"The service user’s subjective experience of crisis and of support from the Crisis resolution and home treatment team (CR/HT). What helps and what hinders in the crisis experience situations?"

Project plan and proposal for Ph.D. program, NHV, Gothenburg.

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Introduction - Project organisation and research field

Buskerud University College, Faculty of Health ((Høgskolen i Buskerud, avdeling for helsefag) has established the project Crisis Resolution and Home Treatment (CR/HT) in Community Mental Health Service: Development, Practice, Experiences and Outcomes which includes three studies:

- The first study focuses on the development of a CR/HT in a local service sector examining the processes and products of its implementation (Main researcher is associate professor Bengt Karlsson, and doctoral fellow sociologist Hege Sjølie).

- The second study focuses on the experiences of CR/HT service-users, especially those with psychosis in relation to crisis, impact on their everyday life, and service use (Main researcher is associate professor Marit Borg). The study described in this plan is a part of this project. (Supervisor for the doctoral fellow is Tor-Johan Ekeland).

- The third study focuses on examining aggregate-level outcomes in relation to the characteristics of CR/HT teams that are in place across community mental health units in Norway, and more specifically in the Health South Region. The results from the project will add to the evidence on the workings and effectiveness of CR/HT services in Norway and internationally (Main researcher is Professor Mervyn Morris).

Three researchers and two doctoral fellows are participating in a 75 % position in the project, along with the main project leader, Professor Hesook Suzie Kim, who has a 20 % position. The project is financed by the Research Council of Norway (NFR) as an SHP project. The main project started in the autumn 2007 and is estimated to end in December 2011. Four researchers who are consultants to the main project are Jaakko Seikkula, Paula McGee, Alain Topor and Larry Davidson.

Drammen Psykiatriske Senter (DPS), which will be the research field for the studies, has established a new service in fall 2007. This service is for persons with mental distress in the area Nedre Buskerud. The team will be developed by using fidelity criteria based on experiences from other teams (National: Follo, Tromsø, International: UK, Australia, USA) as basis. The DPS own employee experiences and empery would also be important in the process of developing the team. The team will be composed of 12 service-providers recruited from the existing interdisciplinary professional staff of the unit. The main objective is that the team will offer support to the service-users within 24 hours of their requests. It will be a 7 days a week service, and as far as possible it will be 24 hour service. The team as a whole will take part in a training program in CR/HT through Buskerud University College (Høgskolen i Buskerud). This course includes all members of the team over ten months including in an individual exam at the conclusion.

Background

Mental illness is common among the general population. Through a lifetime it is about half of the population who experience some kind of mental health problems. In a Public health view it is important to give priority to the area of mental health and to develop research projects and to gain knowledge about various kind of health promotion (Norwegian institute of public health, www.nhi.no)). This can contribute to prevent for difficult health and social situations for
individuals, families, the local community and the society as a whole against painful experiences as well as costs.

Adult mental health service provision in Norway is in a period of rapid transition as it seeks to expand non-institutional mental health care for people with psychiatric problems, and in particular with serious mental problems. In line with World Health Organization policy, and reflecting developments in psychiatric services internationally, models of community care are now becoming established that target to minimize hospitalization. European policy reflects this intention to move from large institutionally based services to more local community based services (European Commission 2005), maximizing the opportunity for acute care and rehabilitation whilst remaining in the family and usual social environment of the individual. The Norwegian Health and Social Directorate targets the creation of Crisis Resolution/Home Treatment teams in all 78 DPS units in Norway by 2008. This is maybe one of the most significant parts of the evolvement in the field of the Norwegian Mental Health services from hospitalisation to non-institutional models of mental health care for people with psychiatric problems (St meld 25, 1996-97, Ruud et al. 2006).

Crisis Resolution/Home Treatment (CR/HT) teams offer a specified service with two specific functions: assessment and direct care. The teams are dedicated to short-time service to respond timely to referrals where the user needs help immediately (urgent). One target of this service at Drammen Psychiatriks Senter is to give persons with a crisis in the region Nedre Buskerud assessment and care in their community and home context. Target user group are persons in crisis and in need for help within 24 hours, the crisis may not primarily be psychiatric in nature. Persons in such circumstances would usually be admitted in psychiatric units if they do not get services from the CR/HT team. Both RCT studies and qualitative researches in the field made in Australia, USA and UK, in particular, shows that many service users are satisfied with the quality of home treatment services (NIMHE 2005). Recent Norwegian research results support these (Hultberg & Karlsson, 2007). The admission rate is also lower in areas where CR/HT teams are a part of the service (Glover et al.2006).

Purpose of this study, service-users descriptions and experiences of crisis and home treatment

Various models of community-based treatment give opportunity to strengthen and enable individuals, in particular those with serious mental distress, to live as independently as possible in their own homes, with their family and social network. People with serious mental distress may through support from CR/HT, among other services, get opportunity to achieve their full potential as autonomous members of society. The service user and the family can also be supported in the process of recovery in everyday life. Maintenance health and quality of life is a minimum standard of living, seen from a public health view: a human right. This is also valid for those individuals which experience serious mental illness. Health and life quality depends on conditions as mental, physical, social and spiritual resources. Satisfactory living condition depends on, and can be compared to conditions of the general population in Norway. The opportunity to be accepted as equal inhabitants in the community can be important.

Crisis Resolution/Home Treatment teams (CR/HT) are one model among a range of services for individuals with severe mental health problems and distress. The aim of this study is to gain in-depth knowledge about how service-user in crisis, particularly those individuals in psychotic crisis, describes their own life-world experiences of the crisis and of their experience of the support from the CR/HT team. It is also of interest how the user describes the experiences with a
CR/HT in contrast to being admitted in an acute unit in a mental hospital following a crisis. This study focuses on the following research questions:

- How do individuals experience and understand mental health crisis?
  - How do they usually deal with mental health related crisis in everyday life?

- How can are the services CR/HT and inpatient treatment be of help as the individual experience and see it? How do the service-users within crisis resolution describe as helpful support?

- The informants social situation and living conditions (E.g. sociodemographic and economic variables), Do these have any impact on the experience of and coping with mental health related crisis?

- As a community service, can CR/HT services support and strengthen the patients and the families’ general quality of life in any ways?

Research reveal that many people within crisis experiences various kinds of care like home treatment useful (Karlsson, 2007, Heath 2004, Borg 2007, Ruggeri et al. 2005, Seikkula et al. 2006). But results differ. Among others Cochrane reviews from 2006 (on crisis intervention) and one in 2007 (on community mental health teams - CMHT), did not find significant differences between inpatient treatment and home treatment. The review shows that about half of the users in the crisis/home care group were unable to avoid hospital admission during their treatment period. But these studies also show that home care helps to avoid repeat admissions, that both patients and families find the form of care satisfactory and that the family burden reduces. Authors conclusion is that crisis treatment at home, coupled with an ongoing home care package, will be an acceptable way of treating people with serious mental distress. But they also emphasize that more evaluative studies are still needed if these methods is to be widely used (Joy, Adams and Rice 2006, Malone 2007). There is still a need for development and knowledge about quality of the services and how users experience the different treatments. More systematized knowledge in this field would make it possible to give each individual opportunity to get a better recovery process, strengthen their quality in everyday life contexts and avoid the unfortunate experience of too many revolving doors (Heat 2005, Joy 2007, Brimbelcombe et al. 2003).

**The paradigm shift in society and mental health services**

In the last four to five decades there has been an international transmission trend in the care and treatment of patients in mental health from the specialized inpatient admission and total institutionalization to community based day care and home treatment (Prior 1991, Heat 2005, Alme 2006, Rund 2005). There has been a paradigm shift in the understanding of how to treat and recover patient with psychosis. Particularly related to persons with schizophrenia disorders where studies show that 20-25 % will gain full recovery and even more will cope with the problems in everyday life (Rund 2005). Research results show that coherence through home treatment, routines in activity (e.g. work) and a stable social context can be conclusive for the recovery (Borg 2007, Borg & Topor 2003). The theory of salutogenesis and sense of coherence emphasizes the importance of recovery-orientated perspectives and the opportunity to find the factors that give each individual’s strategies to cope with crisis (Antonovsky 1979, 1987).
Institutionalisation, power and role expectations

Goffman’s theory of total institution (Goffman 1961) has provided a political and professional basis for sociological and psychiatric theories, ideology and practice, both on the level of the individual and on the system level. Even if the theory was made decades ago, it is still valid to use the perspective to understand relations among patients/service-users and their providers. Goffman’s theory emphasizes negative consequences of being in admission in the total institutions. In mental institution, there has traditionally been a social distance between the inmates and the staff (Goffman, 1961). This distance may be a way to maintain distinctions between the roles of patient and the content in this role against the roles of professional care providers. The role of being a patient is often different from ordinary social roles (Goffman 1982). There are also certain expectations regarding how a person must acts when admitted in the hospital. The expectations of the role of an in-patient person in a mental hospital will be quite different from the expectation to the role of a mentally ill inhabitant who copes with staying in his or her home environment.

Institutionalisation may give the person the feeling of being a mental case more than a free, independent, normal acting person with high self-esteem and personalized relationships based on trust. Goffman assert that in light of the total institutional model, the inpatient person possibly pass through a resocialisation. From their own way to act and function in their society to another more psychiatric way of behaving (Goffman 1961, Weinstein 1994). The feeling of stigmatisation can also be a part of the patient experience when being admitted in a mental hospital. The stigmatisation can also give the patient opportunity and excuses to stay ill (Goffman 1990). One treatment leads to another suffering than the first reason for admission. Access to social roles and not to be accepted in community can be a part of the problem and maintain the stigma for the individual, the family and other in the network (Buizza et al 2007).

The Service-user, the context, living conditions and the everyday life

An important goal for establishing community-based services for citizens with mental health problems is improved life quality and recovery through coping with crisis in well-known environment. A number of persons will benefit from staying at home. Closeness to family, familiar environment and the total ability to carry on with normal life gives opportunity to cope with crisis, strengthen the individual and make the sense of coherence stronger (Antonovsky 1987, Eriksson 2007). If the person is taken out of ordinary context each time a crisis appear, it can be difficult to learn strategies to cope with crisis in everyday life and to maintain ordinary life-roles and tasks.

Inpatient treatment is still important and a necessary part of the service for persons in exceptionally difficult situations. The safety and security is stronger and the continuity in caring over days is easier for the staff. This may be especially critical in family situations in which habitus of family in dealing with crisis or in everyday life is not conductive to recovery. And if the user does not have a home, family and/or friends, money, structured activity etc., it can be necessary to get admitted. Admission may give safety, security and rest from a difficult everyday life. Moreover, for those who live together with someone it can be a possibility to give the care taker(s) some rest if it is difficult to cope with the situation (Khan & Pillay, 2003). Other reasons for admission can be high risk of self-harm or suicide, harm to others (Brimlecomb et al.2003, Heath 2005). Research result shows that living conditions of people with persistent mental distress often is worse than in the mean population. They often live on their own without social connections of continuum; they have low income, and often is social security the only income (NOU 1998: 18, St.prp. nr. 1, 2004-2005).
In examining the experiences of individuals in different social contexts of mental health treatment and care, Bourdieu’s work on everyday practice may have relevance. Bourdieu analyses the society in three terms or key concepts: field, habitus and capital. Field is defined as a network or a system of social positions where power relations are structured. E.g.: The individuals’ interaction with others in everyday life situations at home would be quite different from of interacting with professionals in the field of a mental hospital unit. Habitus is explained as structured structures, where the external structures have become internal (and vice versa). It is learned (socialized), unconscious dispositions for acting in specific ways. Habitus develops through a dialectic process between internalisation and externalisation of structures of the individual and the field. Capital is essential to describe the resources the individual is in possession of and command. Bourdieu has made a distinction of three kinds of capital: economic, cultural and social (Bourdieu 2005, Prieur and Sestoft 2006). The individual’s experience in the context/field, their habitus and which capital they are in possession of will possibly influence on how they experience, describes and cope with crisis. A study of individuals’ experiences and practices in crisis resolution exposed to either CR/HT or inpatient from the perspective of Bourdieu bringing in the concepts of habitus, fields, and capital may provides an in-depth understanding about the nature of social practices associated with these different forms of mental health care. It may also be of interest to get information of the service-users sense of coherence (SOC) in life (Antonovsky 1979, 1987). And connections between SOC and the individuals experience and description of everyday life, crisis and treatment analysed in terms of Bourdieu.

“Psychotic crisis”, what is it and how to threat it?

Definition of psychosis is a difficult area, and so are definitions of “psychotic crisis”. A crisis is traditionally described as a person’s reaction to external stress that overwhelmed her or him, occurring as ones’ usual coping mechanisms for everyday life break down (Heath 2005, Lindemann 1944, Caplan 1964 in Joy 2007). Psychiatric emergency situations are typically defined as an acute disturbance of thought, mood, behavior or social relationship that requires an immediate intervention as defined by the patient, family or community. There is also a definitional distinction between emergency and urgent needs. One description of urgent crisis is that they evolve more slowly than in an emergency situation (Heath 2005). Alvin Toffler uses the description that a crisis is a happening in life that can give opportunities to learn more and get some further (Toffler 1980). This description is not necessarily useful for people with persistent mental illness. It is possible to assume that description and definition of psychotic crisis will be different from the traditional definitions of everyday life crisis. Coping mechanisms of people with severe mental distress will often be different from those of people without severe and persistent mental problems. Usual mechanisms to cope with stress tend to fall apart easily, and acute symptoms for which crisis intervention are needed may ensue. Coping strategies depends on personality, biological, environment/life-situation, social context/network, economic situation and so on. One of our aims in this study is to gain the persons own descriptions and definitions of what crisis is. This will be important for further development of the team and the intervention in crisis or psychiatric emergency situations.

People with mental health problems are often faced with problems associated with when, how, and what sorts of services they should seek in a time of crisis. Their approaches to help seeking is influenced not only by their knowledge of available services but also by their own definition of problems, which may not be appropriate at times, leading them to inappropriate services,
inattention, or delaying in service seeking. The available services in the area and the organisation of these are also of importance which services the service-user will seek. Figure 1.1 view different kinds of crisis and solutions. As a part of this study we hope to gain an understanding about individuals’ experiences and descriptions of the processes involved in crisis resolution.

Figure 1.1 based on a theoretical model of the crisis experience for individuals with severe persistent mental illness, it describes different kinds of crisis and solutions (Ball et al.2005).

Recent research view as users find the service of crisis resolution team at home as a useful alternative to admission this gives possibility to go on with the everyday life (Hopkins et al.2007, Borg 2007, Karlsson 2007, Heat 2005). But there is a need to gain more in-depth information about individuals experiences in order to provide the sorts of support that are necessary for the population. Terms that can structure the experience of acute home treatment are accessibility, availability, consistency, quality, choice/negotiation, communication and changes and endings (Hopkins et al. 2007).

**Methods**

This study is part of the Study #2 in the Main project. The study utilise an inductive qualitative research approach, within a phenomenological framework (Holloway 2005). Development of the study will be done in collaboration with a competence group.

**Developing the project - Competence Group**

A competence group will be established consisting of six individuals with personal experience of severe mental illness and recovery or with experience as family members. The participants will be recruited through the mental health network in Buskerud. Inspired by the concept of participatory research (Borg, M. & Davidson, L., 2007, Davidson, L., et al., 2001), this group will be involved as a reference-group in discussing interview guides and contexts as well as being involved in ongoing discussions during the analysis phase of the entire study. The competence-group will be organized and run by the researchers. The contribution of service users in research is well documented (Davidson, L et al. 2001, Turner, M. et al., 2005). This type of research provides opportunities for in-depth discussions with people having first hand knowledge and expertise as well as providing a more comprehensive way of understanding the recovery process and people’s lived experiences in a contextual way (Davidson, L.,2003, Creswell, C. M. et al., 1992).

**In-depth interviews**

Three interviews will be carried out with each informant. The interval between the interviews will be about one year, the first follow up interview after one year and the second after two
years. 10-12 individuals will be included. All of the interviews will be in a qualitative research approach largely grounded within a phenomenological framework (Holloway 2005, Davidson 1994, Davidson 2003, Davidson et al. 2001, Kvale 1983, Malterud 2003). An ontological fidelity to the experiences of individuals with severe mental illness (Kristiansen 2004) will be emphasised. Trying to grasp and understand life-world perspectives and intentionality will be central (Bengtsson 1999), including the individual’s everyday life as both a practical and societal world and description of crisis (Schütz 1962/1999). It will also be of importance to get information about the informants living conditions and subjective quality of life. The focus is thus complex and multiple, grounded in individual life-world experiences, and examined within individuals’ life-situations. This approach emphasizing life situations and everyday life will extend the slowly growing qualitative research on recovery from severe mental health problems (Davidson 2003, Borg et al. 1998). To extend the understanding of crisis, coping with crisis and mental health problems over time, the impact of professionals as well as others help and support, and experiences of recovery in the context of everyday life, the study is organised with follow up interviews.

Inclusion criteria will be discussed in detail in the competence-group, but the following aspects will be applied as baseline guidelines:

- Individuals with severe mental Illness
- At least two contacts with a CR/HT team but no recent contact during the previous 3 months
- At least one in-patient treatment in an acute psychiatric ward during the past three years
- Has not been admitted the last six months

Recruitment to the study will be done by the senior consultant (avdelingsoverlege) Carsten Bjerke, Sykehuset Buskerud HF, Psykiatrisk Klinikk, Drammen DPS. All In- depth interviews will take place in settings and times chosen by the participating informants. The major areas of inquiry will include:

- The individuals subjective experience of crisis in the context of everyday life, their ongoing recovery, views and expectations of the future; and their experiences of support from the CR/HT team
- The informants experiences in living with mental health problems in their daily life situations, and how they manage daily activities and demands and cope with challenging life situations and different living conditions
- The informants experience of support from family, friends, colleagues and significant others
- their experience of support from mental health professionals, service systems, and other sources during their hospitalization

Data collection process

A semi-structured interview guide will be developed in collaboration with the competence-group. The doctoral research fellow will be responsible for, and carry out the first interview together with the main researcher. The open-ended, in-depth interviews will be audio-taped, with the consent of the participants, and transcribed. The transcribed interviews will then be returned to each informant for his/her review and amendments.

1. All of the interviews will be an in-depth interview focusing on participants’ perceptions, definitions, and experiences and description, focusing on service user’ own experiences.

Each participant in the study will at the end of the interview be asked to fill out a short Quality of Life Assessment form (MANSA) (Ruud et al 2006).
Data analysis:

The data from the in-depth interview will be analyzed according to the established qualitative procedures by Kvale (Kvale 1983) and the procedures applied in the researcher’s previous work (Borg & Davidson 2007, Davidson 1994, Davidson et.al 2001). For the process of analyzing data Nvivo will be used. This is specialised software package for qualitative analysis.

Publishing

There will be published about five article from this project in international (Scandinavian) and national review journals. Temporary plan of publishing:


2010: Presentation of data . Dealing with mental health crisis in everyday life.

2010: Presentation of data - CR/HT versus inpatient treatment – what helps and what hinders?

2011: Presentation of data – The impact of material and social conditions on quality of life and coping with crisis.

2011: Presentation of data - Mental health crisis and stigma.
Ethical considerations

An application for examination of the research design in the main study is recommended by the National Social Science Data Services (NSD, project number 17403) and accepted by the Regional Ethics Committee (REK, project number s-07329a) in Norway. The Applications included information about the data collection: informed consent, confidentiality, anonymity, study design and plans for distributions for all three projects. It will be sent an own application for this part of the project in February/March 2008. Ethical aspect related to the informants is the possibility of vulnerability connected to their mental health illness. The people we are going to interview has been under conditions that has challenging for them. To take care of this it will be necessary that we as interviewers observe their condition true the interview session. All of the participant will also have the opportunity to get connected to the DPS if they are in need of this.

Work schedule - milestones

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<td>Cooperation with The competence group</td>
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<td>Data collection – individual interviews</td>
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<td>Data analyses</td>
<td>Q4 08 – Q3 11</td>
<td>August 2008</td>
<td>April 2011</td>
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<td>Preparation of manuscripts</td>
<td>Q2 08 – Q1 11</td>
<td>March 2008</td>
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<td>Final reports/publication/exam</td>
<td>Q4 11</td>
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Finances

The project is financed by the Research Council of Norway. My position as a fellow researcher employed by Buskerud University College, Faculty of Health, makes that there will be Salary for my research work until Q4 2011 with 75 % fee for the research activity from first of January 2008 to 30th of September 2011, and from first of October 2011 to 31th of December there will be 50 % for the research activity.
References


Ball, J., Links, P.S., Strike, C, and Boydell, K.M. (2005): "It's overwhelming... Everything seems to be too much:" A theory of crisis for individuals with severe persistent mental illness. Psychiatric Rehabilitation Journal; Summer 2005, Vol. 29 Issue 1, p10-17, 8p


Morgan, D. L. (1993): Successful focus groups: Advancing the state of the art. Newbury Park,


NOU 1998: 18 Det er bruk for alle, Styrking av folkehelsearbeidet i kommunene


Other references
Folkehelseintstituttet: www.fhi.no (psykisk helse)
Sosial og helsedirektoratet: www.shdir.no
Supplement to the interview guide:

Crisis
- What do you think about when you hear the word crisis?
- If you have experienced one or more crisis, can you tell about it? (feelings, relations, context, your approaches, etc)

Everyday life
- Can you describe a typical day for you? If the user needs help give cues: Are you engaged in activities as work, sports and pets?
- How do you carry on with your daily life?
- What are the easy things to deal in life?
- What are the difficult things to deal in life?

Family and network
- Can you tell about your relationship with others? (Searching for information about strong and close or neat relationships, what kind of network do they have?)
- How do you think your family or friends usually handle crises?

Service (You want to be more open here)
- Describe to me about your experiences with the most recent CR/HT.
  - You may begin with what prompted for you to get the service.
  - What did the team do? What did you have to do? Who else were involved?
  - What do you think has happened through the Team?
  - How did you feel about their approaches and methods?
  - What happened afterwards?
- Describe to me about your experiences with your most recent inpatient admission.
  - You may begin with what prompted for you to get admitted.
  - What happened as you became an inpatient?
  - What sorts of treatment and care did you receive?
  - Describe your experiences of being an in-patient
  - How did you feel about being a patient?
  - What happened afterwards?

Demographic, socioeconomic variables/structures - Who are the participants in this research?
- Do they manage with the economy in everyday life? (economic capital)
- How would you identify yourself in terms of social position? (Social capital)
- What are your perceptions of the expectations for you in general by the society and by your family and friends? What do you get from your social network? What does your social network mean to you?
  (Descriptions of habitus will come from the set of questions regarding everyday life).