for the duration of his detox, and different course of action would have been suggested. Since C "cannot stand his flat", he may have been "committed" after all. In short, the role of a person's carer cannot be underestimated in the planning and delivery of home-based treatment.

4.2. Case 2: Managing User Dissatisfaction.

I visited A on several occasions towards the end of the first observation period with the Churchfield team. She had a long history of involvement with mental health services. Paul, the social worker I accompanied on my first visit to her home, described her as a person who had "been known to services for about a thousand years". With this comment, Paul presented A as a particular type of service user; she has long-standing, "chronic", mental health difficulties. This contrasts with other service users seen by the team, many of whom are experiencing their first "mental health crisis". Paul's comment also suggests that A's current crisis may not be simply a reaction to a single adverse event; rather, she is a person for whom life is difficult most of time and that now life is more difficult than usual. In short, though this comment is somewhat glib and intended to be humorous, it nevertheless contains significant information. However, the comment may also be seen as belittling. A's experiences have been reduced to her involvement with services; the length of this involvement has been exaggerated for the sake of backstage humour. In short, this comment would be very unlikely to be made in the presence of a service user. (See section 3.1., above.)

Once Paul had shared his expectations with me, he explained that she was currently experiencing unpleasant side-effects to a recently prescribed medication; to use the team's terminology, it had induced a "labile" mood. I had to ask what this term meant,

and I was told “unpredictable, up and down very quickly”. Also, the day centre she usually attended had been closed for the Easter bank holiday so her usual source of support had been lacking. A communication breakdown had occurred between her and the crisis team. She had expected them to contact her the previous Thursday. When the team had failed to do this, she had telephoned them in a state of fury. When we arrived at A’s house, I was interested to see if Paul’s, and subsequently my own, expectations were fulfilled. A showed us in and we sat down on her sofa. I noticed a copy of a magazine written by service-users for service users in the local area. Once we had politely declined a cup of tea, Paul asked a question:

“What’s wrong with your hand, A?” asks Paul.

“It’s just a blister that burst.”

“Blisters don’t usually bleed. What’s happened, A?”

“I was just rubbing it.”

“Okay”. Paul says nothing more on the subject.

Paul’s initial question, and his response to A’s answer, establishes a power relationship. That A has a bleeding blister is not directly related to the purpose of our visit, yet Paul is nonetheless acting as a mental health professional, making A the recipient of his concern. He is trying to ascertain whether or not A has self-harmed. Were she not already established in her role as service user and he as professional, it is less likely he would pathologise the state of A’s hand. He questions the validity of her initial response, “blisters don’t usually bleed”, and asks her to once again give an explanation for the scar. A’s response minimises the scar’s possible significance; she was *just* rubbing it. However, some mental health professionals may consider the deliberate rubbing of a blister as self-harm in itself. Paul’s response suggests that, whether he thinks this or not, he does not deem it necessary to pursue the matter further at this stage. In short, since A is known to Paul as a long-term service-user, he scrutinises her presentation for evidence of particular behaviours. He continues by asking a general question:

Paul asks A how she is feeling. She says she “just cannot wind down.” She has been awake since 4am that morning and has been occupying herself in various ways. She had forgotten to send her friend some poems she had written and was very upset by this. She was angry that she had not been contacted by the team on Thursday night. “I did take an overdose on Friday” she adds.

“What did that do?”

“It just knocked me out. I didn’t think I’d wake up but I did.”

In his question, Paul focuses the discussion to recent events. Though A has a substantial psychiatric history, a crisis team focuses on the immediate problem. The role a person’s history plays is hence limited; were Paul a psychoanalyst in session, this scenario would be profoundly different. However, as stated above, all those present are aware of A’s history and this has already effected Paul’s questioning. A initially responds to Paul’s question by describing her day. She then contextualises this in relation to the crisis team’s failure to contact her.

Paul’s response to A’s assertion that she had taken an overdose is interesting and perhaps surprising to one unacquainted with the workings of mental health services. What is interesting is the very brief time Paul spends discussing it. He asks A one question; what did the overdose do? He does not tell her that she could have died or that such behaviour could lead to her sectioning. This may be because he deems her history and, by implication, knowledge as substantial enough for him not to need to say this. She already knows. Furthermore, she had taken the overdose two days previously and had survived without evidence of complication. Also, the team is now involved so her professed rationale for such an action no longer applies. Hence, the matter is pursued no further.

Paul continues. “I know how frustrated I get if I’m waiting for a plumber...”

“This is different! I have an emotional need!” interrupts A. “I have no support apart from the mental health services!”

“What I was going to say is that waiting for a plumber is frustrating enough, so I know it must have been extremely frustrating for you. If we’ve let you down, we’re very sorry.”

Paul attempts to compare A’s frustration with the frustration of waiting for a plumber. In this way, he may be said to be attempting to “normalise” the situation; everybody gets frustrated when waiting for something that does not appear. A, however, rejects this suggestion angrily; her “emotional need” cannot be compared to a relatively trivial domestic matter. Paul responds to this by stating the limits of his comparison; he knows how she feels to a certain extent, but allows her the reality of her own experience as profoundly different from his own. A professes to have no support apart from the mental health services, and Paul responds by offering an apology for the team’s failure to deliver this support. The discussion continued:

A continues to talk about her misfortune. “If there’s a field, most people can walk across it without tripping over or falling in a puddle. If I walk across it, there’s an earthquake and I fall into the bottom of a ravine.”

A goes on to describe past incidents where she feels she had been let down by the mental health services. She says that someone had promised her “a trip to the Bahamas” and she’d got nothing. Paul asks her what she means by a “trip to the Bahamas”. She tells him it’s just a figure of speech. She goes on to say that the attitude of hospital staff has been that she’s “just lonely”. “I am lonely, but if that was the only problem I would have overcome it by now.” She currently feels isolated because the day centre that she usually attends is closed over the bank holiday. “Remember that depression in itself is isolating” says Paul. There was a long pause.

It is interesting that A uses metaphors to describe both her mental state and the responses of the mental health services. I got the impression that she had used these metaphors before, or had at least rehearsed them. In part, I thought this since she had already

professed to writing poetry. Also, as I was burdened by the preconception that she was a long-established user of services, I suspected that she was used to articulating her thoughts and feelings in this way to professionals and others who would care to listen. In short, A seemed keen to present herself as articulate and imaginative. In presenting this way, it is possible that A was also showing that she has insight, will not be condescended to, and knows what she wants from the service concerned.

Paul appears to acknowledge A as an authority on her mental state, though he nonetheless imparts the advice of a detached and knowledgeable outsider: "Remember that depression in itself is isolating". In framing his advice as a reminder, he is granting that A may already possess the knowledge he is about to share. It is not necessarily the case that Paul deems A to have forgotten such knowledge; rather, it is more likely that he deems her current problem to have detached her from it. In short, Paul is serving to remind A of something she already knows, upon which it now may be helpful to focus. The discussion continued:

Paul asks A about her medication, as it is a bad reaction to her current medication which had led to this crisis. A gets up and walks towards a table in the middle of the room. Paul follows. On the table is the largest assortment of medications I have ever seen outside of a pharmacy. She picks up each in turn and describes what they are for. Paul picks up and reads the label on the particular packet.

"You've got a lot here, haven't you?" says Paul.

"I keep them out so I know what to take when" says A.

A has stopped taking the particular medication which is causing her problems. Paul tells her that things should improve in a few days, once the medication has left her system. She nods in acceptance. She is very tearful.

Once again, A is displaying her knowledge of her long-standing problems. It may be that the ordering of medication here serves in some way to order her mental state; she keeps

them out so she knows when to take them. Although her response to this particular medication is a key factor in her current crisis, it is dealt with relatively briefly. Paul is a social worker, and is hence unlikely to possess the same level of knowledge of psychotropic medication as a psychiatrist or nurse. The knowledge he imparts to A is hence limited; again, he may be reminding her of what she knows already. However, this is not to say that Paul's understanding of the situation is by any means inadequate; rather, he is *framing* it in a particular way (see chapter six). Had A been visited by a psychiatrist that afternoon, the focus, and by implication power-balance of the discussion may have been different. A psychiatrist may have asked and told her more about the medication, and this may have given them a leading, rather than collaborative role in the discussion. This is not to say that a psychiatrist's questions would necessarily be wholly different, as Paul's next health-orientated question demonstrates:

Paul asks A what she has been eating. She says she has had some fruit gums today. Paul tells her that she is no doubt aware of how lack of food can affect mood. She says that she has had anorexia for many years and is well aware of this.

Once again, Paul is treating A as an authority on the situation, and A is responding as an authority. Her many years of experience put Paul in a position where the advice that he can offer her is limited. Paul's next question seemed to serve as an acknowledgement of this:

Paul changes tact. He asks A "what can we do for you now?" A says "I just need someone to talk to." Paul says he will arrange for her to be visited tomorrow. He then asks her what she will do for the rest of the day. She says she is making a flower press. Paul says "is that okay for now?" She says "yes". We rise to leave.

Paul's question suggests that he is now giving A almost total control of the decision to be made: what is going to happen next? A's response is very clear: she needs someone to talk to. Once he has assured her she will be visited the following day, he seeks assurance

from A that she is happy with this. Hence, it seems that A, rather than Paul, has the greater say in determining the subsequent course of action.

In general terms, this case illustrates the empowerment of a service user who has been dissatisfied with the crisis team. This is not to say that the team are offering her compensation for her dissatisfaction. As the discussion between A and Paul demonstrates, A is very much an authority on her presenting problem and she uses this authority to her advantage. She is able to articulate her needs in way that does not allow Paul to interpret them in any way other than she has intended. Despite the degree of conflict evident in A's protestations at Paul's comments, there is also collaboration in the organisation of subsequent care. It is A, and not Paul, who leads this collaboration. Indeed, the whole interaction is a response to A's initial telephone call. Hence, this case is demonstrative of the significance of contextual factors in user involvement.

4.3. Case 3: Assessing Risk and the Limits of Collaboration.

Early in the first observation period with the Newchester team, I visited K. He had been referred to the team a few days before, having self-harmed. On our way to his home, Alex, the nurse I was accompanying, told me he had a long history of depression, which had recently become unmanageable. He had also behaved violently towards others in the past. He then told me that K liked to talk at length about his depression, and desired to begin a service user's self-support group. However, once we had been greeted by K and his wife Mary, Alex made clear that, today, time was limited:

“Okay, well, I've got to keep this visit fairly short as I've got a couple of people to see this morning, but we'll see how it goes....So, how've you been?” asks Alex.

K speaks very quietly. “I had a bad day yesterday. We just went for a visit to town, y'know. At first, I didn't want to go, but I did.” I notice that he is shaking. “We had a flat tire. I got out to change it. There were people around. I got really agitated.” He goes on to say that a security guard from the building outside where

he was changing the tire had agitated him further. He feared the security guard would approach him.

Alex's initial statement asserts his control over the situation. His time is limited, and hence K's is limited also. K replies to Alex's initial question, first with an evaluation of the previous day, and then describing the events that led to this assessment. It is significant that he is describing very recent events; he has already been assessed by the team and they hence have a conception of the broader background factors to K's presenting problem. This contrasts to the case of C, described above, who gave a more extensive personal history since his general, rather than day-to-day needs were being assessed. The discussion continued:

“What would you have done if he had approached you?” Alex asked.

“I don't know. I really don't know.”

I guess that Alex is trying to find out if K is likely to be violent in his current state of mind.

K goes on to describe how sensitive he is feeling at the moment. He says he never used to be like this, and describes some of the jobs he has had in the past where he would often suffer verbal abuse. In those days, he could “just take it.”

K could have said he would have broken down in tears or run away in panic had he been approached as easily as he could have said he would have punched the security guard. This possibility is strengthened by K's subsequent admission of his current sensitivity. Due to K's history of violent behaviour, the original interpretation of Alex's question still holds weight, but Alex has expressed his intention indirectly, hence allowing K to answer in the way he sees fit. Had Alex asked K if he would have assaulted the security guard had he been approached, it is possible that K would have become defensive. A collaborative relationship may have thus been lost. In general terms, Alex is working with

his knowledge of K's past behaviour, but in such a way as to avoid verbally "labelling" him with it.

Alex asks K how he is getting on with his medication. K gets up from his seat suddenly and removes the top from a stool that is between the three of us, next to the main table. From inside the stool, he lifts a toolbox. He opens the box. Inside are numerous packets of medication. "This is my medication", he says decisively, almost as if to shock. I feel he may be playing to my presence slightly. He describes which medication he takes at which time of day.

Alex follows K's description of his medication regime attentively, nodding his head, occasionally giving the odd "mm". He goes on to ask how K is sleeping at the moment. Is the medication helpful in this respect? K replies that his sleep is very poor. He feels very alone at night when Mary is asleep. His mind races. At these times, he often considers self-harm, as he did last night. (He had acted on this impulse several nights previously. This is what led to his referral to the crisis team.) His voice is reduced to a mumble as he describes these feelings.

The way in which K reveals his medication seems somewhat dramatic; his movements and his words suggest that he is making an angry statement: "Look at the mess I'm in. I have to take all this medication." The decisiveness of his actions, and the contrast between this and his previously tearful and anxious presentation, may also be read as K demonstrating, perhaps to himself as well as those present, that he is not powerless: "*This is my medication*". It is an invitation to look at something which is currently a large aspect of his life. This is further evident in Alex's attentive reaction. Like in the case of A described above, the professional appears to be displaying acceptance of the seriousness of the service user's current predicament.

Alex continues the discussion by asking a question that appears regularly in discussions between team members and service users; how are you sleeping? (See chapter three.) K

provides a detailed description of his feelings and why he cannot sleep, but mumbles, as if ashamed, when he describes his desire to self-harm. The discussion continued:

“What stopped you from self-harming last night?” asks Alex.

“Lack of resources” replies K dryly. He goes on to say, however, that since his referral to the crisis team, his mood has lifted slightly but significantly. “I’ve never had this level of support before. I know that someone from the crisis team will come and see me every day. Even when I was in hospital I never had this level of support.”

The dryness of K’s reply to Alex’s question can be read as provocative: he would have self-harmed had he had the “resources”, thus undoing any progress he has made with the team’s support. Perhaps it is then surprising that he proceeds to compliment the crisis team. However, it may be that, having made a statement that is possibly indicative of his being in a similar position to how he was before the team’s involvement, he is suggesting it is not to be read in this way. The team’s support is, in fact, a great benefit to him. Hence, it may not simply be a “lack of resources” preventing self-harm, but also the knowledge that the crisis team’s visit is just a few hours away.

K’s wife, Mary, joined in the discussion:

Mary sits down next to K. She reports on K’s behaviour over the last few days. She says her sons, who live nearby, have been very supportive towards K, but that K is very dependent on her. K leans forward, picks up a box of matches from the table and quickly lights a cigarette with a frown. He shakes the match out forcefully. He looks angry. Mary goes on for some minutes. She talks of K’s collapse a few days earlier. She says that K is “taking in the problems of the world” and that she is always with K. Alex replies to Mary.

“Maybe K needs to try to be less dependent. It’s bad for his self-esteem.” It is interesting how he is clearly addressing Mary although K is right next to her, as it is obviously intended for his ears also.

Here, a process is occurring similar to that described in the case of C, above: the carer is integrated into the discussion. However, in this instance, Mary instigates her own involvement. She is not reacting to a question or comment; rather, she is sharing her experience of K with Alex. Alex responds by suggesting to Mary that K should try to be less dependent. As K is present, he is also being addressed in the third person. (This may also be “bad for his self-esteem”!) Alex is suggesting a means through which K and Mary can improve K’s well-being together, in the absence of a crisis team member. Before Mary can respond to this suggestion, however, K changes the subject:

K starts to talk again. He sounds louder. His focus is on us and he gesticulates. He appears angry. He describes the incident with the tire again, and how he “took shit” in previous jobs. Alex nods and looks at K attentively, resting his chin in his hand. There is a pause.

“Okay. I think we need to finish here. I’ll arrange for someone to come and see you again tomorrow. About the same time?” K nods. “You’ve got the number in case you need to contact us?”

Here, Alex once again asserts control over the situation. It is possible that he has chosen to end the visit because K is now repeating himself. Also, he turns statements into questions, indicating that he assumes an affirmative answer. This adds to his status as the main protagonist in this discussion, which subsequently ends:

“Yes. Thankyou.” K remains on the sofa. Mary rises and shows us to the door. I thank her and K on my way out. Alex and I go back to the car. Mary remains in the doorway of the house. I am conscious of this so I make no comment to Alex, and he none to me.

Alex starts the car up. “He seems very angry” I venture.

“That’s the main thing I picked up on, his anger” says Alex in agreement. “I don’t know if he’s going to act on it. The main priority is risk assessment.” I like Alex’s brutal honesty.

Alex’s statement, that the main priority is risk assessment, has far-reaching implications as to the level of collaboration that can be attained. In contrast to the two cases previously discussed, here the team member holds an obvious balance of power. K’s past behaviour, though not an immediate factor in his current presentation, remains significant to his treatment. (See chapter three, section 2.5.) Since K has been violent in the past, the team’s priority is to minimise the risk of his being violent in the future. This was reflected in Alex’s line of questioning. The assessment of risk is imposed by the teams. The users are asking the teams to improve their situation, not to monitor their behaviour. Hence, risk assessment is likely to detract from user empowerment and limit the extent of collaboration.

5) Conclusion: Audience Participation on the Official Frontstage.

Relationships between service users and crisis team members are not collaborative merely by default. Rather, it is the result of a drive to involve users in the planning and implementation of their care. However, the extent to which such collaboration is possible is limited and will vary in each case. Like teamworking, user involvement is negotiated and will manifest differently from case to case.

Service users may utilise certain aspects of their current problems in self-presentation, such as medication regimes, life histories, and diagnoses. These are subjects on which they are likely to be an authority. Since mental health service users are amongst the most disempowered people in our society, this authority is immensely important. By and large, team members support users in this, encouraging them to apply their knowledge to the

current situation. Rather than claiming to “know what’s best for you”, crisis teams regularly ask users about the effectiveness of their medications, and indeed to clarify that the team’s involvement is helpful to them.

Despite being collaborators in the planning and implementation of their treatment, service users cannot be said to be equal players. They may have more power than in previous decades to discuss and even resist treatment, but treatment itself is the property of the team to give. It may be that the team’s treatment is to be assembled by the users and carers as well as the professionals, but it is still ultimately presented by the team to the user, not vice versa.

Finally, the dramaturgical metaphor utilised in chapter four is also applicable to understanding the dynamics of user involvement. User participation is virtually absent on the official backstage, where they are not physically present. Though service users may be, in part, responsible for the design of the current theatre, they are neither performers nor even stage hands in the two teams studied. Rather, they are the audience, but an audience who nonetheless participates substantially in the performance.

Chapter Six: Expertise.

1) Introduction.

1.1. Chapter Overview.

In this chapter, I consider the significance of expertise in crisis resolution. By expertise, I mean in part those forms of knowledge and organised practice specific to professional disciplines, such as medicine and social work, and also those specific to crisis work which may be transcendent of any such discipline. Beginning with the premise that certain professional disciplines may *frame* particular cases in particular ways, I describe how such disciplinary framings may both complement and compete with one another in the running of the service.

I begin by considering the broader rationale for the crisis teams' multidisciplinary character. In the next section, I examine the specifications for the teams' constitution presented in the Department of Health's (2001) Policy Implementation Guide, and relate these to descriptions of the disciplines of which the two teams studied were comprised. I then consider data from interviews presenting team members' descriptions of their own expertise and those of others within the teams. Following this, I illustrate these general themes by presenting four short case-studies from home visits on which I accompanied different professionals.

1.2. Expertise and multidisciplinaryity.

Though each team is composed of individuals drawn from several different disciplines, it is apparent that, in general, team members collaborate in the process of identifying and treating those in "crisis" regardless of professional standpoint. (See chapters three and four.) Laurance (2003:79) defined a recent development in mental health services:

Talking about what experiences mean is now mainstream in psychology- but it has seeped out slowly to the mental health service. It is not just about providing more talking treatments- it is about the way in which mental health problems are approached. The approach should focus on the whole experience- not just what specific treatments are available for specific symptoms.

Laurance's claim is contestable. It insinuates the previous existence of an opposition between a medical and a socio-psychological framework. In fact it is an oversimplification to suggest that the medical and socio-psychological views of mental illness or mental health problems are opposites; they are simply different (see section 2.2. below). To suggest that psychology is solely concerned with talking and psychiatry solely with treating symptoms is to perpetuate an outdated view of both disciplines. However, Laurance's essential point is that mental health services are striving towards a *holistic* understanding of mental health; that is, an acknowledgement that the nature of a person's mental health difficulties is multifaceted. As previously argued (see chapter three), this is particularly evident in crisis work, where the magnitude of a person's problem may be at its most obvious. In short, the multifaceted nature of crisis requires multidisciplinary understanding. Housley (2003:1) defined the nature of multidisciplinary:

At the core of the conceptual apparatus of multidisciplinary is the concept of knowledge and its social organisation. The concept of multidisciplinary is one that is grounded within a functionalist and systems based account of the social organisation of knowledge. The systems orientated organisation of knowledge in this way is seen as crucial to the efficiency and utility of knowledge systems in solving human problems. Furthermore, knowledge within Western societies has been subject to fragmentation, multidisciplinary, as a systems based concept is an attempt to overcome fragmented thinking and develop holistic modes of enquiry, decision making and practice.

Housley's essential argument here is that the central knowledge base of a multidisciplinary team is dependent on the input of a variety of contributory knowledge

bases (see chapter one). Psychiatry, social work, nursing and support work are distinct professional disciplines, but in the context of a team with a specific intent and purpose, there is a certain commonality of application. The remainder of this chapter explores the function of particular disciplines in the attainment of such commonality.

2) The Expertise in the Teams Observed.

2.1. The PIG on Expertise.

The PIG (Department of Health 2001:13) state that “multidisciplinary assessment of service user’s needs and level of risk” is a “key element” of team practice. Risk may be manifest in a variety of different ways, both medical (such as an adverse reaction to psychotropic medication) and social (such as the possibility that the service user may physically endanger themselves or those around them). In order to consider all possible risks, it may at times be necessary to utilise the expertise of different disciplines. The PIG goes on to refer to expertise in terms of a person’s needs such as monitoring medication and “practical help with (the) basics of daily living” (e.g. help with benefits, housing, childcare etc) (15).

The PIG proceeds (20-21) to present a table, the first three rows of which are reproduced below. For the purpose of clear presentation, I have added a commentary beneath each row. Each row is divided into two columns, but there appears to be little in the way of a consistent formula. Rather, the table is essentially information in boxes and it is not clear why these boxes appear as they do or where they do. (The original table appears in appendix III.)

Though the PIG is regarded as a solid set of criteria, this table is framed as presenting “suggested staffing levels.”

The table below gives details of suggested staffing levels and skill mix for a team with a caseload of 20 to 30 service users at any one time.

<u>Table 3b</u>	
Designated named workers:	Total 14 per team
Key skills:	Team leader plus up to 13 others
<ul style="list-style-type: none"> • High energy level • Team player • Ability to creatively engage service users • Understanding of needs of service users, including specific needs related to cultural background/age/gender etc • Able to co-ordinate care and provide broad range of interventions 	Designated named workers include: CPNs ASW OT Psychologists Support workers including service users Appropriate mix of staff is needed to ensure that all the interventions listed can be provided within the team

The Newchester team did not formally designate named workers, though they did try to designate a consistent worker or set of two or three workers to specific service users. Further efforts were made in the Churchfield team, in that a worker's name would appear on the white-board next to a case description. However, it was not always possible for this worker to attend every visit to that particular person (see chapter five). Nevertheless, the list of key skills presented above and the accompanying comments remain useful as a general description of the expertise necessary for crisis work itself. The necessity of a "high energy level" reflects the high level of demands of crisis work. The need to be a "team player" further emphasises the fact that crisis work is co-operative work (see chapter four). The remaining three "key skills" illustrate the flexibility necessary in working with service users; users should not be subjected to a dogmatic form of treatment

whereby all users are treated in the same way regardless of individual circumstance (see chapter five.)

The composition of the list of designated key workers is significant for the operation of both teams studied. While both had CPNs (community psychiatric nurses) and ASWs (approved social workers: social workers with the power to impose a mental health section) as members, neither had an OT (occupational therapist) or a psychologist at the time of study. The support workers were not service users or former service users, but people who had experience of some form of mental health work, such as auxiliary nursing on psychiatric wards. Interestingly, psychiatrists are not listed as potential “designated key workers”. This may imply that they have a more detached role, “doing psychiatry” for the team when requested. However, their role is far more integrated than this exemption suggests, as is demonstrated in the next row of the table.

<p>Medical staff</p> <ul style="list-style-type: none"> • Active members of the team • 24 hour access to senior psychiatrists able to do home visits is vital 	<ul style="list-style-type: none"> • Involvement from both consultant and middle grade psychiatrists • Level of psychiatric input to be determined by local need and service configuration
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So, medical staff are “active members of the team” but apparently not “designated key workers”. This suggests, though they are integral to the establishment of the team, their profession is so specialized that they must work within its confines rather than flexibly, as the CPNs and social workers do. However, nursing and social work are also established professions and it is hence difficult to speculate as to why psychiatry is deemed as different in this way. It may be to do with the nature of medical training and the nature of the medical profession itself (see section 2.2. below).

As previously explained (see chapter one), the Churchfield team had two part-time consultant psychiatrists and no “middle grade” psychiatrists. The Newchester team had two consultants, an SPR and three SHOs at any given time. However, the medical staff

tended to only work the day (nine to five) shift. This is not to say they were not available “on call” at other times, but this was rarely utilised over the period of study. However, the last point, that the “level of psychiatric input to be determined by local need and service configuration” shows that these arrangements cannot necessarily be described as shortcomings. In a city such as Newchester, other services were available to contain medical emergencies until a consultant from the team could become involved. It is also important to remember that Churchfield was, at the time of study, an aspiring crisis team which was not yet operational 24 hours a day.

In general terms, despite the apparent contradictions in the PIG, the role of the medical staff is consistent: they will cover the specifically medical matters such as prescribing medication and assessing physical health. It is the level of their input and power which will vary between teams.

The table continues with reference to “specialist skills”.

<p>Specialist skills</p> <ul style="list-style-type: none"> • These skills should be available within the team either by employing a fully qualified practitioner or by training other team members • External supervision, support and training needed for ‘non specialists’ providing these interventions 	<ul style="list-style-type: none"> • OT/OT skills • Psychologist/psychology skills • ASW/strong links to social services and ability to undertake thorough assessment and activate services as needed
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One assumes that the specialist skills referred to here are those “key skills” referred to in the first row of the table and indeed those of assessment, intervention, treatment and resolution; in short: crisis work. There exists a hierarchy of power and knowledge within the teams (see chapter four) and this is reflected in the references to training and supervision. The second column refers to skills which do not have specific professional

representation in either of the teams (occupational therapy and psychology). This is not to say that these skills are not practised to a certain degree by other team members. Indeed, nurses, support workers and social workers may have a degree of skill in occupational therapy and psychology. For example, a nurse may have a certain level of training in cognitive behavioural therapy utilised when appropriate (see section 4.4. below). ASWs and strong links to social services were present in both teams and the inclusion of these in “specialist skills” suggests that crisis work is often dependent on other services; such is the complexity of need a crisis team will inevitably encounter.

In general terms, the requirements put forward by the PIG suggest that input is required from a variety of disciplines in both assessment and the delivery of home-based treatment. The PIG does little, however, to describe *what these disciplines actually are*. In the proceeding sections, I consider the nature of these disciplines in further detail.

2.2. *Psychiatry.*

Psychiatry is a frequently scrutinised discipline, by psychiatrists themselves (Laing 1965, Szasz 1972), by doctors of different specialist disciplines (Sinclair 1997), by the media (Laurance 2003), and indeed by social scientists (Goffman 1961, Foucault 1961, Hacking 1998). The many criticisms of psychiatry, though different, are related. Anti-psychiatrists such as Szasz argued that psychiatry is essentially political; an agency of social control. This sentiment is echoed in the work of Goffman and Foucault. Psychiatry’s categorisation of mental illness, the placing of the boundaries between sanity and insanity, will change over time (see chapter one). In medicine, psychiatry may be seen as a low-status speciality (in contrast to surgery or cardiology), since psychiatrists do not treat physically observable symptoms (Sinclair 1997: 245-247). It is hence seen as speculative, unscientific and to an extent out of tune with what Sinclair calls the *medical habitus*.

The *medical habitus* is a system of beliefs and values ingrained in doctors during training. Sinclair argued that the *medical habitus* is not ingrained in professional practice alone; rather, it becomes an entire world-view, influencing the private (psychological) lives of

those initiated. The *medical habitus* is something of a scientific world view, apparently cynical towards alternative perceptions of reality. It is not so much a *medicalised* world view, but an unquestioning world view: that there is a *right* way for a medic to accomplish given tasks. It is also about loyalty to a long established profession. In his penultimate chapter, Sinclair (297) stated that, towards the end of medical training,

Incessant assessment has made them [medical student] aware of the need for institutional conformity in answering questions, rather than asking them or arguing with them.

Hence, the long and rigorous socialization undergone by the medical staff is likely to impact upon their view of the events and the people they encounter. It may be that, by virtue of this training, they will interpret events in terms of symptoms. It is they who will focus on the medical aspect of a person's crisis. Whether or not they are open to alternative formulations is not particularly significant here. Rather, their specific expertise is called upon when the occasion demands. However, this is not to say that the medical framework employed by psychiatrists will not influence those of other professions, as shall be illustrated later in this chapter.

Sinclair was not alone in arguing that doctors are trained in such a way as to segregate them from other disciplines. Becker *et al* (1961) described medical students as very much a self-contained group, while Larson (1977) considered the notion of an "exclusive cognitive identity" belonging to members of any profession. Since medicine is particularly exclusive in this respect, psychiatrists face a particular dilemma. They are both at odds with and contained within the *medical habitus*. To fellow doctors of different specialist disciplines, they may be deemed inferior and unscientific. To fellow mental health professionals such as social workers and nurses, they may be deemed as overly cold and clinical, and hence lacking interpersonal therapeutic skills. There is evidence for this in Barnes *et al* (2000). They conducted a study of interprofessional education which asked mental health professionals to rate each other on particular criteria. The results of this exercise showed that psychiatrists

received significantly poorer ratings for communication skills, interpersonal skills, practical skills and breath of life experience. (574)

Despite all this incessant scrutiny, the discipline of psychiatry retains much of its original power and status. Psychiatrists are essentially “doctors of the mind”. They have, like the surgeons and cardiologists who may be sceptical of their discipline, undergone extensive medical training. Their profession hence commands respect. The influence of their knowledge and hence power in crisis work is, as this study illustrates, of great significance

2.3. Social Work.

Social work, like psychiatry, is an established discipline and has a particular world-view. Its history may be shorter than that of psychiatry and its accompanying body of literature less substantial, but it is nonetheless a specialized discipline requiring specific training. In the field of mental health, its use is integral to establishing a holistic picture of a case. The viewpoint of social workers is likely to be concerned with a person’s social circumstances, more so than psychiatric and medical symptoms. Social work considers things differently to psychiatry.

In a study of practice, de Montigny (1995:39) defined social work in the following terms:

...social work is fundamentally a bridging and colonising enterprise between the realities of people’s daily lives and an institutional reality... Once the shores of daily life are bridged, specific topographical features and particulars can be mapped out using a grid of organizational relevances and concerns.

To de Montigny, social workers, like doctors, apply a specific professional understanding to the situations they encounter. “Institutional realities” and “organizational relevances” are, essentially, the established methods of social work; to apply their expert knowledge

of the containment and resolution of social and domestic problems to the situations they encounter in their work. Like doctors, social workers also have a loyalty to an established profession. As de Montigny (61) continued:

In texts, whether journal articles, monographs, case reports, case assessments, or course papers, social workers both presume and constitute the ontology of the profession as a domain existing beyond their immediate mundane activities.

Hence, de Montigny is implying a sense of belonging to the social work profession on the part of social workers, even when they are not in direct contact with service users, but producing texts. Psychiatric terminology, which will focus more so on the individual's inner mental state, though still relevant, is less likely to be the primary concern of these professionals than it is to those with a medically orientated approach. Fisher *et al* (1984:215) considered the role of social workers in mental health. They should

...aim to mobilise for the client the informal supportive social networks which prevent most of us from requiring formal help with our problems.

In Fisher and his colleagues' opinion, in encouraging service users to seek out informal support networks, social workers to an extent de-medicalise their presenting problems. This may serve to assist in the removal or at least diminishing of the stigma attached to mental illness. Hence, a key role of social workers is to empower the service user, to collaborate rather than passively treat (see chapter five). The view may be taken that, if the individual's circumstances improve, their inner mental state will also improve. However, this is an assumption and lay expectation. The actual professional dynamics may be far less clear-cut.

2.4. *Nursing.*

As stated above, social work and psychiatry are not in opposition; they merely adopt different interpretive frameworks to the situations they encounter. Such frameworks may

be complementary. While it is easy to note the differences between psychiatrists and social workers, the position of nurses is less certain. Some may have an outlook more like that of the social workers, others more like that of the psychiatrists. In short, it is more difficult to speculate on a “common view”. Their discipline is generally practically rather than theoretically driven. As Rydon (2005:79) explained:

Poorly articulated frameworks of philosophy, practice and theory underpin the current problems faced by mental health nurses and contribute to a limited understanding of the practice of mental health nurses... Mental health nursing practice might necessitate mental health nurses to minimize the visibility of their practice in order to accommodate clients.

This suggests that the nurse’s role is a pragmatic one. They will monitor and assist the service user, and report on the service user’s progress to the team. They will establish a therapeutic but pragmatic relationship with the service user, a mixture of containment and empowerment. However, the same practice could be said to be utilized by all crisis team members, but nurses, being the predominant members in both of the teams, will do this most often.

It would seem, then, that what distinguishes nurses from social workers and psychiatrists is that they have less power and less of a specialized purpose (except in the case of the team leaders). However, positive differences may also exist. Indeed, they may be the fundamental “crisis workers”. This contention is supported by recent developments in psychiatric nursing.

Barker (2002) devised what he calls “The Tidal Model” in psychiatric nursing. The Tidal Model is holistic and person-centred in its approach. It views mental distress as a transition; part of a person’s journey from one stage in their life to another. As Barker (2003:100) explained:

...the Tidal Model puts the person's experience, and unfolding life-narrative centre-stage. The nurse provides the necessary support to ensure the person's emotional and physical safety (self domain) helps the person explore and identify what needs to change, to facilitate recovery (world domain) and explore the possible role of professionals, family and friends, in the whole recovery process (others domain).

Though not an officially sanctioned requirement (neither the NSF nor the PIG refer to it), the Tidal Model fits comfortably with aspects of the PIG's definition of crisis resolution: empowering users and carers and learning from the crisis. Since it is not officially sanctioned, one cannot make too much of this model in relation to this study. It was mentioned on one occasion by a nurse from the Newchester team (who suggested I "check-out" Barker's work), but it was not discussed by either team at any time when I observed them. However, it offers a fresh perspective on the role of psychiatric nurses generally; a perspective which is worth mentioning since it shares such commonalities with the practice of crisis resolution.

In crisis resolution, nursing is not to impose treatment, but to negotiate it with the service user. The role of nurses is, essentially, to improve a person's quality of life. While in the past this may have been done through the use of more invasive treatments, the current focus of those such as Barker and indeed crisis resolution teams is on a more co-operative and psychotherapeutic model. Since the majority of workers in both teams are nurses, it is possible that they are the key instigators of a more general team practice, or indeed of a specific practice of *crisis work*. This possibility is discussed further as the chapter proceeds.

2.5. Support Work.

Support work cannot be called a "professional discipline" as such; it has no established body of literature supporting it and requires experience rather than formal qualification. The support worker is there to assist team members, carers and service users, but does not have the power to dispense medicine etc. They do not share the same level of clinical

responsibilities as other team members. Though all team members will provide a level of support to the service user, the support provided by a support worker is specifically to empathise and even befriend. They may also assist in the accomplishment of practical day-to-day tasks, such as shopping and filling in forms.

Gibb *et al* (2002: 341), in a study of a community mental health team, defined support workers as

...a shared resource for the SWs [Social Workers] and CPNs [Community Psychiatric Nurses] providing intensive intervention for clients.

Hence, support workers, out of necessity, are flexible in their approach. Like nurses, their delivery of care is particularly pragmatic; they will “support” team members from whatever discipline. Since they are lay people and not “professionals” they are able to establish a closer relationship with the service user. Their purpose is then to provide the service user with a greater sense of normality than a clinician (working under the necessary professional boundaries) may be able to offer. As Gibb *et al* (347) continued

Though their close working relationship with clients, they [support workers] developed an intimate knowledge of the clients- their norms of behaviour and preferences. This allowed the CSWs [Community Support Workers] to undertake ‘fine detail’ observation which informed swift decision-making by the appropriate SW/CPN.

It is indeed possible that the non-clinical role of the support worker allows them greater access to the lives of service users. They do not *make* decisions on the person’s future treatment. Instead, they influence the decisions of those above them in the team hierarchy. This gives them the freedom *not* to probe for information from the service users. Thus, they are left with a greater ability than other team members to conduct a home visit under the terms of the service user and their carers. While such an approach would achieve

limited results in itself, with the clinical input of other team members it may strengthen the therapeutic value of crisis resolution significantly.

The remainder of this chapter examines the extent to which team members conform to these perceptions of their disciplines and how they utilise their particular skills. I begin this process by discussing the descriptions of team members put forward during interviews.

3) Team members' Descriptions of their Expertise.

In this section, I discuss the responses of a consultant psychiatrist, an SHO, a nurse and a social worker when interviewed about their work, specifically in relation to their professions. In doing this, I hope to illustrate some of the contrasts and commonalities that may exist between professions in crisis work. It should be noted that I am *not* implying that those I interviewed were wholly representative of their disciplines as a whole. Rather, they were authors of emergent themes which shed light on some of the intricacies of crisis work.

3.1. "Sally."

Sally was a consultant psychiatrist who I interviewed towards the end of the second observation period with the Newchester team. I asked her to tell me of any difficulties she had experienced during the setting-up of the service.

There was erm quite a lot of difficulty around the model of the team when we first started with regard to social services and health. Social services felt very much that this was a health model team, and that they hadn't really been involved in the development of it and they really wanted to look at more social models of care for psychiatric crises. And er it took us a long time to negotiate that really and eventually we came to a compromise and social services joined us but we had no social workers when we first started, <really> made it quite difficult. (*Pause.*)

The emergent theme within this segment is of conflict between health and social models of care for experiencing a crisis. Fundamentally, the psychiatrist is framing this difficulty as belonging to the social services. It was they who “felt very much” that the crisis team was a “health model team”. This conception of the teams’ purpose is evident further in the consultant’s reference to “psychiatric” crisis. In framing the “crisis” as essentially psychiatric, those who “wanted to look at more social models of care” are, by implication, potentially undermined. However, it remains evident that the consultant wished social workers to join in that she states that it was “quite difficult” in their absence.

The apparent reservations of social services may be explained by considering both the language of the PIG and the team’s original professional composition. The PIG (2001:11) describes the service is for “adults with severe mental illness” and proceeds to list a variety of predicaments in which the involvement of the service is “not usually appropriate” (See chapter three). Also, the team was initially developed by both senior nurses and psychiatrists. The apparent scepticism of social workers as prospective team members seems explicable since the senior management of the team had already been established without the input of social services.

Unprompted, after a short pause, the consultant proceeded to tell me of her opinion on the conflict between social services and health:

Er my feeling about all this is erm that for some reason in an organisation such as this we get erm bogged down in is it one or is it the other and it can never seem to be both. Whereas really we need each other, y’know, there is definitely a health model in this service and I think that’s fine but there are other bits about the social model of care which must be incorporated too. So there’s room for everybody as long as we don’t fight over it if you know what I mean.

Here, a contrasting theme emerges: the possibility of collaboration. The consultant is saying that the existence of a health model in the service does not negate the need for a

complementary social framework. Indeed, her concluding statement, “there’s room for everybody as long as we don’t fight over it”, suggests that it conflict between disciplines that lead to those disciplines’ polarisation. Professional disciplines may compete with one another and thus fail to complement.

I continued by asking whether specific expertise would be utilised for particular crises:

Depending on, y’know, it might be after assessment or it might be so obvious right from the very beginning we might already identify it. Medics would really be to do with er whether you thought the person might need to be sectioned, <if it’s> not gonna be able to be contained or whether it was really the possibility of some physical complications or erm about medications really.

Here, the consultant refers to the specialised nature of her discipline. She begins her answer by explaining the function of her profession, referring to the power inherent in her role (which is also inherent in the role of the approved social worker); the ability to, under specific circumstances and professional and carer agreement, impose restrictions on a person’s movement for a period of time via sectioning. In short, her profession will always be involved in the cases which are most severe. Psychiatry thus involves both power and kudos. Also, in terms of medications and physical complications, it is only those with medical expertise whose involvement is viable; nurses may have a limited role, social workers and support workers very little, if any role at all, while only psychiatrists possess the knowledge base necessary to engage in such interventions. In general terms, the consultant is describing what her profession can do and what other professions cannot. She goes on to ask for clarification of the original question.

So, you’re talking about first off? (*Yeah.*) Who would you point in which direction? Erm... So first off for medics it’s probably more likely to be erm is it gonna be a section, erm is this person, y’know, organically unwell as well, erm, which needs a doctor to sort that out, otherwise doctors would come in after assessment and always anyone who’s taken on for home based treatment would be seen by a doctor,

erm because it's actually very unusual for us not to treat people with medication as you might have noticed. (*Chuckles.*) Erm it's not that we think medication's the be all and end all, it's just that's that's the way it is. And I also think in home based treatment services you may use more medication than you do in hospital just because you don't have the containment of hospital, so we're using medication in a sort of containment way.

Once again, there is reference to the specialist role of the psychiatrist. The consultant reiterates what she has already said, but it is now framed in terms of the whole treatment process; what happens first at assessment and what happens afterwards when treatment is established. She proceeds to comment that "it's actually very unusual for us not to treat people with medication as you might have noticed" and she appends this comment with a chuckle. The comment and the chuckle has the effect of re-establishing a connection between interviewer and interviewee; she has ceased in merely describing practice and speculates as to my own observations; I "might have noticed" the regularity with which medication is used. It also suggests that she is expecting a response from me (I suspect I gave a smile and a nod). In short, her comment has the effect of momentarily changing my role from that of listener to that of actor; a contributor in this process.

The consultant's next comment seems somewhat defensive: "it's not that we think medication's the be all and end all, it's just that's that's the way it is". It may be that "that's the way it is" means "that's what seems to happen", or it may mean "that's what has to happen". Whatever the case, this comment has the effect of, to an extent, distancing her from this particular practice. The use of medication is not wholly her decision; it is part of a larger process of assessment and treatment devised over a period of time and not by one individual alone. There is hence an emergent theme of team work and team consensus in her comments. The contrast between my own predisposition as a social scientist and hers as a psychiatrist may be of significance here; it is possible that she is speculating that as a *social* scientist, I may be of a predisposition similar to those of the social workers she has previously mentioned; concerned with *social* models of care.

One cannot be sure that she would employ the same rationalisations if being interviewed by a medical student.

The consultant concludes her reflections on the use of medication with the admission that medication is used in a “containment way”. “Containment” is a concept distinct from “treatment”. “Containment” relates to the management of risk, while “treatment” relates to the improvement of a person’s condition. Though such processes are likely to overlap, they are not the same. It may be that, in containing an individual’s condition and, by implication, preventing them from perpetuating harm on to themselves or another, the individual’s condition will eventually improve. Such practice, however, is not the same as directly improving a person’s mood. It also has implications for community care in mental health as a whole. By implication, any autonomy a service user gains by virtue of being treated outside hospital is compounded by a larger intake of prescribed medication.

The consultant continues by describing the role of other disciplines in crisis resolution and home treatment.

With regard to other disciplines social work erm again if it’s about sectioning, cos we have approved social workers in the service, or if it’s erm a particular social crisis which might involve I don’t know, housing, children, those kinds of things that our social workers might be able to be more experti- expert or benefits or... That again probably comes after assessment erm with regard to what we used to deal- we had one occupational therapist who subsequently left and would often, y’know, identify people after assessment that, well I’d like to go and work with that person and it might be to do with very obvious things that occupational therapists do like adaptations of houses, or it might be more about social skills or getting them out or getting them reintroduced to the community or getting them back to work.

Here, there is an emergent theme of differing roles. As with her description of the medic’s role, the consultant begins by describing the role of social workers in the most severe cases where they have the power (by virtue of their expertise) potentially to over-

ride the wishes of the service user by sectioning them. She proceeds to describe the more regular nature of their role; to assist in social and domestic issues. As with the monitoring of medication, this role would be exercised once treatment has been established. She then goes on to describe the role of a now absent profession: occupational therapy. I had asked on a previous occasion why the occupational therapist who had left was not replaced and was told that such a replacement was not necessary as the team had strong links with a local occupational therapy service who could be called upon if required. Hence, though the team currently had no occupational therapist, their role remained relevant to the home treatment process and the consultant's description serves to answer the question of what different professions can offer to home treatment. The consultant continued:

Erm... what else have we got? We don't have any psychologists as you know, erm and the nurses depending on what their background is and their training will pick erm which person they erm y'know the people with cognitive therapy backgrounds might see someone for a few sessions or family ther... We did have erm three people who were doing family therapy when we first started and they would often see families and that was really helpful. So I suppose it's erm usually it's after assessment that those decisions are made erm but sometimes can be made earlier.

Here, the absence of psychologists is not explained, but the description of the nurses' backgrounds serves to illustrate that psychology is important and indeed utilised in home treatment. However, it is interesting that it is nurses who are given the role that would be more often attributed to psychologists. (A more in depth discussion of the nurses' role(s) is presented below with reference to interviews I conducted with two of them.) The preceding report that three people "were doing family therapy" when the team first started is also of interest. Both teams would often involve families and informal carers in home treatment (see chapter five), but the consultant implies that a more specific type of family therapy (in which the family is regarded as a system and the function of each member is considered in terms of a person's presenting problem) was initially practiced by the team. She does not, however, cover this subject in any great depth.

I proceeded by asking a further question, related specifically to her role as consultant:

G.A.: How important is a diagnosis when you're working with somebody?

Sally: For me, as I'm a doctor, extremely important but that's the way I'm trained and I work with diagnoses. And I don't apologise for that erm because I would it very difficult y'know, the point of my medical training is around y'know making a diagnosis and talking about illness and all the rest of it, that's what I do.

It is interesting that the consultant makes a point of *not apologising* for the importance she attributes to diagnoses. Once again, it suggests that she suspects a certain degree of disapproval, if not from me then from those of from other professions and associated viewpoints. She also presents a justification for her view with reference to her medical training. This relates to Sinclair's (1997) *medical habitus* described above. However, she does not, at this point, describe the virtues of diagnoses; merely why it is important to her profession. In doing this, she re-iterates a theme of specialisation, albeit prompted by me, the interviewer. She proceeds to relate this view to the rest of the team.

Er, interestingly, the team seem to have adopted that as being part of what we do. I think it's important as long as that's not the only thing that we do. We don't put a label on somebody, y'know, this is a schizophrenic, as long as we don't use diagnoses in that way, erm then I just see it as erm erm an essential part of the whole. Erm so what other people in the team might do is erm see the person who I've given a diagnosis of schizophrenia to say, but look at well how is this affecting this person now and what is it that we have to do for them? So that doesn't really matter what the diagnosis is. So for erm the person doing the intervention the diagnosis it becomes a little bit immaterial.

Again, the consultant does not explain the virtues of diagnosis. She explains that attributing diagnosis is not a problem if it is regarded as "an essential part of the whole" and that the team don't "put a label" on people. She explains how psychiatric diagnoses

may be complemented by focussing on other aspects of the presenting problem. In contrast to her previous statement that diagnosis is extremely important, she proceeds by claiming that “it doesn’t really matter what the diagnosis is”. This is not necessarily the contradiction it first appears to be; rather, in her reference to “the person doing the intervention”, she is acknowledging that diagnosis is of less importance in the day to day management of an individual case. This is not to say that diagnosis is not important in the understanding of the overall situation; rather that it is of less relevance in the actual process of delivering home treatment. Following this, the consultant finally explains how she believes diagnoses may be useful to the service users themselves.

However er questions will be asked and people will want to know about prognosis and what’s gonna happen and, that’s again where diagnosis helps because you know that there are certain things about this particular illness that you can tell people and educate them about it and you know, how to stay well.

Until this point, the consultant has described how diagnoses are useful to professionals in terms of an overall understanding of the case. However, she now explains how diagnoses are key factors in the education of service users; this is what is described in the PIG (2001:12) as “learning from the crisis”. Psychiatry has an influential knowledge-base; the sharing of this knowledge is an integral part of treatment. Though the original source of such knowledge remains the property of the professional to give, this knowledge is not only applied but also shared. The consultant proceeds to contrast (what she professes to be) the generally consensual attitude towards diagnoses in the crisis team with that found in previous services in which she has worked.

Erm so it’s an interesting question because I have worked in other services where some of the team have objected to diagnoses being made erm and wanted to be more about erm problems rather than y’know illnesses. But I don’t think, we don’t seem to, I don’t know what you think, well, y’know, you’ve watched us. We don’t seem to get into that here. I think it’s because we, there’s a, I think it’s that we’re a bit less precious about other. I think. And I think it’s because people see what each

other does as relatively valuable. So we're not like, if you like, in competition. That's just a part of it.

Once again, the consultant refers to a holistic view of crisis resolution. She also suggests that team members are not particularly "precious" regarding each others' roles. This is not to say that professional identity is not important; rather it is regarded in the context of the team's overall intent and purpose. However, it remains the case that it is psychiatric language which is generally employed in this particular team. Since the consultant earlier reported the initial friction between medicine and social services, it appears that medicine was the victorious discipline in this struggle. Rather than the consensual adoption of medical language, it may simply be that the use of such language is unchallenged.

In general terms, the consultant has described how she perceives the interplay of expertise within the Newchester team, the main emergent themes being conflict, collaboration, specialisation, team consensus, and roles. From her description, it is clear that any tension between different professions is minimal, or at least only subtly manifest. Each profession is, in her view, a functional part of a functioning whole. Hence, team members will focus on their intent and purpose in the context of the broader intent and purpose of the team as a whole. While the consultant's descriptions suggest a clear boundary between different professions in terms of the tasks that they strive to accomplish, an SHO from the same team who I also interviewed suggested that this is not necessarily always the case.

3.2. "*Vera.*"

Vera was an SHO (Senior House Officer) working in the Newchester team during the second observation period. I asked her to describe what she understood by the term "crisis" (see chapter three). She proceeded to relate this to her role within the team.

I think the team are effective enough to distinguish between social crisis and psychiatric crisis not to involve medics where there is a social or environmental or

crisis of that sort. And we are not asked to review such patients. Doesn't happen often, but I think it's a combination of a few things. Things don't work out in a patient's life or relationship breaks or er y'know, due to environmental stressors there's drug or alcohol abuse and mental state changes which usually requires a combination of interventions, both medical and social.

The SHO is applying the expertise of the team of which she currently a member to the variety of "crises" potentially encountered. It is not clear what "doesn't happen often." It may be that it is not often that she is involved in a social crisis, or that she deems a crisis to not often be "a combination of a few things". Since the latter claim is highly contestable and my data in fact supports a counter-claim (see chapter three), one suspects the former to be the case. She proceeds to describe, like Sally the consultant, how a combination of interventions is employed in the delivery of home treatment. She then goes on to describe how, on occasion, roles are adopted by convenience rather than professional background.

And this doesn't happen very often but once people are established as on medication or starting on medication, I'm not the one sole clinician responsible for the follow-up and solving social crisis in other settings that sometimes, very often are used to deal with social crises and sort out housing or speak to people in the council about or the benefits office or write some letters, as part of if they've been refused benefits which is not my job. It's the social workers' job, but I find it easier to do it myself and much quicker to resolve the crisis that would present for example out of hours.

This links to solitary working and role-blurring (see chapter four). In saying that she finds it easier to do such things as "speak to people in the council about or the benefits office or write some letters" if a social worker is currently unavailable, she is presenting herself as capable of such endeavours. If team members were more dogmatic in terms of which professional performs will perform a given task, it is possible that she would not assist in the filling in of benefit forms and that the social workers would resent her doing so.

However, since the SHO professes that such role-blurring exists, it is perhaps the case that crisis work is a broad concept not necessarily confinable to one professional discipline. Indeed, a crisis team member may be a crisis team member more importantly than they are a psychiatrist and a social worker. Some comments made by Sean, a nurse in the Newchester team, support this possibility further. In an interview conducted towards the end of the second observation period, of expertise he said the following:

It's more to do with personalities rather than clinical skills...A certain style of working, not necessarily something you'd get a qualification in.

This is a view which suggests co-operation between disciplines. By this logic, expertise is of lesser importance to crisis work than is multidisciplinary teamworking. However, this is not to suggest that the composition of the teams is insignificant. Indeed, were crisis teams composed of a single discipline it would not necessarily be the case that no conflict would exist between members. Onyett (2003:111) considered team composition in the following terms:

Workforce planning in mental health increasingly emphasises the knowledge, skills, experience and attitudes needed within a team for effective working, rather than a particular combination of traditional disciplines.

Onyett's assertion suggests a certain type of pragmatism in relation to team work. Expertise within a team is of less significance than team membership in itself. However, it is possible that psychiatrists are more concerned with their professional identity than nurses. Both Vera and Sally speak at length of their roles as psychiatrists, while Sean's description is more concerned with team membership. This was also the case with Anna, a nurse in the Churchfield team who I interviewed towards the end of the second observation period.

3.3. "Anna."

I asked Anna "what strategies do you adopt when dealing with someone who's in crisis?"

She replied:

I think that's a difficult one because everybody's so individual... You can't take the same () approach even if it's the same set of problems. I have certain strategies which I employ with people. The first one's relationship building, to be humane and get onto whatever level you need to be on with somebody, whether that's prim and proper or "down there", y'know, talking whatever language with somebody.

The kinds of expertise that Anna describes here are not restricted to any one professional discipline. She is suggesting that establishing a connection with the service user is integral to treatment, of greater importance than knowledge of their diagnosis and associated medications. Hence, the ability to establish a collaborative relationship with the service user is the integral expertise of crisis work (see chapter five). This expertise, however, is in a process of constant modification, since it is applied on an individual level. As Anna continued:

You can't really go into somebody's house with it in mind that this is the strategy we're going to use, 'cos it changes, the goal posts move.

Not only does the strategy change between cases, it also changes with the circumstances of an individual case. I proceeded to ask Anna about specific models of care:

I think the medical model works for some people, for other people it doesn't have a place at all. Psycho-social interventions, I think that plays a big part, cognitive work, CBT, that plays a huge part, brief therapy plays an enormous part, and problem solving, problem solving's a huge one. I think the problem-free talk is a good one, distraction. I mean there's so many. It's like having this tool-bag that you can just dip into and bring out whatever's appropriate for that person.

According to Anna, expertise is utilised in terms of individual need. However, she seems to suggest that the usefulness of the medical model is somewhat limited. Psycho-social interventions and indeed various “talking therapies” are regarded by her as being more broadly applicable. Problem solving is complemented with “problem-free talk”. This suggests that the task of the crisis worker is to do more than simply focus on the crisis in hand. Rather, establishing a relationship with the service user not solely based around the crisis itself is essential to the progress of the case. Anna herself had undergone training in CBT (cognitive behavioural therapy) and I had indeed observed her use of this in home based treatment (see section 4.4. below). However, her concluding statement demonstrates that she does not confine her work to this specialist area; when other strategies are deemed more appropriate, she will use them.

What is most interesting is that Anna is a nurse. Her views seem more like those expected of a psychologist. However, the overall impression that she gives is that in crisis work and short term intervention, a degree of knowledge of a broad range of techniques is of greater potency than expert knowledge of a single strategy. Here, it is worth reiterating that the sizable majority of team members in both Newchester and Churchfield were nurses. Hence, a service user being treated by a crisis team is most likely to be seen by a nurse. Nurses may thus be the key players in the construction of each teams’ general pattern of treatment delivery, like that described in the “key skills” box in the table in the FIG described above. The main theme emergent in Anna’s comments is that the complexity of crisis work and diversity of crisis requires a flexible and individualised approach to treatment. This was not seen to be achieved on all occasions, as the next interviewee’s comments demonstrate.

3.4. “Paul.”

Paul was a social worker in the Churchfield team. I interviewed him towards the end of the second observation period. In contrast to those discussed previously in this chapter, Paul’s comments demonstrated the existence of conflict between professional disciplines

and associated viewpoints. As with all team members I interviewed, I asked him to define a crisis.

People are pigeon-holed into referral criteria driven by managerial agendas rather than the needs of individuals in terms of their mental illness. Now I have a view that this team is seriously under-occupied. The referral boards that we have, visually they're half full. My perception is there is a trend to under-use this team. The referral criteria we have, it's actually too rigid. It's meant to be a health and social care service.

Paul's comments contrast sharply with those of Anna. In his view, service-users are not treated in terms of their individual needs, but in terms of their applicability to the team's referral criteria, criteria "driven by managerial agendas". This comment has the effect of creating a clear distinction between managers, "them", and practitioners, "us". He goes on to hint that the reason why the referral criteria are too rigid is because the team is not regarded as a "health and social care service". The meaning of this comment became clearer as the interview progressed.

If we had someone with a depressive illness say, who wasn't self-medicating, who wasn't eating, then this team should move into the role of seeing that person by consultation, negotiation, three times a day. If that means that we're supervising medication three times a day, if that means we're working alongside and with people to improve their environment, to ensure that they're accessing their benefits and full financial entitlement, if that means we're cooking alongside people, cleaning alongside people, making beds alongside people, then that's what we should be doing. And that's about everything that a medical model of service delivery is not.

It appears that Paul does not believe that a medical model alone is capable of creating an effective service. The team are not, for example, currently "supervising medication three times a day", and this, in Paul's view, is due to a medical model of service delivery being

adopted. His obvious discontent further illustrates the contrast between models of care and associated expertise. However, he does not imply a wish to replace medical with social work dominance. Like Sally's comment that "there's room for everyone", Paul comments that "it's meant to be a health *and* social care service".

In general terms, Paul's references to pigeon-holing and managerial agendas are applicable to team members of different professions as well as to the referral criteria to which potential service users are subjected. Team members may be "pigeon-holed" into certain roles by virtue of their professional affiliations. However, despite references to their specialisations from all the interviewees, none implied a greater importance to their own than to that of others. The working multidisciplinary of crisis teams seems to be generally accepted. It is only when one expertise appears to dominate in some way that conflict arises and the contrasts are emphasised. The same contrasts are also evident in the delivery of treatment, as is illustrated in the following section.

4) Utilising Expertise in Home Treatment.

In this section, I describe and comment upon four home visits, each one attended in the company of a team member with different expertise. Once again, the purpose of this is to identify different approaches to treatment and interpretative frameworks rather than to regard each team member as representative of all those with such expertise. The analysis of these fieldnotes will serve to complement the interview data and further examine contrasts and commonalities between these approaches to crisis work.

4.1. A Visit with a Doctor.

James was a consultant psychiatrist in the Newchester team. I accompanied him on a visit to P during the first observation period. I had met P on a previous occasion (see chapters three and four). He had now been taken on for home-based treatment and had left the short-term respite accommodation where I had first encountered him. James was going to review P's medication.

After being greeted by P's Mother, we sat down on a sofa opposite P. James began the exchange:

“So how have you been since we last saw you?”

“I'm a bit nervous. Worried 'cos I'm running out of sleeping tablets.” He only has three left, and says he fears he'll get worse again if he cannot sleep. James responds by saying “we won't let you run out.” He then asks “do you mind if I write?”

“No” says P as James spreads the yellow folder which are P's case-notes across his knee. He then goes on to ask P how he got on at the residential unit. P's mother gives a loud “tut”. P shouts “Oh come on, Mum!”

Like Alex did two days before, James asks P an open question; P can answer him in a variety of ways. As he did two days previously, P expresses anxieties about medication. He is again met with a reassurance. James' subsequent question is interesting. It appears that he is asking P if he can do what it is conventional for a doctor to do; take notes about the patient with whom they are engaged. However, this question may be read as respectful to P, in that James may be in effect asking “can I be the doctor while you are the patient?” Through the use of a “tut”, P's Mother joins in the discussion:

“He liked it but I didn't” says P's mother. She says she was quite angry and that P didn't get fed. P is now silent. She goes to apologise to James for being angry. James says “that's okay. It's important that we know these things.”

James returns his focus onto P. He asks how he's been sleeping. P repeats that he has been anxious since he returned home and that he is worried about running out of sleeping pills. His mother tells us that he's drinking a lot of Iron Bru. She

chuckles slightly, I guess in a nervous, yet sympathetic way. I look and see that he does indeed have a glass of Iron Bru in his hand and a large bottle of it at his feet.

P's mother makes a comment reciprocated by James. In this way, he is assuring her that her input in this discussion is both acceptable and indeed important (see chapter five). P is, again, concerned about his medication. From my previous encounter with him, I suspect he would do this whether he was addressing a doctor or a team member of a different discipline. His mother adds to the discussion by describing P's intake of Iron Bru. James does not comment on this for the time being.

James asks P to show him the medication he has been taking. P takes a large bag from behind the chair. James rises and collects it. He looks through an assortment of medications, some of which are still in the blue box that was kept at the residential unit.

“Okay. Well I'll give you some more of yellow ones. But they will have to be reduced eventually. But don't worry about that now. I'll just do a general check of your reflexes, because sometimes these medications can slow you down. Okay?”

James is not only doing what is expected of a psychiatrist; he is also responding to P's concerns regarding medication. It is significant that he examines P's medication himself rather than asking P to simply tell him about each one. This is not to suggest that he does not trust P to tell the truth. Rather, it seems that he is utilising his expertise as a doctor to both gain the relevant information and to reassure P that his medication is subject to professional monitoring.

James continues by assuring P that he will give some more of “the yellow ones”. It is significant that he refers to P's medication by colour rather than name. Were psychiatrists debating these pills, it is highly unlikely they would refer to them as “the yellow ones”. Hence, it appears that James is delivering information in such a way that P is sure to understand to what he is referring. It is possible that if James had referred to the pills by

name, P may have asked for a description. Whether this would be the case or not is unknowable, but it appears to be if not James' assumption, then an insurance against this possibility. In short, it appears that James is doing what Anna above defines as getting onto "whatever level you need to be on with somebody". It may be the case that, in referring to the sleeping pills as "the yellow ones", James is supplementing professional knowledge with lay knowledge, or at least a professional term with a lay term. An alternative course of action would be to refer to the pills by name and describe their chemical composition as well as known effects and side-effects. Hence, James' formulation may be somewhat patronising. It is not emphasised or re-emphasised to P that he is on a powerful medication with an associated Latinate name; rather, he will have some more of "the yellow ones". James does, however, tell P that he will check his reflexes to ascertain if the medication is having an adverse effect. Again, he uses a folksy rather than clinical language, "sometimes these medications can slow you down", which has the effect of communicating clarity and reassurance.

P nods and stretches out an arm as James rises. He has had his reflexes tested before. James pinches P's arm muscles and moves his arms up and down, one after the other. P's arms move with him, I guess satisfactorily, as James says they seem to be okay. He sits back down and once more opens P's notes upon his lap.

P says, "I'm sweating a lot. It's worse at night and it stops me sleeping."

James: "How long has this been going on?"

P: "Since I got back home."

The discussion is on P's physical rather than psychological state. This is instigated by both James and P. P has the knowledge that James is a psychiatrist and it may be that he is acting in accordance to this knowledge. It may, however, be the case that P would express these concerns whatever the profession of the visiting team member. However, it may be significant that P has a clinical diagnosis of schizophrenia. It may thus be that P

frames his situation in terms of his illness more so than a domestic problem. A domestic problem does exist regarding his housing (see chapter three) but this is not referred to at the present time. The discussion continued:

James: "How much Iron Bru are you drinking?"

P's mother: "Oh far too much. He just sits there drinking it all day."

P: "About two bottles."

James: "What size bottles?"

P: "This size." He lifts a two-litre bottle.

James: "Well, Iron Bru does contain caffeine, so it can keep you awake and make you sweat. I think you should think about reducing the amount you drink."

P's mother nods at P. "Yes."

James: "Maybe if you just drink one bottle?"

P nods. "Okay."

James is giving P medical advice, sharing his knowledge on the effects of Iron Bru. This knowledge is not solely the property of medical professionals, as is demonstrated by P's mother's interjection, but the fact that it is imparted by such a professional makes it all the more potent. P subsequently agrees to reduce his intake. Despite this, James reiterates his advice:

James repeats that Iron Bru is likely to stop P sleeping and increase his anxiety. He then says:

“Well, you do seem a lot better than when I saw you last week. I’ll write you a prescription for some more medication. Are you okay going out picking up your prescriptions?”

P replies “yes, but I get anxious.” He scratches his head. His mother turns and whispers to me “he’s always scratching his head”. I smile weakly.

Here, the focus begins to shift from the discussion P’s physical health and its relationship with his mental health to a discussion of P’s mental health alone. He gets anxious picking up prescriptions. P’s mother comments to me on a physical habit of P’s, which, in the given context, appears to be related to his anxiety. In scratching his head, it may be that P is demonstrating his anxiety at the concept of picking up medication. His mother’s comment also has the effect of acknowledging my presence and role as observer. The discussion continued with James asking an open question, in contrast to his previous questions specific to medication and physical health:

James asks how P and his mother are coping together generally. P’s mother says, “It’s difficult sometimes. Money can be a problem. He’s not even on DLA.”

James replies “Well, a good way to address these things would be for one of our social workers to come and visit you. We do have social workers in the team”.

P’s mother: “He’s not sure about social workers...”

James: “Well, they will only want to help”.

P’s mother (to P): “He’s not gonna bollock you!” She covers her mouth with her hand, laughing self-consciously. P says okay.

“Okay, well, we’ll send someone round to see you again very soon.”

They arrange a date and we leave, giving courteous goodbyes.

James' reference to the team's social workers is also an admission that he does not possess the expertise necessary for arranging benefits, or at least that a social worker could perform such a task more adequately than he. P's mother's comment is of great significance to the case; P is "not sure" about social workers. This further supports the possibility that P himself regards his situation to be mainly a health matter. Though P makes no comment to this effect, the information given by his mother suggests that P expects profoundly different and indeed less preferable treatment from a social worker than he would expect from a psychiatrist or nurse. Given P's psychiatric history, this perception cannot be said to be groundless; he has indeed had dealings with social workers in the past so his uncertainty is based on more than a popular perception of social workers as punitive. Whatever the case, this discussion is demonstrative of the role of different expertise in home-based treatment; the medic has been a medic and will now call upon a social worker to be a social worker. Both professions engage in a specialist task specific to themselves. There are times, however, when a contrasting approach is utilised. Here, specialised professional knowledge is not what is utilised, but the personality of the team member. This is demonstrated in the following case.

4.2. A Visit with a Support Worker.

I had visited L some days previously in the company of one of the SHOs. She had been very depressed due to an altercation with her neighbours and this was complicated further by her frequent, if not excessive, drinking. She wished to move to a different area. On the assessment board, L's case was defined as follows:

36 yr old f: 6 children. Past H post-natal depression. 2 yr H of alch abuse. Long standing depressive illness.

Val and I were making a routine visit, from which the following fieldnote is taken:

Val and I pull up outside L's house. There are six children, I guess between six and twelve years old, congregating on the doorstep.

"Hello, is ya Mam in?" asks Val.

A girl, who is obviously the eldest of the group gestures us through.

L greets us and we sit around the dining room table. Val asks her how's she's been feeling. L replies that she's been crying a lot. Last night, she brought a bottle of wine but didn't drink it. She is struggling with housing application forms.

Val comments on L's crying: "That's really positive." She goes on to explain that it may be a sign that she is recovering. She goes on to say that "there's nothing wrong with crying. I cry. People ask me why. I say I don't know." I really cannot imagine a psychiatrist saying this.

Val's comments on L's crying have the effect of showing empathy with her mood. She is imparting personal information as to her own emotions. This is the antithesis of the clinical distancing employed by medics. Psychiatrists, with their expert knowledge and professional boundaries, are unlikely be so familiar since this could undermine their appearance as experts. This is what Goffman (1959) called "mystification" (see chapter four). Indeed, it seems that Val is in fact befriending L rather than simply treating her. Though it is essential to establish a collaborative relationship between practitioner and service user (see chapter five), it is often the case that practical and clinical matters take precedence. Here, such precedence appears to be reversed. The discussion continued:

Val goes on to ask about the housing forms. L shows them to Val and says that she still has over a week to complete them. Val responds:

“Right, put those away for this weekend. I’ll get one of the social workers to come and see you next week.” L agrees to this.

“Would you prefer a male or a female?”

“I’d prefer a female.”

Val phones base and speaks to Sean, asking if Linda will be available on Monday to see L.

“She will? Good. See you soon.”

Like James did in the previous case, Val is promising the input of specific expertise in a subsequent visit. As well as giving L permission to relax, she is saying that a social worker would be able to assist with her housing application forms more effectively than she. She also arranges this in L’s presence. This has the effect of assuring L that the visit is arranged and also demystifies the process of making this arrangement. Most visits are made after official backstage consultations between team members which the service user is not party to. Here, the arrangement is made on the official frontstage in full ear-shot of the user concerned. Once the phone call had concluded, L’s eldest daughter entered the room:

The girl who showed us in enters the room. Val says hello. “It’s boring outside” says the girl.

Val asks L if she’s going to be okay until Monday. L says she will.

“You’ll make sure your Mam’s alright?” says Val to the daughter. The daughter nods. We rise to leave.

In the car, Val says “I’d never usually say that to a child”. She goes on to explain that they are a close family and that the daughter is able to contact her Grandparents, who live nearby, if L’s condition is to deteriorate. She goes on to explain that the team are planning to reduce contact with L, who is currently being seen every other day.

“I’m not reducing contact with this woman” says Val. She continues to reflect on the case, defining L as “a tough woman who’s had a very hard life.”

Val’s comments during the car journey demonstrate that she is well acquainted with L and her situation. She is also making a statement on her practice; she would “never usually say that to a child”. In making an exception on this occasion and providing a rationalisation for it, she further demonstrates her knowledge of this case. In her wish not to reduce contact, she is also expressing the judgement that L requires continuing support. What is most significant is Val’s formulation of the case. In sharp contrast to the writing on the assessment board, in which L is defined in terms of her medical history, to Val she is “a tough woman who’s had a very hard life”. It may hence be said that Val is *humanising* the case. Such formulations may not be made only by support workers, but they are especially suited to one in that role; to befriend and indeed *support*. However, to formulise a case in social as opposed to medical framework will not necessarily lead to continued support, as is illustrated in the case described below.

4.3. A Visit with a Social Worker.

I visited D with Paul, one of the social workers from the Churchfield team, during the second observation period. D was living with his ex-partner, also the mother of his child:

We sit in the living room of D’s partner’s house and Paul speaks with the two of them. D describes events of the last few years of his life: his brother had committed suicide, both his parents had died, and he had had the recent, but disastrous affair.

Paul refers to D's bereavements. "My parents both died some years ago. It's always there, but the feelings become less strong over time." He goes on. "This is not what I'd call mental illness. Medication and hospital are not the answer."

Like Val, Paul is giving personal information to demonstrate empathy. Also, in formulating this case as a reaction to bereavement, he is removing any potential medical element. This is not a case he deems appropriate for the further intervention from the team. Though D has evidently suffered several significant losses, he is not deemed as experiencing a psychiatric crisis:

Paul tells D that it is most likely he will make a natural recovery. "If you're no better in two weeks, see your GP and they'll get in touch with me."

Paul's reference to a "natural recovery" serves to emphasise further that D's problems are not pathological. A suspected "natural recovery" from the emotional affects of an adverse event is not the same as a mental health crisis, where the symptoms are deemed excessively severe, possibly out of proportion to its stimuli (see chapter three). What is interesting here is that Paul is a social worker. One does not therefore expect him to *medicalise* D's situation. The absence of a medical issue in itself would not negate further input from a social worker. However, D's presenting problem is emotional, rather than social, domestic, or medical. The absence of a medical factor hence does not necessarily mean that a social and domestic one is present. This is not to say that the teams are not concerned with emotions, as the subsequent case described will demonstrate. Emotional problems, if deemed the result of medical, social, and domestic circumstances, are the key focus of attention in a person's treatment.

4.4. A Visit with a Nurse.

M had a long-standing recurrent condition due to a brain injury he had suffered at work some twenty years previously. He had suffered hallucinations, involving a small malicious character who had told him he could pass through glass unscathed amongst

other things, and a benign larger character who remained silent. On previous occasions, he had been treated in hospital, sometimes for up to six months. Anna, the nurse whose comments in interview are described above, and I visited him during the second observation period with the Churchfield team. He had been defined by those team members who had visited him as “lovely”; this was somewhat unusual.

Anna had been visiting M frequently over the last week. When we saw him, he appeared very cheerful and relaxed. He said he was feeling much better and, though the hallucinations were still present, they were “standing back” from him, “three or four paces”. On a table between us, M had written a list of “positives” (such as walking the dog) and “negatives” (such as the severity of visions as 7 out of 10) over the last two days. He told us that this had been really helpful. Anna told him to congratulate himself and that he had done “really well to keep out of hospital.” He explained that he and his wife were going on holiday next week, and that he would contact the team on his return, hopefully fit for discharge from their care.

On the car journey back to the team base, Anna told me that her CBT (cognitive behavioural therapy) training had been very useful in this case. M’s rating of his daily mood is indeed a technique regularly applied in such therapy. Anna had hence harnessed the expertise she deemed most appropriate to this particular case. Though the initial cause of M’s presenting problem is physical, indeed organic, it is his emotions that are the main focus of treatment on this occasion. This emphasis may indeed have prevented him from again being hospitalised.

In general terms, this case demonstrates the use of specific expertise not confined to a particular discipline within the team. Anna is primarily a nurse, not a specialist cognitive behavioural therapist. However, she is able to provide this type of therapy in the context of short-term intervention. As is demonstrated with M’s recovery, this indeed seems a potent tool.

The four home visits described above demonstrate the application of a variety of expertise, each to a specific presenting problem. James' visit to P demonstrates how the psychiatrist's medical knowledge of the physical body is utilised in crisis work, while Val's visit to L shows how practical help and emotional support can be utilised at an appropriate time. Paul's framing of D's presenting problems as emotional rather than as "mental illness", while looking closely at social and domestic factors, is demonstrative of his professional standpoint as a social worker. It also implies that there are limits to what a crisis team, even with its array of expertise, can do, or is indeed willing to do. While D could have been professionally assisted with his presenting problems, perhaps by long-term counselling or psychotherapy, this assistance was not to be given by the crisis team at this point. Hence, crisis work itself is an expertise used sparingly and appropriately. Anna's work with M shows how a degree of knowledge, if not expert knowledge, of a particular method of treatment can be utilised in intensive short-term intervention. In short, it is in this work between the lone team member and the service user that the application of different expertise is most evident.

5) Conclusion: The Significance and Insignificance of Professional Disciplines.

A mixture of professional disciplines and associated expertise are key factors in the formation and practice of multidisciplinary teams. Roles are clearly designated in terms of professional background. Often, however, these roles may be transcended. A crisis team's practice is the undertaking of crisis work and this need not be confined to any single professional discipline.

In this chapter, I have drawn on several sources in order to describe the nature and utilisation of expertise in the two multidisciplinary crisis teams studied. While the PIG provides a potent starting-point from which to consider expertise, it tells us little about the intricacies involved in their interaction and the realities of their application. Team members themselves seem to describe not one but two designated roles: that which

accompanies their professional background, such as medicine or social work and that which accompanies their status as a member of a crisis team. Since each discipline is united in accomplishing crisis work, there is, for the most part, respect and co-operation between them. In short, contrasts between disciplines, when each discipline is working towards the same end, are by and large complementary. Though there remains a degree of fragmentation in the crisis teams studied, little can be seen in the way of direct conflict. The exception, or “deviant case”, is Paul, the social worker who expressed obvious resentment at the medical model of service delivery he saw in the Churchfield team. Aside from this, it seems that both medical and social models co-exist, apparently comfortably, in both teams. No further tension was, at least overtly, significant.

Certain tasks within crisis work are most applicably accomplished by specific expertise, as is evident in the four home visits. However, even when the psychiatrist or social worker is acting alone utilising expertise specific to that discipline, they are ultimately accountable to the rest of the team. Hence, crisis work imposes limits on the exercise of team members’ expertise as well as necessitating the attainment and utilisation of new knowledge. Such knowledge includes that of co-operation with those of other professional backgrounds in the planning and under-taking of short-term intervention. Integral to short-term intervention is flexibility in the treatment offered. Though limits exist as to the types of cases with which the teams will work, just as a crisis itself is multifaceted, so is the expertise required to treat it. The significance of a team member’s professional discipline will hence vary between cases. There are occasions when a medical element is deemed obvious and occasions when the person would clearly benefit from the input of a social worker. Common to all cases, however, is the need to prevent the crisis from worsening. This can be done with medication and with emotional support. Rarely, if ever, will one intervention be utilised alone.

Chapter Seven: Discussion.

1) Introduction.

1.1. Chapter Overview.

I begin this chapter by reiterating the initial objectives of this study and illustrate the extent to which they have been fulfilled in the previous four chapters. I then go on to discuss this study's central findings before considering the study as a whole in the context of the broader "politics" of crisis resolution. I explain the study's limitations and suggest possibilities for future research. Finally, I suggest some of its implications for policy and practice.

1.2. Summary: Initial Objectives and Current Conclusions.

In chapters one and two, I outlined the initial objectives of this research. These were to consider how "crisis" is identified, how team work is accomplished, the relationship between team members and service users and the utilisation of expertise. In chapters three, four, five and six, I addressed these considerations and reached the following conclusions:

- "Crisis" is multifaceted; there is no single factor in its identification. For a presentation to merit the involvement of a crisis team there is usually an element identifiable as "psychiatric"; that is a significant change in the person's mental health and behaviour thought to be related to "psychiatric illness". Domestic and social factors may be seen as connected with such a change and are considered by the teams. However, these do not, in themselves, merit the teams' intervention, as a "crisis" is identified in terms of a person's presentation rather than their circumstances.

- Team work is achieved through continuing negotiation between team members, in and through routine work and accounts of that work. Though there exist an array of complex professional cultures and professional status within the crisis teams, shared histories, experience and purpose lead to team work and co-operation.
- User involvement is negotiated as a collaborative relationship between team members, service users, and carers. The extent of this collaboration varies from case to case and is ultimately determined by the considerations of the team members.
- Expertise in crisis work is not restricted to any single professional group. Specific professional expertise, such as psychiatry or social work, is utilised when appropriate to the case in hand, but the necessity to “do crisis work” transcends any professional discipline. Medical and social models of mental health crises appear to co-exist, for the most part, reasonably comfortably, since all disciplines are united in achieving the same end.
- Crisis work is often about preventing the crisis from worsening. In this sense it is about containment as well as resolution. The goal of the teams is to *contribute* to its resolution, assisting in that resolution to the extent that they are able. As stated above, users and carers are also contributors; thus crisis resolution is a collaborative enterprise.

These initial conclusions have broad implications, as I shall illustrate in the following section.

2) The Central Findings of this Study.

2.1. *The Outlook and Dilemma of Crisis Work.*

In this section, I relate the key findings of this study to those of recent studies focused on similar topics. I place my work in the broader context of the ethnography of health and social welfare services and the teams therein. In a historical sense, as stated in chapter two, this study follows a tradition of public service ethnographies, e.g. Goffman (1961), Becker *et al* (1961), and Cicourel (1968). For the purpose of this discussion, however, I wish to contrast my work with more recent studies.

I have referred to Sinclair's (1997) study of medical students in previous chapters. Like Sinclair, I have used Goffman's dramaturgical metaphor in order to describe the official and unofficial work of those observed, on both the frontstage and the backstage. However, my work differs from his in that I have applied the metaphor to those who work in the community rather than within the confines of an institution. In doing this, I have shown the similarities between community and institution and implicitly suggested that the crisis team *is* an institution without walls. Sinclair's study also uncovered the existence of the *medical habitus*. As explained in chapter six, the *medical habitus* refers to individuals' loyalties to the established medical profession and its unquestioned worldview. This is an important concept as it demonstrates how a collective may be seen to adopt a particular mind-set in relation to their work. In a similar fashion to the ways that the work of trainee and junior doctors is shaped by the *medical habitus*, to *do* crisis work requires team members to *be* crisis workers. While I do not contend that there is such a thing as a *crisis work habitus*, (such work has simply not been conducted and researched for long enough) certain similarities between the *medical habitus* and what I shall refer to as the *outlook of crisis work* are apparent.

While Sinclair concluded that the acquisition of the medical habitus can alter the entire mind-set of the medical student (301), I make no such grand claims here. However, it is apparent, from the observation of their day-to-day practices, that crisis team members

have a specific approach to their work. This work is about identifying risks and needs and the subsequent course of action to be followed. When a person is referred to the team, this process begins.

Cases are approached pragmatically with a view to ascertaining the most efficient means of achieving the best possible outcome. The nature of this desired outcome may be decided by the team members, the service users and their carers, though it is also determined by professional values and managerial pressures at both local and national level. These values and pressures are primarily about reducing hospital admissions and treating service users as intensively as necessary in the least restrictive environment. There is also an apparent contradiction in that the team specialise in short-term intensive interventions, but will remain involved in a person's care until the "crisis" is agreed, by the team and the service user, to be resolved. Hence, to slip into crude metaphor, crisis resolution teams may be defined as the "emergency service" of community care. The service is prepared, delivered and withdrawn as swiftly as is necessary to reduce, though not necessarily eliminate, need. As previously mentioned, much of crisis work is driven towards preventing a crisis from worsening.

Though team members clearly do their utmost to reduce distress, they are conscious of their limitations. They cannot treat everyone referred to them, nor can they keep everyone out of hospital. Their outlook is hence pragmatic, to do what they can with the situations with which they are presented within the limits of their roles as crisis workers. de Montigny (1995:xvi) made similar observations in his study of social workers:

Social workers cannot easily reshape their practice into an ideal or progressive political form, nor can they morally accept a nihilistic retreat into passivity and acceptance. Indeed, social work practice is always Janus-faced, that is, on the one side it arises as actual social workers' living, breathing and situated activities and on the other, it must articulate extra-local forms of authority and discursively organized power.

Crisis team members face a dilemma in relation to their work. They too must, to a certain extent, be Janus-faced since a tension exists between their prescribed goal as a service and the practicalities of *doing* their work. They are required to be caring, respectful and responsive to service users, while at the same time to contain their deviant behaviour, prevent their admission to hospital and be involved in their care no longer than absolutely necessary. They will refer users onwards as quickly as possible having attained their goal. This goal is to prevent the crisis from escalating, reduce the level of associated risk and, if at times merely by implication, reduce distress to a level manageable in their absence.

The dilemma of crisis work is essentially caused by a tension between providing the best possible care and working to a prescribed model of practice. Presented with a person apparently “in crisis”, team members must decide whether their prescribed model of practice is appropriate in their treatment. If their judgement and the model are at odds, the dilemma of crisis work is apparent. Either the person is not seen by the crisis team or the team will stretch their remit to accommodate them. For example, a person may present in a “crisis” relating to substance misuse and housing difficulties. Though there is no tangible evidence of psychotic illness in this instance, the person may benefit greatly from the intensive involvement of a crisis team. Under the current guidelines, however, the team has no obligation to become involved with them.

Since the crisis teams’ work is so intensive, there seems to be little room to address their dilemma. Rather, the dilemma is contained through the discursive organization of their work. Hence, the teams’ relationships with their officially sanctioned model of working to a certain extent mirror their relationships with service users, since each is based on containment, co-operation and the pragmatic application of prescribed practices. The dilemma does not interfere with the day-to-day practical accomplishment of the crisis teams’ work. Indeed, integral to the crisis work outlook is the necessity to “get on with it”. Despite the dilemma and complications of crisis work the teams’ priority is to treat service users. Integral to the organization of such treatment, as I have shown in chapters three, four, five and six, is the discursive construction and negotiation of the cases to be

treated. To illustrate this further, I refer back to Opie's (1997) paper on team narratives (see chapter two). Opie (Section 4.4. 21⁹) concluded that:

Team work and the generation of team narratives, then, are about 'making things happen' in a complex world. Team work occurs in an environment productive of different narratives because of the heterogeneity of representations available to the team; representation of situations and issues by the user and their significant others; reporting of those representations by team members; and the team members' various representations of users and issues informed by the different disciplines within the team.

Crisis work in particular is about 'making things happen' rather than living up to a grand ideal or rigid set of criteria as to what constitutes a crisis. As I have shown, it is subject to continuing negotiation, influenced by an array of different narratives, in particular those of team members (from an array of professional disciplines and backgrounds), service users, carers, managers and planners. The latter two groups may be absent from the day-to-day accomplishment of crisis work, but they are represented in official documents such as the FIG.

The bulk of crisis work is discursively constructed and treatment itself is often delivered in the form of discussion. As Opie (21) continued:

The team narrative is the result of a recursive and interactive process which enables the team to explore the possibilities and constraints made available to the team through its different constituent knowledge bases (hence drawing on and working with its tacit and explicit knowledges) in order to develop a plan which allows the team to move on but where the plan is also regarded as provisional, as open to change as the users' situations change. The outcome of team work cannot,

⁹ As this paper appears on-line, the pages are not numbered in the original text. However, if saved as a word document, text size 12, the quotation appears on this page. I have hence cited both section and (imposed) page number.

therefore, be a single, authoritative narrative or 'case' defined largely by knowledge deriving from one discipline.

Opie's conclusion resonates significantly with that of this study. Despite there being no single authoritative narrative to crisis work, there are the constraints of the prescribed model of service delivery. Here the dilemma and apparent contradiction of crisis work are further apparent. Though crisis work is perpetually negotiated, such negotiation is confined within the context of a broader requirement of service rationing. This rationing is also a discursive accomplishment, which I proceed to describe.

2.2. User Categorisation and the Limits of Crisis Resolution.

Despite the broad range of techniques which may be utilised in its practical accomplishment, the initial remit of crisis resolution is narrow. The PIG's focus on "mental health crisis" is mirrored in both teams' practices (albeit, to a varying extent between the two). This means that access to the services is restricted. In this sense, crisis resolution extends the focus and importance of diagnosis. Team members do this by using a certain terminology or sets of terms in order to describe the presenting problems of the people whom they serve. Categories, be they formal or informal, diagnostic or otherwise, are hence imposed on the service user by the team. It is these categories, the nature and use of them, the contexts in which they appear, and the implications for team practice arising from their use on which I now focus.

As I have shown in previous chapters, categorization is employed in crisis work for the purpose of homogenizing the various possible narratives which may relate to a specific case and they thus give solid definition to the particular presenting problems (the nature of the "crisis" in hand). They may also be used in order to attain the ownership of "expert knowledge" and hence power. They are thus integral to the discursive accomplishment of crisis work.

Griffiths (2001:679), in a study of user categorisation in two community mental health teams, drew the distinction between *explicit labelling* and *implicit categorisation*. Explicit labelling essentially refers to formal psychiatric diagnosis (manic depression, schizophrenia, personality disorder etc) while implicit categorisation is defined as “constructing a picture of the case in terms other than ‘serious mental illness’”. According to Griffiths, such categorisation is employed when a case is not deemed suitable for the teams’ involvement.

Griffiths continued (680):

One unfortunate legacy of sociological labelling theory was that it focused attention on the social significance of naming, and diverted attention away from the face-to-face interaction from which ‘labels’ emerged...too many medical sociologists still operate with impoverished conceptions of categorisation, in which the emphasis remains on explicit labelling rather than processes of implicit categorisation.

In chapters three and four, I have shown how team members employ both explicit labelling and implicit categorisation in their discursive practices. For example, in chapter four (section 5.2), I explored how explicit labels (depression, long-standing anxiety) were used in the description of a case, followed by an implicit categorisation offered by a consultant psychiatrist: “I think we probably need to get him seen by the Professor of Anxiety at the University of the Anxious!” The explicit labels are contextualised as symptoms or possible symptoms of mental illness, while the consultant’s comment implicitly categorised this patient as simply “needy”: in need of a fictitious expert from a fictitious institution as opposed to the crisis team.

In general terms, the use of labels and categorizations serve a dual purpose; to *order* the service and to *ration* the service. An array of complex presenting problems can be ordered into familiar categories, while failure to conform to a particular category or fitting into the wrong one is likely to restrict, if not prevent the service’s involvement.

There is scope for further research into this area. It follows a long tradition of sociological analysis. Sociologists such as Sacks (1965) and later Silverman (1993) described at length the way social actors and texts often employ “membership categorisation devices” when defining people.

Sacks delivered a series of lectures in 1964 and 1965 in which he referred to “the MIR membership categorisation device”. “‘M’ stands for membership. ‘I’ stands for inference-rich, and ‘R’ stands for representative.” (1995:41.) An inference-rich word or phrase has a pre-established meaning. Certain characteristics may be *inferred* from its usage. The meaning of a word or phrase may be simultaneously further established and newly adapted if it is continually applied.

Membership categorisation, then, merit further attention in relation to crisis services. Since crisis teams are specialist services geared towards the treatment of specific people in particular circumstances, a particular vocabulary of crisis work is present. The *implicit categorizing* and *explicit labelling* described above are two key features of this vocabulary and the identification of these features can demonstrate much in relation to the negotiation of crisis work. For example, saying that a person is “depressed” carries a different implication from saying that a person is “suicidal”; the latter is suggestive of a crisis while the former in itself is not. In general terms, the employment of membership categorisation devices in crisis work serves as a potent tool when the teams are deciding who to include and exclude. An example of this phenomenon occurred during the second observation period with the Newchester team.

During a morning handover, a nurse described a case of a man who was recently released from prison and had been drinking excessively, which had apparently led to him hearing voices. He had a history of threatening people with knives while intoxicated, which had resulted in his previous imprisonment. He was apparently carrying a knife on the night in question, when he had been assessed by the team at accident and emergency. The psychiatric registrar interrupted the nurse’s telling of the case:

Registrar: Where's the psychiatric bit?

Nurse: There ain't one, basically. He was just absolutely hammered. I mean we suspect he's been drinking more. First of all he told us he drank one pint to drink last night. His sister was there and she said but you went to the labour club, how many did you have there? Oh, I had seven there! (*Giggles.*) ... We suspect he's got absolutely blitzed, gone out again, it seems it's all this issue of assault on people with a knife when he's drunk. We think he's probably drinking a damn sight more than what he's letting on.

Registrar: We are not agents of social control. (*Laughter.*)

The registrar is requesting an inference-rich explicit label in relation to this case; "the psychiatric bit". The nurse's reply is that such a label cannot be attached and instead offers two inference-rich implicit categorizations: the person is "absolutely hammered" and "absolutely blitzed". Both these categorizations imply excessive alcohol intoxication rather than serious mental illness. Hence, the registrar's response is an inference-rich implicit categorization of what crisis workers, in his view, are *not*: "agents of social control". The use of this phrase provokes laughter, perhaps because it implies an explicit politicization of the team's purpose which is not usual in the teams' day-to-day practice. The registrar could have made the same point in a less intellectualized manner by simply saying it is not the team's purpose to control a person's drinking (at least in the absence of an underlying psychiatric problem). However, had he simply said "it's not our job to deal with drinking", he would have attached no inference-rich categorization as to *what the team are not*. This would not have provoked the laughter which followed, since it implies no possibility of an exaggerated political conspiracy in crisis working. The laughter hence seems like a response to the use of an unusually explicit politicization (or defence against such potential politicization) of the team's daily activities. Because it is unusual for a psychiatrist to employ such a phrase in this context, it may sound melodramatic to this particular receptive audience. It would not be unusual or melodramatic for sociologists to talk about "agents of social control". Crisis workers,

however, use a different professional language. Thus, the team's laughter at the use of this phrase may occur because the psychiatrist is using language from a discipline other than his own: he may be said to be *acting* like a sociologist.

The above example demonstrates the political dimension of crisis resolution. As well as the politics inherent in its delivery, it is necessary to consider further the broader political circumstances in which crisis resolution emerged, since it is, as I shall show, inextricably linked to the practical accomplishment of crisis work. Such a task serves to illustrate further the place, significance and purpose of this study.

3) Crisis Resolution: Part of a "Third Way" in Mental Health?

As stated in chapter one, in 1998, the then Health Secretary, Frank Dobson, told the House of Commons that community care had failed and that he wanted a "Third Way" in mental health. Though this statement is in itself highly contentious, even vacuous, it is indeed the case that many significant reforms in mental health services have taken place since it was made. The "third way" is a political term which has long been in use and been employed by various political movements. It was a term sometimes used to describe social democracy during the Cold War, and was, according to Giddens (2000:1) "distinct from American market liberalism on the one side and Soviet communism on the other". In the current political context, however, its meaning has somewhat deviated. It is a term that refers to the ideas of Giddens (1998, 2001) and the (debatably) centrist politics of the New Labour government.

"The Third Way" is a term which has been attacked as lacking substance (Faux 1999) and feigning a radicalism which is, actually, non-existent (Hall 1998). It is true that the third way is an elusive concept. As a political philosophy, it can be placed somewhere between socialism, liberalism and conservatism, but this tells us nothing, except perhaps of its seemingly contradictory nature and its potential applicability to almost any set of circumstances. However, in the context of mental health services, we can understand "the third way" as a middle ground in mental health care, existing between hospitalisation and

the less intensive involvement of a CMHT. Unlike hospitalisation, crisis resolution neither restricts movement nor relocates a person; unlike CMHT involvement, crisis resolution is intensive.

As described in chapter one, The National Service Framework for Mental Health (Department of Health: 1999) outlines three community-based services which may be said to fit this “third way” in mental health, early intervention, assertive outreach, and crisis resolution. Each of these services may be said to work more intensively with a smaller caseload than regular CMHTs, and may, to a greater or lesser extent, prevent hospital admissions. Early intervention services work with those apparently experiencing the initial symptoms of psychotic illness for the first time. Assertive outreach services work with those who have severe, complex and long term mental health problems and who are reluctant to seek care and treatment. Like crisis resolution, these are recently established specialist services, addressing specific areas of mental ill health. Though the existence of these teams has undoubtedly increased the range of services available, the type of service one may expect to receive may have become more prescribed according to what is deemed as one’s specific need.

Crisis resolution is definable as part of a “Third Way” in mental health, if one interprets this elusive concept as a “middle way” between hospitalisation and CMHT involvement. The service has come into existence in the light of the perceived failures of previous services and because of its apparent cost-effectiveness. Crisis resolution hence has a political dimension and this is mirrored in its practical accomplishment. Indeed, service users referred to a crisis team often have three choices: the intensive involvement of the team, hospital admission (often only available to the “sectionable”) or no service at all. It is “midway” between institutionalisation on the one hand and neglect on the other. In terms of its application, crisis resolution is somewhere between the guidelines of the PIG and the pragmatism necessary for its day-to-day practical accomplishment. There is hence a tension between the written and the practical.

There are contradictions and paradoxes in crisis resolution. The service's positioning between institutionalization and the lower-level involvement of a CMHT does not mean it is able to do all that these services are able to do. While it is less restrictive to a person than institutionalization, it may still be an imposition. People being seen and treated by a crisis resolution team may indeed feel that their freedom is restricted, since its involvement is but one of very few choices available to them. The intensive involvement of a mental health service may also serve to increase a person's sense of being stigmatized, unless stigma itself is specifically addressed in treatment. In short, despite avoiding the perceived problems of CMHT involvement (that it is not intensive enough), crisis resolution is open to the possibility of over-use.

Although a person in receipt of a crisis team's treatment is more closely monitored than a person being cared for by a regular CMHT, there are limits to a team's involvement. Though the service is used as an alternative to hospitalisation, it cannot provide the same level of monitoring as hospital itself. Crisis team members cannot be present twenty-four hours a day. A sudden deterioration in a person's mental condition and an increase in risk to themselves or others may hence be missed. A person may harm themselves half an hour after a crisis team member has left them. While people in hospital also self-harm, the situation can be contained more quickly in such an environment than it can if the person is at home. Hence, there is always the possibility that, if crisis resolution services are overly relied upon as an alternative to hospital, certain tragedies may be less preventable. This makes such services vulnerable to accusations of neglect.

In general terms, though crisis resolution services provide the positives of both hospitalisation and CMHT involvement (intensive involvement without confinement), they also have the potential to perpetuate the negatives (over-intensity or under-involvement). It is hence a partial solution to previous problems, bringing with it potential problems of its own. This is not to say that crisis resolution services are *a bad thing*; indeed, the positives will far out-weigh the negatives if the services are utilised successfully. However, the important point here is that, though crisis resolution escapes the dogmas of institutionalization and regular CMHT involvement, it is in itself dogmatic

in the sense that it will only treat specific people in a specific way. Despite the flexibilities of expertise and the pragmatism employed in the negotiation of service delivery, it remains a particular model of service which will operate under particular conditions. In light of this ‘grand conclusion’, it is necessary to consider the limitations of this study.

4) The Limitations of this Research.

4.1. Crisis Resolution in a Specific Area.

Both teams covered in this study belonged to the same organisation, the Mental Health NHS Trust, which managed and provided mental health services in a specific geographical area. Each team’s potential “caseload” was made up of the population of a different part of this area. Though each of these two locations is, in some ways, quite different, certain demographic features are essentially the same.

In both areas, large psychiatric hospitals are still in operation, albeit on a lesser scale than in the past. One cannot thus conclude that the absence or presence of such institutions is a major factor in the teams’ different hours of operation.

The Newchester team serviced a largely urban population, centred on a particular city and surrounding towns. The Churchfield team provided a service to individuals in small towns and villages in a nearby locality. It is not this study’s purpose to speculate on the significance of these area differences, but some key factors are worth mentioning. The Churchfield team had limited hours of operation. The Newchester team were a twenty-four hour service. This did not necessarily reflect any significant cultural differences existing between the two areas. It could be assumed that the area covered by the Churchfield team was a “sleepy” semi-rural area that did not require a twenty-four hour service. However, this was not the reason for their limited hours. All one can reasonably conclude is simply that the Newchester team had been set-up as a twenty-four hour service with a gate-keeping role while the Churchfield team had not. The Churchfield

team were waiting for the appropriate mechanisms to be put in place (such as additional staff) so that they could begin operating as a twenty-four hour service.

Neither area in the region had a large population of people from black and minority ethnic groups. Though such groups were more prevalent in Newchester, they remained proportionately very small in comparison to other cities, such as London or Manchester. Hence, this study covers an area which is relatively mono-cultural and cannot be said to reflect the ethnic diversity of the country as a whole. Thus, factors such as cultural sensitivity and inclusive services cannot be commented on to any great extent in this particular study. In general terms, there is scope for further ethnographic research into crisis teams operating in other parts of the country where there is a greater diversity in the population.

4.2. The Two Teams.

As stated in chapter two, it was not my intention to commend one pattern of working over another; rather, I sought to present similarities and differences between the two patterns that I have identified. Of the two teams studied, only Newchester could claim to be a fully-fledged crisis resolution team conforming to the guidelines of the PIG. The Churchfield team was aspiring towards this, but had not yet become a twenty-four hour service with a gate-keeping role.

Despite the differences in working hours and professional composition, the actual day-to-day practices of the team were essentially the same. Indeed, the general conclusions summarised above apply equally to both the teams. Both teams identified and responded to “crisis”, they had almost identical referral processes and handover rituals, both negotiated teamwork amongst themselves and user involvement with users and carers. Both teams were united in “doing crisis work”, though they also did psychiatry, social work, nursing and support work when the occasions demanded.

4.3. *Fixed Observation Periods.*

The observation periods took place over 16 months. As stated in chapter two, I alternated between the two teams over this time; two weeks, followed by a month in Churchfield, repeated in Newchester. Some months later, this was followed by another month in Churchfield and concluding with another month in Newchester. Hence, I spent a total of five months in the field, which was an appropriate period of data collection for a study of this size. A longer period may have resulted in too much data for the level of attention appropriate, while a shorter period may have restricted the scope of the study. It was my intention to become familiar with the field before speculating as to the dynamics of crisis work as a practical accomplishment. However, despite this rationale, the fact that these observation periods were *fixed* may be said to have limited the scope of the study.

The time I spent with both teams had to be negotiated between my supervisory team, the team leaders and myself. I did not have the option of “showing up” when I felt like it, and no one in the team contacted me to say “come in today because something exciting is happening”. Also, the observation periods took place in Spring, Summer and Autumn. Had I been able to negotiate an observation period in the winter, I would not only have filled in a gap, but been able to theorise as to any seasonal factors in crisis resolution as a practical accomplishment, such as how the teams may address such factors as Christmas-related depression. This study, then, is not concerned with seasonal factors in crisis resolution. There is hence scope for further research into such matters.

4.4. *The Limits of Access and Data Collection.*

As described in chapter two, there were limitations as to what I could observe. It is practically impossible to observe every occurrence that takes place during the time in the field. It is also possible that, as in any overt observation study, my presence had an effect on the behaviour of those observed. My initial assumptions and initial objectives would also be reflected in my interpretation of events. However, no ethnographic study can

claim to be wholly “objective”. Interpretation is integral to analysis, as Silverman (1993:36) explained:

The attempt to describe things ‘as they are’ is doomed to failure. Without *some* perspective or, at the very least, a set of animating questions, there is nothing to report. Contrary to crude empiricists, the facts *never* speak for themselves.

My analyses are of those things that were observable to me in my time with the teams. I was not able to visit every service user whose case I considered interesting. I was not permitted to visit service users the team considered potentially dangerous to others and those the teams thought likely to be intimidated by the presence of a researcher. In this sense, I saw what the teams let me see. I also observed as a social researcher, conscious of the particular phenomena I wished to report on (how a crisis is defined, how team work is accomplished etc).

It is possible that a more experienced researcher, perhaps previously trained as a mental health professional, could get round the restricted access imposed by the teams. Though it was the teams’ intention to protect both service users and myself, the teams may not have deemed this necessary were I an established health service research professional. My role as student was hence restricted, but I was nonetheless able to collect a rich variety of data. One cannot say with any certainty whether the data to which I was not given access would have been any richer or of greater use. However, it is worth making the comment that as a student without formal training in mental health work, I was able to interpret my observations without recourse to any “professional agenda”. Were I a trained social worker or psychiatrist, I may have been predisposed to one interpretation of events over another.

4.5. A Staff-Focused Study.

This study was focused on team members and their daily activities. Though I also observed service users, it was in the context of the team members’ interaction with them.

I am aware that an additional focus on the reported experiences of service users would have added a further dimension to this study and perhaps provided the disempowered with a louder voice. However, I realised early on that if I focused heavily on the reported experience of service users, this would have distracted me from the study of crisis resolution as a practical accomplishment. My primary concern was to report upon workings of the team. I did not seek to measure user satisfaction or dissatisfaction, but that is not to say that such a study could not be conducted. In short, I chose to, in effect, “shadow” the teams in order to understand how crisis work is done. Though service users may have been able to tell me much about the *effect* of crisis resolution, they could have told me little about its day-to-day practical accomplishment, since much of this takes place in their absence.

Service users did have a prominent part to play in this study, since it is their needs which determine the operation of crisis work. In their absence, their needs are discussed and plans are made. In their presence, these plans are put forward and, to an extent, explained. To simplify, though this is essentially a staff-focused study, service users are always present in one way or another.

5) Some Implications for Policy and Practice.

5.1. Service Rationing.

A recurrent theme of this study has been the apparent restriction of crisis services to those deemed severely mentally ill. Though I have described how, in practice, the accomplishment of crisis work is somewhat more flexible than this in that crisis is multifaceted, the fact remains that the service is rationed; there is always a strong psychiatric element to the crises that the teams seek to resolve. Crisis resolution is not for service users with long-term “chronic” mental health difficulties unless they experience a particularly severe episode. In general terms, these services are geared towards the treatment specifically of psychiatric crises. Caplan’s inclusive model of “crisis” as an inner world collapse has been replaced by its psychiatricisation. Any crisis in which

identifiable psychiatric illness is not a prominent factor is not the concern of these teams. Also, mental health problems alone do not merit the teams attention unless they are severe enough to be identified as crises.

Service rationing is a significant factor in crisis work. Such rationing does not take place by virtue of the official guidelines alone. As Griffiths (2001:696) explained:

Resource allocation decisions are not just a matter of supply and demand, but also reflect the human service workers' subjective understandings of the priorities and pressures affecting them. Rationing decisions, like ethical judgements more generally, have 'tacit components' arising from the unspoken context of professional norms, local knowledge, and assumptions about the constraints affecting routine work.

Service rationing is negotiated and accomplished within team discussions. As I illustrated in chapter three, a person may be visited and assessed by a team member before their suitability for treatment is determined. The person who the GP deems in need of a crisis team may not be deemed as such by the teams themselves. The guidelines in the PIG are hence a factor in negotiation, not the instigator of its conclusion. People who do not fit into the referral criteria of the PIG may still be seen at the teams' discretion, and this must be acknowledged by policy makers.

It is an asset to the teams that they are able to negotiate amongst themselves when a referral is appropriate without the necessity of referring to pre-written material. Related to this is the observation that the referrals can be inappropriate and that, conversely, potentially appropriate referrals may be committed to hospital. The latter is less likely to occur if the team has a gate-keeping role, like the Newchester team. The gate-keeping role is thus essential if the teams are to reduce hospital admissions significantly.

Crisis teams achieve the policy requirements of service rationing. Since resources for new services within the NHS remain scarce, these requirements may be necessary at the

present time. However, the prescriptive nature of service rationing means that many of those who may benefit greatly from the intervention of a crisis team simply are not seen. Conversely, some who may benefit from another service, be it in the community or an institution, are compelled to be seen by a crisis team in the first instance. Service users may thus be subjected to assessment after assessment before referral to the most appropriate service.

As crisis resolution services evolve, it may be necessary for the policy makers to grant the teams a greater level of discretion as to who they see. The individual and collective judgements of crisis workers and crisis teams need to be respected if these services are to achieve their optimal effectiveness. Such judgements are currently utilised, but the ever-present backdrop of current policy requirements restricts their scope. In the future, it is not only necessary but perhaps inevitable that *the workers will have their say*.

5.2. Understanding Crisis Work.

As I illustrated in chapter six, the ability to “do crisis work” is just as important as belonging to a specific professional discipline or background. This is not to say, however, that there is a need for a specific qualification in crisis work. Knowledge of such work is attained through informal observation and practice. However, if such services are to be retained long-term and more such services established as is the government’s intention, further research into the process of “doing crisis work” would be greatly beneficial, if not a necessity. The establishment of a larger knowledge base around these services goes hand-in-hand with the maintenance and evolution of such services. I have, I hope, in this study, contributed to this expanding knowledge base.

5.3. Addressing the Needs of Users and Carers.

As I argued in chapter five, the involvement of users and carers in the practical accomplishment of crisis resolution is significant but currently limited. For the future evolution of such services, their needs must be addressed. This is already happening to a

certain extent, in that the nature of the care provided is constantly negotiated once their involvement with the teams is established at an individual level. However, consideration should be given to their needs prior to referral. It is indeed rare for a service user to self-refer (at least this was the case with the two teams studied); rather, they are often required to present to a GP or casualty department before contact is made on their behalf.

The service users are the authorities on their particular experiences. The utilisation of professional expertise is most effectively employed as a response to this rather than an imposition. People experiencing a mental health crisis are not necessarily powerless. They may be experiencing a crisis of such severity that hospitalisation would be necessary in the absence of a crisis team, but this is not the same as the need to be sectioned under the Mental Health Act. The involvement of crisis resolution services is not intended as a substitute for sectioning, a subject that I cannot comment on here. The point is that the involvement of a crisis team is not imposed involuntarily and hence, as volunteers in the arrangement, it may be beneficial for the service users and their carers to be given more autonomy in instigating the involvement of the teams in the first instance.

5.4. Crisis Resolution and Related Services.

As previously stated, crisis resolution teams are but one of an increasing spectrum of mental health services available. It is therefore important that other new services (assertive outreach, early intervention), established services (psychiatric hospitals, CMHTs) and referring services (GPs, casualty departments, the police) are not only aware of the existence of crisis services, but also of the way they work and whom they see. This study has not sought to discover the extent of such cross-service awareness, it being primarily concerned with the workings of crisis teams. However, it is easy to imagine the difficulties arising in the absence of effective dialogue between services.

Since inappropriate referrals to these teams are commonplace, and some appropriate referrals potentially over-looked, it would seem that many service users are not benefiting

as much as they could from their existence. People may be referred to the teams who are better suited to the involvement of an early intervention service, while an assertive outreach team may assertively reach out to a person who is, in fact, in crisis. In short, the variety of services available has the potential, if not managed carefully, to create confusion. Hence, a whole systems approach is necessary. For crisis resolution teams to work to their optimum effectiveness, it is vital that related services know how best to use them.

5.5. Summary of key recommendations.

- Crisis team members need to work beyond the guidelines of the PIG when the occasion demands.
- Crisis resolution services need to be researched further.
- Service users should be able to negotiate their initial involvement with crisis services to a greater extent.
- For crisis services to attain optimum effectiveness, they must work closely with related services.

6) Conclusion.

In this study, I have shown how “crisis” is defined as psychiatric but that the psychiatric element does not exist by itself. Rather, an array of social and domestic factors is often evident in its construction. Responses by the teams are planned accordingly and the appropriate expertise is utilised. Expert knowledge is reflected in the professional composition of the crisis teams, but membership of these professions overlaps with membership of the teams themselves. Loyalties are hence mixed, at times conflicting, but, for the most part, they comfortably co-exist.

Teamwork is based on co-operation, unity of purpose and mutual support. All of these are discursively accomplished, and backstage performances are integral to frontstage service-delivery. Service users are not merely the recipients of this delivery, but are also to an extent its instigators and collaborators.

I have shown how these findings are demonstrative of a pragmatic outlook inherent in crisis work. Alongside this outlook, there is an accompanying dilemma of flexibility in practice versus fidelity of a model. This outlook and dilemma is, on the one hand, reflective of the teams' need to achieve their ends, to follow specific guidelines and conform to a certain model of working. On the other, it is reflective of the necessity for individual and collective judgement, for negotiation, co-operation and consensus. In other words, the practical realities of delivering a crisis resolution service cannot be explained by the guidelines alone.

Service rationing is a prominent factor in crisis resolution. Such rationing is accomplished not only through reference to the PIG but also through the negotiated categorisation of those people referred. Further research is required in this area, since this will lead to a fuller understanding as to how some may be denied access to crisis services. This denial of access needs to be questioned. Mental health services should strive towards inclusiveness, not to create and perpetuate social divisions between those who qualify and those who do not. This is not to say that the teams' involvement should extend to those experiencing a minor "life-crisis"; rather, the intensity of need should be the defining factor as to a person's suitability for treatment rather than whether or not there is evidence of acute psychiatric illness.

Crisis resolution has a political dimension. A simplistic view would be that these services are simply used to reduce hospital admissions. This could be cynically regarded as placing numbers and costs above the needs of people. This is not my contention, since this study has shown how team members are very responsive to the needs of service users.

To a certain extent, crisis services may be imposed upon rather than chosen by service users. As users do not refer themselves, general practitioners and accident and emergency departments remain the intermediaries between those in crisis and emergency mental health care provision. Crisis services may relieve the burden of psychiatric hospitals; however, they do not and are not intended to relieve referrers. Though emergency provision is changing from hospitalisation to crisis resolution services, there is currently a post-code lottery determining which of the two a person will receive. They cannot currently choose between the two services. In this way, current policy denies those experiencing crisis their potential to ascertain the form of treatment most suitable for them; the local services will be said to *know what's best*.

Crisis services need to evolve. At the moment, they are working well in that they are successfully reducing hospital admissions, are demonstrably sensitive to the needs of service users, and are genuinely offering these users a greater degree of autonomy in the planning and execution of their treatment than would be available in hospital. In short, they are, for most part, successfully reducing the suffering of many. However, the services could work better if the necessity of their flexible working practices was acknowledged. They could be more inclusive and further facilitate long-term improvement in the mental health of services users if the short-term intervention they provide were more explicitly geared towards “learning from the crisis”. Currently, the containment factor may out-balance the learning factor.

Crisis and learning are inextricably linked. Crisis is the result of a change, is a change in itself, and is an instigator of further, long-term, change. It is, in one way or another, a turning point in a person's life, where lessons may be learned and behaviours modified accordingly. If a person can be helped to reflect on the causes of the crisis, such a crisis is less likely to be repeated, while if potential risks to self and others are the main concern of those involved in a person's treatment, such treatment may be more concerned with behaviour management than education. This links back to the contrasts between Caplan's original “crisis theory” and the psychiatricisation of crisis. While it was Caplan's view that a crisis is a “life event”, from the pragmatic standpoint of contemporary crisis

resolution services, it is a time when risk has to be managed. This is not to say that a crisis cannot be both a “life event” facilitating long-term behaviour change *and* a period in which intensive risk management is required; rather, the emphasis shifts from the former to the latter because crisis teams are publicly accountable. If a person in receipt of their care causes serious harm to themselves or others, it is the teams who will be required to explain why this occurred despite their input. This further illustrates the dilemma of crisis work; the will to be educative and therapeutic may be, to an extent, compromised by the necessity to prevent potential tragedies and the associated negative publicity.

In general terms, despite exclusion criteria and service rationing, the practical accomplishment of crisis resolution is perpetually negotiated both amongst team members and between team members and service users. In this sense it is flexible, but may appear solid. At the point of delivery, crisis resolution is a pragmatic rather than a dogmatic practice.

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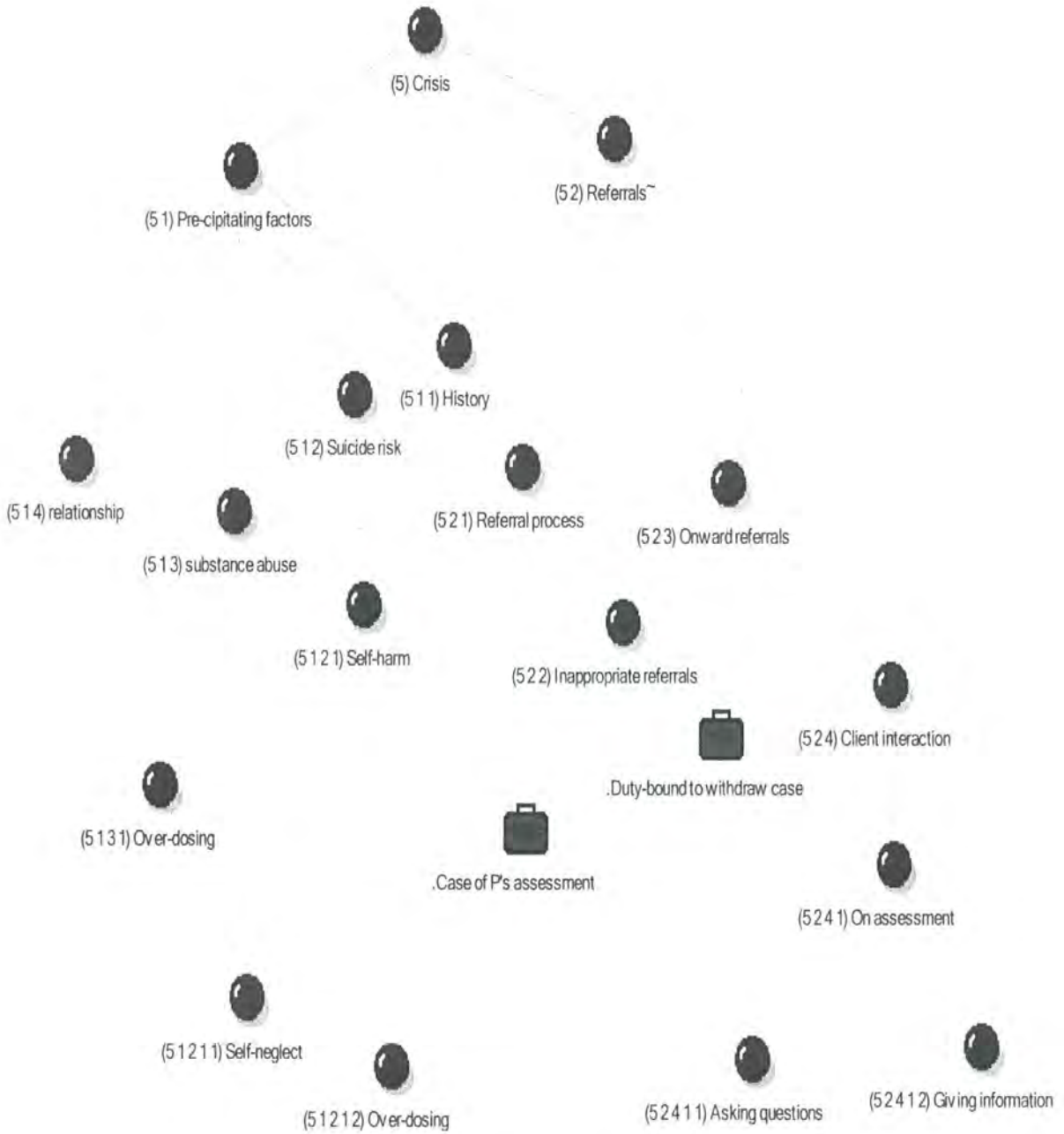
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APPENDICES.

APPENDIX I: A TREE DIAGRAM.



The above picture is an example of a hierarchal coding (a “tree node”) lifted from NVIVO. The root of the tree is “crisis”, from which the other topics stem. This particular “crisis” node is concerned with initial presentations; one “branch” refers to referral, the other to the precipitating factors collected by the teams at the time of referral (the justifications given by the referrer for the referral). It goes on to present “nodes” related to assessment. Here, there is an obvious over-lap as some of the “precipitating factors” node could again appear as further “branches” stemming from the “giving information” node. Included in this tree diagram are two “cases” to which particular nodes were of clear relevance.

In NVIVO, I was able to call up all the data I had on a particular subject by selecting an appropriate node or case. This greatly reduced the time taken in data analysis.

Further “crisis” tree nodes exist with different branches; for example “psychiatric crisis” and “social/domestic crisis” from which further branches, e.g. “schizophrenia”, “housing problems” stem.

It is not possible to print a definitive “tree node” in this way since so many “nodes” overlap with one another. For example, “client interaction” also forms part of the “user involvement” tree node. In the “cases” which form part of this node, an array of other nodes is present.

In short, what is reproduced here is a small part of a vast and complex tapestry. To reproduce this in its entirety would be of limited use and profoundly difficult to decipher.

APPENDIX II: PROJECT DOCUMENTS.

1. Information letter to staff members.

Crisis Resolution in community mental health.

About this Research.

General:

This research intends to explain how crisis resolution teams work. I want to understand what occurs in the day to running of the team. In particular, I wish to look at how decisions are made in relation to crisis resolution.

The project is run jointly by the XXXXXXXXXXXXXXXXXXXXXXX Mental Health NHS Trust and Durham University. It is PhD supervised by Dr Roger Paxton, Head of Psychology and R & D Director for the Trust and Prof. John Carpenter and Mr. Robin Williams from the University. It is funded by the Trust and the Economic and Social Research Council (ESRC). At the end of the project I will write a PhD thesis.

Purpose:

I hope this study will lead to an improved understanding of the workings of crisis resolution teams. There are very few studies which look at *how* community mental health teams work on a day-to-day basis. This is what this study hopes to describe.

Role and confidentiality:

My role will be similar to that of a trainee health professional on an observation placement. I will not work with patients/users or have any case responsibility. I will be obliged by the same standards of confidentiality as a health trainee and respect these standards. I have an honorary contract with the Trust and have had a CRB check. Any data collected relating to individuals, both team members and service-users, will be anonymised in the thesis and in any subsequent publications. When I observe home treatment, it will be with the service user's informed consent.

Method:

Like a student, most of my time will be spent accompanying staff in their work and watching what people do. I will ask questions to clarify my understanding of what I observe and take part in informal discussions. I will occasionally take notes when appropriate. I will also ask to tape record some formal team meetings and transcribe them. I will check the agreement of those present on each occasion that I do so.

Later in the project I will also ask to interview some members of the team about policies and practices in order to check out my conclusions from the observations.

If you wish for further information, I am happy to answer any questions or queries.

2. Consent form for staff members.

Title of research: Crisis resolution teams in community mental health.

Consent to participation.

Statement of principal investigator

I have explained the study/research to the clinician/team member.

I have also discussed what the study is likely to involve, the benefits and risks and any particular concerns of those involved.

Information sheet has been provided

Signed:

Date

Name (PRINT) Job

title

Statement of clinician/team member

▪ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

▪ I understand that my participation is voluntary and that I am free to withdraw at any time, without having to give any reason.

▪ I understand that the researcher may be present to observe, without undue interference and judgement, all aspects of my work.

▪ I understand that the researcher may wish to record team meetings in which I am participating.

▪ I understand that if I agree to tape-recordings being made that they will be kept in a locked cabinet and destroyed at the end of the study.

▪ I agree to take part in the above study.

Name of clinician/team member (PRINT)

Signature

Date

3. *Initial letter to services users and carers.*

Project Title: Crisis Resolution and Community Mental Health.

Date: 26/03/03.

Letter to service users and carers.

My name is George Anderson. I work at Durham University and with the
XXXXXXXXXXXXXXXXXXXXXXXXXXXX Mental Health Trust. I am carrying out research
on the crisis resolution team in your area. We hope the findings will help team members
to give the best possible service to users and carers.

While it mainly the team itself that I am looking at in this research, your experience as
carers and service users is obviously very important.

You do not have to agree to take part in this research and if you don't it will not have any
effect on your care and treatment.

How will this research affect you?

This research will only affect you if you agree to me writing an account about what
happened when you were visited by the team. Parts of this may be included in the final
report. All research is confidential and you will not be referred to by name in the report.
If you agree to me accompanying the team when they visit you, but later change your
mind about being included in the research, this is no problem. You can let me know by
writing to the above address or phoning me on the above number.

I may also ask if you would be willing to be interviewed some time. If you were to agree
to this, I would ask you to tell me about your experience of the home treatment team's
visits and how they have affected you. This interview will be recorded and the tapes will
be wiped at the end of the study. This is not part of your treatment.

If you are willing to be featured in this research, I will also ask if I can look at your
medical records. Once again, any information extracted will be confidential. You can still
participate in the research without agreeing to be interviewed or to me looking at your
medical records.

Who will read the report?

A research report will be sent to Durham University. It may also be read by other
professionals and service-users. However, I will make sure that your identity remains
confidential. You shall not be referred to by name or any other identifying factors (such
as your address).

Whether or not you decide to take part in this research, the service you receive will in no way be affected. However, please let me know within the next 24 hours if you are willing to be included in this research. If, in the meantime, you want to discuss this further, I am willing to answer any of your queries.

What is the benefit for you in taking part in this research?

We are hoping that the results of this research ensure that service-users and their carers receive the best possible service in the future. It is an opportunity for you to share your experience of home treatment and help the service develop further.

With best wishes,

George Anderson.

4. *Letter to service users and carers regarding interviews.*

Project Title: Crisis Resolution and Community Mental Health.

Date: 27/03/03.

Letter to service users and carers.

As you may remember, I am carrying out research on the crisis resolution team in your area. We met when you were visited by the team. I am writing to you now to ask if I could interview you. Your experience as carers and service users is very important to the study. I am hoping that you will be able to tell me what you thought of the treatment that the team offered and what you would want from such a service in the future.

You do not have to agree to be interviewed. If you don't agree, this will not have any effect on your care and treatment. You can have another person present in the interview if you wish. You can chose the time and place you wish to be interviewed. The interview is likely to last around an hour.

As always, I will make sure that your identity remains confidential. You shall not be referred to by name or any other identifying factors (such as your address). If you agree, I will tape record the interview. I will keep the tapes in a locked cabinet and wipe them at the end of the study. I will not tell any member of the crisis team what you say, unless you ask me to.

If you have any questions, please let me know. Phone me on (*number of the team base*). Please let me know within the next three days if you agree to participate.

With best wishes,

.....

5. Initial consent form for service users and carers.

Patient identifier:

Patient agreement to research

Title of research: Crisis resolution teams in community mental health.

Consent to observation of team visits and access to clinical records.

Statement of principal investigator

I have explained the study/research to the patient/carer/

I have also discussed what the study is likely to involve, the benefits and risks and any particular concerns of those involved.

Information sheet has been provided

Signed:

Date

Name (PRINT) Job

title

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

SignedDate.....Name

(PRINT).....

Statement of patient/carer

- I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without having to give any reason, without my care and treatment or legal rights being affected.

- ▪ I understand that sections of any of my clinical notes may be looked at by the researcher where it is relevant to my taking part in research. I give permission for this individual to have access to my records.
- ▪ I agree that my GP may be informed that I am participating in this research.
- ▪ I agree to take part in the above study.

Name of patient (PRINT)
Date

Signature

Name of caregiver (PRINT)
Date

Signature

Relationship to patient

6. Interview consent form.

Patient identifier:

Patient agreement to research

Title of research: Crisis resolution teams in community mental health.

Consent to interview.

Statement of principal investigator

I have explained the study/research to the patient/carer/

I have also discussed what the study is likely to involve, the benefits and risks and any particular concerns of those involved.

Information sheet has been provided

Signed:

Date

Name (PRINT) Job
title

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

SignedDate.....Name
(PRINT).....

Statement of patient/carer

- I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without having to give any reason, without my care and treatment or legal rights being affected.

▪ ▪ I understand that if I agree to tape-recordings being made that they will be kept in a locked cabinet and destroyed at the end of the study.

▪ ▪ I agree to take part in the above study.

Name of patient (PRINT)
Date

Signature

Name of caregiver (PRINT)
Date

Signature

Relationship to patient

7. Protocols.

Project title: Crisis Resolution and Community Mental Health.

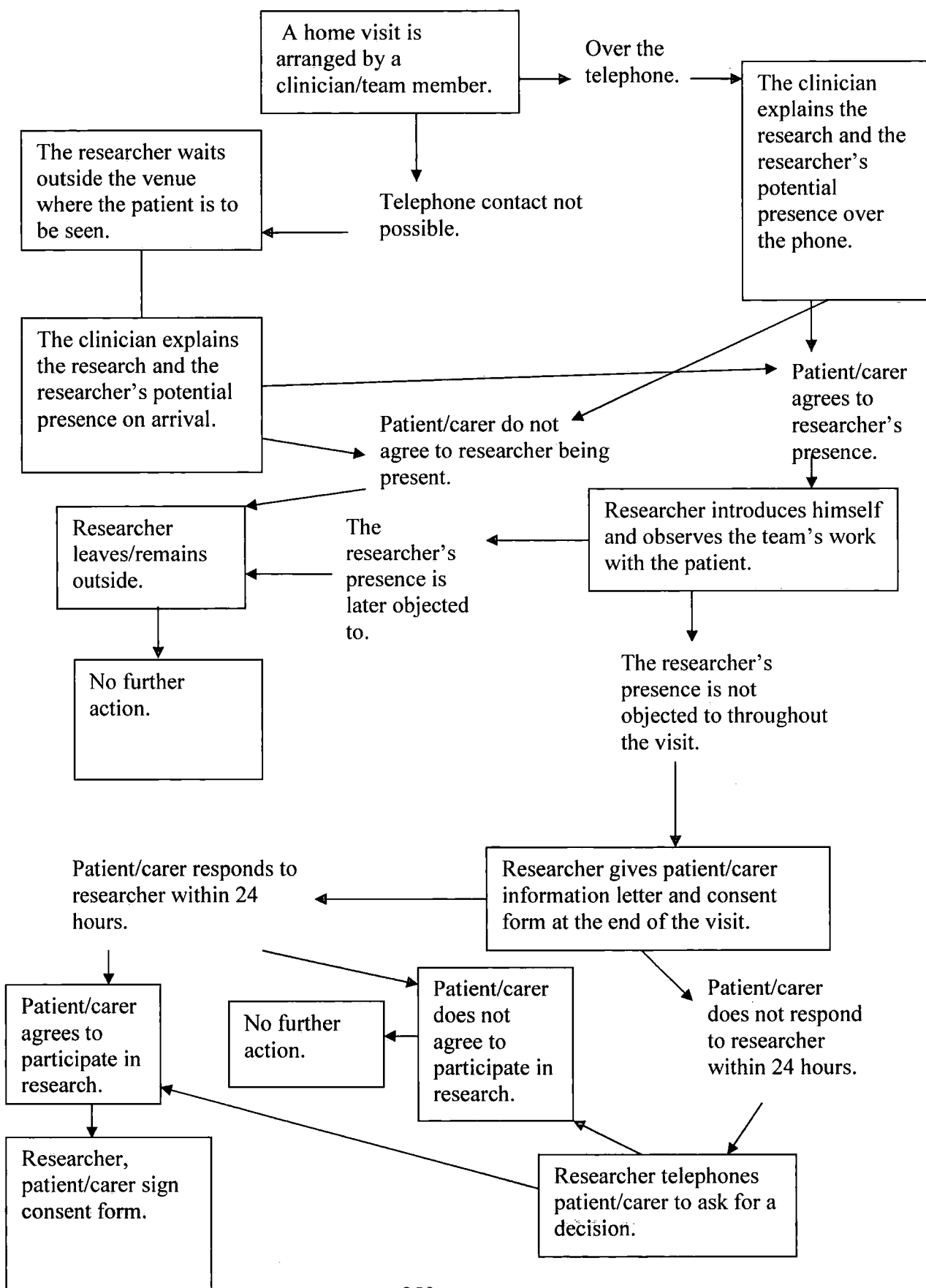
Date: 27/03/03.

PROTOCOL FOR OBTAINING CONSENT FROM PEOPLE EXPERIENCING A MENTAL HEALTH CRISIS.

- 1) Where possible, a patient and/or carer will be informed by the clinician of my potential presence before my arrival. This will normally be over the phone when a visit is arranged. The clinician will explain that “we have a researcher currently attached to the team, looking at how we work. Is it okay for him to accompany us when we visit you?” If the patient and/or carer have any questions, the clinician will answer them at this point. The clinician will explain that whether they agree to the researcher’s presence or not, their treatment will not be effected. The patient and/or carer will have the opportunity to refuse access.
- 2) In a very small number of cases, a prior introduction may not be possible. In such cases, I will wait outside the venue where the patient is to be seen. A clinician will explain that I am outside and I would like to observe how the team is treating them, but that I will not do so without their permission. Rather than attempting to deliver a detailed description of the project at this point, the clinician will explain that “we have a researcher working with the crisis team looking at how we operate. Would it be okay for him to come in? You don’t have to agree, and if you don’t, it won’t have any effect on the service you receive. You can ask him to leave at any point without having to give a reason. Is that okay?”
- 3) If my presence is verbally accepted at this point, I will respectfully come in and observe, giving the patient and/or carer further information if required. If it is not, or I am asked to leave after initially being invited in, I shall leave at once. At the end of the meeting, I will give an information letter for the service user and carers.
- 4) The patient and their carers will be given 24 hours to decide whether they are willing to be included in the research or not. The number of the team base will be given on the information letter.
- 5) If there is no reply after twenty four hours, I will phone the patient or carer (unless there are more explicit contact arrangements in place). I will explain the research further if necessary.
- 6) If the patient and carer agree, I will take them a copy a copy of the consent form, either on my next visit with the responsible clinician or independently, as they prefer. I will ensure that they fully understand the project, discuss any concerns and sign the form. I will invite them to sign the form only if they are agreeable. I

will emphasise that they may withdraw their consent at any time without having to give a reason.

- 7) If they sign their consent form, I will explain that I may approach them in future to ask for permission to interview. If I do this I will ask them for separate consent for this.



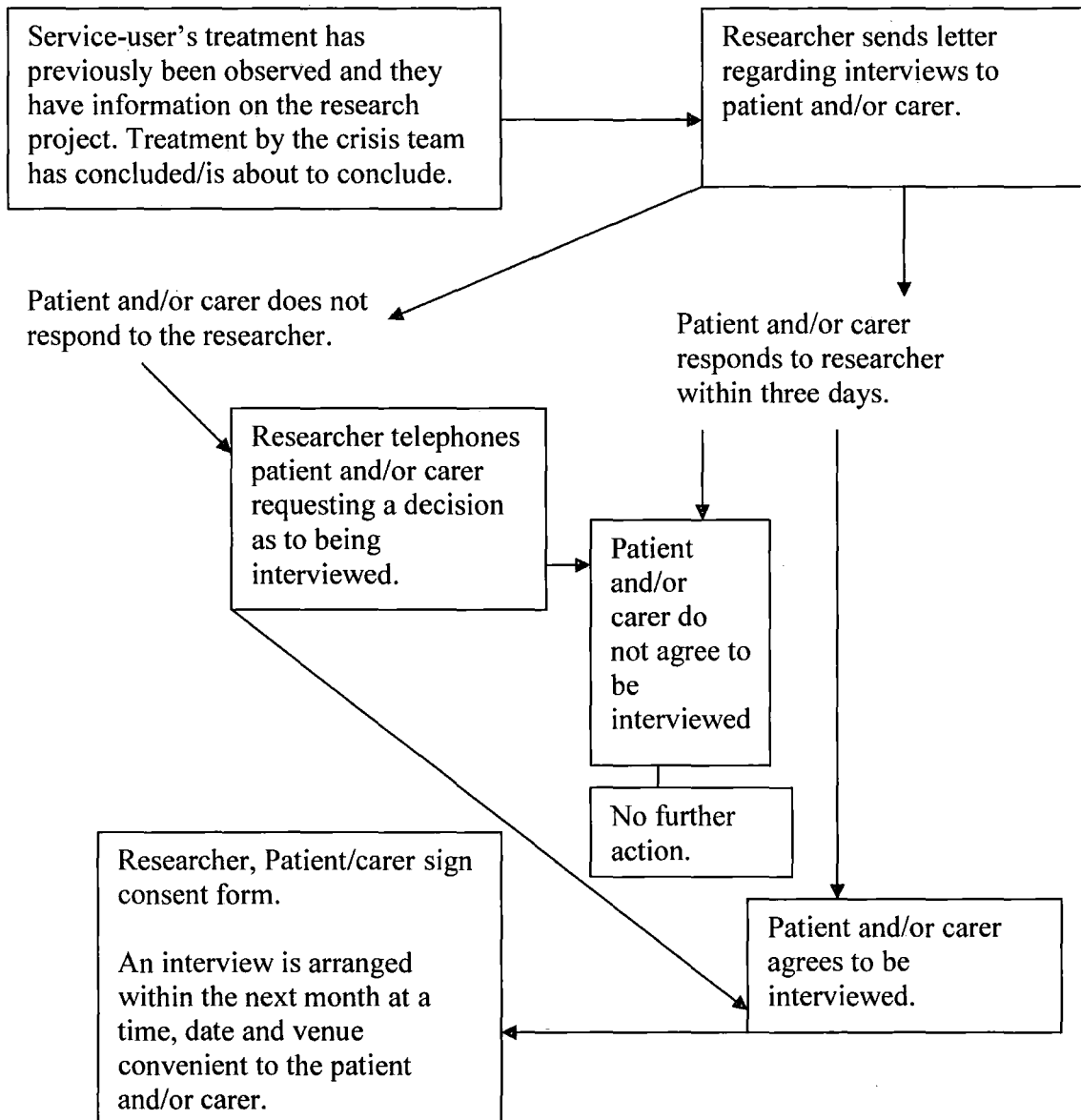
Project title: Crisis Resolution and Community Mental Health.

Date: 27/03/03.

PROTOCOL FOR OBTAINING CONSENT TO INTERVIEW SERVICE-USERS.

- 1) If a patient/carer has already agreed to the researcher observing their home treatment by the crisis team, I will write to them once their involvement with the team has concluded, requesting a response (verbal or written) within the next three days. The patient and/or carer will have been informed by the researcher that an interview may be requested in the earlier documentation relating to the research. If, on an earlier occasion, a patient and/or carer who has agreed for their treatment to be observed but has stated that they do not wish to be interviewed, they will not be approached. If the patient and/or carer have any questions, the researcher will answer them at this point. The researcher will explain that whether they agree to be interviewed or not, their treatment will not be effected. The patient and/or carer will have the opportunity to refuse access.
- 2) If after three days, the patient and/or carer have not responded to the researcher, the researcher will telephone (unless there are more explicit contact arrangements in place) and ask for a decision as to whether or not they agree to be interviewed. I will explain the research further if necessary.
- 3) If the patient and/or carer do not wish to be interviewed, there will be no further action and no further contact from the researcher.
- 4) If the patient and/or carer agree to be interviewed, a time, date (within the following month) and place will be arranged for the interview to be conducted. This will be in line with the patient and/or carer's preference.
- 5) Service users and carers will have the opportunity to discuss the research at any time I am available. They will also be entitled to withdraw consent at any time.
- 6) Before the interview, the researcher will ask if the patient and/or carer has any further questions.
- 7) Once the interview is complete, the patient and/or carer will be invited to contact the researcher at any time if they have any further questions.

Note: This procedure is illustrated in the attached algorithm.



8. *Letter to GPs.*

Project title: Crisis Resolution and Community Mental Health.

Date:

Re: XXXX XXXXX.

Dear Dr Xxxxxx,

I am writing to advise you that the above patient has agreed to take part in a research project on crisis resolution teams. The main focus is on the team's operation and it will include observation of their work with patients. I will ask patients for their consent to these observations. I will also interview selected patients and their carers about the team's work, again with their consent. I do not anticipate any risk to the patient from participating in this observational study.

This letter is sent for your information only. You are not asked to supply any material for the research. If you would like to know anything else, please do not hesitate to contact me.

Yours sincerely,

George Anderson.
PhD Student/Honorary Research Associate.

**APPENDIX III: The Mental Health Policy Implementation Guide:
Crisis Resolution/Home Treatment Teams.**

3. CRISIS RESOLUTION/HOME TREATMENT TEAMS

3.1 Who is the Service for?

Commonly adults (16 to 65 years old) with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder) with an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary. (NB) In every locality there should be flexibility to decide to treat those who fall outside this age group where appropriate.

This service is not usually appropriate for individuals with:

- Mild anxiety disorders
- Primary diagnosis of alcohol or other substance misuse
- Brain damage or other organic disorders including dementia
- Learning disabilities
- Exclusive diagnosis of personality disorder
- Recent history of self harm but not suffering from a psychotic illness or severe depressive illness
- Crisis related solely to relationship issues

3.2 What is the service intended to achieve?

People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care. The majority of service users and carers prefer community-based treatment, and research in the UK and elsewhere has shown that clinical and social outcomes achieved by community-based treatment are at least as good as those achieved in hospital. A crisis resolution/home treatment service should be able to:

- Act as a 'gatekeeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service
- For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week

- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible
- Remain involved with the client until the crisis has resolved and the service user is linked into on-going care
- If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge
- Reduce service users' vulnerability to crisis and maximise their resilience

Experience indicates that the following principles of care are important:

- A 24 hour, 7 day a week service
- Rapid response following referral
- Intensive intervention and support in the early stages of the crisis
- Active involvement of the service user, family and carers
- Assertive approach to engagement
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs
- Learning from the crisis

3.3 What does the service do?

There are four phases to crisis resolution – assessment, planning, intervention and resolution. The table below discusses each of these phases in detail.

Table 3a

Key component	Key elements	Comments
AGE, CULTURE DISABILITY AND GENDER SENSITIVE SERVICE	<ul style="list-style-type: none"> • 24 hour access to translation services should be available • Single sex accommodation and gender sensitive services should be provided if needed <p>(See section 8 of this guide for guidance on developing culturally sensitive services)</p>	<ul style="list-style-type: none"> • The high prevalence of diagnosed psychosis in certain cultural groups emphasises the importance of developing a culturally competent service • Needs of different groups should be explored and services adapted appropriately
ASSESSMENT	<ul style="list-style-type: none"> • Initial screening to ensure service is appropriate for the patient • If inappropriate, make referral to other services and ensure adequate continuity of care • Physical health assessment where appropriate • If appropriate, multi-disciplinary assessment of service user's needs and level of risk • Assessment should actively involve the service user, carers/family and all relevant others e.g. GP 	<ul style="list-style-type: none"> • Rapid – available within one hour of referral • Assessment to take place in service user's home wherever possible • Problem solving approach

PLANNING	<ul style="list-style-type: none"> • Produce a focused care plan • Decide on number of visits and level of input • Begin discharge planning at an early stage 	<ul style="list-style-type: none"> • Team approach and team decision making • Active involvement of the service user • Include input from family/carers • Care plan must be flexible enough to respond rapidly to changes in the clinical situation
INTERVENTION - the following interventions should be available:		
Designated named worker	<ul style="list-style-type: none"> • Responsible for co-ordinating the service user's care • Provides continuity of care and ensures effective communication within the team 	<ul style="list-style-type: none"> • Service user and family/carers involved in selecting named worker and aware of how to contact him/her
Intensive support	<ul style="list-style-type: none"> • Frequent contact (including home visits) throughout crisis • Ongoing risk and needs assessment • Service must have the capacity to follow service user throughout the crisis 	<ul style="list-style-type: none"> • In the early phase, several visits a day may be needed

Medication	<ul style="list-style-type: none"> • Immediate, 24 hour access to medication • Delivery and administration of medication to service users who require intensive monitoring • Care designed to improve concordance (co-operation with treatment) • Service user involved in decision making and monitoring effects of medication • Standard side effect monitoring tools to be used regularly by service user and staff 	<ul style="list-style-type: none"> • Staff need training in storage and use of medication as well as concordance training • Links with hospital and local pharmacies required to ensure continued supply • Careful attention to avoiding/reducing side effects vital if engagement and concordance are to be maintained
Practical help with basics of daily living	<ul style="list-style-type: none"> • Help with benefits, housing, childcare etc 	<ul style="list-style-type: none"> • Empowering service users and respecting their independence is crucial • Service user/family/carers must be involved in all decision making
Family/carer support	<ul style="list-style-type: none"> • Ongoing explanation to family/carers • Education about the crisis and the service user's illness • Arrange practical help as needed 	<ul style="list-style-type: none"> • Involvement of carers/family and provision of support during crisis are key components of recovery

Interventions aimed at increasing resilience	<ul style="list-style-type: none"> • Range of therapies for both service user and family/carers should be available including: <ul style="list-style-type: none"> • Problem solving • Stress management • Brief supportive counselling • Interventions aimed at maintaining and improving social networks 	
Relapse prevention	<ul style="list-style-type: none"> • Individualised early warning signs plan developed and on file • Plan to be shared with primary care, GP and others as appropriate • Relapse prevention plan agreed with service user and family/carers • Effort made to identify and reduce conditions that leave the service user vulnerable to relapse 	<ul style="list-style-type: none"> • Changes in thought, feelings and behaviours precede the onset of relapse but there is considerable variation between service users. Development of individualised plans can be effective in reducing the severity of relapse
Crisis plan	<ul style="list-style-type: none"> • Service user and family understanding of when to call for help • 24 hour contact number supplied to client/family/carers 	<ul style="list-style-type: none"> • Easy access to help 24 hours a day

Respite	<ul style="list-style-type: none"> • Access to respite facilities preferably in non hospital surroundings e.g. cluster homes, community hostels etc. • Access to day care facilities 	<ul style="list-style-type: none"> • Community residential care should be in small , family style accommodation that emphasises 'normal living' and has an 'open door' policy • Day care can be very effective in helping both service user and family/carer cope with crisis and recover
Links with in-patient services	<ul style="list-style-type: none"> • If hospitalisation required, regular, formal joint (inpatient staff and home treatment staff) review of patients should take place to ensure that the service user is transferred to the lowest stigma/least restrictive environment as soon as clinically possible • Home treatment team to be involved in discharge planning process • Service user/family/carers to be actively involved in discharge planning process 	<ul style="list-style-type: none"> • Primary care and other services to be involved as appropriate and kept informed of discharge plans

RESOLUTION	<ul style="list-style-type: none"> • Discharge planning should begin early • Information about the crisis, interventions and ongoing care should be exchanged with relevant others (GP, CMHT) • Discharge possibilities will be dependant on clinical situation and local service provision but could include transfer of care to: <ul style="list-style-type: none"> • Primary care • Assertive outreach team • Early intervention team • Continuing care • Other mental health services 	<ul style="list-style-type: none"> • Prior to discharge the team should ensure that: <ul style="list-style-type: none"> • There is good understanding (service users, family, carers, relevant others) of why the crisis occurred and how it could be avoided in future • Coping strategies have been explored with the service user and family/carers • Relapse prevention plan is in place • Service user/family/carer have had an opportunity to express their views about the service and contribute to service improvement
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In some areas the assertive outreach service nor the early intervention service provides home visits out of hours. A key function of the crisis resolution/home treatment service is to provide this type of intervention and support out of hours. Links need to be established between the three teams so that:

- Handover and referrals are made easily
- Crises are anticipated and contingency plans are known to all involved in care
- Early intervention and assertive outreach service users are aware of whom to contact out of hours
- Staff from the assertive outreach team and/or early intervention team could participate in the crisis resolution/home treatment team out of hours rota
- Agreements for an out of hours crisis service for under 16 year olds can be established

3.4 Management of service and Operational Procedures

Model of service delivery

Crisis resolution/home treatment services are best provided by a discrete, specialist team that has:

- Staff members whose sole (or main) responsibility is the management of people with severe mental health problems in crisis
- Adequate skill mix within the team to provide all the interventions listed above
- Strong links with other mental health services and a good general knowledge of local resources

Formation of service

- An audit of pathways of care, current service provision and local epidemiology should be undertaken initially. Information from this audit should then be used to develop an implementation plan
- The employment of a project manager to oversee the formation of a crisis resolution/home treatment team should be considered

Caseload

- Each team is likely to cover a population of approximately 150,000 and have a caseload of 20 to 30 service users at any one time
- However, the size of population that each team covers will depend on a number of different factors. A needs assessment needs to be undertaken prior to the formation of a crisis resolution/home treatment team to calculate likely service usage. Factors to take into consideration include:
 - Geography of the area
 - Demography and epidemiology
 - Health and Social Service boundaries

(See section 8: *Tailoring Services to Local Needs* for more information)

Staffing

The table below gives details of suggested staffing levels and skill mix for a team with a caseload of 20 to 30 service users at any one time.

Table 3b	
Designated named workers:	Total 14 per team
Key skills: <ul style="list-style-type: none"> • High energy level • Team player • Ability creatively to engage service users • Understanding of needs of service users, including specific needs related to cultural background/age/gender etc • Able to co-ordinate care and provide broad range of interventions 	Team leader plus up to 13 others Designated named workers include: CPNs ASW OT Psychologists Support workers including service users Appropriate mix of staff is needed to ensure that all the interventions listed can be provided within the team

<p>Medical staff</p> <ul style="list-style-type: none"> • Active members of the team • 24 hour access to senior psychiatrists able to do home visits is vital 	<ul style="list-style-type: none"> • Involvement from both consultant and middle grade psychiatrists • Level of psychiatric input to be determined by local need and service configuration
<p>Specialist skills</p> <ul style="list-style-type: none"> • These skills should be available within the team either by employing a fully qualified practitioner or by training other team members • External supervision, support and training needed for 'non specialists' providing these interventions 	<ul style="list-style-type: none"> • OT/OT skills • Psychologist/psychology skills • ASW/strong links to social services and ability to undertake thorough assessment and activate services as needed
<p>Support workers</p> <ul style="list-style-type: none"> • People with health, social care or appropriate life experience or personal experience of mental health problems/treatment 	<ul style="list-style-type: none"> • Number of support workers to be determined by the team • Support workers to reflect the demography of the local population
<p>Programme support</p>	<ul style="list-style-type: none"> • 1 wte administrative assistant • IT, audit and evaluation support may also be needed

Hours of operation

- The service should be available 24 hours a day, 7 days a week
- A shift system reflecting differing working patterns is required. A minimum of two trained case workers should be available at all times
- Evening/through the night working is usually an on-call system
- Medical on call rota should allow senior psychiatrist to undertake home visits 24 hours a day
- Assessment team for acute assessment of new referral (available 24 hours a day): two trained case workers and a senior psychiatrist
- Home visits to known service users (available 24 hours a day): two case workers

Referrals

Referral to the service should be easy and pathways of care clear to all involved. The service should have a system in place that allows direct referrals from primary care, community mental health teams, ASWs, staff on inpatient wards, the criminal justice system, non-statutory agencies, former service users and their family/carers, A+E departments and other parts of the acute medical service.

Risk assessment and policy on violence

- Each team should have a written policy outlining the level of risk the team is able to manage
- Operational policy should explicitly address staff safety

Staff training should include:

- Principles of the service, cultural, gender and anti-racist training
- Skills in delivering all of the interventions listed above
- Team building, colleague support and working within a team framework
- Medication - storage, administration, legal issues, concordance training, side effect awareness
- Use of Mental Health Act and alternatives to hospital treatment
- Benefits to service user and family/carers of home treatment approach

Service user information

Service users and their family/carers should be provided with the following information:

- Description of the service, range of interventions provided and what to expect
- Name and contact details of care co-ordinator and other relevant members of the team
- Contact details for out of hours advice and help
- Care plan and comprehensive information about medication
- Relapse prevention and crisis plan
- Discharge plan
- How to express views on the service.

Continual service improvement

Regular audit of the service should be undertaken to ensure that gaps in service provision are filled. Audit should always include feedback from service users and their family/carers.

3.5 Evidence for further reference

Outcomes of Care

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