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PEOPLE IN CRISIS SERVICES

Section A: How do staff in NHS crisis services understand and
experience their role?
Word Count 7913 (840)

Section B: How do staff in crisis services discuss and position people in
crisis: A Foucauldian discourse analysis.
Word Count 7997 (291)

Overall Word Count
15910 (1098)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2017

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

Summary of the MRP

Section A

A review of the literature regarding staff's experience of their role in crisis services revealed three main areas of the role: forming relationships and empowerment, risk management and control, and organisational and role constraints. Forming relationships and empowering people along with managing risk were highlighted by staff as the key tasks of their role. Organisation and role constraints impacted on how staff viewed and experienced attempting to perform their role.

Section B

A Foucauldian discourse analysis was conducted of interviews with 12 staff members in NHS crisis services regarding their experience of people in crisis. Four discourses emerged from interviews; 'medical diagnostic', 'personal responsibility', 'limited resources for the scale of the problem' and 'human experience and emotion'. The dominant discourse 'medical diagnostic' positioned people in crisis as different to staff and lacking power. Staff were experienced as being positioned as experts, required to find the correct diagnosis and treatment for passive service users. Practices such as avoiding people deemed difficult to help, in particular people diagnosed with borderline personality disorder, were legitimised. A competing discourse of human experience and emotion positioned both staff and people in crisis as humans with emotions, legitimising staff validating emotions and not immediately attempting to find solutions or treatments.

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Section A:

How do staff in NHS crisis services understand and experience their role?

Word Count: 7913 (plus 829 additional words)

Abstract

Attempts have been made to improve NHS crisis services (Department of Health, 2014). Policies focus on the least restrictive practice and minimising expensive hospital admissions (Department of Health, 2000). This literature review aims to understand how staff in NHS crisis services, namely acute wards, crisis resolution home treatment teams and day treatment teams, understand their task. A further question is how they experience attempting to fulfil the task. A systematic literature search of CINAHL, Psycinfo, ASSIA, Webofscience and Medline found 15 relevant papers. Three main areas were identified: therapeutic relationships, risk management and organisational and role constraints. Staff viewed their tasks as forming therapeutic relationships with service users and managing risk. The experience of performing these tasks was impacted by organisational and role constraints. The need to control risk and organisational constraints can potentially hinder forming therapeutic relationships and legitimise coercive practices. Clinical recommendations are for policies and service providers to privilege the therapeutic relationship and clinical supervision. Further research is needed to develop the understanding of how staff talk about the service users they see while attempting to fulfil their role.

Keywords: crisis services, staff, task, experience

Introduction

In recent years in the United Kingdom (UK), the need for improved mental health services has been recognised in government policies (Department of Health, DH, 2011). Increased attention is being given to improving services for people in acute mental health crisis (DH, 2014). The mental health crisis concordat (DH, 2014) outlines four expectations of services: that people can access support before crisis point, that urgent and emergency access to crisis care is available, that services meet people's needs appropriately and that work is offered to prevent future crisis. However, evaluations have found that people have not seen improvements in crisis care (Gibson, Hamilton & James, 2016). Accessibility and suitability of mental health crisis services have been highlighted as poor by independent reviews (Mind, 2011). Police cells have also been used illegally as a safe place under section 136 of the Mental Health Act 1983, as opposed to a designated safe space (Her Majesty's Inspectorate of Constabulary, 2013).

Mental health crisis care in the National Health Service (NHS) is offered by three core services: crisis resolution home treatment teams (CRHTTs), day treatment teams (DTTs) and acute psychiatric wards. CRHTTs were established as a means of reducing hospital admissions and are tasked with deciding who to work with at home and who requires admission (DH, 2000b). Research has found CRHTTs effective at reducing hospital admissions, along with positive service user feedback (National Audit Office, 2007). DTTs are also judged as an alternative to acute inpatient care in terms of cost effectiveness, length of treatment and service user satisfaction (Priebe et al. 2006). DDTs' role is to provide an alternative to acute inpatient treatment and enable service users to leave inpatient services sooner (Joint Commissioning Panel for Mental Health, 2013). Acute inpatient services are designed to 'provide a high standard of humane treatment and care in a safe and therapeutic setting for service users at the most acute and vulnerable stage of their illness' (DH, 2002, p.

5). They are positioned as a last resort, as service users should be offered treatment in the 'least restrictive setting' possible (DH, 2002). Following the introduction of the NHS and Community Care Act (DH, 1990), hospital admissions are offered as short term care for psychiatric crises. With research and policy focusing on developing crisis services in the community, acute wards offering this crisis care have received less attention (Bowers et al. 2005). Research has highlighted that acute wards have multiple problems, in relation to lack of therapeutic activities, therapeutic relationships and time spent with service users (McAndrew, Chambers, Nolan, Thomas & Watts, 2014).

The current economic climate and Government focus on austerity in which the NHS and these crisis services find themselves, has led to a focus on providing cost effective and efficient services (DH, 2011). This focus on efficiency and targets can lead to crisis services focusing on managing risk and bureaucratic paperwork, rather than the psychological and emotional needs of the service users (Bjorkdahl, Palmstierna, & Hansebo, 2010). The Mid Staffordshire NHS Foundation Trust public enquiry (2013) highlighted that when the financial system is given utmost importance, aspects of care and compassion are neglected.

The economic, policy, service and political context within and outside the NHS will impact how crises are constructed. According to post structuralist theory, such as Foucauldian discourse analysis (FDA), a concept like crisis can only be defined within the context it exists (Willig, 2008). Discourses are systems of thoughts, including ideas, attitudes and practices which construct the concepts they refer to (Foucault, 1972). Over time, discourses can become unquestioned truths. Language is seen as a powerful tool which constructs the world, therefore how crisis is described will construct it in a certain way.

A lack of attention has been paid in policy to defining the concept of a mental health crisis (Tobitt & Kamboj, 2011). There are no definitions of crisis provided in guidelines like *No Health Without Mental Health* (DH, 2011), possibly as it is seen as a taken-for-granted

truth and knowledge assumed. When definitions are provided, they are often in relation to risk and services. For example, the DH describe the role of crisis resolution home treatment teams (CRHTTs) as working with 'psychiatric crisis of such severity that without the involvement of CRHTT, hospitalisation would be necessary' (DH, 2001, p, 11). DH guidelines outline acute wards as suitable for 'service users in the most acute and vulnerable stage of their illness…whose circumstances of acute care needs are such that they cannot at that time be treated at home.' (DH, 2002. p, 5). This language constructs the object of crisis as an entity that is decided against service thresholds, highlighting the flexible nature of the construct of crisis within a social context.

Crisis theory aims to explain crisis as something which exists distinct from services (Caplan, 1964). Crisis theory proposes a four phase model as someone's mental state moves from homeostatic equilibrium to increasing disequilibrium, with existing coping strategies failing to reduce distress (Caplan, 1964). However, it has been argued that crisis theory is not appropriate to apply to mental health services due to the types of presentations and brief time of intervention (Ball, Links, Strike, & Boydell, 2005). Some qualitative research with CRHTT staff found a clear consensus on the concept of crisis between staff, despite the lack of clear definition in policy (Tobitt & Kamboj, 2011). The identifying factors of a crisis were outlined as 'a noticeable recent disruption to everyday behaviour and/or psychological functioning; a risk of harm to the individual and/or others; and, additional support being required.' (Tobitt & Kamboj, 2011, p. 680).

Theories of services and tasks

The primary task of crisis services is often left vague or not described (Bowers et al. 2005). The task is outlined more clearly for CRHTTs and DTTs as keeping people in the 'least restrictive' treatment, keeping them out of hospital (DH, 2002). For acute wards it has been argued that the task has been left vague, despite guidelines to offer treatment and care in

a therapeutic environment (Bowers et al. 2005, DH 2002). FDA (Foucault, 1972) would argue that the discourses that surround crisis services, such as ideas of a least restrictive environment and seeing the most severe crisis, positions staff in a certain way. These positions define power relations and legitimise certain practices.

Menzies-Lyth's (1960) theory considers how primary tasks limit the culture and forming of a social system. This theory was derived from a physical health setting; however, the focus on dealing with anxiety and the task are pertinent to the role of crisis service staff. Menzies-Lyth (1960) outlines how staff experience feelings of 'pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse these feelings; envy of the care they receive' (p. 440) as they encounter people's physical or psychological suffering and have limited means to help them. The service and nurses distanced themselves from the complex emotions of meeting a whole person. This had partly been achieved by referring to people as their illness rather than name, such as 'the liver in bed 10' (p. 444). Tasks had become the key work of the nurses, completing practical tasks as opposed to spending time with patients or relatives. Dissatisfaction was heightened by not witnessing recovery, only seeing patients at their most acute, similar to the experience of staff in mental health crisis services.

Aims and rationale of the review

The aim is to review the literature which explores the experience of staff working in crisis services within the NHS. As policy describes the role of staff and crisis is defined against service limitations, it is important to understand how staff themselves construct their experience and how they are positioned (Willig, 2008). Much research has been conducted in similar services in other countries. However, due to the economic, political and social differences between countries, only studies from the UK will be used. It is particularly pertinent to review crisis services in the current economic climate, as inpatient services are

the most expensive mental health services, with each occupied bed costing over £2000 per

week (Mind, 2011). The literature reviewed will date from 2000 when the DH introduced

CRHTTs as a means of reducing hospital admissions (DH; 2000b).

Research questions

Considering the position of staff in NHS crisis services, the questions to be asked of

the research were:

- How do staff in crisis services understand their task?

- How do they experience attempting to fulfil this task?

Method

Search Methodology and Inclusion Criteria

A literature search was conducted of CINAHL, Psycinfo, ASSIA, Webofscience and

Medline databases. Research found via Google Scholar and from searching the reference lists

of relevant papers, was also included in the review. The search terms used were:

- crisis intervention OR psychiatric units OR psychiatric hospital admission OR partial

  hospitalisation AND

- mental health personnel OR clinicians OR staff AND

- views OR perceptions OR attitudes OR experience

This search strategy produced 2770 papers. Two hundred and forty duplicates were removed.

The remaining titles were reviewed and research not related to staff in crisis services was

screened out. One hundred and forty-eight papers remained and their abstracts were screened.

This left 29 studies, which were then reviewed for eligibility under the following inclusion

criteria:

- Conducted in the UK. Due to the political, economic and social landscape varying

  across countries it was deemed relevant to limit the review to studies in the UK. The

context within which NHS crisis services exist will position staff in certain ways and impact their understanding of their role (Foucault, 1972). As the context varies across countries the findings and implications of the research questions may alter.

- Conducted with staff in NHS crisis services, namely acute wards, CRHTTs and DTTs, for working age adults. Crisis houses are less commonly used and were deemed beyond the scope of this review (Slawson, 2016).

- Conducted since 2000 as this is when the DH created CRHTTs.

- Staff experience or similar concepts, such as staff views, were the object of the research.

- Qualitative methods of both data collection and analysis.

- Original research.

This process left 15 papers; Table 1 provides details of each of these. See Figure 1 for a PRISMA flow diagram of this process.

Review framework

The review drew on Noblit and Hare's (1988) meta-ethnography method for reviewing and synthesising the fifteen studies. Noblit and Hare suggest the following seven stage process to conducting an ethnographical review:

1. Getting started.

2. Deciding what is relevant to the initial research.

3. Reading the studies.

4. Determining how the studies are related.

5. Translating the studies into one another.

6. Synthesising translations.

7. Expressing the synthesis.
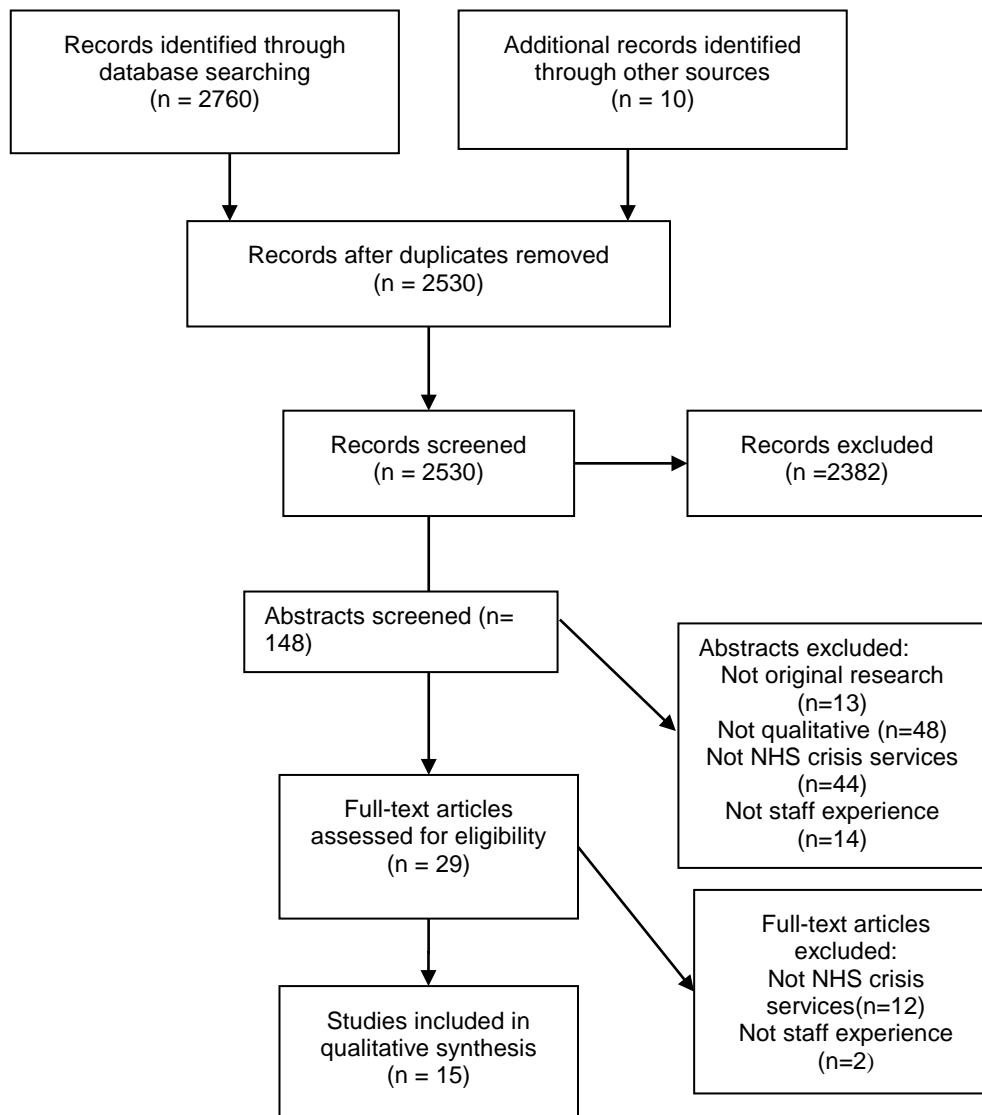
Figure 1: Adapted PRISMA diagram (Mohert, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009).

All 15 papers were deemed relevant to the initial research questions of how staff in crisis services understand their task and how they experience fulfilling this task. Following reading the papers and highlighting the key findings, it became clear that they were reciprocal and lines of argument could be developed from synthesising them. A lines-of-argument synthesis involves building a picture of an organisation or culture through synthesising research findings (Noblit & Hare, 1988). The synthesis of findings cannot be reduced to

mechanical steps (Britten et al. 2002). However, Noblit and Hare claim the concepts should

aim to cover all of the data, and in this case all the papers contributed to the interpretations.

The author made interpretations of the lines of arguments based on the key findings of the

papers (see Table 1), which produced three key themes: forming therapeutic relationships and

empowerment, risk management and control, and organisational and role constraints (See

Results section for presentation of these). These interpretations were discussed and clarified

with the author's supervisor.

Quality Appraisal

To determine the quality of each of the papers Mays and Pope's (2000) criteria for

assessing qualitative research was used. Mays and Pope argue that qualitative research can be

assessed according to its validity and relevance. The validity of research can be judged along

six criteria

- triangulation,

- respondent validation,

- clear exposition of methods of data collection and analysis,

- reflexivity,

- attention to negative cases and

- fair dealing.

Research was judged relevant based on either producing new knowledge or increasing

confidence in existing knowledge. Further, the relevance of findings can be increased if the

findings can be generalised to other settings. Each paper was appraised using Mays and

Pope's criteria (see Table 2). The quality of the papers considered against Mays and Pope's

criteria is also highlighted throughout the results section and limitations section.

Table 1

Reviewed papers

Title	Authors/ Year	Study design	Sample details	Key findings
Empowerment in the interpersonal field: discourses of acute mental health nurses	Lloyd, 2007	Ethnomethodological. Semi structured interviews.	Purposive sample of 10 staff; nursing assistants, staff nurses and ward managers in one acute unit	Nurses identified the main aspect of their role as forming relationships with service users. However, a conundrum was raised between relationships and a need to take control of service users. Team working assisted with difficult decisions.
Restriction and control: the perception of mental health nurses in a UK acute inpatient setting	Hall, 2004	Interpretative methodology. Semi structured interviews, meeting minutes, staff records, local policies, dependency records and observational records	Twelve qualified nurses in one acute setting	Social control through every day norms of acute settings were highlighted such as surveillance, observation and seclusion. Staff valued forming therapeutic relationships which can be negated by the need for control
Staff experiences of working in crisis resolution and home treatment	Freeman, Vidgen, Davies-Edwards, 2011	Semi structured interviews. Interpretative Phenomenological Analysis	Five participants; three female, two male. Four qualified mental health nurses and one support worker. From one CRHTT in urban South Wales	Staff were motivated by empowering service users. Stressors involved not seeing positive change and a lack of supervision. Coping involved drawing on personal resources as

				well as relying on the team
Closeness, chaos and crisis: the attractions of working in acute mental health care	Deacon, Warne & Mcandrew, 2006	Ethnography study, of a 24 hour period. Data from observation, listening to interpersonal dialogues and asking questions	Two wards, one acute and one Psychiatric Intensive Care Unit	Nurses were responsible for the overall ward environment. Nurses formed strong relationships with service users and can enjoy the chaotic nature of acute wards
Experiences of stress among nurses in acute mental health settings	Currid, 2009	Hermeuneutic phenomenology of eight semi structured interviews	Eight qualified mental health nurses from a variety of pay bands in four acute wards in London	Nurses described distancing themselves from service users due to fear of violence. Organisational tasks meant nurses had little time to plan or get to know service users. They could not switch off after work
Physical restraint in a therapeutic setting; a necessary evil?	Perkins, Prosser, Riley & Whittington, 2012	Thematic analysis of fifteen individual interviews and focus groups (number unspecified)	Thirty nursing staff in one acute setting. Individual interviewees were nine women and eight men between 25 and 56 years old. Having worked in acute services for 18 months to 25 years	Nurses decision to restrain was influence by: contextual demands, lack of alternatives, the escalatory effects of restraint and perceptions of risk. Nurses felt restraint was necessary due to unpredictable service users and the ward environment
Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and	Bonner, Lowe, Rawcliffe & Wellman, 2002	Analysis using Miles & Huberman (1984) method. Semi structured interviews regarding six incidents.	No demographic information except 12 staff members and six service users	Staff felt a pressure to maintain a calm environment on the ward. Restraint was seen as a

staff in the UK		Two staff and one service user interviewed for each incident		result of failed communication. Knowing the patient was seen as crucial to reducing restraints. Debriefing was rarely provided for staff or patients
Nurses experiences of working in Crisis Resolution Home Treatment Teams with its additional gatekeeping responsibilities	Begum & Rriodan, 2016	Thematic analysis of semi-structured interviews with six nurses	Six nurses from two local CRHTTs	Nurses saw gatekeeping as a specialist role that they fulfil, they valued keeping people out of hospital. However, reduced inpatient beds increased pressure for CRHTT nurses
"Risky Business": a critical analysis of the role of crisis resolution and home treatment teams	Rhodes & Giles, 2014	Two phases of study: phase one a descriptive overview of 11 CRHTT services, phase two a detailed analysis of three CRHTT. Semi-structured interviews used and themes identified	Phase one, team leaders or service manager interviewed from each of 11 CRHTT. Phase two a team leader, mental health nurse, approved mental health professional and psychiatrist and a member of CMHT interviewed.	Gatekeeping responsibilities could prevent therapeutic work. Limited resources further lessened staff's time to spend with service users.
Clinical Psychologists working in crisis resolution and home treatment teams: a grounded theory exploration	Murphy, Vidgen, Sandford & Onyett, 2013	Grounded theory analysis of interviews with 11 clinical psychologists	11 clinical psychologists, years qualified ranging from 1-13, years in CRHTT from 1-5.5 and whole time equivalent from 0.3-1. From CRHTT across England and Wales	Clinical psychologists saw their role in CRHTTs as similar to other CPs however the medical model was dominant. They valued offering a psychological view of severe distress

Shame and acute psychiatric inpatient care: healthcare professionals	Jones & Crossley, 2012	Qualitative analysis of three focus groups	Fourteen staff in total; six men and eight women. Comprised of psychiatrists, occupational therapist, social workers and mental health nurses	Staff felt shame through performing organisational tasks instead of being with service users. They felt shame due to stigma of how other professionals and service users perceive them
Discourses of blame: accounting for aggression and violence on an acute mental health inpatient unit	Benson, Secker, Balfe, Lipsedge, Robinson & Walker, 2003	Discourse analysis (Potter & Wetherell, 1987) of three interviews	Psychiatrist with six months' experience in an acute ward. Senior nurse with 20 years experience in acute services. Service user with past experience of acute admissions	Staff used discourses which positioned the service user as 'mad' or 'bad'. Their concern was to exonerate themselves from blame for violent incidents
Nurses' accounts of locked ward doors: ghosts of the asylum or acute care in the 21st century?	Ashmore, 2008	Thematic content analysis (Burnard 1991) of eleven interviews	Qualified nurses across seven acute wards where the door had been locked at some stage.	Staff were unaware of policy to support their decisions to lock the ward door. They recognised locking the door was becoming more frequent and the decision to lock or unlock the door was rarely communicated to service users
Investigation into the acceptability of door locking to staff, patients and visitors on acute psychiatric wards	Muir-Cochrane et al. 2012	Data driven inductive analysis (Boyatzis, 1998) of thirty-five interviews	Fourteen registered nurses, fifteen patients and six visitors across three acute wards. One locked ward, one occasionally locked ward and an open ward.	Staff believed that locking the door reduced absconding, which prevented being blamed for this and feelings of shame. Open wards created a sense

				of anxious vigilance for staff.
Once-a-week psychiatric ward round or daily inpatient team meeting? A multidisciplinary mental health team's experience of new ways of working	Fiddler et al. 2010	Phenomenological-hermeneutical analysis (Lindseth & Norberg, 2004) of twenty-one interviews	Twenty-one interviews with seven nurses, one social worker, two occupational therapists, three psychiatrists and eight managers in one acute ward and two community mental health teams associated with the ward.	Traditional ways of working felt safe yet staff felt a need for urgent change. Change was found possible and valued.

Results

The synthesis of the papers, which drew on ideas from Noblit and Hare's (1988) lines-of-argument synthesis produced the following themes: forming therapeutic relationships and empowerment, risk management and empowerment, and organisational and role constraints.

Forming Therapeutic Relationships and Empowerment

A number of the papers found that staff in crisis services viewed forming relationships with the service users in crisis a key part of their task. Lloyd (2007) conducted research using ethnomethodological principles, which enables understanding of how group members create a culture. Lloyd (2007) interviewed nursing staff in an acute mental health ward to identify how they empower service users. Two of the four themes identified emphasised the importance nurses placed on forming relationships with service users. Lloyd (2007) presented the theme working with mental illness, as nurses felt their main purpose was 'being with the service users, physically and mentally in order to develop a culture of understanding and to enable a smooth progression through hospital' (p. 489). However, limited evidence was provided in terms of quotes for this, in fact the evidence given for the theme concentrated on staff feeling a need to take a 'detached approach' initially, 'a lot of our day involves giving medication and watching…' (p. 488).

The theme 'making connections, people not service users', emphasised how nurses formed relationships on an equal level with service users. Individuals were referred to as 'people' rather than patients in nurses' speech. This differing language would indeed position service users differently (Willig, 2008). Again, limited quotes were offered as evidence for this theme. Making connections with service users was seen as a means of empowering them. How connecting with service users empowered them was not defined. However, participants did suggest multiple levels of this relationship forming through physical care, one to one conversations and advocating for service users.

Lloyd's (2007) research aims are valuable in developing insight into nursing practice in acute wards. The focus on culture meant the ethnographic methodology used was appropriate. However, the context of the research is not described. The location of the acute ward used in the study and demographic details of the nurses interviewed would allow readers to assess whether the findings could be related to other settings (Mays & Pope, 2000). The limited evidence provided for the themes also means assessing the analysis conducted is challenging.

Hall (2004) also conducted research with nurses and aimed to consider the 'reality of nursing in acute psychiatry in the United Kingdom, and the factors that influence day to day care' (p. 542). Unlike Lloyd's (2007) research, Hall describes the acute ward setting in the East of England which shared characteristics with other acute wards. The nurses felt that the role of the ward was offering safety and treatment to people and then helping them to return home. They emphasised how crucial the nurse-patient relationship is to help service users 'feel safe, understood, supported' (p. 546). Both Lloyd and Hall only considered nurses' accounts, other disciplines in the acute settings may have produced alternative data. Hall described measures that were taken to improve the strength of the findings: respondent validation, external researcher and cumulative validation against other studies were used.

Staff in CRHTTs also viewed forming relationships as part of their task. Freeman, Vigden, and Davies-Edwards (2011) conducted an interpretative phenomenological analysis of interviews with five staff in a CRHTT with the aim of exploring the aspects of the work that staff found stressful and how they coped with these. Within the master theme of

Table 2

Quality Appraisal of the Papers Using Mays and Pope's (2000) criteria

Study	Triangulation	Respondent validation	Exposition of methods	Reflexivity	Attention to negative cases	Fair dealing	Relevance
Lloyd (2007) Empowerment in the interpersonal field: discourses of acute mental health nurses	Purposive sample of nurses from varying grades	Yes: participants were asked to comment on the themes	Clear description of methods of data collection and analysis	Conducted within hospital setting to get close to the culture. Do not highlight researcher's previous experience or views	None	Views from managers to nursing assistants incorporated	Small scale study within one hospital with 10 nurses. Findings relevant as they add new knowledge of nurses' experiences
Hall (2004) Restriction and control: the perception of mental health nurses in a UK acute inpatient setting	None; all participants were qualified nurses on the same ward	Yes: however, no information was given about the manner in which this occurred	Clear description of the methods of data collection and analysis.	Yes; provided researcher stance that reality is socially constructed	Yes; difference of opinions were highlighted throughout the findings	No; only qualified nurses	Attempts were made to choose a research setting similar to others. Increases knowledge regarding nurse's role in acute settings
Freeman, Vidgen, Davies-Edwards, (2011) Staff	Some, due to range of time spent working in CRHTT.	None	Yes, clearly described. A significant number of	The researcher owning their perspective was mentioned, but	None, no contradictions to themes were	No, limited sample is however	Adds knowledge to area of CRHTT staff experience but

experiences of working in crisis resolution and home treatment	One team and four of five participants were mental health nurses.		quotes were provided	the position was not explicitly given.	highlighted	acknowledged	limited sample must be considered when generalising findings
Deacon, Warne & Mcandrew, (2006) Closeness, chaos and crisis: the attractions of working in acute mental health care	A large amount of data was collected through ethnographic observations over three years	None	No real explanation of data analysis was provided. Limited data provided to evidence themes	Researchers acknowledged their belief that their analysis may make nursing on acute wards 'attractive'. However, how this impacted analysis was not detailed	None, no examples given of contradictions to the findings	Study solely focussed on nurses' experience	Adds knowledge of the everyday role of nurses, however the focus on making this positive limits generalisability
Currid, (2009) Experiences of stress among nurses in acute mental health settings	Some, due to four acute wards being used and nurses from a variety of pay bands	Yes: themes were generated alongside participants	Description of theory of hermeneutics but limited description of analysis conducted. Data was provided to support themes	No consideration of researcher position provided	No alternative views provided	Views of nurses from different pay bands were considered	Valuable knowledge added about the stress and health of nurses.

Perkins, Prosser, Riley & Whittington, (2012) Physical restraint in a therapeutic setting; a necessary evil?	Yes, both individual interviews and focus groups were used. A range of nurses were used including managers	None	Clear description was provided of the methods. A significant amount of data was provided to support findings.	No researcher biases were made apparent	Attention was explicitly paid to alternative views	A wide range of perspectives were incorporated as 30 staff were interviewed	Strong study in that the high number of staff and description of setting increase generalisability. The findings add necessary knowledge about restraint
Bonner, Lowe, Rawcliffe & Wellman, (2002) Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK	Views of both staff and service users were gathered.	None	Good description of the interviews was provided but limited detail about analysis was given. Data was provided for themes	No researcher biases were made apparent or consideration given to other people being interviewed about the incident	There were discrepancies between staff and service user accounts which were acknowledged	A limited number of people were interviewed, the researchers acknowledged this	Limited in terms of detailed description of analysis. Provided new knowledge of the negative experience of restraint for staff
Begum & Rriodan, (2016) Nurses experiences of working in Crisis	None	None	Limited description of analysis procedure was provided. Themes are	Researcher explained their position as working in a CRHTT but no explicit	None given	Participants were deliberately picked to gain an understanding	Provided new information about nurses' experience of gatekeeping. However,

Resolution Home Treatment Teams with its additional gatekeeping responsibilities			supported by quotes.	consideration of the impact this might have on the findings		of gatekeeping; that they were not representative of all CRHTT nurses was acknowledged	applicability was limited due to the specific sample
Rhodes & Giles, (2014) "Risky Business": a critical analysis of the role of crisis resolution and home treatment teams	Eight different CRHTTs were used initially followed by three differing CRHTTs	Discrepancies were checked with participants. Team leaders checked the final report	Clear description of interview topics and analysis were given. Very limited data to support themes	Not considered	Particularly strong as CRHTTs were selected based on differing elements of the role	Good range of professions used and differing teams	Applicability to other CRHTTs was high due to the large number of CRHTTs involved and variation in staff. New knowledge on how teams manage pressures
Murphy, Vidgen, Sandford & Onyett, (2013) Clinical Psychologists working in crisis resolution and home treatment teams: a grounded theory	Some based on differing levels of experience and various locations of CRHTTs	None	Detailed description of method and analysis. A substantial number of quotes were provided to support themes	The paper cites the need for the researcher to 'own' their perspective but does not make this explicit	Attempts were made to capture the full complexity of the data via line by line analysis	All CRHTT psychologists were offered the chance to take part. Eleven with a wide range of experience participated	Generalisability was high due to the number of CPs interviews. New knowledge was generated regarding CPs role with recommendations made

exploration

Jones & Crossley, (2012) Shame and acute psychiatric inpatient care: healthcare professionals	Data was collected from three focus groups of varying professionals	Yes: groups were conducted with participants to validate findings	Clear description of questions and analysis procedure. Significant quotes support themes	That researcher bias could have impacted the findings was noted but no explicit description of these biases was given	Evidence was provided of alternative views to the themes	Attempts were made to incorporate views of various professional backgrounds	The well described study was applicable to other acute settings. Knowledge of staff's shame was valuable.
Benson, Secker, Balfe, Lipsedge, Robinson & Walker, (2003) Discourses of blame: accounting for aggression and violence on an acute mental health inpatient unit	Yes, interviews were conducted with service user and staff about the same incident	None	Good description of method and analysis. Quotes were provided to evidence discourses	No explicit consideration of researcher impact or the impact of interviewing staff and service users about the same incident	Evidence of each of the three participant's views were provided	Incorporates the views of both service user and staff	The study was well described. The knowledge of blaming service users in discourse is valuable for future research
Ashmore, (2008) Nurses' accounts of locked ward doors: ghosts of the asylum or acute care in the	Some, due to nurses being from seven different wards	None	No description of how codes were developed. Good level of quotes provided to	No explicit consideration of reflexivity	Variations in accounts was provided	Nurses were from varying trusts and acute wards	No description of the demographics of wards was given making assessing applicability difficult. The

21st century?			evidence categories.				knowledge generated was new
Muir-Cochrane et al. (2012) Investigation into the acceptability of door locking to staff, patients and visitors on acute psychiatric wards	Yes, visitors, service users and staff were all interviewed	None	Clear detail of methods and analysis is provided. Quotes to support themes were limited	No explicit consideration of reflexivity was provided	Comparisons were made between different views regarding door locking	The use of visitors, service users and staff ensured a range of perspectives was gathered	Enough detail was provided to assess the applicability of findings. The findings add knowledge to Ashmore (2008) findings
Fiddler et al. (2010) Once-a-week psychiatric ward round or daily inpatient team meeting? A multidisciplinary mental health team's experience of new ways of working	Some triangulation due to the use of staff from different professions	None	Detailed description of method and analysis. Quotes were also provided to evidence themes	No explicit consideration	Some consideration and evidence was provided of difficulties with new ways of working	Specific attempts were made to obtain views of a number of professionals	The setting and study was well described enabling applicability to be assessed. The knowledge added of how staff experience change is beneficial

motivating factors, staff spoke of the opportunity they have to build relationships with service users: 'the home treatment aspect- visiting clients, interacting with them, building up relationships with them' (p. 80). A further motivating factor was seeing improvements in service users, leading to a personal sense of achievement. Alongside this, participants highlighted that a main function of their role was to empower service users and prevent them being admitted to hospital. It could be argued that how well a service user is, is judged by whether they remain in the community or not. Murphy, Vigden, Sandford and Onyett (2013) supported this finding as clinical psychologists in CRHTT also cited satisfaction based on preventing hospital admissions.

Freeman et al.'s (2011) study is of worth to develop an understanding of an under-researched area, CRHTT staffs' subjective accounts of their work. Freeman et al. claim that five people is an adequate sample for an IPA study (Smith, 2004). However, all participants were white British and four were nurses, meaning the diversity of experience was limited. Voluntary sampling was used as opposed to purposeful attempts to recruit a diverse range of clinicians with potentially alternative views. Freeman et al. do not own their subjective positions, despite the quality criteria cited recommending this to allow readers to assess its impact (Elliot, Fischer & Rennie, 1999).

Deacon, Warne and McAndrew (2006) claimed that the development of the 'ideological notions of community based care' (p. 751) have left working in acute settings unattractive. Deacon et al. openly approached their study with a view that an analysis of acute nurses' work could highlight it as a desirable role. By conducting an ethnographic study of two wards, the study aimed to understand what nurses do. Their analysis led to two thematic headings: the comfort of closeness, and surviving and thriving in chaos and crisis.

The nurses described feelings of closeness with the service users, often using the word 'love' to describe how they felt about them. For example, one nurse was quoted as saying

'He's completely bonkers but I absolutely love him' (p. 753). Deacon et al. (2006) argued that this language, along with observations that nurses were willing to come in on days off, showed an emotional reciprocity. The ethnographic methodology allows every-day practice to be analysed (Allen, 2004). This was despite nurses finding it difficult to describe their roles and what they did to gain such closeness, similar to Lloyd (2007). However, the ethnographic methodology failed to account for how staff and service users contributed to creating this culture. The researchers' desire to present acute nurses' work in a positive light may have impacted the interpretation of data. Language such as 'bonkers' has connotations of 'madness' and can stigmatise service users. This language could be viewed as a way of positioning service users as different, therefore creating distance rather than closeness.

Risk Management and Control

Risk management was highlighted by a number of papers as a role of crisis staff. Lloyd (2007) described how staff experience 'the nursing conundrum' (p. 489) of attempting to build therapeutic relationships, but having to take control of service users to manage risk. In discussing this, Lloyd suggests that nurses need to be able to discuss risk management openly and develop their knowledge of an evidence base to support their decision making.

Coercive Practices. Deacon et al.'s (2006) second theme, 'thriving and surviving in chaos' emphasised that mental health nurses are highly skilled at managing aggression and crisis. They provided an example of a nurse calming a patient who was becoming aggressive, and maintaining a therapeutic relationship. Nurses felt managing crisis was their responsibility and that this allowed them to demonstrate their skills (Deacon et al. 2006). However, the need for crisis staff to take control may legitimise a number of restrictive practices. Hall (2004) described how nurses engaged in less therapeutic work, instead using surveillance and control to manage crises. One nurse stated 'observing the door has become

habitual and gives a custodial impression' (p. 545). The nurses also acknowledged that they

experienced this as becoming 'domineering and warder like' (p. 545).

The role of managing risk was also used in justifying door locking and not

communicating with service users (Ashmore, 2008). Ashmore (2008) conducted a thematic

content analysis of semi-structured interviews with 11 qualified mental health nurses. He

found that nurses saw controlling risk as part of their role and locked the ward doors, despite

being unaware of policy regarding this. Nurses then experienced fear when unlocking the

doors. Informing service users of locking the door was deemed unimportant. Nurses cited less

absconding and less paperwork related to incidents as benefits. Nurses were positioned as

needing to minimise all risk, which easily justified locking the doors. Indeed, nurses stated

that locking doors was a way of protecting themselves from potential blame and criticism if

something went wrong.

Muir-Cochrane et al. (2012) conducted a data-driven inductive analysis (Boyatzis

(1998) of 14 interviews with registered nurses, 15 interviews with service users and six with

visitors, regarding the acceptability of door locking. Similar to previous studies (Hall, 2004;

Ashmore, 2008), nurses felt more in control when the door was locked, fulfilling what they

viewed as their role of managing risk. Muir-Cochrane et al. highlighted how nurses

experienced the role of managing risk on the ward as a constant 'anxious-vigilance' (p. 46).

Locking the door could be justified by reducing staff anxiety and increasing therapeutic time

spent with service users. Importantly, Muir-Cochrane et al. acknowledged the anxiety staff

felt, and recommend education and clinical supervision to explore the impact of practices on

service users and nurses, and to develop the most collaborative care possible.

Both Ashmore (2008) and Muir-Cochrane et al. (2012) only used nursing staff,

however the nurse in charge is often positioned as the decision-maker regarding door locking.

The aims of both studies were worthwhile in an under-researched area with a potentially significant impact. Muir-Cochrane et al. provided comprehensive detail of their analysis and evidence from the data to support their themes. Ashmore indicated in detail, using evidence from the data, the dilemma faced by nurses and the dangers of returning to an 'asylum' regime. Both studies considered the need for nurses to reflect on decisions and develop collaborative care, as well as the need for wider scale research to strengthen transferability of the findings.

Another practice which is legitimised in order for staff to manage risk, is physical restraint (Perkins, Prosser, Riley & Whittingdon, 2012). Perkins et al. (2012) conducted a thematic analysis of interviews with 30 nurses to explore staff attitudes to restraint and identify influences on decision making. They used a discourse of risk assessment and progressive de-escalation to minimise risk to self and others, similar to that in policies (DH, 2004). However, this conflicted with findings that in reality, decisions about risk and whether to restrain were often an instinctive response; 'It was almost a reflex action in the sense that you make all these judgements very quickly and the safest thing to do seemed to be to take him straight onto the floor' (Perkins et al. 2012, p. 47). This raises questions as to how staff are positioned in a professional role and use a certain discourse to justify this. Their position may mean staff are unable to openly discuss their practice.

Perkins et al. (2012) found that the decision making of staff was often over-ridden by a need to 'control the service user's behaviour' (p, 46). A restraint was deemed successful when a service user submitted to staff's wishes. There was a tension between maintaining a therapeutic environment and the best interests of the individual; one participant claimed 'I mean when you are working on a ward like this, I am always well aware that shouting, screaming, commotions on a ward affects all the other patients…so I felt I needed…to calm

the situation down' (p. 46). Restraint was legitimised by the need for staff to remain in control. Perkins et al. claim restraint was used as a way of managing a ward by staff unable to form therapeutic relationships amid organisational constraints.

Perkins et al. (2012) offered strong recommendations to introduce the six core strategies model (LeBel, 2011) and suggested staff were unable to implement previous training. This research attempted to tackle the important and complex issue of physical restraint. Participants may have been more open due to the considerations of confidentiality and conducting interviews away from the workplace. By using 30 staff, with variation in age (25 to 56 years old) and experience (18 months to 25 years), a variety of views were gathered. However, other stakeholders may have added alternative data. The thematic analysis process was well described and variation between accounts was actively sought, along with providing strong evidence by way of quotes for the results. There was however no acknowledgement of the reflexive nature of analysis and the researchers' own positions; this is important, especially with an emotive topic.

Bonner, Lowe, Rawcliffe and Wellman (2002) conducted research with both service users and staff, aiming to explore the lived experience of restraint. The theme 'the ward atmosphere: disturbed wards and disturbed patients', was presented as an antecedent to incidents; this was similar in Perkins et al. (2012). Staff also emphasised the distress and discomfort they experienced with physical restraint, seeing it as a real last resort; 'It makes me feel like we've failed and it frightens me' (p. 468). The idea of restraint indicating failure may highlight, as Perkins et al. suggested, a failure to form therapeutic relationships. Staff cited knowing the service user as helpful in containing their distress. Staff experienced the lack of debriefing after restraints as damaging to therapeutic relationships. The experience of ethical dilemmas around restraint were summarised in this quote; 'You have to weigh up

whether you're using manipulation, coercion or persuasion in managing difficult patients' (p. 470).

Bonner et al. (2012) researched six incidents; one service user and two staff members were interviewed regarding each. The interview procedure described was appropriate in meeting the aims of the study. However, reflexivity was not considered and it could be argued participant responses would have been impacted by knowing other staff members and service users were being interviewed regarding the same incident. No demographic detail was provided regarding the participants or the acute setting, impacting transferability. Significant recommendations were made to alter restraint courses in the UK, as well as establishing policies about debriefing. Bonner et al. argued, as Perkins et al. (2012) did 10 years later, that training needs to focus on engagement and early warning signs, rather than aversive strategies.

Assessing Risk. Within CRHTTs, risk management does not involve physical restraint, but involves decisions regarding admission to and discharge from acute wards, known as gatekeeping. Begum and Riordan (2016) conducted a thematic analysis of interviews with six community psychiatric nurses working in two CRHTTs. They focussed on how nurses experienced the gatekeeping role alongside other CRHTT work. The nurses saw gatekeeping very much as part of their role and experienced it as an expert role.

> *We like no other service can offer a service with skilled staff who have specialist experience in gatekeeping so we have the resources and knowledge to manage risk at home and don't have to rely on hospital when people are unwell. (p. 48)*

One of the core principles of this role was ensuring the least restrictive methods of care. Nurses described using a positive framework to assess risk. Nurses were afforded an

experience of being an expert and holding power by the gatekeeping role. As with restraint, risk averse strategies like admission were more likely when staff did not know a service user.

Begum and Riordan (2016) provided an insight into nurses' experience of gatekeeping in CRHTT. However, Begum and Riordan's aim of understanding the experience of gatekeeping in addition to nurses' other responsibilities was not fulfilled. The findings presented no considerations of gatekeeping alongside the rest of the nursing role. Other research has suggested that gatekeeping, due to the level of urgency, can draw resources away from home treatment work and forming relationships (Rhodes & Giles, 2014). Furthermore, no consideration was given to the potential influence of the primary researcher working in a CRHTT and how their role may have influenced the interviews as well as analysis. Begum and Riordan do however clearly present the factors that influenced gatekeeping: risk management as well as organisation constraints.

Emotional Impact. If the task of risk management takes precedence, and therapeutic relationship building is sacrificed, then violence and aggression may increase (Currid, 2009). Currid (2009) conducted a hermeneutic phenomenological analysis of interviews with eight mental health nurses across four acute wards in London. The aim of the study was to explore occupational stressors, the lived experience of stress and the meaning of this experience for staff working in acute mental health care. Violence and aggression was one of three themes, along with pressures and inability to switch off from work. Analysis revealed how nurses might be prevented from interacting with service users due to fear of violence as explained by one nurse: 'We felt helpless, but if something happened they'd have said why you put yourself at risk which I know isn't right but I have a family to think of' (p. 43). Like Muir-Cochrane et al. (2012), this focus on staffs' emotional experience positioned them as human beings attempting to fulfil a frightening task.

Currid's (2009) findings provided new insights into the real experience of mental health nurses, as the idea of not interacting with service users due to fear was rarely raised elsewhere. The hermeneutic phenomenology method was well justified and emphasised how we experience the world through language (Dowling, 2004). The methodology was collaborative as the themes were generated alongside the nurses, allowing triangulation of the data. By using mental health nurses from a range of pay-bands, there was some diversity of participants. However, using other disciplines would have provided a wider scope and potential alternative views, as the aim was to understand staff experience, not nurses' in particular. The study was also conducted in a trust under financial constraints, although it could be argued many trusts are currently very restricted financially. However, the findings did offer real clinical recommendations of support sessions, supervision and training for staff, to give them the resources to fulfil their therapeutic role. The challenges of freeing up staff time to attend supervision and training was noted, along with the need to employ more staff.

Organisational and Role Constraints

Tension and organisational pressure. The research highlights the experience of organisational and role constraints for crisis staff attempting to fulfil the tasks of relationship building and risk management. Begum and Riordan (2016) found that the organisational pressure of a reduction in beds impacted on nurses' experiences of working in CRHTT. The demand to create beds heightened 'risk and risk-taking approaches in the community' (p.51). Staff experienced an ethical dilemma in relation to discharging service users from hospital, as described by one nurse, 'Sometimes we screen and discharge when the service user isn't ready just to create a bed.' (Begum & Riordan, 2016, p.49)

Begum and Riordan (2016) suggested that inappropriate referrals from other services also impacted on the role of CRHTT. Rhodes and Giles (2014) emphasised this finding in a

thematic synthesis of interviews across three CRHTTs where they aimed to understand the

interface between CRHTTs and other mental health services. Rhodes and Giles highlighted

the pressure experienced by staff in CRHTTs, with both inter-professional and inter-team

tension common. Tension was enhanced by disputes regarding risk, both in gate keeping and

delayed discharge. Large numbers of referrals from community mental health teams (CMHT)

for gatekeeping meant limited availability to conduct home treatment, an element of the work

that other studies highlighted as important to staff and the therapeutic relationship (Freeman

et al. 2011). The gatekeeping role may further constrain CMHT staff from becoming more

skilled at managing risk, hence increasing the workload for CRHTTs. It is clear from these

findings that the expert position CRHTTs are placed in can produce feelings of satisfaction

(Begum & Riordan, 2016) but can also constrain their work as well as the skills of teams

around them.

CRHTTs in the study had attempted to resolve tensions between gatekeeping and

home treatment work and meet targets surrounding both (Rhodes & Giles, 2014). Attempted

solutions ranged from imposing formal requirements for all potential hospital admissions to

be gate kept, timeframes on CMHT accepting CRHTT referrals and dropping the gatekeeping

role completely. Risk assessment was largely impacted by personal judgement and therefore

by staff's experience of the capacity of the service. Rhodes and Giles (2014) highlighted the

uncertainty of the task for CRHTT staff, and dissonance between therapeutic work and

gatekeeping, while constrained by service capacities decided by policy and funding.

Rhodes and Giles' (2014) research is valuable in that it provides an insight into the

complex task faced by CRHTTs and varying approaches of services to managing multiple

pressures. Thematic synthesis (Thomas & Harden, 2008) was utilised as a way to create novel

hypotheses about CRHTT. The sample across eight different sites also included a number of

stakeholders from differing disciplines, allowing for varied data. Discrepancies between teams made the conclusions rich. However, the study failed to address one of its research questions regarding the role of psychiatrists; no findings were presented for this. Limited quotes were provided to support the findings, especially regarding solutions to the challenges where no data was given as evidence. Furthermore, no demographic detail was provided regarding the region the study was conducted in, therefore applicability to other areas of the UK cannot be assessed. Raising awareness of the challenges CRHTTs face, and concerns regarding staff retention was beneficial and met the aims of the study, however no real recommendations were offered.

Clinical Psychologists' (CPs) role in crisis services is not included in the previous studies. The role is distinct and requires CPs to have protected time for assessment and formulation, while remaining included in the team structure (British Psychological Society, 2008). Murphy et al. (2013) provided a grounded theory explanation of the role of CPs in CRHTTs in the UK. They analysed interviews with 11 CPs, aiming to increase understanding of CRHTT functioning and CPs' work. CPs saw their role comprised of psychological formulation, evaluation and research, service development, leadership and supervision and support. In attempting to fulfil these multiple roles, CPs highlighted a number of constraints. For example, although psychological understanding of service users was valued, due to the organisational challenges of high workloads and fast-paced work, the medical approach was more often employed. Having to discharge service users rapidly also meant CPs were unable to provide longer term, structured therapy. CPs felt the team could be reactive and faced challenges when attempting to encourage reflection on cases. Murphy et al. provide recommendations for CPs to articulate the many aspects of their role in CRHTTs.

Murphy et al.'s (2013) grounded theory is firmly based in the data presented within the interviews, with quotes provided to evidence each theme, category and subcategory of the theory. By approaching all CPs in the CRHTT Psychologist Network, they enhanced the generalisability of their findings, with 11 interviewed and demographic details provided. The variety of levels of deprivation in the areas studied provides evidence of transferability. It could be argued that gaining the perspectives of other disciplines on CPs' role would have been beneficial to highlight potential differences in explanation. The grounded theory analysis of the data was described in detail and the quality guidelines outlined (Elliot et al. 1999), making the study replicable. However, the six areas of questioning in the interviews were not outlined; this would have provided further detail of how the data was generated. Overall this study is of high quality and met its aims.

The experience of staff constrained by the fast pace of work and throughput of service users extends to inpatient units. Staffing levels and throughput lessened the opportunities for knowing service users on wards, increasing the chance of violence and restraint (Perkins et al. 2012). Lack of staff time can also lead to inconsistent care as cited, 'If some clients are treated differently then that creates tension between staff and clients and it can lead to resentment, frustrations, so behaviours can get difficult.' (Perkins et al. p.45). Nurses in Perkins et al.'s (2012) study described being constrained in their role and 'expressed a resigned acceptance of the conditions and limited options which they felt gave rise to the need for physical interventions' (p. 48). Perkins et al. succinctly summarised the concerns, 'Restraint…was embedded within routine mental health practice as a legitimate intervention to deal with a situation exacerbated by organisational constraints and the failure to develop a therapeutic relationship with service users' (p.49).

   Fear of blame and shame. Perkin's et al.'s (2012) concerning conclusion resonates with Currid's (2009) study. Currid found that, due to an increased focus on standards and targets, mental health nurses on acute wards experienced high levels of paperwork, pressure from low staff levels and a lack of beds to accommodate service users. With organisational needs taking priority, Currid argued that the therapeutic work becomes superficial (Hummelvoll & Severinsson, 2001). Further to this, staff reported being unable to distance themselves from work, '…and when you go home you think "oh my god did I do the job properly or did I miss anything?"…I just think about the situation at work all the time, you can't switch off.' (p. 44). Currid (2009) argued this fear is driven by a fear of blame due to the 'increasingly litigious climate of the health service and risk-averse health service management' (p. 44). The impact of the organisational constraints on the experience of working in crisis services is clearly significant.

   Fear of blame was also found in Jones and Crossley's (2012) study. Jones and Crossley aimed to understand situations where service users and mental health professionals both experience shame and how this shame may impact on the quality of care. The staff phase of the study used three focus groups and highlighted two themes of shaming and blaming, and entrapment in professional roles. Shaming and blaming was based on staff describing being 'caught up in organisational tasks and so doing to rather than being with another in difficult times' (Jones & Crossley, 2012, p, 132). Jones and Crossley felt this was an unintended consequence of organisational policy and led staff to feel moral shame. An example of this was taking away someone's rights, due to their mental health but also due to treatment regimes. One participant stated 'I've taken your autonomy away. I'm really sorry. Look I don't want to give you this injection but we can't go on like this because it's shameful isn't it.' (Jones & Crossley, 2012, p. 132). The limits of the medical model to explain distress

could enhance the experience of doing to, as described by a participant, 'When we discuss the diagnosis with a patient, sometimes I feel shameful. I can't put across the diagnosis.' (Jones & Crossley, 2012, p.133).

The shame experienced by staff was enhanced by the scrutiny surrounding decisions about risk, like suicide reviews (Jones & Crossley, 2012). Staff also felt shame due to envy from service users who viewed them as healthy, 'they think that we have a perfect life' (p. 133). Staff also felt stigmatised by other professionals for working with people with mental health difficulties: Goffman (1963) described this as 'courtesy stigma'.

Jones and Crossley's (2012) research is of worth in focussing on staff wellbeing, especially the experience of shame, which is often neglected. They provided clinical recommendations of reflective spaces for staff. This recommendation arose from staff finding talking about hidden feelings in focus groups helpful. The potential that staff may have felt unable to raise contrasting views in focus groups was not considered in the research. Jones and Crossley acknowledged the small scale of the study, being in one site in Wales, as well as the potential for researcher bias to influence the findings. However, the context of the ward and social demographic were not given. Although the focus groups and areas of discussion were conveyed, no theoretical basis of data analysis or quality assurance was offered, making quality assurance and replication difficult.

The constraints of professional roles are also highlighted in Benson et al.'s (2003) discourse analysis. Benson et al. aimed to develop understanding about how staff and service users construct accounts of violent incidents. They looked at what understandings and beliefs individuals drew on to explain incidents and how they then positioned themselves in relation to these. They conducted three interviews regarding two separate violent incidents, with a psychiatrist, a senior nurse and the service user involved, and used Potter and Wetherell's

(1987) approach to discourse analysis. Both the psychiatrist and senior nurse drew on a professional discourse to describe the violent incidents, which positioned them not as individuals but professionals with shared accountability. Benson et al. argued that the service user was positioned within a 'mentally ill' discourse legitimising coercive practice and discrediting her account. Staff also used a contradictory discourse which linked the service user's violence to her personality, therefore invalidating her need for care. Placing themselves within a professional discourse constrained the staff with how they could then talk about the incidents. For example, both made attempts to make their accounts factual by giving detailed accounts and lists, 'she was very angry, very demonstrative waving her finger' (p. 921).

The professional position also meant both staff members distanced themselves from emotions, 'It didn't make me feel anything…quite embarrassed I suppose when someone actually punches you…I don't think she she hasn't injured me at all' (p. 920). Benson et al. (2003) argue that not providing an emotional response serves to distance staff from the incident, with a view that it is not professional to be too emotionally involved. This is concerning, considering the powerful emotions and recommendations for openness in previous studies (Jones & Crossley, 2012). The professional discourse serves a purpose for staff, in exonerating them from blame. Within a system of zero tolerance for violence, targets and expectations on staff to prevent all violence, staff are constrained to this position of having to exonerate themselves from blame (DH, 2000a). Worryingly, this professional discourse then places blame on service users. Benson et al. conclude that the very targets and guidelines (DH, 2002) which urge a shift to an open culture may constrain staff to a rigid position within a blaming culture.

Benson et al. (2003) have attempted to study violent incidents, a challenging area to research. This is valuable and the use of discourse analysis is well suited to understanding

how the violent acts were constructed and those involved were positioned. However, Benson et al. found particular difficulty in collecting accounts regarding incidents, possibly due to this potential for blame. Reflexivity was not considered and the method of interviewing two staff members and the service user about the same incident was likely to impact the findings. However, the analysis was well described and in-depth, with valuable findings presented, which raise questions about staff's need to exonerate themselves from blame.

   Changing practice. Fiddler et al. (2010) highlighted how challenging it can be to move out of the fixed positions within roles and change practice. They conducted well described interviews with 21 staff, comprised of seven nurses, one social worker, two occupational therapists, three psychiatrists and eight managers from an acute ward and two CMHTs linked to the ward. The aim was to highlight staff experience of changing to daily meetings from traditional weekly ward rounds. Staff experienced a tension between feeling safe with current practice but wanting change to enable delivery of quality care. Traditional ward rounds were experienced as serving the interests of staff and maintaining the power of psychiatrists and the hierarchy. The power of the medical model discourse was highlighted and ward rounds experienced as outdated. After changing to daily meetings staff experienced more power rather than being governed by psychiatrists' instructions at the weekly ward round. They also experienced improved relationships with service users.

   Fiddler et al. (2010) have provided relevant and important findings of the experience of changing practice and the constraints around this. Their data collection was conducted until no more data emerged (Patton, 2002). A significant number of quotes were also presented, allowing readers to assess the accuracy of the claims made, as well as three researchers contesting the analysis (Mays & Pope, 2000). The phenomenological-hermeneutical analysis

was well described and was appropriately selected to 'make sense of experiences that phenomenology describes' (Lindseth & Norberg, 2004).

Discussion

Limitations

The literature regarding staff experiences within crisis services is limited: this review found 15 papers in total. Crisis services for the purpose of the review were conceptualised as CRHTTs, DTTs and acute inpatient wards. However, no research was found which was conducted with staff from DTTs. This may be a limitation of the search terms and databases searched or an indication that this is an area with sparse research.

Quality of studies. A number of the studies were small scale; Benson et al. (2003) in particular only analysed three interviews. Six of the studies used only nurses, meaning generalising the findings to crisis services across the UK is challenging. Mays and Pope's (2000) quality criteria emphasises the need for detailed description of the procedure of qualitative research. The level of description of the method and data analysis was limited in some studies (see Table 2), such as Deacon, Warne and McAndrew (2006) and Currid (2009), meaning that assessing how applicable the findings are to other services is difficult.

Various methods of data collection were used to gain an insight into the experience of staff. A number of the studies did not reflect on how the method of data collection, such as interviews (Benson et al. 2003) or focus groups (Jones & Crossley, 2012) might have impacted on the data collected. Ethnographic studies offered an attempt at getting closer to the experience of staff and highlighted everyday practice (Lloyd, 2007; Deacon et al. 2006). Acknowledging the researcher's position is important in allowing the impact of this on the research to be assessed (Mays & Pope, 2000). There was a striking lack of consideration of the researcher's own position regarding the research questions, despite a number of studies

noting its importance. Only Hall (2004) acknowledged their own social constructionist position (see Table 2).

Some of the papers were of high quality, especially Jones and Crossley (2012) who provided detailed description of the methodology used along with a high number of quotes to support their findings. Perkins et al. (2012) also provided a high level of detail, interviewed a large number of staff, and provided quotes to support their findings, allowing the applicability of their findings to be assessed. However, some studies provided limited quotes, such as Deacon et al. (2006) which impacted the reader's ability to assess their analysis. It is important to highlight that all of the studies were highly relevant as they provided new knowledge or enhanced existing knowledge of often challenging areas to research (Mays & Pope, 2000).

Main Findings

Despite the limitations, tentative conclusions can be drawn regarding what crisis staff view as their task and how they experience performing the role. Staff in in both acute wards (Lloyd, 2007) and CRHTTs (Freeman et al. 2011) emphasised forming therapeutic relationships as their key task. Staff felt they held an important role in empowering service users to understand and manage their crisis; this included CPs (Murphy et al. 2013). These findings are in line with policy regarding the role of staff within crisis services (DH, 2002). Staff experienced shame when they were unable to be alongside service users and had to take control for them, using coercive practices such as restraint (Jones & Crossley, 2012).

The task of managing risk was also highlighted as a key task for crisis staff. Staff in CRHTTs described the experience of gatekeeping as being positioned as an expert in risk, which gave some satisfaction. However, this constrained CRHTT staff's role and prevented therapeutic work (Begum & Riordan, 2016). On acute wards, staff described a desire to

manage the ward environment and risks for individuals. They could do this in a skilful way and managing crisis highlighted nurses' skills (Currid, 2009). However, needing to manage risk in a ward and the potential for blame legitimised a number of coercive practices, such as door locking and physical restraint (Hall, 2004; Perkins et al. 2012). Staff experienced these coercive interventions negatively and felt shame, feelings of failure and anxiety.

How staff experience the tasks of forming relationships with service users and managing risk is significantly impacted by organisational and role constraints. The ability of staff to form therapeutic relationships is impacted by low staff levels, a lack of beds and attainment targets (Perkins et al. 2012, Begum & Riordan, 2016). The lack of relationships with or knowledge of service users increases the likelihood of hospital admission (Begum & Riordan, 2012) and the use of coercive practice like restraint in hospital (Bonner et al. 2002). Staff experience feelings of shame and stress outside of work due to the level of scrutiny from managers, peers and lay people (Jones & Crossley, 2012; Currid, 2009). Staff can attempt to distance themselves from these difficult feelings of blame and shame through professional and medical discourses, which distance them from service users (Benson et al. 2003).

Considered in terms of Menzies Lyth's theory (1960), the systems and policies involved in crisis services of risk assessment and scrutiny could be viewed as defences against the anxiety of being with people in distress. Crisis staff viewed their task as being alongside those in distress, however organisational and role constraints limited their ability to do so. Clinical recommendations are made for policies and training to promote relationship building rather than control and zero tolerance (Perkins et al. 2012). The prevailing discourses of professional roles, risk management and the medical model also position staff as distanced from service users and unable to be emotionally invested (Benson et al. 2002). Discourses can legitimise certain practices (Foucault, 1972) and become taken-for-granted truths; in this case

practices like restraint and door locking are legitimised and seen as normal (Perkins et al. 2012). Shifting away from traditional practice comes with its challenges, yet Fiddler et al. (2010) found it is possible. Clinical recommendations for supervision and reflective spaces to consider the flexibility of practices, the emotional experience of the task for staff and how to create collaborative practice, are made by many studies (Muir-Cochrane et al. 2012; Currid, 2009; Murphy et al. 2013).

Future Directions

Further research is required to explore the experience of staff working within crisis services. An evidence base is growing regarding the tasks of being alongside those in crisis while managing the risks. The influence of policies, targets and external scrutiny is particularly high in this area, with the potential for staff to distance themselves from the difficult emotions experienced and in turn legitimise coercive practices. Much of the research found focussed on nurses' experience. It would be of interest to study views of other professionals, in particular the views of psychiatrists as they are often the responsible clinician, therefore holding ultimate responsibility for risk (Mind, 2015). The studies found also emphasised the impact of staffs' emotional experience and organisational constraints on increased levels of coercive practice. It may be beneficial to study practice that reduces coercive practices, including service users' views on what might benefit the forming of relationships in crisis services. Further, as organisational constraints impacted the role, studying non NHS organisations, possibly those in other countries, may provide insight into reducing these organisational constraints or good practice elsewhere. It would be of interest to understand the discourses surrounding crisis services in other countries and whether staff experience their role differently.

What is also unknown from the papers found is how service users are positioned by staff conducting this challenging role. What discourses staff draw on will impact how both staff and service users are positioned (Foucault, 1972). Further, investigation of these positions will also highlight what practices and views are legitimised towards service users. This may be especially important in considering service users that staff struggle to fulfil the tasks of forming relationships with and managing risk. This is implied in some of the studies (Benson et al. 2003; Deacon et al. 2006), however detailed analysis of the language used when discussing service users would add greater understanding to the current challenges in crisis services and potential future directions.

References

Allen, D. (2004). Ethnomethodological insights into insider-outsider relationships in nursing

    ethnographies of healthcare settings. *Nursing Inquiry, 11,* 14-24. doi: 10.1111/j.1440-

    1800.2004.00201.x

Ashmore, R. (2008). Nurses' accounts of locked ward doors: ghosts of the asylum or acute

    care in the 21st century? *Journal of Psychiatric and Mental Health Nursing, 15,* 175-

    185. doi: 10.1111/j.1365-2850.2007.01184.x

Ball, J. S., Links, P. S., Strike, C., & 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, 29,* 10–17. doi:

    10.2975/29.2005.10.17

Benson, A., Secker, J., Balfe, E., Lipsedge, M., Robinson, S., & Walker, J. (2003).

    Discourses of blame: Accounting for aggression and violence on an acute mental

    health inpatient unit. *Social Science and Medicine, 57,* 917-926. doi: 10.1016/S0277-

    9536(02)00460-4

Begum, R., & Riordan, S. (2016). Nurses experiences of working in crisis resolution home

    treatment teams with its additional gatekeeping responsibility. *Journal of Psychiatric*

    and Mental Health Nursing, 23, 45-53. doi: 10.1111/jpm.12276

Bjorkdahl, A., Palmstierna, T., & Hansebo. (2010). The bulldozer and the ballet dancer:

    aspects of nurses' caring approaches in acute psychiatric intensive care. *Journal of*

    Psychiatric and Mental Health Nursing, 17, 510-518. doi: 10.1111/j.1365-

    2850.2010.01548.x

Bonner, G., Lowe, T., Rawcliffe, D., & Wellman, N. (2002). Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing. 9,* 465-473. doi: 10.1046/j.1365-2850.2002.00504.x

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A., & Warren, J. (2005). The nature and purpose of acute psychiatric wards: The Tompkins acute ward study. *Journal of Mental Health, 14,* 625-635. doi: 10.1080/09638230500389105

Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development.* Thousand Oaks, CA: Sage Publications.

British Psychological Society. (2008). *Briefing paper No 30: The role of psychologists working in crisis resolution and home treatment (CRHT) teams.* Leicester: Division of Clinical Psychology.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesis qualitative research: a worked example. *Journal of Health Services Research & Policy, 7,* 209-215. doi: 10.1258/135581902320432732

Caplan, G. (1964). Principles of preventive psychiatry. London: Tavistock publications.

Currid, T. (2009). Experiences of stress among nurses in acute mental health settings. *Nursing Standard. 23*(44)*,* 40-46. doi:10.7748/ns2009.07.23.44.40.c7108

Deacon, M., Warne, T., & McAndrew, S. (2006). Closeness, chaos and crisis: The attractions of working in acute mental health care. *Journal of Psychiatric and Mental Health Nursing, 16*, 750-757. doi:10.1111/j.1365-2850.2006.01030.x

Department of Health. (1990). *The National health service and community care act.* London:

Her Majesty's Stationery Office.

Department of Health. (2000a). *National health service zero tolerance zone.* London:

Department of Health.

Department of Health. (2000b). *The NHS plan: A plan for investment, a plan for reform.*

London: Department of Health.

Department of Health. (2001). *The mental health policy implementation guide.* London:

Department of Health.

Department of Health. (2002). *Mental health policy implementation guide: Adult acute

inpatient care provision.* London: Department of Health.

Department of Health. (2004). *Mental health policy implementation guide: Developing

positive practice to support the safe and therapeutic management of aggression and

violence in mental health in-patient settings.* London: Department of Health

Department of Health. (2011). No health without mental health: a cross-government mental

health outcomes strategy for people of all ages. London: Department of Health.

Department of Health. (2014). *The mental health crisis care concordat.* London: Department

of Health.

Dowling, M. (2004). Hermeneutics: An exploration. *Nurse Researcher, 11*(4), 30-39. doi:

10.7748/nr2004.07.11.4.30.c6213

Elliot, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of

    qualitative research studies in psychology and related fields. *British Journal of*

    Clinical Psychology, 38, 215-229. doi: 10.1348/014466599162782

Foucault, M. (1972). *The archaeology of knowledge and the discourse on language.* New

    York: Pantheon Books.

Fiddler, M., Borglin, G., Galloway, A., Jackson, C., McGowan, L., & Lovell, K. (2010).

    Once-a-week psychiatric ward round or daily inpatient team meeting? A

    multidisciplinary mental health team's experience of new ways of working.

    International Journal of Mental Health Nursing, 19, 119-127. doi: 10.1111/j.1447-

    0349.2009.00652.x

Freeman, J., Vidgen, A., & Davies-Edwards, E. (2011). Staff experiences of working in crisis

    resolution and home treatment. *Mental Health Review Journal, 16,* 76-87. doi:

    10.1108/13619321111158016

Gibson, S., Hamilton, S., & James, K. (2016). *Evaluation of the crisis care concordat*

    implementation. Retrieved from McPin foundation website: http://mcpin.org/wp-

    content/uploads/CCC-Evaluation_Report.pdf

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Engelwood Cliffs,

    NJ: Prentice Hall.

Hall, J. E. (2004). Restriction and control: The perceptions of mental health nurses in a UK

    acute inpatient setting. *Issues in Mental Health Nursing, 25,* 539-552. doi:

    10.1080/01612840490443473

Her Majesty's Inspectorate of Constabulary. (2013). *A criminal use of police cells: The use of police custody as a place of safety for people with mental health needs.* Retrieved from: https://www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf

Hummelvoll, J, K., & Severinsson, E. (2001). Coping with everyday reality: Mental health professionals' reflections on the care provided in an acute psychiatric ward. *The Australian and New Zealand Journal of Mental Health Nursing, 10,* 156-166. doi: 10.1046/j.1440-0979.2001.00206.x

Joint Commissioning Panel for Mental Health. (2013). *Guidance for commissioners of*

acute care - inpatient and crisis home treatment. Retrieved from http://www.jcpmh.info/wp-content/uploads/jcpmh-acutecare-guide.pdf

Jones, A, C., & Crossley, D, R. (2012). Shame and acute psychiatric inpatient care: Healthcare professionals. *International Journal of Mental Health Promotion, 14,* 125-138. doi: 10.1080/14623730.2012.719302

LeBel, J. (2011). Restraint and seclusion prevention in the USA: Core strategies to reduce and sustain gaps. In I. Needham, H. Nijman, T. Palmstierna, R. Almvik, & N. Oud (Eds.), *Violence in Clinical Psychiatry* (pp. 440-443). Retrieved from: https://www.researchgate.net/publication/236211690_Proceedings_of_the_7th_European_Congress_on_Violence_in_Clinical_Psychiatry

Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching the lived experience. *Scandinavian Journal of Caring Services, 18,* 145-153. doi: 10.1111/j.1471-6712.2004.00258.x

Lloyd, M. (2007). Empowerment in the interpersonal field: discourses of acute mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 14,* 485-494. doi: 10.1111/j.1365-2850.2007.01116.x

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *British Medical Journal, 320,* 50-52. doi: 10.1136/bmj.320.7226.50

McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. (2014). Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing, 23,* 212-220. doi: 10.1111/inm.12044

Menzies-Lyth, I. (1960). Social systems as a defense against anxiety: An empirical study of the nursing service of a general hospital. *Human Relations, 13*, 95-121.

Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). *Report of the Mid Staffordshire NHS foundation trust public inquiry: Executive summary.* Retrieved from:

http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report

Mind. (2011). *Listening to Experience: An Independent Inquiry into Acute and Crisis Mental Health Care.* Retrieved from:

https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

Mind. (2015). *Sectioning: Terms you need to know.* Retrieved from:

https://www.mind.org.uk/information-support/legal-rights/sectioning/terms-you-need-to-know/#.WZa5hIWcGP9

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for

　　　systematic reviews and meta-analyses: The PRISMA Statement. *British Medical*

　　　Journal, 339. doi: 10.1136/bmj.b2535

Muir-Cochrane, E., Merwe, M., Nijman, H., Haglund, K., Simpson, A., & Bowers, L. (2012).

　　　Investigation into the acceptability of door locking to staff, patients, and visitors on

　　　acute psychiatric wards. *International Journal of Mental Health Nursing, 21,* 41-49.

　　　doi: 10.1111/j.1447-0349.2011.00758.x

Murphy, N., Vigen, A., Sandford, C., & Onyett, S. (2013). Clinical psychologists working in

　　　crisis resolution and home treatment teams: A grounded theory exploration. *The*

　　　Journal of Mental Health Training, Education and Practice, 8, 181-195. doi:

　　　10.1108/JMHTEP-11-2012-0037

National Audit Office. (2007). *Helping people through mental health crisis: The role of crisis*

　　　resolution and home treatment services. Retrieved from: https://www.nao.org.uk/wp-

　　　content/uploads/2007/12/07085.pdf

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: synthesizing qualitative studies*.

　　　Newbury Park: Sage Publication.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.)*.* Thousand Oaks,

　　　CA: Sage Publication.

Perkins, E., Prosser, H., Riley, D., & Whittington, R. (2012). Physical restraint in a

　　　therapeutic setting; a necessary evil? *International Journal of Law and Psychiatry, 35,*

　　　43-49. doi: 10.1016/j.ijlp.20111.11.008

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology, beyond attitudes and behaviour.* London: Sage.

Priebe, S., Jones, G., McCabe, R., Briscoe, J., Wright, D., Sleed, M., & Beecham, J. (2006). Effectiveness and costs of acute day hospital treatment compared with conventional in-patient care: randomised controlled trial. *The British Journal of Psychiatry: The Journal of Mental Science, 188,* 243-249. doi: 10.1192/bjp.188.3.243

Rhodes, P., & Giles, S, J. (2014). "Risky business": A critical analysis of the role of crisis resolution and home treatment teams. *Journal of Mental Health, 23,* 130-134. doi: 10.3109/09638237.2014.889284

Slawson, N. (2016, January 26). The mental health crisis centres keeping people out of A&E. *The Guardian.* Retrieved from https://www.theguardian.com/society/2016/jan/26/mental-health-crisis-centres-keeping-people-out-of-a-and-e

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1,* 39-54. Retrieved from: http://www.tandfonline.com/doi/abs/10.1191/1478088704qp004oa

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8,* 45. doi: 10.1186/1471-2288-8-45

Tobitt, S., & Kamboj, S. (2011). Crisis resolution/home treatment team workers'

      understandings of the concept of crisis. Social Psychiatry and Psychiatric

      Epidemiology, 46, 671-683. doi: 10.1007/s00127-010-0234-y

Willig, C. (2008). Introducing qualitative research in psychology (2nd ed.). Maidenhead,

      England: Open University Press.

Section B

How staff in crisis teams discuss and position people in crisis: A Foucauldian discourse

analysis.

Word Count: 7997 (plus 269 additional words)

For submission to Psychology and Psychotherapy, Research, Theory and Practice

Abstract

Objectives

To explore which discourses staff in crisis services draw on when discussing people in receipt of crisis services. As well as attempting to answer how those with borderline personality disorder diagnosis are positioned by these discourses and what the subsequent consequences are for people in crisis.

Design

This study utilised a qualitative design. Individual interviews were conducted with participants to generate personal and reflective accounts.

Method

Twelve staff members from home treatment, day treatment or acute ward teams were interviewed. Questions related to their experiences of people in crisis. Foucauldian Discourse Analysis was used to highlight the discourses used when talking about those in crisis.

Results

Four main discourses were present in language used: 'medical legal', 'personal responsibility', 'limited resources for the problem', and 'human experience and emotions'. People with a diagnosis of borderline personality disorder (BPD) were positioned differently to those with other diagnoses. Staff were positioned as experts needing to diagnose and cure distress. The discourse of human experience and emotions highlighted the emotional aspect of working with people in crisis, especially those with a BPD diagnosis.

Conclusion

The prevailing discourses within NHS crisis services remain those of the medical model, legitimising ideas of classic mental illness and practices of medication and control. This impacts the position of people with a BPD diagnosis. Further reflective spaces are

required to highlight the flexibility of these discourses, practice, and the importance of

emotions raised by those in distress.

Keywords: Acute, crisis, discourse, borderline personality disorder

Introduction

Mental Health Crisis

The term 'mental health crisis' is often used, yet there have been few attempts to define it (Tobitt & Kamboj, 2011). Crisis theory (Caplan, 1964) proposes a four phase model as someone's mental state moves from homeostatic equilibrium to increasing disequilibrium, with existing coping strategies failing to reduce distress (Caplan, 1964). Tobitt and Kamboj (2011) found that staff in National Health Service (NHS) crisis services held a common view of crisis as 'a noticeable recent disruption to everyday behaviour and/or psychological functioning; a risk of harm to the individual and/or others; and, additional support being required.' (Tobitt & Kamboj, 2011, p. 680). These definitions position a crisis as an individual's problem and something that requires support from others.

NHS crisis services are tasked within this context as offering support and treating people during a mental health crisis. They are formed of acute wards, crisis resolution and home treatment teams (CRHTTs) and day treatment teams (DTTs). Department of Health (DH) guidelines do not attempt to conceptualise crisis (DH, 2001). Crises are defined for CRHTTs as of such severity that otherwise they would require hospitalisation (DH, 2001). For admission to an acute ward, people must be in acute crisis and too vulnerable to be cared for at home (Crisp, Nicholson & Smith, 2016). Based on these definitions, a crisis and its severity are defined by whether a service can be offered.

Research has highlighted the many challenges faced by those working in crisis services. Staff in crisis services view forming relationships with service users in great distress, and aiding their recovery, as their priority (Lloyd, 2007). However, the need to focus on managing risk for the person and others around them makes forming relationships and therapeutic work challenging (Rhodes & Giles, 2014). Staff are also under pressure from

policy and management to ensure no incidents occur, leading to significant stress (Currid, 2009; DH, 2000). These intense emotions and pressures can lead to a number of controlling practices, like locking ward doors (Muir-Cochrane et al. 2012) and restraining service users (Perkins, Prosser, Riley & Whittingdon, 2012).

Diagnosis and the Label Borderline Personality Disorder

Those that are seen in mental health crisis services are viewed in line with much of Western culture as having individual, diagnosable mental health conditions (American Psychiatric Association, APA, 2013). Diagnostic tools and measures, such as the Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-V: APA, 2013), define mental health illnesses based on observable symptoms. Criticisms of diagnosis highlight that these mental illnesses are positioned at an individual level, ignoring social dimensions (Smail, 2005).

The 'essential features' of the diagnosis borderline personality disorder (BPD) are defined in the DSM-V as 'impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits' (APA, 2013, p,663). Whether personality disorder (PD) should be positioned within models of mental illness has long been debated (Castillo, 2003). The BPD diagnosis in particular is controversial, as identification of a number of the features of BPD like 'inappropriate anger' cannot be done objectively and involves moral and cultural judgements (Berger, 2014). However, the BPD diagnosis is the most commonly seen PD diagnosis in NHS services (DH & National Institute for Mental Health England, NIMHE 2003).

The label of BPD has implications, often leading to exclusion from services (DH & NIMHE, 2003). The policy *Personality Disorder: No Longer a Diagnosis of Exclusion* (DH & NIMHE, 2003) introduced plans for those with a BPD diagnosis to be treated with

specialist therapies and identified skills for working with people with a BPD diagnosis as a

gap in staff training. Research has highlighted the implications of a BPD diagnosis for people,

as staff hold more negative attitudes towards them than those with a schizophrenia or

depression diagnosis (Markham & Trower, 2003). Those with a BPD diagnosis feel services

interpret their distress as them being difficult and view them solely based on their diagnosis

(Morris, Smith & Alwin, 2014). It has been argued that the reaction of staff is not stigma

related, but due to the complex challenges people with a BPD diagnosis face in forming

relationships (Sansone & Sansone, 2013). However, studies have found that staff held more

negative attitudes about those people labelled with BPD than people displaying the same

symptoms without the label (Newton-Howes, Weaver & Tyrer, 2008).

Despite guidelines suggesting only brief crisis interventions for those with a diagnosis

of BPD, a large proportion of people diagnosed with BPD experience hospitalisation (Binks

et al. 2006). Bateman and Fonagy (2006) have claimed a crisis for people with a BPD

diagnosis is likely to involve a suicide attempt, harm to self and impulsive violent acts.

People with BPD diagnosis can be seen by staff in acute services as a 'destructive whirlwind'

(Woolaston & Hixenbaugh, 2008). Studies found staff in crisis services often fear they are

being manipulated and find it difficult to build relationships with people with a BPD

diagnosis (Rooney, 2009). In line with these views, staff display high levels of behaviours

that socially distance or reject those with BPD diagnosis (Westwood & Baker, 2010).

Theory and Rationale

Discourses are 'systems of thoughts comprised of ideas, attitudes, courses of actions,

beliefs and practices which construct the subjects of which they speak' (Foucault, 1972).

Over time, discourses can become regimes of truth. They serve to position individuals and

can open or close certain actions for them. Language reflects current discourses and is

therefore not a benign description of the world, but a powerful tool to construct and impact the world. Foucault (1972) emphasised how language can legitimise power and maintain embedded power relations. Foucauldian discourse analysis (FDA) aims to highlight discourses, the meanings created and consequences of them (Parker, 2012).

As highlighted, distress is often viewed as a treatable mental health diagnosis (Harding, 2012). When people in crisis enter into mental health crisis teams, whose aim is to treat them amid multiple targets and cost saving agendas (Harding, 2012), it is important to understand this from the view of FDA in terms of how service users and staff are positioned, how entities like crisis and diagnosis are constructed and what practices are therefore legitimised. An understanding is needed of how staff in crisis services talk about, and therefore construct, the people who they see in crisis. This is especially important in relation to those with a diagnosis of BPD due to the moral and cultural judgements involved (Berger, 2014), the negative attitudes of staff (Markham & Trower, 2003) and practices such as maintaining distance from them (Westwood & Baker, 2010). Discourses which surround those with a BPD diagnosis and how they are positioned within NHS crisis services requires investigation to understand these attitudes and practices.

Research Questions

The study aimed to answer the following questions: what discourses do staff draw on when discussing their experiences of people in receipt of mental health crisis services? Further questions related to these discourses to be answered are:

- How do the discourses used position those with a diagnosis of borderline personality disorder?

- What are the consequences of the positions given to individuals in crisis services?

Method

Context

Participants were recruited from three semi-urban London boroughs. The demographics of these boroughs varied in terms of levels of deprivation and health related outcomes (Office for National Statistics, 2011). The teams recruited from were comprised of two CRHTT, one DTT and two acute wards.

Design

This study utilised a qualitative design. Individual interviews were conducted with participants to generate personal and reflective accounts. Foucauldian discourse analysis (FDA) was used to analyse discourses used when talking about the discursive object of 'people in crisis' (Willig, 2008). FDA is a qualitative method of analysing language which sits within a social constructionist epistemology. Discourses are networks of meaning created through language and actions which create perceived reality (Willig, 2008). Discourses both enable and constrain what can be said by whom, when and where (Parker, 1992). They offer subject positions which then have implications for how people experience the world. Existing power can be legitimised by discourses, while institutional practices can both legitimise discourses and be justified by them (Foucault, 1972). This could be the case within NHS crisis services, as practices are justified by the discourses surrounding them. Over time, discourses can become taken-for-granted truths. This is concerning regarding the position of those with a diagnosis of BPD as highlighted in previous research (Westwood & Baker, 2010). FDA aims to highlight these discourses and understand the relationships between them and practice.

Procedure

The author recruited staff through attending team meetings. Information sheets were provided for staff to read (see Appendix D). Interviews were arranged by email at least a week in advance. Staff were provided with consent forms and reminded that they could withdraw consent at any point. Interviews were conducted in NHS buildings in meeting rooms to maintain confidentiality. Interviews lasted between 40 and 75 minutes. All interviews were audio-recorded and transcribed by the author.

Analysis. Interview transcripts were read and re-read utilising the six-step model of FDA (Willig, 2008):

1. Discursive Object: Highlight all instances that refer to the discursive object, in this case 'people in crisis'. See Appendix F for an interview transcript with instances of the discursive object highlighted.

2. Discourses: Identify the discursive constructions of the object within wider discourses.

3. Action Orientation: Examine the possible functions of constructing the object in these ways and the relation to other constructions in the text.

4. Positions: Identify what subject positions the constructions offer or limit.

5. Practice: Explore what practices the positions allow or limit.

6. Subjectivity: Explore what effect the subject positions have upon the participants' understanding of 'people in crisis'.

See Appendix G for a table of stages two to six of the analysis procedure for every instance of the discursive object.

Participants

Twelve staff members were interviewed. All names used in the report are pseudonyms. No incentive was offered for participation. Purposeful attempts to recruit a

range of professions and experience were made. Five staff worked in CRHTTs, five worked

on acute wards and two in DTTs. See Table 3 for demographics.

Table 3

Participant demographics

Pseudonym	Age	Gender	Ethnicity	Time in role	Profession
Moses	53	Male	African-Asian	25 years	Staff Nurse
Dave	51	Male	Irish	10 months	Nurse
Lisa	39	Female	White British	9 years	Clinical Psychologist
Jane	33	Female	Mixed Black/White	1 year	Social Worker
Joan	47	Female	White British	10 years	Social Worker
Frank	55	Male	White British	9 years	Nurse
Fo	67	Male	Indian	45 years	Nurse
Ashley	57	Female	White British	25 years	Support Worker
Grace	44	Female	African	6 years	Occupational Therapist
Sarah	30	Female	White British	2 years	Occupational Therapist
Blessings	47	Female	Black African	8 years	Healthcare Assistant
Lesley	31	Male	Chinese	11 months	Healthcare Assistant

Inclusion criteria. Staff must have worked in an NHS crisis service, specifically an

acute ward, CRHTT or DTT, in a client-facing role for at least six months.

Service-user Involvement

Initial ideas for the research were presented to a service user coproduction group,

who also conduct research in the London boroughs. Feedback was incorporated as

appropriate. For example, the service user coproduction group emphasised the need to not

solely focus on people with a BPD diagnosis in interviews, due to the potential negative

impact this may have on staff responses. The service user coproduction group also suggested

that asking staff to discuss examples of their work with people in crisis may help to draw out discourses. Asking staff for case examples was therefore added to the interview schedule. Consideration was given to how challenging staff may find sharing their views. Further prompts were added to try and help staff share their thoughts, along with the researcher attempting to take an understanding stance in interviews.

Interview Schedule

The semi-structured interview schedule was developed using interview guidelines (Willig, 2008). See appendix A for the full interview schedule. The initial question introduces the concept of people in crisis attending the service. Further questions related to experiences of individuals asking for examples to allow a personal account of those in crisis. The diagnosis BPD was introduced in order to understand the specific discourse surrounding the diagnosis.

Ethical Considerations

Ethical approval was granted by the Salomons Research Ethics Committee and Research and Development approval granted from the local NHS trust (see Appendix B and Appendix C). Feedback was given regarding confidentiality of the locations of interviews, potential distress to participants and response to any concerning practice raised. These points were considered and acted upon.

Quality Assurance

Four aspects have been identified as indicators of quality for qualitative research: credibility, transferability, dependability and confirmability (Hannes, 2011).

Credibility. The author's supervisor with experience in FDA projects provided audit of the interpretation of data. This involved the author's supervisor checking the analysis of the first four interviews and highlighting the evidence for the discourses. The author's

supervisor then checked the final analysis and a discussion was held regarding the evidence for the discourses. Quotes are used throughout the results section to provide evidence of the discourses located in the text.

Transferability. Demographic data is provided along with the context that the research was conducted in.

Dependability. To improve clarity of the decisions made, an annotated interview transcript (Appendix F) and coding book (Appendix G) are provided. A research diary was also kept throughout the process to increase awareness of researcher bias (Appendix I).

Confirmability. The author endeavoured to develop an awareness of their own views of topics discussed through attending individual therapy prior to conducting the interviews. A bracketing interview was also conducted with the author's supervisor during analysis (Ahern, 1999; Appendix J). The bracketing interview was conducted in an attempt to understand potential pre-existing biases the author held. Particular attention was paid to the author's background in relation to those with a diagnosis of BPD. The bracketing interview enabled the author to consider their motivation for the study, which was to highlight and challenge potentially damaging discourses for people with a diagnosis of BPD. The author held a pre-existing bias that more pejorative discourses may be evident when those with a BPD diagnosis were discussed. During the study the author developed a greater sympathy for staff as the discourses surrounding those with a BPD diagnosis also positioned staff as powerless.

Results

When considering what discourses staff drew on when discussing the discursive object of 'people in crisis', four discourses were present; 'medical and diagnostic', 'personal responsibility', 'limited resources for the scale of the problem' and 'human experience and emotions'. How these discourses position people diagnosed with BPD will be discussed. The

social positions and practices legitimised by the discourses will also be highlighted, along

with tensions between discourses (Billig, 1988).

Medical and Diagnostic Discourse

The dominant discourse, present in all of the interviews, was medical and diagnostic.

Within this discourse, staff were seen as experts. A positivist discourse was present with

diagnoses constructed as concrete truths that staff as scientists could observe and discover.

Service users were referred to as patients and staff's professional titles were used, defining

them as separate groups. Staff were positioned as holding power and needing to treat unwell

service users. 'But I see, you have to bear in mind they have come in, they are not well and

need help' (Moses). The position of service users is to be passive, accept this help and

recover, moving from the position of unwell to well. What this recovery constitutes, moving

on from services, is predetermined for them by staff and policy makers. 'So we see them

becoming well, come onto the ward unwell they settle down, be treated and get well and go

home' (Moses).

Within the medical diagnostic discourse, service users are positioned as people who

can be understood based on their diagnosis. Staff can legitimately assume, even prior to

meeting them, what actions service users might perform.

Blessings:

> *Or somebody coming in with personality disorder…and just start cutting, cutting,*
>
> *cutting where you have to come start dressing wounds… You don't know when they*
>
> *will do it because they are quite secretive, they hide things, they hide sharps.*

Staff have to deliver treatment to people, in this case through the physical care of

dressing wounds. The diagnosis also legitimises attributing ways of being to somebody's

personality, such as being secretive. The positivist discourse surrounding diagnosis means

that staff are positioned as needing to investigate someone and discover their diagnosis. 'Everyone at first thought she was acutely unwell but the more we saw her, because she kept going away and coming back, the more the personality disorder came out' (Ashley).

Staff believed there is a correct treatment dependant on the diagnosis, a discourse of positivism. This legitimised a number of practices for staff, such as observation and detention.

Dave:

> *they are given medically checked out or detoxed and they're observed…I think what often has actually helped now, fair enough is the DOLS, the deprivation of liberty and they get used and the five two section so I think now that's made a big difference to them.*

This position and the practices of staff are further justified by the positivist discourse, believing that what they are doing is right and helpful, indicated here as doctors, who hold the most power, prescribing the 'correct medication'.

Moses:

> *Obviously in an acute ward you have the MDT who support you with the doctors will prescribe the correct medication, could be sometimes, unfortunately because people refuse to take oral medication then we would have no resort but to restrain them and inject them.*

This extract highlights that the service users have the least power and are unable to move from their passive position to refuse this 'correct' treatment.

Further to their actions towards service users, the medical diagnostic discourse allows staff to remove responsibility when asked about people whom it has been difficult to help. People who have not recovered are positioned as illegitimate cases.

Frank:

> *So you're working with people at much lower level and with a lot more social problems, practical problems and that is what's sparked off their emotional, whatever you want to call it, their emotional reaction so basically if you sort their housing benefit out they're fine and they don't need you anymore.*

The work with people who are 'mentally ill' is positioned as higher and of more importance than those with social problems. Assisting with 'emotional reactions' is classed as illegitimate. This is the case for certain diagnoses as well, especially BPD, which is highlighted as not a mental health problem in its omission from statements.

Joan:

> *Yeah, well there's lots and lots of people we've got lots and lots of difficulties who aren't classically mentally ill, you know like schizophrenia or bipolar. Treating, I suppose the hopes are that the distress that they have can be resolved by the medical model and so and it can't and there's limited resources to assist recovery and lots of lifestyle issues and childhood experiences.*

Personality disorder is also openly talked about as not a mental health problem.

Jane:

> *I think people are more sympathetic in their language so it's…some people may say that schizophrenia is more of a genuine mental health problem than personality disorder which is not really viewed as a mental health problem, it's a behavioural issue.*

Those with a diagnosis of BPD are positioned as unable to be helped, or to go from 'unwell' to 'well' within the medical discourse. Further, assumptions can be made about people to justify this position, such as someone's history and agency over their actions, which challenge the discourse of the passive patient.

Jane:

>   *I think people are perhaps more sensitive to someone with schizophrenia because it's, it's a genuine mental health problem, it can be triggered by, I think their history is probably more significant…so if they're responding to voices or hallucinations erm I think people are more sympathetic towards that than someone who is regularly self-harming.*

Interviewer: Why do you think that is?

Jane:

>   *Because people think, they think that you can't help having schizophrenia that's if it's an organic mental health problem but you can prevent yourself behaving in a certain way, you know cutting yourself.*

This idea of organic illness upholds views of altered brain chemistry and those with schizophrenia not having control over their behaviour. Those with a BPD diagnosis are positioned differently, as responsible for their actions, which legitimises staff not feeling sympathy towards them.

Within the medical diagnostic discourse, service users lack power to make decisions about their diagnosis, this is held by the psychiatrists within teams. Service users are viewed as believing in this discourse and wanting certain diagnoses, holding a positive belief that these diagnoses will explain their experience and lead to treatment. Joan highlights this 'Kick in yeah and say that you are feeling like this because you have got bipolar or you have got serious mental illness. I think it's sometimes easier for people to accept.'

In spite of personality disorder being positioned as an illegitimate mental health problem, within medical diagnostic discourse, staff are powerless to decide whether it is treated or not.

Frank:

> *when I first started my career, psychiatry wouldn't, they said you can't treat people*
>
> *with personality disorders, there's not an illness to treat, whereas now they treat all*
>
> *of them, nearly all of them they put on medication... psychiatrists are in a difficult*
>
> *position because they've been forced to... treat people with personality disorders and*
>
> *I suppose they think well our main treatment is medication.*

This highlights that staff hold power over those they view as patients yet have no power over the wider policy context. Staff are positioned as having to use the treatments legitimised by the medical discourse, namely medication, with people with a BPD diagnosis. Those with a BPD diagnosis do not get 'well' with this treatment and return to services, a behaviour which is not legitimised by the medical discourse. Frank describes this 'It doesn't feel like we're helping them in any way, we are just institutionalising them more. By enabling them to be in services longer, we are not breaking the cycle, we are part of the cycle.'

Personal Responsibility

Within the personal responsibility discourse service users are positioned as people with agency rather than passive patients; this contrasts with the medical diagnostic discourse. They are afforded actions such as expressing their distress. Staff are positioned as people whose role is to assist them to express and understand this distress.

Joan:

> *Occasionally you get people who are not very good at expressing themselves and it*
>
> *might take a bit longer to get to the bottom of what's the problems. But most people*
>
> *are very able to express what their difficulties are and to get a tangible solution*
>
> *together to work towards, yeah.*

Service users are positioned within this extract as having some ability and can legitimately express distress. The practice of allowing service users time to express their distress is legitimised for staff. An overlap with the medical discourse is that of a positivist discourse that there is a problem that can be understood and a solution found.

Conflict arises within this discourse as staff still hold expertise in recognising a service user's potential for change and what interventions are helpful and manageable.

Lisa:

> *But it's about having realistic goals, like maybe a few years ago I would have been like 'oh we've got to get her into group psychotherapy' now I think I'd be setting her up to fail, doing that. It's about giving her more realistic steps.*

The use of the word 'giving' indicates some passivity on the part of the service user. Ideas that there is a correct treatment are maintained, including those of psychotherapy.

Grace:

> *Sometimes you're not really in the mood to take on some complex psych education or psychology based group you know, you won't be able to manage that one until you get better. Because sometimes people are not well enough to do any psych education or any psychology based groups.*

The use of the terms 'not well enough' and 'until you get better' indicate an overlap with the medical discourse.

Staff described their position of offering a service that people often want. 'You know, it's pretty full on but I do feel as a psychologist in this team I'm normally offering people something they want or have asked for' (Lisa). This position enables questioning and the practice of prioritising service users' desires, as Fo describes, 'Ask them where you'd like to

sit, what I'd like to do, explain the way you are from, the purpose you are there to see them, what you can offer them and what they are expecting from you'.

There is a conflict between the agency afforded to service users within the personal responsibility discourse, and the positivist discourse of what 'treatment' is correct, as staff lack power to influence the decisions of service users to adhere to what is viewed as correct treatment.

Moses

> *If we take one group of people who needs help, then you have another group of people who needs help but doesn't want to accept the help. 'I don't want to come administer medication', 'I don't want you to take me somewhere where I'm supported, I'm okay'*

Within this extract, people are separated into distinct groups based on their engagement with staff's treatment plan for them. The subject position of staff as knowing the correct treatment, legitimises practices which may enforce this on people in distress, such as restraint or sections.

Blessings

> *all the restraining and things we did, I felt bad. Because she didn't want to listen to us or she didn't want to abide by any boundaries or stuff like that, if she wants something she wants now, now, now and then when staff say no she start shouting and screaming and that.*

This extract is about a service user on an acute ward with a diagnosis of BPD, they were afforded agency as not wanting to listen or abide by boundaries. Ideas of expression of distress, in this example screaming, as negative and damaging, are held. The practice of restraining the service user and negative feelings associated with this were justified through assigning responsibility to her.

Staff are able to feel appreciated and take some responsibility for their work when what they offer has helped people. Staff highlight feelings of having done the job in this case.

Sarah

> *Well I suppose you come to make a difference and you sort of validate your day by hoping to make a difference…So with clients that erm really do need support in certain areas and you can kind of create an intervention and get to a goal at the end, it might be a difficult process but if you can get to that goal at the end it feels like you've done what you signed up for.*

Staff are able to justify times when they have not reached a service user's goal through having offered them their expertise, yet the service user with agency has made a decision not to engage in the techniques or change their behaviour in ways suggested.

Sarah

> *We needed her to engage in a routine and try and do some of these techniques and she wasn't really doing it … It's difficult when you try and support people, people have to, you can lead a horse to water but you can't make it drink sort of thing, that's difficult.*

The use of words like 'needed' and 'have to' indicate the importance staff afford the interventions offered. By positioning service users as needing to engage staff maintain their position as experts and lessen responsibility for poor outcomes. Jane describes the emotional experience of taking responsibility: 'I feel a real personal responsibility in responding to someone in crisis that you have to do the right thing, you have to say the right thing, erm so it can weigh heavy on your heart sometimes'. This personal responsibility discourse and the medical discourse positions staff as professionals and leaves them under pressure to do 'the

right thing'. This pressure may be lessened by shifting the personal responsibility to service

users.

Limited Resources for the Scale of the Problem

A discourse of limited resources for the scale of the problem was also evident within

the interviews. Service users were positioned as those with a problem that was too large, and

staff as experts yet without the needed resources to help them. The scale of the problem could

be seen as too large in an individual, making it difficult for staff to help or hold hope for any

change for them.

Lisa:

> *we will offer her those services but it's a bit heart sink you know. You just think, how*
>
> *much change is possible but then people always surprise you in good and bad ways*
>
> *but I think for me, that's when it's difficult when you just think like it's already too*
>
> *difficult for people at this young age.*

There is some overlap with the personal responsibility discourse as the service user is

positioned as someone with a difficult life and staff expected to offer them something that

aids change, yet feeling that this is unlikely. People who present with lots of social problems

which need to be addressed are positioned in this case as those who cannot be helped.

Moses:

> *A lot of people is actually still on the ward not discharged because of that, or from*
>
> *day one they get admitted they get referred to…housing…its very very hard to find*
>
> *accommodation but it's seriously from week one they look at all this.*

Service users in this situation may get labelled as delayed discharges, with staff

coming under scrutiny for the fact that someone has not recovered and moved on from the

service.

The lack of resources discourse positions staff as powerless to help service users in some situations. Lack of time is a frequently noted concern.

Ashley:

> *when we had more time and we didn't turn people over so quickly, I would do all their benefits claims with them. I still do a little bit but there's not really enough time now to do it…I'd take them to appointments, I'd go to their house and help tidy it up. Real pieces of work.*

In the extract, staff were doing 'real pieces of work' when they could assist service users with their social situation. This positions staff now as not doing real pieces of work, instead 'turning people over'. Tension is evident with the medical diagnostic discourse which does not legitimise working on social circumstances.

Some overlap with the medical legal discourse emerged when talking about service users who require more resources, the diagnosis of BPD was raised here.

Frank:

> *without lots of resources you can't really do anything with those type of patients. A lot of those patients need… a lot of psychological input and not many of them are going to get it. So, you can see why they just keep coming back.*

People with a diagnosis of BPD are positioned as a 'type of patient', one needing lots of resources to enable them to change. Staff within crisis services are positioned as powerless to help those with a BPD diagnosis due to lack of resource, a hopeless position is established where they will keep returning to services without any change. This position leaves people open to attributing negative characteristics to those with a BPD diagnosis. Lesley defines a good person as 'accepting treatment, accepting that they've got an illness and moving on forward and showing us that they can move forward before they get discharged'. Those that

are not accepting treatment offered and moving on to be discharged cannot be seen in this

case as good people. This example again was raised when discussing somebody with a

diagnosis of BPD.

The number of people with the diagnosis of BPD is also positioned as a problem that

cannot be solved.

Frank:

> *We've got to see those people now, we haven't got the resource to give them effective*
>
> *treatment so let's just carry on…it's probably too big a problem to actually for*
>
> *anyone to actually do anything about because (the trust) clearly haven't got the*
>
> *money to treat all those people.*

This overlaps with the medical diagnostic position of staff being made to see people

with a BPD diagnosis and lacking power to decide this. The staff are positioned here as

powerless, the service users even more powerless and even the trust powerless due to not

having the money to pay for services. Staff practice therefore involves continuing with the

current approach, sticking to protocol and the set ways of working within the service

limitations.

Fo:

> *Well people with personality disorder who stretches you, you need to take a firm line*
>
> *and draw boundaries like, you know like going on a visit to someone and you like to*
>
> *keep me talking too long so say look my visit is for half an hour.*

Staff's position and closeness to boundaries and protocol becomes more rigid with

people with a BPD diagnosis, due to them being seen as those who will 'stretch' staff and

teams. Sticking to protocol and the set programmes offered may enable staff to diminish

responsibility associated with service users they have not helped.

Fo:

> *People appreciate what you have done for them...not everybody will like you as a service but that puts the bad ones to the side and you feel oh well we have done a good job, let's get on with it.*

The phrase 'get on with it' also brings in cultural discourses surrounding making do with what one has and not complaining. This discourse may prevent exploration or discussion of current ways of working.

Dilemmas can arise for staff when they believe a service user they have developed a relationship with requires more resources than the service can offer.

Frank:

> *I wasn't going to discharge her because I don't think that she should be. On the other hand, I know the realities and the practicalities of the service mean that we cannot, we're a crisis team... our service isn't set up to do that so it's a bit of a dilemma.*

Frank has positioned himself as considering the service user's needs, yet the discourse of limited resources legitimises discharging her regardless. Both Frank and the service user hold limited power to alter this.

Human Experience and Emotion

A discourse of human experience and emotion was evident and relatively distinct. Staff discussed the huge distress that service users were in when attending crisis services. Lisa describes this, 'people are yeah pretty raw pretty emotional, lots of high anxiety, agitation, sometimes anger.'. Service users are referred to as 'people' and emotion words are used like 'anger' and 'anxiety'. These are seen as real observable entities that any human can experience. This distress positions service users as human beings with emotions and legitimate reactions to life events.

Within this discourse with service users positioned as human beings in distress, staff

position themselves 'with' service users.

Ashley:

> *sometimes I've actually wanted to cry with somebody because the story they're telling*
>
> *me is so, so sad, you know and that it just makes us human ... I can actually see that*
>
> *and could imagine myself, you know, if I was in their shoes how horrible it must be.*

Unlike within the medical model, practices of listening to and recognising these

emotions in service users are legitimised. This allows staff to 'imagine' the life of the other

person. Forming relationships with service users becomes possible when considering the

position of the other person. In some cases, these relationships were seen as stronger than any

others service users may have. Joan described the relationship the team had with a service

user with a BPD diagnosis: 'we were people she could always turn to… sort of saw us as this,

I know it doesn't sound very ethical but aunties in the background. Stability where she hadn't

had her own.'. Questioning the ethics of this highlights a tension between forming a

relationship and the professional boundaries of the medical discourse. The use of 'aunties'

suggests the strength of the relationship and draws on discourses of family bonds, assuming

these are helpful.

Within this discourse of human experience and emotion, staff are also allowed the

action of having an emotional reaction to the service users that they see. These reactions may

be fear of someone hurting themselves or sadness at someone's continued distress on

returning to the team.

Lisa:

> *You know, I think it's at the heart of it there's a bit of sadness from a human*

perspective of you know, that person is still going through the same stuff and you

know here we are again with it.

This extract highlights again both staff and service users as humans. However, within their position as people who are meant to help, staff's actions are limited to those that could be helpful.

Lisa:

> *I think people need you to be accepting of 'this is how bad I feel and I can handle it'*
>
> *and that's what you have to give, even if it's an absolutely horrific history or a very*
>
> *upsetting chain of events, you know I'm not going to be very helpful if I broke down as*
>
> *well.*

Service users are positioned as vulnerable people for whom staff's emotions may be damaging. The position for staff of needing to be 'helpful', does not allow expression of their strong emotions.

It is difficult to afford space for human experience and emotion alongside the dominance of the medical diagnostic discourse. Due to this tension, the emotions of connecting with service users can also be positioned as dangerous to staff. This legitimised practices of developing ways of 'coping' and 'getting on' with the job.

Frank:

> *I think you've got to have a thick skin... I think it protects you emotionally...if you*
>
> *were getting too emotionally connected to too many patients I think it would be too*
>
> *difficult to manage yourself. Especially with the fact that we don't get that much time*
>
> *to talk about this sort of stuff, you've just got to deal with it really.*

This extract describes the discharge of someone with a BPD diagnosis that Frank felt was discharged too early. The term 'patients' highlights the medical discourse and distances

people in crisis as distinct from staff. Connecting with people in crisis is viewed as

dangerous, a dissonance is evident between connection and the professional position. Within

this tension, practices of avoiding people who create strong emotions, like those with a PD

diagnosis, is legitimised.

Lesley:

> *sometimes the doctor might even say to some PDs or behaviour problems who might*
>
> *have different diagnosis, 'I'm not sure, just ignore them and there'll just go away' or*
>
> *'just ignore them because they're seeking the attention and you're not doing them any*
>
> *favours by giving them that attention'. So it's good for us because then we don't have*
>
> *to deal with it. Sorry but you know they're exhausting.*

The power of the psychiatrist on the ward is highlighted, holding authority to be able

to tell people to 'ignore' people seeking attention. Lesley discussed service users within a

medical discourse as 'PDs', legitimatising avoiding them and any emotions aroused by the

work. This fear of the emotions may be explained somewhat by Ashley 'if you didn't have a

laugh and a joke you'd go mad…we do say things that might be a little bit inappropriate

sometimes but it is what keeps us sane as well, it really, really does.'. The emotions

experienced by staff which are raised by service users are positioned as dangerous and staff

here fear going 'mad'.

The discourse of human experience and emotions did also allow the positioning of

staff and service users as humans in a way that legitimised curiosity. Conversations about

how to work with people raising strong emotions and thinking about all aspects of them were

legitimised.

Jane:

> *We're just doing our job, seeing them and monitoring their mental state, making sure*

> *they're safe but they are the person who is actually doing that cycle themselves. So*
>
> *it's quite sad that, that's their lives.*

In this extract staff are positioned as just doing a job, however they are able to recognise the sadness of the human experience of service users. Staff's position within this discourse is not one of being an expert and having to treat service users, rather offering a positive experience of being heard.

Ashley:

> *It's just sometimes listening, they just want someone to listen to them... I say it is okay*
>
> *to be angry, I would be angry too, you know make them feel that things are okay and*
>
> *we haven't all got to you know conform or because everybody's different.*

This extract highlights difference. The practice of validating emotions rather than avoiding them or attempting to control them is legitimised. This is further explained by Lisa.

Lisa:

> *regardless of everything that's really difficult in her life, I gave her an hour of being*
>
> *taken seriously, being listened to, having somebody really care about what she thinks,*
>
> *being able to tell me really awful things and not freak out and confidential safe space.*

The practice described is one of being alongside service users and openly caring and listening to the human experience and emotions presented.

Discussion

Investigating the discourses drawn on when staff in crisis services discuss people in crisis highlighted four discourses; medical diagnostic, personal responsibility, limited resources for the scale of the problem and human experience and emotions. The different discourses afforded service users and staff varying positions. Those with a diagnosis of BPD

were positioned as those with responsibility over their actions; practices towards them of avoidance and control were legitimised.

The prominent discourse was that of medical diagnostic which maintains a positivist view of diagnosis as a real and treatable entity. The staff within NHS crisis services are positioned as those who must discover and treat these illnesses, as suggested by policies (DH, 2001, DH, 2014). The treatment is often medication, where staff, particularly psychiatrists, hold power to give a correct diagnosis and medication. Within this discourse it was those who were passive, demonstrated a reduction of symptoms through medication and moved on from services, who were viewed as successfully treated people. This links to previous research which has suggested services have been created to suit diagnoses of psychosis (Tyrer, 2004).

For those with a diagnosis of BPD, this medical diagnostic discourse positions them as having a real diagnosis, but one that is not viewed as an illness like schizophrenia. The wider policy context of treating people with BPD diagnosis positions staff as powerless. Treating those with a BPD diagnosis with medication, like other diagnoses in crisis, is legitimised. This is despite guidelines suggesting specialist therapy for individuals with BPD (DH & NIMHE, 2003). Consistent with previous research, moral judgements of being bad or manipulative people were assigned to those with a BPD diagnosis (Bodner, Cohen-Fridel & Iancu, 2002). This meant that staff could avoid them unless they were presenting with significant risks, which is in line with service users' experiences (Morris et al. 2014).

Within the personal responsibility discourse, service users were afforded more agency. However, they were placed in distinct groups; those accepting the help offered and those who did not. Those seen as not conforming to the expertise of staff, especially on acute wards, could be subject to controlling practices, such as restraint. This was found in previous research regarding restraint and door locking on wards (Muir-Cochrane et al. 2016; Perkins et

al. 2012). Those with a BPD diagnosis were often positioned as not engaging, maintaining

them in a position of being difficult, as service users have previously reported experiencing

(Morris et al. 2014). Staff responsibility for service users who did not recover was

diminished, as service users were held responsible, ensuring that current practice remained

unquestioned.

The discourse of limited resources for the scale of the problem further positioned

those with BPD as not helped by crisis services. There was some conflict regarding the

importance of helping with social problems; even if deemed important, staff did not have

time to assist with these issues. Crisis for those with a BPD diagnosis is often triggered by

social circumstances or interpersonal events (Fonagy & Batemen, 2006). The need to

discharge service users quickly legitimised discharging those with a BPD diagnosis who were

finding relationships with the service helpful. Limited time for staff to discuss the emotional

element of their work further distanced those with a BPD diagnosis. This is supported by past

research, which suggests that due to lack of time to talk and resources, staff reject those with

PD diagnosis (Chester, 2006).

The discourse of human experience and emotions positioned service users as humans

with emotional experiences, with staff also allowed to feel emotions. The practice of

validating and being alongside someone's distress was legitimised, potentially allowing

relationships to form which staff and service users highlighted as important to wellbeing

(Currid, 2009; Morris et al. 2014). However, feeling intense emotions, often raised by those

with BPD diagnosis (Bateman & Fonagy, 2006), was also feared by staff. Limited time to

discuss emotions legitimised avoidance of emotions. The practice of acknowledging emotions

and considering the position of the person in crisis opened conversations about those in crisis

as humans and allowed staff freedom not to have to immediately treat them.

Limitations

The findings of this study must be considered alongside its limitations. Efforts were made to gain the views of staff across differing crisis services and a variety of professions (see participants section). However, no psychiatrists were interviewed due to lack of availability. As they hold such power within the medical diagnostic discourse, the views of psychiatrists may have been of interest. The teams recruited from were also from one NHS trust. The discourses present may be in part due to the culture of the trust and area of the country and may not be present within other teams.

Although efforts were made to understand the researcher's position (see quality control section), it should be noted that the perspective of the researcher can never be removed from the analysis process (Ahern, 1999). The researcher's own experience of working within crisis services and working with those with a BPD diagnosis may have impacted on the interviews and analysis.

Research Implications

The discourses present when staff discuss those they see in crisis services highlight a number of valuable avenues of further investigation. Exploring the conflict between positions afforded to service users, who are expected to be both passive and take personal responsibility, could highlight important challenges for services. Exploring discourses service users and staff draw on would highlight potential differences between how they position themselves and each other. Further research with those with a BPD diagnosis, to understand the experience of seeking care from services where avoiding your distress is legitimate practice for staff, could inform future policy and service provision.

The discourse of human experience and being alongside a service user in crisis requires further investigation. The value of the practices this discourse legitimised to service

users in crisis requires investigation. This discourse being more prevalent in CRHTT and DTT rather than acute wards, could indicate the power of the medical diagnostic discourse within acute wards. How crisis service staff, especially on acute wards, can allow rather than avoid or control the emotional experience of service users, requires further investigation.

Clinical and Theoretical Implications

Staff in crisis services need to be offered the experience of talking about the emotions raised by being faced with humans in distress. A barrier to this are the subjective positions afforded by the medical diagnostic discourse of staff as experts and people in crisis as mentally ill. Staff highlighted a lack of time and spaces that feel safe to discuss emotions, in part due to the administrative practice associated with the medical discourse. The tension between being alongside someone in distress and having to treat them, often with medication, may be alleviated through open discussion. Protected clinical supervision and reflective practice spaces were raised as beneficial, as supported by past research (Crawford, Adedeji, Price, & Rutter, 2010).

Service providers need to acknowledge the challenges staff face and ensure they feel they are completing relevant work, despite people not following the traditional medical recovery path. Protocols and guidelines for staff on how to support people with a BPD diagnosis in crisis, valuing practice such as validating emotional responses, are required. Bateman and Fonagy (2006) recommend adhering to a collaboratively agreed crisis plan. This challenges the power differential of the medical discourse, affording service users a voice. This may result in fewer practices like distancing from those with BPD diagnosis. Further training should be available for staff working with people with a BPD diagnosis, to allow questioning and thinking about current practice rather than placing responsibility with those who remain in crisis.

Conclusion

Four main discourses surrounded the discursive object 'people in crisis'; medical diagnostic, personal responsibility, limited resources for the scale of the problem and human experience and emotions. The positivist ideas of the medical discourse position staff as experts needing to find the correct diagnosis and treat them appropriately. Service users, especially those with a BPD diagnosis, are then positioned differently based on their diagnosis. Further discourses of personal responsibility can legitimise continuing the status quo of practice, as responsibility for not recovering is placed on service users, who do not follow the model of being passive and moving on from services. Further, the limited resources for the scale of the problem discourse maintains the position of people with social problems or those who cannot be treated briefly as powerless and unable to be helped. Considering emotions was legitimised within the discourse of human experience. Staff were afforded a position of being alongside service users, who were viewed as people in distress, and having done meaningful work by validating their experience. As forming relationships and being with service users is considered crucial by both service users and staff (Currid, 2009; Morris et al. 2014), further exploration of this discourse is required. Formal reflective spaces need to be offered to staff to allow exploration of their emotions and ensure practices to control or avoid service users who create strong emotional reactions, like those diagnosed with BPD, are avoided.

References

Ahern, K. J. (1999). Pearly, pith and provocation: Ten tips for reflexive bracketing. *Qualitative Health Research, 9,* 407-411. doi: 10.1177/104973239900900309

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

Bateman, A., & Fonagy, P. (2006). *Mentalization-based treatment for borderline personality disorder: A practical guide.* Oxford: Oxford university press.

Berger, B. (2014). *Power, selfhood and identity: A feminist critique of borderline personality disorder. Advocates' Forum.* Retrieved from: http://ssa.uchicago.edu/sites/default/files/uploads/AdvocatesForum_2014_PowerSelfh oodAndIdentity.pdf

Billig, M. (1988). *Ideological dilemmas: A social psychology of everyday thinking.* London: Sage Publications.

Binks, C. A., Fenton, M., McCarthy, L., Lee, T., Adams, C. E., & Duggan, C. (2006). Psychological therapies for people with borderline personality disorder. *The Cochrane Database of Systematic Reviews, 1.* doi: 10.1002/14651858.CD005652

Bodner, E., Cohen-Fridel, S., & Iancu, I. (2011). Staff attitudes towards patients with borderline personality disorder. *Comprehensive Psychiatry, 52,* 548-555. doi: 10.1016/j.comppsych.2010.10.004

Caplan, G. (1964). *Principles of preventive psychiatry*. London: Tavistock publications.

Castillo, H. (2003). *Personality disorder: Temperament or trauma.* London: Jessica Kingsley Publications.

Chester, R. (2006). *Team talk and personality disorder: a discursive analysis* (Doctoral

dissertation). Retrieved from http://roar.uel.ac.uk/3822/

Crawford, M. J., Adedeji, T., Price, K. & Rutter. (2010). Job satisfaction and burnout among

staff working in community based personality disorder services. *International Journal*

of Social Psychiatry, 56, 196-206. doi: 10.1177/0020764009105702

Crisp, N., Nicholson, K. and Smith, G. (2016). *Building on progress: Achieving parity for*

mental health in Northern Ireland. Retrieved from http://www.caapc.info/

Currid, T. (2009). Experiences of stress among nurses in acute mental health settings.

Nursing Standard. 23(44)*,* 40-46. doi.org/10.7748/ns2009.07.23.44.40.c7108

Department of Health. (2000). *National health service zero tolerance zone.* London:

Department of Health.

Department of Health. (2001). *The mental health policy implementation guide.* London: The

Department of Health.

Department of Health. (2014). *The mental health crisis care concordat.* London: The

Department of Health.

Department of Health and National Institute for Mental Health in England. (2003).

Personality Disorder: No longer a diagnosis of exclusion. Leeds: NIGMR and

Department of Health.

Foucault, M. (1972). *The archaeology of knowledge and the discourse on language.* New

York: Pantheon Books.

Hannes, K. (2011). Critical appraisal of qualitative research. In J. Noyes, A. Booth, K.

Hannes, A. Harden, J. Harris, S. Lewin, & C. Lockwood (Eds.), *Supplementary*

Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of

Interventions. Version 1. Retrieved from: http://cqrmg.cochrane.org/supplemental-handbook-guidance

Lloyd, M. (2007). Empowerment in the interpersonal field: discourses of acute mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 14,* 485-494. doi: 10.1111/j.1365-2850.2007.01116.x

Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviour. *British Journal of Clinical Psychology, 42,* 243-256. doi: 10.1348/01446650360703366

Morris, C., Smith, I., & Alwin, N. (2014). Is contact with adult mental health services helpful for people with a diagnosable BPD? A study of service users views in the UK. *Journal of Mental Health, 23,* 251-255. doi: 10.3109/09638237.2014.951483

Muir-Cochrane, E., Merwe, M., Nijman, H., Haglund, K., Simpson, A., & Bowers, L. (2012). Investigation into the acceptability of door locking to staff, patients, and visitors on acute psychiatric wards. *International Journal of Mental Health Nursing, 21,* 41-49. doi: 10.1111/j.1447-0349.2011.00758.x

Newton-Howes, G., Weaver, T., & Tyrer, P. (2008). Attitudes of staff towards patients with personality disorder in community mental health teams. *The Australian and New Zealand Journal of Psychiatry, 42,* 572-577. doi: 10.1080/00048670802119739.

Office for National Statistics. (2011). *2011 Census data.* Available from: https://www.ons.gov.uk/census/2011census/2011censusdata

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London: Routledge.

Parker, I. (2012). Discourse analysis: Dimensions of critique in psychology. *Qualitative Research in Psychology, 10,* 223-239. doi: 10.1080/14780887.2012.741509

Perkins, E., Prosser, H., Riley, D., & Whittington, R. (2012). Physical restraint in a therapeutic setting; a necessary evil? *International Journal of Law and Psychiatry, 35,* 43-49. doi: 10.1016/j.ijlp.20111.11.008

Rhodes, G., & Giles, S. P. (2014). "Risky business": a critical analysis of the role of crisis resolution and home treatment teams. *Journal of Mental Health, 23,* 130-134. doi: 10.3109/09638237.2014.889284.

Rooney, C. (2009). The meaning of nurses experiences of providing one to one observations: a phenomenological study. *Journal of Psychiatric and Mental Health Nursing, 16,* 76-86. doi: 10.1111/j.1365-2850.2008.01334.x

Sansone, R. A., & Sansone, L. A. (2013). Responses of mental health clinicians to patients with borderline personality disorder. *Innovations in Clinical Neuroscience, 10,* 39-43. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3719460/

Smail, D. (2005). *Power interest and psychology: Elements of a social materialist understanding of distress.* Ross-on-Wye: PCCS Books.

Tobitt, S., & Kamboj, S. (2011). Crisis resolution/home treatment team workers' understandings of the concept of crisis. *Social Psychiatry and Psychiatric Epidemiology, 46,* 671-683. doi: 10.1007/s00127-010-0234-y

Tyrer, P. (2004). Getting to grips with severe personality disorder. *Criminal Behaviour and Mental Health, 14,* 1-4. doi: 10.1002/cbm.555

Westwood, L., & Baker, J. (2010). Attitudes and perceptions of mental health nurses towards borderline personality disorder clients in acute mental health settings: a review of the

literature. *Journal of Psychiatric and Mental Health Nursing, 17,* 657-662. doi:

10.1111/j.1365-2850.2010.01579.x

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Maidenhead,

England: Open University Press.

Woolaston, K., & Hixenbaugh, P. (2008). 'Destructive whirlwind': nurses' perceptions of

patients diagnosed with borderline personality disorder. *Journal of Psychiatric and*

Mental Health Nursing, 15, 703-709. doi: 10.1111/j.1365-2850.2008.01275.x

Section C

Appendices of supporting material

Appendix A

Interview Schedule

What is it like for you meeting people when they are in crisis and come in to your service?

Could you tell me about an experience that you have had working with people who it has been difficult to help in your service?

- Could you give me an example without using the person's name?

- What was this experience like for you?

- What was it that meant it was hard to help/ work with this person?

- How did the team work with this person?

- What treatment was offered and what happened?

Could you tell me about when the service is able to help people?

- Could you give me an example without using the person's name?

- What was this experience like for you?

- In what way was it different to the previous example?

- Were there any challenges dealing with this person?

- How did the team work with this person?

- What treatment was offered and what happened?

What are your experiences of people with different diagnosis?

- Does diagnosis make a difference or not, in your experience?

- What has your experience been like of working with people who would be said to have borderline personality disorder?

- Could you give me an example? (without naming the individual)

Is there anything else that you would like to say?

Appendix B

Salomons Ethics Approval Letter

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Appendix C

Trust R & D Approval Letter

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Appendix D

Participant information sheet

How do staff talk about those they see in mental health crisis teams?

Hello. My name is Rob Percival and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?
The purpose of this study is to better understand how staff talk about working with adults who present in mental health crisis teams. We are all drawn into talking about others in certain ways. Past research suggests that thinking about how we talk about our experiences can lead to more understanding of how we view others. Some research has suggested people talk in different ways about people with different diagnosis, like personality disorder. This research aims to add to the understanding of how people are talked about and therefore viewed in crisis teams.

Why have I been invited?
You have been invited to take part in the study due to working in crisis services where you experience individuals under great distress. You will have worked with a number of different individuals during this time and have an understanding of who it has been challenging to work with.

Do I have to take part?
Taking part in the study is completely voluntary. It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?
I will be coming to your work place to discuss the research with people beforehand to give everyone a chance to ask questions about it. If you decide to take part in the study then I will interview you individually. The interview will consist of open questions about your experiences of working with people that come into crisis services. I will also ask about what you have taken from these experiences and what might help services. The interview will last between 45minutes and an hour. Interviews will be conducted in an ▇▇▇▇ NHS site. I will ask for your consent for the interview to be audio recorded. I will not inform your manager or other staff members whether you chose to participate in the study or not.

What are the possible disadvantages of taking part?
Sometimes people can find it hard to discuss past experiences, especially with someone that

you do not know. If during or after the interview you feel stressed or concerned by anything then please contact me on the phone. You could also discuss this in your clinical supervision at work. If you do not feel comfortable with these options then staff counselling support is available or local charities that help people with distress. I would encourage you to think carefully about whether you want to tell me anything difficult. I would have to break confidentiality if I was concerned about yours or anyone else's safety. Or if I was concerned by something you raised about your practice. I would then have to tell my supervisor, Dr John McGowan and follow relevant NHS policies. If I have to do this then I would aim to tell you beforehand if possible.

What are the possible benefits of taking part?
I cannot promise that you will see direct benefits from this study to your team and work with people. However, the results of the study could impact on how services help both staff and individuals especially those individuals that can be seen as most difficult to work with.

What if there is a problem?
Any complaint that you have or any undue distress that you suffer due to taking part in the study will be addressed. Please see part 2 for details.

Will my taking part in the study be kept confidential?
Yes. Your name and any details will be stored in a password protected database that only I will have access to. What you say in your interview will not be linked to your name or details thus making sure you remain anonymous. Further details about this are outlined later in this information sheet.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 More detail of the study
What will happen if I don't want to carry on with the study?
You can leave the study at any point without having to give a reason for this. I would still like to use what you had said up to the point that you decide to leave the study. However, if you feel strongly about this then that information can also be destroyed.

What if there is a problem?
Complaints
If you wish to make a complaint about the study then in the first instance please contact me either via email at r.percival267@canterbury.ac.uk or via phone on 07974529486. If you do not wish to make your complaint to me then you can contact Prof Paul Camic, Resaerch Director, Salomons Centre for Applied Psychology, Canterbury Christ Church University on 03330 117 114 or paul.camic@canterbury.ac.uk or follow the ███ NHS foundation trust complaints procedure.

Will my taking part in this study be kept confidential?
Your participation in the study will be kept confidential. Your name will be stored in a password protected database that only I will have access to. Your interview will be stored on a password encrypted memory stick and deleted off of the Dictaphone before I have left the NHS building. I will ask a few details about yourself like how long you have worked in the service, your role, age and ethnicity, this information will be stored as a number and not linked to your name. When I transcribe the interview it will then be deleted. When your interview is transcribed you will remain anonymous, meaning that what you have said will not be linked to your name in any way. Anonymous data will be stored for 10 years. I would also encourage you when talking about service users to not use their names to ensure their anonymity. The only time that I would have to talk to other people about you in a way that would break confidentiality would be if I was concerned for your safety or someone else's. Or if you raised any issues in your practice that are concerning. In this case I would tell you beforehand if possible and would then talk to my supervisor as well as following relevant NHS policies.

What will happen to the results of the research study?
The study will be submitted to Canterbury Christ Church University as part of my doctorate qualification in Clinical Psychology. A copy of the final report will be kept in the Canterbury Christ Church University library. The results will be in the public domain as a final report will be on the University's website (Create). I also plan to publish the study in a national journal. Anonymised quotes from the interviews may be used in this publication, these will not be attributable to you. If you want a presentation of the findings then please contact me and I will return to your workplace to present the findings and discuss them with you. I will also make a summary document of the findings available to you.

Who is organising and funding the research?
The research will be funded by Canterbury Christ Church University and Surrey and Borders NHS trust.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable approval by both the ███████ Research and Development department as well as the Canterbury Christ Church University ethics committee.

Further information and contact details

If you would like to take part in the study or speak to me and find out more about the study, you can leave a message for me on a 24-hour voicemail phone line at 0333 011 7070. Please say that the message is for me (Robert Percival) and leave a contact number so that I can get back to you. Alternatively you can email me at rp267@canterbury.ac.uk. If you are unsure whether to participate then you can talk to me about this or talk to a colleague.

Appendix E

Participant Consent Form

Title of Project: How do staff talk about those they see in mental health crisis teams?
Name of Researcher: Robert Percival

Please initial box
1. I confirm that I have read and understand the information sheet dated.................... (version............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

3. I agree to my interview being recorded and understand how this will be stored and deleted.

4. I agree that anonymous quotes from my interview may be used in published reports of the study findings.

5. I agree to take part in the above study.

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix F

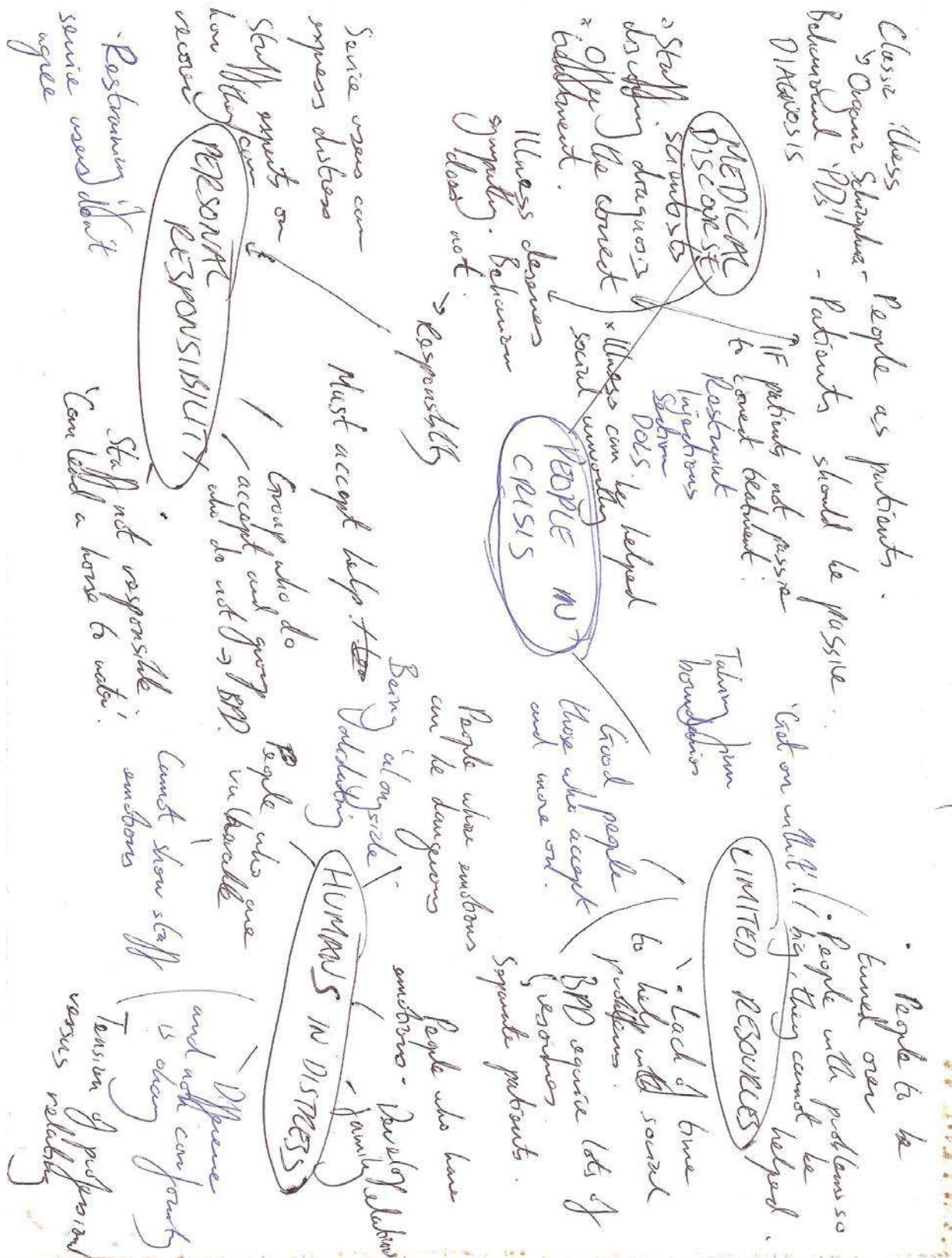Annotated Interview Transcript of Stage 1: Identifying Discursive Object 'People in Crisis'

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Appendix G

Analysis Coding Book

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Appendix H

Draft Mind Map

MEDICAL DISCOURSE

PEOPLE IN CRISIS

PERSONAL RESPONSIBILITY

HUMANS IN DISTRESS

LIMITED RESOURCES

Classic illness → Organic Schizophrenia → People as patients.
Behavioural 'BD' - Patients should be passive
DIAGNOSIS

- Staff sometimes offering diagnosis
- Offer the correct entitlement.

Illness → lessens
sympathy. Behaviour
'chosen' not. → responsible

If patients not
to accept treatment:
- Restraint
- Injections
- Section
- DoLS

'Get on with it!' : people
with problems so
they cannot be helped.

People to be
turned over
- people with problems so
cannot be helped.

Taking on
boundaries

Good people
those who accept
and move on

People where emotions
can be dangerous

People who have
emotions - lack of
family relation

- lack of time
to help with social
problems.
BPD require lots of
resources
- separate patients

Service users can
express distress

Staff expects or
low threshold
reasons

Must accept help.
Barry alongside
Volunteering.

People who do
accept and group
can do not → BPD
in vulnerable

Group who do
accept and group
in vulnerable

Staff not responsible
- emotions

Cannot show staff
emotions

Difference
is okay
Tension of professional
versus reliability
and not comfort

- Restraining if
service user don't
agree

Staff not responsible
house to wait.

Appendix I

Abridged Research Diary

August 2015

The study received approval from Salomons. I have lots and lots of questions to be finding the answers to about discourse analysis and Foucauldian discourse analysis. I have been interested in how different people are talked about for a long time. Maybe it's from how I have always been talked about, or trying to change how I am viewed and talked about. Attempting to move away from the positions that people create for you can be difficult.

September 2015

Meeting with service user coproduction group, who have conducted research in a number of teams in the borough that I will be. They have conducted lots of interviews and a number have BPD diagnosis. The meeting was a real eye opener to their experience. They described feeling like they were offered the same thing again and again when they call urgent help lines. 'Go and have a relaxing bath' stuck with me. It did make me think about the difficult position the person on the end of the phone is in too, having limited tools to try and relieve someone in huge distress. One service user in particular got me thinking about the positions people are placed in, claiming they felt sorry for psychiatrists. I considered how inflexible the positions might be or become for both service users and professionals, potentially especially psychiatrists.

Really wrangling with the idea of how up front to be about a lot of the focus of the analysis being about BPD. The discursive object is people in crisis yet one of the research questions is those with BPD diagnosis. It explicitly raises BPD in the information sheets and talks about how discourses position people differently so the study is clear. I just consider my own position in this, bringing in the diagnosis to get a clear example if one is not given. As well as my follow up questions about examples of people with a BPD diagnosis. I will need to watch for how I consider these questions.

July 2016

Real frustration as a team that I had been in touch with drops out entirely from the study, claiming they are too overwhelmed and had a difficult CQC inspection recently so feel it would be too sensitive. Had really hoped to get going and get my data as I am fast become aware looking at other discourse analysis how large a task the analysis will be. Discussions with external supervisor about recruitment and spreading the net wider to other teams in the borough were reassuring.

August 2016

First interviews done. What a relief, especially after the drop out. The first interview felt very stilted and stuck to language that I wondered almost came from policy. I wonder what impact coming in to a service and talking to people has, do they think I am under cover CQC. I feel like I explained myself well enough but I felt very bored during this interview and struggling to know how much to probe and continue questioning things. Concerned about analysing and worried if all my interviews are like this but then surely it still constructs something.

Really mixed sets of interviews recently. One in particular that I noticed a real reaction in myself as those with a BPD diagnosis were discussed as not being worthy of sympathy. I guess my view of professionals might have played a part here in thinking they should be empathic. I should be aware of this in future interviews and analysis.

November 2016

Transcribing, transcribing, transcribing. I really have a lot of data, which I should feel grateful for. At points during transcription I find myself really immersed an interest in what is being said. Starting to notice ideas that seem to be coming up in a number of the interviews, like lack of time and moving people on. Interested to think about how this positions people.

January

Recently been considering and noticing how emotive some of the interviews are. This may be being enhanced for me due to being on placement in a speciality service for people with BPD diagnosis. Started the analysis and really looking in depth at one interview. It is a really big task. I knew this but wasn't maybe quite prepared for how large. Finding it tough to be doing this around placement both due to the high levels of distress at placement, how related it is to the study but also just time. Feeling resentful at points trying to do bits of the research in the mornings before placement. Reflecting on this in supervision and using reflective group has

been useful. Feeling under pressure to get it done, which does not feel helpful when need to really analyse in depth. Especially because I worry time pressures and being under scrutiny will make me want to get it 'right' rather than be more social constructionist and interested.

Met with my supervisor to look over the initial codes and think about analysis. Really helpful to think about what a discourse analysis code is and the language. Need to keep thinking about the function of the language. Bracketing interview also really helped me to think and question myself about the study. Why I chose to study BPD but especially crisis, is a question I will keep thinking on. I think it does have something to do with emotions and being able to be open. My therapy was very much around allowing myself to feel and express unformed and uncontained emotions, something I struggled with. Possibly people in crisis and those with a BPD diagnosis are able to do that but then the sense of shame after can be huge. I have found myself in early analysis and interviews feeling quite judgemental of staff who want to shut down emotion but then also being able to relate with them in terms of my own fear of my emotions.

February

Starting to get some form of discourses together. How they construct positions for service users, people with BPD diagnosis and staff is becoming apparent. I see myself being drawn towards the ideas of emotions and allowing emotions, need to be aware of not positioning this as the correct thing to do based solely on my own ideas. Really interesting, the shift of responsibility or power from staff to service users, what this does, who is then taking responsibility and what this allows. Considering how these discourses construct the world around them is slightly more challenging, what views and practices they legitimise. What might be being assumed or taken for granted? Still so many questions, constantly questioning. Need to read more about the context and more about discourse analysis. So much going on in life around this at the moment, at points making it easier to focus on work and at others adding to the pressure.

March

Is what I am doing correct, is anything correct? The discourses that have emerged, make sense to me but I can't help but question whether they only make sense to me. Looking back into the data, this language is definitely there and these positions make sense from it. My supervisor has been great at helping with this, providing confidence in my discourses but

questioning some of the titles of them. Whether the titles cover what the discourse actually is saying. I think I am getting closer to something which is meaningful. Reading about authoring the truth so not actually finding a truth. The constructions of people with BPD diagnosis and the staff that work with them, really do feel like something that is worthwhile questioning. With the current political scene though, I cannot help but feel a sense of hopelessness for things improving at points during the analysis, questioning and consideration for others does not feel high on the agenda of the UK at the moment.

Appendix J

Bracketing Interview During Analysis

Supervisor: So I thought the questions, and we can think of them together, but I thought the most important ones were; why this subject? What's personally interesting you about this subject and the more we flesh that out we can start to look for questions related to that which are things like what do you expect, you know it's more along that and perhaps even a little bit of some of your feelings you had during the interviews. So if we start with wider subjects, two subjects PD and also crisis so for you personally why did you choose this?

Researcher: I think from my own experience of working in teams, both teams that deal with people who have got a diagnosis of PD and crisis so mostly erm I guess, mostly from two jobs I had previously before training, one which was in a forensic PD service, community forensic PD service and meeting a lot of people there who just were so angry about how they had been treated by services. Most were kind of pushing on a bit, bit older and they had, had some awful experiences. From there I went into working on an acute ward as an assistant and erm I guess just hearing how people do talk about people, mostly with PD and people in general who come in that they find don't kind of progress almost as they would want them to. Just the amount of time spent talking about those people in meetings and. Yeah, so for me I think it came partly from that really.

S: When you say how they talked about it can you say how it made you feel? Because it most of come from an emotional place, why we choose a particular focus as well, it's got to have that energy as well, it's got to matter.

A: Do you mean how I…

S: How did you feel about how they talked about PD patients in those services?

A: Erm quite angry I think as well at points. I feel like yeah, just, yeah really kind of pissed me off how people would just take away any kind of idea of the experience that person was going through. I guess I kind of was very aware I was only there for a year so I was almost in a privileged position in a way that I kind of came in and wasn't, I guess I wasn't a nurse on the ward all the time for example so part of me could understand a bit what they were saying. I guess I didn't have quite such intense relationships almost at points with some of the people on the ward. But just yeah I guess it angered me and also disillusioned me slightly in 'okay well how are these people going to have an okay experience here if everyone is discussing them like they're just the worst people in the world who don't deserve to be here almost'.

S: Did you find yourself identifying more with patients than staff, I mean when you're talking about this it's quite a lot from their perspective, do you think you would naturally go to that or?

A: Erm, er possibly I guess I, parts of the role I enjoyed the role were the informal parts of playing table tennis on the ward or sitting and having a chat and getting told like, what are you doing kind of thing? I remember being really annoyed when people would be told off for doing that stuff with some of the service users on the ward. Erm so possibly.

S: What did you enjoy about that?

A: Er it just felt a bit more natural almost than sitting in a ward round certainly

S: I mean did it, did the experience of that kind of human contact did it inform your interest in any of this study?

A: Erm

S: It's like you playing table tennis they're not seeming like PD patients, you see them in another context and actually its, its self-fulfilling prophecy or something like that, I just wonder what it was?

A: Yeah I think so, I think that and partly in the outpatient service I was in, we'd sit and have lunches and I remember trying to set up an art project and it was very much a different, different ways of interacting with these people who yeah are talked about like they can't be interacted with and they don't have anything else other than just what they put on to other people in a way.

S: What would you say that did to you as a formative experience?

A: Erm I think for me it took away a fair bit of anxiety about people, people who are in services. It took away almost that mystery of oh yeah those PD people or even people with psychosis on the ward as well, it was like okay. I think it also enhanced my frustration with the medical model and diagnosis, it almost made that feel for me like it doesn't fit at all erm yeah

S: No, it makes sense. Have you noticed that its informed you as well as a sort of clinician as well? What's it done to you as a clinician? Having contact with people that you're not, that one model says can't do contact you know.

A: I guess it's made me, I wonder if it's made me want to be more flexible that sometimes services allow in terms of what you can offer. I think it's made me want to question, it's definitely made me question services more on what is offered and who's missing out on services because of that or because of how it's offered. I think as a clinician in terms of working with people as well I think it's, I think it just has enhanced my curiosity in a way to not, I don't think I'd ever in the past kind of assume I knew what was going on for someone but I think even more so now, it's kind of led to me wanting more human interactions and trying to understand people rather than being prescriptive in any way.

S: That makes sense. What about, this is going to be hard to answer, that's your relationship to patients, what about your relationship with other treatment staff. Did it position you in a particular place when you were becoming more curious, perhaps other people were not you know?

A: Yeah, er, yeah I guess I can, I guess I feel like its positioned me as kind of, I don't know I've got psychiatry in mind I guess which is a bit stereotypical but yeah it feels like it has that position, I keep saying doesn't fit almost goes against the psychiatric, a lot of psychiatrists I've worked with since these jobs in terms of not questioning anything. Or questioning people

on what's felt like a thin veil, question them just to get to the point of doing what they want to do as clinicians.

S: How would you describe your emotional response to that?

A: Er

S: With emotional words

A: Yeah, I think again kind of angry but a fair bit of sadness as well that these, just in terms of that being set and this person, this service user for example who may not have a voice or position of power just very sad that they are in the system and that's where it's at. And I do feel like, I do wonder if part of it is keeping those people, keeping that distance from 'oh these people are crazy, we need to keep that distance because maybe I'm not that far from that' for staff.

S: What do you mean? So because you have a different view you might be marginalised like the patients

A: No I guess I was going away from me again and thinking about staff feeling like they have to distance themselves from patients to think that they couldn't possibly be anything like them and not allow themselves to be in touch with yeah, their own maybe perspectives or own emotions that might not be closer to what people would call normal sometimes.

S: Yeah, is that an interest for you then about is that one of the things in your career that you're interested in about the relationship between the professional self and the personal self, you know the distance between them.

A: Yeah, I think so, I think, yeah how much of your personal self you can bring in to being a professional and I guess how much you use your own reactions to things when working with people, when being a professional and how much you are allowed to do that.

S: What does your intuition say?

A: Erm my intuition says it can be a really great thing to use a fair bit more of personal and I also often think you should do this.

S: Is that intuition or…

A: No, I feel like that's partly what you think you shouldn't do because of what is said.

S: So if you could see crisis treatment for BPD developing, suppose you were in charge of it, what would you be shaping it to look like, based on your understanding now? What would you desire it to look like?

A: Gosh, I guess somehow moving away from the medical model to, I guess to a point of people in crisis being able to express what is going on, to be able to put out there, in any means that they find able I guess whether that is talking, whether that is drawing or writing or whatever people do. Finding some way of finding a safe space for them when they are in that immediate emotional intensity when they need to be kept safe. So I know crisis houses at the moment are on the rise at the moment, a bit, I think, which sound like they are moving

slightly away from the medical model. Erm so I guess that and then from there potential for some psychological work when they are not in crisis afterwards, in places, yeah I guess in places like I've experienced that do tend to do a good job almost day community type which have been informed by therapeutic communities but people are also out in the community erm yeah.

S: Why? Why does that appeal?

A: Erm

S: On a personal level, why, you know?

A: I think, I think because those kind of places that I've experienced doing that well form genuine relationships with people who find it very hard to form relationships.

S: Why does that appeal to you? Do you feel it's anything to do with your story?

A: Erm possibly, I guess. Why does that appeal to me? I guess something about it being longer term, people being held there and I guess thinking about my story, I guess, thinking about how long it takes maybe to. I guess thinking about my own story in a way I feel like it takes a long time to realise things about yourself or for me to realise things about myself and then make any kind of small changes in my own life. So I feel like the idea of kind of longer term help for people whose lives have been much more chaotic and traumatic than mine, the idea that, I feel like yeah for me it makes sense that it would take a long time and there would be a lot of challenges in forming any meaningful therapeutic relationship. Even before they can start thinking about themselves and making any small changes in their lives.

S: Someone once asked me why I specialised in BPD treatment, it's incredibly challenging question actually in terms of your own life. Why would you choose this or I think you could ask it about any group but so I can ask you. Are you aware of why you would choose people given this diagnosis to focus on?

A: Erm

S: So we are looking for parallels between your story and theirs.

A: I guess erm, yeah I'm not sure, I guess I'm at a point at the moment where I'm questioning if this is something I am going to continue to specialise in after training. I'm wondering whether it's something about, yeah it is a very difficult question.

S: It is isn't it.

A: If it's something about that, that, that challenge of what it's like to push yourself to form a meaningful relationship and to feel, I guess to feel kind of okay within that relationship. Erm I guess thinking about myself I'm aware that I kind of tend to keep a lot in and not kind of present my full self to people and I guess thinking about people with BPD diagnosis it's almost all out there in this very emotional way and I guess for me I'm very much more hold my emotions back and much more in my head. I think that has been a challenge for me over the years to let more and more out. I'm not sure how that relates to why I'd be drawn to working with or specialising in people with BPD.

S: Maybe it's not just specialising in people with BPD, it's people with BPD in crisis where everything is on show and they can't just hold these things in. Although and yeah, that's very interesting what you describe if your tendency is the other way then there must be somewhat fear of what it would be like to be taken to the other end of your comfort zone in a way, to sort of like. Which I think is their experience as well because so often quite private as well, you sort of actually don't, only get to know what's going on when it's too late.

A: Yeah, sure its that kind of shame almost when it has all been put out there.

S: Yeah, shame, shame is a good word actually isn't it. Er so, what did you think you would find in this study? I think we can't do a study without having pre written it so do you have a sense of what you pre wrote about the study?

A: Yeah, I guess I thought I'd find lots of people saying that, that crisis services don't help these people and why are these people here making my job really hard. Yeah, I thought I'd find that, I thought I'd find yeah that was the main one I guess, I thought I'd find people being like it doesn't work why and why have we been told we have to see these people as well. In terms of kind of policies and the criteria. I kind of felt, yeah I thought I'd find people saying yeah we've been told we have to see these people, we don't know what to do with them, they mess up everything when they come here.

S: So that's a very clear description of not only what people would say but how they would be positioned as staff in a slightly, yeah being a little bit forced against their natural tendency to do part of the job they don't want to do and how about you in relation to that kind of image of a staff member would that be confirming something you'd have seen in the past or that you were angry at or had some emotional response to?

A: Er yeah I feel like that would be confirming for me that kind of, how what I said in the past, how I've heard people be talked about and yeah confirm that kind of anger almost for me of like erm yeah. I guess what has been interesting, really interesting for me, transcribing and listening back to some of the interviews has, I've had a lot more sympathy for staff that I've interviewed than I thought I would actually.

S: That's interesting

A: Listening back, almost like I feel like there's been a bit of parallel of disempowered people in crisis going to them and staff feeling really disempowered as to what they can offer and then feeling like they are just told what they have to do and stuck in this very. There was lots more talk than I expected about legality and fear of coroners court, which thinking about it I should have probably thought that might come up as well and just staff feeling really scared almost of working in these crisis services. They feel completely full to the brim and full to the brim with people that they find really hard to help.

S: Did that in any way shift your position in relation to the patients, perhaps not just seeing them as the victims of this system but seeing other people as the victims as well, sometimes the patients having some responsibility. Did that, did your image of the patients change as well as your image of the staff?

A; Ah

S: I know you didn't interview patients

A: Yeah, I guess in my mind I kind of saw them as being in it together a bit more but kind of. Erm its not really answering your question but it felt to me like it was frustrating these conversations couldn't be had between staff and patients. Some kind of movement to change services and neither staff of patients feel like they are working. I guess what I heard is that patients come in and staff tell them what they have to do even though they think, they don't think that's necessarily the right thing or erm. I guess in terms of my view of the patients, I erm I'm not sure how much my view changed really, I guess I felt like maybe they were together with staff a bit more I think. Yeah, I feel like, I felt quite sad for them in terms of there was lots of talk of people coming back to services. Yeah, it made me feel a bit sad in terms of things not changing in a way.

S: Okay last question, what would have been the worst outcome of this study? What did you not want it to find? Medical model was right?

A: Ha, yeah maybe. What did I not want it to find

S: Let the prejudices flow

A: Okay

S: Go full Donald Trump on this

A: I guess I didn't want it to find that. What didn't I want it to find? I guess I didn't want it to find that staff, yeah, that staff completely bought in whole heartedly that everyone should be medicated and that, that PD is this thing that is this very real thing that is something that's almost like a, yeah, that PD is like a and all diagnosis is like this set in stone thing that is real and

S: Like a disease or?

A: Yeah, like a physical disease that they just need to be able to find the right drug and it will all go away and it will be okay and if only they could do that then everything would be solved. Yeah

S: I think that's really good and if I was you, it's not as though, a lot of the questions I've asked you, you've probably have a lot of thoughts afterwards and I would add some journal entries. Specifically I think the more you can link it and you don't have to say what those things are, link those interests in the study with your own autobiography perhaps also amplifying the feeling response to some of it then I think that would be complete. I think that's a proper bracketing interview with a sort of follow up journal. It's not as though you publish those specific details but I think being able to show there was a process. How was it, lastly? How was it being interviewed?

A: More challenging that I thought actually

S: In what way?

A: I guess thinking about those bigger questions like why, why think about BPD? Why specialise in this area and like thinking about parallels, yeah with my own autobiography in a way. I might just stop this actually.

Appendix K

Letter and Summary Report to R & D

Salomons Centre for Applied Psychology

Runcie Court,

David Salomons Estate

Broomhill Road

Tunbridge Wells

TN3 0TF

Email: rp267@canterbury.ac.uk

CSP/IRAS Reference: 193585

Dear Sir/Madam,

I am writing to inform you that I have now completed the research project entitled: "How do staff talk about those they see in mental health crisis teams". This project was conducted as part of my doctoral qualification in Clinical Psychology, and has been submitted to Canterbury Christ Church University (Salomons).

Please find attached a summary report of my findings from the research project. If you have any queries about the research or the findings then please feel free to contact me on the email address provided.

Yours sincerely,

Robert Percival

Trainee Clinical Psychologist

End of Research Summary Report

This research project was a Foucauldian Discourse Analysis of how staff in crisis services spoke about the people that they see in crisis. The objectives were to see how staff talked about those people they see in crisis, how this way of talking positioned people in crisis especially those with a diagnosis of borderline personality disorder and to consider the consequences of these positions for people in crisis.

Twelve staff members were interviewed. Five staff members were from home treatment teams, five from acute wards and two from day treatment services. Interviews lasted from 40 minutes to 75 minutes and were audio recorded and transcribed by the researcher. The six stage model of Foucauldian discourse analysis was used to analysis the interviews (Willig, 2008).

Four discourses were present in the transcripts. The main discourse was called 'medical diagnostic'. This discourse positioned staff as holding power and expertise, it drew on positivist discourse that there is a correct diagnosis and treatment for people which staff need to discover. Staff were in a position of assigning characteristics to people in crisis based on their diagnosis. People in crisis were positioned as passive and receiving treatment. Certain people were positioned as cases that should not be seen due to not being mentally ill. Social issues were viewed as not the role of crisis staff. People with a diagnosis of BPD were seen as not worthy of sympathy within the medical discourse and positioned differently to those with a 'classic mental illness'. Staff feel frustration that those with a BPD diagnosis return to services and do not feel they are able to help them from their position within the 'medical diagnostic discourse'. Despite holding power in relation to service users, staff are powerless in that policy dictates who they accept into the team.

A discourse of 'personal responsibility' positioned those in crisis differently to the 'medical-diagnostic' discourse. Within 'personal responsibility' discourse people in crisis were afforded some power, to express their distress and decide whether or not to engage with what crisis staff offer. Staff were positioned as experts in terms of what interventions to offer. However, when an intervention had been offered staff were powerless as to whether service users engaged with this. This could legitimise practices to control service users, like restraint, the responsibility for these practices was placed with people in crisis for not engaging or being passive. For people who it had been difficult to help in crisis, staff were able to distance themselves from responsibility, as service users were positioned as having to engage. This led to not questioning current practices and what was offered to people.

'Limited resources for the scale of the problem' was a further discourse that positioned staff as experts yet without the resources to offer what was needed. People in crisis were positioned as those who have problems too large to be helped by crisis services. For those with a BPD diagnosis, they were positioned as needing lots of resources for any change to occur. Staff cited that there are too many people with a BPD diagnosis for services to help

them. Similarities could be drawn with the 'personal responsibility' discourse as staff were referred to 'getting on with it', again not questioning current practices. The 'limited resources' discourse can also legitimise discharging people and 'turning them over'.

The discourse 'human experience and emotions' constructed people in crisis as humans in distress. It positions staff as people with emotions too, such as sadness that someone is still in distress when they return to the service. Some staff were concerned that feeling emotions or 'connecting' with too many service users could lead to their own emotions becoming too much, or them going 'insane'. They described a need for a 'thick skin'. With this fear practices like avoiding those who create strong emotions like people with a BPD diagnosis was legitimised. Some staff described noticing their emotions and managing them. Practices like 'being alongside' a service user in distress are legitimised without staff having to immediately treat them.

Clinical implications of this study were for crisis team staff to be afforded formal reflective spaces. These could enable staff to consider the flexibility of these discourses, to question their current practice rather than position those, like those with BPD diagnosis, who the service finds difficult to help as responsible. Policy also needs to highlight improved ways of working with people with a BPD diagnosis in crisis. Staff training would also be beneficial to enable them to feel they are doing worthwhile work with people who do not follow the traditional 'passive' route of the 'medical diagnostic' discourse.

I plan to disseminate the results of this study through publication in the British Psychological Society's journal 'Psychology and Psychotherapy: Theory, Research and Practice'.

Appendix L

Summary Report for Participants

Salomons Centre for Applied Psychology

Runcie Court,

David Salomons Estate

Broomhill Road

Tunbridge Wells

TN3 0TF

Email: rp267@canterbury.ac.uk

Dear Participant,

Thank you for taking part in my research project. The project was called 'How staff in crisis services talk about those they see in crisis'. The objectives were to understand how staff talked about those people they see in crisis, how this way of talking positioned people in crisis especially those with a diagnosis of borderline personality disorder and to consider the consequences of these positions for people in crisis.

Twelve staff members were interviewed. Five staff members from home treatment teams, five from acute wards and two from day treatment services. Interviews lasted from 40 minutes to 75 minutes and were audio recorded and transcribed by the researcher. The six stage model of Foucauldian discourse analysis was used to analysis the interviews (Willig, 2008).

Four discourses were present in the transcripts. The main discourse was called 'medical diagnostic'. This discourse positioned staff as holding power and expertise, it drew on positivist discourse that there is a correct diagnosis and treatment for people. Staff were in a position of having to discover this diagnosis and treat it. People in crisis were positioned as passive and receiving treatment. Certain difficulties were seen as not as important in this discourse, like social problems or those diagnosis deemed not a 'classic mental illness', such as borderline personality disorder (BPD). Staff feel frustration that those with a BPD diagnosis return to services and do not feel they are able to help them from their position within the 'medical diagnostic discourse'. It was possible within this discourse to not feel sympathy for those with BPD diagnosis. Staff were powerless to decide who they accept into the team, as policies decide this. The practice of treating those with a BPD diagnosis with

medication, or like a 'classic mental illness' was legitimised within this medical diagnostic discourse.

A discourse of 'personal responsibility' positioned those in crisis differently to the 'medical-diagnostic' discourse. Within 'personal responsibility' discourse people in crisis were afforded some power, to express their distress and decide whether or not to engage with what crisis staff offer. Staff were positioned as experts in terms of what interventions to offer. However, when an intervention had been offered staff were powerless as to whether service users engaged with this. This could legitimise practices to control service users, like restraint, the responsibility for these practices was placed with people in crisis for not engaging or being passive. For people who it had been difficult to help in crisis, staff were able to distance themselves from responsibility, as service users were positioned as having to engage. This led to not questioning current practices and what was offered to people.

'Limited resources for the scale of the problem' was a further discourse that positioned staff as experts yet without the resources to offer what was needed. People in crisis were positioned as those who have problems which can be too large for them to be helped by crisis services. For those with a BPD diagnosis, they were positioned as needing lots of resources for any change to occur. Staff cited that there are too many people with a BPD diagnosis for services to help them. Staff were in a position of having to 'turn people over' and unable to engage with some difficulties, such as social problems. Similarities could be drawn with the 'personal responsibility' discourse as staff referred to 'getting on with it', and not being able to or having the space to question current practices.

The discourse 'human experience and emotions' constructed people in crisis as humans in distress. It positions staff as people with emotions too, such as sadness that someone is still in distress when they return to the service. Some staff were concerned that feeling emotions or 'connecting' with too many service users could lead to their own emotions becoming too much, or them going 'insane'. They described a need for a 'thick skin'. With this fear practices like avoiding those who create strong emotions like people with a BPD diagnosis was legitimised. Some staff described noticing their emotions and using them to help understand people in crisis. Practices like 'being alongside' a service user in distress are legitimised without staff having to immediately treat them.

Clinical implications of this study were for crisis team staff to be afforded formal reflective spaces. These could enable staff to consider the flexibility of these discourses, to question current practice rather than position those, like those with BPD diagnosis, who the service finds difficult to help as responsible. Policy also needs to highlight improved ways of working with people with a BPD diagnosis in crisis. Improved policy could enable staff to feel they are doing valuable work despite some people not following the traditional route of the 'medical diagnostic' discourse. Increased training for working with people with BPD diagnosis may assist in staff coping with the emotions raised rather than practices like avoiding people.

Thank you for taking part. If you have any questions regarding the study or the findings then please feel free to contact me on the above email address.

Yours sincerely,

Robert Percival

Trainee Clinical Psychologist

Appendix M

This has been removed from the electronic copy

Appendix N

Summary Report for Salomons Ethics Panel

<u>End of Research Summary Report</u>

This research project was a Foucauldian Discourse Analysis of how staff in crisis services spoke about the people that they see in crisis. The objectives were to see how staff talked about those people they see in crisis, how this way of talking positioned people in crisis especially those with a diagnosis of borderline personality disorder and to consider the consequences of these positions for people in crisis.

Twelve staff members were interviewed. Five staff members were from home treatment teams, five from acute wards and two from day treatment services. Interviews lasted from 40 minutes to 75 minutes and were audio recorded and transcribed by the researcher. The six stage model of Foucauldian discourse analysis was used to analysis the interviews (Willig, 2008).

Four discourses were present in the transcripts. The main discourse was called 'medical diagnostic'. This discourse positioned staff as holding power and expertise, it drew on positivist discourse that there is a correct diagnosis and treatment for people which staff need to discover. Staff were in a position of assigning characteristics to people in crisis based on their diagnosis. People in crisis were positioned as passive and receiving treatment. Certain people were positioned as cases that should not be seen due to not being mentally ill. Social issues were viewed as not the role of crisis staff. People with a diagnosis of borderline personality disorder (BPD) were seen as not worthy of sympathy within the medical discourse and positioned differently to those with a 'classic mental illness'. Staff feel frustration that those with a BPD diagnosis return to services and do not feel they are able to help them from their position within the 'medical diagnostic discourse'.

Within 'personal responsibility' discourse people in crisis were afforded some power, to express their distress and decide whether or not to engage with what crisis staff offer. Staff were positioned as experts in terms of what interventions to offer. However, when an intervention had been offered staff were powerless as to whether service users engaged with this. This could legitimise practices to control service users, like restraint, the responsibility for these practices was placed with people in crisis for not engaging. For people who it had been difficult to help in crisis, staff were able to distance themselves from responsibility, placing this with people in crisis. A lack of questioning current practice was legitimised.

'Limited resources for the scale of the problem' positioned staff as experts yet without the resources to offer what was needed. People in crisis were positioned as those who have

problems too large to be helped by crisis services. For those with a BPD diagnosis, they were positioned as needing lots of resources for any change to occur. Staff cited that there are too many people with a BPD diagnosis for services to help them. Discharging people was justified by limited resources discourse and not questioning practice was again legitimised.

The discourse 'human experience and emotions' constructed people in crisis as humans in distress. It positions staff as people with emotions, such as sadness that someone is still in distress when they return to the service. Some staff were concerned that feeling emotions or connecting people in distress could be harmful for them. This fear legitimised practices like avoiding those who create strong emotions, like people with a BPD diagnosis. With people in crisis positioned as humans, practices like being alongside a service user in distress are legitimised without staff having to immediately treat them.

Clinical implications of this study were for crisis team staff to be afforded formal reflective spaces. These spaces allow staff to discuss the emotions involved in meeting people in crisis and their positions within these discourses. Policy needs to highlight improved ways of working with people with a BPD diagnosis in crisis. Policy and staff training needs to emphasise the importance of forming relationships with people in crisis to enable staff to feel they are doing beneficial work without having to immediately treat people.

I plan to disseminate the results of this study through publication in the British Psychological Society's journal 'Psychology and Psychotherapy: Theory, Research and Practice'.