

**A Collaborative Investigation of the Experiences
of Elders using an Older Adult Home Treatment
Team: From Understanding to Action**

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**A thesis submission in partial fulfilment of the requirements of the
University of East London for the degree of Professional Doctorate in
Clinical Psychology**

November 2020

Word Count: 28,122

ACKNOWLEDGEMENTS

I want to express my gratitude and thanks to Mike, Gerry, Marella, John and Len who made this project possible. I have been moved by the stories and by the commitment and support that you have given to the project. The experience of working alongside you has been both compelling and enriching.

I want to thank the Older Adult Crisis Resolution/Home Treatment team, who helped me with recruitment and were open to travelling this journey with me, and taking the experience openly and thoughtfully.

To Dr Maria Castro Romero, my thesis supervisor, for providing a creative space and seeking to find ways to make this project as collaborative as possible. To my fellow narrative peers, who showed solidarity and curiosity, and a reflective space where I could explore ideas.

To my dearest friends and family, who have supported and encouraged me when I struggled to believe in myself. Special thanks to my partner Ugo for being patient; my sister Diana for having faith in me; and to everyone who has been happy to provide a listening ear when this task has challenged me.

ABSTRACT

Introduction: Older Adult Crisis Resolution Home Treatment Teams (OA-CRHTT) have become more prominent in NHS services in recent years. The research on such services thus far has focused on the business aspect of measures, namely hospital admissions. There is no current evidence exploring the experiences of elders using these services, and how these services are perceived by elders.

Method: Five co-researchers were recruited from an OA-CRHTT in inner London, and agreed to engage in a Participatory Action Research (PAR) project. Narrative analysis was used to investigate how the co-researchers experienced support from the OA-CRHTT. A particular focus was paid to the element of action based on the findings of this research project. Narrative stories were created using a collaborative framework. The data was analysed by first creating personal narratives and then having a group collective statement based on these narratives.

Results: The interpretation from the personal narratives suggest that elders who have not had prior experience with mental health services require support in understanding the service and how it operates and what it is meant to provide, and that stigma played a role in perceptions of engaging with an acute community mental health team. Humanising care was reported as the main factor of what elders found as useful, with a need for understanding and good assessment to be achieved.

Discussion: Co-researchers each presented different aspects of what they found helpful about the service, steeped in their own context and experience of services. The need for dominant narratives regarding elders about the ability for services to be responsive to these was imperative. Implications for the research highlight the need for further investigation of elder views of the workings of CRHTT for elders, specifically hearing from people who are diagnosed with dementia, and elders from marginalised groups.

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List of Abbreviations

Below is a list of the most commonly used abbreviations in the current study.

CRHTT – Crisis Resolution Home Treatment Team

OA – Older Adults

PAR – Participatory Action Research

NA – Narrative Analysis

PPI – Patient and Public Involvement

NHS – National Health Service

CP – Clinical Psychologist

BME – Black and Minority Ethnicity

PREFACE

My curiosity in Older Adult Crisis Resolution Home Treatment Team (OA-CRHTT) arises from working in acute mental health services, and more recently as a clinical psychologist trainee. Before entering training, I had become aware of how power is disproportionately shared between the 'professional'¹ and the 'patient', and how reliant the public is on the information provided by 'medical professionals'. To inform the reader of how I have come to be influenced by experience, I provide some examples in Appendix A.

Coming into clinical psychology training, aware of the challenges caused by disproportionate power and lack of open communication in the relationship between the professional and the patient, it was refreshing to be presented with ideas from Liberation Psychology and Critical Community Psychology. These approaches, alongside my experience, have provided me with clarity about my values and ethical stance, and inform this research. The key concepts this thesis is based are the centrality of language, transparency and collaboration. I understand language to be a source of power, which positions us and others into dominant or subjugated roles. Here, I will use 'I' in this research, to indicate that my points of view are a reflection from a personal position, rather than a place of objectivity (Banister, 2011). Also, the term 'Elders' will be used instead of the more common term 'Older Adults' (OA). The term OA places elders in direct comparison to the 'working age' (WA) adult group, highlighting what is viewed in western society as the detrimental aspects of getting older. Contrastingly, Elder places emphasis on being a valued member of the community and being worthy of respect (Castro Romero, 2016).

Drawing on my values of transparency and collaboration, this is a Participatory Action Research project (Martin-Baró, 1996); recognising that individuals have knowledge about what works and finding ways to bring the service-users' experience and voice into practice and action.

¹ The terms professional and patient have been used with inverted commas to highlight that these terms hold particular meanings about roles within society and stereotypes that inform such roles. However, for ease of readability this will not be present throughout the remainder of the document.

This project focuses on an OA CRHTT due to the paucity of research in this area. Such a service is yet to be implemented nationally; however, there is evidence of growth in acute community services for elders (Toot, Devine, & Orrell, 2011). Therefore, research looking into the experiences of elders using this service would be clinically useful at this juncture.

1 INTRODUCTION

Mental health services for elders have long been neglected in policy planning within the UK's National Health Service (NHS), leading to underfunding and reduced specialist provision (Beecham et al., 2008). As the population of people aged over 65 is set to rise; so too are the projections for increases in depression and dementia within this age group (Royal College of Psychiatrists, 2018). Despite an awareness that the needs of elders are different from those of other age groups, many of the service models from specialist mental health adult services have been transferred to elders' services, without consultation with elders themselves.

Multiple government policies and statutory service documents identify that service-user participation in the mental health system is valuable and necessary, yet there are limited examples of its implementation in the literature. In this introduction, I argue that it is the role and responsibility of Clinical Psychologists (CP) to ensure that service-users are a pivotal part of the process of service development, in line with guidance from the British Psychological Society (British Psychological Society [BPS], 2012).

This chapter begins with an exploration of the context of elders in the UK; I will then discuss how participation can uphold high standards of services. Finally, I will critically review the literature for OA-CRHTT teams.

1.1 Context

The way in which knowledge is known and created is historically and culturally influenced (Gergen, 1973); therefore, psychological research should endeavour to acknowledge and incorporate the impact of contexts on the individual. This section provides an overview of the contexts of elders and health services in the UK, with specific focus on the historical, societal and political influences. To begin with, I will discuss who the term 'elder' refers to within this research.

1.1.1 Contextualising Elders

For the last 50 years, an individual in the UK met the threshold for the term elder at the age of 65, determined by the age at which men could collect their pensions (Hilton, 2015). Increases in life expectancy and a rise in birth rates during the 'baby boom' period mean that the number of people aged 65 years and older in 2017 increased to 18% of the population, and is due to increase to one in every four people by 2040 (Bloom, Kirby, & Scott, 2019). Pension ages for those currently defined as 'working-age adults' (those between the ages of 18-64), has recently risen to 68 years old, suggesting that the determined age to qualify as an elder is fluid and reliant on factors such as economic and health provision. Supporting this, NHS England identify that it is challenging to define elders by numerical age, as people can age at different rates (NHS England, n.d.). This research has recruited from an NHS OA service which uses the criteria of age 70 and above, for simplicity, this age threshold will be used in this research.

The definition of elders based solely on age, can homogenise people placed into this group, and negate further curiosity about other dimensions that they may hold (Lane, 2017). Elders, like other groups, are diverse in a variety of dimensions, such as class, ethnicity, gender, ability, educational background, wealth, religion, sexuality, and many other areas. Additionally, they also differ in generation, with the term elder given to people who fought in WWII, those that were evacuated as children during WWII, and people who were born into the post-war 'baby boom' generation who would have experienced the post-war benefits of NHS/welfare society: contributing to the different life experiences they may have had. Aspects of each of these dimensions connect each elder to different stories, identities and histories.

While widely varied as individuals, as a group, elders suffer from discrimination in the form of ageism. Ageism is one of the most common forms of discrimination in Europe (Abrams, Russell, Vauclair, & Swift, 2011). The next section identifies possible reasons why ageism is so prevalent in our society, and how dominant discourses about elders' impacts on the health care they receive.

1.1.2 Dominant Discourses about Elders

White and Epston (1990) highlight that as individuals, we do not live in a vacuum and are impacted by our context, including stories that are told and stories that we tell about ourselves and others. Unlike other characteristics, our age changes through time. Hence, stories that we hear, or tell, about elders as children or adults can become solidified by the time we become elders (Bennett & Gaines, 2010). We establish ideas of what it is to be an elder, what elders do, how elders feel, long before we have reached that stage in our lives.

Prilleltensky & Nelson (2009) state that 'In individualistic societies, disadvantaged people often internalise the dominant cultural narratives, which hold individuals responsible for the problems they experience, leading to self-blame or denigration' (p.136), highlighting how the strength of dominant cultural narratives can impact the individual. Two examples of dominant discourses regarding elders are discussed below.

1.1.2.1 *Burden*

Elders have been systematically marginalised since the emergence of the industrial revolution and capitalism (Phillipson, 1982). The value of a person within a capitalist society is measured by their productivity, accumulation of wealth, and labour-power. However, as elders historically were forced to retire at a certain age, they are viewed as no longer 'contributing' to the welfare system. Additionally, others perceive that elders use more health and social care services. Political ideologies place emphasis on the distribution of the country's wealth to the electorate, creating conflict between different groups about who is deserving and 'puts in' to the systems, and who 'gets something out' of the system in an improper way. In the media, elders are described as 'bed blockers,' with articles headlined with 'Bed blocking by Elderly patients rises' (Daily Mail, n.d). Headlines like this fuel the dominant discourse that elders are a 'drain' on resources, although the article discusses the lack of funds to provide sufficient services for elders, the headlines suggest that the fault lies within elders, and not with social structures, such as the government.

The widely held view that elders are an economic burden to society is countered by statistics about the economic wealth they create (Age UK, 2019); people aged over the age of 65 contribute almost 160 billion a year to the UK

economy through employment (54 bn), informal caring (95 bn), volunteering (3 bn) and informal childcare (7.7 bn).

1.1.2.2 Natural Decline

The natural decline discourse suggests that a natural degeneration of physical and mental health is common to all persons in older age (Hilton, 2015). It proposes that mental health problems are an inevitable part of ageing (Moriarty, 2005). Elders are more likely to be exposed to life events such as retirement, loss, and on-set of a long-term health condition, which are all possible triggers of mental health difficulties. If we hold the view that decline is inevitable, it encourages the stance that interventions and preventative measures are unnecessary. For years, this resulted in the lack of recognition of common mental health difficulties amongst elders (Mortimer & Green, 2015).

Moreover, this discourse has fuelled beliefs that elders will all experience intellectual limitations that prevent them from being capable of making decisions about themselves (Crawford & Walker, 2004). Demonstrating the widespread prevalence of this discourse a recent study found that 40% of young people (aged 18-24) reported that there is no way to escape dementia when getting old (Royal Society for Public Health, 2018).

The World Health Organisation (2013) reported that mental health and many common mental health problems are, in fact, shaped to a great extent by the social, economic, and physical environments in which people live. The social determinant model of mental health accepts that while some older people will experience mental health from organic or physiological causes, it is often a combination of social conditions and personal attributes that comprise elders' mental health. The following section explores the impact of dominant discourses within healthcare in the UK.

1.1.3 NHS Mental Health Care and Elders: A Historical Perspective

Historically, Geriatric medicine has commonly been viewed as inferior to other areas, as noted by one clinician, who worked in the 1950s as a psychiatrist:

Because there was no interest in them, it fell to the most junior doctor to go there once a week to see if anyone needed to have their chest listened to. The most neglected parts of any mental hospital were the old age wards.

(Hilton, 2015:185)

With such views so prevalent, it is perhaps no coincidence that people under the 'double jeopardy' of both old age and mental health experienced such high levels of neglect in the first years of the NHS (Graham et al., 2003). In both significant reforms of the NHS, in the early 1970s and then again in the millennium, several policy documents were published for the areas of mental health and older adult health separately (Department of Health and Social Security, 1971:1972; Department of Health, 1999:2001). This separation resulted in separate streams of funding for elders' mental health care, which led to severe underfunding of services for elders. Paradoxically, the National Service Framework documents (DoH 1999:2001) highlight the need for equality of services, while also reinforcing structural ageism which allowed the provision for elders with mental health difficulties to fall through the gaps.

1.1.4 Equality Act

The introduction of the Equality Act 2010, made it illegal to discriminate based on age, as well as other protected characteristics. A section of the Equality Act describes the responsibilities of people working within the public sector as having a Public Sector Equality Duty (PSED), which obliges public sector services to both avoid discrimination and promote positive equality and foster good relations between groups (Hill, 2011). To promote anti-discrimination practices, organisations have to look at both the internal landscape of the individual practitioner (attitudes and beliefs), and the external landscape of the organisation (social structures, systems, processes, organisational policies) (Okitikpi & Aymer 2010). For example, the MacPherson report (MacPherson, 1999) stressed the impact of organisational racism within the Metropolitan Police: demonstrating that public service organisations can nurture discriminatory practices through their systems, cultures, and processes. Similarly, elders have been denied the same access to mental health services

in comparison to WA adults due to structural policies and frameworks that are established in the NHS.

There have been debates on whether the treatment of elders with mental health difficulties should be incorporated into existing adult services, or if specialist services should be developed. The Royal College of Psychiatrists (2018) states that age-specific services which employ people with specialist skills in this area, produce better outcomes. Several services, such as CRHTT, Early Intervention Teams, and Assertive Outreach Team, have been rolled out nationally for WA adults, but not elders.

CRHTT teams were introduced for WA adults to provide an alternative to acute psychiatric admission, by creating an acute psychiatric community team which would provide intensive home treatment: the teams aim to provide 24/7 access and can visit people at home up to twice a day depending on need (Johnson et al., 2005). During such visits, the CRHTT aims to provide coping strategies, address social and family stressors and re-engage or enhance engagement with support networks with the aim of alleviating the mental health crisis (Streater, Coleston-Shields, Yates, Stanyon, & Orrell, 2017). To create services that would bring the NHS in concordance with the Equality Act on the issue of Age would cost an additional 2 billion per year, which made up one-seventh of the NHS annual mental health budget (Beecham et al., 2008).

The Five Year Forward View (2016), sets out government targets for health care provision, including mental health care. Nonetheless, elders' mental health seems to have been left behind, with little focus given to thinking about the specific needs of this group (Royal College of Psychiatrists, 2018). Despite surging need in this area, legislation making it unlawful to discriminate, and awareness of ageism as a source of discrimination, it is somehow still possible to have a mental health care service for elders which is underfunded, has declining access and relies on where a person lives, i.e., the postcode lottery of services (Age UK, 2019).

In summary, this section has demonstrated how societal discourse of ageing marginalises elders, by promoting discriminatory ageist attitudes that highlight a

narrow view of ageing, and subjugate positive discourses of elders which demonstrating their value, their resilience, and their many contributions in our society.

To ensure that structural discrimination that permeates our society is tackled; ways of creating alternative discourses and bringing in the perspective of elders need to be established. Liberation psychology (Martin-Baró, 1996), suggests that this be achieved by siding with the marginalised groups to support an equal society and creating opportunities for participatory praxis which would support such an endeavour. The next section discusses the concept of participation and its emergence within mental health care.

1.2 Participation

The importance of participation in creating knowledge, reducing inequalities, and developing services within NHS mental health services has long been established. It was heavily influenced by the Service User Movement, who brought focus for further equality in care, challenging professional knowledge, and the emergence of knowledge by experience (Ehrenreich, 1978; Watkin, 1987). Alongside the development of the Service User Movement was the rise of Patient Participation Involvement (PPI) groups begun by General Practitioners; in response to public needs by using service-user experience to improve services, influenced by consumerism (McEwen, Martini, & Wilkins, 1983). The use of participation in NHS Commissioning has now become embedded in NHS policy, making it a legal requirement under the National Health Service Act 2006 (NHS England, 2017).

The concept of participation, and what it refers to, is so widespread that it has been described as encompassing 'everything and nothing' (Croft & Beresford, 1992). This research will utilise the definition produced by Ocloo & Matthews (2016), who describes it as an activity that is done 'with' or 'by,' not 'for' 'about' or 'to.' The choosing of this definition is heavily influenced by my own interests in Liberation psychology. The next section will review the connection between

participation and liberation psychology, and how this translates to how research can be conducive to creating knowledge from a bottom-up perspective.

1.2.1 Liberation Psychology and Participation

'A psychology that works for and with people involves participation.....with psychologists and researchers engaging in the co-creation of knowledge, strategies and interventions with participants in specific context' (Moane, 1999 p.194), this statement highlights the prominence that is placed on participation in a Liberation Psychology theology. Liberation psychology aligns with a critical psychology perspective, promoting the use of psychological theory and tools to benefit people considered to be marginalised or oppressed (Martin-Baró, 1996). It is practised throughout the world and is present in the writings of feminist theologians (Chesler, 1972; Miller, 1986; Moane, 1999), and black liberation theologians (Hooks, 1993), and community psychologists (Montero & Sonn, 2009). One of the most influential writers of Liberation Psychology was Martin-Baró; in his role as a Jesuit priest and social psychologist in El Salvador, he highlighted the needs of the people in the state of war and oppression during the latter part of the twentieth century. Martin-Baró was heavily influenced by Freire's (1970) critical pedagogy of education, specifically the concept of *conscientización*; the process of personal and social transformation, by persons developing critical awareness of one's social reality through dialogue with others based on cycles of reflection and action (*praxis*).

Martin-Baró established three ways the discipline of psychology could change to bring about a source of transformation, rather than a source of conformity. Firstly, a *new horizon*, working on systems that impact the individual and not just on the individuals themselves, acknowledging and placing into context how the collective can influence personal distress. This addressed the individualising nature of psychiatry and psychology at the time, asking psychologists to look at broader themes rather than individual pathology. Second, a *new epistemology*, to understand the world from the perspective of the dominated, not from the view of the dominator. He asks 'what would clinical psychology look like from the perspective of the marginalised?' 'Where we stand determines what we see, and what we define as the problem' (Martin-Baró, 1996 p.14). It is these

concepts that draw heavily on participation, by placing emphasis on creating knowledge from a bottom-up approach, and the importance of entering into a true dialogue with people from marginalised communities to identify what requires change. Finally, he identifies *a new praxis*, stating that it is not enough for psychologists to place themselves in the perspective of other people, we should enter into a new praxis with the marginalised. He states that psychologists cannot be objective, but are subjective and should use this bias to stand alongside people who are marginalised. This highlights that information derived from psychological research is heavily biased by the position a researcher holds. This also demonstrates the need for psychological research to be rounded, allowing the contribution of many perspectives, but highlights the need to place the perspective of the marginalised as central. The essence of liberation theologies is to start from the place of experience for theological reflection and build on this (Todd, 2011).

As identified in Afuape, Hughes, & Patel,(2016), several considerations need addressing when working toward a liberation psychology framework. For instance, true transformation cannot occur by interventions aimed at the micro-level of human interaction only; they need to infiltrate the macro-level structures also. Additionally, the power relationship between the 'liberator' and 'liberated' requires constant reflection, who determines who needs to be liberated from what, and who has the power to make this decision. Liberation psychology has been influential in re-focusing the nature of what psychologists do, and importantly, how it is done; however, if true dialogue is to occur the question of power needs examining. To start, this can be demonstrated by the person with power openly listening to the views of the marginalised (Moane, 1999). The next section will identify models of how participation can be conceptualised on a practical basis.

1.2.2 Models of Participation

Arnstein (1969) argues that participation allows those marginalised in society to join in to determine how information is shared, how services operate, and how resources are allocated. His model splits eight levels of participation into three groups: non-participation, degrees of tokenism, and degrees of citizen power (Figure 1).

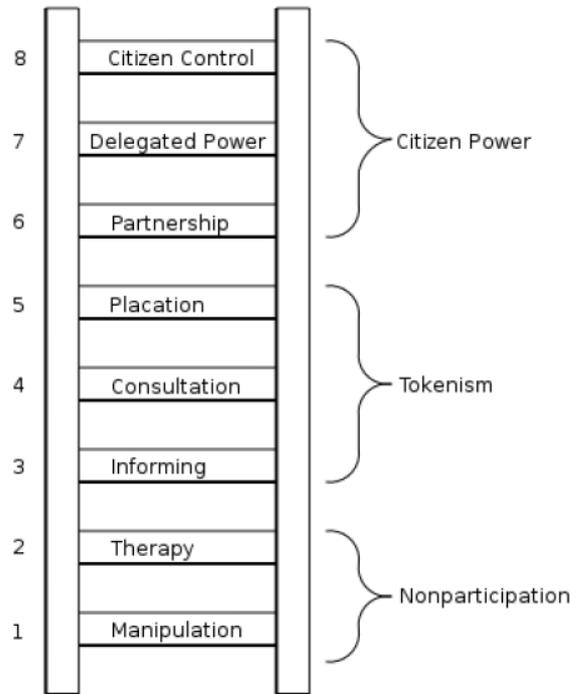


Figure 1. Arnstein (1969) model of citizen participation

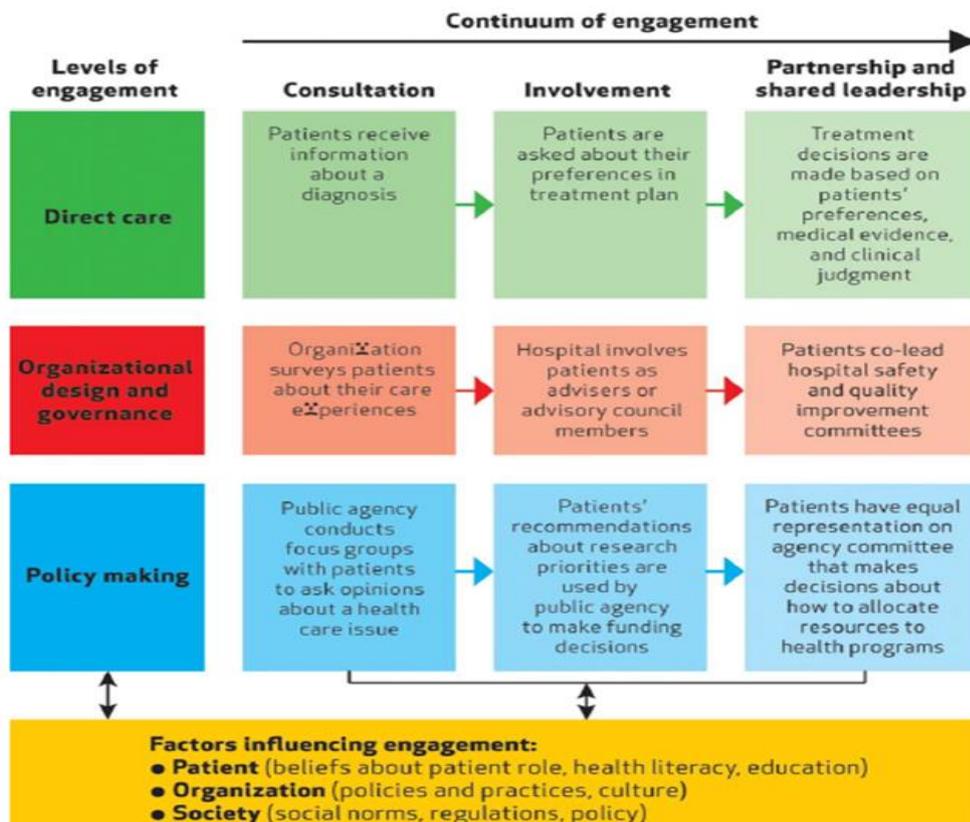


Figure 2. Carman et al. (2013). Framework of participation

Arnstein (1969) acknowledged that the model places powerless citizens and the influential citizens at opposite ends, to highlight the division that lies between them, such as power and resources. Additionally, it highlights that people in power might give positions to those in marginalised communities at any point on the ladder, but real engagement is heavily influenced by the motives that drive them. User-led research is highly valuable and has changed knowledge by the process of changing the method in which knowledge is created. Good examples of this have been demonstrated by the Service-user Research Enterprise (SURE) in their work on reviewing the literature on ECT and patient-generated outcome measures for acute care (Rose, 2014). A question that lives within the realms of service-user involvement is: What is the eventual aim? It is argued that models of participation which emphasise the endpoint as 'user control' fail to take account of the experience and knowledge of health and social care staff (Benbow, 2012a; Tritter & McCallum, 2006). Carmen et al. (2013) developed a framework of participation specifically for the healthcare environment, which separates the different areas service-users and their families may engage in participation (e.g., direct care, organisational design, and governance, policy-making), along a continuum of engagement, which leads towards 'partnership and shared leadership' as the ultimate level of engagement (Figure 2). This matrix framework is sensitive to the 'shared' nature of knowledge that is created between service providers and service-users while incorporating factors that impact on engagement/participation.

1.2.3 Participation and Elders

Academics and policymakers are now committed to user involvement of elders to ensure that research questions and methods meet their needs (Bindels, Baur, Cox, Heijing, & Abma, 2013). Nevertheless, within the health care systems, elders are marginalised, not just from the strategic and operational decisions regarding elder mental health care, but regarding decisions about their direct care (Audit Commission, 2000; 2002). The dearth of elders in the service user movement is evident by their absence from a survey of service user movements in the early twenty-first century (Wallcroft, Read, & Sweeney, 2003). Issues raised by service-user movements at that time, such as employment and detention under the Mental Health Act, were not associated

with elders needs, providing a possible explanation to elder scarcity (Benbow, 2012b). That such movements are often associated with increased activity, and therefore associated with youth rather than elders, as people perceive elders lacking the energy to take part (Castro Romero, 2016), or simply because old age is associated with lack of activity (Social Care Institute for Excellence, [SCIE], 2004), may also contribute to our understanding.

The benefits to elders of participation, in all its various forms, has been evidenced. In a review of 30 studies, Fudge, Wolfe, C, D, & McKeivitt, (2007) found such benefits include increased knowledge, empowering elders to be active in their local community, awareness and confidence, and meeting others in similar situations. Relating to the links of marginalised communities, the participation of elders within research about elder healthcare also provides access to seldom heard views (Blair & Minkler, 2009). However, drawbacks to engagement have been identified; the power imbalance between 'researcher' and the 'researched', with concerns that the need for service-user input outweighs the practical implications of their involvement and the reality of that involvement, which may add further to their oppression (Doyle & Timonen, 2009). There also appears to be a notable exclusion of groups of elders, specifically those from Black and Minority Ethnic (BME) populations and elders diagnosed with dementia (Littlechild, Tanner, & Hall, 2015).

There have been examples of the use of PAR with elders in the health and social care context: Baker and Wang (2006) conducted a photovoice study focused on the experiences of elders with chronic pain. From their reflections, they have advised when conducting participatory research with elders to limit the number of phases to improve attrition rates and accommodating people with physical health conditions that may make coming together as a group more challenging. Reed, Cook, Bolter, & Douglas, (2006) provide recommendations for the involvement of elders in the co-researcher role which include: making the project exciting and purposeful, be clear about expectations, try to avoid jargon, have different ways for people to take part, and offering practical support.

1.3 Literature Review - Review of Older Adult CRHTT teams

A systematic database search was performed to inform this narrative literature review. A search of CINAL, PsychArticles, PsychInfo, and Scopus was performed using a subject term search with terms synonymous with 'crisis resolution team,' combined with the term 'elder', between July 2019 and September 2019. A total of 22 papers were identified via EBSCO and 43 articles via Scopus. The titles were first checked for relevance, after which a review of the abstracts was conducted. Google Scholar and Research Gate were also searched using similar terms. Reference and citations were also checked for relevant papers. Appendix B provides a detailed account of the search, including terms used and limiters applied.

1.3.1. Older Adult Crisis Resolution/Home Treatment Teams

In comparison to WA-CRHTT, there is less provision dedicated to OA-CRHTT teams across the UK, specifically for elders suffering from dementia (Streater, Coleston-Shields, Yates, Stanyon, & Orrell, 2017). An example of the types of intervention offered by an OA-CRHTT, and a care pathway, is demonstrated in Figure 3. In recent years the provision of acute community services for elders has increased (Toot et al., 2011), yet there is a lack of consistency on how these services develop and what they offer. Streater et al., (2017) conducted a scoping review of OA community teams offering crisis services for people diagnosed with dementia in England, and identified a potential 234 individual services; of which 57 team managers provided a partial or full response. Responses identified the array of services established; from Home Treatment Teams (HTT) to dementia and intensive support team, memory services, dementia crisis support, dementia rapid response, intensive recovery service; all of which differed in their delivery, policy and procedures. WA-CRHTT use the Home Treatment Accreditation Scheme (Baugh, Blanchard, Hopkins, & Singh, 2019) as a method of maintaining standards. However, OA-CRHTT does not use such a system; therefore, it is difficult to identify what they should offer and how their performance can be reviewed.

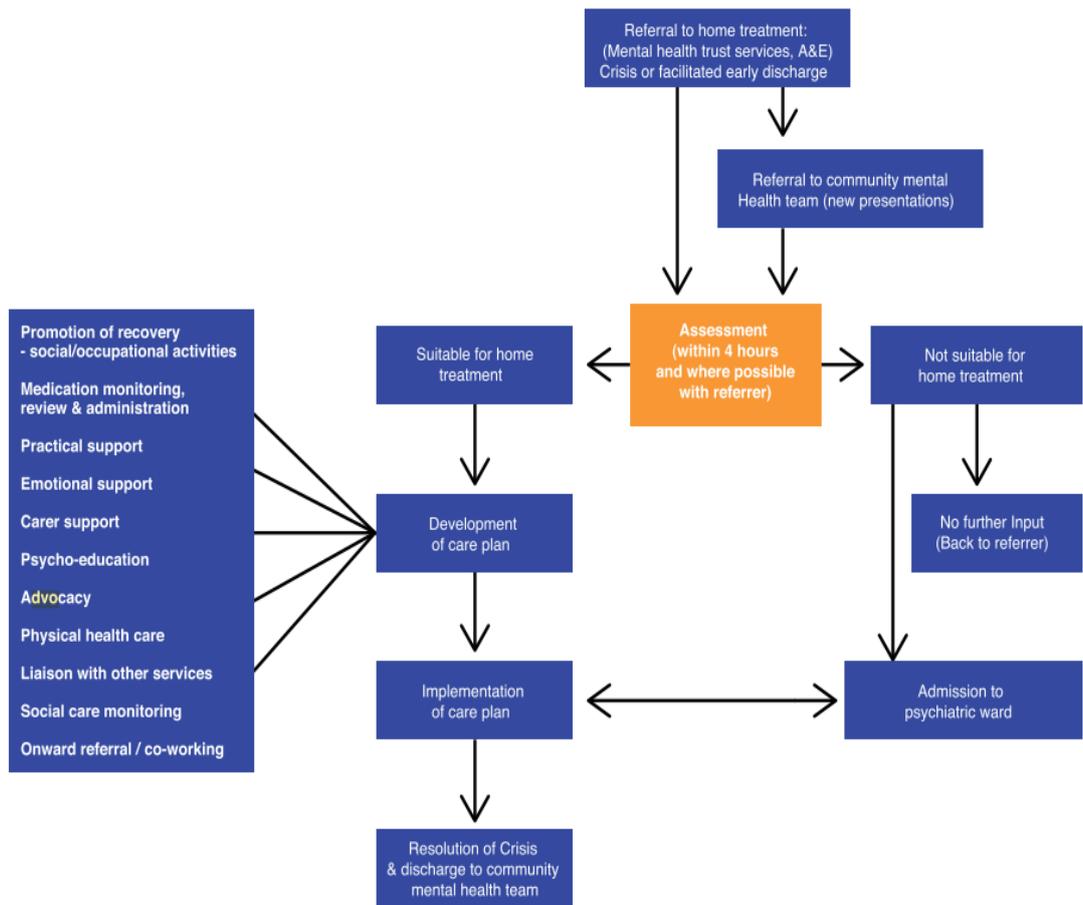


Figure 3. Mills (2012) model of OA-CRHTT

1.3.2. Integration vs Specialism

One significant difference in the current provision is between teams that provide all-age care versus specialist services for elders. There is a concern about the limited numbers of elders accessing all-age CRHTT services (Regan & Cooper, 2008). A survey conducted in 2008, found that from 17 CRHTT providing ‘all-age’ services, five had elders on their caseload, and only two teams provided services for people with dementia (Regan & Cooper, 2008). Staff in WA-CRHTT may be less likely to think about promoting their service to elders. Additionally, people might not expect the service to be open to elders and therefore create fewer referrals. Societal expectations may also have an impact, as, within the UK context, many elders move from independent living into hospitals and care homes, and there has been less emphasis on supporting elders in their homes. However, benefits of supporting elders in the home environment have been

identified, such as preventing further decline in health and dependence, supporting elders to retain a sense of control and belonging by remaining in familiar surroundings (Caplan et al., 1999).

The Joint Commissioning Panel for Mental Health (2013), recommended that elders have equitable access to CRHTT teams as WA adults but advised that this should be delivered by staff specially trained to work alongside elders, skills which might be underdeveloped without pre-existing experience. Mental health professionals working with elders need to consider the following factors: reliance on family support rather than mental health services, less likely to ask for help even when it is offered (Meeks & Murrell, 1997); increased focus on carer support, increased liaison with GP's and secondary health care in preventing physical illness as a cause of admission (McNab, Smith, & Minardi, 2006), and supporting placements in care homes in the community (Regan & Cooper, 2008). Consequently, the care provided to elders should be substantially different from that provided for WA adults or children.

The discussion of integration vs specialism is focused on the topic of age, e.g., should services be 'all-age' or 'age-specific'; however, less focus was found in the literature on another dichotomy, between organic and non-organic mental health difficulties. On the one hand, the purpose of a CRHTT is to prevent psychiatric inpatient admissions; therefore because many people diagnosed with dementia are in psychiatric inpatient environments, it seems equitable that they have access to a service such as CRHTT. On the other hand, the needs of people diagnosed with dementia are different from an elder suffering from depression, consequently may require more specialist support. Therefore, there is an argument to further research if OA-CRHTT fully meets the needs of both groups, or if there needs to be further consideration of care pathways for elders.

1.3.3. Evidence of Effectiveness

There is limited research on the effectiveness of specialist OA-CRHTT's, with research that is available in the form of cohort studies (Dibben, Saeed, Stagias, Khandaker, & Rubinsztein, 2008; Ratna, 1982; Sadiq, Chapman, & Mahadun, 2009; Villars et al., 2013), descriptive studies (McNab, Smith, & Minardi, 2006;

Richman, Wilson, Scally, Edwards, & Wood, 2003) or audit (Fraser, Clark, Benbow, Williams, & Burchess, 2009). This section will report on the impact of OA-CRHTT in the main areas measured: number of admissions, length of admission, and symptom reduction.

The number of in-patient admissions to a psychiatric hospital is the most widely reported measure in the literature reviewed (Dibben et al., 2008; McNab et al., 2006; Ratna, 1982; Richman et al., 2003; Sadiq et al., 2009). All four studies suggest that an OA-CRHTT reduces the number of inpatient admissions in comparison to the number of admissions before the service began, or in comparison to a similar service in another area. Ratna's (1982) cohort study suggests that the introduction of an OA-CRHTT was able to increase the likelihood of people staying at home during a psychiatric crisis from between 12-46%. However, the comparable data was taken from a different part of the country, in a different decade and therefore is not valid as a direct comparison. Using data from pre and post setup of an OA-CRHTT service, inpatient admissions for elders contracted between 20 – 40% (Dibben et al., 2008; McNab et al., 2006; Sadiq et al., 2009). Richman et al. (2003) reported that an OA-CRHTT was able to prevent 30 potential hospital admissions in five months. It is of note that each of these studies varied in the length of time for data collection (ranging between six months and a year) and that each study used a different model of OA-CRHTT (either as an extension of a WA-CRHTT, inclusion/exclusion of people diagnosed with dementia, hours of availability). All four of these studies reported that the setup of an OA-CRHTT provision occurred at the same time as closures for other services for elders (OA inpatient beds, and day centres) therefore it may be challenging to ascertain if the changes were solely due to the introduction of a new OA-CRHTT, or because of a reduction in capacity elsewhere in the system.

The length of inpatient admission can be impacted by OA-CRHTT in two ways, by delaying admission or by creating opportunities for early discharge. Three studies reported on the length of admissions after the introduction of OA-CRHTT (Dibben et al., 2008; Fraser et al., 2009; Sadiq et al., 2009). Two reported that access to an OA-CRHTT resulted in no change to the length of admission (Dibben et al., 2008; Sadiq et al., 2009), and Fraser et al. (2009)

reported that only 3% of inpatient discharges were referred to the OA-CRHTT. Based on this information, OA-CRHTT appears to make no difference in the length of inpatient admissions.

Symptom reduction as a measurement was used in one study conducted in Florida (Cohen & King-Kallimani, 2011). This study is one of the few reports of an OA-CRHTT service from outside of England; it has a different model of care where the average length of intervention is 18 weeks and does not include elders diagnosed with dementia. From a sample of 42 elders treated by this service, there was a significant reduction in psychiatric symptoms measured by the Brief Psychiatric Rating Scale (BPRS)(where lower scores indicate less psychiatric difficulties) from assessment (10.3 ± 5.1) to discharge (5.0 ± 3.9); a statistically significant decrease of 5.3, $t(42) = 0.34$, $p < .0.005$.

In understanding what is meant by the term effectiveness, we need to identify how it is measured; taking a critical look at this may highlight the organisational focus, and how organisation structure may be contributing to discrimination (Castro Romero, 2017). In the main, papers reporting on effectiveness measure this in business terms; the number of admissions, or the length of stay in hospital. The value that is placed on these measures represented what the researchers, and possibly commissioners believe to be necessary. The aim to reduce hospital admissions is likely to be desirable, as it leads to maintaining skills and independence. Nevertheless, it is also representative of a business model, which ascertains that providing care at home is a cheaper form of care. Here, effectiveness is measured in a functionalist and economic framework, rather than one that places humanising at the forefront of care. Interestingly, the literature search found few examples of specialist OA-CRHTT or a variation of such teams in other countries, possibly due to multiple terms that are used to describe such teams. However, the study from the USA was the only to report on symptom reduction, whereas all studies from the UK, included information on hospital admissions. The reduction in the number of admissions tells us little about the reduction in symptoms for individual elders; instead, it suggests the acuity of the presentation of some elders was managed in the community.

What factors should we consider when exploring if a service is effective, and serves a useful purpose for the people that will use it? Is it about providing ‘best and dignified care’ (Regan & Cooper, 2008), or about keeping to the standards set, such as standard seven of the National Service Framework – promoting the independence of elders with mental health problems (Obinwa, Goel, & Sule, 2010)? Or is it about gaining knowledge about what works best for whom and presenting these options? It is not just about the questions, but how they are framed and who the respondents are. As there was no qualitative research reviewing the experience of elders using an OA-CRHTT found in the literature, the following section provides an overview of common themes identified in research conducted for WA-CRHTT.

1.3.4. Qualitative Research

There are multiple studies which have explored the service-user experience in WA-CRHTT (Carpenter & Tracy, 2015; Hopkins & Niemiec, 2007; Klevan, Karlsson, & Ruud, 2017; Morant et al., 2017; Nelson, Miller, & Ashman, 2016), as well as investigations into what service-users wanted from a crisis service (Lyons, Hopley, Burton, & Horrocks, 2009), and studies that have been user-led (Middleton, Shaw, Collier, Purser, & Ferguson, 2011; Taylor, Abbott, & Hardy, 2012). A review of the aforementioned studies identified factors seen as helpful in a crisis, alongside factors that could be improved.

One of the most widely reported factors perceived as helpful is the humanising way in which care was delivered. Humanisation refers to ‘practices that take the perspectives and values of people who are part of the practice into consideration’ (Visse, 2012). A sense of feeling understood as ‘normal human beings’ (Winness et al., 2010), appeared necessary in such a challenging, and at times chaotic, period of life. Again, studies that were user-led also noted humanising as an important factor in a helpful interaction, alongside being able to maintain consistency with the staff and information regarding their symptoms (Taylor et al., 2012). One case study highlights the importance for service users to retain some power when interacting with mental health services, which can be more challenging in an inpatient environment. Here, CRHTT clinicians were

able to share power which appeared to mediate the effect of feeling safe, accepted and understood (Nelson et al., 2016).

Other aspects that reoccurred in the literature for WA-CRHTT as helpful in a crisis were the rapid access to the service (Carpenter & Tracy, 2015), with same day response seen as ideal (Morant et al., 2017). This might lend itself to the acuity of a mental health crisis and wanting immediate healthcare assistance, and CRHTT being easier to access than hospital care (Winness et al., 2010). Rapid access to a service is likely to reduce the impact of further stress that can at times be caused when waiting for help (Winness et al., 2010). Additional research identified the issues that can arise from having a workforce that work on a shift rotation (due to the 24hr access of CRHTT), specifically that being seen by large numbers of people and having a lack of consistency in care can be problematic (Carpenter & Tracy, 2015), especially if it is felt that staff have not communicated effectively with one another about the care plan, or if the staff member was unaware of the details of the individuals presentation. Replicating results found elsewhere in mental health literature, the quality of the interaction for service users appears of utmost importance.

1.4. Relevance to clinical psychology

A number of reasons justify the relevance of this study to Clinical Psychology. Firstly, it is the role of CPs to support quality improvement and service development in acute services (BPS, 2012), which can be achieved by investigative research. The literature review highlighted that the majority of the literature on OA-CRHTT thus far is being completed by nursing and psychiatry professionals, with CPs distinctively lacking contribution. There are currently no specific policies requiring services to implement specialist OA-CRHTT; therefore it is vital to have contributions from all professions so a more enriched discussion can take place if such policies are considered in the future.

Secondly, thus far, the research literature regarding OA-CRHTT in the UK context has mainly focused on business and economic arguments when thinking about the usefulness of OA-CRHTT. Psychology can provide a

humanising context to service provision by positioning the view of the service user as central to the research. Involving service-user views can support acute teams to develop and maintain a holistic philosophy, based on the values of care, rather than the structures of care (Relton & Thomas, 2002) . The service-user perspective is multidimensional; however, reoccurring themes of the benefits of service-user involvement include the provision of alternative perspectives on the understanding of mental health, therapy, social inclusion and power (Tait & Lester, 2005).

Finally, the role of a CP working in acute psychology is primarily focused on supporting the multidisciplinary team (MDT) in their work, through training, reflective practice and consultation. The information gained through this research can be incorporated into the development of these interventions.

1.5. Research Aims and Questions

1.5.1. Aims

This study aims to develop ways of understanding and to share knowledge, of an OA-CRHTT through actively involving elders in the research process and creating spaces for dialogue and praxis, leading to conscientización and action. Findings from this study aim to influence how SU perspectives can be incorporated and developed into working OA-CRHTT practice.

1.5.2. Research Questions

This research is guided by PAR methodology; therefore the research questions have a focus on practical issues and problems (Stainton Rogers, 2009), and are broad so that they can be subject to further investigation in collaboration with the co-researchers.

1. How was the intervention provided by the OA-CRHTT perceived by the elders?
2. Did any aspects of the intervention help resolve the 'crisis'?
3. What could be done differently to improve the service?

2. METHODOLOGY

This chapter describes my rationale for choosing PAR as a guiding methodology (Martín-Baró, 1994). I outline how using a Pragmatic approach, alongside Axiology, I am able to keep a focus on the participatory and action aspects of the research. The process of coming to a decision about the type of analysis used is discussed and how this integrates with a PAR methodology. The procedure of making research decisions will be outlined, with details of the relationships between myself and the co-researchers.

2.1. Research Design

2.1.1. Research Paradigms

The chosen area of inquiry and the method of carrying out research are often guided by research paradigms: a set of beliefs or a group of ideas that guides ways of thinking about or viewing the world (Killam, 2013). These paradigms stem from philosophical debates regarding the nature of reality (ontology), and what knowledge is possible to know (epistemology). Carter and Little (2007) describe Epistemology as a justification of knowledge; stating your position on what knowledge is possible to know, and how can we obtain it. One of the central debates between different epistemologies is ‘...the extent to which qualitative data are seen as mirroring and reflecting reality’ (Harper, 2012:87). This is known as the realist – relativism debate. Guba and Lincoln (1994) presented four research paradigms; positivist, post-positivist, critical theory, constructionist. These move from a positive/realist position at one end of the spectrum, which suggest there to be one reality that can be objectively studied, to constructionism at the other end of the spectrum. Constructionist ideas are relativist, in that they believe that there can be multiple realities which are co-constructed with others (Burr, 2015). Although the positioning of psychological research is dominantly held by the epistemological paradigm, it has been difficult to ‘fit’ such a paradigm to this project. Epistemological positions do not provide an adequate explanation of the researchers’ stance and relationship to the research inquiry. Firstly, choosing an epistemological stance is a choice.

The presentation of the stance may create coherent associations between the methodology, methods and analysis, but it does not address why such an epistemological position is chosen (Harper, 2012). Moreover, a focus on epistemology allows for neglect of other factors, which will also have an influence on the research inquiry process, such as the intended audience, available resources, the values of the researcher, and supervisor of the research (Priebe & Slade, 2006). Lastly, it reduces the ability to be fluid within the research process, as it ties the researcher into a position of constraint, which may not align with the function of the actual research. The following section will present how my values have impacted on the design of this research. It will also present an alternative paradigm, pragmatism, and offer explanations as to why this paradigm was selected.

2.1.2. Axiology

The term 'axiology' in regards to research refers to 'what the researcher believes is valuable and ethical' (Killam, 2013). I will present how my values of transparency, commitment to action, social justice, and collaboration, have been influential in the research methodology.

2.1.2.1. *Transparency*

My clinical work is strongly influenced by a belief in the importance of transparency. To be transparent is not just to be honest about your position but also what informs your decisions. It allows for trust to develop between people and demonstrates respect for an individual's ability to make their own choices.

2.1.2.2. *Commitment to action*

In a research context, I believe in creating change when the status quo is identified as inadequate. I accept the essential task of thinking before taking action but identify that thinking without consequential action is negligent in the arena of health care. This stance is influenced by Freire, (1970) notion of praxis vs blah blah blah, where praxis is the n

otion of reflection and action, and 'blah blah blah,' represents words with no meaning.

2.1.2.3. *Social justice*

I have experienced and witnessed the impact of poverty, classism, racism, sexism, and stigma. Although I am now a part of some dominant groups, it takes only a moment to recollect the feeling of being marginalised, the feeling of having to fight for what others seem to have so easily, and being disheartened by numerous challenges it would require for my peers and I to succeed. It would be presumptuous for me to assert that other people who would be considered as belonging to marginalised groups have experienced the same feelings, but my own experience is what spurs my commitment to creating a community that promotes social justice.

2.1.2.4. *Collaboration*

How can we know what skills people have, what people view as necessary, what it is that is needed to improve services if we do not ask and be fully open and willing to act on people's responses to our questions? Collaboration is a value I draw from my reading on critical adult pedagogy (Freire, 1970), through which I have learned the necessity of collaboration in assisting change.

2.1.3. Pragmatism

Several factors were considered when choosing a pragmatic approach. Pragmatism is an alternative paradigm from epistemology. Where epistemology is focused on 'how, and what, can we know?' (Willig, 2008:8) Pragmatism is focused on 'What is this for? What do I want to do here? What is the best way I can go about this?' (Jones Chester, 2007). There is an emphasis on what works, but also a more in-depth enquiry into consequences and meanings of actions, where actions can be examined and reflected upon (Denzin, 2012). Actions and change are fundamental aspects of pragmatist research. The focus on action lends itself to the PAR component of this project. It is vital to ensure that a focus toward action be consistent throughout the research, but also due to the nature of PAR, the potential to take a more flexible approach to research to ensure that co-researchers views could be incorporated without the constraints applied when working within an epistemological position.

In addition, in recent times, there has been a move by neo-pragmatists who highlight the need for an interpretive approach that is explicitly anti-positivist and

places great emphasis on contextual influences (Denzin, 2012). There is also an acknowledgement that all research activity is connected to the political. This sits alongside liberation theory by standing beside people that are marginalised and thinking about what will work best for the improvement of that situation using a collaborative and bottom-up approach.

2.1.4. Participatory Action Research

PAR was chosen as a guiding methodology² for this research as it brings together a framework for conducting research which joins practice, theory, and experience. It creates space for power to be shifted between 'knowers' and 'learners.' In consideration of the historical abuse of elders in the mental health system, PAR guides the research to stay focused on engaging in praxis.

This study is bringing together people who have used a service where there is no opportunity to meet with other users of that service. Therefore, I had planned in advance that it would be essential to meet as a group and informed potential co-researchers that I was looking for individuals who wanted to be a part of a project in which they could be involved in different aspects of the research from start to end. Due to the limited time and resources, some decisions, such as the one to bring people together in a face-to-face group, were made in advance of the group meeting, other decisions such as research questions also had to be defined before the beginning of the project, as they were required prior to gaining ethical approval.

2.1.5. Power

As a PAR guided project, I was acutely aware of power relationships within the group. I was aware of my position within the group as an 'expert' on research, but also other aspects of my identity, which may place me in a position of power. As a highly educated, White-British, working-age woman, I could be perceived as too 'professional,' or not quite 'getting it.' This was openly discussed in our first group meeting, and it was suggested that we would use 'common sense' to guide us in this arena. I was also aware that as a group of

² The term 'guiding methodology' has been used to acknowledge that due to the nature of this project full PAR has not been possible.

co-researchers, there would be differences in gender, education, previous profession; therefore, in my role as a facilitator, I attempted to ensure that everyone was able to share their opinion if they wanted to do so.

2.2. Ethical Approval

Ethical approval was granted from the Health Research Authority (Appendix C). Ethical approval was also given by the School of Psychology Research Ethics Sub-Committee at UEL (Appendix D), and approval was gained from the Research and Development department of the concerned NHS Foundation Trust (Appendix E).

2.3. Procedure

2.3.1. Consultation Stage

Prior to recruitment for the research project, I consulted with the service-user group for the OA mental health community service from the same London borough as the recruitment site. The research project was welcomed by the group, and there was particular enthusiasm for the use of PAR. I received this response as an invitation to continue with the project.

The service-user group provided feedback on the information sheets and consent forms (Appendix F and Appendix G, respectively). The group advised that I should be present in the reading of the information sheet, stating that my tone of voice and passion were helpful in bringing excitement and clarity to information being relayed. Furthermore, it was suggested that the information sheet should be more informal (e.g., using the term 'you' instead of 'participant').

Additionally, I consulted with the manager of the OA-CRHTT, who was a key collaborator for the project. We discuss where group research meetings could be held, and considered accessibility and familiarity. It was decided that a room in a local OA acute day centre service, as many people who had used the OA-CRHTT would be familiar with this location.

2.3.2. Recruitment

Co-researchers were recruited from a single NHS site in an inner London Borough. This site was chosen as I had established professional connections within this service. No further sites were selected due to the time scale of the project and the different ethical approvals required.

Staff working at the specified OA-CRHTT were asked to invite service-users to participate in the research. If consent was given, their name and contact details were noted and given to me. In line with ethical protocols, the staff indicated that verbal consent had been agreed by recording this on the co-researchers' NHS electronic notes. I telephoned potential co-researchers to provide further information about the study and offer the option of a face to face meeting in the co-researchers' home or a community location to go through the information sheet.

It was essential to provide face to face meetings to discuss the information sheet as it offered people an opportunity to ask questions about the study in a private setting and ensure that they became familiar with me, which was hoped to reduce any potential anxiety about meeting other co-researchers in a group setting. The participatory nature of the project and the long-term commitment required were stressed during these meetings. Consent forms were completed if interest was expressed in participating. Continued contact with co-researchers was maintained by their preferred method (e.g., text, telephone, and letter).

2.3.3. Inclusion Criteria

Co-researchers had to meet the following criteria:

- Under the care of OA-CRHTT team in the past six months
- Not under the care of the OA-CRHTT team at the time of recruitment
- Able to communicate verbally
- Over the age of 70
- English speaking
- Has the capacity to consent to participate in research

2.3.4. Co-researchers

Overall there were twelve people who provided consent for me to contact them via telephone regarding the research, from which nine people agreed to meet face-to-face to discuss the research further. Five stated that they would like to take part in the research, three declined, and one was not eligible as, although they had used the OA-CRHTT within the last six months, they were unable to remember this contact.

The co-researchers all identified as being from a White-British background, the group consisted of four men and one woman, between 70-81 years of age. All were familiar with the location of the group meeting and reported that they would be able to attend without assistance.

Pseudonym	Face-to-face	G1	G2	II	G3	G4	G5	G6	G7
	Recruitment	Phase 1	Phase 2	Phase 3	Phase 4				Phase 5
Edward	✓	✓	✓	✓	✓	✓	✓	✓	✓
James	✓	✓	✓	✓				✓	
Larry	✓	✓		✓					
Marella	✓	✓							
Matthew	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 1. Involvement of co-researchers in the research process
(G = group meeting, II = Individual Interview)

Table 1 provides information about the participation of the co-researchers in the research project. Two co-researchers withdrew from the research meetings due to mental health difficulties. Our only female co-researcher, Marella, left the project after our first meeting, after contributing to decisions about clarification of research questions and the method of data collection. James was able to attend two group meetings and also participated in an individual interview before mental health difficulties hindered his involvement. After the first group meeting, Larry withdrew from attending further group meetings, as he had

become very fond of the people who worked at the OA-CRHTT team, and found it difficult to hear other co-researchers discuss their discontent. Larry and James were not present for many of the group meetings, however, as they had participated in individual interviews and provided feedback on their personal narratives their views were represented through the information they had provided.

2.3.5. Phase 1 – Introductions and Data Collection

This meeting facilitated three primary purposes; for the group to become familiar with one another and think together about how we would work together in a respectful way, to explore further research questions, to decide how data would be collected.

We began by introducing ourselves to one another and opened a discussion on how we wanted to talk with one another in this group, several ideas were raised and noted down, and these became our expectations of each other in the group (Appendix H). There was much discussion about being open and requesting that I am also transparent with the group; co-researchers identified that the profession of psychology has a history of deception when conducting research. The group directly asked if the discussions we had in group meetings would be analysed, and I confirmed that they would not. The group members agreed for audio recordings of the meetings, so that I could keep a record of how decisions were reached.

In line with my value of transparency, I informed the group before we embarked on the project that the OA-CRHTT has no obligation to act on our findings but that the team are aware of the research and are very keen to learn from the project. I also acknowledged that I would benefit from this research as it formed one element for an award in a Clinical Psychology Doctorate.

The research questions were shared with the group. These questions had purposefully been made quite broad to allow for changes once the group was established. A comprehensive discussion was held, with a suggestion of including research questions on other services (e.g., A&E), it was explained that

the ethical approval was for OA-CRHTT only. Ultimately, the group felt that the questions already specified were appropriate.

Aware that knowledge regarding methods of data collection was varied amongst the co-researchers, I provided information about the two forms of data collection that I thought were feasible; individual interviews or a focus group. The group asked questions about the advantages and disadvantages of each method and decided to have individual interviews, as they thought this would allow them to speak more openly about their experience.

2.3.6. Phase 2 – Choosing Analysis

The group was presented with two options for analysing the data; a thematic analysis (Braun & Clarke, 2006) or a form of narrative analysis, known as Storying Stories (McCormack, 2000a, 2000b, 2004). I choose these two options holding in mind specific requirements. Firstly, how tangible it would be for the analytic methods to be understood by a novice researcher, therefore increasing the likelihood that the co-researchers would be able to participate in parts of the analytic process. Similarly, detailed guides provided for both forms of analysis, which would aid the first point. Furthermore, the analytic method had to provide opportunities for individual analysis (by the main researcher), and collaborative analysis (by the group), which would satisfy the requirements of examination for a doctoral thesis, whilst also attending to the importance of PAR within this project. Finally, the expertise of the main researcher and supportive supervision were also considered in this selection. After reviewing examples of each form of analysis within a group meeting, the group choose narrative analysis. One of the main factors in the group's decision was how the data could be kept as close as possible to what is said within the interview. Notations from this discussion are found in Appendix I.

2.3.7. Phase 3 – Data Collection and Analysis of Individual Interviews

Individual interviews were conducted with four of the five co-researchers. Interviews were conducted using a narrative approach, using open questions to encouraged narrative responses, as suggested by (Riessman, 1993) (See

Appendix J). Each interview was analysed by the main researcher with feedback from co-researchers, and stories were created from each interview.

2.3.8. Phase 4 – Collective Analysis

This phase spanned over four group meetings (meeting 3, 4, 5, and 6). After conducting the analysis of each individual's story, each co-researcher was asked if they would like to share aspects of their story with the group. Either the story as it had been completed or parts that had been most valid or represented of something vital to them. Everyone gave consent for their whole story to be shared with the group.

The group analysis was conducted with an emphasis on an iterative process between the main researcher and co-researchers; however, in the main, it was led by the main researcher. As we went through the process, notes were written down and placed on large sheets of paper, so we could start to collect our ideas together for a collective statement (Appendix K).

2.3.9. Phase 5 – Move to Action

In the final group meetings, we formed a collective statement. The group selected information based on what messages they thought were important to communicate and what actions they would like the OA-CRHTT to consider. The group decided that they would like to meet with the OA-CRHTT staff members to discuss the research, and stipulated an agenda for this meeting (Appendix L). This meeting took place, with several actions taken forward.

2.4. Ethical considerations

2.4.1. Informed Consent

Informed consent was obtained from all co-researchers who were required to sign a consent form (Appendix G). Co-researchers were required to have the capacity to provide consent to their involvement in this research project. Capacity is understood as the ability to make decisions for one's self, which is neither static nor broad, but instead time and decision specific (Department of

Constitutional Affairs, 2007). If during the recruitment process, there were concerns that the co-researcher does not have the capacity to consent to participate in this research project, a capacity test would be conducted by the researcher (please see Appendix M for guidance on capacity testing). A concern regarding capacity to consent would be triggered by the potential co-researcher demonstrating difficulty in understanding, retaining, or weighing up the information regarding participation, and their ability to communicate their decision, as informed by the Mental Capacity Act (2005). This research project spanned a long period of time, and therefore the capacity to consent to continued participation was regularly checked. This was achieved by using the processual consent methodology developed by Hughes and Castro Romero, (2015).

2.4.2. Discomfort or Harm

It was possible that co-researchers may become distressed by talking about the experience they encountered, whilst accessing an OA-CRHTT. I provided all co-researchers with an opportunity to debrief after each research interaction and advised on methods in which support could be accessed if required.

2.4.3. Confidentiality and Anonymity

Co-researchers were advised verbally, and in the information sheet that if the main researcher were concerned about risk, at any point during the research process, a third party (e.g., GP, OA-CRHTT team) would be informed. During the recruitment process, co-researchers were made aware that other co-researchers would be present during group meetings, and therefore complete confidentiality would not be possible. It was encouraged that confidentiality within the group is maintained by group members.

Each co-researcher was offered the opportunity to create or be given a pseudonym to be used in any documentation that was written regarding the project.

2.4.4. Right to Withdraw

Anyone choosing to take part in the research was informed that they had the right to withdraw, without the need for explanation, disadvantage, or consequence. However, it was agreed that if this right were exercised, it would need to be prior to the analysis of data, which would take place two weeks after the data had been collected.

2.5. **Evaluative Criteria**

A personal narrative is not meant to provide an insight into what is 'out there' but rather a process of meaning-making; therefore, it cannot be measured using tests of consistency, as narratives can change over time, and with each telling (Riessman, 1993). However, other methods of rigour can be applied to the qualitative researcher, such as audibility and reflexivity (Spencer & Ritchie, 2012). The reporting and documenting on how research decisions are formed provides an audit trail in which the researcher can demonstrate transparently. Although it would be unlikely in narrative research for narrative analysis to be replicable, due to the situated nature of the data being produced, audibility does allow for evidencing of the research process, which then allows it to be opened for questioning.

2.5.1. Reflexivity

Due to the stance of this project, it is not seeking an 'objective' understanding or wanting to discover a 'truth' within the data. Hence, as the researcher, I will use openness about my values and beliefs and examine the results from a reflexive stance, reviewing how my presence within the research process has impacted on the data.

2.5.2. Validity

Prevailing concepts of validity within scientific research often refers to the 'truth' of the data, which positions the results within a realist epistemology. Riessman, (1993, 2008) argues that validity in narrative analysis should review the 'trustworthiness' of the results, which instead describes a social process. This

project will use Riessman's (1993) method of validity as it is specific to narrative research and encourages the researcher only to utilise the methods of evaluation that are suitable to their project, allowing for flexibility and a nuanced review. Riessman (1993) identified four areas in which validity might be evaluated; these are persuasiveness, correspondence, coherence, and pragmatic use (See Section 5.2.1.).

3. ANALYTIC PROCEDURE

3.1. Transcription

Emerson and Frosh (2004) argue that transcription in and of itself is a part of the analysis, which is motivated and clouded by the assumptions of the researcher. Transcriptions were completed by the main researcher for all group meetings and individual interviews. Transcribing convention stipulated by Jefferson (1985) was used (see Appendix N). When all transcriptions were typed, they were checked against the recordings to ensure accuracy.

3.2. Narrative Analysis

NA explores the experience of people in their day to day lives, while also exploring the wider social and cultural resources on which people use to inform meaning in their lives. It focuses on the use of language and understands it as communication about reality, but also as a function to construct individual identity. The assumption in NA is that stories are constructed, and then reconstructed, often with an adaptation of the story in each telling (Mishler, 1999). The adaptations can occur at different levels, in the telling, the interpretation, and in the reading (Riessman, 2008).

3.3. Analytic Procedure: Personal Narratives and Interpretive Analysis

Storying stories is a narrative method of analysis developed by McCormack (2000a, 2000b, 2004): the principles of the method are taken from the broad arenas of feminism and postmodernism. This method also draws from both forms of a narrative framework, 'narrative analysis,' and 'analysis of narrative' (Polkinghorne, 1995). Whereby, data about events and actions are gathered, from which stories are generated through a process of emplotment (Narrative

Analysis), or where the researcher seeks out stories as data, after which they analyse across those stories for themes (analysis of narrative).

McCormack (2004) created personal narratives taken from the transcripts over several interviews with each individual, and then integrated the text of these narratives with analysis, creating an interpretive story (this steps of this process are described in Appendix O). Here, we have created personal narratives that stand-alone, followed by an interpretive analysis. This adaptation was agreed upon, as the co-researchers had viewed an example of this method (Klevan, Davidson, Ruud, & Karlsson, 2016), and felt that the message was powerful when the personal narrative remained as an unbroken text. Table 2 provides a guide to the steps taken for the composition of the personal narratives (Narrative analysis) and the composition of the interpretive analysis for each of the personal narratives (analysis of narrative).

Steps	Tasks
Step 1: Composition of the personal narrative	<ul style="list-style-type: none"> ➤ Active Listening: Re-connect with the conversation ➤ Locate the narrative processes in the transcript. ➤ Creation of middle stories ➤ Temporal order of middle stories ➤ Return middle stories to the participant for comment or feedback. ➤ Use visual form and text strategies to enhance the presentation.
Step 2: Composition of the interpretive analysis.	<ul style="list-style-type: none"> ➤ Emplotment analysis ➤ View transcript through the lens of <ul style="list-style-type: none"> - Language - Context - Moments ➤ Take into account views highlighted by these lenses, as well as feedback and journal notes to create the interpretive analysis.

Table 2. Process of analysis adapted from McCormack (2004)

When the personal narratives were completed, a copy was given to the co-researcher who contributed to that interview, and feedback was requested with the following questions:

- Does this fit with your memory of our conversation?
- Is there anything that I should add in?
- Is there anything that I should take out (omit?)
- Any other comments?

3.4. Analytic Procedure: Group Analysis

Human communication is infused with storytelling (Riessman, 1993), which is an interactive and mutual activity. It has been identified that when groups share their stories and reflect upon them collectively, this can then develop into a type of action research (Murray & Sargeant, 2012). The personal narratives that had been created were used as data for the group analysis. Keeping focus on our agreed research questions, we listened to each story as a group and took time to reflect on what felt poignant about each story, and asked;

- What felt important about that story?
- What can we learn from that story?
- What experience would we identify as helpful?
- What experience do we think could be done differently?

The group had initially contemplated if we were able to use the same story process by McCormack (2004) to create a collective narrative, however in light of the differences of experience between the stories and the desire to provide clear recommendations to the OA-CRHTT, it was agreed that we would create a collective statement, which would be based on a review of the discussions we held. Holding this in mind, we brainstormed our ideas onto a broadsheet of paper. There were lots of points that had been made. With an overview we discussed;

- What aspects of this conversation do we think it is important to highlight?
- What would we like others to take from what we have learned?
- What would others need to know about how we have arrived at this point?

4. RESULTS

This chapter details the narrative analysis created by storying the transcripts from individual interviews, as developed by McCormack (2000a, 2000b, 2004). Each personal narrative is presented separately and provided first so that the reader can enter the story without an analytic explanation, allowing the reader the opportunity to be curious and open to how they receive the story (Riessman, 2008). Due to word limits; an example of the composition of the personal narrative (step 1) is provided in Appendix P. Then, the analytic process follows with a focus on emplotment, language, context and moments. An example of the composition of the interpretive analysis can be found in Appendix Q.

The chapter is closed with a collective group statement, which highlights areas that the co-researchers identified as helpful and unhelpful aspects of working with the OA-CRHTT.

4.1. Larry's story: They're Like Family

As in our previous meetings, Larry is dressed in a sharp suit. As I entered his home for the first time, it was evident that like his appearance, his home is in pristine condition. Larry is partially sighted, and despite having many operations in recent years to reduce pain in his body, his confident nature and easy company completely distract any appearance of him experiencing pain. Larry was widowed seven years ago...and now lives alone. He shows me pictures of his large family and tells me about the support his daughter gives him with great pride. At 81 years of age, Larry tells me about his first and only experience of mental health services.

“Look, I was in a lot of pain, I had something wrong with me spine, and they had to put mental bits in between my bones. As I say, the doctor told me I would have a little bit of pain when I get home. When they say it was a little pain, *Jesus Christ* them doctors don't know!! So I went to the GP and I said ‘I need more painkillers, I need help’, and the thing about it was, I said ‘If you don't give me help I will go and buy a bottle of scotch, take a few tablets with the scotch,

and end it all'. In that moment I was all ready to do what I wanted to do, because I couldn't stand the pain!

I would have only done it that day!

Well, then two gentlemen (from the OA-CRHTT) were at my door: the doctor had called them. They had a good talk to me about something, and the next thing you know the girls [from the OA-CRHTT] are here! Without them girls, I wouldn't have known where I'd have been today.

There were four of them girls, and like you, they're like family when they come in. I sort of adopted them, you know. You've not murdered anyone, you're not just a patient or anything, you know, *they talk to you like your family*: and that's the most important thing about it! They were coming round here once or twice a week, I think, and it gives you a boost you know, it makes you more happy. The important thing about it is they talked to you nice... in a nice roundabout way. They talk sensible, they know what happened to me, and so they didn't talk silly by asking me questions about the whisky. They know what they are doing; they got the brains up there to talk to people who have been on the edge of this and the edge of that, you know. If they didn't do their job, the majority of elderly people would go crazy. Services like this didn't exist 60 years ago, so people should be **grateful** to them girls for the work they do!

It was around Christmas, and my daughter was due to go on holiday with her family. But instead, she wanted to stay with me, she was concerned cause of what I said to the doctor, about the pain I was in. She wasn't going to go [on holiday], even though the crisis team were coming to see me! So I said 'do us a favour, ring up the crisis team', and I told them I was in a lot of pain, and I want to go back into hospital. But the thing about it was I thought they would send me to the *normal hospital* [physical health]. And when we went there, I said 'Where you going???' she said 'the hospital' I said 'it ain't up here!' It was a shock for me you know, it really livened me up. Cause I said to em before I was going, I said 'what have you done to me?'..., but I knew I was doing it for a purpose, so she could go on holiday you know.

You never know what is behind the brick wall, till you go there and see how these people are. As soon as I went in I didn't like it. They put me in a cell right at the end:

It was freezing cold!

I couldn't sleep in there!

The shower flooded the room!

And I couldn't eat their grub!

I was voluntary. But, I didn't go out of that place. I mean, I didn't know about going out. I had people come and say I would get you out at the end of the day, I said 'Don't be silly if I go out of here now, they would be knocking and kicking that door in for me, to take me back in there'. *The place needs bombing and building again!*

When I got home, I had another set of people coming around, checking I was taking my medication and that. I *kept* telling them I don't need them. I told the girls from the crisis team about it, and they made a call and said it was due to stop at the end of the week. When it was stopped, I got a bill for 264 quid!!.... Anyway, I paid it, but the hospital said it was a free service. I'm an independent bloke, you know! They call me Mr. Dapper down that doctors. The doctors are wanting to give me help in here [at home], go get my shopping and do my cleaning, I said 'Listen, while I am capable of doing it, I will do it myself, I don't need help from nobody. And if I do need help, I got a daughter'.

Anyway, I saw the girls for a bit when I came out of hospital. They could see you were getting better, they gradually stopped coming you know. I mean they're terrific girls you know, I mean that from the bottom of my heart. They come around a few times afterwards and they said, 'I think you'll be alright now'. After a week, you say 'I wish them girls would come around here again', but gradually you establish yourself.

You gotta do things and that's it!"

4.1.1. Larry's Interpretive Story

Emplotment

The introduction to Larry's story focuses on his role as a family man, as although he lives alone, he is very much supported and connected to his family. Larry's story involves multiple characters, where he, his daughter and the girls (crisis team workers) have significant parts, and the GP, surgical doctors and men from the crisis team, and I have supporting roles. Additionally, multiple narratives are weaved into Larry's story, including narratives of resistance, independence, sacrifice, and family. The story begins with Larry recounting the pain he was suffering from a recent operation, and as a result of his assertion to the GP of what he would do if he were not given appropriate help! The emphasis on the story of pain demonstrates resistance to mental health terminology of 'depression' or 'suicide'. The GP, concerned about this assertion of taking pills and whisky, contacted the OA-CRHTT. It appears unclear if at the time of referral, Larry thought that such a service would be useful. The story of his contact with OA-CRHTT develops when the characters of the girls are introduced. The visits from the girls highlight what Larry found helpful about the OA-CRHTT, in particular, the connection between him and the girls that developed through mutual respect and care.

Larry characterises his inpatient admission as a story of his sacrifice for his daughter, knowing that she would only be reassured enough to go on holiday if he was being cared for by nursing staff 24/7. The story takes a turn when Larry realises that he had sacrificed more than he anticipated when he was admitted to a psychiatric ward, rather than a general ward. His lack of preparation for this, and the shock of the environment on the ward were in complete contrast to his visits from the girls, instead of making him "more happy", the ward represented a prison, where his whole demeanour appeared to change. The assertive and social Larry became resigned to his position and did not question the rules about going out. Larry seems to do this all in the name of sacrifice and does not proportion blame to anyone regarding not being informed of where he was going. After being discharged, Larry reclaims his independence, by telling a story about the admiration he receives for his smart attire at the doctors, he

continued to enjoy some visits from the girls and begrudgingly accepts that the maintenance of independence means letting go of the contact with them.

Lens of Language

Larry tells his story from a first-person account, using multiple direct quotes from different characters to add an element of drama to the story. This style draws the audience in, making them feel present in the telling of the story. He uses commanding words in his narration, calling for the immediate attention of the audience (e.g. "Look, [I was in a lot of pain]"), but also uses humour to accentuate his point (e.g., "Jesus Christ them doctors don't know"), leading the audience to attach to their own experiences of pain and how challenging it is to convey this to others.

The use of humour and authority in tone lends itself to the self-image that Larry creates for himself in the story; as "Mr Dapper", a working-class gentleman with style and charm. The staff at the GP surgery gave Larry this name, but he owns it with pride; a demonstration of the worth he places on how others perceive him in his ability, not just to look after himself, but to do it with style. This pride in his appearance connects with the story of independence that is present throughout the personal narrative: from his self-descriptor as an "independent bloke", to the way he immaculately keeps his home, and his assertion to the GP that "I will do it myself".

Interwoven with the story of independence, is the story of resistance of mental health labels. A clear separation develops between how Larry talks about physical health versus mental health. This distinction is apparent through Larry identifying himself as the subject when speaking about his physical pain, by using the subject pronoun 'I' (e.g. "I had something wrong with my spine"). In contrast, when the story develops to talk about his experience of mental health services, pronouns locate others as subjects (e.g. "see how these people are"). This separation creates a distancing effect for the audience, ensuring the listener continues to be aware that his story is about pain. For Larry, it seems that independence and mental health difficulties are not compatible, and to retain his independence, he must detach himself from associations with mental illness, resulting in his story of resistance. His desire to position himself

separately from mental health may also be influenced by its connection to criminality, as he describes the hospital environment using language that conjures images of prisons, demonstrated by the use of the term “cell”, and his metaphor “behind the brick wall”. Furthermore, when he describes a general hospital as the “normal hospital”, he places the mental health hospital in the opposing position as abnormal.

There was a stark contrast between Larry’s description of the men from the OA-CRHTT who first assessed him, and the female workers. “The girls” were central to Larry’s story; in particular, their ability to connect with him through mutual respect and kindness, which he identified, was the most crucial aspect of his contact with the OA-CRHTT. Larry’s use of the word “adopt” concerning the girls, demonstrates his warmth and affection for them. I wondered about the choice of the term ‘girls’, which indicates children, and not ‘ladies’ or ‘women’, or some other derivative of an adult female. It could be due to the likely age difference between Larry and the female staff. Additionally, it made me think about his relationship with his daughter, as he asserts “if I do need help, I got a daughter”; I wondered if it was more acceptable for Larry to be provided support by family, hence the need to ‘adopt the girls’, placing them in position as his children and, therefore an acceptable source of support. Furthermore, I wondered if the girls created an atmosphere of family, demonstrated by the tone they used with him, and their careful choice of language to ensure that Larry was able to maintain his identity as someone independent.

Lens of Context

Our interview reminded me of when I first met with Larry to discuss the research project, when he relayed much of what we discussed in the interview and was keen to take part in the research as a way of showing gratitude and support for the girls. At the start of the interview, Larry informed me that he struggled to listen to other co-researchers opinions about their experience of OA-CRHTT during our group meeting, as he felt that this was a direct complaint about the girls, which infuriated him.

In the situational context of the interview, Larry aligned me with ‘the girls’ (e.g. “Like you, they were like family when they come in”). Frequent use of ‘you know’ is found throughout the story, but appears more frequently when the focus is on

the girls. Larry was aware of my previous role in a CRHTT team, so may have been indicating this, but I considered what actions I was taking in the interview that may have made me similar to the girls. For example, I noticed myself being tentative in the way I asked Larry how the OA-CRHTT team might have been more helpful, in response to his keen sense of duty of valuing what 'the girls' from the OA-CRHTT do. I wondered if they were also tentative in how they assessed Larry's plans to take pills and whisky, in response to his wish to not be asked about this directly.

This story appeared to draw on numerous dominant discourses, such as the conceptualisation that mental health difficulties are associated with criminality, and generational responses to health care.

Historically, there have been multiple connections between the criminal justice and the mental health system. Moreover, the media has sensationalised infrequent events of someone diagnosed with schizophrenia being accused of murder. The inclination for Larry to distance himself from being associated with mental health difficulties may also be explained by the way he associates mental illness with criminality. Larry's appreciation of the respectful way he was treated by 'the girls' appears to be countered by the expectation that he was going to be treated like a "murderer".

References to generational narratives about receiving help were also present. In one statement, Larry contrast services from the 1960s with current provision, thus "people should be grateful to them girls for the work they do". The emphasis on this statement takes from the generational aspect of dominant narratives that would have been prevalent when Larry was growing up during and after WWII, where resources were limited, and before the conception of the NHS. Concurrently, he may also be drawing on the dependent position that elders are given in our society, where elders are expected to 'be grateful' for what they receive from services.

There were also examples of counter-narratives. In particular, Larry's demonstration of independence resists the dominant narratives that elders are

dependent on others and incapable of looking after themselves, thus, burdensome.

Lens of Moments

One particular moment struck me during the interview, and again while reading Larry's story; this was the shock Larry expressed at being admitted to a psychiatric hospital, and the story of sacrifice and love that underlined it. "It really livened me up", this quote demonstrates Larry's bewilderment and the need for him to have his wits about him. The priority Larry places in getting his daughter and her family to go on holiday creates a powerful demonstration of the lengths he will go to in order to look after his family. The extent of the sacrifice is realised when he arrives at the psychiatric hospital; he does not proportion blame to not being informed about which hospital he was going to, and instead remains focused on reasons of why he was going. He describes the admission as very unpleasant and it becomes apparent that the lack of information provided meant that he did not challenge his right to go out, which appears out of sync with his usual assertive character.

4.2. Matthew's story: Accurate Assessment equals Good Care

Matthew experienced mental health difficulties for the first time in his 70 years. As someone who is usually quite chilled out, he tells me how many friends and family thought he would be the last person to be affected by a mental health crisis. Matthew went to see his GP and explained that he was going through stages of worry, anxiety, extreme anxiety... As his crisis continued, Matthew told me that he went onto experience obsession, paranoia and psychosis....

"My GP notified the crisis team, who came to visit me. They were monitoring my progress, my welfare, and my health. They were telling me about their available service, or signposting, or whatever. But, what they were offering wasn't of any use to me, because I could not function at that stage. They visited on about three occasions, but they really just kept saying that you could phone us or we can refer you somewhere to some organisation where you could sort of engage in therapeutic activities, like Art Therapy, but I couldn't cope with that!

I always presented myself, if you like, as someone who is fairly intelligent, articulate and all that sort of thing, as though I didn't have a problem. Or, the severity... I think maybe I masked that? Had my real state of mind been understood, I don't know what action they would have taken. I mean they may have made the referral to um, the crisis house earlier. They were doing their best without understanding the situation, and I didn't really get anything from it. So they weren't really part of my life, um, until I self-referred to A&E.



It got to stage where I thought I would **lose control of my mind**, and maybe, become a danger to myself and others, you know? I mean this wasn't picked up by the crisis team or anything like that; it really was a self-analysis and referral, so I referred myself to A&E, with a view of admitting myself to a psych ward. I said I need help, you know. So when I initially spoke with someone at A&E, they recommended whole heartedly that I go along with my intention of going to a psychiatric ward. She told me

'It can be dangerous,

There are frequent assaults,

And a lot of thefts — but you do have your own room that you can lock'.

Well, this didn't sound very reassuring, particularly considering my state of mind at the time. Now, if they were members of the crisis team, *and I don't know if they were*, um, total incompetence, negligent, bad advice. They were as bad as it gets. Anyway, so I was in the A&E department, and what happened was then the psychiatrist came to see me and had a chat, AND then two other people from the crisis team came, now these people were from the crisis team. They said

'You do not want to go on to a psych ward, believe me!'

Instead, they said

'We are going to refer you to the crisis house'

I was concerned that this might not be effective, but they said,

'Give this a go; **your life depends on it!**'

Getting me into the crisis house from A&E was the most helpful aspect of the crisis team in my case. Now, if it hadn't been for them I would have possibly ended up in a very unpleasant environment, you know. Let's say, they saved my life!

So I went to the crisis house, which was absolutely wonderful, very kind, compassionate, but it wasn't any good for me because I was just getting worse and **worse** and **WORSE**. Now I don't know if the crisis house and the crisis team work closely together, I think they do... Well, anyway, I met a lovely psychiatrist there, who said well look

'I don't think there is anything I can do for you here,

So I have contacted the hospital,

And arranged for you to have a bed on [the acute inpatient psychiatric ward for older adults].

I was given some reassurance about the Ward, but I was desperate. Desperate, you know? I knew I needed significant and effective help. My daughter and I had a look around the Ward the day before I went, and it seemed OK so I admitted myself. I wasn't sectioned or anything, you know.



The medical staff on the Ward was fantastic. Things were gradually getting better with the help of medication, so on and so forth. By the time of my discharge, I had developed the resilience, if you like, to deal with the issues that had caused the breakdown in the first place. Someone from the home care

team did come and see me shortly after I was discharged back at home, and that sort of thing, but I didn't need help, you know, I was functional by that time.

If it wasn't for the two I saw at A&E, and the consultant at [Crisis House], I would have had problems. Even though I hadn't met them before, they knew what was wrong, and they knew what they were doing, and they did what was best. Let me put it like this when I was acting as a lawyer; I acted on behalf of people who had problems. Initially, starting my career, I am by nature quite a compassionate, empathetic person, all that sort of thing. Um, it was good that I could relate with the humanistic quality, if you like, to people who were in trouble. After a while, without losing that, you do tend, to sort of, if you like, to hone it to a certain objectivity to function effectively on that person's behalf, using the qualities or skills that you have for that particular profession. I would describe good care in the crisis team as someone that has compassion, but objectivity, the ability, the intelligence or qualifications however you want to describe it of accurate assessment of what the client is experiencing, and the best way to deal with that!"

4.2.1. Matthew's Interpretive Story

Emplotment

Matthew is the central character in his story, with the other characters taken by health care professionals, the GP, OA-CRHTT team staff, A&E staff, and the psychiatrist at the crisis house. Matthew's story delves quickly into his initial interactions with staff from the OA-CRHTT. Similarly to his presentation with the OA-CRHTT, Matthew introduces himself to the audience, at a point where he has lost the ability to function. The beginning of his story revolves around a mismatch between his needs and the provision of interventions provided by the OA-CRHTTT.

Matthew goes on to query what may have led to this mismatch, was it because he speaks eloquently, and staff from the OA-CRHTTT mistook this as a signal that he was coping? Or, was he masking the severity of his symptoms? Possibly both. He reflects that he may have received more effective help sooner if there had been an increased sense of understanding of his state of

mind. Not receiving the necessary help from the OA-CRHTTT, Matthew discards them as a method of support and instead makes an assessment of his own needs and decides to go to A&E and request a psychiatric admission.

The middle section of the story draws attention to the multiple assessments that took place to assess him for an informal psychiatric admission, and the multiple directions in which he is pulled by the different advice given by each professional. Here, Matthew takes the reader through a journey of his decision-making process, where he contemplates an informal psychiatric admission or a crisis house. He chooses a crisis house and is happy with this choice, as it leads him to meet with a good psychiatrist who advises that he needs more substantial support which can only be provided by a psychiatric hospital. Ironically, this was in line with his initial instinct. However, from Matthew's perspective, the interaction with the OA-CRHTT in A&E saved him from an 'unpleasant environment' and led him to the excellent interaction with the psychiatrist, where he felt understood, and, therefore, was a necessary part of his journey.

In the finale, Matthew draws on his professional skills to provide a clear depiction of what good OA-CRHTTT care should consist, namely, accurate assessment.

Lens of Language

Matthew tells the story of a journey seeking an understanding of his situation from a first-person account. He effectively uses direct quotes to dramatise the conversations in A&E which guided his decision-making process; this encourages the audience to weigh up the information with him and invites them to contemplate what their response may have been to this scenario.

I noticed several dichotomies in the text, between life and death, sanity and madness, and help that was either useful or ineffective. Matthew is concise and reflective in his account; he rarely pauses and communicates his points with clarity. These skills reflect Matthew's professional position as a lawyer, with the dichotomies replicating the judicial system in which he practised. I started to associate his story with a surmising of a case, where an argument is presented,

questions are poised (e.g., “maybe I masked that?”), and a recommendation is made at the end, i.e., the need for accurate assessment.

Matthew draws on his professional qualities and language to tell his story and create his identity within the story, as a thoughtful, educated and reflective man. Although this is Matthew’s first experience of a mental health crisis, it is difficult to retain this as he demonstrates his familiarity with specialist clinical language (e.g., “self-referred”, “a danger to myself and others”) as well as words associated with his profession (e.g., “negligence”). In the story, he takes the reader through stages of reflection and decision making, which is akin to the role of a mental health clinician; this connects him to positions of power held by mental health clinician, rather than the subjugated role of a passive ‘patient’.

Matthew uses particular language to describe himself in the personal narrative: for instance, he refers to himself as “fairly intelligent, articulate and all that sort of thing”. The latter part of this sentence is vague but points to a shared understanding of what the traits of being intelligent and articulate are, possibly aligning himself with me as someone who has similar levels of education. This drew on taken for granted assumptions, which emphasised his highly educated background and status and social norms that one might expect from someone who has received this higher level of education. With this in mind, he also removes himself from these assertions about his intelligence, by placing the clause “if you like” before these self-descriptions. This then places the agreement of such statements with the listener, rather than being seen to own the statements himself.

Matthew demonstrates agency in many aspects of his personal narrative. Chiefly, this is evident in his use of ‘I’ in the decision-making process. For example, when he reviewed his mental state and felt that he was losing control of his mind, which then prompted his decision to go to A&E. Again, where Matthew refers to his decision about going to a psychiatric ward, he highlights that it was his choice to be admitted, by placing it in contrast to being sectioned – where a decision would be made by someone else.

Through the lens of language, the workers from the OA-CRHTTT are positioned into two different roles, of either being ineffective or saviours. Although he was able to highlight the purpose of the initial home visits from the OA-CRHTTT (e.g., “to monitor his health”), for Matthew this appeared irrelevant as he was struggling to function at this stage. This point is illustrated by the phrase “they just kept saying”, highlighting the repetition of the advice. This phrase also indicates that at this time, words were not useful, and later, he points to the action that needed to take place.

The lack of usefulness is placed with the workers from the OA-CRHTTT, positioning them as not understanding his need. Interestingly, at one point, Matthew reflects that this may have been difficult for the workers to do as he may have “masked” the severity. In comparison, the workers from OA-CRHTTT that Matthew met within A&E are perceived as providing practical help, at a crucial decision point in his journey. These staff are awarded accolades of saving his life, by rescuing him from an ‘unpleasant environment’ – a psychiatric ward. Here, action was taken for Matthew; he was dissuaded from his desired course of action to an alternative. He seemed to admire their expertise in the assessment of his mental state and knowledge of the mental health services available. At the end of the story, Matthew elaborates why the staff at A&E were helpful, by providing an example of qualities that he has gained through his career. Here, again, using his professional abilities to place him on an equal footing with the OA-CRHTT staff.

Lens of Context

The situational context of our interview was also strongly influenced by our joint professional status. Matthew relayed the story to me in a way that felt like he was surmising for his audience, who he was aware also held professional status. I felt like a junior colleague who was being gifted with his knowledge and expertise, whom he was enthusiastic about helping and supporting in this project.

Within the cultural context, two particular discourses relate to broader narratives. The first is the distinction alluded to between being intelligent and having a mental health disorder. These highlight historical narratives, still

present, or the demise of intelligence when impacted by mental health, and/or the assertion that mental health difficulties do not impact people from certain social classes.

The second is the narrative that associates mental health wards with danger; which in Matthew's story is delivered as a warning by the A&E staff (e.g., "It can be dangerous"). Matthew easily believes this, due to the permeation in society that mental health wards, or people with mental health problems, are dangerous. Yet, counter to this narrative, when Matthew does admit himself to an inpatient ward, he finds it very useful and the staff very helpful in his recovery, citing it as one of the most vital aspects of his recovery.

Lens of Moments

There were several moments that seemed important in this story, as a listener and audience member. The first was when Matthew questioned how much he may have masked the severity of his mental health distress to the workers of the OA-CRHTTT, in the interview this was a real moment of questioning of himself and reflection on his part of the interaction.

The other moments, were where individual decisions were advised (e.g. the admission to the crisis house). These appeared like junctions in Matthew's personal narrative that represented a choice, a change and opportunities for someone with knowledge of mental health to take control, rather than having to make the decisions himself. Until that point, Matthew had been holding much of the responsibility for his care, being able to trust another's decision appeared to come with some relief and allowed him to be supported.

4.3. Edward's story: Self-referral or Oblivion

Edward worked for many years as a Chemist in product design, a role which involved a lot of responsibility and decision making. Alongside his career, he has also managed difficulties with Bipolar and alcohol dependence for the past 40-45 years. At 75 years old, Edward is retired; and has established and maintained good connections within his community. He regularly attends a

local Bridge club, which he describes as an excellent way to keep his memory sharp. Edward has also built up good relationships with his GP, and fellow parishioners at the local church, which he has found a helpful resource when experiencing mental health crisis.

Edward welcomes me into his house where a hot pot of coffee and biscuits are prepared; it is difficult for me to remember that he has limited vision as he seamlessly pours us each a cup of coffee. Edward speaks to me with clarity about his experience of mental health crisis, and underlines that it is important that he is not misunderstood:

“Well, I think I was very low. I know I started drinking, and for a while that got me out of the depression but then the drinking becomes more and more, and then it is more and more depressing, you know, it’s a self-destruct mechanism really. And then I was, well, I was having suicidal thoughts on and off earlier in the episode, then it became really serious, **so it was either get help or cop out...**

I was gonna just fill myself up with pills and alcohol and that would have been it. And it would not have been a half-hearted attempt. It would have been one hundred percent. No way back. I had seen the crisis team before, so I had the number and I contacted them straight away. I realised that I was in that situation and, it was sort of my last, last chance saloon really. **It was a self-referral or oblivion...**

The crisis team consultant came and saw me at home; I had previously met her at the acute day centre so she wasn’t totally out of the blue. I told her that I was not allowed near Lithium at all, because I have had acute lithium poisoning in the eighties - I know that inorganic chemicals can cause very severe reactions, even very minute forms. As a result of the lithium poisoning, I started suffering from severe chest pains, angina, and all sorts of things. Soon after, they offered me a pacemaker, but at that time they had problems with lithium batteries that leaked, so I took my chances without one - She arranged the hospitalization within a couple of days, she was very understanding, and realised that the cycle I was in had to be broken, and knew exactly how to go about doing it. On reflection, this did help.

I suspect the crisis team may have removed any medication I could have gone for [to take an overdose]. I had to go into hospital as they wanted to keep a check on me physically whilst changing my medication and this could not be done safely while I was at home. I was reassured really that help was on its way, it's a bit difficult to recall exactly these things because, at the time you're so physically and emotionally in turmoil that um, it's difficult. But, I can't see it being done any better. **If I hadn't of got immediate help it's almost certain that I wouldn't be here!**

When I was admitted to hospital, I explained that if I went onto very heavy doses of the drug they use, the interaction had disastrous effects on me physiology, so they put me on a low dose, and I was alright. However, new concerns with my heart have been raised, and it is possible that I may now need a pacemaker, if I am not too old! From hospital, I was referred to the acute day unit, I was going there on Tuesday, Wednesday and Thursdays... hmmm, I might have seen the home care team during that time, but basically my care was with the acute day unit.

People try and be helpful, of course. But sometimes, it is difficult when people come into the house and things are moved around. I do have some vision, but it is peripheral really, and it can be very difficult for me to see things that are right in front of me. It can cause a degree of anxiety and a lot of wasted time when things are not where I expect them to be."

Edward hands me an appointment letter from his CMHT for what appears to be a review with the psychiatrist and asks "I assume this is for some sort of assessment? I don't know exactly what this doctor does or why? The letter is addressed from the centre (where my care coordinator is based), and it is signed from the home treatment team, I think? It's not? From the community team is it? Is that different from the home treatment team then?"

4.3.1. Edward's Interpretive Story

Emplotment

Edward starts his story with a severe and grave tone, stating that he had become “very low”, and was using alcohol in an attempt to feel differently. The bold statements at the end of the first two paragraphs indicate the difficult predicament in which Edward had found himself. He speaks explicitly about his plans to end his life, leaving the audience in no doubt about the gravity of the situation he was in, emphasised by the expressions “no way back” and “oblivion”. The OA-CRHTTT are described as characters that aid him to receive help, and there is a sense of relief that he does access support. He alludes to previous mental health crisis by his knowledge of the OA-CRHTTT, and this empowers him to feel confident that there is someone that can help.

It is the consultant psychiatrist who comes to see Edward for his first and possibly only contact, with the OA-CRHTT in this episode. The familiarity with her appears to enhance the potential for the meeting to be productive immediately. In their meeting, Edward demonstrates confidence in relaying his knowledge, of how to manage his health and of medication reactions, which is met with respect and understanding and lays the foundation for a collaborative discussion about what should happen next. Edward finds this interaction reassuring and is happy with the result of a referral for inpatient psychiatric admission.

Edward continues to connect to the narrative of knowledge when he tells me about being admitted to hospital and again relaying vital information about how his body responds to medications. He then shares concerns raised about the condition of his heart and contemplates if he is “too old” for treatment. The decision to attend hospital prompted investigations into the condition of his heart, which endorses the recommendation the consultant psychiatrist made for inpatient admission.

Once discharged, Edward seems to be managing with a referral to the acute day unit, and if he did have contact with the OA-CRHTTT, it appeared insignificant by this time, as his needs were met at the acute day unit.

When asked what was helpful about OA-CRHTTT, Edward launches into a narrative on mastering his limited vision; this is the first time he speaks explicitly about how his limited sight can impact on him. Here, he highlights the intrusive nature of home visits, which can relate to OA-CRHTTT services as well as other community mental health services, and how the smallest of unintentional movement by a guest in his home can go on to cause hours of anxiety.

Finally, the story ends with a series of questions that Edward asks me, using my knowledge of services to help him decipher who his letter is from. In this interaction, Edward, who has spent a long time talking to me about in detail about his interaction with OA-CRHTTT, becomes aware that the OA-CRHTTT and the community health team are different. He asks me to explain how the system works.

Lens of Language

Edward and the consultant psychiatrist from the OA-CRHTTT represent the main characters in a story about mutual knowledge and respect, and I play a supporting role. Edward's tells his story in the first-person, but the lack of a conversational element leads the audience to listen, rather than be a part of the story. In addition to the main story, there are many narratives to be found here. For example, the narrative of expertise, in Edward's life as a professional, demonstrated by the use of specialised language; the narrative of survival from mental health difficulties; the narrative of persistence in learning to manage a life with limited sight, and a narrative of connection to his community. While Edward does speak about his interaction with the OA-CRHTTT, he also zooms in on the different areas of his life, highlighting the multi-faceted and intertwined nature of his life.

The personal narrative creates a self-image of Edward as a man who is informed and in control. Through the lens of language, there is a palpable sense of Edward holding control of the crisis. He draws on his professional status and specialist knowledge (e.g. "I told her that I was not allowed Lithium", "I know that inorganic chemicals"). He is the giver of information, rather than the recipient of it. From this, he creates a position of respected authority, which gives him the confidence to speak, to be heard, and engage in dialogue with mental health

professions to reach the desired outcome. In quite a striking manner, Edward talks about alcohol as something “self-destructive”, this word describes an internal battle, meaning that he owns the power to either self-destruct or get help, highlighting the prevalence of control in his self-image.

From the story, the audience has a limited sense of how Edward connected on a relational level with the consultant psychiatrist, as he stays quite factual. However, the team itself are perceived as being the access to support when Edward was feeling suicidal (e.g., “It was a self-referral or oblivion). He does highlight that he was assessed quickly, and reassured by OA-CRHTT involvement, and ultimately feels that if he had not of contacted them, there would be dire consequences. Edward’s story highlights the importance of being able to access crisis services through self-referral directly, and the crucial ability for OA-CRHTTT to respond quickly. He seems assured from his previous experience that this service can and does help him during periods of mental health crisis, which has aided his decision to return to the service in this episode.

Edward invites some speculation about other interventions by the OA-CRHTTT during this crisis; specifically, that they had removed medication to keep him safe. However, he was uncertain about this, stating that the physical and emotional turmoil of the crisis made it difficult to remember certain events. His assumption that the OA-CRHTTT did so suggests that he feels cared for by the team and that they acted in his best interests at a time when he was vulnerable.

Lens of Context

Edward was a warm host and had prepared for our visit by making the coffee and setting out biscuits in advance of my arrival – I later wondered if preparation is one method he had learnt to manage his limited vision and maintain his independence. It was clear that he had made a note in his mind to ask me about the letter from the community psychiatrist, and he stood up with purpose and asked me to wait while he retrieved it. This letter was a catalyst to our discussion regarding the structure of mental health services, which Edward was very curious. This interaction allowed me to feel that we were able to exchange

ideas and knowledge, again promoting a story of mutual respect and knowledge.

“I may now need a pacemaker if I am not too old!” In this throwaway comment, Edward connects to a dominant social narrative of the value of elders in our society. By “too old” it was unclear if Edward thought that he might not have many years left and, therefore may not be deemed worthy of having the operation, or if he felt his body was too old physically to manage the operation.

There are several counter-narratives in Edward’s interpretive story. Firstly, he actively seeks out and requests help, when needed. Edward plays an active role in his health care decisions and choices, unlike others in his generation, specifically other men. His active role in his health allows him to know that his health is being appropriately managed, and provides an entry point for collaboration between Edward and health care professionals. This is also noticeable in his proactive stance in maintaining a good community network, in his church and at the local bridge club, noting that bridge helps to keep his mind sharp and his day’s full, promoting good mental health. Secondly, is the counter-narrative of control. Aged 75, he lives alone with limited vision and manages a recurrent mental health condition. He maintains independence and control in his life by managing his shopping; his finances, he travels by public transport independently and uses the support of others only when he deems it necessary.

Lens of Moments

The story takes a turn when Edward speaks about the wasted time spent looking for items that have been moved by a guest. This sentence unexpectedly moved me. Edward appears to manage so well with his limited sight, that I had not imagined the dedication and persistence required to gain this level of confidence, and the frustrations of moving just one object. Suddenly, it felt that the control that he held is highly dependent on how others move and respond, and for the first time I became acutely aware of both his strength in patience and vulnerability.

4.4. James's story: It's Awkward!

James and I first met many years ago, when I was working for the working-age adult CRHTT. He is now in his mid-seventies. He lives in sheltered accommodation for elders, where there is a warden present during the day: he gets involved with some of the communal activities at his accommodation and has frequent contact with a good friend, and his two nieces. He has experienced difficulties with anxiety and depression for the past 40 years, which have prevented him from working, and over the years he has had frequent contacts with the OA-CRHTT.

"I tend to wait until things get quite bad. You know, instead of doing it at the time.

I am sure it was the last time?

I was in my flat and I wasn't feeling all that good,

I was feeling a bit,

What you call like very depressed,

And I had um.... panic attacks,

If you know what I mean?

I don't call them as early as I should.

See I don't want to bother them,

Don't want to sort of like, like make myself a nuisance,

If you know what I mean?

It's very um,

It's very hard to,

You know,

To um,

Just to pick up the phone and explain to them is,

You feel you can't, sort of like, say actually what is wrong with you,

If you know what I mean?

You can't explain that,

Sort of how you feel,

Or anything like that!

...

Um, when I do contact them, I just say that I feel very depressed, and then I'll say that I want someone to come around, and then they send someone around.

The time goes quicker when they are here,
But it can be difficult when they go.
I suppose perhaps it broke the time up
If you know what I mean.

When they was gonna go,
It was you know,
A bit more awkward to um,
To do things,
If you know what I mean?

I know because a lot of them haven't got the time,
They um,
They go on,
They gotta see different people as well.

I know they see different people but then, but then when they see me
When I'm not all that good,
It seems like I have wasted their time.

It's very awkward like to sort of like carry on after they have gone, after they
have left...

...

Sometimes, I go to the um mental place and um sometimes I see the home treatment team.

The home treatment team are trying hard,
And help you as much as they can,
Sort of like by like encouraging you

To do things more for yourself at home,
Talking with you and going to the shop with you.

When you're at home,
You don't really feel like cooking or anything like that,
Or doing anything,
Not really because it is always too much of an effort to do it.

At least up at the hospital,
You had your,
You know,
You had your meals up there as well.

But it seemed a bit sort of frightening in a way,
If you know what I mean,
Because you don't know how people are going to react if you don't offer them a
cigarette.

The last time I was there,
There was this man and he kept making himself a right nuisance,
And I was a bit frightened in a way really.

...

It's change mostly, that I worry about, and I'm trying to find out how I can make myself actually better.

It is um;
I find it is awkward,
Uh,
Like to explain how you feel to the crisis team.

I think they do try hard in a way,
But then,
I think it's um,
You know it's very hard to explain to them how I feel.

And it's very hard to think,
To think about that when you're depressed,
You don't know how to sort of like get out of it,
If you know what I mean?

YOU KNOW IT'S LIKE GOING
THROUGH A TUNNEL,
AND YOU NEVER
GET TO THE
END OF
IT.

I hope what I have said is alright?"

4.4.1. James's Interpretive Story

Emplotment

James's personal narrative describes a saga of struggle with anxiety, and the pressure this places on his relationships (in this instance, the OA-CRHTTT). The main characters within the story are James and the OA-CRHTTT staff.

James begins his story with a confession, which is about his delay in self-referring to the OA-CRHTTT. It is unclear why he has this sense of their being a 'right time' to contact the team, and if this is something he has been told or something he believes. In this story, James demonstrates that despite wanting help, asking for it can be tough.

The second story demonstrates James's struggle in being with the OA-CRHTTT. The story brings to light positive aspects of what happens when James does contact the OA-CRHTTT. His request is validated by sending someone to see him. The company of the team during visits helps time to pass and adds some structure to the day. Nevertheless, this is contrasted with the complicated feelings that arise after they have gone.

The third story represents being stuck between a rock and a hard place as he weighs up the pros and cons of staying at home with OA CRHHT support or going to the hospital. He reflects positively that the OA-CRHTTT try hard to help him do things that he would struggle to do by himself, but states that it requires too much effort to stay at home as he has to be active in looking after himself, especially when they have gone. Alternatively, at the hospital, he has access to 24/7 support and can take a more passive role, but from experience, he worries about being vulnerable to exploitation from other patients. This story highlights the drastic difference in levels of support between OA-CRHTTT and hospital.

The final story is about hope, the times that it is there and the times when it is hard to find. James starts with his aim for the future, demonstrating his belief that a future is possible. In this story, the content feels quite repetitive, and similar themes are presented from the first story, that of the challenges of living with depression and struggles he faces to express himself. The story has come full circle.

Lens of Language

James moves between first person and second person narrative within the story, inviting the audience into his shoes, creating a close connection between James's feelings and the reader, this is particularly noticeable in the last two paragraphs when James speaks about his feelings and his interactions with the OA-CRHTTT. This move between first and second person narrative is achieved by using the pronoun 'you'. In his form of narration, he is hesitant and uncertain, frequently pausing and interrupting his flow of speech, such as with uh and um. However, what James is unable to express in words, is easily felt in the non-verbal communication and his delivery, therefore he has found ways of communicating his feelings to others. In his character, he creates himself as a vulnerable bystander, feeling unable to do what he perceives is expected of him by the OA-CRHTT (e.g., being able to self-refer at the appropriate time), and feeling guilty for needing others to help him.

In his story, James creates a self-image of someone who is lost but is persistently trying to overcome this feeling by trying to establish relationships with others. The sense of feeling lost is established by the struggles he faces; it

is difficult for him to think, or know what to say, representing a strong sense of uncertainty and doubt in his mind. He also describes feeling unable to “get out of it”, when speaking about feelings of depression. An example of James seeking to establish connections with others can be witnessed by his repeated use of the phrase “if you know what I mean?” While the phrase ‘you know’ is frequently used in colloquial language, James is seeking more than this. He is seeking validation and reassurance that I understand what he is expressing, as having a shared understanding of his feelings creates a form of connection with others.

James uses terms which may reflect feelings of being unworthy of attention from the OA-CRHTT team staff, by stating that he ‘does not want to be a burden’ or be a ‘nuisance’, or feeling like he has wasted their time. James’s relationship with the team is challenging for him. On the one hand, he is expressing the desire to contact them and be in their company, finding them useful in doing tasks alongside him. On the other hand, he finds the intimacy of the relationship anxiety-provoking, describing the need to entertain them, indicating that being with him is meant to be a productive part of their time, rather than a support for him. Here, there appears to be some form of role reversal, with James needing to provide care for the carer, which may be emphasised by the interaction taking place in his home, rather than in a setting where he might expect to receive care (e.g., hospital).

When James talks about the uncomfortable feelings he is left with once the OA-CRHTT depart, it felt quite striking. James is caught between finding it challenging to talk to the team when they are there and to manage to be on his own once they have left, continuing the theme of a struggle.

James feels acutely aware that the OA-CRHTTT see other service-users, and he alludes that the team may prefer to spend their time elsewhere, or that this is a factor which prevents them from spending time with him. This awareness of other service-users appears to be the only thing he is sure about (e.g., “I know because...”), in a story of hesitations and uncertainties.

He puts the team in the position of 'trying hard' to help him, indicating that it may be difficult for them to succeed at this task. James may be reflecting on his years of experience of working with mental health teams and his evaluation that perhaps his mental health difficulty is difficult to help. The OA-CRHTTT respond rapidly to his request for support, once he tells them how he feels; however, it is the uncertainties about the interactions that seem to cause him distress. For someone who struggles with change, I am left wondering how James manages the frequent change in staff members who visit from the OA-CRHTTT.

Lens of Context

The situational context between James and I was unique, in that he is the only co-researcher I had met with in a professional capacity, many years ago. Although I had met with all co-researchers several times before conducting interviews, I had no knowledge of their interactions with mental health services beforehand. With James, I had hoped that his familiarity with me made him feel more comfortable, however it could have made him place more emphasis on doing a good job. At the end of the interview, he appeared to want validation that he had provided what I was looking for, that he had fulfilled his part.

James draws strongly upon wider dominant narratives in his story. The most poignant is the burden narrative. James states that he feels like a burden to the OA-CRHTTT staff, and is so concerned by this that he hesitates to make a self-referral. It is likely that this is connected to James internalised narratives of people with mental health difficulties, and elders, known as double jeopardy. His position in society has made him feel unworthy of support, and a drain of the resources of the OA-CRHTTT staff.

Lens of Moments

When James spoke the second to last sentence of the story – "You know it's like going through a tunnel, and you never get to the end of it", I was both astounded and saddened at the same time. I was astounded, as this was the only time that he used a metaphor, and he said it with such clarity and meaning, without any hesitation or pauses, and it conceptualised his whole narrative so well. Yet, it saddened me, as James suggested in his story that he has been

hoping for improvement for so long, it feels frustrating that the light is still eluding him, and the professionals involved in his care, despite efforts.

4.5. Collective Statement

The collection statement, below, was presented in a meeting with seven members of the OA-CRHTTT, alongside three members of the research group (myself, and two co-researchers). The collective statement has been adapted to highlight the main points raised; a full version can be found in Appendix R. A picture of the themes discussed to create this statement can be found in Appendix K.

4.5.1. Older Adult Home Treatment Team Research Collective Statement Kindness

The staff from the OA-CRHTT were able to demonstrate kindness, compassion, and consideration. This was particularly emphasised in one story, where the OA-CRHTT were described as “being like family”, that they brought an “easiness” to being in their company and were able to ask questions in a respectful way, which was essentially important. Larry’s story highlighted that the interaction with the home treatment staff in and of itself, made him happier.

Assessment

At its best, the Home Treatment Team acted collaboratively and swiftly, which lead to effective intervention. In discussion, we acknowledged how this was aided by a person’s own knowledge of what worked for them in a mental health crisis, and their ability to relay this with clarity. Edward explained that he has been living with bipolar for many years and therefore had a good knowledge of what medications worked for him and what the health implications might be for certain medications. He was able to discuss this in his first meeting/assessment with the Home Treatment Team, which was with the team psychiatrist.

Together, they quickly identified that Edward needed a hospital admission whilst his medications were changed so that his physical health could be appropriately monitored. Edward’s story highlighted that a quick response to his needs at the time was vital.

In contrast, Matthew's story spoke about difficulties in being able to express himself to the OA-CRHTT staff during the assessment process. We recognised that a person in crisis may not feel confident, at the time of assessment, to provide an accurate description of what they are experiencing for a variety of reasons. In discussion, we thought that Matthew's ability to present himself as someone who is articulate, alongside masking the severity of his symptoms, meant that his verbal responses may have hidden the extent to which his symptoms were affecting him. As this was his first contact with mental health services, he also did not know what services the Home Treatment Team could offer and was not informed of this fully when he started working with the home treatment team, leading him to wonder about the point of them visiting in the initial stages.

Communication

We think that communication and understanding between the staff and the individual in crisis is key. When this has worked well, lifesaving action has taken place. However, on other occasions we noticed how a breakdown in communication led to severe misunderstandings. In Larry's story, he explained that he had asked to go to hospital, but thought he would be in a physical health hospital. Once admitted to a psychiatric hospital, he also did not know that as a voluntary patient he could go on leave at any time.

We noticed how a person's confidence and concern about what others might think may impact on the ability to communicate for a person experiencing a mental health crisis. James's story spoke about his worry of talking to the staff, and often feeling unsure of what to say, concerned that he was being a nuisance. This made us think about dominant social stories about elderly people being a nuisance. We also recognised how much this dilemma caused him increased levels of anxiety.

Summary

From our review of the stories we have come up with areas which we would like you to consider;

- Assessment

We asked ourselves the question ‘how can the person in crisis be encouraged to accurately describe and understand what is happening to them?’ And, what can the home treatment team do to conduct an accurate assessment? We recognise that each person’s experience of a mental health crisis is individual, and each person may require something different from the home treatment team. That being said, where possible we think that it would be useful to place emphasis on an assessment approach which involves the person and the system around the person, such as GP’s and family and friends. We also noted that the persons that are most able to make good use of the home treatment team are those that have good knowledge about what this team can offer. Therefore, an explanation of what the team do, and what they offer should be relayed at the assessment stage, especially for people who have not had contact with the team before.

- Communication

As described, experiencing a mental health crisis can be a confusing experience, it is difficult to hold onto information during the time of crisis and it can also be difficult to remember what happened during the crisis. To ensure that communication and understanding between the person in crisis and the home treatment team is clear we think it is important that a clear plan of action is established and created collaboratively. We understood that there can be a lot of information to take in about treatments and recommendations during a mental health crisis. Therefore, we also think it would be helpful to have a written summary once a person is discharged, listing any diagnosis given, recommended treatments, and referrals to onward services. At the point of discharge we also think it would be helpful to signpost people to local or national organisations that may be able to provide support and information.

4.5.2. Responses and Actions to the Collective Statement

The meeting followed a pre-determined agenda that was set by the research group (Appendix L). I read the statement aloud, and a reflective discussion took place. The OA-CRHTTT responded to each point in an open discussion, which involved an iterative process between the OA-CRHTTT and the research group. The discussion was respectful and enthusiastic. The co-researchers were able

to learn about some of the processes of working in an OA-CRHTT team, and the staff members were able to think about the assumptions they held about their service-users knowledge of what the service provides. The next section identifies the actions taken forward.

Firstly, the OA-CRHTT staff felt that it was vital that they use a systems approach in their assessment process. Many staff felt this was already in practice, but wanted to ensure that it became ingrained within their practice. Therefore it was agreed to include it in the assessment proforma as a prompt to staff. OA-CRHTT staff acknowledged that friends, family, and other members of the community are vital in providing support, but also in providing in-depth information about how the current mental health difficulties have impacted upon the service-user.

An agreement to create a booklet for service users was reached to provide a tool in maintaining excellent communication between staff and service users. The booklet will hold information on the teams contact details, care plans made on each visit, and information regarding any onward referrals or important details. The service-user would hold this booklet at all times. Staff felt that this could be a useful tool in ensuring collaborative conversations about the service-users care plan and did not add massively to any additional administrative tasks for staff. Staff invited the co-researchers to help develop the booklet in collaboration; the invitation was readily accepted.

The final action was for the personal narratives to be shared with staff from the OA-CRHTT and staff on the older adult inpatient wards. Staff were intrigued by the exerts in the collective statement and wanted to hear more of the stories. In turn, the co-researchers were eager for their stories to be heard as they thought it could provide staff with an excellent learning opportunity.

Both parties reported finding the meeting enjoyable and a good opportunity to reflect on the provision of elder crisis care.

5. DISCUSSION

Within this chapter, I will discuss the results in light of the literature, followed by a critical review of the challenges and limitations posed by the research. Finally, I will suggest recommendations for acute services with elders, from a clinical psychology perspective, which stem from the outcomes of this research.

5.1. Research Findings and Existing Literature

This section will explore the findings from both the individual analysis of the interpretive stories and the collective statement; highlighting which text the findings were drawn from. The first two research questions are answered here; however, the third question about what could be done differently contributes to the recommendations.

5.1.1. How was the intervention provided by the OA-CRHTT perceived by elders?

The personal narratives all explored different aspects of the intervention, be that the connection with staff, access to help and usefulness of the service. As a narrative analysis was used, the answer to the question incorporates how the stories were told, and understanding the context of the teller in relation to the intervention, as well as the content.

The data used to answer this question was taken from the personal narratives and the interpretive analysis conducted by the principal researcher.

5.1.1.1. *Stigma of MH*

There is an established research base that highlights the impact of stigma on people accessing support with mental health difficulties. In the interpretive narrative's told, it was co-researchers who were experiencing their first interaction of mental health services that echoed the stigma associated with mental health services users held in Western society.

Both Larry and Matthew used the dominate narrative of people with mental health problems as being dangerous, in regards to how they were treated and what treatment options would be suitable. This narrative was identified in Matthews's willingness to perceive acute psychiatric wards as dangerous (after being informed by healthcare staff that this was the case), and Larry's shock at the respect he was shown by the girls, as a result of placing mental health users alongside murderers. Additionally, the dominate narrative of the link between perceived low intelligence linked with mental ill-health is also present, an example was highlighted in Matthews description of himself as intelligent and articulate, and eluding that this may have made it difficult for staff from the OA-CRHTT to identify that he had a problem [with his mental health]. There has often been a stigmatizing link between mental health and criminality, likely emphasised by western society's fascination with homicides committed by people who have been deemed mentally unwell (Henderson, 2018). In response to this, it has been found that the most common response to such stigma is the concealment of symptoms (Isaksson et al., 2018), providing one possible explanation why Matthew 'masked' the severity of symptoms to the crisis team, and why Larry emphasised the impact of pain.

What is intriguing is that James and Edward, who have both had long-standing links with mental health services, did not place their experience into this context. There could be multiple reasons for this; they have learned to live with the stigma; they have associated mental illness with their own lives rather than with society's perception of it. It seems relevant that in this instance stigma particularly impacts the elders that have not had contact with services before.

5.1.1.2. Knowledge of the system

Similarly to research conducted by Lyons et al. (2009) on WA-CRHTT, differences were identified between those previously familiar with the service, and those using the service for the first time. However, unlike Lyon's et al., where the difference lies in being able to access services, in this research the difference appeared to be in the context of knowledge of what was available and an understanding of how the service works.

In his personal narrative Edward produces a story which emphasises how useful the service can be, he knew where to access help, was aware he could self-refer, and had good knowledge of his mental health difficulties and what needed to be done with his medication, and had a plan in mind of what he thought would be the best solution for him, an inpatient admission. Conversely, Matthew struggled to identify how the OA-CRHTT could help him in the first instance, he was drawn to different treatment paths and not having this knowledge was reliant on staff supporting him in making this decision, which appeared to create further confusion at the time of crisis. In later discussions, he noted his surprise that OA-CRHTT could offer medication or had access to a psychiatrist. Additionally, Larry was not aware of the informal status provided in psychiatric hospitals, and his story identifies his resigned character when admitted. The mental health system is complicated to a novice, with service users and their families requiring much support in being about to navigate this system in a way that is easy to understand so that they can make informed choices about their care, and be aware of their legal rights.

The historical practices in which elders have been treated in the mental health systems, where their view has not been taken into account, highlights how important it is for services to focus on this, and learn ways of communicating this information effectively. 'Crisis', are often turning points in people's lives with decisions having consequences that long outlive the crisis. Being able to work collaboratively means being aware of what options are available, and what the potential paths of treatment are.

Both stigma of mental health and knowledge of the system are mediated by having experience of using mental health services. Therefore elders accessing the mental health system for the first time may require more psycho-education and more emphasis on normalising and working in collaboration.

5.1.1.3. Using MH services and impact on independence

The literature discussed how elders are caught in many dominant narratives about how they should engage with other generations, and on health services

and society. Many of the dominant narratives highlight the burden placed on society by the growing number of elders who require health care, placing the blame in the individual, rather than political resources. Others highlight the need for 'active elders', working towards having independence and not being reliant on others. In the personal narratives presented, there was plethora of examples that highlighted the challenging space between independence and accessing support; this was most poignant in James' story. James desperately does not want to be a 'burden' to the OA-CRHTT, and this mediates his behaviour with how he engages with them. In other personal narratives, there is a determination to 'get on' with things or to manage the situation in their way. In Larry's story, the issue of independence was contrasted with the concept of accessing help – he enjoyed having the 'girls' come around, but felt that to regain his independence he would have to give this up, a dichotomy was drawn. Generational views of when it is acceptable to receive help or the mentality that was prevalent in WWII generations of 'getting on' with things and being self-reliant may be factors contributing to elders desire to access support. Elders' perception of mental health treatment was found to be closely aligned with their perceived need, in many instances suggesting that they would instead handle the problems themselves, this may be a factor which delays OA's from accessing services and therefore means that they have arrived in contact with services in worse health.

The role of hegemonic masculinity may also play a role in this balancing act between independence and dependence, with all four stories created by elder men, it may also demonstrate the influence of cultural expectations placed on elder men in dealing with their emotional selves, e.g. to get on with it, not to be perceived as weak or vulnerable. Hegemonic masculinity has shown to impact on suicide rates, is a cause of great concern as men have a higher rate of completed suicide than women across all age groups, including the over 65's, with a substantial rise in completed suicides in Elder men from 9.1 per 100,000 in the 80-84 age group to 17.1 per 100,000 in the 85-89 age group (Office for National Statistics, 2018). Drawing a direct link to the support that OA-CRHTT are able to offer.

5.1.2. What, if any, aspects of the intervention helped resolve the 'crisis'?

Unlike the literature on OA-CRHHT, none of the personal narratives gave importance to the OA-CRHTT reducing, or delaying or avoiding hospital admission. The aspects of care that appeared helpful during crisis were often related to the therapeutic relationship between staff and service users, namely: respect, accurate assessment (being understood), and collaborative working. Both personal narratives and the collaborative statement answer this question.

5.1.2.1. *Humanising interactions*

Collaboration, Understanding and Kindness were concepts used in the group statement to describe intervention aspects perceived as helpful. Alongside these, I would add respect to the list of concepts that would fit under the umbrella of Humanising care. Humanisation refers to “practices that take the perspectives and values of people who are part of the practice into consideration” (Visse, 2012). The practice of humanising care should be evident from the macro-level structures of policy to the micro-level of individual interactions (Castro Romero, 2017).

Humanising care was noted in personal narratives. In Larry’s narrative, being treated with respect and kindness appears to have allowed him to establish a good rapport with the staff from the OA-CRHTT. It seemed that OA-CRHTT staff adapted their language to conduct risk assessments in a way that incorporated Larry’s dignity. Edwards’s narrative describes being a part of the process, actually informing the process of what needed to happen, to which the OA-CRHTT responded with respect and collaboration; treating Edward as a unique person, with his own skills and knowledge, he is not a passive recipient of care, and agency.

Similarly to these findings here, being seen as ‘ a human’ by CRHTT staff was highlighted as essential in qualitative research about WA-CRHTT (Hopkins & Niemiec, 2007; Winness et al., 2010). Indeed, collaboration and holding humanistic values are seen as values on which CRHTT are established (Klevan, Karlsson, Ness, Grant, & Ruud, 2018). Furthermore, humanising care

is specifically significant for elders, who views have traditionally been ignored or worse, not sought (Hilton, 2015).

5.1.2.2. CRHTT vs inpatient Admission

Within this study, three stories resulted in a psychiatric inpatient admission, and the fourth story narrated experiences of previous admissions. The literature identifies that the role of CRHTT is to avoid or reduce hospital admission, where possible, being less restrictive form of care that enables the person to receive health care in their home environment, thus reducing the likelihood of institutionalisation and maintaining daily activity skills (Caplan et al., 1999). From the personal narratives, some preferences of treatment pathway were evident from the start. For example, Edward preferred hospital admission as a method of keeping himself safe from suicide and ensuring that his physical response to medications would be closely monitored. In other personal narratives, it was more complicated; for example, Matthew initially held negative views (of danger) of inpatient environments but in hindsight reported it to be a crucial aspect of his treatment. Equally, James highlighted the dilemma about feeling more supported by staff in an inpatient environment, while feeling anxious about having to manage interactions with other inpatient service-users. From the analysis, all but Larry (who was unaware he was going to a psychiatric hospital) were complimentary about hospital admission. This positive response led me to question the assumption that most people would prefer to stay at home when experiencing mental health crisis, based on what is known about preferences of care for WA adults (Johnson et al., 2005). Elders do have different needs to the WA population; they are more likely to have a physical health condition, which may make any treatments and interventions more complicated to implement in a community setting. Elders are also more likely to live alone therefore be socially isolated, which may mean they benefit from the level of support provided in hospitals.

5.2. Critical Review

5.2.1. Trustworthiness of Analysis

The validity of the analysis uses Riessman (1993) framework (as stipulated in section 2.5.2). This framework includes four areas which demonstrate validity: persuasiveness, correspondence, coherence, and pragmatic use.

The persuasiveness of interpretation in NA is demonstrated when it is 'reasonable and convincing' (Riessman, 1993:65). Persuasiveness was achieved by using three methods. Firstly, the use of direct quotes taken from the co-researchers to create their personal narratives. Second, the inclusion of situational context of the interviews within the personal narrative; this action allows readers to recognise that the story has been within a relational context between me and the co-researcher, and in the context of a research interview where co-researchers are responding to questions posed. Finally, peer review was sought and aligned strongly with themes already identified. A story is identified as good when it encourages other readers 'to look where I did, and see what I saw' (Peshkin 1985, cited in Connelly & Clandinin, 1990:8)

Credibility can be strengthened when interviewees can check the analysis and confirm that it is representative of the interview discussion (Lincoln & Guba, 1985). During the creation of the personal narratives, I collected the feedback of co-researchers at two points; after the creation of the middle stories, and when the final interpretive stories were complete: which strengthens the correspondence of the creation of the personal narratives.

Agar and Hobbs (1982) suggest that there are three types of coherence to validate an interviewee's story: global, local, and themal. The analysis section aligns with this by reviewing the personal narratives through language (local), and wider context (global), while also discussing instances where the personal narratives converge and differ in the discussion section (themal).

Pragmatic use, also described as transparency, was adhered to by making visible the method of analysis used (Appendix Q), and the process of story creation (Appendix P).

5.2.2. Methodological Limitations

5.2.2.1. *Co-researcher Access to Study Participation and Implications*

Ethical standards require that the recruitment of participants (co-researchers in this research) from NHS services should first be approached by clinicians that the participant is familiar with. Therefore, I was reliant on the judgement of OA-CRHTTT staff to decide which potential co-researchers met the inclusion criteria, which exposed the process to potential bias. Firstly, staff may have only wanted to refer people they thought were more likely to frame the service in a positive light. To counter this, I made myself available to discuss the inclusion criteria and encourage contact with potential co-researchers who met this. Secondly, those who did not have a good experience with the OA-CRHTT may have been less inclined to participate when contacted by staff directly, in the first instance.

Furthermore, it is unknown if the sample who agreed to be contacted were representative of people accessing the service as a whole, or if there were potential barriers in either accessing the study or accessing the service for other groups (e.g., elder women, elders from BME backgrounds). Consequently, the research implications are limited by the lack of fuller representation. For instance, cultural variations or gender differences in how elders relate to the main results of humanising care, independence and stigma could not be explored. Additionally, other areas of potential interest such as ease of access, helpfulness of the intervention for people with dementia, and what support families may require did not arise within the personal narratives; hence, creating gaps in knowledge.

5.2.2.2. *Attrition*

High attrition represents one of the major challenges this project faced. Two of the co-researchers moved into periods of mental health crisis during the six-

month research project and had to place their participation on hold, or withdraw. This may be one reason why more qualitative or participatory research is currently lacking in this area, yet it should not deter researchers from these topics as research moves away from the rhetoric of elders being less likely to participate, and instead brings a focus to identify methods to increase accessibility (Beresford, 2013). Drawing on values of collaboration and transparency, I discussed with co-researchers at the start of the project what action they would like me to take if they were affected by mental health issues. When it did occur, I spoke with them individually; it was agreed that they were welcome to contact me should they feel that they wanted to re-join, offering the possibility of returning to the project, which one of the co-researchers did.

5.2.2.3. Level of Participation

The use of PAR as a guiding methodology has strongly influenced decisions in the method of data collection and method of analysis. Using Carmen et al. (2013) framework to identify the level of participation, this project focused on the area of organisational development and governance, and on the continuum of engagement achieved between Involvement and Partnership and Shared Leadership. Some of the aspects of this project were shared (decision making around the method of data collection, method of analysis); however, there were no shared leadership in organising events or leading meetings, therefore I, as the principal researcher, had more ownership over this aspect.

5.2.2.4. Methodology Selection

Using narratives ensures that the humanising element of 'care' in the healthcare professions is brought to the forefront and allows the audience to connect emotionally to research. Research conducted on the topic of illness narratives provide historical accounts and influence societal understanding of illness through time (Kleinman, 1988). In the interviews, there was lots of rich information. All the personal narratives told stories about the entire crisis, which is difficult to unravel from working with the OA-CRHTT. However, within this, there was rich information about other services that the co-researchers found helpful, such as the acute day unit. As the research was to focus on OA-CRHTT, it seemed difficult to involve this within the interpretive stories. However, if a form of thematic analysis were used, this data may have come

more to light, or if there was more reflexivity on the research questions once the project had started this may have been more appropriate.

5.2.3. Reflections

PAR projects are long-lasting, and the information analysed by myself and the group serves to provide some aspect of the action that has led from it, yet there are more action points to take forward, and it is yet unknown how this may materialise as when we enter into PAR projects it is difficult to foresee the nature and length of time, that the project will take.

The co-researchers who took part in interviews are homogenous in relation to their gender and ethnic background, all four being White men. This group were reflective of elders who were referred to me as potential co-researchers by the OA-CRHTT. The interpretive stories are therefore representative of a hegemonic social group and are lacking perspectives of from other groups (e.g. elder women, elder people from BME background, elders with a diagnosis of dementia). Such lack of diversity is a consistent and unacceptable finding in participatory involvement in services (Beresford, 2013), and led to my reflections of what potential barriers may have been present in this research design which impeded the inclusion of people from different social groups. One clear barrier was that of language, with the requirement for all co-researchers to speak English. In addition to this, Beresford (2013) highlights that it can be difficult to discuss issues related to women in a mixed-sex environment, and consequently the idea of a group meeting may have deterred some women. Furthermore, the lack of diverse representation, from an area that is rich in cultural diversity, may be suggestive of which groups of elders are accessing acute mental health services and those who are not.

Although similar in some respects, the co-researchers who participated in interviews shared difference in other areas, such as professional status and education. It is of interest that the two co-researchers who continued participation throughout the process were also those with a professional background; a number of factors could have impacted this. It is possible that the participatory and evaluative demands of the project were not made as

accessible to others. Additionally, it could be that the co-researchers who had a professional background felt more empowered by their status and education, and therefore were more familiar with their opinion being sought and regarded.

Challenges

During the recruitment process, I noticed that many of the people I spoke to found it difficult to decipher which mental health staff worked for the OA-CRHTT, or who the OA-CRHTT team were:

“Just like previous meetings, (name) seemed to know about the crisis team, but needed help in placing who they were and what they provided! Is this an indication that the team need to introduce themselves in a more thorough way? I wonder if it is helpful that mental health services appear seamless, or confusing? Does it matter to people who provides the service, if they are getting the service required?”

(Extract from reflective journal dated 26.03.19).

This raised awareness of how consumed services are with maintaining knowledge of their teams, yet to service-users it appears that we are all seamlessly linked to one another, but also this may represent challenges in knowing whom to contact when in a crisis situation.

Ethics

Co-researchers were provided with the opportunity to choose a pseudonym; however, four out of the five co-researchers wished to use their real first names in the research, stating that they were happy with the stories that had been created and possibly demonstrating their alignment with the project, not as participants, but as co-researchers. They requested this on the knowledge that this project would be published, and that health care professionals involved in their previous and possible future care would have access. The BPS (2014) guidance for research with human participants rightly identifies the need to respect the privacy of the individuals, however in using narrative stories it is

clear that some stories will be easily identifiable to people that know the co-researchers. The guidance also states that 'Where a participant wishes to have their voice heard and their identity linked with this, researchers will endeavour to respect such a wish' (p9). To overcome this, it was agreed to comply with the University guidelines; therefore, pseudonyms have been used in this thesis. However, any future publications will use the real names of the co-researchers.

Stainton Rogers (2009) suggests that critical researchers are not just concerned with who gains and who loses in regards to outcomes, it is also important to think about who gains and who loses within the research process. All of the participants were enthusiastic about the project, many as a way of 'giving back'. However, I had not anticipated that people may become offended by open discussions about working with the OA-CRHTT, and this clearly impacted one members desire to return to a group environment. Those that remained reported to find the experience positive. I learnt a tremendous amount from the process of this research project, specifically in the complexity of working as a group where power was not evenly distributed and the remits of what powers could be shared.

5.3. Research Implications

This research has utilised a PAR guided framework alongside a pragmatic approach; highlighting the importance of creating knowledge through praxis, and ensuring that actions stem from this knowledge. Praxis is an ongoing process that requires continued opportunities for dialogue and reflection. Consequently, the recommendations below are one part of a broader dialogue and should only be applied with the commitment to further cycles of reflection and action in dialogue with elders. This section will review data from the collective statement and interpretive analysis and frame recommendations from a clinical psychological perspective.

5.3.1. Clinical Practice

The intricate nuances of humanising practice are, at times, lost in an era of target-driven healthcare. The way clinicians respond when elders are

experiencing their first contact with mental health services provides a template of how wider society may respond and therefore, can be a useful tool in tackling stigma if approached with the values of humanising care. To maintain and improve upon the good examples of humanising care demonstrated in the personal narratives, it needs to be at the core of OA-CRHTT practice, not just in words, but also in action. The clinical practice of CPs within CRHTT roles is often delivered through indirect work by facilitating reflective practice and consultation. The reflective practice offers a protective space in which clinicians come together as a team to reflect on their interactions with service-users, allowing for ideas to be shared and new approaches to engagement to develop. In this space, CPs can draw on examples the team bring to highlight how humanising practice is used effectively. Creating and supporting a team ethos of collaboration between clinicians and service-users may also enhance humanising practice.

Effective communication and transparency about what the CRHTT offer, were indicated of areas of importance within the collective statement. As demonstrated by the personal narratives, experiencing a mental health crisis can be a confusing time, where it can be difficult to retain information. Incorporating service-users within the experience and making sure they are informed at all stages of the options available (if there is a choice) and what the option consists of are vital aspects of demonstrating respect and collaboration, they can also form the basis of discussions between service-user and clinician. Practical ways in which this can to achieve this are by providing three types of document. The first is an information leaflet providing information on what the service offers. The second, generated in the discussion between co-researchers and clinicians (section 4.5.2.), is a small booklet held by the service-user that logs each visit made by the clinicians from the OA-CRHTT and notes bullet point actions/care plans. Finally, a copy of the discharge summary should be provided; this would allow an opportunity for the service-user and clinician to discuss onward referrals, and check for understanding, and provide them with official documentation outlining the intervention they received. All of the above suggestions can and should be created alongside elders, keeping the focus on what information they would find useful, and how to share this information in a format which can be easily understood. All these documents

aim to improve communication and collaborative working between service-users and clinicians.

5.3.2. Service Level

To improve the assessment and understanding of elders needs when experiencing a mental health crisis, OA-CRHTT staff should have training in systemic principles. Each personal narrative demonstrated that co-researchers had a unique experience of working with the OA-CRHTT, influenced by their particular context. Systemic ideas focus on the ability to maintain and apply curiosity (Cecchin, 1987) and understanding people in their context (Burnham, 1993). Martin & Stott, (2010) highlight how using systemic ideas can enhance the engagement of the service-users and create a more comprehensive understanding of the problem. In particular, the systemic model may allow clinicians to start generating curiosity and questions from the point of referral, encouraging the assessment process to be more tailored and specific to the individual.

Additionally, a systemic model encourages clinicians to think about the impact of the wider network, such as family members but also organisations, communities, and societal influences. It can encourage clinicians to consider if dominant narratives such as the expectation of independence, the stigma of mental health difficulties, generational views about accessing help, among others, are operating in elders life, which will then allow clinicians to adjust their responses accordingly. The 'wider network' would likewise include the OA-CRHTT team and individual clinicians, bringing greater awareness of how the team/clinicians may be impacting on the situation.

Systemic ideas are based on psychological concepts, placing CPs in an essential role for delivering training and providing ongoing consultation. The use of systemic ideas is not new to the work of CRHTT, and when the WA-CRHTT were established, they focused on similar concepts. However, over the years, this has been eroded whereby WA-CRHTT have become focused on monitoring and clinicians have become less skilled in utilising systemic ideas (Morant et al., 2017).

5.3.3. Policy/Political

The exportation of services from working-age adults to elders is endemic in our society, and CPs must focus on issues of power and seek change for marginalised communities through legal justice and policy change (Afuape et al., 2016). We should ensure that we are not using 'pre-understanding' of what is helpful for elders by focusing only on exporting knowledge from working-age adult research and business models of care. As part of the leadership responsibilities within the CP role, input into developing care pathways and developing policy, based on research that is focused on what is helpful, alongside elders are paramount. This includes advocating for specialist services for elders, and equality of access to acute community services.

5.3.4. Future research

This research worked alongside a small group of elders, with four personal narratives produced. Given the growing number of OA-CRHTT services being developed in the UK, more research is required in collaboration with elders, on what is helpful in times of mental health crisis. This would allow a broader understanding of the multiple views of elders, which can then inform treatment interventions, pathways and policy. For example, this study was focused on the personal narratives of four White-British men, research with elder women and elders from a BME background, who may have different experiences to White-British men, is vital in order to understand and include the experiences from a range of contexts. Considering the difficulties in recruiting people from a BME background, it may aid future research to recruit/advertise the study in any relevant BME forums/local community groups within that specific NHS Trust, if available. Furthermore, we were unable to learn about the experience of using a CRHTT from the perspective of someone with an organic mental health difficulty, such as dementia, and therefore unable to ascertain how useful a CRHTT service is for this group. Future research should explore the usefulness of a CRHTT model for people with organic disorders, their carers and families.

I would advocate for future research to continue to use PAR principles, to ensure the knowledge of elders is incorporated and acted upon, thus moving

away from a health service that has historically marginalised elders and toward collaboration and true dialogue.

To date, most of the research on OA-CRHTT has measured their usefulness based on a reduction in hospital admissions. This data alone is not sufficient in understanding if the service is perceived as helpful to the elders using it, and if the service is providing a level of care that supports a reduction in distress. Further research should centralise the focus on quality of interventions and usefulness of the OA-CRHTT. This may include recommendations made from this research, such as if training staff in a systemic approach has an effect on service-user experience.

5.3.5. Conclusion

This is the first study to investigate elder's experience of OA-CRHTT's with a purely qualitative methodology in England. The interpretive stories provided rich descriptions, not just of the co-researchers perception of the crisis team, but of their whole crisis experience. This allowed for a broader conceptualisation of the research. The co-researchers spoke of the importance of respect and care they received from staff working at the OA-CRHTT, and for some this was what most helpful aspect of the intervention. Others identified good assessment as lifesaving and essential in a time of need. In addition, there was a call for more emphasis on understanding the person and clear communication and information. This research has provided a clinical psychology stance, further influenced by liberation and critical community psychology, this said, the implications and recommendations can be utilised by all interested in the acute community care of elders. The implications highlight the need for national research and guidance to ensure equity and specialism for this area and further qualitative research to understand the perspective of elders.

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APPENDIX A – PREFACE

Firstly, I recall a meeting with a service-user with whom I had been meeting with to discharge from a Working Age (WA) CRHTT team. It was our first meeting, and colleagues had told me that she was 'resistant' to the offer of referral for Cognitive Behaviour Therapy, which the team deemed to be the most appropriate treatment. I asked 'What would you like to do?' Contrary to being 'resistant', this woman had multiple skills and ways of coping, which suited her preferred way of living. This encounter highlighted for me the assumption that as professionals 'we know best', and by holding this individual in a 'patient' role we, as a team, presumed that she was unable to make decisions about her recovery.

On another occasion, I met with a young man who had recently been discharged from a psychiatric hospital. He was angry with services and explained that despite being willing to go into hospital informally, he was for some reason, unbeknown to him, sectioned under the Mental Health Act (1983). He explained that he was unable to pursue his chosen career because of this, as there was an exemption to people placed under section. For me, this highlighted two important lessons; the actions taken by professionals during a mental health crisis can have a detrimental impact long after the crisis has been resolved. Secondly, these interactions can influence a person's long term view of mental health services.

APPENDIX B – LITERATURE SEARCH

Using guidance taken from Sutton's (2012), three elements were considered in defining the scope of the literature reviews:

- WHO = what the research is about?
- WHAT = what must the researchers find out about to answer the research question?
- HOW = how will the study impact on the who

The guiding question in the literature search was: what information is known about OA-CRHTT?

The following search terms were used to access the literature regarding CRHTT teams for elders. The searches were carried out in July – September 2019.

Search term 1 – subject term search

- "crisis resolution team"
- "home treatment team"
- CRT
- CRHTT
- "crisis resolution"

The terms in search term 1 were searched together with the terms in search term 2 using the Boolean operator 'AND'.

Subject term 2 – subject term search

- Old*
- Old* adult
- Elder*
- Pension
- Senior*
- Geriatric*
- Aging

- Geropsychology
- Geriatric psychiatry
- geriatric patient*

Limiters included:

- English language only
- Between 1990 - 2019

These search terms and limiters were used in the following databased: CINAL Plus, Psychinfo, Psycharticles via EBSCO and Scopus. A total of 22 papers were identified via EBSCO and 43 articles via Scopus. The titles were first checked for relevance, after which a review of the abstracts was conducted. Google scholar and Reseach Gate were also searched using similar terms. Reference and citations were also checked for any relevant papers.

Inclusion criteria:

In addition to the limiters applied, all studies were considered regardless of:

- the country of origin
- the type of methodology

The search identified relevant pieces of literature, which included scoping reviews, discussion papers, conference presentations and book chapters.

EBSCO = 51 results

English language = 46

1990-2019 (papers identified between 1991-2014) = 22

7 relevant articles

Scopus = 46 documents

English language = 43

14 relevant articles

4 removed as duplicates= 10

APPENDIX C – HRA APPROVAL LETTER



Miss Lucy Adamczyk
Trainee Clinical Psychologist
[REDACTED] University of
East London
School of Psychology, University of East London
Water Lane
London
E15 4LZ

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

13 February 2019

Dear Miss Adamczyk

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title:	A collaborative investigation of the experiences of elders using an older adult home treatment team; from understanding to action
IRAS project ID:	244436
REC reference:	19/LO/0169
Sponsor	University of East London

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Catherine Feuilleau

Tel: 02082234422

Email: researchethics@uel.ac.uk

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 244436. Please quote this on all correspondence.

IRAS project ID	244436
-----------------	--------

Yours sincerely

Rekha Keshvara
Senior Assessor

Email: hra.approval@nhs.net

Copy to:



List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [sponsor insurance letter]		31 July 2018
HRA Schedule of Events	1	09 January 2019
HRA Statement of Activities	1	09 January 2019
Interview schedules or topic guides for participants [Focus Group Topic Guide]	1	27 November 2018
IRAS Application Form [IRAS_Form_02012019]		02 January 2019
IRAS Application Form XML file [IRAS_Form_02012019]		02 January 2019
IRAS Checklist XML [Checklist_02012019]		02 January 2019
Letters of invitation to participant [Invitation Letter]	1	27 November 2018
Other [Peer review feedback response]	1	19 December 2018
Other [Supportive agencies contact details]		20 December 2018
Other [Certificate of Employers' Liability Insurance]	1	29 January 2019
Participant consent form [consent Form V2]	2	29 January 2019
Participant information sheet (PIS) [Participant Information Sheet V2]	2	29 January 2019
Referee's report or other scientific critique report [Peer review feedback]	1	27 November 2018
Research protocol or project proposal [Research Proposal]	1	27 November 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		19 December 2018
Summary CV for student [Student CV]		19 December 2018
Summary CV for supervisor (student research) [Academic Supervisor CV]		27 November 2018

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards?	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No application for external funding has been made
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments

Section	Assessment Criteria	Compliant with Standards?	Comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

This is a single site study and therefore, there is only one site-type.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS or on the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net, or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor's position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator is expected to be in place at the participating site.

GCP training is not a generic training expectation, in line with the [HRA/HCRW/MHRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken.

Use of identifiable patient records held by an NHS organisation to identify potential participants should be undertaken by a member of the direct care team for the patient, so it would not normally be acceptable for this to be done by staff not employed by that organisation. A Letter of Access (or equivalent) would be expected for any external NHS/research staff undertaking all of the other activities for the study once consent from the participant is in place. The pre-engagement checks should include a standard DBS check and Occupational Health Clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

APPENDIX D – UEL ETHICS APPROVAL LETTER



6th March 2019

Dear Lucy,

Project Title	A collaborative investigation of the experiences of elders using an older adult home treatment team; from understanding to action
Researcher	Miss Adamczyk
Principal Investigator	Miss Adamczyk

I am writing to confirm that the application for the aforementioned NHS research study reference 19/LO/0169 has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is 6th March 2023. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please confirm that you will conduct your study in accordance with the consent given by the Trust Research Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Fernanda Silva
Administrative Officer for Research Governance
For and on behalf of
University Research Ethics Committee (UREC)
Email: researchethics@uel.ac.uk

APPENDIX E - LOCAL NHS APPROVAL LETTER

[Redacted]

Reply all|

Tue 26/02, 16:44

Lucy ADAMCZYK;

[Redacted]

+2 more

Dear Lucy,

Further to email below regarding the **Confirmation of Capacity and Capability at [Redacted]**, you can now begin recruitment at [Redacted] Older Adult Home Treatment Team Service.

Researchers are reminded that following confirmation of capacity and capability the first participant is expected to be recruited within **30 days** as part of the high level objective. Recruitment is the enrolment of an individual person meeting specific inclusion criteria into a research study and is therefore a study participant who has both provided informed consent. Please can you inform me when you recruit your first participant from [Redacted] so I can update our database?

Letter of access are not needed.

All the best with your project!

As always please do not hesitate to contact me or **Navdeep ji** if you have any further questions or queries.

Kind Regards,

[Redacted]
Costings & Contracts Assistant

[Redacted] | [Redacted]
[Redacted] | [Redacted]

APPENDIX F – INFORMATION SHEET



INFORMATION SHEET

University of East London
School of Psychology
Stratford Campus
Water Lane
London, E15 4LZ

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

My name is Lucy Adamczyk. I am a trainee clinical psychologist studying at the University of East London. As part of my studies, I am conducting the research which you are being invited to participate.

Picture of researcher here

What is the research?

The study aims to talk with people who have used Older Adult Home Treatment Teams so we may:

- Gain an understanding of your experience of using this service
- Understand what aspects of using the service were helpful

I am conducting research into people's experience of using an Older Adult Home Treatment Team. My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as you have used the Older Adults Home Treatment Team in [REDACTED] NHS Foundation Trust within the past six months.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way, and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to:

- Join a group with other people that have used the Older Adult Home Treatment Team. A maximum of eight people will be in the group. The group will meet at an NHS building located in [REDACTED] or [REDACTED]. Support with getting to and from the community setting can be provided by taxi if travelling to this location is something you would like help with.
- There will be two phases to this study, and you are welcome to participate in both.
- The first phase is a focus group, which will last 60-90 minutes (which will include refreshment breaks with tea and snacks). There is an opportunity for the focus group to be conducted over several meetings, if needed. The focus group will talk about topics regarding your experience of accessing the Home Treatment Team, for example how you were referred, what intervention you received, and if there is anything you found particularly helpful or unhelpful.
- Focus groups are a way of gaining an understanding about your experience, therefore all that is needed is your thoughts, memory, and knowledge of **YOUR** experience.
- The second phase is the analysis of the focus group. This will include participation in further group meetings (maximum of four), to decide how best to analyse the data gathered in the focus group, complete the analysis of the group, with a view of taking action in response to the results. Again, no previous research skills or knowledge are required.
- The focus group and further meetings will be audio and video recorded and then transcribed. I, my supervisor (Maria Castro-Romero), and the examiners will be the only people that are able to view the written transcriptions. I will be the only person to listen and watch the recordings outside of the group.
- If you choose to participate you will be given a £10 High street voucher.

- If you plan to travel with a carer/family/friend, an area can be arranged for this person to wait whilst you take part in the research, where there is access to refreshments.

PARTICIPATION IS YOUR CHOICE AND WILL NOT IMPACT ANY CARE THAT YOU RECEIVE FROM NHS SERVICES.

Your taking part will be safe and confidential

University of East London is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after the information and using it properly.

Your privacy and safety will be respected at all times.

- As a participant in a group, your identity and the information you discuss will be seen and heard by other group members. Group members will be asked not to repeat what is said in the group, to people outside of the group.
- All transcriptions of the data will be anonymised.
- As it is a group discussion, you are not required to share personal/confidential information about why you accessed the Home Treatment Team, but are asked to talk about your **experience** of using the service.
- You do not have to answer all questions asked, and can stop your participation at any time. This will not impact on the receipt of the voucher provided for taking part.
- Talking about your experience may make you upset or distressed. If the researcher notices they will raise this with you. This will not impact the voucher you receive for participating in the research.
- I will offer the opportunity to debrief once the focus group has finished should you want to talk about how taking part in the research made you feel.

- If you express any concerns about your own safety during the interview, I will raise this with you. I will contact your GP or other appropriate service if you require extra support.

What will happen to the information that you provide?

What will I do with the information you provide:

- Any personally identifying details will be held on a password protected NHS and University of East London computer.
- Your name and contact details will NOT be linked to any information you provide. All names will be changed for your anonymity.
- The full transcriptions of data may be viewed by my supervisor (Maria Castro-Romero) and by the examiners. Written extracts of the information you provide will be published on a free access academic website.
- Personal information such as contact details will be destroyed once the data collection is complete.
- Audio and video interview recordings will be moved from the NHS site to the University of East London via a password protected memory stick. All recordings will be deleted once the data has been transcribed and analysed. Electronic copies of the transcripts and consent forms will be placed on a University computer which has password protection and will also be held for five years, physical copies will be held in a locked cabinet within the University of East London for five years.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide up until the point of analysis of the data, which will take place two weeks after the data was collected in the focus group. You will not be required to return the voucher provided for your time if you decide to withdraw your data.

Contact Details

If you would like further information about my research or have any questions or concerns about how your information might be used, please do not hesitate to contact me.

Lucy Adamczyk

Email:

If you have any questions or concerns about how the research has been conducted please contact the research supervisor, Maria Castro-Romero. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: m.castro@uel.ac.uk
Tel: 020 8223 4422

or

Chair of the School of Psychology Research Ethics Sub-committee:
Dr Mark Finn, School of Psychology, University of East London,
Water Lane, London E15 4LZ.
(Email: m.finn@uel.ac.uk; Tel: 0208 223 3000)

Consent Form



UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Title of research: A collaborative investigation of the experiences of elders using an older adult home treatment team; from understanding to action

Researcher: Lucy Adamczyk

IRAS no.: 244436

Initial Boxes

1. I confirm that I have read the participant 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 medical

care or legal rights being affected.

3. I understand that the researcher will have access to recordings of the data, and that the researcher supervisor and the external examiners will have access to anonymised transcripts of the data.
4. I understand that a third party (e.g. my GP or the relevant home treatment team) will be contacted by the researcher if the researcher has concerns about my safety or the safety of others.
5. I understand that information will be recorded using audio and video equipment, and anonymised verbatim quotes from these recordings will be used in published documents that will be accessible to the public.
6. I agree to take part in the above study.

Name of
Participant

Date

Signature

Name of
Researcher

Date

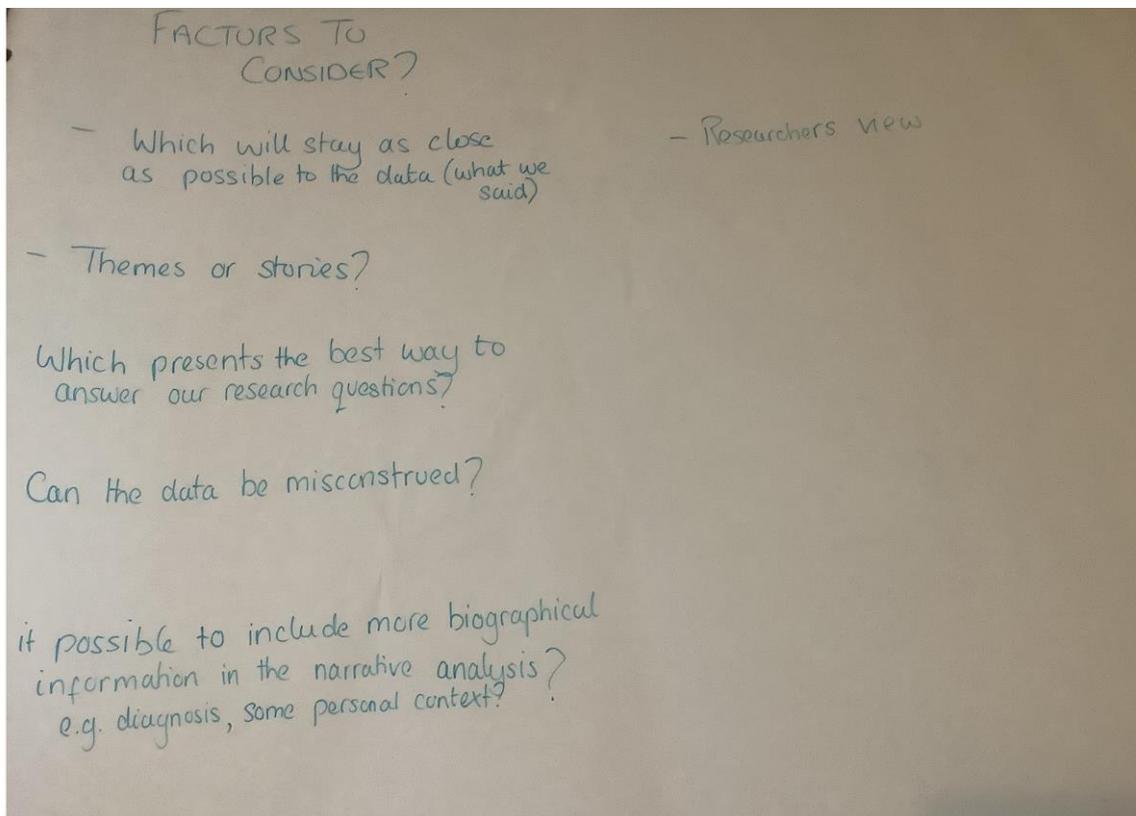
Signature

APPENDIX H - GROUP PRINCIPLES

These group principles were developed with the co-researchers in our first meeting.

- Being honest, but any thoughts are freely offered (e.g. you don't have to share if you don't want to)
- Not to talk over one another/give space for people to talk
- No abuse, no criticism of one another e.g. respecting other person's point of view and privacy.
- For people to be able to make suggestions if they can think of something helpful for others, using our individual knowledge to help others.

APPENDIX I – ANALYTIC METHOD – GROUP CONSIDERATIONS



APPENDIX J – NARRATIVE INTERVIEW GUIDE

Opening statement

“I am interested in hearing about your recent experience of working with the Older Adults Home Treatment Team. I would like you to say as much or as little as you want. I am interested in your understandings and opinions. I may ask further questions to make sure I have understood what you have said.”

Questions

Main question

“Can you tell me about your recent experience with the OA-CRHTT, from the time you were referred to the time you were discharged, as if you were telling me a story?”

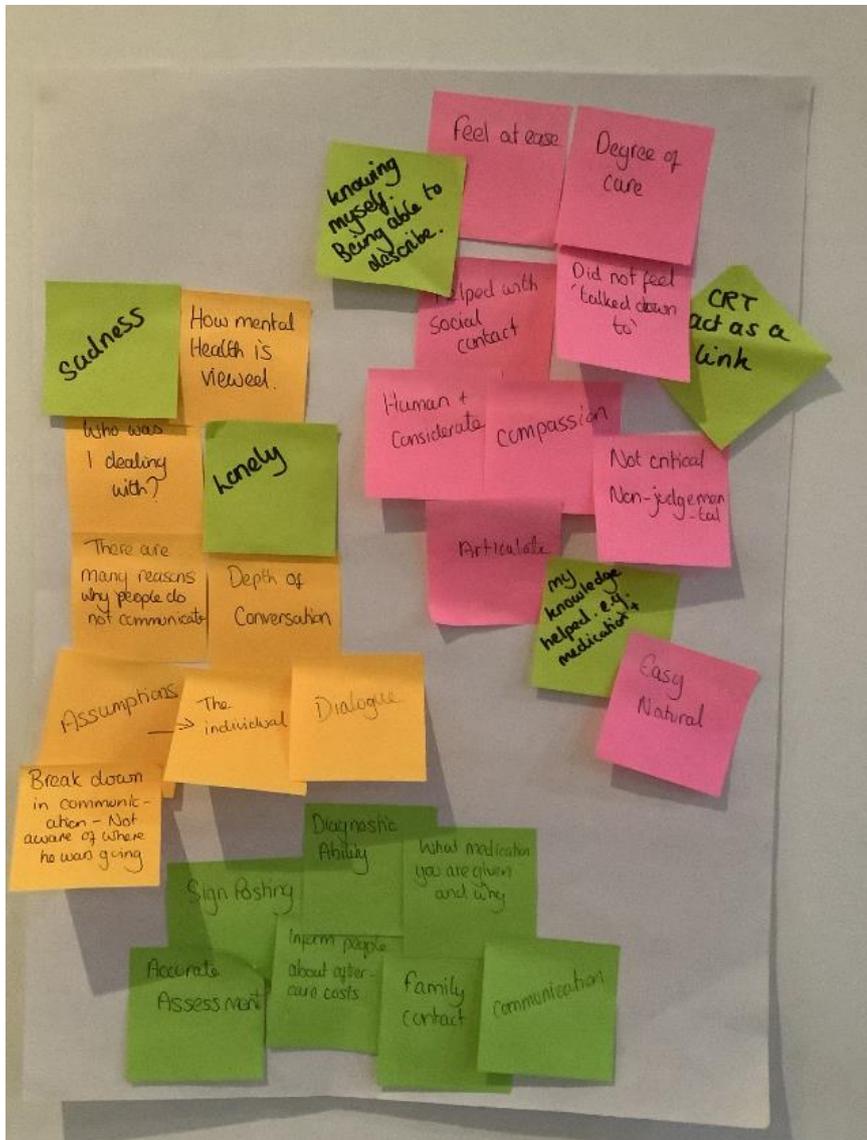
Follow-up questions

- Were there aspects of working with the OA-CRHTT that were particularly helpful?
- Were there aspects of working with the OA-CRHTT that you found less helpful?
- What could be done differently to improve the experience?
- What helped resolve the ‘crisis’?

Prompts

- Can you tell me more about that?
- Tell me what happened?
- What was that like for you?
- How did that impact you?

APPENDIX K – COLLECTIVE STATEMENT BRAINSTORMING



APPENDIX L – AGENDA FOR FEEDBACK MEETING

This agenda was created by the research group for the meeting where feedback would be provided from the research.

Agenda

- Staff members to be sent a copy of the research group's statement beforehand so they have time to reflect on it
- Introductions
- Reading of the statement
- Open to questions from OA-CRHTT
- An opportunity for the group to ask the OA-CRHTT questions
- A discussion which identified any possible moves to action based on the meeting.

APPENDIX M - CAPACITY TEST

Below is a excerpt from the Department of Constitutional Affairs, (2007) guide on the Mental Capacity Act 2005.

Two stage test of capacity

- Does the person have an impairment of the mind or brain?
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question?

Assessing ability to make a decision

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

APPENDIX N – TRANSCRIBING GUIDE

Based and adapted from Jefferson, 1984

Jefferson, G. (1985). An exercise in transcription and Analysis of Laughter, in T. A. van Dijk (ed.), Handbook of discourse analysis Vol.3. London: Academic Press. Cited from discourses and social psychology. Potter and Wetherell

It is not <u>right</u> , not right AT ALL	Underlining indicate the words are uttered with added emphasis; words in capitals are uttered louder than the surrounding talk
[psychiatric hospital]	Square brackets indicates words/names that have been omitted to ensure confidentiality. Material inside the brackets is clarifying information.
(p) (4)	J. numbers in brackets indicate pauses timed to the nearest second. A 'p' in brackets indicates a pause which is less than 3 seconds.
I think. hh I need more	J. a full stop before a word indicates an audible intake of breathe
I (COULDN'T TELL YOU) THAT	Round brackets indicate that material in the brackets is either inaudible or there is doubt about its accuracy
<LA: speech><L:speech>	This indicates overlap, where both people are talking.

APPENDIX O – ANALYTIC STEPS: STORYING STORIES

Table found in McCormack, C. (2004). Storying stories: a narrative approach to in-depth interview conversations. *Social Research Methodology*, 7(3), 219–236.

Stage	Steps	Tasks
Construct an interpretive story (stage 1)	Step 1: Compose the story middle	Re-connect with the conversation through active listening. Locate the narrative processes in the transcript. Return enriched and constructed stories to the participant for comment and feedback. Respond to the participants comments. Form the first draft of the interpretive story middle: <ul style="list-style-type: none"> - List agreed story titles - Temporal ordering of story titles - Add the text of each story Redraft story middle: <ul style="list-style-type: none"> - View the transcript through multiple Larryses: language, context and moments - Take into account the views highlighted through these Larryses.
	Step 2: complete the story – add a beginning and ending	Compose an orientation and choose the title. Add a code. Use visual form and textual strategies to enhance the presentation. Share the story with the participant. Reflect on the story in light of the participants comments. Compose an epilogue.
Compose a personal experience narrative (stage 2)	Step 1: construct a personal experience narrative	Temporally order the interpretive stories in a single document. This document forms the personal experience narrative. Share the personal experience narrative in the light of the research question(s).
	Step 2: construct an epilogue to close the narrative	Reflect on the personal experience narrative in the light of the research question (s). Add an epilogue to summarise these reflections and close the narrative.

APPENDIX P – STEP 1 ANALYSIS - COMPOSITION OF THE PERSONAL NARRATIVE

- **Active listening**

Who are the characters in the conversation?

GP

Doctors at the hospital (physical hospital)

'The Girls' (crisis team workers)

The two fella's (crisis team workers)

Daughter

Larry

What are the main events?

Pain from the back operation

A moment of suicidality

Meeting the team

Respect/Family

Decision process of going to XXXXXX [Psychiatric Hospital]

Accessing acute day service

Paying for a home care service]

Independence

Gratitude

As a researcher how am I positioned during the conversation?

Larry positioned me alongside 'the girls' from the OA-CRHTT. Larry was aware that I previously worked in a CHRT, and may have been commenting on this aspect of being similar to the girls. Additionally, he may have also been referring to my gender and age (if staff from the OA-CRHTT are similar in age), or my mannerisms. An abstract from the text is presented below.

[50 – 60] LA: And what was it you said, urm they treated you like a family?

L: Yeah

LA: Can you say a little bit more about that?

L: Yeah, well look. (p2) It is just like me and you ok you know. The thing about it is, with them girls they were coming here every week, and they rung up and said 'alright to come' 'yeah, 11 o'clock lovely'. But when they walked in you didn't treat them like strangers >LA: hmmm< L: I sort of adopted, I liked every...the four of them you know, really nice. An the thing about it that's important is they talked to you nice and all you know, do it in a nice round about way, and their way, they know what they are doing, they got the brains up here to talk people who have been on the edge of this and the edge of that you know but eh. No, I think they're, they're a team and a half them girls, I really mean that from the bottom of my heart >LA: hmmm<

How am I responding emotionally and intellectually to this participant?

I find myself eased by Larry's charm; he is naturally outgoing and friendly, whilst also being a private person. Larry informed me at points during our conversation that he was unsure if he would attend the next group meeting, as he struggled to sit quietly while others spoke about aspects of the OA-CRHTT that could be different or improved. I notice myself being tentative about how to frame questions based on his view about how he felt during the group meeting.

[275 – 293]

(talking about attending the acute day centre)

L: I really like it in that place and eh, I never went there today because the television in my kitchen broke down and on top of that I went shopping with my daughter, and she wouldn't go until the television was mended. But getting back to those girls though. And when we was in that room talking about it, I don't who was said about it like no respect for me. That geezer sitting next to me, I dunno who he was, the thing about it was he was going on and on and on about this hospital, and if I remember I said 'What hospital are you talking about?' and he said [psychiatric] Hospital you know and then he is going from one to the other, And I thought to myself I am not going to listen too much to this.

LA: That's fair enough

L: You know

LA: But coming back to that, when you said earlier it sounded like you sounded like, quite upset, that someone was saying something that wasn't nice

L: Nah, it wasn't kind, it wasn't nice

LA: You know, I don't wanna ask if there is anything they did that wasn't nice, that's not the question. I am just wondering if there is anything they could of done that would have been more helpful?

L: Yeah, praise them girls up a bit more, not put them down.

LA: I mean the actual crisis team when they came like

L: Oh no

Intellectually, I was intrigued that Larry was not placing blame with the OA-CRHTT or hospital staff about his admission or stay in a psychiatric hospital, as he seemed to have been unaware of where he was going, or the rights he was entitled to when he got there.

- **Locate the narrative processes within the transcript**

Below abstracts from the original transcript are shown to demonstrate how one of the middle stories was constructed from the text. In the interview transcript, Larry gives brief details of the story, including the evaluation, some of the events, and the coda.

62 LA: No, I really think the world of them girls. You know as I say, without them coming round ere
63 every, I means it's once or twice a week I think, I forget now, it gives you a boost you know, it makes
64 you more happy. When they go, you feel more relieved with yourself and gradually, they know, they
65 could see you were getting better, they gradually stopped coming you know. But then you know
66 you're on the, on the right again you know. It's just a one off thing with me and you know >LA:
67 yeah< L: and I wanted my girl to go on holiday and I thought that's the only way. But the thing about
68 it was I thought they would send me to the XXXXXXX [physical health] hospital itself >LA: OK< L: So
69 what happened, my daughter got hold of my step-daughter and they took me up there. And when I
70 went there, I said 'where you going', she said 'Highgate hospital' I said 'it ain't up here' >LA: Right< L:
71 And when we got in there, Jesus Christ I was shocked.
72 LA: So you thought you were going to...
73 L: The normal hospital, normal hospital.

Comment [01]: Narrative 3 - Evaluation

Comment [02]: Narrative 3 - What happened

Comment [03]: Narrative 3 - Coda

Comment [04]: Narrative 3 - Coda

By using augmentation I found other extracts that provided additional elements of each narrative (below);

[Type text]
L Individual Interview

108 LA: Right OK.

109 L: I wanted to go there because I wanted to get my. See over the, I've been in that hospital three
110 times having something wrong with my back, but this time they said cause you're a bit older and you
111 always look smart, he said, we'd do it for you, and I thought well, let's get it done then you know.

112 Then when I come out of there, he said you'll have a little pain and then when you get home [deep
113 breathe in] you can't sleep, I can't sleep now, I haven't slept properly since a week before Christmas
114 >LA: Oh my goodness< L: I am up three or four times a night, you know and **um I had to get that girl**
115 **of mine on holiday**. She, she's got a family of her own down in XXXXXX [Daughters home town], and
116 she is up here three days a week, she's just gone a little, about two hours ago. Done me shopping for
117 me, and that's it you know. But without them ladies, phew [indicating visually], they done me a
118 favour [inaudible].

119 **LA: So you wanted your daughter to go away, >L: She wasn't gonna go< LA: and she wasn't going to**
120 **go. Even if the crisis team were here, she still wanted to be with you, because she knew you was at**
121 **home and she was worried about you >L: that's it yeah< LA: So you said, I'll go**.

122 L: No, I said to her, oh **oh** I said let me think about it a minute. **So I said do us a favour, ring up the**
123 **crisis team. So she rung them up for me, and I said could you get, I'm in a lot of pain and I want to go**
124 **back into hospital. >LA: OK,< L: As I say it was the wrong place, I didn't want to go up there. >LA:**
125 **Right< L: Because, as I say when you drive, when I used to drive past there years ago, you never**

Comment [05]: Narrative 3 - Evaluation

Comment [06]: Narrative 3 - Abstract

Comment [07]: Narrative 3 - What happened

167 L: Yeah, but I didn't think I was going in that place though, that's the thing about it!

168 LA: So how did you feel about it?

169 L: **it was a shock for me you know, it really livened me up. Cause I said to em before I was going, I**
170 **said 'what have you done to me', but I knew I was doing it for a purpose, so she could go on holiday**
171 **you know.**

172 LA: And then how, did you see the crisis team when you once discharged from hospital as well?

173 L: I see **em** in **there**, they came to see you twice, or two, three times.

Comment [08]: Narrative 3 - What happened

• Creation of Middle Stories

This part of the analysis involves looking for narrative processes in the transcript by paying attention to recognisable boundaries such as a beginning and an end.

- Abstract (summarises the point)
- Evaluation (why the story was told/highlights)
- Orientation (who, what, where, when)
- A series of linked events
- Coda (brings the story to a close)

Five middle stories were created. Examples of three of the middle stories within Larry's transcript are presented below.

Middle story 1

Evaluation: Look, I was in a lot of pain

Orientation: I had something wrong with me spine, and they had to put metal bits in between your bones then down you know.

Abstract: I went in the hospital. I had that done in there. As I say when I come home he said to me you will be in a little bit of a pain, and I said well that's nothing I've had bigger knocks than this. But when I got home ere, the pain, it's the worst pain I have ever had in my life! there's one, cause I've I've had a few good hidings in my time, but the pain is nothing towards what I had you know. Then when they said it was only a little bit of pain, Jesus Christ, them doctors don't know.

What happened?: so I went to the doctors and I said 'more painkillers I need help' and the thing about it was, I said if you don't give me help I will go and buy a bottle of scotch I said, take a few tablets with the scotch and end it all. In that moment I was all ready to do what I wanted to do because I couldn't stand the pain, I would have only done it that day! Well the next thing I know, two men [from the crisis team] were at the door, the doctor had called them, And Anyway, had a good talk to me about something, the next thing you know the girls are here.

Coda: without them (girls), I wouldn't have known where I'd have been today

Middle story 2

Evaluation: 'they're like a family when they come in'

Orientation: There was four of them weren't there? That came from the crisis team. there was Jo, Beatrice, the one who just had the baby, I can't pronounce her surname, and then the blonde headed one, Heidi or Heldi or something

Abstract: Because, they really you know, talk to you like you though your family, that's the most important thing about it, they talk to you, you're not just you're a patient or anything you know, they talk to you like your family.

What happened? : No, I really think the world of them girls. You know as I say, without them coming round ere every, I means it's once or twice a week I think, I forget now, it gives you a boost you know, it makes you more happy.

I sort of adopted, I liked every...the four of them you know, really nice. An the thing about it that's important is they talked to you nice and all you know, do it in a nice round about way, and their way, they know what they are doing, they got the brains up here to talk people who have been on the edge of this and the edge of that you know but eh. No, I think they're, they're a team and a half them girls, I really mean that from the bottom of my heart.

It was really nice you know, it wasn't one of them girls that I didn't love in some respect you know. The way (p2) they treat ya, you ain't [inaudible], you ain't done a murder or anything like that, you've just been ill for one day and they treat you with respect that is the most important thing about it.

When they go, you feel more relieved with yourself and gradually, they know, they could see you were getting better, they gradually stopped coming you know.

I mean they're terrific girls you know, I'd go and see them now you know, because they were nice kids, but then they come around a few times afterwards and they said, I think you'll be alright now.

Coda: praise them girls up a bit more

Middle story 3

Evaluation: It's just a one off thing with me and you know, I had to get that girl of mine on holiday.

Orientation: I wanted to go [to hospital]. She wasn't going to go [on holiday], even if the crisis team were here!

Abstract: My daughter wanted to stay with me, because she knew I would be on my own at home and she was concerned because of what I said to the doctor and the pain I was in.

What happened: So I said do us a favour, ring up the crisis team, and I said could you get, I'm in a lot of pain and I want to go back into hospital. But the thing about it was I thought they would send me to the XXXXXX [psychical health] hospital itself. my daughter got hold of my step-daughter and they took me up there. And when I went there, I said 'where you going', she said 'XXXXX [psychiatric] hospital' I said 'it ain't up here'. it was a shock for me you know, it really livened me up. Cause I said to em before I was going, I said 'what have you done to me', but I knew I was doing it for a purpose, so she could go on holiday you know

Code: I thought I was going to the normal hospital, Jesus Christ I was shocked!

- **Temporal ordering of stories**

The stories were ordered in chronological order. The stories were:

1. Look, I was in a lot of pain
2. They're like family when they come in
3. I had to get that girl of mine on holiday
4. You never know what is behind the brick wall
5. I'm an independent bloke

- **Return middle stories to the participant for comment and feedback**

Larry and I had a telephone conversation where I read through the middle stories that I had found in the text and asked him to comment on the following questions;

- Does what I have written make sense to you?
- How does this account compare with your experience?
- Have any aspects of your experience been omitted?
- Do you wish to remove any aspects of your experience?
- Feel free to make any other comments.

Larry commented that the stories provided a good reflection of our interview, and he went on to provide further thoughts and details of his experience. For example, in response to the story 'they're like family when they come in', Larry further expressed his gratitude to the OA-CRHTT by stating that such a service did not exist 60 years ago, and therefore people should be more thankful for the service they receive nowadays. Additionally, after reading the 'You never know what is behind the brick wall' story, Larry provided further detail of the struggles that he had whilst as an inpatient, specifically regarding the poor shower facilities, and difficulties sleeping in the inpatient environment. These elements were used to create the final interpretive story.

Larry informed me that he no longer wanted to participate in group meetings, as he found it frustrating to listen to fellow co-researchers talking about the OA-

CRHTT. Specifically, he felt angered that other co-researchers were making comments on how the service could be improved. He provided consent for his story to continue to be used in the research, and for the story to be read aloud to the co-researchers in the research group.

Below are copies of the paper in which I made notes on during our conversation to capture his feedback.

Narrative 1 -

- Talked about how much pain he was in at that time.
- Ask that I change the word men to gentlemen - describing Ax with HTT.
- No other suggestions for changes.

Narrative 2

- 'Yeah that's about it'
- You would have a service like this 60 yrs ago - you wouldn't have anything.
- They looked after you
- All others want is to abuse the system.
- No recommended changes.

Narrative 3

- I wouldn't go back (acute ward).
- I used to call the room my cell
- I was doing it for the one I love - daughter
- Happy with story.

APPENDIX Q – STEP 2 ANALYSIS EXAMPLES: LARRY

View the transcript through multiple Lenses

Language

The transcript is viewed through the Lens of language, with a focus on what is said, how it is said, and what remains unsaid. Below are excerpts from the transcript that relate the context of language.

Frequent use of the phase 'you know'

62 LA: No, I really think the world of them girls. You know as I say, without them coming round ere
63 every, I means it's once or twice a week I think, I forget now, it gives you a boost you know, it makes
64 you more happy. When they go, you feel more relieved with yourself and gradually, they know, they
65 could see you were getting better, they gradually stopped coming you know. But then you know
66 you're on the, on the right again you know. It's just a one off thing with me and you know >LA:
67 yeah< L: and I wanted my girl to go on holiday and I thought that's the only way. But the thing about
68 it was I thought they would send me to the XXXXXX [general] hospital itself >LA: OK< L: So what
69 happened. mv daughter not hold of mv step-daughter and they took me up there. And when I went

Comment [01]: Request for understanding

Comment [02]:

Comment [03]:

Comment [04]:

Comment [05]:

Words used to describe self-image

326 L: You know, when you get to my age at nearly 82. I mean I got friends, and I tell you want I look at
327 that sometimes and I go 'what's the matter with you! Your shoes are worn out down the back', don't
328 send them to the menders and get them done or anything like that, but that's their way. They go
329 'why you wanna put a suit on' I say listen 'it's me, I've always done it, I can't wear a pair of jeans, I

Comment [06]: Self-image

[Type text]

L Individual Interview

330 don't like jeans and trainers are for holiday, end of story. They go yeah you're right I suppose, I say I
331 know I'm right. I go to the doctors, I put a suit on, you know when you could just walk down there
332 with a pair of tracksuit bottoms on, but you know, it ain't me. It's respect, I think it is you know, it's
333 respect.

Comment [07]: Self-image. Holding respect for yourself.

334 LA: I think that sound like, it's something really important to you

335 L: It is to me, they call me Mr Dapper down that doctors.

Comment [08]: Self-image

336 LA: Do they?

337 L: Yeah, they say you are always looking dapper.

Metaphors or other form of imagery

150 on well with everybody in there you know, >LA: I'm sure< L: they knew me and had a laugh you
151 know. The thing was when it come to that Christmas time, erh, I have never been banged up, well I
152 say banged up, I call it banged up to me it was prison for that long a time in a place like that you
153 know. I mean, I had people come and say I would get you out at the end of the day. Don't be silly if I
154 go out of here now they would be knocking on my, kicking that door in for me, to take me back in
155 there. Whether there would of I didn't know.

156 LA: Was you on section?

Comment [06]: Similar to prison

Comment [07]: Confirms he felt like it was a prison

Comment [08]: Conjures imagery of an escaped prisoners on the run.

Context

Situational

Placing me as one of 'the girls'

50 LA: And what was it you said, urm they treated you like a family?

51 L: Yeah

52 LA: Can you say a little bit more about that?

53 L: Yeah, well look. (p2) It is just like me and you ok you know. The thing about it is, with them girls
54 they were coming here every week, and they rung up and said 'alright to come' 'yeah, 11 o clock
55 lovely'. But when they walked in you didn't treat them like strangers >LA: hmmm< L: I sort of
56 adopted, I liked every...the four of them you know, really nice. An the thing about it that's important

Being tentative in questions

288 LA: You know, I don't wanna ask if there is anything they did that wasn't nice, that's not the
289 question. I am just wondering if there is anything they could of done that would have been more
290 helpful?

291 L: Yeah, praise them girls up a bit more, not put them down.

292 LA: I mean the actual crisis team when they came like

[Type text]
L Individual Interview

293 L: Oh no

Wider narratives

Counter narrative re: independent elder

Dominant narrative: family provide a caring role

- 293 L: Oh no
- 294 LA: Cause I know that you are very grateful for them coming, and I know that they did their job as it
295 is, but if there job could include other things, is there anything could have done that would have
296 been more helpful for you at that time?
- 297 L: Look, I don't, I'm an independent bloke, you know, don't ask me. I met people from doctors and
298 all that wanting to give me help in ere, go get my shopping and do cleaning, I said listen here while I
299 am capable of doing it I will do it myself, I don't need help from nobody. And, if I do need help I got a
300 daughter, and that's all there is, you know. If I don't need help off of no one. There might come a
301 time where I might need it, but the thing about it is, not this time you know, I don't. But them girls,
302 as I said about the cleaning, I said I will do it, you know, a bit. They always said that to me, you know
303 'you keep it nice', and I said if you do it every day it doesn't get dusty or dirty, 'why do you do it
304 everyday?' cause I said I gotta live in here where people, when I open that door people can look in
305 and see your bed ain't made, [shakes head and sighs] no way, I means that, that how I feel about
306 myself, you know, I like being nice and clean.

Moments

Realisation of the psychiatric hospital admission

- 64 you more happy. When they go, you feel more relieved with yourself and gradually, they know, they
65 could see you were getting better, they gradually stopped coming you know. But then you know
66 you're on the, on the right again you know. It's just a one off thing with me and you know >LA:
67 yeah< L: and I wanted my girl to go on holiday and I thought that's the only way. But the thing about
68 it was I thought they would send me to the XXXXXX [general] hospital itself >LA: OK< L: So what
69 happened, my daughter got hold of my step-daughter and they took me up there. And when I went
70 there, I said 'where you going', she said 'XXXXX [psychiatric] hospital' I said 'it ain't up here' >LA:
71 Right< L: And when we got in there, Jesus Christ I was shocked.
- 72 LA: So you thought you were going to...
- 73 L: The normal hospital, normal hospital.
- 119 LA: So you wanted your daughter to go away, >L: She wasn't gonna go< LA: and she wasn't going to
120 go. Even if the crisis team were here, she still wanted to be with you, because she knew you was at
121 home and she was worried about you >L: that's it yeah< LA: So you said, I'll go
- 122 L: No, I said to her, oh oh I said let me think about it a minute (in a tone of voice that indicates he
123 was feigning this) So I said do us a favour, ring up the crisis team. So she rung them up for me, and I
124 said could you get, I'm in a lot of pain and I want to go back into hospital. >LA: OK,< L: As I say it was
125 the wrong place, I didn't want to go up there. >LA: Right< L: Because, as I say when you drive, when I
126 used to drive past there years ago, you never know what is behind the brick wall, till you go there
127 and see how these people are. They were people, they were people like you know with brain
128 damage or whatever. And I tell you, I cried one night in there, seeing this young kid and this young

Journal notes

I was shocked hearing Larry talk about his last minute realisation of which hospital he was attending, and his lack of awareness of the implications of being an informal patient in a psychiatric hospital. I felt aggrieved for him. I was wondering how this mix-up in communication was allowed to happen? Yet, what was more striking is that Larry did not appear to share my ideas on where the responsibility lies for this lack of communication (i.e. with the CRHTT staff). He continued to hold them as perfect. Something clearly very secure, humane, and affirming was established in his relationship with the girls.

Bringing together the views highlighted by multiple Lenses

The interpretive story reflects the working it out nature of our conversation by

- Expressing the explicit and clear way in which Larry appreciated the support of the girls.
- Demonstrating his perspective that this was a one of moment, by highlighting and separating this within the text.
- Showing his dissatisfaction and anger with the way in which he received care as an inpatient by creating short sentences and lists within this paragraph
- Highlighting my talk and his talk, by changing the font which was used.
- Highlighting the feature which he found most helpful, and therefore related to the research question – respect.
- Including myself within the conversation and highlighting the situation in which we were in, by setting the scene in the introduction of our previous knowledge, and also the inclusion of me within the comparison of the girls.
- Using ellipsis (...), to demonstrate a poignant moment in our interaction, eluding to the important of this statement.
- Using exclamation when Larry discusses how the doctors had underestimated the type of pain that he might experience after the operation.
- Inclusion of phases which Larry used in the transcript to describe mental health using language taken from a forensic perspective.

APPENDIX R – COLLECTIVE STATEMENT

We are a collective, who accepted invitations to be part of a group to investigate the experiences of elders using the Older Adult Home Treatment Team, and have since met on multiple occasions. To share our experiences, four of us engaged in interviews with a researcher, which was then made into individual stories. Two of us continued to attend meetings with the researcher. We read the individual stories together, and from this reading, we created this, our collective statement.

Although we all had contact with the Older Adult Home Treatment Team, all of our individual experiences with them team, and of our own ‘crisis’ were very different. Our stories are specific to us, as individuals, they are about our experience, and come from our perspective. The differences between our stories may demonstrate the individual nature of experiencing a mental health crisis and what aspects of treatment we value as important. Therefore, this statement is a patchwork of our individual stories, which highlight areas that we think are important. We acknowledge that there are other perspectives. But we will say, that experiencing a mental health crisis makes even the simple everyday tasks beyond difficult, and for some of us it made our lives a living hell.

Kindness

The staff from the Home Treatment Team were able to demonstrate kindness, compassion, and consideration. This was particularly emphasised in one story, where the Home Treatment Team were described as “being like family”, that they brought an “easiness” to being in their company and were able to ask questions in a respectful way, which was essentially important. Larry’s story highlighted that the interaction with the home treatment staff in and of itself, made him happier.

“I sort of adopted them, you know. You’re not just you’re a patient or anything you know, they talk to you like your family, and that’s the most important thing about it.”(Extract from Larry’s story)

Assessment

At its best, the Home Treatment Team acted collaboratively and swiftly, which led to effective intervention. In discussion, we acknowledged how this was aided by a person's own knowledge of what worked for them in a mental health crisis, and their ability to relay this with clarity. Edward explained that he has been living with bipolar for many years and therefore had a good knowledge of what medications worked for him and what the health implications might be for certain medications. He was able to discuss this in his first meeting/assessment with the Home Treatment Team, which was with the team psychiatrist.

Together, they quickly identified that Edward needed a hospital admission whilst his medications were changed so that his physical health could be appropriately monitored. Edward's story highlighted that a quick response to his needs at the time was vital.

"The consultant came and saw me at home..... I was reassured really that help was on its way, it's a bit difficult to recall exactly these things because, at the time you're so physically and emotionally in turmoil that um, it's difficult. But, I can't see it being done any better. If I hadn't of got immediate help it's almost certain that I wouldn't be here." (Extract from Edward's story)

In contrast, Matthew's story spoke about difficulties in being able to express himself to the Home Treatment Team staff during the assessment process. We recognised that a person in crisis may not feel confident, at the time of assessment, to provide an accurate description of what they are experiencing for a variety of reasons. In discussion, we thought that Matthew's ability to present himself as someone who is articulate, alongside masking the severity of his symptoms, meant that his verbal responses may have hidden the extent to which his symptoms were affecting him. As this was his first contact with mental health services, he also did not know what services the Home Treatment Team could offer and was not informed of this fully when he started working with the home treatment, leading him to wonder about the point of them visiting in the initial stages.

“Had my real state of mind been understood, I don’t know what action they would have taken. I mean they may have made the referral if you like to um, the crisis house earlier.” (Extract from Matthew’s story)

Communication

We think that communication and understanding between the staff and the individual in crisis is key. When this has worked well, lifesaving action has taken place. However, on other occasions we noticed how a breakdown in communication led to severe misunderstandings. In Larry’s story, he explained that he had asked to go to hospital, but thought he would be in a physical health hospital. Once admitted to a psychiatric hospital, he also did not know that as a voluntary patient he could go on leave at any time.

“But the thing about it was I thought they would send me to the XXXXXX [general] hospital. And when I went there, I said ‘where you going’, she said ‘XXXXXX [Psychiatric] hospital’ I said ‘it ain’t up here’. It was a shock for me you know, it really livened me up.” (Extract from Larry’s story)

We noticed how a person’s confidence and concern about what others might think may impact on the ability to communicate for a person experiencing a mental health crisis. James’s story spoke about his worry of talking to the staff, and often feeling unsure of what to say, concerned that he was being a nuisance. This made us think about dominant social stories about elderly people being a nuisance. We also recognised how much this dilemma caused him increased levels of anxiety.

“See I don’t want to bother them, don’t want to sort of like, like make myself a nuisance if you know what I mean? It is very um, it’ very hard to, you know to um, just to pick up the phone and explain to them is, you feel you can’t sort of like say actually what is wrong with you, if you know what I mean.” (Extract from James’s story)

Summary

From our review of the stories we have come up with areas which we would like you to consider;

- Assessment

We asked ourselves the questions how can the person in crisis be encouraged to accurately describe and understand what is happening to them? And, what can the home treatment team do to conduct an accurate assessment? We recognise that each person's experience of a mental health crisis is individual, and each person may require something different from the Home Treatment Team. That being said, where possible we think that it would be useful to place emphasis on an assessment approach which involves the person and the system around the person, such as GP's and family and friends. We also noted that the persons that are most able to make good use of the home treatment team are those that have good knowledge about what this team can offer. Therefore, an explanation of what the team do, and what they offer should be relayed at the assessment stage, especially for people who have not had contact with the team before.

- Communication

As described, experiencing a mental health crisis can be a confusing experience, it is difficult to hold onto information during the time of crisis and it can also be difficult to remember what happened during the crisis. To ensure that communication and understanding between the person in crisis and the Home Treatment Team is clear we think it is important that a clear plan of action is established and created collaboratively. We understood that there can be a lot of information to take in about treatments and recommendations during a mental health crisis. Therefore, we also think it would be helpful to have a written summary once a person is discharged, listing any diagnosis given, recommended treatments, and referrals to onward services. At the point of discharge we also think it would be helpful to signpost people to local or national organisations that may be able to provide support and information.