

Crisis Resolution and Home Treatment in Community Mental Health Service: Development, Practice, Experiences, and Outcomes

Introduction

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 disorders. In line with World Health Organization policy as well as the European policy (1), and reflecting the developments in psychiatric services internationally, models of community care are now becoming established that minimize hospitalization and maximize acute care and rehabilitation provision within the context of the family and immediate social environment of individuals. Perhaps the most significant recent development is ‘Crisis Resolution/Home Treatment’ (CR/HT) teams that provide an alternative to in-patient acute care services. A range of advantages to this transfer of service has been reported, including de-stigmatization, greater satisfaction by service-users and carers, improved outcomes, and more direct expenditure on care by service-providers. More fundamentally, it has marked a shift in the locus of care from hospital to community, with opportunities for understanding and treating illness experiences in context, leading to a greater emphasis on psychosocial approaches, and involvement of service-users and carers as active partners in care provision, and re-focusing outcomes of services aligned to daily lives, employment, and other aspects of social inclusion.

Norwegian Mental Health services are also actively engaged in community service development, currently near completion of a ten year national initiative to restructure mental health services, including the recent national strategy for establishing a CR/HT team in each community mental health service (2). The Norwegian Health and Social Directorate targets the creation of CR/HT teams in all 78 DPS units in Norway by 2008 (3), as was accomplished in England by 2004 (4). This directive is based on international research evidence that suggests CR/HT to be preferable to and an effective form of reprovision of acute institutional care.

There are evidences on CR/HT from international studies of their effectiveness, and emerging evidence on these services in Norway (5). Impact of CR/HT services has been examined using established outcome measures such as hospitalization and patient satisfaction. Although CR/HT teams have been developed within a set of well defined characteristics (‘fidelity criteria’) (6), the ways teams function, achieve their targets and practice are less well defined and seem greatly influenced by local factors. Implementation of CR/HT services is complex because it is an additional or new service that is also a form of reprovision, requiring resource reallocation and reconfiguration. The process of organizational development, implementation, resource management, practice, and leadership dynamics may be unique to each service, and may impact not only on the establishment of practice patterns but also on service-user experiences and outcomes.

We derived our research focus and research aims by identifying key issues that impact on the development CR/HT as a component part of community based mental health services:

- Integration of CR/HT teams with in-patient and other community services (6);
- Limited knowledge of how CR/HT actually works from the service-provider perspective and how it is practiced;
- Limited knowledge of how individuals or family members understand and define crisis situations, and their ways of finding help inside and outside the mental health services network;
- Limited knowledge of service-users experiences and views of receiving crisis support from CR/HT, particularly in comparison to earlier experiences of in-patient care; and
- Limited knowledge of the impact of CR/HT on macro-level outcome measures in relation to the characteristics of CR/HT teams and their practice.

The research aim of this study is to explore questions stemming from these points by examining CR/HT from three discrete perspectives; (a) the process of development and implementation of a CR/HT team in a local service unit; (b) the experiences of individuals who have used CR/HT service, with a particular focus on severe and enduring mental illness (especially those with psychosis); and (c) the impact of CR/HT teams on macro-level outcomes across the mental health service areas nationally and more specifically in the Health South Region of Norway.

Background

Crisis Resolution/Home Treatment (CR/HT) teams are a model of provision that offer a specified service with two clear specific functions: assessment and direct care. CR/HT teams are community based mobile teams available to respond rapidly to referrals of individuals in crisis. The team applies an assessment process that determines the most appropriate service for the individual, from among a range of options including hospitalization, treatment by the team itself (i.e., home treatment), crisis resolution by the team, and next-level referrals to health or social services. Although referrals to CR/HT are for people in crisis, the crisis may not be primarily psychiatric. In such circumstances an assessment judgement will consider next-level referrals to more appropriate health or social services, or the team may attempt to resolve the crisis. This latter function is an extension of the role of mental health services, who are able to offer a timely response to emotional distress of individuals and families, even when the crisis is primarily social in its presentation.

The literature provides some insights into the effectiveness of CR/HT teams both at macro and individual levels. Established CR/HT teams in England have been shown to significantly reduce hospitalization. Glover and colleagues (7) report that teams providing a full 24 hour 7 day a week service reduce hospital admission on average by 32%, whilst teams without 'full cover' also reduce admission on average by 10% in comparison with areas without these services. There are also other reported benefits including user satisfaction and family engagement (7). For example, Hultberg and Karlsson (8) note that the service-users of a CR/HT team felt a greater sense of control, an appreciation for having choices and opportunities for participation. However, the literature is lacking specifically in three areas: (a) understanding the impact of local context in the implementation of CR/HT teams, and development of their practice patterns as an emerging process, (b) knowledge about service-users' experiences with CR/HT teams going beyond their satisfaction with care, and (c) relationships between the characteristics of CR/HT teams and outcomes at aggregate levels.

At the CR/HT team level, new ways of working are required to reflect changes in service demand, care environment, decision making and clinical responsibility. Relationships between professions, their roles and responsibilities alter but effective team working remains central to providing a safe and effective service. There are many variables that impact on the working of teams, with each CR/HT team developing its own patterns of work within the context of local services, team dynamics and the needs of the community it serves. For example, CR/HT team practices and effectiveness is influenced by the role and functioning of hospital and other community teams, making it important to capture their impact on the CR/HT's service. Gaining an in-depth knowledge of the processes influencing team development will not only add knowledge important to creating new teams, but also in examining the successes and failures of existing teams.

In addition, a critical part of understanding the impact of these teams is the service-user and family experience. The impact on service-users and families is not only changes in accessibility, responsiveness, and satisfaction in relation to participation and user focus. It can also create a shift in focus from illness deficits to a strengths based approach, mobilization of personal resources, and the recognition of citizenship rights. Of particular interest is whether alternatives to hospitalization such as acute care at home can have a more positive impact on individuals and their families, and alter the perception of cause, problem presentation and the course of mental health problems.

In general, the major outcome measure to examine the impact of CR/HT teams on an aggregate level has been hospitalization rates. However, a simple examination of hospitalization rates may not yield the actual impact of CR/HT teams (6) as there are other macro-level factors that influence hospitalization rates. Thus, it is necessary to examine outcomes in relation to various features of local service settings and service organizations. In addition, one major factor that seems to impact on outcome measures is the number of hours of operation by CR/HT teams. Although 'fidelity' criteria have been developed and are the basis for instituting CR/HT teams, each CR/HT team develops specific patterns of services and practices. There is a need to examine the service outcomes in the aggregate in relation to the characteristics of CR/HT teams.

Aims of the Project

The specific aim of the Project is to develop and advance comprehensive knowledge about workings of CR/HT from three perspectives. The first study focuses on the development of a CR/HT in a local service sector examining the processes and products of its implementation; 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; the third study focuses on examining aggregate-level outcomes in relation to the characteristics of CR/HT teams that are in place across DPS 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 HTCR services in Norway and internationally.

The secondary aim of the Project is to strengthen the quality and competence of research at HiBu in the developing area of mental health service provision with a specific focus on community mental health. The project will enhance and extend existing research expertise of the faculty in community mental health care, eventually leading the researchers of the project to form a core for research leadership at the Institute. It will train new researchers by involving doctoral fellows and Master's students in the project. As the project involves a close relationship with local Mental Health Services, this will increase collaboration between the service sectors and the researchers.

Study 1: Development of a CR/HT service

Research Aims:

The overall aim of this study is to gain knowledge regarding implementation of CR/HT teams. The study will describe and examine the processes of developing a CR/HT team, the patterns of practice that become established within the team, and the CR/HT's impact on local mental health services. The following research questions will be addressed in this study:

1. What processes are discernable in developing a CR/HT team within an existing community mental health service unit?
2. What are the practice patterns and modalities used/developed by members of a CR/HT team?
3. How does implementation of a CR/HT team impact on professional roles, interdisciplinary relationships, and team dynamics within an existing community mental health service unit?
4. What is the impact of a newly implemented CR/HT team on other local mental health services, multi-disciplinary and inter-agency working at a community level?
5. What are major patterns of patient pathways through the CR/HT services?

This study is a prospective case study in the action research perspective applying a co-operative inquiry process and a fieldwork method to describe and examine the development of a local CR/HT team within a wider health and social care system. The study will follow a CR/HT team's development over a two-year period, beginning with the process of how a CR/HT team becomes established and integrated within the wider range of services available, and how team organization and functioning evolve. It will include documenting the establishment of various protocols and patterns of practice within the team for CR/HT, and mapping out various patient pathways through the services it offers.

The project is intended to support service development, and thus the research team will be a transparent presence within the service, providing regular but formalized feedback of research data from this study throughout the project period in an on-going development of a local CR/HT team.

Research Setting:

The study will be carried out at the Mental Health Services of Buskerud South Service (BSS), comprising five municipalities:

BSS - municipalities	Nedre Eiker	Drammen	Lier	Røyken	Hurum
Population	22000	58000	22000	17900	8700

As with other services across Norway, BSS is currently in the process of negotiating reorganization of services to implement and integrate new CR/HT teams. A new CR/HT team is expected to be introduced at Sykehus Buskerud, HF, Psykiatrisk Klinikk, Drammen, DPS in the fall of 2007, where this research will be carried out. The target date for the team to become operational is September 2007, concurrent with the proposed commencement date of the project. However the

researchers of the project are already negotiating and preparing to work with the unit on its implementation plan, including developing policies and procedures, and preparing an orientation program for the staff. The team is expected to be composed of 10 to 12 service-providers recruited from the existing interdisciplinary professional staff of the unit.

Research methods:

The study as a prospective case study with an action research orientation applies two specific methods: co-operative inquiry process and fieldwork method. These are methods appropriate for an in-depth understanding and examination of transition/change, as well as for a description of how knowledge is developed and applied by participants in situ.

Co-operative inquiry is applied to a variety of research approaches, but is viewed to be most appropriate in action research, especially that based upon a participatory philosophy (9). Action research has been advanced in Norway in the 60s and 70s through researchers like Løchen (10) and Mathisen (11) and in the last ten years by others (12, 13 & 14), and has achieved a considerable acknowledgement, both nationally and internationally, especially in mental health research. While the “traditional” mental health research is developing “knowledge for understanding,” the focus within action research is “knowledge for action” (12, 15). Co-operative inquiry involves not only integrating theory and research into practice of participants (14) but also developing new knowledge through the inquiry process (16). The central issue in co-operative inquiry is to develop a research that is grounded in a clinical context and in collaboration with people in that context (13). Researchers and participants as co-researchers work collaboratively in identifying problems, deciding on themes for inquiry, selecting a research design, and designing projects for clinical implementation (14, 17). In co-operative inquiry changes in practice can run parallel to the research process. As it is crucial for researchers to take an active part in the ongoing, changing process and not being outside observing the events in this type of research, the research is with people rather than on people (16).

In applying co-operative inquiry in this study, the members of a newly created CR/HT team will be co-researchers. The co-operative inquiry process will be applied by multi-stage focus group interviews with participants (team members), in which the researchers for the study will be facilitators. Focus group meetings will be held monthly in order to discuss the processes through which the change is implemented and uncover the types of knowledge developed and used in practice by the members. The topics of discussion at these focus group meetings will be regarding overall service re-design, team organization and functioning, and practice development. However, the focus group, in the spirit of co-operative inquiry, will have the active voice in raising topics of concern in the development and implementation of the team. In addition, the focus group will also examine the progress of implementation, service experiences including patient pathways, impact on other services and agencies, and service-user responses. These meetings will be audio-taped, transcribed, and summarized for feedback to the participants (co-researchers) at following meetings in order for the team to experience ‘dialogue-based’ changes in developing the CR/HT team and its practice.

Fieldwork method will be applied in conjunction with co-operative inquiry. Fieldwork, in the tradition of sociology that includes participant observation and in-depth interviews (18), will be applied to describe the patterns of practice by the members of a CR/HT team. Participant observation and in-depth interviews with the team members in practice will be carried out once per month in order to capture (a) how the team responds to referrals, (b) what and how clinical decisions are made, (c) how the team works with service-users and their families, and (d) what resources from a wider network are brought into the practice.

Data Analysis:

Research using co-operative inquiry is based on a hermeneutic-phenomenological approach (9), thus the data analysis is based on this perspective. Co-operative inquiry tries to describe phenomena as precisely as possible and analyse their essential qualities by using phenomenological reduction proposed by Kvale (19). The focus group interview data will be analyzed applying Kvale’s method (19). The data will be analyzed and summarized for feedback to the group so that

there will be an on-going progression in the group's discussions. In order to address research questions #1, 3, 4, and 5, the final analysis of the complete set of data at the conclusion of the study (after two years), will focus on describing the processes and progress in implementing the team within a local mental health service unit.

The data from the fieldwork component of the study will address specifically the research questions #2 and 5. Fieldwork notes will be recorded according to Schatzman & Strauss (18), and will be analyzed to identify various patterns of practice and in order to map out changes in the patterns over a period of two years. The data analysis of fieldwork will be on-going in order to guide the ensuing fieldwork over the period of 2 years.

Study 2: Experiences of Service Users

Research aims:

The aim of this study is to gain an in-depth understanding of the experiences of service-users of a CR/HT, especially those of individuals with psychosis. The specific research questions are:

1. What is the subjective experience and understanding of mental health problems of service-users with psychosis in their everyday life situations, especially in relation to how individuals define mental health crises, deal with the situations, and seek professional care?;
2. How do service-users with psychosis experience their encounters with CR/HT services?

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 health-care seeking are influenced not only by their knowledge of available services but also by their own definitions of problems, which may not be appropriate at times, leading them to inappropriate services, inattention, or delaying in service seeking. There is limited knowledge of how service-users understand and define their problem-situations, their ways of finding helpful help inside and/or outside services, or their views on home treatment.

In this study we will focus on the experiences of service-users with psychosis in the context of CR/HT utilization. First, we focus on individuals with psychosis, because this is a group in need of tailored community services requiring continuity and flexibility, with emphasis on personal strengths and relationship-building rather than on pathology and adaptation to the patient role (20, 21, & 22). It is important to gain insights into how individuals with psychosis view their experiences with a CR/HT team in contrast to in-patient services. This knowledge may be relevant in reducing the high number of readmissions in acute psychiatric treatment (6). Secondly, investigating subjective experiences of psychosis from a phenomenological perspective as in this study (23, 24, & 25) provides insights into how individuals view their situations, define crises, and make sense of their problems. As emphasised by Larsen (26), it is essential to appreciate the person with psychosis as someone often making great efforts to come to terms with surrounding societal cultural expectations, norms, values and perceptions. Thirdly, eliciting subjective experiences will also offer understanding regarding psychosis in the material, cultural and social context, a crucial aspect of community life for individuals with mental health problems (21, 26, & 27). Living conditions surveys have a deeply-rooted tradition in Norway (28), and such surveys reveal that areas such as housing, education, social contact, and income have been found to be well below the average for individuals with serious mental health problems (29). There is a need to gain first-hand knowledge of the effects of social and economic conditions of life on individuals with psychosis, especially in relation to crisis situations. Fourthly, service-users' skills and coping strategies are often ignored and undervalued by professionals (20, 22, 30, & 31). Understanding how individuals bring forth their own resources and skills in dealing with psychosis and related crises, will aid in developing support systems that incorporate self-determination, personal skills and user-preferences. Finally, emphasizing the everyday life situation is of particular importance in understanding the processes of recovery (27, 32). Much work remains to gain an in-depth understanding regarding subjective experiences of the recovery process, especially when recognizing 'mental health' as not only a question of health, but also a whole life concern with societal, cultural, and political dimensions. In this study the aim is to describe how individuals with

psychosis live everyday life in spite of their continuing mental distress as well as how they experience crises in relation to CR/HT service.

Methods:

This study is a qualitative study applying two sequential methods to address the research aims: focus-group and phenomenological methods. The focus-group component will be initiated as the first step followed by the phenomenological component. A focus-group (33) will be assembled composing of five to six individuals with personal experience of psychoses and having had experiences with recovery and support by CR/HT teams. Inspired by the concept of participatory research (21, 34), this group will not only describe and reflect upon their own experiences but also be involved in developing interview contents and inclusion criteria as a *reference-group*. The group as a *reference-group* will be involved in ongoing discussions during the analysis phase of the entire study. The focus-group will be organized and run by the researchers. The contribution of service-users in research is well documented (34, 35) and 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 (24, 36).

1. Selection of individuals to participate in a focus-group - Five to six individuals will be recruited through the mental health network in Buskerud. Participants in the focus group will be adults with psychosis (between 25 to 65 years of age), having had personal experiences with CR/HT teams but are currently stable and in recovery.
2. Focus-group meetings – Three meetings related to living with mental health problems, and developing inclusion criteria and interview contents, and 3 meetings to discuss the findings from both components of the study will be held. Each meeting is expected to last for 2 hours.
3. The focus group process – The process of the focus group will follow the recommended procedures for applying this method for research (33, 37, & 38). The researchers will prepare general interview guides to be used as departing points for discussions at meetings, and will conduct the focus group interviews as facilitators, listeners, and observers in order to learn more deeply into the meanings of discussions. All focus group meetings will be audio-taped with the consents of participants. Audio-taped data will be transcribed verbatim, and will be analyzed for themes, common ideas, and conclusions. The focus group's reflections will be sought on data analysis.

The second component of this study will apply a phenomenological approach involving 10-12 individuals with psychosis, who have had at least one encounter with a HTCR team. A qualitative research approach largely grounded within a phenomenological framework (23, 24, 34, 39, & 40), having an ontological fidelity to the experiences of individuals with psychosis (41) is chosen for an in-depth understanding of subjective experiences. Trying to grasp and understand life-world perspectives and intentionality will be central (42), including the individual's everyday life as both a practical and societal world (43). The focus is thus complex and multiple, grounded in individual 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 (24, 44).

1. Inclusion criteria will be discussed in detail in the focus-group, but the following aspects will be applied as baseline guidelines: (a) individuals with a diagnosis of psychosis, (b) having had at least one contact with a CR/HT team but no recent contact during the previous 3 months, and (c) having had at least one in-patient treatment in an acute psychiatric ward during the past two years.
2. Recruitment and selection of study participants will be made among the service-users of Sykehus Buskerud, HF, Psykiatrisk Klinikk, Drammen, DPS starting in January 2008, as the local CR/HT team is expected to be established in the fall of 2007.
3. Inquiry process – All interviews will take place in settings and times chosen by the participating informants. A semi-structured interview guide will be developed in partnership with the reference group (of the focus-group component). The main researcher and a doctoral research

fellow will be the interviewers. The major areas of inquiry will include (a) the informants' experiences in living with psychosis in their daily life situations, and how they manage themselves and cope with challenging life situations, (b) their experience of mental health care professionals, service systems, and other sources of support especially during their hospitalization, and (c) their experience of crisis, especially in relation to the CR/HT team, their perceptions regarding their crisis situations, ongoing recovery, and the future. The open-ended, in-depth interviews will be audio-taped, transcribed, and then returned to each informant for his/her review and amendments. Three interviews will be carried out with each informant: the first focusing on participants' perceptions, definitions, and experiences; the second as a follow-up interview to review the transcripts and expand on the first interview; and the third interview to be held six months after the second interview with focus on their ongoing recovery and general life situations.

Data analysis:

Data analysis for the focus group component will be on-going throughout the research process. The transcribed meeting data will be analyzed to extract major themes, conclusions, and ideas emerging as combined perspectives of the group. The analyzed data will then be given back to the focus group for their elaboration, feedback, agreement, and revisions. The conclusions from the 3rd meeting will be used to develop the inclusion criteria and interview guides for the second component of the study. The data from the phenomenological component of this study will be analyzed according to the established qualitative procedures by Kvale (19) and the procedures applied in the researcher's previous work (21, 24, & 34). The analyses from both components will be used to address the research questions.

Study 3: CR/HT Outcomes Study

Research Aims:

Introduction of CR/HT teams has been associated with a reduction in hospital admissions in trials. The primary objective of the study is to establish whether the introduction of CR/HT teams has a similar impact on hospitalization in Norway. In order to establish the impact of introducing these teams, there is a need to establish a clear set of criteria for determining the characteristics of teams. Fidelity criteria have been developed to identify key components of CR/HT teams in order to establish data-sets that are comparable across teams. Services by CR/HT teams are not uniform across teams however, and it is critical to examine the outcomes, especially in terms of hospitalization, in the context of such variations. The critical issues to be addressed in this study are thus related to identifying impact of CR/HT services on hospitalization rates and examining associations between the functioning of CR/HT teams and hospitalization rates as outcomes. The major research aims of this study are:

1. To describe variations in the characteristics of established CR/HT teams in Norway utilizing the model fidelity criteria;
2. To examine the aggregate psychiatric in-patient use rates for all Health Regions in Norway for two 12-month periods, and examine relationships between the operation and existence of CR/HT teams in the regions and the outcome measures; and
3. To examine relationships between the characteristics of CR/HT teams and the aggregate psychiatric in-patient use rates in all DPS units of Health South Region in Norway for two 12-month periods.

This study applies a survey method and the use of secondary data in addressing these research aims, with a focus on the description and examination of CR/HT in relation to outcomes. The research aims #1 and #2 are oriented to obtain national data in Norway regarding CR/HT teams and in-patient service use rates so that we can gain insights into the national picture of how these two sets of data may become linked. At present, there is no way to link the outcome measures (hospitalization rates, etc.) to each CR/HT team in a given DPS. Therefore, we will first examine the national picture of CR/HT teams (Research Aim #1) through a survey in order to establish a set of standardized data for such teams. Currently there are about 30+ CR/HT teams for 78 DPS units in Norway (3). With the mandate to establish CR/HT teams in all DPS units by 2008, it would be

possible to ascertain a national picture with a second round of surveys. The data for Research Aim #2 will be obtained for all regions of Norway in the annual survey of hospitals for psychiatric admissions. There will be an exploratory examination of relationships between the outcome measures and CR/HT services by linking the data for the Research Aims #1 and #2. This will be exploratory as the data cannot be linked specifying hospitalizations with DPS. In order to address Research Aim #3, we will collect additional data for the Health South Region from the hospital organizations in the region so that we will be able to identify in-patient uses by people in specific DPS units.

The survey for Research Aim #1 will involve utilizing standardized ‘fidelity’ criteria to construct a survey questionnaire in order to establish a common data set for all services in Norway. Fidelity criteria include those related to team composition and functioning, working hours/days, team size, skill mix per population and geographical location served, and gatekeeping function. Since fidelity criteria are applied in developing and implementing teams, these form a critical basis from which a set of comparable data can be established to characterize CR/HT teams and evaluate their impact on service-uses.

Methods:

This is a descriptive, quantitative study applying a survey design. Three sets of data will be collected for the study: (a) Data set #1 will be on CR/HT teams, and will be obtained through a questionnaire and interview survey of CR/HT teams in all DPS units in Norway carried out annually for two consecutive years, and will be used to address Research Aim #1; (b) Data set #2 will be obtained from the annual standard statistical records of the health administrative areas on adult (18 – 64 years of age) hospitalizations and bed-days for general psychiatric services, excluding sub-specialty services from SINTEF Helse, and will be used to address Research Aim #2; and (c) Data set #3 will be obtained from all hospitals in the Health South Region identifying in-patient uses by DPS and admission referrals, and this data set together with the data from Data Set #1 on CR/HT teams for the Health South Region will be used to address Research Aim #3. Data collection will be done for two 12-month periods beginning in January 2008 for 2008-09 and 2009-10 for all three sets of data.

Data analysis:

The survey data for Research Aim #1 will be analyzed to describe variations in the characteristics of CR/HT teams according to the fidelity criteria. A cluster analysis will be carried out to identify prototypes of CR/HT teams according to the criteria. For Research Aim #2, various descriptive statistical analyses will be carried out to show differences among the Health Regions and also to show the changes from Year 1 to Year 2. Although it may not be possible to match the CR/HT with outcome data in an exact manner, there will be an exploratory examination of associations between CR/HT characteristics and outcome data at the national level using the data sets #1 and #2. For Research Aim #3, all CR/HT teams in the Health South Region will be linked to outcomes within the hospitals of the region, and relationships between CR/HT teams and outcomes will be examined using ANOVA.

Ethical considerations

Participants in Study #1 and #2 are expected to give consent freely. The study will develop protocols to protect the participants’ privacy and confidentiality. As Study #3 will utilize available public data in aggregate forms and data from questionnaire, there is no threat to individual privacy and integrity in this study. Appropriate approvals will be obtained for the studies from the (national) Social Science Data Service and at the regional level by the Regional komité for medisinsk forskningsetikk, Sør-Norge (REK Sør-Norge) (Medical Ethics Committee for Region South) prior to the project’s implementation.

Research personnel

Project Director – Dr. H.S. Kim will be responsible for the overall conduct of this project. Dr. Kim has an extensive experience in coordinating and conducting multi-study projects.

Researchers for Study 1 – Dr. Bengt Karlsson will be the principal researcher for this study. He has an extensive experience in working with a CR/HT team at Follo DPS since 2003.

Researchers for Study 2 – Marit Borg who is expected to receive a doctoral degree in June, 2007 will be the principal researcher for this study. She has an extensive research experience in the study of recovery of persons with severe mental disorders.

Researchers for Study 3 – Prof. Mervyn Morris will be the principal researcher for this study. He has an extensive experience in development of community based mental health services both in the UK and internationally.

Doctoral Research Fellow #1 – Hege Widerberg will participate in Studies #1 and #3, and carve out her doctoral research within these two studies, linking CR/HT characteristics and outcomes.

Doctoral Research Fellow #2 – Monika Knudsen Gullslett Winness will participate in Study #2, and carve out her doctoral research related to this study focusing on service-users and families.

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