Research Project Portfolio

The University of Nottingham

Division of Psychiatry and Applied Psychology
School of Medicine

Doctorate in Clinical Psychology

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What is a crisis? Service user, carer and professional understandings of crisis; a Q-methodological approach.

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Submitted in part fulfilment of the requirements for the

Doctorate in Clinical Psychology

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I would also like to thank Dr Lisa Ball who helped to guide the ethical approval process, and to the crisis team and to Self Help UK for their willingness to participate and their support throughout the process of recruitment.

On a personal note I would like to thank my parents, Janet and Robert Davies. Your unwavering support has been a blessing throughout my academic journey and many others.

Finally, I dedicate this thesis to my beautiful daughter Ava, my little bird. Your smiles, giggles and our adventures together have kept me grounded through this whole process.

I love you more, I love you most.

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Thesis Abstract

Background. This topic was proposed by the Service User and Carer Advisory Panel (SUCAP) which informs and supports Clinical Psychology training at The University of Nottingham. The project developed due to their concern about the ambiguity of crisis. They suggested that their understandings may be different from that of professionals. The reconfiguration of acute mental health services influenced the nationwide implementation of community treatment alternatives. However, crisis has remained a poorly operationalised concept, which can lead to problems in clinical practice. An increase in empirical efforts has aimed to establish clarity and increase the clinical utility of definitions. Despite these efforts, little is known about how service users and carers understand crisis. As suggested by the SUCAP, it is unclear if there is commonality within understandings of crisis. Due to the multiple stakeholders, exploring understandings of crisis from multiple perspectives could be useful in clinical practice.

Aim. This study aimed to use Q-methodology to investigate multiple perspectives of crisis. By including service users, carers and professionals the research aimed to highlight consensus and discrepancy within these perspectives.

Method. Twenty-six participants were recruited from a National Health Service crisis team, a third sector crisis service and an independent carer support group. In Phase One, clinical interviews with 16 participants (taken from each group) were conducted. Qualitative analysis aided the process of constructing a Q-set of 78 statements that represented the understandings of a crisis experience. In Phase Two, 13 participants (some of whom took part in Phases One and Two) completed the Q-sort procedure, in which they rated the extent to which each statement was characteristic of crisis. To support analysis and interpretation, demographic information was obtained, and pre/post questions elicited reflection on their completed Q-sorts. An inverted factor analytic method was used to analyse the Q-sort data.

Results. The results of each Phase are discussed. The rotated two factor solution accounted for fifty percent of variance in people's understandings of crisis. Factor one related to the understanding of crisis as an experience which can be defined by changes

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in awareness and perception of reality. Factor two related to the understanding of crisis as intense emotional pain, which is largely related to fear, anxiety and despair. Contrary to existing definitions of crisis, risk and mental illness were not highlighted as central characteristics of crisis. Different pairs of 'groups' (service user/professional; carer/professional; service user/carer) had little impact on the amount of shared understanding. However, understandings of crisis were highly variable between individuals. Furthermore, service users' understandings were more variable than those of professionals or carers.

Discussion. Although the findings offer some support to current theories of crisis, they contrast with the dominating characteristics of crisis represented in policy and empirical literature. This suggests that over deterministic definitions of crisis, that focus on risk and mental illness, are insufficient. These findings have implications for both clinical practice and future research.

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Statement of contribution

Journal article and extended paper

- Project design: Kerry Davies, Dave Barber (SUCAP), Dr Mike Rennoldson and Dr Thomas Schroder (research supervisors)
- Applying for ethical approval: Kerry Davies, assisted by Dr Lisa Ball (Local collaborator), Dr Mike Rennoldson and Dr Thomas Schroder (research supervisors)
- Literature review: Kerry Davies
- Recruiting participants: Kerry Davies, with the help of the crisis team
- Data collection: Kerry Davies
- Data analysis: Kerry Davies (supervised by Dr Thomas Schroder and Dr Simon Clarke)
- Write-up: Kerry Davies (supervised by Dr Thomas Schroder and Dr Simon Clarke)

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Preparation of the journal paper

The following paper has been prepared for the Community Mental Health Journal. For submission guidelines see Appendix A.

Word counts

Journal article: 6475 words, excluding tables, figures and references.

Extended paper: 43,332 words, excluding tables, figures, references and appendices.

Total word count: 52,239 words, (excluding references and appendices).

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Journal Article

Title: Understandings of 'crisis' from service user, carer and professional perspectives: A Q-method study.

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Keywords: crisis, service user perspectives, carer perspectives, crisis resolution, home treatment

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Abstract

Clear understandings of presenting problems are a priority in mental health services due to their influence on service provision. However, crisis is a problematic term that is poorly defined within the contemporary Crisis Resolution Home Treatment (CRHT) model. This research aims to further recent empirical attempts to conceptualise crisis by investigating service user, carer and professional understandings of crisis, and the areas of similarity or difference between them. A Q-methodology approach highlighted two central characteristics of crisis: perceptual change and intense emotional distress. Understandings of crisis were highly variable, which has implications for clinical practice and recovery from crisis.

Background

This topic was proposed by a Service User and Carer Advisory Panel (SUCAP) which informs and supports Clinical Psychology training at a UK university. The panel reflected the ambiguity about understandings of crisis. They suggested that their understandings may be different from that of professionals and that their perspectives were not well represented in current understandings of crisis.

The configuration of service provision for 'crisis' or 'mental health crisis' has changed in the United Kingdom (UK) with home treatment now recommended as best practice (Department of Health, 2001, 2000). This has led to a greater provision of a community-based alternative, namely Crisis Resolution Home Treatment Teams (CRHTs) (Glover, Arts & Babu, 2006; National Audit Office, 2007). UK policy states that CRHT involvement should be available to people aged 16-65, with severe mental illness and 'with an acute psychiatric crisis of such severity that without involvement of (CRHTs), hospitalisation would be necessary' (Department of Health, 2001, p.11). Further 'common sense' definitions that have been used in research relate to functional disruption, risk of harm, and the insufficiency of available support (Johnson et al. 2005).

This study is not alone in highlighting the ambiguity and problematic use of the term crisis (Callahan, 1994, 1998; Tobitt & Kamboj, 2011). Tobitt and Kamboj (2011) recently highlighted that the definition of crisis within CRHTs lacks clinical utility and that conceptual elaboration of crisis has been overlooked in CRHT policy. Clear understandings and definitions of presenting problems are important because they guide action (Callahan, 1994), for example by influencing triage systems and what interventions are offered (Ball, Links, Strike, & Boydell 2005; Brennaman, 2012). Tobitt and Kamboj (2011) have suggested that clearer understandings and definitions of crisis are an 'urgent priority' due to increasing emphasis on the rights of patients to access community treatment.

Some have argued that the application of Crisis Theory literature is appropriate and useful within contemporary crisis services (Callahan, 1998; Bridgett & Polak, 2003). Crisis Theory (Caplan, 1964) proposes that a crisis is a period of time in which there is a disturbance to the natural state of 'emotional homeostasis' or equilibrium of a person (or system), during which usual coping mechanisms and resources are ineffective giving rise to emotional distress. The theory discusses the time of crisis as an opportunity for psychiatric efforts, due to the person being in a state in which they are more open to new resources and ways of coping. Hoff (2001) similarly defines crisis as 'an acute emotional upset arising from situational, developmental or sociocultural sources' (p.4). Despite Crisis Theory's origins in community psychiatric and preventative approaches it has not been a clear influence in CRHT policy (Tobitt and Kamboj, 2011). This possibly reflects some debate about whether the theory is applicable to the presentations encountered in contemporary mental health services (Ball et al. 2005; Brimblecombe, 2001). Tobitt and Kamboj (2011) suggest that due to this debate and the lack of empirical study, the term 'crisis' has remained ambiguous and poorly operationalised leading to difficulties for CRHT staff and referrers. Tobitt and Kamboj (2011) conducted a study that aimed to investigate how crisis is understood amongst professionals working in CRHTs. They wanted to further understand the 'form' and nature of crisis, as well as contributory factors in order to generate a new theory to inform practitioners and policy. They characterised crisis as a short term loss of usual functioning usually triggered by a stressor (sometimes combined with an underlying vulnerability) that requires additional support. Crisis was understood as always presenting a risk of harm, and was thought to develop in varying ways over time. However, there was not consensus between all members of the team, with some themes being labelled 'debated' such as the presence of extreme emotional distress and biomedical causes. Interestingly, the two essential features of the definition offered in CRHT policy (presence of severe mental illness/suitability for admission) (Department of Health, 2001) were not central findings of the study. Therefore, within one mental health team there are differences in understandings of crisis, and they have varying levels of

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agreement with CRHT policy definitions of crisis. Although these findings contribute to our understandings of crisis, they focus on professional understandings, thereby overlooking service user and carer perspectives. The Joint Commissioning Panel for Mental Health (JCPMH, 2012) highlighted the importance of service user and carer perspectives in a 'negotiated definition' of crisis, and an exploration of service user and carer perspectives has been suggested as an important avenue for research (Johnson, Needle, Bindman & Thornicroft, 2008). More widely, there has been increasing emphasis on service user and carer involvement and participation in both service provision (NHS England, 2013) and research (Wallcraft, Schrank & Amering, 2009).

Our research aims were derived directly from service user and carer input. Furthering the research by Tobitt and Kamboj (2011), this research aimed to investigate multiple perspectives of crisis. The research aimed to explore the understandings of crisis of the people who experience it - service users, carers and professionals. A further aim of the research was to explore areas of consensus and discrepancy within these perspectives.

Q-methodology was considered adept in meeting these aims due to the analytic process of drawing out differences in perspectives, rather than aiming for consensus. Further understanding the consensus and discrepancies in the way that people understand crisis could help improve the accessibility of crisis teams and processes of referral and assessments (Tobitt & Kamboj, 2011). This research does not aim to reach a further definition of crisis, although it is acknowledged that highlighting multiple perspectives could contribute to future re-definitions of crisis. Definitions (in effect) reduce possibilities down, so as to offer structure and clarity. However, this research aims to open up new possibilities for understandings of crisis to emerge. Q-methodology was considered useful, due to its pursuit of 'infinite hypothesising and new insights' (Watts and Stenner, 2012).

Method

Q-methodology. Q-methodology is the systematic exploration of subjective opinions, attitudes and beliefs (Stephenson, 1982; McKeown & Thomas, 1988). The theoretical underpinnings of Q-methodology are explored further in the extended paper. The method permits the study of similarities and differences in understanding. Participants express their view point through the Q-sort. In a Q-sort participants sort a series of statements to fit a quasi-normal fixed response grid. The body of statements i.e. the Q-set, reflects what is known about the topic. Each Q-sort reflects the participant's agreement or disagreement with the statement in reference to their understanding of crisis. The process of sorting and ranking statements enables the understanding of each person to be captured, so that it can be subject to investigation (Watts & Stenner, 2012). Each Q-sort is analysed through the inversion of traditional factor analytic techniques (Stephenson, 1935). The Q-sorts become the sample and the participants become the variables. Analysis highlights correlations between understandings. The exploratory method is recommended for topics that are yet to be clearly defined and operationalised, and for which multiple perspectives and opinions are likely to exist (Thomas & Watson, 2002, Watts & Stenner, 2005). It has been deemed a useful methodology for studying attitudes towards mental health (Dziopa & Ahern, 2009) and health behaviours (Van Exel, de Graaf & Brouwer, 2006), and has been used with varying participant groups that have included staff (dit Dariel, Wharrad & Windle, 2010) and service users (Eccleston, Amanda & Rogers, 1997).

Participants. In Q-methodology participants are often selected based on their knowledge or experience of the research topic (Chinnis, Debra & Stephen, 2001; Cordingley, Webb & Hillier, 1997). Stratified sampling was used in order to collect data from the population that represented the central stakeholders of the term 'crisis'. For more information see extended paper.

Participants (n=26) were all service users, carers or professionals with experience of crisis. They were recruited from an NHS based CRHT, a carer support group and a third sector organisation providing peer support and low intensity intervention. The participant group as a whole was made up of ten males and 16 females, with a mean age of 50.6 (SD=16.30). The demographics by groups are summarised in Table 1. All potential participants apart from service users were approached by the primary author. Service users were identified and approached by their usual care team due to ethical considerations. All participants gave written informed consent. For more information see extended paper.

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Table 1

Participant demographic information

Phase One (n=16)			Phase two (n=13)		
	Gender	Age		Gender	Age
NHS CRHT staff (n=4; 3 clinical; 1 management)	2 male, 2 female	M=41.5 (SD=15.76)	NHS CRHT staff (n=5)	1 male, 4 female	M=47 (SD=12.98)
NHS service users (n=3)	3 male	M=41 (SD=7.55)	NHS service users (n=3)	1 male, 2 female	M=32 (SD=11.78)
Carers (n=5)	1 male, 4 female	M=69.4 (SD=5.41)	Carers (n=3)	3 female	M=68.6 (SD=7.09)
Third sector (n=4) (2 management; 2 clinical and personal experience)	2 male, 2 female	M= 42.5 (SD=5.92)	Third sector staff (n=2; both clinical experience)	2 female	M= 26.5 (SD=2.12)

Note. The sum of the total number of participants in each phase exceeds that in the overall number of participants due to 3 participants from Phase I also taking part in Phase II.

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Procedure

Sampling the concourse and defining the Q-set. The first stage of a Q-methodological study is to define the concourse. The concourse is a set of statements that reflects all that is known about a topic (Watts & Stenner, 2012). In this study a 'hybrid' method of assembling the concourse was used (McKeown & Thomas, 1988) which combines naturalistic (interview) methods with ready-made (literature) methods. Semi-structured interviews were conducted with a total of 16 participants, the interviews were designed to explore how they understood crisis (see extended paper for more details of the interview process). After transcription of the voice recordings, key themes were identified (see Table 2). See extended paper for details of the analytic method.

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Table 2

Themes and subthemes identified in the interview data

	The nature of crisis	Causes of crisis	The 'crisis' experience	Coping/attempts at resolution
Subthemes	'it's the difference, from them normally to them poorly'	'underlying vulnerability'	Emotional experience	Continued ineffective attempts at resolution
	'hard to explain, and hard to understand'	Internal trigger	Cognitive experience	Withdrawal
	'it's different for everyone'	'people cause crisis'	Perceptual changes	Help seeking
	'crisis as temporal'	'the impact of the world we live in'	Impact on functioning	The frustrated approach
	Understanding crisis	'the straw that broke the camel's back'	Confusion	
			Risk	
			The need for help	
			Carer burden	

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Statements that represented the crisis experience theme were directly extracted to form the Q-set. The collection of statements was condensed by removing duplicated meaning and choosing statements that best reflected the theme as a whole. This process was assisted by the research team and service user input. As is common in Q-methodology, the statements from interviews were supplemented with statements generated from existing literature. A final Q-set of 78 statements was assembled to specifically examine the experience of crisis. Each statement was transcribed onto a set of numbered cards for use in the Q-sort procedure. For more information, see extended paper.

Conducting the Q-sorts. All Q-sorts were conducted in the participants' own homes, places of work or NHS site depending on their preference. Participants (n=13, see Table 1) were asked to provide their age and gender. All participants were given an instruction sheet detailing how to complete the Q-sort process; the primary author was present to support this process. The process used followed guidance from Watts and Stenner (2012). Participants were asked to read the 78 statements. They were first asked to organise the statements into three piles 'mostly characteristic' of crisis, 'least characteristic' of crisis and 'neutral/unsure'.

Participants then sorted the statements again. Participants were asked to begin with the most characteristic pile and lay all the statements out so they could be seen. They were asked to place the two statements that they thought were 'most characteristic' of crisis in the +6 column of the quasi-normal fixed response grid (as shown in Figure 1) and to then continue placing statements in the other descending columns until all statements in the 'most characteristic' crisis pile were ordered along the distribution. Participants were then asked to continue the process with the other two piles, either continuing in the same direction with their neutral pile or starting at the other side with their 'least characteristic pile'. Participants were given ample time to rearrange their responses. After indicating that their Q-sort was complete the number of each statement was recorded onto a corresponding response grid. On completing the Q-sort, participants were asked a brief set of questions designed to elicit reflection on the statements and the Q-sort process and were subsequently debriefed.

Figure1
The quasi-normal fixed response grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
2												2
	4	4								4	4	
			6						6			
				8				8				
					9		9					
						10						

Note. The values at the bottom of each ranking column indicate the number of statements that was permitted

Statistical analysis. All data was analysed using PQ method (Schmlock, 2014). Responses from the Q-sorts (n=13) were entered into the program. A by-person correlation of each Q-sort with every other Q-sort was conducted. Centroid analysis of the resulting correlation matrix revealed two factors. A three-factor solution added little to determining defining characteristics of crisis. After exploring the resulting factor solutions of rotating by hand, the varimax solution provided the superior rotation. Determining a preference for one factor solution over another is not a fixed process in Q-methodology (Watts & Stenner, 2012). The two-factor solution (varimax rotation) had the greatest explanatory power and the greatest distinction between the factors. Therefore, it was considered that this solution had a

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greater ability to demonstrate participants' views. For a more detailed account of the analytic process and decision making see the extended paper.

The rotated two factor solution accounted for 50 percent of variance in people's understandings of crisis. Values above 35% are generally accepted as providing a good factor solution (Kline, 2014). Table 3 highlights the rotated factor matrix and highlights the Q-sorts that were significantly associated with each factor ($p<0.01$). The value which demonstrated significance at this level for the current data set was 0.29. This value was obtained using the guidance given by Watts and Stenner (2012) (see extended paper for details).

Table 3
Participants and their associations with the factors

Participant number		Factor One	Factor Two
1	NHS crisis team – professional	0.65	0.19
2	NHS crisis team – professional	0.67	0.45
3	NHS crisis team – professional	0.51	0.56
4	NHS crisis team – professional	0.78	0.40
5	Third sector crisis service	0.85	0.23
6	NHS crisis team – service user	0.18	0.81
7	Independent carer group	0.53	0.34
8	Independent carer group	0.71	0.32
9	Independent carer group	0.41	0.38
10	NHS crisis team – service user	0.62	0.24
11	NHS crisis team – service user	0.25	0.21
12	NHS crisis team – professional	0.32	0.54
13	Third sector crisis service	0.08	0.66
Overall percentage of explained variance		**31%**	**19%**

Note. Shading indicates significant loadings on factor one and factor two, or confounding loadings on both factor one and factor two

As shown in Table 3, three participants' understandings of crisis were only significantly associated with factor one and two participants' understandings were only significantly associated with factor two. Of the remaining eight participants, seven were significantly associated with both factors, highlighting that their understandings incorporated both of the identified characteristics of crisis. One Q-sort (Participant 11) failed to load significantly on either factor. This is common in Q methodology and reflects an interesting and distinctive viewpoint not shared by other participants. This is discussed more in the results section of the extended paper. A factor array was computed for each factor, indicating the average ranking assigned to each statement. This produces a Q-sort that demonstrates the shared viewpoints of participants on each factor and is, therefore, used to interpret the meaning associated with each factor.

The study protocol (Appendix B) was given ethical permission by the local National Research Ethics Service (NRES), and permission to recruit from the local NHS trust was granted by their Research and Development department (see Appendix C of the extended paper).

Interpretation and results

A holistic approach to factor interpretation was used, as advocated by Watts and Stenner (2012). This involves systematically constructing a crib sheet for each factor that organises the statements in positions determined by the factor array. The crib sheet outlines the position of each statement, therefore indicating how each statement contributes to the commonly held understanding identified in each factor. The crib sheets for each factor can be found in Appendix D of the extended paper. The by-factor rankings are shown in Table 4. Interpretation involves consideration of each statement and oscillating attention from one statement to another, building an understanding of the relative positioning of each statement in relation to others. A narrative description of each understanding is then constructed (Watts & Stenner, 2012). The highest and lowest ranking statements are generally considered the most informative, although

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holistic interpretation that attends to all statements is considered superior as statements that are positioned around zero can sometimes identify pivotal understandings (Watts & Stenner, 2012). Interpretation was initially conducted by the primary author, followed by further consideration with co-authors. Detailed narrative descriptions of the two distinct characteristics of crisis were constructed. For a more detailed exploration of the analytic process and interpretation please see the extended paper.

Table 4

By-factor rankings of statements in the Q-set

Factor One statement distribution	Equivalent ranking of statement in Factor Two
Statements ranked at +6	
44 You can't see reality	0
46 You're not aware of what is going on	-2
Statements ranked at +5	
8 Dying seems like a way to stop the pain	1
14 You just don't want to be here anymore	2
32 You can't see a future	2
48 You can't take care yourself, it's unsafe	-2
Statements ranked at +4	
23 Thinking strange things, things that aren't real	-2
25 You have no insight	-1
30 You lose all hope	1
49 You can't eat, can't sleep, can't work, can't do anything you used to	4
Statements ranked at +3	
37 Pure fear	1
50 You just can't function anymore	5
59 You do outrageous things	-2
66 Chaos takes over ordered thinking	1
67 Absolute despair	2
68 The sense of totally losing control	4
Statements ranked at +2	
9 You're not being normal, normally you would never be like that	0
28 You're trapped with it	-1
31 Desperation to feel safe	-1
51 You know that things are happening outside of yourself, but you can't react to it	-1
53 It's your worst nightmare times by a million	2
55 You feel totally disengaged from the world	0
71 An overwhelming feeling of not being able to cope	2
78 You feel so unsafe	-3
Statements ranked at +1	
33 You feel totally shut off from everyone	5
36 It's like you're screaming so loud and everyone seems to be just walking by	-2
41 You feel totally worthless	4
42 It does something to me that is inexplicable	-3
60 It's like you're dead already	0
61 It's not about me or my personality	-2
63 You feel numb	0
69 You don't know why you are doing what you are doing	0
72 You feel like you're going crazy	0

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Statements ranked 0

6 Its restricting, something you can't seem to move through	-1
16 Unbearable restlessness	4
19 You stop taking your medication	-6
40 Incomprehensible rage	-4
43 You can't see it coming	1
56 A total meltdown, falling to bits	4
57 You experience a level of distress that would not be expected	5
74 Extreme anxiety, panic	6
75 You're not 'you' during that time	-1
76 It completely overpowers you	1

Statements ranked at -1

5 It takes over your life	1
10 You just can't cope anymore	3
21 It becomes bigger than you	-1
22 It's so powerful	1
27 It blocks everything else out	1
29 It's totally unpredictable	0
35 It's hard to explain, and hard to understand	2
70 Your thoughts overtake you	0
73 Your life gets smashed	-2

Statements ranked at -2

2 It's very confusing, you just don't know what to do	2
7 You feel that nobody understands you	3
20 It's a medical problem	-3
38 Intense emotional pain	6
39 It's when distress goes beyond what is normal	2
45 You usually know you're in crisis	-2
62 You couldn't imagine things getting any worse	3
64 You are totally overwhelmed by your emotions	3

Statements ranked at -3

12 It's very confusing, not knowing what to do, where to go	-1
13 You want to do something to feel better, maybe drinking or drugs	-6
17 You stop talking to people, shut yourself away	3
26 You can understand your crisis	-4
47 You function, get up, work, eat and breathe, but you just go through the motions	2
58 The barriers just go up	0

Statements ranked at -4

4 There is something wrong with you	-4
15 It's a bit like a wound	-3
24 With the right amount of stress we would all feel that way	-5
52 You know when it's coming	-5
54 You just need to be with people	-4
65 It's frightening, very, very frightening	5

Statements ranked at -5

1 There is hope that things will get better	-3
3 A very normal reaction	-5
34 It's a normal life experience	-5
77 It's like treading on eggshells	-1

Statements ranked at -6

11 If you've been there before, you have a sense that things will get better	-5

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Factor One: 'you can't see reality'. Factor one has an eigenvalue of 5.44 and explains 31% of the study variance. Four participants were significantly associated with this factor. Of these participants, two were staff members from a CRHT, one was a crisis worker in the third sector service and one was a service user. All were female.

This factor relates to people understanding crisis as an experience which is defined by changes to awareness and perception of reality (44: +6; 46: +6). Alongside this altered state of awareness is reference to not being able to understand the crisis experience (26: -3), thinking strange things that are not real (23: +4), and chaos taking over thinking (66: +3). These experiences coincide with the sense of losing control (68: +3), fear (37: +3), feeling unsafe (14: +5; 32: +5; 31: +2) and increased risk, with references to ending life (8: +5;).

When in a crisis, it seems people are likely to lose a true sense of what other people perceive as 'reality'; they may make decisions and judgements that may appear to be irrational and their perspectives of the situation may not seem to make sense. They may be aware of this impairment and feel like they are 'going crazy' (72: +1) and may be confused by their own experiences (69: +1). On the other hand, they may lack insight (25: +4). There is a sense that this experience is 'inexplicable' (42:+1) and therefore might be very isolating. This disconnection from reality appears to, therefore, correspond with feeling disengaged from the world (55: +2) and a sense of being trapped with your experience of crisis (28: +2) and unable to access the people or things around you (33: +1; 36: +1). Statements referring to crisis as a 'normal' reaction were ranked least like a crisis within this factor, thereby giving the sense that this experience is not understood as normal (18: -6; 3: -5), but that there is not something 'wrong' with the person (4: -4). Similarly 'it's not about me or my personality' was ranked towards the 'most characteristic' (61: +1).

Factor two: 'emotional devastation, anxiety and debilitation'. Factor two has an eigenvalue of 1.02, and explains 19% of the study variance. Two participants were significantly associated with this factor. Of these participants, one was a service user (male) and one was a carer (female).

This factor communicates something about the nature of crisis as being intense emotional pain (38: +6) that is completely overwhelming (64:+3) and beyond what anybody could conceive of or imagine (57: +5; 26: -4). The experience is so utterly terrifying (74: +6; 65:+5) that it is debilitating, cutting them off from their life and the things that are important to them (33:+5; 49; +4) and from their loved ones (7:+3; 17: +3; 33: +5). The emotional pain is so devastating that they experience a total meltdown and feel broken (56: +4). They feel swept up in the devastation, and lose all control and agency (68: +4; 2:+2). People identified how they could sense this lack of control, and felt they had to sit with the feeling of not being able to do anything to escape it. The experience changed the way they felt about themselves – the feeling of worthlessness (41: +4). There is the feeling of total powerlessness in the face of the crisis that is all powerful (22: +1). The link to increased risk for this factor was related to the total lack of hope. There is no sense that things could get better and people cannot see a future (32; +2; 30: +1). Death seems like the only way out of the emotional pain (8:+1). This understanding of crisis suggests that there is no 'order' to a crisis. Crisis is unpredictable and you can't understand it (43: +1; 26:-4; 7:+3). Although other emotions such as despair were also highly associated with the crisis experience (67:+2), it was anxiety/panic related statements that were particularly present in this understanding of crisis.

Similarly to Factor One, there is a sense of the crisis as not being something 'wrong' with the person (19: - 4), but it is not 'normal' either (3:-5; 34:-5). Therefore, people may describe the emotional experience based on the difference to 'normal', or the disparity from their own baseline functioning.

Similarities and differences in understandings of crisis. Demographic information relating to each Q-sort allowed the researchers to contextualise the statistical findings (see Table 2 and Table 3). Four out of the seven professionals were significantly associated with both Factors One and Two. All three carers' understandings of crisis were significantly associated with both factors. Service users either identified with Factor One or Two, or no factor at all. No service users understandings of crisis were associated with both factors. These findings suggest that professionals' and carers' understandings of

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crisis more commonly incorporate both the perceptual changes and the emotional impact of crisis and they, therefore, may have a wider or more comprehensive perspective of crisis. Service user understandings of crisis are possibly more associated with one characteristic or another. One possible hypothesis for this finding could be that during crisis service users may have a narrowed perspective due to an intense concern or preoccupation with one aspect of crisis. Carers or professionals may be less overwhelmed by the crisis due to being involved but not directly at the centre of the experience, and therefore may be able to hold a wider perspective.

The coefficient of determination (R-squared) was computed for each pair of participants. This compares all pairs of Q-sorts and highlights the degree to which those two participants had similar or different understandings of crisis. Table 5 shows the percentage of shared understandings (R squared) for all pairs of participants. No statistical 'cut off' was used to determine whether or not the amount of shared understandings was numerically significant; instead these values were considered qualitatively. A higher percentage indicates a higher shared understanding of crisis, and vice versa. The percentage of shared understandings within and between groups was also computed (Table 6). This highlights the degree to which the individuals in each groups had similar/different understandings, and the degree to which the understandings of each group were similar/different to other groups.

Table 5
The percentage of shared understanding between participants

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13
Role	CRHT	CRHT	CRHT	CRHT	TS-CS	S.USER	CARER	CARER	CARER	S.USER	S.USER	CRHT	TS-CS

	Percentage of shared variance (%)												
1 CRHT	100	30	29	27	30	6	12	34	10	23	3	12	2
2 CRHT		100	38	24	44	18	21	41	14	31	11	24	11
3 CRHT			100	13	31	24	17	25	11	24	14	21	19
4 CRHT				100	44	4	32	30	16	20	2	6.7	2
5 TS-CS					100	13	32	38	20	43	2	20	7
6 S.U						100	11	9	17	19	4	24	33
7 CARER							100	26	15	10	11.5	7	8
8 CARER								100	17	24	13	16	7
9 CARER									100	9	0.3	19	13
10 S.U										100	1	10	3
11 S.U											100	5	2
12 CRHT												100	6.7
13 TS-CS													100

Note. CRHT (participant worked in NHS crisis team); TSCS (participant worked in a third sector crisis service); S.U (participant was a service user); CARER (participant was a carer)

Table 6
Average shared variances within and between groups

Shared variances within groups		Shared variances between groups	
Service users	8% (SD=9.45)	Service users/professionals	19% (SD=13.7)
Carers	19% (SD=5.85)	Service users/carers	13% (SD=9.45)
Professionals	21% (SD=12.85)	Carers/professionals	20% (SD=12.12)

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The findings suggest that there were no stark differences between the amounts of shared understanding between different groups. This suggests that there is no greater disparity between the understandings of service users and professionals than there is between carers and professionals, or in fact within groups of professionals. The percentage of shared understandings between service users and carers was somewhat lower.

When examining the individual pairings, a greater amount of variance between individuals can be observed which ranged from as low as 0.3% to as high as 44%. This suggests that although the two factor model identifies two main characteristics of the way people understand crisis, there is a large amount of variability between individuals' understandings. In particular, the shared variance among service users was much lower than among professionals or carers. Furthermore, the idiosyncratic findings associated with Participant 11, who did not load significantly on either factor and showed very low shared variance with any other participant, suggests that there may be some further understandings of crisis that are not well captured by the two factor model.

Discussion

This research aimed to develop our understanding of service user, carer and professional perspectives of crisis, and to explore areas of consensus and potential difference between them. Despite the ambiguity of crisis, the application of Q-methodology resulted in highlighting a common structure in the understandings of the crisis experience. These understandings were organised around two main characteristics of the experience: the impact on perception ('you can't see reality') and the emotional experience ('emotional devastation, anxiety and debilitation').

Perception and thinking have previously been linked to crisis. For Caplan (1964) crisis is the period of disequilibrium following the event/trigger. The disequilibrium is caused by both the ineffective attempts at resolution and the person's awareness of that inability and, therefore, the perception that there will be no resolution. Aguilera (1998) also suggested the importance of the subjective meaning making or appraisals about the triggering event and the associated coping behaviours. Tobitt and Kamboj (2011) found that professionals in CRHT teams identified 'functional disruption' as always present in a crisis, which included some reference to the impacts on coping and 'mental control'. However, the findings of Tobitt and Kamboj (2011) place little emphasis on the impact of crisis on 'mental control'. This is contrary to the findings of the current research which highlights perceptual changes as central to the way people understand crisis.

The experience of intense emotional pain as central to the crisis experience supports the understanding offered by Crisis Theory literature (Lindemann, 1944; Caplan, 1964; Hoff, 2001). Caplan (1964) described crisis as a disruption to the emotional equilibrium that cannot be resolved and thus causes emotional tension, described as extreme anxiety and 'hopelessness and ineffectuality' (Caplan, 1964, p.40). Hoff (2001) later defined crisis as 'acute' upset, and Lindemann (1944) first referred to 'emotional crises'. The current study also found that people understand the emotional experience of crisis as extreme anxiety, as well as despair and hopelessness. These emotional experiences were associated with a sense of being trapped and hopeless, and unable to effect change, which is similar to the 'ineffectuality' described by Caplan (1964).

However, the centrality of emotional distress has not been synonymous across all findings. The presence of 'extreme emotional distress' was debated among crisis team professionals (Tobitt & Kamboj, 2011), and was considered not always to be indicative of crisis. Some professionals linked extreme mental distress to mental illness and indicated the necessity of determining the presence of a mental illness before determining suitability for CRHT input whereas others felt the presence of emotional distress was more important than mental illness. This reflects an important debate that is central to crisis intervention in which some understand mental illness as a potential consequence of crisis (Caplan, 1964), whereas others explicitly link crisis to severe and enduring mental illness (Ball et al, 2005) and potential organic origins (Tobitt & Kamboj, 2011). This debate has become somewhat more significant in the context of definitions in CRHT policy and literature that propose the presence of mental illness as central to crisis (Department of Health, 2001). The findings of the current study suggest that the way people understand crisis is highly variable; therefore, an openness to different ways of understanding crisis is likely to be more useful than any firm preference for (or against) one understanding over others.

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Although risk was not identified as a factor in its own right, holistic interpretation revealed that it was a core feature of both factors. This suggests that although crisis might increase risk for some, it might not define the way that they understand their experience. This finding reflects the debate about the relationship between crisis and psychiatric emergency (Callahan, 1994) which has implications for determining appropriate clinical action and improving outcomes (Callahan,1998; Brennaman, 2012).

The findings of this research suggest that understandings of crisis are better defined by perceptual and cognitive changes and the extreme emotional distress experienced rather than by the presence of mental illness and risk of harm which is central to the definitions in policy (Department of Health, 2001), some professional understandings (Tobitt & Kamboj, 2011), and 'common sense' definitions used in empirical research (Johnson et al., 2005). The findings of this research suggest that these definitions could risk 'missing the point' and invalidating the core of the crisis experience.

The findings suggest that pairings of professionals/service users, service users/carers, or carers/professionals did not impact significantly on the amount of shared variance between understandings. However, irrespective of group there is a lot of variability between individuals' understandings. Furthermore, service users' understandings had a greater level of variability, having much less shared variance than professionals or carers. The findings also suggested that professionals' and carers' understandings of crisis were more likely to reflect both of the characteristics of crisis identified, whereas service users were more idiosyncratic and were more likely to reflect one or the other. It is possible that, throughout their recovery, service users become aware of the parts of the crisis experience that are psychologically significant for them. This may also suggest that professionals and carers are able to have greater distance in their perspectives, therefore being able to attend to multiple aspects of the crisis. Professionals also have the advantage of drawing on multiple experiences of crisis which are likely to influence wider perspectives.

Clinical implications

These findings have implications for both policy and recovery. Firstly, overly deterministic definitions of crisis overlook the variability of understandings of crisis. Therefore, re-evaluating these definitions in policy in order to encompass a wider range of understandings and less prescribed determinants of crisis could influence a more inclusive approach to crisis provision.

Due to the variability within understandings of crisis a case by case crisis formulation approach may be more beneficial. Case by case crisis formulation would guard against a one size fits all approach to determining eligibility for crisis intervention. This could help to empower service users to define their own understandings of crisis and recovery which is thought to influence better outcomes (Caplan, 1964; Slade, 2009; Weinstein, 2010). Although this may seem resource intensive, the two factor model gives some guidance which could act as a starting point from which to develop negotiated understandings and shared decision making which is also linked to improved clinical outcomes and positive long term effects (Joosten, DeFuentes-Merillas, De Weert, Sensky, Van Der Staak, & de Jong, 2008; Simon, Wills & Harter, 2009; Farrelly et al., 2015). The variability and un-predictability of crisis may present challenges for clinicians, adequate supervision and offering a reflective space could support wellbeing and reduce burnout (Edward & Hercelinskyj, 2007), give opportunities for learning and development, and support staff in feeling confident in their practice (Platzer, Blake, & Ashford, 2000; Paget, 2001).

Limitations

Due to ethical considerations, the service user participants were deemed to be in recovery from crisis. This retrospective account of the crisis could be considered a limitation; due to this we are unable to observe the understandings during a crisis. However, what this adds is a recovery perspective which is also clinically useful. Additionally, service users were recruited from a crisis team and, as such, it is likely that their perspectives will have been influenced to some extent by socialisation to professional and mental illness discourse. Due to ethical considerations all service user participants were identified by staff within the crisis team as being ready to discharge. These judgements about who to include, and potentially who not to include, could have influenced the perspectives gained.

Future research

Further to the two factor model providing a 'starting point' there is the possibility that further research could serve to develop the Q-set into a more accessible and manageable clinical tool. Several participants

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commented that they felt they had a better understanding of their experience of crisis after completing the Q-sort process. Professionals also commented that the procedure could have benefits as a clinical tool for use in recovery and when planning discharge.

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1. Extended background

1.1 Background of the research question

This thesis was originally proposed by a member of the Service User and Carer Advisory Panel (SUCAP). The SUCAP offers support to the Doctorate in Clinical Psychology programme at the University of Nottingham. Members of the panel felt that service user and carer understandings of crisis were not well represented in current professional/service level discourses. They suggested that it was possible that service users, carers and professionals understood crisis differently and reflected on their experiences of this when using or attempting to access crisis services. The aim of the research was to expand our understanding of different perspectives of crisis in mental health services.

When defining the research question it was understood that most people have an implicit understanding of what a crisis is, due to the common use of the term crisis in lay discourse. However, with regards to mental health services this term may refer to something more specific, and it may be a term that represents multiple perspectives. Therefore in considering the research question, the term crisis was considered to have multiple stakeholders. The Joint Commissioning Panel for Mental Health (JCPMH, 2012) identified the importance of incorporating the perspectives of service users, carers, professionals and services/policies when defining crisis.

Two overarching questions were identified:

1. What are the understandings of crisis held by the people who experience it: service users, carers and professionals?
2. Are these understandings similar or different?

Due to the focus on understandings of crisis within mental health services, a background of the current national community crisis provision model (Crisis Resolution Home Treatment teams, CRHTs) and its efficacy will be reviewed. I will then go on to consider the existing literature and identify how this contributes to an understanding of crisis. This review will consider the multiple stakeholders – service user, carer and professional perspectives as well as perspectives from policy and relevant theoretical

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understandings of crisis. Consideration of theoretical understandings will specifically draw on Crisis Theory (Caplan, 1964), systemic understandings of crisis, understandings of crisis and mental health symptomology or illness, and understandings of crisis as distinguishable from psychiatric emergency.

Search strategy for literature review

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The systematic literature review (Davies & Rennoldson, 2013) conducted to inform this thesis searched the following online social science and medical databases: PsychINFO (1806-2014), Medline (1946-2014), EMBASE (1980-2011) and CINAHL (2001-2011). The first 100 papers elicited through Google scholar were also screened. Web of Science (1900-2014) was used to trace articles that had cited the identified papers. Further information about the selection process and inclusion/exclusion criteria for the systematic literature review (Davies & Rennoldson, 2013) is provided in Appendix E.

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The key search terms used were: crisis intervention, crisis management, crisis resolution, crisis resolution home treatment, crisis resolution home treatment team, CHRT, crisis centre, mental health crisis, service user, client, patient, experience, view, satisfaction, perspective, evaluation. Terms were exploded and used singularly or in conjunction as appropriate for each database.

To identify relevant articles for the wider literature review this search strategy was expanded to include the terms: crisis, crisis theory, family crisis, life crisis, emergency mental health care, psychiatric emergency and crisis care.

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1.2 Crisis intervention in the UK

The service provision for severe and acute mental health difficulties has recently undergone reconfiguration and implemented the CRHT model nationwide. The teams were intended to reduce admission to psychiatric facilities and to provide rapid access to alternative services (Johnson, Zinkler & Priebe 2001; Johnson, et al., 2005a; Department of Health, 2001, 2003). Services now boast less of a focus on institutional care with a greater provision of community-based alternatives (Glover, Arts & Babu, 2006; National Audit Office, 2007). UK Government policy directed the national introduction of the CRHT model (DoH, 2000, 2001,2003; HM Government, 2014).

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UK policy guidance instructs that CRHTs be available to people aged 16-65, with severe mental illness and 'with an acute psychiatric crisis of such severity that without involvement (of CRHTs), hospitalisation would be necessary (Department of Health, 2001). CRHTs are multidisciplinary teams designed to act as gatekeepers to admission, providing intensive short-term care that is accessible 24 hours a day, seven days a week. Clinical interventions include symptom management, but the model also addresses social needs that precipitate crises and have practical, educational and crisis prevention elements (Johnson, Zinkler & Priebe 2001; Johnson et al., 2005a, 2005b; Roberts & Ottens, 2005; Sjolie, Karlsson & Kim, 2010). CRHTs are designed to work in partnership with Community Mental Health Teams (CMHTs), providing an additional service of rapid assessments, intensive monitoring and frequent visits. Since their introduction in the 1980s they have become available across the nation (Crompton & Daniel, 2007).

The model requires a multidisciplinary approach, drawing on resources from emergency services, mental health services and social services to manage risk in the community. The Crisis Care Concordat documents an agreement by health, social care and emergency services and government bodies to support crisis service provision (HM Government, 2014). The document highlighted that when community crisis intervention and multidisciplinary working does not go well people do not receive adequate services and lives are lost. The defined aims of the document were not only to offer emergency interventions, but to offer support with recovery and support to help prevent future crises. This was highlighted as important due to the health and economic benefits of early intervention and preventative approaches (Knapp, McDaid & Parsonage, 2011). This appears to suggest that crisis is understood as being related to health and social needs. Secondly, it is an experience that is associated with risk, and lastly that it is an experience that may respond well to preventative and early intervention approaches.

There is an established and agreed 'best practice' level of service involvement (HM Government, 2014) and national standards for CRHT care have been developed (The Royal College of Psychiatrists, 2015). However, Barker, Taylor, Kader, Stewart & Le Fevre (2011) argue that there is less available guidance on how such a service can be effectively implemented in the context of recent economic/resource confines, which has

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been directly linked to the efficacy of CRHT input (National Audit Office, 2007). Therefore, despite its aims it is useful to consider the efficacy of the model in practice, and to explore the extent to which it meets the needs of people in crisis.

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1.3 The efficacy of CRHTs

Considering efficacy and effectiveness studies of the CRHT model could also help add to our understanding of crisis. What people find helpful during a crisis informs us about what it is about the crisis experience that people find most difficult or challenging.

It is acknowledged that many efficacy studies have primarily measured economic benefits, such as reduced admission rates and length of stay, to quantify CRHT effectiveness (Carpenter, Falkenburg, White & Tracy, 2013; Hubbeling & Bertram, 2012; Barker et al., 2011; Johnson et al., 2005a; Johnson et al., 2005b). However, not all findings suggest such benefits, with some studies reporting no change to admission or length of stay (Tyrer, Gordon, Nourman, Lawrence, Curran, Southgate et al., 2010) and some indicating no impact on admission rates (Forbes, Cash & Lawrie, 2010) and increased length of stay (Keown, Tacchi, Niemiec & Hughes, 2007). The evidence is limited by the research often coinciding with bed closures (Tyrer et al., 2010; Barker et al., 2011). For example the implementation of CRHTs in the study by Barker et al. (2011) coincided with a 30% reduction in psychiatric bed provision; therefore, not all of the reduced admission rates can be directly associated with CRHT involvement.

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Hubbeling and Bertram (2012) highlight the difficulties in linking readmission rates to a CRHT model, concluding that there is no evidence for its superiority above other admission-reducing interventions. They suggest that studies have only explored efficacy in comparison to hospitalisation, therefore neglecting a comparison against other possible admission-reducing interventions such as crisis houses (Johnson, Lloyd-Evans, Howard, Osborn & Slade, 2010) and day hospitals (Priebe et al., 2006). Similarly, Jacobs and Barrenho (2011) and Tyrer et al. (2010) found reductions in bed use in areas with or without CRHTs, demonstrating similar efficacy of other models. No studies have had adequate power to demonstrate an increase in serious incidents with the introduction of CRHTs (Hubbeling & Bertram, 2012).

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Quantifying efficacy in this way and seeking the support of one model of crisis provision over another is less useful to the aims of this thesis, as it informs us less about a broader understanding of crisis as an experience. What could be more helpful is consideration of what service users find helpful about crisis intervention considering that the consumer perspective of crisis services is important as it allows us to identify needs that are being met and those that are not. Unmet needs or dissatisfactions could inform us about a facet of crisis that is currently not targeted by existing services.

1.4 Service user perspectives of crisis services

A recent review highlighted that our understanding of service user perspectives of the usefulness of crisis interventions remains limited (Sjolie, Karlsson & Kim, 2010). However, the existing literature can help in considering what is useful in supporting people through crisis. Winness, Borg and Kim (2010) conducted a review of service user experiences of CRHT involvement. Critical components of helpful treatment were: access and availability, being understood as a normal human being, and dealing with crises in an everyday life context. Furthermore, building positive relationships with professionals providing support, having some control and being able to participate in their recovery were valued by service users (Winness, Borg and Kim, 2010; National Audit Office, 2007; Hopkins & Niemiec, 2007).

A further review of the literature highlighted some helpful and unhelpful aspects of crisis interventions (Davies & Rennoldson, 2013). All twelve studies reviewed highlighted that service users found access to support and safety helpful in supporting them through crisis. Service users highlighted that access to support was related to feeling safe. Knowing that the service was there for them whenever they might need it was important; therefore, 24/7 availability was specifically highlighted as important (Hopkins & Niemiec, 2007; Coleman, Donnelly, Davies & Brace, 1998; Goldsack, Reet, Lapsley & Gingell, 2005; Clark, Khattak, Nahal & Linde, 2008). Unsurprisingly, difficulties accessing services were said to exacerbate crisis (Middleton, Shaw, Collier, Purser & Ferguson, 2011). Considering how this informs our understanding of crisis, this suggests that crisis is a time when you can feel very unsafe and that is it, therefore, associated with intense emotional experiences such as fear, anxiety and despair, also, that having access to people who can support and care for you is important in increasing

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safety. This could link to physical safety such as having someone there to talk to about thoughts of harming or ending life, but maybe also to the sense of emotional safety. Considering psychological theory, it is a well-established understanding that humans are drawn to connect and seek proximity to others during time of need (Bowlby, 1988) because relationships can provide comfort and safety.

Alongside being able to access support, service users also highlighted some helpful and unhelpful characteristics of the support given. Workers who demonstrated expertise such as knowledge of their difficulties and their ability to signpost and deliver potential interventions were highlighted as providing comfort in a time of confusion (Hopkins & Niemiec, 2007). Although this finding was aimed at evaluating the effectiveness of crisis intervention, what this adds to our understanding of crisis is that it is an experience that generates a sense of confusion. However, the manner in which the sharing of knowledge and expertise is executed can be unhelpful. Service users identified that too much information was considered overwhelming (Clark et al., 2008; Goldsack et al., 2005), and that the use of mental health terminology and convoluted language can be confusing (Clark et al., 2008; Hopkins & Niemiec, 2007). One service user described being given *'bits and pieces'* of information in general conversation (Goldsack et al., 2005) which was helpful and more accessible for someone trying to comprehend new information and manage intense distress. Therefore, these findings imply that crisis is an experience that generates confusion and that it may be extremely demanding on a person's cognitive capacity.

Service users frequently highlighted the importance of relationships with service providers. The ability of staff to listen and hear the voices of service users, to be respectful and non-judgemental, and to be genuinely caring and kind were identified as helpful when in crisis and were thought to reduce the associated distress. Some studies reported that service users had experienced dismissive and disinterested staff, suggesting that this was unhelpful (Karlsson, Borg & Kim, 2008; Clark et al. 2008; Baronet & Gerber, 1997; Hopkins & Niemiec, 2007; Goldsack et al., 2005; Middleton et al., 2011; Khalifeh, Murgatroyd, Freeman, Johnson & Killaspy, 2009). This seems to link to understandings of effective therapeutic relationships and engagement in mental health settings, and their influence on clinical outcomes (Lambert & Barley, 2001;

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Gomes-Schwartz, 1978). Therefore, such information may add less to our understanding of the crisis experience than it does to our more general understandings of distress and help seeking/receiving processes.

Continuity of care was also highlighted as important in crisis (Hopkins & Niemiec, 2007) with a lack of continuity making it difficult to build relationships due to the repetition of information-sharing (Hopkins & Niemiec, 2007; Clark et al., 2008; Middleton et al., 2011). However, again this tells us less about what is needed specifically in a crisis than it does about what people in distress need when they access help. Continuity of care is linked to service user satisfaction as well as clinical outcomes across presentations and types of services (Adair et al., 2005; Jones et al., 2009). Service users discussed that it is important in crisis, because it was thought to contribute to the professional's knowledge of the individual's circumstances. This was thought to reduce the chance of inadvertently increasing distress by triggering underlying psychological difficulties (Middleton et al., 2011) and to reduce the chance of increasing risk by not being sufficiently aware of the person's history and risk assessments and protocols in place (Clark et al., 2008). What this tells us about the crisis experience is that common factors highlighted as good practice in mental health services are also helpful in crisis. What might be different in crisis is that these factors are increasingly important due to being linked to risk management.

CRHTs particularly reduced voluntary admission rates (Johnson et al., 2005b), which might suggest that some people prefer to recover from a crisis at home. However, the review of service user perspectives (Davies & Rennoldson, 2013) highlighted the complexity of treatment at home. A key finding in this review was that preference for home treatment was context dependent. Admission is viewed as helpful when the home environment is contributing to the crisis, when people feel overwhelmed by the stress of everyday life or when they feel they are too unsafe at home due to suicidal ideation (Clark et al., 2008). Therefore, hospitalisation may serve to reduce these stressors while allowing the individual to recover to a point at which their context seems more manageable. Again, this suggests that crisis is understood as depleting a person's resources and ability, or perceived ability, to cope.

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This is possibly further supported by service users who highlighted the helpfulness of practical support during crisis, although this could also be more related to treatment in their home context. Service users talked about needing help to manage the practical and continuing demands of the home context such as housework, shopping, self-care and help taking medication as prescribed (Clark et al., 2008; Middleton et al., 2011; Goldsack et al., 2005). Financial advice and support with housing and debt advice were also highlighted as helpful; this suggests that these factors are either impacted by the experience of crisis or can contribute to and/or be seen as part of the crisis itself (Clark et al., 2008; Middleton et al., 2011; Goldsack et al., 2005). Childcare and parenting were highlighted as a particular responsibility that can feel overwhelming during crisis (Khalifeh et al., 2009). These findings suggest that crisis may be understood by service users as a psycho-social experience. The study concludes that mothers generally prefer home treatment as regards their mental health needs; however they highlighted difficulties meeting the needs of their children. They felt a lack of emotional connectedness and felt they couldn't interact with their children. This impacted on how they viewed themselves as mothers, further exacerbating distress. They highlighted that, at times, the children were exposed to distressing 'symptoms' such as self-harm and public nudity, and children also become carers for their parent. This therefore suggests that crisis might be understood by service users as a system rather than an individual experience. This understanding was possibly further supported by the perspectives of their children (n=5), who communicated preference for admission due to their parents being unable to care for them, fearing for their mothers safety and being scared of their mothers.

Overall, consideration of service user perspectives of crisis intervention may suggest that service users understand crisis as a time when you feel very unsafe, with intense emotional experiences such as fear, anxiety and despair. That crisis is understood by service users as confusing and impacting on cognitive capacity and coping resources and ability (or perceived ability) to cope. The findings suggest that service users may understand crisis as a psycho-social experience, possibly as something that is experienced by an individual or a family system. Consideration of the available service user perspectives presents some interesting hypotheses about what their understandings of the crisis experience might be. However, what is also of concern for this thesis are

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professional understandings of crisis, which leads me to consider what understandings can be drawn from further literature sources.

1.5 Understandings of 'crisis' in mental health settings

Crisis is a term that is frequently used in mental health settings yet is often poorly operationalised. The understandings from policy are communicated both through their definitions of crisis and their recommendations for service provision. Policy guidance states that CRHT input should be available to people aged 16-65 with severe mental illness and 'with an acute psychiatric crisis of such severity that without involvement (of CRHTs), hospitalisation would be necessary (Department of Health, 2001, p 10). The Joint Commissioning Panel for Mental Health produced an overview entitled 'what is crisis?' (JCPMH, 2012). The service-orientated definition describes crisis as an event that causes significant mental distress and behavioural change that negatively impacts a person's mental health, their life and their social networks. They suggested that crisis is a situation which is beyond manageable for the individual, and that crisis can be associated with risk of 'psychiatric emergency'.

Tobitt and Kamboj (2011) argue that CRHT policy does little to characterise the essential features of crisis, instead providing loose guidance that lacks clinical utility. They highlighted the complexity of defining crisis and sought to clarify this by investigating the understandings of professionals working in CRHTs. Tobitt and Kamboj (2011) noted that many participants were initially confused about the concept of crisis and there were many areas of crisis that were debated before analysis revealed some areas of team consensus. Analysis of interview data highlighted the common factors used to identify someone as 'in crisis' or not. Factors that always signify crises were: functional disruption, risk of harm and the need for additional support. Often present were extreme mental distress and the high likelihood of admission without CRHT input; these factors were classed as 'debated' as not all respondents reflected this understanding of crisis. Times when a referred 'crisis' was not considered a crisis were when the referrer was unsure or 'stuck' about what to do for the best or when the difficulties were more representative of a long term enduring mental illness or a low level baseline functioning and when the experience lacked the 'severity' to warrant it a crisis. Regarding theories of crisis, participants all communicated an understanding of

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underlying vulnerability to crisis, and several 'origins' of crisis were identified such as life stress, systemic crisis and previous trauma. Interestingly, the two essential features of the definition offered in CRHT policy (presence of severe mental illness/suitability for admission) was not reflected in the teams' understandings of crisis.

A crisis trajectory was identified, indicating that after a phase of 'normative functioning' the crisis started to develop and over time increased with intensity. The 'peak' of the crisis represented three patterns. One pattern was considered the 'window of opportunity' for crisis intervention; discussed as the prime opportunity for intervention this phase approaches resolution before the 'peak'. Another trajectory described a crisis that has progressed so quickly that intervention could not be offered before the peak, and the final trajectory pattern was described as 'momentum phenomenon' in which a pattern of gradually increasing speed and exacerbation is described. The peak is then followed by a period of resolution, with the crisis 'end point' signifying a return to normative functioning. Similarly, although variability was observed in recovery, some consensus suggested some common patterns. Some described people having an 'instant effect' which was demonstrated by a rapid and significant reduction in distress following the first appointment; this was thought to reflect a relief and reassurance that someone was there to help and was thought to be more commonly experienced by people who were newly presenting to services. The other observed pattern was that recovery can be fluctuating, with some people experiencing a burst of recovery from the initial emotional distress but then slowing down with complete resolution taking longer to achieve. Once again there was some disagreement about what crisis resolution involved; while some thought the problem or cause of crisis needed to be resolved others thought resolution was aimed at the emotional response.

The team also identified three 'clusters' of crisis representing prototypical patterns that cases are usually more or less similar to. Firstly, they discussed an 'enduring needs' cluster. This represented people who have enduring mental health needs and substantial contact with secondary services. They also discussed a 'new presenter' cluster that is characterised by little or no engagement with other services, usually referred by accident and emergency departments with anxiety/depression and a risk of harming themselves. The third 'cluster' was called 'emotional intensity' which described people

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with a ‘problematic personality presentation’ who are ‘emotionally unstable’ with on-going risk behaviours, for whom crisis is ‘the norm’. Although authors are keen to highlight that clusters do not represent ‘groups’ of service users, it is difficult to see how clusters of crisis pattern and groups of service users differ from the descriptions offered. These clusters also represent a dominating medical and diagnostic-driven understanding of distress and crisis, which turn the focus more towards individual pathology and illness.

Overall, within mental health settings there are some broad understandings of what crisis intervention should offer from policy guidance, and Tobitt and Kamboj (2011) offer insight into some of the understandings of crisis from CRHT professional perspectives. These understandings suggest a potential underlying vulnerability for crisis that is triggered by external stressors interrupting normative functioning and proceeding to a period of crisis escalation, crisis peak, and recovery. The authors discuss a period of confusion within the accounts of professionals, which lead to some debate about what is and is not a crisis. The variability of crisis leads to difficulty in establishing an absolute definition, although they reach a general consensus in the findings. Despite reaching consensus, this process tells us that it may be difficult to have an absolute and fixed understanding of crisis and that a more fluid understanding that holds within it areas of debate, difference and variability might be more clinically useful. Therefore, looking not just at what people say but at the process of collating different perspectives can contribute to an understanding of crisis.

Considering these professional perspectives leads to curiosity about what may have generated these understandings and if they seem to have been generated from clinical experience alone or a more implicit theoretical underpinning. Some have argued that the contemporary CRHT model is an atheoretical approach to service provision (Johnson & Needle, 2008), due to the lack of explicit theoretical foundations. Similarly, Tobitt and Kamboj (2011) highlight that little effort/progress has been made in embedding the CRHT model within a theoretical framework, which has led to a lack of conceptual clarity. Therefore, further consideration of the theoretical understandings of crisis could offer further insights.

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1.6 Crisis theories: a potential theoretical foundation

The following sections will offer an overview of some theories of crisis in order to consider how they may have influenced our understandings. Efforts to define and understand the phenomenon of crisis have been documented since the early 1900s. Caplan's (1964) crisis theory has been the basis upon which other theorising has developed, and therefore, I will consider this in addition to other relevant theoretical developments.

Crisis Theory. Crisis Theory (Caplan, 1964) proposes an explanation for how crisis comes about, what happens during a crisis and the factors that influence crisis outcome. Caplan (1964) proposed that a person or system is generally in a state of 'emotional homeostasis' or equilibrium. They may experience certain problems which cause some tension but these are quickly resolved over time by their usual re-equilibrating (coping/problem solving) mechanisms. Usually the tension is short lived and not intense due to the knowledge that resolution will soon come. In crisis, however, the problems faced are larger and pose a significant threat to fundamental needs being met. As such, usual re-equilibrating mechanisms are ineffective, which can lead to crisis. The theory discusses the time of crisis as an opportunity for psychiatric efforts, due to the person being in a state in which they are perhaps more open to new resources and ways of coping.

The origin of crisis intervention is rooted in the work of Dr Eric Lindemann, a psychiatrist/psychologist specialising in grief and loss, and the theory's emergence is specifically linked to the Coconut Grove fire in Boston in 1942. This tragic incident resulted in the death of almost 500 people causing devastation and mass grief in the community. After the fire, Lindemann discussed 'emotional crises' and identified that understanding them, and the contexts in which they occur, could help develop preventive efforts (Lindemann, 1944). Dr Caplan worked alongside Dr Lindemann, and later operationalised 'crisis theory' and introduced a preventative and community-based treatment approach.

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How crises come about: 'hazardous situations'. Caplan (1964) proposes that potential problems or initial stimuli that could evoke a crisis situation can be predicted within any sociocultural context. However, the precipitant is not the crisis, the crisis is the period of disequilibrium following the event/trigger. This predictive ability of the theory offers the possibility of listing the potential 'hazardous circumstances' which the majority of people would perceive as stressful/problematic. Callahan (2009) distinguished 'normative' stressors from 'traumatic' stressors. Examples of normative stressors are those that reflect the expected developmental trajectory. Biological and role transitions such as birth, puberty, illness and death are all examples of developmental situations that present challenges to resources and a threat of loss. These stressors mark the transitions between phases in someone's life which can evoke cognitive/affective upset and can be thought of as 'developmental crises' (Erikson, 1959). These triggers refer to transitional points in a person's history when they have faced novel and unavoidable challenges such as significant losses (loved ones, employment), illness or sociocultural transitions of role such as marriage/parenting (Caplan, 1964; Erikson, 1959). The way that these potential stressors are then perceived, and the meaning that is attributed to them is then further influenced by personal experience and context, alongside sociocultural values and beliefs (Caplan, 1964).

More contemporary theorising (Collins & Collins, 2005) has also suggested a 'developmental-ecological' perspective, highlighting the significance of developmental and wider contextual issues on crisis. Hoff (2001) defines crisis as 'an acute emotional upset arising from situational, developmental or sociocultural sources' (p.4). Collins and Collins (2005) suggested contextual factors such as relationships, economic resources/strains, community and societal influences were important to the crisis context. These factors impact on how someone perceives themselves or the situation, the resources they have to deal with challenges/difficulties, and the impact of the crisis with regard to the extent of impairment. Perception of the crisis and the ability to cope with it has been described as a key element in a person's vulnerability to crisis (Aguilera, 1998; Golan, 1998). This life-span consideration of crisis helps to predict situations that could lead to crisis and is therefore in line with Caplan's (1964) suggested preventive approach.

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Callahan (2009) also discussed the link between 'traumatic' stressors and crisis, for example rape, kidnap, bombings, natural disasters etc. As Callahan describes, traumatic stress became the focus of crisis intervention in the 21st century. This was influenced by various terrorist and natural disasters. Although Callahan originally saw 'emotionality' (heightened emotional distress) as a problematic concept in crisis due to the possibility of people being in a state of dissociation (Callahan, 1994), he later distinguished this from a posttraumatic stress response (Callahan, 2009). Callahan (2009) concluded 'crises are substantially similar whether they are triggered by normative or traumatic stress' (p.16); however extended complex trauma responses such as posttraumatic stress disorder should be considered differently and require more longer-term treatment. Therefore, after traumatic stress there may be a period of crisis within which crisis theory and intervention is appropriate; however, if the disturbance continues, the presentation can develop into a posttraumatic disorder.

Therefore, this theorising documented some of the stressors that can interrupt a person's 'equilibrium' or normative level of functioning. The theories suggest a large range of potential stressors, largely external stressors that are either considered normative within the persons expected developmental trajectory, or traumatic and unexpected. The impact of these stressors is similar; they present difficulties which are outside of the person's ability (or perceived ability) to cope. The theories appear to present crisis as an experience in time, therefore temporal in nature. The temporal nature of crisis is also reflected by contemporary time-limited crisis interventions (Department of Health, 2001), and distinctions between crisis and longer term 'enduring' mental health conditions (Tobitt & Kamboj, 2010). As such, it seems fitting to consider the nature of crisis over time in greater depth.

The crisis trajectory: responding to 'hazardous situations'. Caplan (1964) highlighted that the significance of crisis is how it changes and develops over time. The person is in a period of time when they cannot resolve the difficulties and the timeframe of resolution exceeds the person's expectations, which are based on past successful resolutions. This leads to further increased tension and fear of no resolution. As described by Hoff (2001) this represents 'acute emotional upset…resulting in a temporary inability to cope by means of one's usual problem solving devices' (p.4).

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Caplan further described the temporal quality of crisis. He explained that if you were to magnify the pattern of equilibrium it would show small deviations from the normal patterns over an extended period of time. In comparison, magnifying crisis or disequilibrium would show major challenges and deviations from the normal pattern, or frequent challenges/disparities which may appear as a series/cluster of smaller crises.

Therefore, a critical characteristic of crisis is that it is relative to time. The crisis is a short term acute change to the usual patterns, equilibrium and emotional homeostasis of the individual/system. Caplan (1964) identified that crisis usually lasts between four to six weeks, which has been frequently cited by other crisis theorists (Golan, 1998; Callahan, 1994; Brennaman 2012). These ideas of crisis as temporal continue to be reflected in later theories. For example, Callahan (1994) refers to 'time aspects' and disruption of equilibrium. Golan (1998) refers to an 'upset in a steady state' that moves through the phases from equilibrium through disturbance to readjustment and a new equilibrium. Brennaman (2012) proposes the 'crisis' is a period of between four and six weeks duration during which there is an experience of 'disequilibrium in psychosocial functioning' and again precipitated by either external triggers or underlying vulnerability, similar to that identified by Caplan (1964).

The period of disruption and attempts at resolution are associated with frustration and tension which cause discomfort and 'upset' such as anxiety, guilt, shame etc. (Caplan, 1964). Hoff (2001) later described this as 'acute emotional upset', therefore emphasising the intensity of the experience. The trajectory of this tension/upset can vary. It may fluctuate in a series of peaks or rise at a steady rate. This acute emotional upset impairs usual functioning. In the face of the insoluble problem the person experiences 'hopelessness and ineffectuality' (Caplan, 1964, p.40). It is this ineffectuality that Caplan links to the observed 'disorganisation of functioning', a series of ineffective/maladaptive attempts to solve the problem. The level of impairment is thought to parallel the intensity and duration of emotional upset (Caplan, 1964). Impact on functioning during crisis is also an established characteristic in later literature (Hoff, 2001; Callahan, 1994).

Caplan organises the crisis trajectory in four characteristic phases: (1) an initial rise in tension from the original stimulus which initiates coping resources; (2) a lack of

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successful resolution and the continuation of the original stimulus gives rise to further tension and ineffectuality; (3) the further rise in tension leads to either needs resignation (gives up) or perceptual distortion (new ways of thinking about the problem/trying to solve it); (4) in the face of continued tension and failure to resolve the problem the tension rises with such an increased burden that it results in major disorganisation and drastic consequences.

Factors which influence crisis outcome. In crisis theory, the manner in which resolution is achieved influences the future health and resilience of the individual/system. The new equilibrium is different, and this difference can be for the better or worse. Therefore, they can emerge from the crisis a more or less healthy version of themselves. Crisis is often referred to as an opportunity due to the person being in a state in which their repertoire of coping strategies is ineffective, as such they may be more willing to try out new methods and accept help from others (Aguilera, 1998; Callahan, 1994; Golan, 1998). The new equilibrium can lead to a greater satisfaction of needs and new coping resources may have been developed leading to developed resilience and increased regard and confidence for their own abilities. This seems to be less emphasised in some of our understandings of crisis in policy (Department of Health, 2001) and staff perspectives (Tobitt & Kamboj, 2011), although it features in others (JCPMH, 2012). What is more apparent in these contemporary understandings is the focus on maladaptive coping that may have developed and can continue to cause damage to the individual and their contexts, thereby increasing the likelihood of further crises and problematic and maladaptive coping in times of stress. This is possibly due to the opportunity presented by crisis being less concerning to services, therefore directing service efforts to preventing further distress and damage and avoiding relapse.

Caplan (1964) states 'every crisis represents a novel situation in which novel forces, both internal and external, are involved' (p.41); therefore, although previous experience may influence crisis outcome it does not determine it. Caplan identified personal, family and sociocultural factors that impact crisis outcome.

Personal factors relate to whether or not the crisis situation resonates with any significant experiences in the person's history and how those experiences were

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approached/resolved. Memories of old problems that are in some way linked to present problems can be stimulated into consciousness, presenting additional emotional complexities and burdens and possibly initiating 'previously used pathological defence mechanisms' (p.41). Similarly, differences to previous experiences can offer new possibilities for resolution. The perception of the stimulus/event as stressful and problematic, and their perception of their ability to cope with it, also depends on experience, cultural influences and personality.

Sociocultural factors are discussed as the individual's/system's milieu and interactions with other people/systems. Caplan (1964) states 'a man does not usually face his crisis alone, but is helped or hindered by the people around him, by his family, his friends, neighbourhood, community, and even nation' (p.43). The importance of utilising members of the individual's social network is also reflected in more contemporary crisis literature and approaches to intervention (Hoff, 2001; Bridgett & Polak, 2003). The sociocultural context influences the 'interjected values and traditions' which impact the way the individual perceives themselves, the problem and their ability to achieve resolution. Values and traditions also impact whether they might try to cope alone, how able they are to access the resources around them, and how available these resources are. As their tension comes to climax the person is usually involved, not only in efforts to access and utilise his own resources but to solicit help from others. Caplan discussed how at each boundary between the individual in crisis and those they interact with is the need to negotiate mutually satisfactory ways forward. These interactions must act twofold: to meet the unsatisfied need that is the cause of tension but also to locate the individual in a position of power and control over his recovery in order to develop and sustain their perception of themselves as effective. They must be supported to regain/retain important roles in order to protect their belonging and operation within their significant relationships.

The people who can more strongly affect the individual and the crisis are those who are most connected to them through 'primary bonds of his basic needs for love and interaction and those who fit in with his needs for authority and dependence' (Caplan, 1964, p.48). Caplan discusses not only the importance of family and loved ones but also members of the community such as religious spokespersons, writers who offer comfort

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or older people known for their wisdom, alongside medical professionals, care workers and social workers. This reflects some attachment-based understandings of achieving basic needs and service user perspectives of needing people to 'be there' during crisis (Davies & Rennoldson, 2013).

Families in crisis. As discussed, crisis theory was established and developed in the context of community tragedy and war time contexts and, therefore, the understanding offered is one related to understandable responses to difficult circumstances and not of individual pathology. Further to Caplan's (1964) Crisis Theory, other theorising around this time was also developing conceptualisations of crisis within a family unit. Hill (1949, 1958, as cited in McCubbin & Patterson, 1983) proposed the ABC-X family model of crisis. Similar to Crisis Theory, the model proposes that the crisis (X) is the result of an interaction between a precipitating event (A), the family's resources available to cope with the event (B), and the families shared perception/meaning of the event (C). The crisis (X) is described as the state of disequilibrium and immobilisation of the family system. This is similar to the disturbance to the equilibrium and the ineffectuality/hopelessness described by (Caplan, 1964). McCubbin and Patterson (1983) proposed an extension to this theory by considering crisis as a double ABC-X model, therefore, not only considering what leads to crisis, but also what leads from it. The double 'A', therefore, included both the precipitating event but also the build-up of stressors that can result from crisis. The double 'B' refers not only to the resources at the time but to the emerging/diminishing resources during a crisis. The double 'C' referred both to perceptions and meanings about the event, but also perceptions of the crisis itself and perceptions of the accumulated stressors and coping. This factor also notes the importance of family held values and beliefs. The crisis (X) encompasses both the immediate impact of the event but also the impact of the event on coping, adapting, functioning or impairment.

Johnson, Needle, Bindman and Thornicroft, (2008) highlighted that social and family difficulties have a 'very large role' in crisis development and resolution. Despite some people arguing that contemporary CRHTs are atheoretical, this observation was to some extent recognised by the CRHT model which intended to include interventions to maintain and improve social networks (Department of Health, 2001). Service user

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research highlighted the importance of practical help (Davies & Rennoldson, 2013); however, a systems level focus and interventions are less explicit. Some contemporary treatment approaches are somewhat more individualised, seeking to increase individual coping capacity and understandings of crisis as relating to illness and individual pathology, therefore, contrasting the primary focus with the context in the family model of crisis (Hill 1949, 1958, as cited in McCubbin & Patterson, 1983).

Furthermore, contemporary publications continue to value systemic understandings and approaches to crisis intervention that contrast individual pathology and medically-based understandings of crisis that influence some of the understandings in contemporary health settings (Tobitt & Kamboj, 2011). Bridgett and Polak (2003a) provide an understanding of a crisis as a 'non-illness' brief reaction to stress which involves either individuals or social systems, during which maladaptive coping strategies may be used. They also highlight that crises can take the form of a 'connected series' in which there can exist multiple unresolved crises that can span across social systems. They describe the individual as belonging to a series of overlapping systems of interactive human relationships. These social systems are vulnerable to internal conflict and external stress/pressures. Within these systems, people are interconnected. Actions by any person within the system changes the context for all of the others and, as such, the system develops and changes in a circular process. Consequently, Bridgett and Polak (2003a) argue for a systems approach to intervention beginning with the identification of the social system crisis, whether that is a bereavement or loss, financial or employment problems, accommodation problems etc. Polak (1967) indicated admission to hospital as a 'social systems crisis' in itself. The described assessment and intervention continues to target systemic issues, using 'system meetings' to begin group/family therapy to promote change and recovery, both regarding home treatment and facilitating discharge (Bridgett & Polak, 2003b). As these understandings are contrary to some of the more medically and diagnostically informed understandings of the crisis experience, it seems important to further explore the associations between crisis, illness and hospitalisation.

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Crisis and mental illness. Mental health and illness-related discourses have appeared throughout this introduction. This draws attention to a tenuous link between crisis and mental illness that appears in some understandings of crisis. Due to the exploratory nature of this research, the intention of referring to these terms and highlighting the link to mental illness is to investigate many perspectives and not to further propose a link between illness and crisis or to argue against it.

The tenuous link between crisis and mental illness appears in most crisis theories, however, some more explicitly than others. For Caplan (1964) changes in personality or emotional/cognitive experiences understood as mental illness are the result of not adjusting to the challenge/transition in a healthy way. Rather than crisis being the result of illness, Crisis Theory proposes that mental ill-health can be a consequence of the attempts at resolution. For example, an individual manages to maintain his/her roles and position within the family by largely coping in avoidant and self-destructive patterns. Their distress is protracted and directed inwards which can lead to mental ill-health such as depression and negative self-perceptions associated with blame, loathing and guilt. Alternatively, a system reorganises to accommodate the crisis and to meet the needs of the individual in crisis. Not only is the role of the individual altered, but the roles of family members change to accommodate the crisis. The reorganisation can resolve the crisis for the individual at the expense of the needs of other family members; in this example, mental ill-health can then manifest in a carer or loved one. Caplan (1964) suggested that it is best not to understand the impact of crisis on mental health solely with regard to the individual presenting to services, but to consider the impact on the people supporting crisis resolution. The theory implies that it is not only the referred individual who is at risk of deteriorated mental health, the mental health of the people around them can be equally if not more affected. Therefore, crisis presents a unique preventative opportunity when individuals and families may present to services at a time before some severe and enduring mental ill-health has developed.

Contemporary understandings of CRHT staff also reflect a distinction between crisis and severe and enduring mental health to some extent, although medical and pathology-based understandings are equally apparent (Tobitt & Kamboj, 2011). Furthermore,

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contemporary theories of crisis (Ball et al., 2005; Brennaman, 2012) have developed in order to fill the suggested lack of theoretical underpinnings and in order to resolve the suggested difficulties in applying Crisis Theory (Caplan, 1964) within a mental health setting. Ball et al. (2005) developed a theoretical model of the crisis experience specifically for individuals with severe and enduring mental illness. Ball et al. (2005) critique the use of Crisis Theory (Caplan, 1964) due to illness not being implicitly linked to crisis development. Subsequently their proposed alternative theory is largely synonymous with Crisis Theory, with the only marked difference being the conceptualisation of crisis as a symptom of mental illness, rather than a consequence.

The model offered by Ball at al. (2005) developed from the need to understand the frequent crises experienced by people who have severe and enduring mental illness. This perhaps reflects the understandings discussed previously about different 'groups' of service users or 'clusters' of presentations that are commonly associated with crisis (Tobitt & Kamboj, 2011), which reflect a more diagnostic categorisation.

The model suggests an underlying vulnerability as 'setting the stage' for crisis. Underlying vulnerability in this model refers to the relatively prolonged and enduring experience of mental health symptomology; however, it also encompasses a vast array of psycho-social experiences such as loneliness, homelessness, abuse and poverty. In this model the cause of crisis is located within the 'underlying vulnerability' as either an external trigger or an exacerbation of mental illness symptoms (that can occur without an external trigger). Although relational conflict and sleep disturbance were cited as a precipitant by some participants, the authors comment that this was rare. Similarly, the crisis is defined as the emotional experience of feeling overwhelmed and lacking control. Ball et al. (2005) further distinguish the emotional experience into 'types' of crisis. They highlight four types of crisis: (1) agitation, anger and aggression; (2) being low; (3) feeling anxious and (4) euphoria. The person's response to the crisis was also included in the model, identified as either help-seeking or managing alone. The authors also identified numerous factors that contribute to resolution and prevention. Resolution is defined as the feelings of being overwhelmed and out of control subsiding.

Ball et al. (2005) propose that their model adds to existing theory by making explicit the link between an increase in mental illness symptomology and crisis, and by

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highlighting that not everyone seeks help and support. However, it could also be argued that some key elements of existing Crisis Theory were overlooked. For example, Golan (1998) suggested that hazardous events that perpetuate crisis can be a result of an 'external blow or internal change', therefore referring to changes in internal rather than external states. Secondly, Caplan (1964) referred to how maladaptive ways of coping may have developed which can continue to cause damage to the individual and their contexts, therefore supporting the idea that 'managing alone' can be understood as one of many coping responses. Furthermore, if the person was effectively able to manage alone, the person would be unlikely to present to crisis services. When Caplan (1964) refers to individuals not experiencing crisis alone, he refers to whether or not the system around them is a help or hindrance. In situations where the individual tends towards managing alone, it is possible that their system is a hindrance, or previous experiences of crises or challenges have resulted in maladaptive coping patterns (Caplan, 1964).

What Ball et al. (2005) add to theory is an explicit link between the impact of protracted experiences of mental illness on vulnerability to crisis. However, the shift in understanding crisis as a symptom of pathology appears to be the only difference from crisis theory (1964). This turns Caplan's (1964) understanding of mental health on its head: rather than mental ill-health being the bi-product or consequence of crisis, the model by Ball et al. (2005) proposes crisis as a symptom of a severe and enduring mental illness presentation. The proposed need for 'treatment' whether in hospital or at home, further reflects this debate. The treatment pathway is largely determined by how the presenting difficulties are understood; Callahan (2009) suggests that definitions direct action. What might therefore be useful is to further consider how crisis is associated to hospitalisation, and how this can inform our understanding of crisis and to what extent it is similar or distinct from psychiatric illness.

Crisis, illness and hospitalisation. The need for hospitalisation or home treatment is possibly further complicated by the lack of clarity and distinction between crisis and psychiatric emergencies. Callahan (2009) identified that many understandings of crisis were problematically synonymous with definitions of psychiatric emergency and the need for hospitalisation. For example, Johnson et al. (2005) describes crisis as a situation in which psychological health has deteriorated to the extent that there is

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potential for harm, therefore requiring the individual to be admitted to psychiatric care. Callahan (2009) suggests that psychiatric emergencies are 'relatively unpredictable, acute situations that demand an immediate response' (p.167). If no response is forthcoming this may result in physical harm or serious biopsychosocial deterioration with a poorer prognosis. Callahan (1994) suggests there are only three types of psychiatric emergency: suicide, violence and psychosis. Callahan (1994) identified the need to distinguish psychiatric emergencies from crisis in order to guide action, as treating psychiatric emergency with crisis intervention could be harmful and likewise crisis does not warrant emergency care. Johnson et al. (2008) later define psychiatric emergencies as situations in the context of mental health illness which need immediate action due to high risk. In contrast, psychosocial crisis is a common human response to psychosocial stressors and not a manifestation of illness. Therefore, this understanding differs to those proposed by Ball et al. (2005) and Brennaman (2012) as it explicitly excludes illness.

However, Hoff (2001) discusses the problems with linking stress, crisis and illness. Hoff (2001) highlighted that illness is a subjective concept and the relationships between stress, crisis and illness are tenuous and debated. Furthermore, overly simplistic psychological models of stress, crisis and illness based on cause-effect logic can increase labelling and harmful narratives/unhelpful attitudes about presentations such as personality disorder (Hoff, 2001). Ball et al. (2005) seem to propose a link between severe and enduring mental illness and crisis without consideration of the mechanisms that establish this link and how these individuals would be better supported by services/families/communities due to this model.

Considering hospitalisation further, and reflecting back on systemic understandings, Bridgett and Polak (2003) suggest that hospital admission leads to crises becoming understood as individual pathology. It has been proposed that the social context of the ward has no bearing on the social context of the individual (Polak, 1971). As such, the influence of the social context is easily overlooked. Bridgett and Polak (2003a) suggest that hospitalisation localises the problem within one individual and can promote social processes of labelling, scapegoating and extrusion that can ease some of the system-level distress which can, in part, advantage some family members (permit avoidance

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and reduce blame and responsibility) while pathologising and disadvantaging others. Treatment in hospital settings results in unresolved social issues that have the potential to cause future problems (Polak, 1967). Bridgett and Polak (2003) suggested that the difficulties can then 'reactivate' on discharge. They suggest that resolving the crisis within the social systems that the individual interacts with can be beneficial for recovery thereby supporting the concept of home treatment and the CRHT model (Department of Health, 2001). Where hospitalisation is unavoidable, Bridgett and Polak (2003b) suggest a sensitive consideration of the social system crisis and conscientiously planned discharge as ways of reducing further readmission.

This empirical literature appears to raise two important contrasts in the understandings of crisis, whereas some understandings emphasise crisis as a result of contextual difficulties some understandings represent more medical and diagnostic/pathology-based approaches. The two understandings also seem to be associated with the two main approaches to treatment; home or hospital-based care. These influences could be seen as setting the stage for contemporary and individual understandings of crisis constructed and held by the service users, carers and professionals who experience it.

This section has detailed the background of the CRHT model, its efficacy and the service user perspectives of CRHT involvement. Research has been considered that contributes to our understandings of crisis. The distinctions between crisis and psychiatric emergency and illness have been considered and the links to service provision and improved clinical outcomes have been discussed. The following sections will detail why the current research is important, and the associated clinical implications.

1.7 The current study

The problem with understanding crisis. The complexity and variability of the crisis experience seems to contribute to an array of varying understandings of the nature of crisis. However, there are further factors that make crisis ambiguous. Tobitt and Kamboj (2011) highlight that little effort/progress has been made in embedding the CRHT model within a theoretical framework, which has led to a lack of conceptual clarity. As Callahan (2009) said, 'the concept of a crisis is much less clear [than behavioural emergency], and the word crisis is used to describe a wide variety of

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situations in the psychological and mental health literature' (p.14). Another factor that complicates our understanding of crisis is the multidisciplinary professional involvement. This leads to different perspectives on the aetiology of crisis and, therefore, different ideas about intervention and prevention. Variability is still noted within samples of professionals working within the CRHT model. Tobitt and Kamboj (2011) noted differences within understandings of crisis even within one crisis team, further reflecting the challenge in reaching consensus. This multiplicity of stakeholders, therefore, causes further difficulty in conceptual clarity.

Rationale and clinical implications. The development of this research was influenced by a service user and carer panel associated with the university which highlighted that service user understandings of crisis were under-researched.

Callahan (1994) contested the notion that the professional should determine how we define crisis. Similarly, the Joint Commissioning Panel for Mental Health (JCPMH, 2012) suggested that the identification and understanding of a crisis should be arrived at through negotiation between the stakeholders. Although we are more aware of the theoretical and professional understandings of crisis due to research, literature and policy, we are less aware of the understandings of service users and carers. Tobitt and Kamboj (2011) recommended that further research into the understandings of service users and carers is vital due to the lack of empirical knowledge of their perspectives. This research is in line with current national drivers for service user involvement and participation in health care (NHS England, 2013). Involving service users in defining their own experiences of crisis is thought to be an important avenue for research for improving crisis service provision (Johnson et al., 2008).

Clear understandings of clinical presentations are important because they guide action (Callahan, 1994). Understandings of presenting problems influence clinical guidance and the ways that we approach resolution, in terms of psychological formulation and intervention (Johnstone & Dallos, 2013). Therefore, the way we understand crisis influences service provision in terms of how we triage and what interventions to provide and when (Ball et al., 2005; Brennaman, 2012). However, research has found that common understandings of crisis between professionals are difficult to reach (Tobitt & Kamboj, 2011). The SUCAP also suggested that it was possible that service users,

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carers and professionals understood crisis differently and reflected on their experiences of this when using or attempting to access crisis services.

This research could help us to understand different perspectives, so that these differences can be better navigated, in order to promote positive engagement and avoid crisis situations being overlooked. This is particularly important due to the proposed distinction between crisis, psychiatric emergency and risk of harm, and the associated links to clinical outcome (Callahan, 1994; Brennaman, 2012). Tobitt and Kamboj (2011) have highlighted that clear communication and understandings about crisis is important for negotiating access to crisis services. They have suggested that furthering our understanding of crisis could improve the clarity and appropriateness of the understandings of crisis that determine access to services and intervention type, thus enabling better clinical outcomes. The presence of service user perspectives within this process is particularly relevant given the increasing focus on the rights of patients experiencing acute mental health problems to access community treatment (Tobitt & Kamboj, 2011) and the legal responsibilities held by professionals such as Approved Mental Health Professionals (AMHP) and Responsible Clinicians (RCs).

Aims. This research aims to develop our understanding of what a crisis is from the perspectives of the people who experience it, both directly and indirectly.

Two overarching questions were identified;

1. What are the understandings of crisis held by the people who experience it; service users, carers and professionals?
2. Are these understandings similar or different?

The following sections detail the development of research design that was considered appropriate in fulfilling this aim and answering the research questions.

2. Extended methods

This chapter expands on the methods section of the journal article by providing a deeper exploration of the theoretical underpinnings of Q-methodology and epistemological

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2.1 Theoretical foundations of Q-methodology

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Q-methodology emerged from the thinking of William Stephenson (Burt & Stephenson, 1939) as a divergence from the traditional statistical technique 'factor analysis' invented by Charles Spearman, Stephenson's mentor. Before considering this divergence in more detail it is useful to contextualise the method within theoretical considerations with regards to subjectivity and the logic of abduction.

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Operant subjectivity. Stephenson disagreed with the idea that subjectivity was purely a mental experience (Robbins & Krueger, 2000). Instead he retrospectively likened his thinking about subjectivity (and his pursuit of a measure for it) to the thinking of William James (1980). James (1980, as cited in Watts & Stenner, 2012) proposed subjectivity as an activity, and critiqued psychology's 'preoccupation with mental entities' (Watts & Stenner, 2012, p.28). Watts and Stenner (2012) conclude 'in James' way of thinking…neither subjectivity (as mind-stuff) nor objectivity (as world-stuff) were to be taken as primary…both as mere derivatives of what he called the pure experience' (p.29). Both Stephenson and James held a non-dualistic way of thinking, which proposed there could be no split between subjectivity and objectivity, and that one could not be conceived of without the other (Good, 2010). This way of thinking refuted the superiority of objective scientific study over the quest to understand subjective experience. Although scientific study of the objective dominated traditional scientific paradigms, Stephenson set about to develop a methodology which would allow for the scientific study of the subjective.

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This leads to further consideration of the idea of subjectivity as an activity. Stephenson proposed that the process of Q-sorting marks subjectivity as a verb, an activity, and not a mental entity. Watts and Stenner (2012) discuss two modes of activity, one characterised by object-reference (or reference to objective world) and one characterised by self-reference (one's experience of yourself in relation to the object). The process of Q-sorting is subjective and self-referent. When the Q-sort is considered purely as the 'action of sorting' the result becomes an expression of subjectivity. Operationalising subjectivity as a behaviour means we are able to capture and measure it objectively via

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the completed Q-sort. However, when interpreted, it becomes the object of further experience. The interpretation of the object again becomes subjective and so on. Thereby, demonstrating Q-methodology as a complimentary process of subjectivity and objectivity, in which one cannot exist without the other.

The finished Q-sort provides a snapshot of subjectivity. These points of view are not enduring concepts and exist only in the time point and context in which they are captured. Therefore, they are constantly evolving. In Q-methodology different viewpoints are embraced, and viewpoints are no less 'factual' than objective ones despite their variances. It would be unfathomable to try and study subjective experience without variance. It is, in fact, this variance that can assist further understanding.

The logic of abduction. Many approaches to research are either deductive or inductive. Deductive approaches begin with a theory and then seek support for it. In inductive approaches, observations are made and data is gathered from which a theory is formed. As Watts and Stenner (2012) discuss, abduction is a less known form of logic and one that is intended 'for discovery and theory generation' (p.39). Similarly to induction, the data is gathered and observed prior to theory, the difference being that rather than looking to describe the findings, an approach based on the logic of abduction seeks to explain why the area of study manifests in such a way. This approach is geared towards infinite hypothesising and new insights. Stephenson saw Q-methodology as a way of generating hypotheses from the outcomes of exploratory statistical analyses. These analyses highlight how findings manifest themselves, providing the source of further hypotheses and explanation. The researcher may begin to suspect a particular relationship within the findings, and can use judgement within statistical procedures to create opportunities to reveal unexpected findings.

The development of 'Q' and its divergence from 'R'. Factor analysis seeks to reveal patterns of association between variables (Watts & Stenner, 2012). When compared to Q-methodology, traditional factor analysis methods are usually referred to as 'R methodology'. The method is based on 'Pearson's r' correlation. These methods tend to measure multiple variables (for example psychological traits), using various tests, and then look to find the patterns that emerge between them. An individual's response or performance can then be compared to the usual pattern.

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In order to understand the subtle differences between the Q-method and the R-method, Watts and Stenner (2012) suggest consideration of the 'individual difference' tradition. The individual difference tradition sought to diverge from common nomothetic approaches that aimed to uncover similarities and enable generalisability. Instead the individual differences approach sought to explore variability. R-methodology was often used to explore how individuals differed regarding particular psychological traits. However, it did this through a process of standardising scores within the population. Therefore, findings became less representative of 'individual difference' and more representative of how a person differed from the 'norm'. In Q-methodology, scores are standardised relative to all scores given by the individual (not the population) (Watts & Stenner, 2012).

R-methodology explored differences according to the measurement of variables deemed statistically important to the population but not necessarily important to the individual. Additionally Stephenson noted that the R-method failed to represent the individual as a whole. The measurements of the variables essentially measured 'parts' of people, such as height, weight, cognitive abilities etc. It draws from these measurements a 'norm', and then compares individuals to this norm, rather than comparing them due to their actual differences to one another. The development of Q-methodology started from the aim of wanting to shift analytical attention from the variables to the person. Q-methodology is, in effect, a by-person factor analysis. Rather than people being measured by tests and according to traits, the person measures the object of study. In other words, the person identifies which statements are 'psychologically significant' to them, and which are not. Therefore, in this research the variables represent the participants and the sample population is the information that is available for them to measure. The information available to them is called the concourse (Cross, 2005). Of course, the key to supporting this process is the conscientious identification of a heterogeneous pool of information that is representative of the object under study. In Q-methodology this is a set of statements called the 'Q-set'.

The Q-concourse and the Q-set. Stephenson referred to 'communicability' which represents all available information about the object under study. The concourse is the culmination of this 'communicability' described as the 'universe of statements for [and

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about] any situation or context' (Stephenson, 1986a, p.44). The concourse is defined by the research question and design. It is acknowledged that assembling the full concourse around a particular topic is unlikely and that the true extent of it may never be known. However, Watts and Stenner (2012) refer to the concourse as the 'fertile soil from which new subjectivity grows' (p.34). It is from this concourse that a set of statements representative of this 'universe' of information is selected, this is called the Q-set. Watts and Stenner (2012) describe how 'concourse is to Q-set what population is to person sample' (p34). In single-participant studies all statements will be self-referent to the person, whereas in larger studies there will be a culmination of statements from different points of view, but also information that pertains to the context of the enquiry for example cultural and organisational perspectives.

2.2 Why Q-Methodology?

Crisis is commonly referenced in mental health discourses yet people's understandings of crisis are somewhat under-researched. As such, an exploratory research design was indicated. Crisis is not a physical object measurable within the confines of traditional methodological paradigms; it is an experience that is highly variable and therefore subjective. Q-methodology is recommended for exploratory research seeking to understand such variability and subjectivity (Thomas & Watson, 2002; Watts & Stenner, 2005).

Furthermore, crisis is an experience that involves multiple stakeholders. Stainton Rogers (1995) described Q-methodology as suiting research questions interested in many voices. It was assumed that there would be variance within the viewpoints that emerged. Q-methodology has been said to encompass the advantages of both qualitative and quantitative methodologies providing a technique by which these subjective viewpoints can be held constant enabling commonalities and differences to be examined (Cross, 2005). Baker, Thompson and Mannion (2006) suggest Q-methodology is a useful approach for unfamiliar areas in health research due to 'eliciting structure from complex data whilst remaining mindful of subjectivity and personal interpretation' (p.18).

The current research originated from service users and carers who felt their understandings of crisis were not well represented within the literature. Q-

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methodology's emphasis of psychological significance and self-reference permits the identification of alternative and less dominant perspectives (Farrimond, Joffe & Stenner, 2012). Watts and Stenner (2012) identify Q-methodology as positioning the participant as active in the measurement process, counter to being 'passively subjected to measurement' in traditional methods. Therefore, the method was considered well placed for identifying a range of perspectives, including those that are less common or surprising and counter intuitive to the researcher.

This leads me to consider the influence my own positioning as a mental health professional had on my choice of methodology. Q-methodology neither tests nor imposes a priori meanings (Coogan & Herrington, 2011); the researcher cannot predict how the Q-sorts will be configured (Stainton Rogers, 1995). The participants impose their own meaning/structure on the data (Kitzinger & Stainton Rogers, 1985). As such, Peritore (1989) argues that the method respects the integrity of the person's viewpoint. It allows unexpected and potentially counterintuitive accounts to emerge (Baker, Thompson & Mannion, 2006) Therefore, I felt Q-methodology was advantageous in aiding the discovery of marginalised and less dominant perspectives whilst helping to limit the extent to which my own understandings influenced the findings.

Consideration of other possible approaches. Interpretative Phenomenological Analysis (IPA) (Quinn & Clare, 2008) may have been a useful approach due to its focus on exploring how people make sense of their experiences. However, the theoretical foundation in hermeneutics necessitates interpretation as central to the analytic process. As previously discussed, staying close to the meaning of participants and limiting the researchers influence on the findings was considered important. Furthermore, IPA is an idiographic approach; therefore, it aims to understand how a given person understands their particular experience, in that specific time and context. Although this would have achieved the aims of this research in part, it would have limited the exploration of divergent accounts and an understanding of crisis across groups which Q-methodology permitted.

Thematic analysis was considered another suitable method. However, although the flexibility of thematic analysis can be an advantage, it can result in difficulties in the analytic process in terms of the fact that what can be said about the data can be so broad

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that it can be 'paralysing to the researcher trying to decide what aspects of their data to focus on' (Braun & Clarke, 2006, p. 27). Crisis was considered to be a highly variable experience, and diverse viewpoints and contradictions were expected. While thematic analysis can be effective in drawing out contradictions between participants (Braun & Clarke, 2006) crisis as a concept was considered so obscure that the factor analytic process within a Q-methodological approach had the benefit of identifying core structures (Watts & Stenner, 2012). Furthermore, although divergent accounts could have been sought using thematic analysis the method is more commonly used to highlight common themes and patterns within the data, and therefore convergent accounts (Braun & Clarke, 2006). Conversely, the imposed normal distribution of a Q-sort enables the exploration of difference through parametric intergroup comparisons (Zraick & Boone, 1991). This was considered clinically useful because understanding difference within crises could influence service provision and help to avoid misunderstandings, miscommunications and frustrations between stakeholders.

Repertory grids may have offered an alternative way of exploring how people construct their understandings of crisis. Repertory grids are a method used to construct a cognitive map of the way an individual makes sense of experience. The method is based on personal construct theory (Kelly, 1955) which proposes that individuals develop 'personal constructs'. The term 'personal construct' refers to an organised system of understanding that is based on the experiences of the individual. The repertory grid method allows researchers to capture this individual sense-making, and as such it is an idiographic method. Although generally used in this idiographic manner, it has also been used to compare personal constructs between people, for example using linguistic analysis, Q-type factor analysis or multivariate statistics (Tan & Hunter, 2002). This requires a nomothetic approach in which the same rep grid structure is used with all participants, running the risk that such 'supplied constructs' could be interpreted by respondents in quite different ways. Using a wider range of open statements, rather than a narrower range of forced bipolar constructs, mitigates that risk. Furthermore, being able to compare multiple perspectives is central to the analytic process involved in Q-Methodology and, therefore, this approach was favoured.

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Ontological and epistemological considerations. An awareness of the way we understand knowledge and how that is acquired can be helpful in considering how researchers position themselves, especially in terms of how they understand their influence on the research. Ontology refers to the nature of the social world and what can be known about it, and epistemology is concerned with the nature of knowledge and how we can acquire it (Snape & Spencer, 2003).

It is possible and appropriate to conduct Q-methodological enquiries within the context of various ontological and epistemological positions (Watts & Stenner, 2012). This research was conducted within the framework of a critical realist (CR) stance. CR is a philosophical position that combines realist ontology with relativist epistemology and has developed out of critical awareness of the limitations of both positivist and post-modern approaches (Crossan, 2003; Clark, 1998). CR recognises the reality of a 'mind-independent' world as well as the importance of the events and social discourses. As such, the material world exists in reality but the way that we know this world is influenced by the way that we experience it, including our social and historical contexts. CR synonymously accepts the notion of a 'true' reality and defends the notion that knowledge is constructed. With regard to the pursuit of knowledge, critical realists favour scientific theorising and 'robust relativism' (Niinniluto, 1991; Wikgren, 2004, p.13).

CR was considered compatible with this research because Q-methodology has a dual focus on both the importance of studying subjective experience and the pursuit of ways of studying it with scientific rigour. It values both subjectivity and objectivity, offering a coherent yet flexible epistemological basis from which to evaluate both qualitative and quantitative elements of the study.

Critique of Q-methodology. Despite the advantages of Q-methodology, it is criticised for the following reasons. Reliability is considered one method of determining a tool's utility. The Q-set is considered a tool and the Q-sort the behaviour by which subjectivity is measured. There has been debate over whether Q-methodology can consistently measure a person's point of view. Whereas some propose test-retest reliability of 0.80 and above (Brown, 1980), others have questioned the extent to which such tests of reliability are appropriate in Q-methodology (Watts & Stenner, 2012).

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Reflecting back on the discussions of operant subjectivity, the notion of test-retest reliability is arguably negligent in the context of operant subjectivity. In other words, the Q-sort is a snapshot of subjectivity, a point of view which is not an enduring concept and which exists only in the time point and context in which it is captured. Points of view are constantly evolving and, therefore, one would expect some variance between time points. Q-methodology does not purport to measure stable attributes.

Another criticism is that participants in a Q-methodology study are constrained by the statements provided. As Cross (2005) describes: 'people can "tell a story" only if they have the appropriate statements to tell it'. Thus, a wide sampling of the concourse is vital, a criticism which can be minimised by appropriate and thoughtful study design.

Further to these limitations, Q-methodology can be said to constrain participants through implementation of a 'forced matrix' method. Consequently, this could have the effect of forcing a participant to negatively rate a statement with which they agreed. Baker, Thomson and Mannion (2006) counter this argument by specifying the vast variations that are available to the respondent. They highlight that, for a simple 10 item Q-sort, there would be 1,209,600 potentially unique sorts (p.9). Similarly, Brown (1980) demonstrated that the impact of forced sorts is minimal and not statistically significant, and the advantage of the forced choice methods is that the participants have to consider their responses more carefully (Watts & Stenner, 2012).

2.3 Study design

A two phase research design was developed. In Phase One the Q-concourse was assembled and the Q-sort tool (Q-set) was developed. In phase two, the Q-set was piloted prior to further data collection via the Q-sort. Further detail on each phase is provided below.

Phase I: assembling the Q-Concourse. It is acknowledged that assembling the full concourse around a particular topic is unlikely and that the true extent of it may never be known. However, the aim in assembling the concourse is to thoroughly represent the available understandings of crisis. To do this, I identified pre-existing information through internet literature searches and supplemented these understandings with interview data. McKeown and Thomas (1988) describe this as a 'hybrid' method,

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combining naturalistic (interview) methods with ready-made (literature) methods. They also argue that the assembly of the Q-concourse is driven by the aims of the study. As discussed, a limitation of Q-methodology is that participants are constrained by the statements provided (Cross, 2005). Therefore, using additional interview data to enable representation of a wide range of understandings of crisis was necessary because (a) in itself interview data expands the understandings of crisis already available, and (b) it allows the generation of a set of statements that provides the scope needed for participants to effectively communicate their subjective perspectives of crisis. Without including interviews, the Q-set would only include statements from pre-existing literature which is largely dominated by professional and theoretical perspectives. This could be considered limiting. Interviews were thought to elicit the perspectives that are less well documented. Statements were extracted from the assembled Q-concourse in order to construct the Q-set. The process of constructing a Q-set that is representative of the concourse about crisis is considered in more detail in later sections.

Phase II: the Q-sort. The Q-set was then used to collect Phase Two data in which participants were asked to rank the statements according to how characteristic they are of crisis. This process captures each participant's subjective construction of crisis. This enables further exploration of the different understandings of crisis using statistical analysis, in order to explore whether or not these were similar or different between service users, carers and professionals. The opportunity to effectively explore this is largely influenced by the sampling strategy.

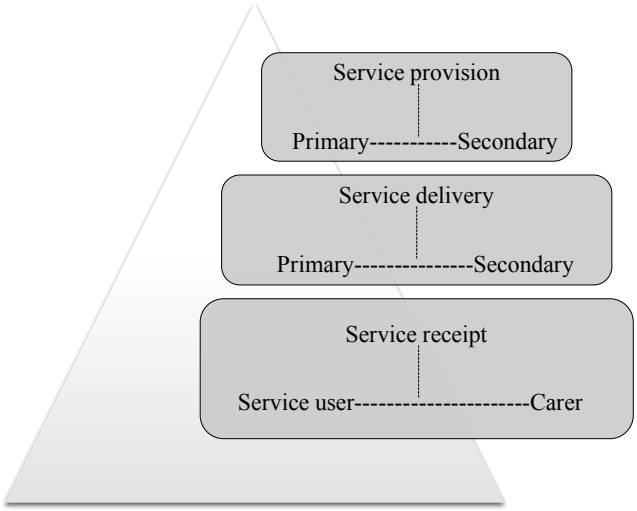
Sampling strategy. There is no specific requirement to have a large sample size in Q-methodological studies (Watts & Stenner, 2010); what is of greater importance is the selection of participants who can address the research question. Therefore, this section explores the sampling method further. The sampling method was particularly important in answering the research questions due to the wish to explore the understandings of crisis held from different perspectives (service user, carer and professional), and whether or not they are similar or different.

Stratified sampling was used in order to collect data from the population that represented the central stakeholders of the term 'crisis'. In doing this I first considered there to be three levels; service provision, delivery and receipt as illustrated in Figure 2.

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Figure 2

Levels of stakeholders



Sampling was biased towards service delivery and receipt levels. The rationale for this was twofold. Firstly, one of the core aims of this study was to include multiple perspectives. Professionals, service users and carers are central stakeholders of crisis. Secondly, service provision perspectives represent a collectively held perspective that is socially meaningful due to its influence on service delivery and receipt, for example, through such policy documentation as the Policy Implementation Guidelines (Department of Health, 2001), the Crisis Care Concordat (HM Government, 2014) and other doucments concerned with provision of crisis services. Therefore, it was considered that discourses at the lower levels would still be permeated by this dominant meaning (albeit to varying degrees), yet contain a more experiential focus. Existing documentation allowed service level perspectives to be represented within the Q-sort. Prioritising data collection at service delivery and recipient levels enabled the perspectives that are less well documented within literature to also be well represented within the Q-sort.

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Although service provision and delivery levels both represent a professional discourse, I decided that there was an important differentiation regarding the perspectives of professionals with clinical roles. Professionals with clinical roles were considered to have direct personal experiences of working with crisis as well as an understanding of crisis as a clinical presentation through training. Therefore, professionals who worked directly with people who experience crisis were sampled.

The inclusion of the third sector organisation presented an interesting addition. A sample representing service provision was included due to the following rationale. 'Self Help UK' is a third sector organisation which offers phone-based support and intervention to people experiencing crises. The organisation also provides a 'sanctuary' which is a 24/7 access to face-to-face peer support delivered in a therapeutic environment that is designed to provide comfort and safety. This space is not residential, and support is offered by volunteers and staff with personal experience of crisis whose role is supported by extra training. This is a somewhat different service model to the typical crisis services offered in the NHS, and was, therefore, considered to add to the pursuit of scope in the Q-concourse. Although the sampling strategy was largely influenced by the research question, the recruitment of participants within these samples was also influenced by ethical considerations.

Justification for inclusion and exclusion criteria. People with experience of crisis were included in the research. As discussed in the sampling strategy, this experience may have been personal experience, professional experience or experience in a caring capacity. These three groups of stakeholders were considered useful in balancing the dominance of professional and service level discourse in the pre-existing literature. Although it was acknowledged that staff may have views that represent the professional discourses, they also have direct personal experience of crisis due to their positions as professionals and observers.

In order to be able to meaningfully engage with the study, participants were required to be able to read and communicate in English due to resource considerations. Participants were required to be over the age of 18 and have the capacity to consent. The decision to include only participants over the age of 18 was made due to the research and development of CRHTs related to working age adults (18-65) (Johnson

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et al., 2008). Due to the research being based at a CRHT it was thought unlikely that it would attract any participants out of this age range. People experiencing a current crisis were excluded as participation may have adversely impacted their wellbeing. This exclusion criterion was further justified by considering the impact that a current crisis may have on the person's ability to reflect on the experience and their capacity to consent. Taken together these considerations influenced the decision not to include people experiencing a current crisis.

Ethical considerations. The research was organised and sponsored by the University of Nottingham. The study was reviewed and given favourable opinion from the National Research Ethics Service Committee (East Midlands – Nottingham 1) on 23rd February 2015 (Appendix C). The study was also given permission by the Trusts Research and Development Department on 25th May 2015. Following construction of the Q-set, the tool was reviewed as a major amendment by the sub-committee, again receiving favourable opinion on 13th January 2016 and continuing permissions from the NHS Trust on 27th January 2016. This process was to protect the interests of the participants. The following potential ethical issues were considered.

It was acknowledged that sensitive issues would likely be discussed within the interviews and statements would relate to previous adverse experiences. The risk of causing emotional upset or distress was considered alongside academic supervisors and the service user consultant to the project. We concluded that the benefits of including service user perspectives in the research outweighed the potential risks. We considered what could be put in place to minimise this risk. The process of gaining informed consent made participants aware of this risk. Using an opt-in process was thought to reduce pressure to participate. To further reduce burden, the length of interview was deliberated; 30 minutes was considered the minimal time needed to explore the perspectives of participants. My training in clinical psychology was considered to equip me with the necessary skills to manage risk and distress should this occur during interview. Involvement of the usual care team ensured that all participants had support available to them.

Due to the nature of crisis there was the possibility of disclosure of current risk of harm, either to self or others. This would have led to the researcher having to break

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confidentiality in order to ensure the service user's safety. Asking the usual care team to identify people with previous experiences of crisis, yet not in current crisis was thought to help minimise this risk. Participants were fully informed about this exception to confidentiality during the process of gaining informed consent. For information sheets, consent forms and debrief sheets please see Appendix F.

I also considered the position of the participants employed by current crisis services. The interview required them to draw on their own views of crisis as clinicians and their understandings of the service remit. I acknowledged that there might have been some concern about the interviews being used or accessed by their managers, especially due to the interview being recorded. I tried to ease this concern by outlining the specific purpose of the interviews and exceptions to confidentiality.

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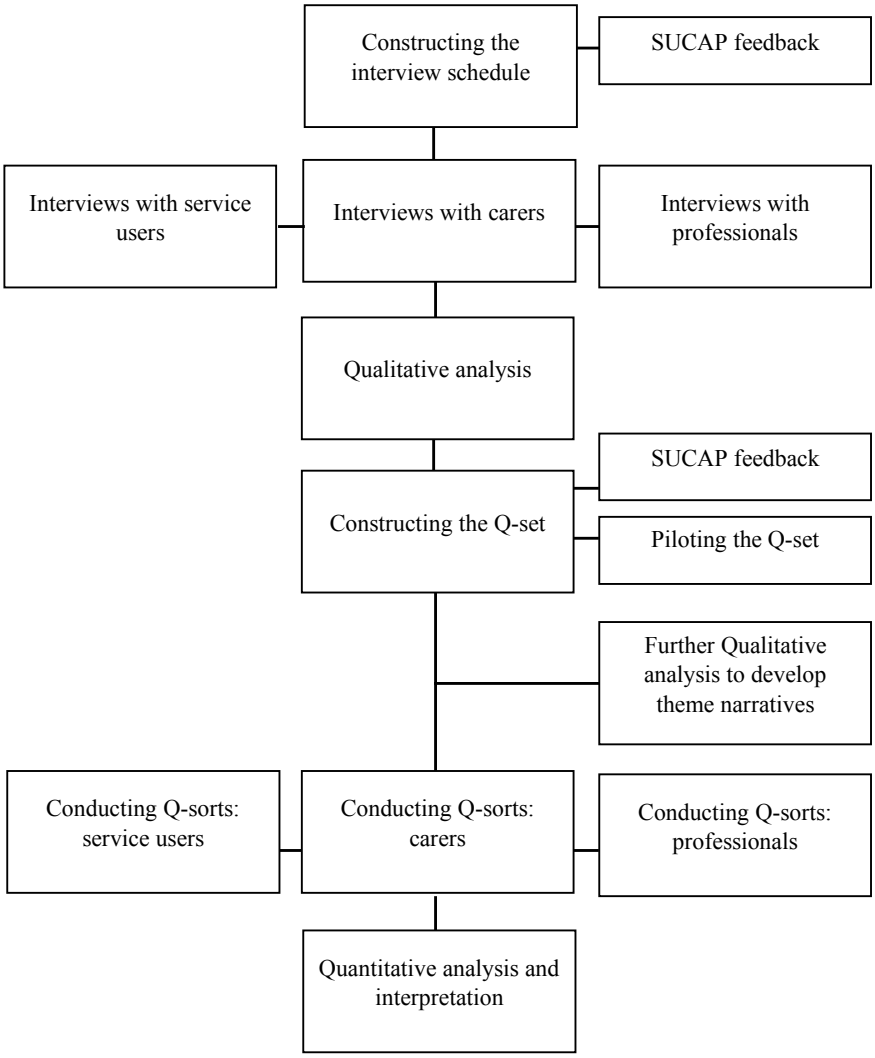
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2.4 Procedure

Overview of study procedure.

Figure 3
Diagrammatical representation of the study procedure



Note. Further detail about the Q-sort procedure is offered in Section 2.8 and 2.9.

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The interview. The interview schedule can be found in Appendix G. The interviews were semi-structured. Discussion about crisis was prompted using open-ended questions in an effort to minimise my influence on the data (for example: 'How would you explain a crisis to someone who has no experience of it?'). Nevertheless, some influence over the data was unavoidable due to questions and prompts being necessary to elicit data rich enough to represent the Q-concourse and to provide some guidance to the participants should they find the open-ended questions difficult. In all cases the interviewer reviewed the questions in the schedule prior to ending the interview to ensure the participants were all given comparable opportunities to discuss crisis. However, some questions were highlighted specifically for professionals that were not asked of other participants. These questions elicited reflections on the breadth of their experience of crisis over their caseload, drawing out differences between crises and also trying to unpick the clinical thinking behind what determines an experience of crisis or not.

Recruitment: Phase I.

Service users (n=3). Service users were approached via the crisis team. I attended the multi-disciplinary meeting during which potential participants were identified. These service users were classified as 'green' in a traffic light risk system and were being held for some monitoring before discharge from the crisis team. Holding for a short period of time appeared to reflect some level of stability in their presentation and recovery. Therefore, the discussions between the team and me related to risk of relapse, as well as known risks to participant and researcher. Seven potential participants were identified. Two were identified as possible high risk for further crises. Therefore, five service users were initially approached by a member of their usual care team after being identified as not in current crisis. Three, of the remaining five, expressed interest in participation after being given information about the study. During informed consent procedures, all participants were given the opportunity to re-read the information sheets and discuss any queries or concerns. Informed consent procedures followed those approved by the local NRES, and permission to recruit from the local NHS trust was granted by their Research and Development department (Appendix C). Informed consent was gained from all three service users. Service users were interviewed in their own homes in the presence of their crisis worker (at their request).

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Carers (n=5). I first made contact with the carers group when developing the protocol of the study for review by the REC. I attended another group meeting to discuss the information sheet and four carers expressed interest. Subsequently, one carer communicated a preference to be interviewed with their partner. Therefore, there was a total of five participants from this group. All carers had experience of supporting someone in crisis; this was either their spouse/partner or their child. Carers were interviewed in their own homes (n=4) or at the Mental Health Unit (n=1).

NHS professionals (n=4). Contacting service managers assisted my initial approach of the crisis team during the development of the study and preparation of the protocol for REC review. At this time the team was informed of the development of a research project and I spent some time observing a referral meeting. Four crisis team staff expressed interest in participating; these consisted of the team manager, and three clinically trained professionals. All NHS professionals were interviewed at the Mental Health Unit. As regards conducting the interviews, the team felt that, due to the nature of their responsibilities within the crisis team, flexible interview times would be preferable. Therefore, I arranged to spend a day with the crisis team to allow people to participate around their clinical responsibilities.

Third sector professionals (n=4). The Chief Executive of Self Help UK approached me after seeing the study advertised in the Institute of Mental Health's newsletter. The organisation expressed an interest in participating in the research and, therefore, an amendment was submitted for REC review. Subsequent to REC approval (Appendix C) interviews were conducted with staff holding managerial positions (n=2) and staff offering direct support and intervention to service users (n=2). Staff offering support and intervention inhabit both a clinical role and a peer support role due to having experienced a crisis themselves prior to gaining employment/training via Self Help UK. Therefore, these participants offered combined personal and professional perspectives of crisis.

2.5 Constructing the Q-set.

Mc-Keown and Thomas (1988) outline two approaches to constructing the Q-set, either structured or unstructured. Whereas a structured method is guided by theoretical considerations and a priori hypotheses, the unstructured method applied in this study

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selects statements presumed relevant to the topic due to their emergence in the Q-concourse. Watts and Stenner (2012) discuss the importance of effort and rigour in constructing a Q-set, and provide some loose guidance for this process. However, no one superior or fixed strategy is suggested as methods vary according to the research question being asked. Brown considers developing a Q-set 'more an art than a science' (1980, p.186) and the fundamental aim is to select a broad enough range of statements that would enable all viewpoints on the topic to emerge in the Q-sorts (Barbosa, Willoughby, Rosenberg & Mrtek, 1998).

The unstructured approach was considered preferable for this research because the statements emerge from the data, therefore remaining close to the meanings of the participants. The structured approach suggested by Mc-Keown and Thomas (1988) is based on theory and a priori hypotheses. Structuring the Q-set according to theoretical perspectives could be limiting. Therefore, the unstructured approach allowed attention to this.

The process and approach to synthesising the Q-concourse and selecting statements developed and changed as I became more acquainted with the data. Despite drawing on the loose guidance (Watts & Stenner, 2012), the volume, richness and complexity of the data was difficult to synthesise and reduce to a manageable set of statements without a structured approach. Responding to the volume and complexity of the data I looked to qualitative methodologies as a way of organising and analysing the interview data.

The application of qualitative analysis of the Q-concourse is not necessary in constructing the Q-set. However, this process enabled me to become familiar with the data, and provided structure and a way of organising the data to ensure the Q-set was representative of the larger concourse. The following section details the process of using qualitative analysis to support the process of constructing the Q-set. This includes the approach to synthesising the data, selecting statements and piloting the final Q-set.

The process of analysis: Phase I. The aim of analysis of the interview data was to arrive at a Q-set that was representative of the concourse. The approach to analysis was guided by Braun and Clarke (2006), with reference to Miles and Huberman (1994) and Watts and Stenner (2012) when considering the requirements of the analytic process

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within a Q-methodological approach. The aims of analysis of the interview data was to arrive at a Q-set that was representative of the concourse.

Thematic analysis, specifically the approach described by Braun and Clarke (2006), was chosen because it provides a systematic procedure for analysing qualitative data. Due to the mass of qualitative data to be analysed and the minimal procedural guidance given within Q-methodology literature, the clear guidelines for conducting analysis and methodological rigour in thematic analysis make this an appropriate methodology for this study (Braun & Clarke, 2006).

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As Braun and Clarke (2006) highlight, their approach to thematic analysis gives clear procedural guidance while also providing flexibility. Unlike other methods, for example conversation analysis (e.g. Have, Hutchby, Wooffitt & Silverman, 1999), interpretative phenomenological analysis (e.g. Smith & Osborn, 2003), grounded theory (e.g. Glaser, 1992) and discourse analysis (e.g. Burman & Parker, 1993; Potter & Wetherall, 1987), thematic analysis is not tied to any specific theoretical or epistemological standpoints (Braun & Clarke, 2006). This flexibility was considered beneficial for the current research, in which the epistemological and ontological position is based within a critical realist paradigm but with a greater or lesser focus on constructivist and realist perspectives within the individual phases of analysis.

Further to the benefits of flexibility, thematic analysis can be conducted in either a semantic or latent approach. With a semantic approach, themes are identified within the explicit meanings of the data. However, a latent approach takes a greater interpretative stance, going beyond semantic content and identifying underlying and implicit meaning (Braun & Clarke, 2006). A semantic approach was taken in the current research. This approach combined both the pragmatic benefits needed to organise the data and was well suited to the Q-methodological approach. The approach allowed data to be organised in a way that ensured that the various understandings of crisis were represented within the Q-sort tool. Furthermore, remaining close to the explicit meaning of the data (at the semantic level) ensured the statements reflected the meaning of the participants.

Thematic analysis can also be conducted using a deductive or inductive approach. A deductive approach is driven by the theoretical or analytical interest of the researcher

(Braun & Clarke, 2006), whereas in an inductive approach the themes identified are closely linked to the explicit meaning of the data. As previously discussed, remaining close to the meanings of the participants was important for both the research question and the Q-methodological approach. As such, an inductive approach to analysis was taken.

Step 1: becoming familiar with the data. Due to resource considerations I was unable to transcribe the interview data myself, as is usually recommended as good practice (Braun & Clarke, 2006). Interviews were transcribed verbatim by a transcription service. However, I was able to conduct all of the interviews, and therefore was involved in the interactive means of data collection. This was useful in analysis as I could recall the participant and the conversations. As is common in Q-methodology studies, consideration was given to organisational and policy documents in order to represent the service level perspective of crisis. Two important service level documents were reviewed (Department of Health, 2001; HM Government, 2014) and analysed alongside the transcribed interview data. As suggested by Braun and Clarke (2006) I began analysing the data by reading and re-reading the transcripts. Initial notes were made during this process to assist with generating initial codes.

Step 2: generating initial codes. The beginning of the coding process in thematic analysis starts with the production of initial codes. Coding was done manually by assigning loose codes to the 'meaning units' within the data that related to crisis. A meaning unit, sometimes called a recording or coding unit (Krippendorff, 2012), refers to semantic elements of data that are considered to represent similar ideas, concepts, beliefs and idiographic themes related to the main phenomena (i.e. 'crisis' in this study). This process of initial coding was applied systematically to the whole data set. Space was left between analysing one transcript and the next, in an attempt to reduce the influence of my familiarisation with one perspective of crisis on another. Text was considered line by line and the question asked of myself and my supervisors was 'what words within this sentence refer to some meaning(s) about crisis?' The codes were initially written on the transcripts.

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Step 3: searching for themes. This step re-focuses the analysis to a broader level of themes. I reviewed the data and began to group the codes into common meanings. All identified 'meaning units' were input into a database. This sorts the data extracts into all potential themes. The process of grouping and labelling was intended merely to organise and represent, and was not for interpretation. The overarching themes developing were considered in terms of how they related to each other, how they could be distinct from one another, and what they added to a broader conceptualisation of crisis. Themes and sub-themes began to emerge. The purpose of searching for themes was to organise the data in such a way that statements would represent the full breadth of viewpoints and not just those that were more dominant. A thematic map began to form, and was used to bring structure to the large number of themes.

Step 4: reviewing themes. Themes were reviewed and refined to ensure that all statements within a theme were representative of the overall meaning. No themes were disregarded from the analysis at this stage, as this would not be appropriate in this study design. All viewpoints, no matter how contradictory or 'unsupported' by other data, are within the concourse and should, therefore, be represented within the Q-set. At this point the thematic analysis was considered at a point that was appropriate for selecting statements that represent each theme.

Selecting the statements. From the qualitative analysis it was noted that the data collected represented a much wider concourse about crisis than could be effectively communicated in one Q-set. Consideration of the themes and the developing thematic map led to the decision to focus on the experiential account of crisis. This decision was influenced by needing to provide participants with statements that are effective at allowing them to communicate their perspectives. In order to include all the themes associated with crisis, the Q-set would have either been too large and therefore unmanageable, or too broad and therefore lacking the depth needed to allow participants the scope to construct their subjective accounts.

There are two characteristics of an effective Q-set; coverage and balance (Watts & Stenner, 2012). The Q-set must cover all the relevant ground in the concourse and thinking of each statement as an individual carpet tile is offered as an analogy (Watts,

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2008). My supervisors and I reviewed and extracted statements from all themes that reflected an experiential description of crisis (as highlighted in the thematic map) to ensure the representation of all viewpoints. The statements were considered further in the light of the following questions that were thought to promote coverage:

- Does the range of statements reflect the range of experiences found in the Q-concourse?
- Does the statement make an original contribution to the Q-set?
- Is the statement self-referent?

To promote balance, the set of statements (91) was considered as a 'whole'. The balance of the Q-set was considered by looking for 'unsightly gaps' or 'redundant overlaps' (Watts & Stenner, 2012). The process of constructing the Q-set was conducted by my supervisors and I. Differing opinions were discussed; however, the number of available statements to choose from helped us to reach consensus.

After considering gaps and repetition a set of 72 statements was phrased into the 2nd person in order to allow the same Q-set to be utilised by people with direct or indirect experience of the crisis. This also promoted cohesion of the Q-set (Donner, 2001). The statements were then sent for review by the SUCAP panel. The panel members were asked to provide their feedback. They were particularly asked to consider if there were any statements that they did not agree with (and why), if there was anything they considered had been missed, and if the statements were appropriate for use by service user and carer populations. The panel's feedback suggested that the Q-set was missing a sense of the temporal nature of crisis; this was considered and a further 6 statements were added. The final Q-set consisted of 78 statements that reflected the 12 themes identified in the qualitative analysis (see Table 9 and Figure 4). The full set of statements is provided in Appendix H.

The decision to focus on the experiential accounts of crisis also led to further consideration of the wider developing themes. The following process highlights how the themes were developed in order to provide narrative descriptors sufficient to communicate the wider findings.

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2.6 Further qualitative analysis

After selecting the statements for the Q-set, the themes were considered further in order to provide a more detailed description and synthesis of the data.

Step 4 continued: reviewing themes. Themes were reviewed and refined again with a view to building a narrative description. Consideration was given to emerging patterns but also to contradictory or idiosyncratic findings due to the apparently highly variable nature of crisis. Therefore, contradictions within themes were not only accepted but highlighted as part of what appeared to be the overall sense of crisis. Braun and Clarke (2006) advise considering internal homogeneity and external heterogeneity. This was considered by thinking about what the overarching meaning of the theme was, and how it was different to other themes and, therefore, what it added to our understanding of crisis.

Step 5: defining and naming themes. In this step, the original data extracts were reviewed and considered again. Sub-themes were added that allowed larger and more complex themes to be understood and communicated appropriately. This also allowed the contradictions and the unpredictability communicated by the data to be illuminated by the narrative. To test for the themes' coherence they were discussed with supervisors and further defined and modified. Themes were named according to direct quotes where possible, where this was not possible, names were given that were considered to give a true sense of what the theme was about.

2.7 Quality assurance

Reflexivity. As discussed, due to my epistemological and ontological views I considered reality to only be knowable through our experience of it and that we acquire knowledge in a process of selectively attending to and constructing our own understanding. Therefore, throughout the process of developing the project, building relationships with stakeholders of crisis and while collecting and analysing data, I was aware that I was building my own perspective of crisis. In order to monitor the development of my perspective, I kept notes of meetings attended, of the things that I had noticed and new things that I had learned.

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Efforts were made to assume an inductive approach consistent with the qualitative focus of this part of the analysis. I limited my engagement with theoretical and service level understandings of crisis prior to analysis of the interview data. However, it was necessary to consider some of the research base through applications for ethical and trust approvals. Initial coding of the data was separated in time, in order to allow each dataset to be approached in its own right. Of course, it is impossible to un-know what is known and, as such, it is impossible to code each transcript in true isolation. However, not imposing explicit coding rules was thought to minimise the influence of knowledge gained from one transcript on to another. Throughout data collection and analysis I continued to annotate my personal reflections of crisis. I also tried to consider what impact my professional role was having on the findings (see extended reflections). This was particularly evident in the more interpretive stage of analysis when building descriptive accounts of themes. This is most likely due to broad aims of the semantic analysis to represent the whole data set that was more procedural than interpretive. In the more interpretive analysis I noticed the way that I was thinking and likened it to psychological formulation and noticed myself drawing upon my knowledge of psychological theory to construct my understanding of the data. However, using a reflective diary was thought to bring this thinking more explicitly into my awareness, so that this could be monitored and discussed in supervision throughout the analytic process.

Reliability checking. In attempts to assure reliability in the coding process, a selection of data was coded by myself and my two supervisors (both with training in Clinical Psychology). My supervisors were asked to identify meaning units within the data that communicated something about crisis. As discussed above, this direction was intentionally broad; the question asked of my supervisors was 'what words within each sentence refer to some meaning(s) about crisis?' Initial coding was also checked, firstly by comparison of coded transcripts (Appendix I) and secondly during supervision. Reliability was checked in order to ensure meaning units were not being missed. Each set of coded data was compared to one another.

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2.8 Phase II: The Q-sort procedure

Preparing and piloting the Q-sort materials. The decision was made to conduct all Q-sorts by hand, rather than using any computer programme. This decision was made by reflecting on guidance and considerations highlighted by Watts and Stenner (2012), as well as considering the resources available for the current study. Completing Q-sorts by hand was considered preferable for various reasons: firstly when trialling the computer versions I found it was difficult to manipulate the Q-sort due to being forced to attend to one statement at a time, and then being presented with the next, instead of being able to continuously shift statements around while organising ideas about crisis. Doing this with a card-based Q-sort was perhaps more labour intensive for recording but allowed more ease in the active manipulation of the sort. In postal and computer-based sorting the researcher may miss the opportunity to collect post-sort information as participants may not offer these reflections after these methods; this information allows a deeper understanding of the Q-sort (Watts & Stenner, 2012). The Q-sort procedure is somewhat complex, and even detailed instruction sheets could lead to errors being made. The presence of the researcher allows quality checking of the procedure and completed sort (Watts & Stenner, 2012). All of the statements were printed onto white card and laminated; cards were all the same size, and were formatted/styled identically. Each card was numbered on the back in order for the Q-sorts to be recorded and input for statistical analysis. The fixed distribution with one space for each card was printed on large card. The statements and procedure were piloted by the researcher and another trainee clinical psychologist in order to determine ease of use and clarity of instructions.

Pre and post sort questions were defined (Appendix I). Pre-sort questions are useful for noting any demographic information that could be thought to influence the perspective given (Watts & Stenner, 2012). In this study, gender, age, and whether the participant was a professional, carer or service user was noted. Professionals were asked to explain their role. This information is useful in factor interpretation, and their role is particularly relevant to the research question when trying to understand differences in perspectives between groups.

Brown (1980, p.200) suggests that post Q-sort questions/interview 'is an important step often overlooked in Q studies'. Watts and Stenner (2012) advise that questions allow

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the participant to reflect on the meanings of the statements ranked at each pole. These statements are considered critical to their understanding of what a crisis is or is not. Participants were asked to consider why these statements were so important (or not) to crisis. Participants were also asked if any statements didn't fit at all or caused them difficulty when sorting. They were then asked if there was anything missing from the Q-set. Shifting away from the individual statements, participants were asked for reflections about the process of trying to pin down their understanding of crisis. The function of this interview is to achieve a fuller and more detailed understanding of the individual Q-sort.

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2.9 Recruitment: Phase II

Service users (n=3). The recruitment method in Phase Two was identical to that in Phase One. Service users were approached via the crisis team when they were advised that the Q-set had received ethical approval and the research and development department of the trust had endorsed the continuation of the study. Again, service users identified as low risk and ready for discharge from the crisis team were highlighted and discussed. Three service users agreed to take part in the study after being given the information sheet (Appendix F). During informed consent procedures, all participants were given the opportunity to re-read the information sheets and discuss any queries or concerns. Informed consent procedures followed those approved by the local NRES, and permission to recruit from the local NHS trust was granted by their Research and Development department (Appendix C). Informed consent was gained from all three service users. Service users were interviewed in their own homes.

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Carers (n=3). I attended another carers' meeting to discuss Phase Two of the study. I decided to access further participants this way due to being asked to feed back some preliminary findings to the group, and also due to being sensitive to their roles as carers and the possibility that circumstances may have changed, thus impacting on their willingness to be contacted for further participation. Three carers expressed interest in participating in the second phase, two of whom had participated in the first phase and one of whom had not. All carers had experience of supporting someone in crisis; this was either their spouse/partner or their child. Q-sorts were completed in their own

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homes (n=2) or at the Mental Health Unit (n=1). Again, informed consent procedures were adhered to as approved by the local NRES.

NHS professionals (n=5). On receiving ethical and trust approval for the continuation of the project, I contacted the crisis team to arrange a suitable time for recruitment/participation. All Q-sorts were completed at the Mental Health Unit. As regards conducting the Q-sorts, the team felt that, due to the nature of their responsibilities within the crisis team, flexible participation was preferable (as in Phase One). This would enable them to prioritise their clients' needs. Therefore, I arranged to spend a day with the crisis team to allow people to participate around their clinical responsibilities. Five staff members were willing and able to participate at this time. Again, informed consent procedures were adhered to as approved by the local NRES.

Third sector professionals (n=2). On receiving ethical and trust approval for the continuation of the project, I contacted The Chief Executive of Self Help UK to arrange a suitable time for recruitment/participation. All Q-sorts were completed at the Self Help UK offices, and two professionals were willing and able to complete the Q-sort procedure. These professionals had clinical, but not personal, experience of crisis. Again, informed consent procedures were adhered to as approved by the local NRES.

Conducting the Q-sorts. The procedure was influenced by consideration of the guidance offered by Watts and Stenner (2012). The same procedure was followed for all participants.

1. Informed consent procedures followed
2. Pre-sort questions were asked – demographics.
3. The distribution was laid out on the table and the researcher had the Q-sort record sheet to hand to note any qualitative observations
4. The participants were shown the statements, and were told that each of the statements was something that someone had said about crisis. Therefore some of the statements might seem to be very similar to their own understanding of a crisis, but others may seem less so. They were told that the process was about determining what they thought a crisis was like, therefore it was their perspective that was important.

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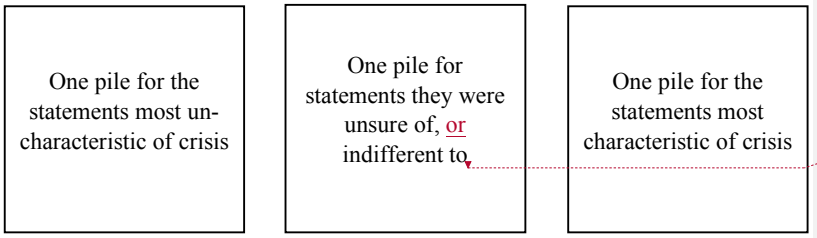
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5. Participants were asked first to put the statements into three piles as shown below. There were no limitations about how many cards could be placed in each pile.



6. Participants were shown the distribution and rankings were explained. The distribution had the words 'most characteristic of crisis' and 'most uncharacteristic of crisis' at the poles for reference. The participants were told that each space under each ranking category would count for the same ranking. Therefore, whether a statement was at the top or bottom of the same ranking made no difference to its value to them. Participants were also told that minus rankings did not necessarily mean disagreement with the statement, merely less agreement in comparison to the more highly ranked statements.
7. Participants were asked to begin with the most characteristic pile and lay all the statements out so they could be seen. They were asked to begin placing the statements on the distribution so that they reflected the two most significant statements for them, and so on, as they moved down the distribution.
8. They were told that the researcher was there to help if necessary, to clarify the procedure or to discuss the meaning of statements. However, participants were largely left to their own devices to complete the process. When participants required clarification of meaning, I asked them to consider what the statement meant for them rather than trying to impose my own understanding.
9. Once participants had finished arranging the 'most characteristic piles' the researcher noted where the pile of statements ended (on the response sheet) to assist with interpretation if necessary.

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10. Participants were then asked to continue the process with the other two piles, either continuing in the same direction with their neutral pile or starting at the other side with their 'least characteristic pile'.
11. Once the participant had finished sorting they were asked to review their sort and make any changes until they felt happy with it.
12. The participants were asked the post-sort questions (Appendix J) and the completed Q-sort configuration was recorded (Appendix K).

2.10 Analysis: Phase II

During analysis in Q-methodology, the process is looking to identify portions of shared meaning (factors) within the understandings of crisis captured in the Q-sort process. The analytic method is a data reduction technique in which the output is reduced to the shared meaning or common variance within understandings, and these meanings are extracted for further interpretation.

Watts and Stenner (2012) discuss how the first choice within analysis is between an inductive or deductive strategy. In explaining the difference between these approaches in relation to Q-analysis they liken the process to cutting a cake. An inductive approach uses statistical methods to highlight a preference within the data of how many factors are present. In the cake analogy they liken this to the nature of a cake as having six chocolate buttons which indicates that six slices would make sense for that particular cake. In a deductive approach, the researcher may be influenced by literature or hypotheses that may make them inclined to test out imposed factor structures on the data. Returning to the cake analogy, Watts and Stenner (2012) discuss how if seven children came to the party you would be more inclined to cut the cake into seven pieces.

This research took an inductive approach. Watts and Stenner (2012) refer to this as letting the data take the lead. This was considered as meeting the exploratory aims of this research.

PQ Method offers researchers two means of achieving this process: through centroid analysis or principal component analysis. In this study a centroid analysis was conducted.

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Principal component analysis (PCA) is a similar method to centroid analysis, and the methods often produce very similar results (Watts & Stenner, 2012). However, the underlying statistical process and the analytical process are quite different. PCA produces what could be considered a mathematically superior solution that should be accepted. In Q-methodology this is often not considered the best method of analysis (Watts & Stenner, 2012; Brown, 1980). The 'best' fit in mathematical terms is not always considered the 'best' fit with regard to meaning and making sense of the data. As such, Q-methodology proposes that the opportunity for infinite solutions is key to the meaning-making process. Centroid analysis has less statistical finesse than PCA (Watts & Stenner). However, it is favoured in Q-methodology due to it providing researchers with the option to manually rotate factors in an exploratory and investigatory fashion, or in a manner that is theoretically driven. This option is preferable, as it gives a graphical representation of the factor solutions which allow researchers to visually track rotations. This is often considered the most meaningful approach to arriving at factor solutions, despite not being the most statistically superior.

In an inductive approach the data leads the researcher by indicating how many factors are present. Returning to the cake analogy, the number of slices (factors) are indicated by the number of chocolate buttons. PQ Method offers the option to check how many factors would be extracted based on the associated residual correlations. This means that it extracts factors until there are very low correlations within the 'left over' data. In other words, it tells us the number of chocolate buttons our cake has. Of course, in Q-methodology this is considered a guide and does not limit the process of manual rotations and exploration of multiple potential factor solutions.

The program suggested a two factor solution should be extracted. The two factor solution and a three factor solution were explored to allow comparison.

Exploring factor solutions. At the end of the factor extraction process the output is a table of numerical values called the 'unrotated factor matrix'. Therefore, there was one factor matrix for the two factor solution and one factor matrix for the three factor solution. The next step in the analytic process was to determine which of these factor solutions provided the most informative option. To do this there are several possible methods, as discussed in Watts and Stenner (2012). Commonly this includes

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examining the common variance explained by each factor and the degree to which the factors represent the understandings of each participant.

Eigenvalues and variance. Within the output is reference to eigenvalues and variance. These values tell us about the communality, or amount of shared understanding, within the factors. They offer an indication about the potential explanatory power of the factor. Low eigenvalues (<1.00) are often used as a cut off point for the extraction and retention of factors. This is called the Kaiser-Guttman criterion. This argues that any factor with an eigenvalue >1.00 should be retained. In the two factor solution both factors met this criterion. This method is commonly used and widely accepted by factor analysts. However, Q-methodology rarely proposes one method of considering the data and, therefore, individual factor loadings were also considered.

With regard to variance, factor solutions that explain a combined variance of 35-40% or above are considered a sound solution (Kline, 2014). Together the two factor solution accounted for 50% of the variance. The residual data had low correlations (0.007), suggesting that there were no associations in the data that were unaccounted for by the centroid analysis. The three factor solution failed to account for any further shared understandings within the data. Therefore, a two factor solution was considered the most informative.

'Significantly loading' Q-sorts. The values within the columns of a factor matrix (see Table 6 for an example) are often referred to as 'factor loadings'. Factor loadings can be thought of as correlations between the participant's understanding and each factor. As they can be considered correlations, they can be positive or negative. Each factor loading denotes the degree to which each participant's understanding of crisis (each Q-sort) was represented by the factor. Watts and Stenner (2012) discuss that looking at how many of the factor loadings are 'significant' can contribute to decision making because reviewing the individual values can tell us more about how helpful the factor solution is in answering the specific research question.

To determine the value that is significant (at the p<0.01 level) the following equation is applied (see Watts and Stenner, 2012). The standard equation for determining significant factor loading value for any study:

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2.58 x (1/√number of statements in the study)

When applied to this study (2.58 x (1/√78) = **0.29**212) the value that is significant at the p<0.01 level is 0.29. This value enabled the researcher to consider which Q-sorts loaded significantly (value of 0.29, in either direction) on to the extracted factors in an eyeball analysis.

This allowed significant factor loadings to be highlighted within the factor matrix (see Table 6). Another criterion for determining retention of factors is the presence of two or more significant factor loadings (Watts & Stenner, 2012). This criterion was achieved by both the two and three factor solutions. However, within the three factor solution all participants loaded significantly onto factor one, whereas only very few participants also loaded onto the other factors. Further to the third factor adding no further explanatory power, it also had the effect of not being as informative about the differences between people's understandings.

Factor rotation. Rotating the chosen factor rotation allows the factor loadings to be mapped out in a graphical format so that the relative positions of people's perspectives can be viewed spatially. The closer two viewpoints are in the space between the factors indicates the communality of two people's perspectives, similarly the distance between two viewpoints represents difference.

There are two ways of rotating the factor solutions, either by hand or 'varimax'. Rotating the factor solution by hand allows the researcher to manipulate the map by hand and visually track the changes in positions. By hand methods are usually advocated when there is a clear theoretically or conceptually-driven reason to manipulate the factor solution. In inductive analyses which are data driven, as in this research, varimax solutions are usually preferred (Watts & Stenner, 2012). The varimax solution aims to ensure that each factor is defined from another (Watts and Stenner, 2012). This means that each Q-sort will have a high factor loading in only one factor loading. Of course this may not be the case for all Q-sorts, but the aim is to distinguish the two viewpoints and to maximise the amount of variance that is explained by the factor solution. A combination of the two methods can be used and is recommended with regard to exploring and observing the data. Therefore, in this research both methods of rotations were used.

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Explorations using hand rotations of the data failed to improve on the un-rotated factor solution, thereby not increasing the amount of variance explained or producing any notable clarity between viewpoints. When considered graphically, the varimax rotation had rotated the factor solution by approximately 45 degrees clockwise; all participants were then contained in one quadrant and, therefore, all loadings in the varimax solution were positive. The varimax solution was thought to increase distinction between Factor one and Factor two, while still explaining 50 percent of the overall variance. Therefore this solution was selected as it was considered to offer the most informative accounts of the two distinct ways of understanding crisis that were found within the data. Table 6 shows Q-sorts that loaded significantly onto Factor one, Factor two and those that were confounding (loading both on Factor One and Two) in both the un-rotated and the varimax rotation factor solutions.

Following the eyeball analysis, Q-sorts one, four, five and ten were highlighted in the Q-analysis as participants whose understandings of crisis was most representative of Factor One. Q-sorts six and thirteen were highlighted in the Q-analysis as participants whose understandings were most representative of Factor Two. Interestingly, Q-sort eleven was the only participant not to load on either factor. This will be considered further in the results section.

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Table 6

Comparison of significant factor loadings between unrotated and varimax solutions

Participant number	Factor One (Un-rotated)	Factor One (Varimax)	Factor Two (Un-rotated)	Factor Two (Varimax)
1	0.64	0.65	0.24	0.19
2	0.80	0.67	0.05	0.45
3	0.75	0.51	-0.14	0.56
4	0.65	0.78	0.44	0.40
5	0.82	0.85	0.33	0.23
6	0.63	0.18	-0.54	0.81
7	0.63	0.53	0.05	0.34
8	0.76	0.71	0.17	0.32
9	0.56	0.41	-0.06	0.38
10	0.64	0.62	0.18	0.24
11	0.32	0.25	-0.02	0.21
12	0.58	0.32	-0.24	0.54
13	0.46	0.08	-0.47	0.66
Overall percentage of explained variance	42%	**31%**	8%	**19%**

Note. Shading indicates significant loadings

2.11 Phase II: The process of interpretation

As discussed, a two factor solution was chosen due to its representing two distinct ways of understanding crisis. Together Factor one and Factor two represented 50% of the variance. Within Q-methodology there is no fixed approach to factor interpretation (Watts & Stenner, 2012; Brown, 1980). The approach is determined by the question that is being asked and the meaning and knowledge wanting to be gained from the analytic

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process. The two factor solution suggested that there are two distinct ways that people understand crisis. The configurations of the two distinct understandings are communicated by each factor array. To interpret these factor configurations the factor arrays are explored as a whole, with each item in the array being considered as a clue that leads us to an understanding of the viewpoint. In Q-methodology, it is the whole viewpoint that is pursued and not the highest and lowest rankings in a configuration. Watts and Stenner (2012) argue that interpretation based on the highest and lowest ranking statements is 'a strategy open to attack on both methodological and ethical grounds' (p.149). They argue that to include and emphasise the significant statements within a configuration makes sense; however, it is the inter-relationship of all the statements within each factor that should drive interpretation. As such, both positive and negatively ranked statements contribute to the building of factor narratives. This can be understood further with reference to the scale used during the Q-sort procedure. Positive statements can be considered as 'most characteristic' of the factor, whereas negatively ranked statements can be considered 'most-uncharacteristic', although it might be tempting to assume that statements ranked around the zero may assume a neutral position or lack significance or meaning which are possibilities. However, Watts & Stenner (2012) propose they can sometimes be pivotal to understanding the viewpoint and therefore holistic interpretation is vital.

However, interpretation of large factor arrays is a huge task and in attempts to do justice to the pursuit of the whole, a 'crib sheet' strategy recommended by Watts and Stenner (2012) was used. They regard this methodical approach as 'thorough and rigorous' (p.150), proposing that the end point of this method of interpreting factor arrays is to 'appreciate the viewpoint of [the factors] fully and completely' (p150). The process is as follows:

1. Generate a 'crib sheet' for each factor to be interpreted. Please see Appendix D for the crib sheets for Factor one and Factor two. This process promotes a holistic interpretation by forcing the researcher to engage with every item in the factor array.

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2. Start by considering the highest and lowest ranked statements. Consider each statement and ask the questions 'Why is it ranked here?' 'What does it mean?' and 'What is it trying to tell me?' and generate hypotheses.
3. Consider why each item might have importance in the context of crisis.
4. Oscillate attention. Move focus in on each item, and then out to the configuration as a whole, trying to make sense of each statement's place in the story of the configuration as a whole.
5. Continue to observe all the other potential statements within the configuration, considering which are important to the story as a whole and what they add to the story.
6. Applying demographic information to the interpretation: 'What about the nature of the participant's? – adds understanding to the perspectives given.

The following steps were taken in addition to the guidance from Watts and Stenner (2012), due to the particular questions being asked in the current study.

7. Considering the statements that were most different or most comparable between Factor One and Factor Two, in order to understand how they were distinguishable from one another.
8. Reflecting on idiosyncratic findings, and generating hypotheses.
9. Considering the shared variance between different 'groups' of participants and generating hypotheses.

Exploring similarities and differences in understandings. In order to examine the similarities and differences between individuals' understandings of crisis, all correlations between pairs of participants were squared. This is referred to as the coefficient of determination (R squared). This value is the percentage proportion of overlapping variance between two variables. In Q-methodology variables are participants, therefore the value represents the shared understandings between two participants.

This highlights which participants had greater similarities in viewpoints, and which had greater differences. Table 7 presents the percentage of shared understanding for all pairs of participants. No statistical 'cut off' was used to determine whether or not the amount of shared/unshared variance was statistically significant; instead these values were

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considered qualitatively. A higher shared variance was determined to indicate a higher shared understanding of crisis, and vice versa.

Table 7
The percentage of shared understanding between participants

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13
Role	CRHT	CRHT	CRHT	CRHT	TS-CS	S.USER	CARER	CARER	CARER	S.USER	S.USER	CRHT	TS-CS
	Percentage of shared variance (%)												
1 CRHT	100	30	29	27	30	6	12	34	10	23	3	12	2
2 CRHT		100	38	24	44	18	21	41	14	31	11	24	11
3 CRHT			100	13	31	24	17	25	11	24	14	21	19
4 CRHT				100	44	4	32	30	16	20	2	6.7	2
5 TS-CS					100	13	32	38	20	43	2	20	7
6 S.U						100	11	9	17	19	4	24	33
7 CARER							100	26	15	10	11.5	7	8
8 CARER								100	17	24	13	16	7
9 CARER									100	9	0.3	19	13
10 S.U										100	1	10	3
11 S.U											100	5	2
12 CRHT												100	6.7
13 TS-CS													100

Note
CRHT (participant worked in NHS crisis team)
TSCS (participant worked in a third sector crisis service)
S.U (participant was a service user)
CARER (participant was a carer)

From the percentage of shared understandings for each pairing, the average shared variances within and between groups was computed. This was calculated by summing the percentage of shared variance within each pair in a group and dividing this number by the number of pairs in the group (the mean), as shown again in Table 8 for clarity.

Table 8
Average shared variances within and between groups

Shared variances within groups		Shared variances between groups	
Service users	8% (SD=9.45)	Service users/professionals	19% (SD=13.7)
Carers	19% (SD=5.85)	Service users/carers	13% (SD=9.45)
Professionals	21% (SD=12.85)	Carers/professionals	20% (SD=12.12)

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3 Extended results

Although some main findings are communicated in the journal article, the limitations of preparing a manuscript for publication restricted the scope for discussing some of the wider findings of this thesis. The decision to focus the Q-set on statements related to the crisis experience was made after consideration of the significant amount of data gathered in phase one and the feasibility of offering a Q-set that was both manageable in size and that offered the necessary scope of meaning in order for participants to be able to construct their perspectives. However, this meant that not all themes that emerged from the qualitative data would be included in the Q-set. Further qualitative analysis led to the development of narratives that could sufficiently communicate these wider findings. Furthermore, there were some further quantitative findings that were outside the scope of the journal article that will be discussed in the following section. I will discuss the idiosyncratic and unexpected findings in more detail, such as the responses from Participant 11 which did not load onto either factor, and were not convergent with any other respondent's account.

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3.1 Results: Phase I

Four overarching themes were developed, as well corresponding sub-themes, as demonstrated in Table 9 and in the thematic map (Figure 4). The thematic map organises the themes along a linear trajectory from the factors that contribute to the development of the crisis, through to resolution. It is acknowledged that, although the linearity offers clarity, crisis trajectories are often more capricious, as described in the theme 'crisis as temporal'.

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Table 9

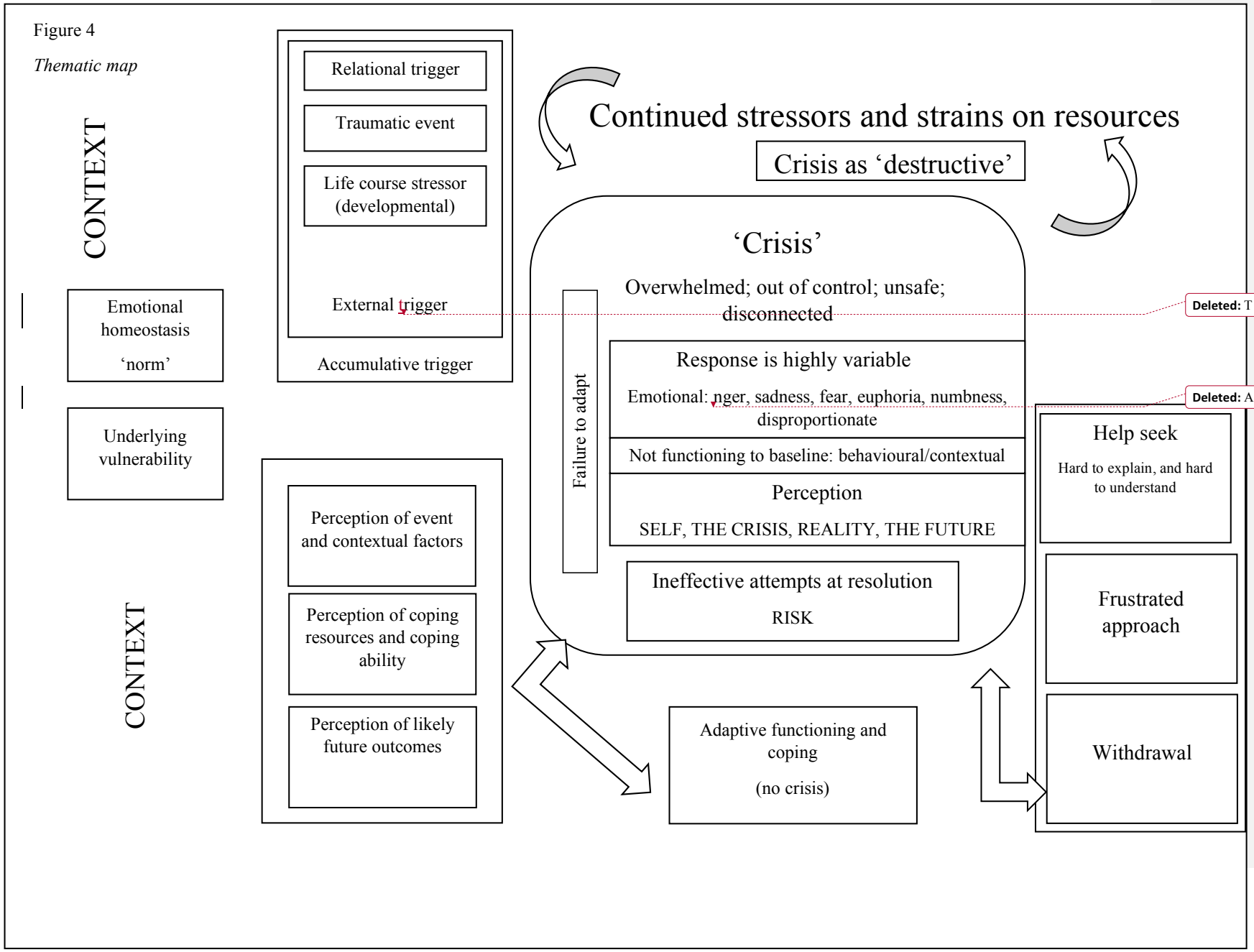
The generated themes and sub-themes.

	Themes			
	The nature of crisis	Causes of crisis	The crisis experience	Coping/attempts at resolution
Subthemes	'it's the difference, from them normally to them poorly'	'underlying vulnerability'	Emotional experience	Continued ineffective attempts at resolution
	'hard to explain, and hard to understand'	Internal trigger	Cognitive experience	Withdrawal
	'it's different for everyone'	'people cause crisis'	Perceptual changes	Help seeking
	'crisis as temporal'	'the impact of the world we live in'	Impact on functioning	The frustrated approach
	Understandings of crisis	'the straw that broke the camel's back'	Confusion	
			Risk	
			The need for help	
			Carer burden	

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Figure 4

Thematic map



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The nature of crisis. This theme relates to the overarching nature of crisis. Within this overarching theme were themes of 'difference, from them poorly to them normally', crisis as 'hard to explain and hard to understand', crisis as 'different for everyone', crisis as temporal and the way that people construct understandings of crisis.

'It's the difference, from them poorly to them normally'. When defining the situation as a crisis people referred to knowledge of the individual's baseline or 'normal' self or functioning, and participant descriptions of crisis were often formed as comparisons to this. Participants highlighted that '*to see the crisis they need the full picture of him'*, which suggests that this difference is a central way of identifying crisis. When describing crisis they reflected on the difference '*from them poorly to them normally'* and the sense of the person being unrecognisable: '*I didn't recognise him'*. Some participants spoke about behaviour, such as: '*some things he would never do, he started doing'*; emotional state: '*he was aggressive, that's just not him'* or a decline in their presentation or self-care: '*he was unshaven, rough, but he usually takes care of himself'*.

The importance seemed less placed on the behaviour or the presentation, but on the difference to the person's 'normal'. Being in crisis, therefore, reflected being in a state that would not be expected of a person. Interestingly the same comparative technique was applied to more commonly held 'expected' or 'proportionate' responses. There was a sense that people were assessing what they would expect to be a 'normal' response to the circumstances. There was a sense that '*normal distress can be misconstrued as a crisis',* which suggests that crises are understood in part as 'abnormal' responses. Crisis was understood as when '*emotional distress is above what we would expect as normal*' and is, therefore, disproportionate.

'Hard to explain and hard to understand'. Participants communicated the difficulty of describing or defining crisis. This theme appeared to relate to other themes of confusion and the high variability in crisis. However, I felt there was something important to highlight about the nature of crisis as inexplicable and confusing. This difficulty was sometimes due to the fact that '*so many factors contribute'* and feeling like '*there is no answer'*. Not only was it '*a hard thing to explain'* but it can also be difficult to understand. Professionals discussed the confusion when '*sometimes people*

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don't seem to have any stresses', and that the complex nature and variability of people's experiences of crisis makes it more difficult to develop understandings. Some participants felt that the very nature of crisis is that '*it doesn't make sense'* and advised that people '*don't try and understand it'*, because understanding is less important than being able to validate someone's experiences, to '*acknowledge that whatever it is for that person, it is valid and real'*.

'Different for everyone'. Another thing that makes a common understanding of crisis so difficult to reach is the high variability of crisis experiences. There was a sense that crisis can be '*different for everyone'*. Some participants talked about '*different types of crisis'*. Some participants attributed this variability to diagnosis, where as some discussed the '*strategies of the person'* or how '*different people have different tolerance levels'*. When discussing an individual's experience of multiple crises the sense seemed to be that '*each crisis can be different'*, although not always. Some people report commonalities between some crises but complete differences with others. As such there was some discussion of crisis as '*unpredictable*', and that people found it difficult to prepare for or anticipate '*we didn't anticipate how it would get out of control or how we couldn't handle it'*. Therefore crisis can be different for different people, the same person can have multiple crises that can be very different, and when a person is in crisis the actual experience of it can seem highly variable and unpredictable.

Crisis as temporal. Key to the nature of crisis is the sense of the experience as relative to time. Participants described crises by referring to several characteristics of crisis trajectories, from onset to progression, and referring to both duration and recovery.

Participants described the nature of onset as either rapid or gradual. One participant discussed how their crisis '*spiralled in a weekend, from relatively stable to absolutely mad within a weekend'* and another reflected that things '*take a turn for the worse so quickly'*. This rapid deterioration was described as '*flipping so quickly it's scary'*, thus suggesting the potential of the onset of crisis to be dramatic and rapid, which possibly increases fear/anxiety. Reflecting the previous theme of being highly variable, there was also the possibility of a gradual onset. Participants discussed being aware of the onset '*I could see the build-up*', and described a repeated experience of crisis as coming '*back in*

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little drips'. These different onset trajectories have different implications for intervention, as will be considered in the discussion.

Descriptions of the duration and how the crisis progressed through time also varied. As regards duration, one participant commented, '*how long is a piece of string'*, and the general sense of duration of crisis is that '*it can last hours, or days, or months and months'* but '*you begin to appreciate that it has a timescale*'. Participants highlighted that '*crises pass in time'* which is an important consideration in terms of intervention. As regards progression through time, some participants saw a crisis as '*continuous, no ups and downs until he's recovering'* while others described it as '*a continuum that never really stays still'*. Some described feeling that '*it gets worse before it gets better'*, but there was a general agreement that '*some days it's less than others, some days it's worse than others'* and '*things fluctuate'*. Attending to the nature of the crisis trajectory appears important in assessment/intervention as when the trajectory had a sense of continuous deterioration '*he just got worse and worse'* '*got lower and lower'* this sparked consideration and concerns about risk. Additionally, some people referred to the sense of sometimes being stuck '*it's like a record, you know, stuck on repeat'* and it can feel like *'it's just going and going and going and going'*. Attending to this nature of crisis trajectory could also inform further assessment and intervention.

Within this category, some terminology emerged that was potentially central to an experience being defined as a crisis. Participants discussed a part of the crisis trajectory as the *'crisis point'*. This appears to be associated with awareness and help seeking, for example '*the crisis point is when they present to services'* and '*crisis point is when they recognise it as a crisis'*. However, it also seems to represent severity in presentation, or a severe incident that leads emergency services to become involved '*services see a crisis when something explodes'*. Again, the '*explosion*' or crisis point can be the result of an accumulation of difficulties, '*a catalogue of errors leading to an explosion*'. Some professionals appeared to hold more fixed understandings of the crisis point '*the crisis point lasts for 72 hours'*; however, other people expressed more flexible understandings of the crisis point: '*it's the peak, when it's at its worst'* that may only be known in retrospect of the crisis as a whole. However, some people described how '*there wasn't*

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an explosion' highlighting that, although there may be a commonly held expectation of a severe incident or '*explosion*', this may not be a key distinguishing feature.

The commonality of fluctuations continued when discussing recovery: '*there is a pick up, then a time of fluctuation, then stability'*. However, the initial stages of recovery were described as '*fragile'*. This could be because '*bad days have more power'*. The comparison between the better and worse days may cause more discomfort and fear of relapse. Some referred to these fluctuations as recovery '*blips*', distinguishing them as a common feature of recovery and not as a feature of further deterioration: '*sometimes he has a blip, after a crisis, when he gets confused, but it's not a crisis'*. Of course, due to the nature of recovery from crisis it appears there may be some difficulty in distinguishing a fluctuation in the progression of crisis from a fluctuation that signifies the fragility of recovery. This is an important consideration for passage through crisis intervention and when assessing suitability for discharge. Once more, it is clear that the nature of crisis as highly variable also permeates this theme of crisis having complex, iterative and variable trajectories.

Understandings of crisis. This was a standalone and overarching theme that permeates through the explanations of crisis. The theme reflects the influence of current bio-psycho-social debates about the origins or cause of mental illness and mental health/wellbeing on how people go about constructing their understandings of crises.

Whereas some understandings referred to genetic vulnerability, heredity or crisis as related to mental illness with an '*organic'* origin, others contradicted these pathology-based explanations. Pathology-based explanations were unsurprisingly saturated with medicalised terminology such as '*entrenched mental health issues'* and diagnostic labels such as *'schizophrenia'*, '*bi polar'*, '*personality disorder'*, '*OCD*', '*a psychotic episode'*, '*extreme high levels of anxiety'*, and '*paranoid delusions'*. These explanations were also illness-based, with some referring to crisis as '*it's just because they're ill'* or '*it's a medical problem'*.

Contrary understandings were that of crisis as '*a normal reaction'* and '*a sane reaction to insane circumstances'*. These understandings reflect more social and psychological understandings of the crisis experience. For example, one participant discussed how '*when people are bereft they do experience suicidal type thoughts'*, and how '*we're not*

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perfectly designed to cope with everything'. One participant felt that '*it's not about me or my personality'*. Some found these normalising understandings helpful: '*they reassured me that I wasn't going mad, it's normal'*, while others clearly saw the benefit of medical understandings and intervention '*I don't see things when the meds are helping me'*. Within non-medical understandings of crisis there seemed to be a tendency to defend themselves against pathology; '*there is nothing wrong with me as a person'* or to defend others *'it doesn't mean that there is anything wrong with the person'*.

Causes of crisis. Participants discussed their perspectives on the common causes of crisis. This overarching theme reflected five sub-categories which are explored below.

'Underlying vulnerability'. A common theme throughout the transcripts was the presence of an underlying vulnerability that makes a person more at risk of experiencing a crisis. Examples of underlying vulnerabilities were a *'history of trauma'* or '*a history of mental health difficulties'*. These predisposing factors appeared to be linked to a general sense that some people's experiences and (perhaps) genetic characteristics can lead to an '*emotional fragility'* or '*a lower resilience to life stressors'*. Although there was some mention of innate vulnerability (genetic/heredity) there was also a sense of this category as developmental and as a result of life experiences. This part of the category reflects less individual pathology and more of a common human vulnerability. Some participants referred to crisis as '*a dormant possibility for anyone'* with a sense that '*it can strike any of us at any time'* in the presence of stressful circumstances.

Internal triggers. This category related to the understandings of genetic vulnerability, heredity or crisis as related to mental illness with an organic origin. Some participants described this as '*a chemical imbalance*'. Some participants wondered about the heredity of mental health difficulties '*schizophrenia is in our family'* regarding some organic predisposition to crisis. When participants discussed the presence of enduring mental illness medication concordance appeared to be a factor, suggesting understandings of biological effects of medication 'treating' the problem. One professional reflected on non-concordance with medication in enduring conditions '*they start believing they don't need their medication'* which can then lead to fluctuations in wellbeing and the increase of symptomology.

'People cause crisis'. People referred to the cause of crisis as '*very often to do with relationships'*. For some people the lack of social contact and meaningful relationships can contribute to the development of crises, with one participant explaining '*most people I would diagnose as being lonely'*. Further to loneliness was the sense of social isolation lessening access to support. On the other hand, some people identified that coping with social contact can contribute to the development of crises '*I can't cope with people because they just irritate me'*, which can lead to further difficult social situations such as loss of employment and loss of social networks. The extreme distress caused by the breakdown of relationships and the loss of family units were cited as causal factors: '*the relationship ended and it hit him hard'*. Not only was loss cited during the end of relationships, but also '*the loss, the bereavement'* when loved ones pass away. Maltreatment and victimisation in relationships were cited as causal factors of crisis and people discussed experiencing '*abuse in relationships'*, '*betrayal*', and bullying at work.

Not only were relational difficulties cited as causes of crisis, they were also discussed as factors that can ease or exacerbate distress, and that the experience of crisis can impact on the quality and stability of relationships. Therefore, the association between crisis and relationships is complex, and will be considered throughout other themes.

'The impact of the world we live in' Participants discussed the significance of contextual triggers on the development of a crisis. This category related to the stress generated by the '*social and economic pressures'* of western society cultures. One professional labelled this as '*exogenic depression, coming from outside social factors'*.

There was a general sense that change produces stress, and people talked about '*life changes'* as potential triggers for crisis. Even changes that were welcomed, such as promotion, can cause crisis. Some people reminisced about previous successes: *'I bought this house, I functioned really highly*' but how high pressured roles can lead to unexpected influence on their wellbeing: '*I literally just got too much responsibility, I got stressed'*. Not being able to attain our own or other people's expectations can therefore generate crisis due to thoughts of failure and the impact of how they are perceived by themselves or others. People discussed the strain of coping with these expectations: *'he tries too much, puts too much pressure on himself'*. Of course, not

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being able to meet expectations can also lead to losses. '*Financial difficulties'* and *'deprivation'* caused by economic changes and unemployment/redundancy were cited as major stressors. People talked about how this not only leads to financial strain but to *'losing their role in life, their independence'*. Extreme losses such as *'being made homeless, having children took into care'* were discussed and span both contextual and relational themes.

Apart from the '*dog eat dog'* culture, there was also a contradictory cultural shift discussed. One professional reflected on working with *'generations that have never worked, we are not designed to do nothing, we have to do things, to interact with people and I think not doing that really impacts on mental health'*. This participant referred to the lack of employment or meaningful activity that impacts negatively on wellbeing, yet can be supported by common beliefs and attitudes held by their families and peers who have similar experiences.

'The straw that broke the camel's back'. People often listed the build-up of events that caused crisis, for example *'loads of things led to it, my past, bullying, losing my kids, deaths, just loads of things'*; another participant listed *'stress, family illness, losing their jobs, benefit problems, relationship trouble, financial difficulties'*. The '*build-up of tensions'* was described as leading to a point at which one thing *'pushes them over the edge'* or '*trips people over into that crisis'*. Some participants referred to being '*pushed over the edge'*, a point at which there was an unbalancing between stressors and the ability to cope. Some people reflected on their ability to cope with stressors: *'I'd coped with anxiety for twenty odd years, I'd struggled with loads of things'*; however, there came a point at which their stress exceeded these resources. This suggests that it is *'not about someone's ability or resilience',* but about a succession of stressors and a tipping point between coping and not coping.

Some people described the accumulation as sudden; however, others had contradictory viewpoints and described coping with stress over a long period of time. People said '*it took its toll on me',* and '*I struggled with it for two years and then I couldn't take it anymore'* reflecting that dealing with stress over a long time depreciates a person's resources and resilience to further stressors. However, others discussed how they

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struggled to cope because *'it all came at once'*, suggesting an accumulation of difficulties in a short period of time can also contribute to the development of a crisis.

The experience of crisis. The overarching sense of the crisis experience was that it is '*a nightmare, but real, very real'*. Another participant suggested that to understand what a crisis is like you should *'take your worst nightmare and times it by a million and you're still not even close'*. Others referred to it as '*having a meltdown'*, *'a complete breakdown'*, '*falling to bits'* and a sense of a total loss of control. Crisis seemed to come with a sense of being totally overwhelmed; participants described it as '*so intense it takes over everything about you'*, their lives being consumed by it '*for quite a while we just lived his crisis'* and it having immense '*power, it is, it's very powerful*'. The impact of the crisis is restrictive, rendering people powerless: '*it's like you're left with it and there is just nothing you can do*'. One participant described the powerlessness as '*excruciating*'. Further to this overarching sense of the crisis experience, the following sub-categories were defined in order to try and make sense of the experience further.

Emotional experience. The range of emotions described were fear, despair, sadness, worthlessness, euphoria, rage, anxiety, depression, panic, and worry. As discussed, for some people being alone or suffering losses in personal relationships can contribute to the development of crisis. As regards the emotional experience of this, people described the '*feeling of loneliness'*. Rather than describing one emotional response, participants often referred to many emotions occurring at once '*the powerlessness, the rage, the anger, it was a dark place, it's a very very very very dark place'*. One participant described the rapid fluctuations between emotional states, saying, *'one minute I'm depressed, one minute I'm anxious'*. Participants described this as being *'emotionally out of control'* or '*emotionally dysregulated'*. The dysregulation of emotion perhaps exacerbated fears further; one participant said *'I feel like I'm going crazy, I'm in a constant panic about everything*' and the sense of being '*very afraid of where those emotions may take them'*. The emotional experience was described as so devastating that '*it's pain, it's not just distress',* which leads to a sense of there being no resolution: '*you can't sit with your emotions, but you don't know what to do with them*'. Alongside this was the experience of a complete lack of emotional reactivity:

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'*completely shutting down emotionally' and feeling 'dead already, so to die is just a formality'*. Another characteristic of the emotional experience was incongruence. Some participants discussed how '*he says he is alright, but he is miserable all the time'*. Another participant reflected on an observation of a member of the emergency services *'I was in such a horrendous rage, but [he] said I was calm'*.

Cognitive experience. Further to the emotional experience, that seemed core to the crisis experience, was the presence of distressing cognitive experiences. Central to this theme, as with the emotional experience, is the sense of thoughts as '*sending my mind out of control*'. One participant described this experience as '*chaos takes over ordered thoughts and thinking*', and how '*his thoughts had overtaken him*'. Some described that although they had no control of their thinking, their thinking had control over them describing how '*my subconscious starts taking me back to the dark place*'. This was described as impacting on the ability to perceive anything outside the crisis, as people described being '*soaked up in what's going on in your own mind*'.

Changes in thinking were observed by others; some described incoherent speech reflecting the sense of not being able to '*get their thoughts together*'. People could also observe when thoughts were losing a sense of reality with some people describing their loved one '*thinking people are disrespectful towards him…sometimes thinking people talk down to him, when we hear a lot about that it's a sign [of crisis]*'. This illustrates that changes in thinking can highlight the presence or beginning of a crisis, with this example in particular emphasising some obsessive qualities to thoughts.

Perception. Alongside the cognitive changes experienced during crisis it also seemed to impact perception. When analysed, this theme appeared to comprise three categories; perception of reality, the crisis and the future.

Perception of reality. The presence of changes in thinking also relates to some of the more unusual experiences and beliefs that can be experienced during crisis. Participants described varying unusual experiences. Some discussed '*an increase in religious rhetoric*' or '*quite grandiose delusions…about being used specially by God*'. Other participants described paranoid beliefs: '*I had so many conspiracies, fears and beliefs…that people were out to get me*', or seeing things that they later recognise as not being true '*a smokey grey man, you can't see his face, wherever the smokey grey man*

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was it was bad' or unusual auditory experiences *'he started hearing voices'*. These perceptual experiences can lead to changes in behaviour: '*he started shouting out in the night, as though he was talking to someone*'. Although participants were able to retrospectively reflect on their unusual experiences as not real, carers reflected that being there for someone during this time was very challenging and frightening. When loved ones '*couldn't see reality'* they discussed how '*whatever you said, he wasn't understanding*' and '*trying to reason with him was useless*'.

Somewhat different from these experiences was the sense of being disconnected from reality: one participant said '*it's like you're screaming, screaming so loud and everyone is just walking by…it feels like everyone is rushing around and you're moving at a snail's pace, a bit like they do on films*'. This disconnect appeared to impact the perception of time: '*a full day could flicker by in front of me, it's like that kind of speed*', and, therefore, would possibly be connected with reduced functioning.

Additionally, one participant discussed how '*it seems to block out any ability to see anything that isn't the negative thing*' therefore, even if good things happen in their lives they can struggle to see them. This did not seem to reflect ideas of pessimism, rather how crisis is obstructive and damaging to the ability to perceive things as they are due to how emotionally devastating it can be. One participant referred to this in the following terms: '*it robs you of every ability to see anything other than what is causing the pain*'. This impact on perception has implications for assessment, intervention and recovery.

Perception of crisis. There were some differences in people's awareness of their crisis. This lack of awareness of being 'in' crisis is somewhat different to lacking insight as was discussed by some participants. Other participants discussed having insight into their crisis, that '*sometimes people can understand it*'. One participant reflected '*I knew I had a problem*' whereas others discussed how '*you're not aware of what's going on*', and a complete lack of awareness of being 'in crisis'. One participant reflected that this awareness of crisis is variable between crises, saying '*sometimes he knows he is in crisis*'. This awareness is sometimes prospective with one participant stating 'you know when it's coming (crisis)', whereas others discussed only

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retrospective awareness '*I can look back and see the signs, but not at the time*' and '*I couldn't see it coming*'.

Perception of the future. Participants discussed a '*bleak*' outlook for the future and described themselves as '*very hopeless*' and '*ambivalent or despondent about the future*'. They discussed how they '*can't see a future*' and '*there is no sense of there being a future*'. With this perception of their future comes a challenge for engagement in intervention and recovery-based thinking. If participants see '*no visible way to get to a place that doesn't feel so overwhelming and painful*' it highlights areas for intervention and support. This theme also relates to risk during crisis, which will be discussed in more detail in a later theme.

'It takes away your ability to function'. Many participants discussed how crisis '*takes away your ability to function*' in many areas such as sleep and appetite leading to losing weight, poor concentration and lack of energy and motivation. Participants discussed how they lost the ability to work '*can't work, losing their job*'. One participant listed the impact on their functioning as '*crying at work, panic attacks, wouldn't eat anything, couldn't sleep, shaking, nervous and jumpy, that kind of thing*' and another referring to a '*lack of facial animation*'. Other physiological experiences which could impact the ability to function at their baseline included symptoms of experiencing trauma '*I had bad flashes*' *[flashbacks]*. It is clear that these characteristics could exacerbate the crisis further by impacting on employment, health and relationships. However, not all participants described loss of functioning in all areas. One participant described a loss of functioning in their role at work, leading to unemployment; however, they were able to function in order to take care of physical needs. As such, they described eating, washing and exercising, and commented '*I functioned normally physically*'; the impact on emotional experience was the most debilitating for this participant. The concern related to this theme is when '*functioning is reduced to a level that is not safe*' and '*their life is becoming seriously impacted upon*'. One participant discussed how '*they can't even concentrate to take part in the assessment*' indicating how the impact on functioning can complicate processes of assessment and intervention.

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Confusion. One commonality of the crisis experience was a sense of confusion and the unknown. One participant described the dilemma of trying to help their loved one as '*needing to support them, but not knowing what to do*'. Navigating a crisis can be difficult as '*there is no logical way forward*' and contact with services can be particularly confusing for carers; one participant discussed '*phoning up all the time trying to see what's going on, but they wouldn't talk to me*' and the sense of desperation of wanting to know that their loved one is safe. This was elaborated on by another participant who said '*lack of communication from services made it much worse for the family*'.

Crisis was described as '*very confusing, not knowing what it's about*', and there is a sense that '*they don't know where to go'*, '*what to do*', and there is '*nobody to show you how to manage the situation*'. This sense of not knowing what to do was described as '*one of the most frightening things about it*'. The lack of guidance or clear way forward could lead to carers feeling de-skilled or as if they have failed to protect/help their loved ones; one participant said, '*we tried to do what was best but it just ended up in the worst situation anyway*'.

Risk. The sense of people being at risk, either a *'danger to themselve*s' or others, was a common theme although this was not consistent across all experiences of crisis. '*Risky*' thoughts were discussed on a spectrum of different '*levels of risk*'; some referred to people who were communicating *'not really wanting to kill themselves, but wanting the distress to stop*' and others who had determined '*a plan of ending their life*' or attempt suicide. Self-harm appeared to be along this spectrum with some expressing the concern that '*it's a blurry line between self-harm and attempted suicide*'. People talked about '*doing something that's not safe*' and '*absconding*'. One participant discussed how '*they might be vulnerable to exploitation*'; therefore there was a sense that although they might not actively try to harm themselves they might behave in ways that lead to '*situations where they're at risk, of harm from themselves or others*'. Some people also discussed thoughts about wanting to harm other people while they were in crisis. At times, the presence of risk highlighted the need for immediate intervention '*he did something, to himself, they realise he needed to be in hospital*'. However, some participants were keen to highlight that '*it's not about risk*', reflecting that not everyone

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is a risk of harm '*he's not a danger to others*', and some people do not experience thoughts of wanting to harm.

The need for help. Unsurprisingly the common sense idea of the '*inability to manage on your own*' highlighted another theme: that people in crisis need help. One participant said '*it will pass but sometimes people are desperate, they need a safety net*'. Needing '*something that makes them feel safer*' was a common theme in the interviews. One participant identified how '*they need a cross between a life coach and a counsellor, marriage guidance and a social worker*'. Not only did participants talk about the individual at the centre (for want of a better description) of the crisis, but also people reflected that '*it may not be them that's calling for help, it may be their neighbour or relative*'. This reflects that although people need help, recognising that or accessing help can be difficult during a crisis. It also reflects that carers and people within their networks also need help and support. There was a further consideration of when people need help: one participant discussed '*people tend to need support in the early hours of the morning*'. Rather than discussing complex interventions, there was a sense that '*it's just about being, about people being there with you through it*' and that '*sometimes just speaking to somebody can help*'. As with the variability of the emotional experience of crisis, the need for help was thought to fluctuate. One participant discussed that available support might contribute to this fluctuation: '*their cope-ability in the early hours of the morning when there's nobody can hit a peak'*.

Carer burden. One theme that particularly adds to our understanding of crisis is that carers also feel the burden of crisis. Perhaps somewhat unsurprisingly the intensity of crisis appears to take its toll on carers, contributing to feelings of burnout. Carers talked specifically about their concerns about risk and fearing for the safety of their loved ones. They discussed feeling responsible for monitoring risk and their loved ones well-being, for example checking on them late at night: '*go over late at night, just to check his lights were on*'. What seemed to contribute to this was limited communication between services and carers, resulting in them feeling '*desperate to know that he was okay*'. This stress contributes to what was described as '*the crisis is always there for carers, watching for the slightest thing*', '*you've got to be so careful, not to over react or under react*'.

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The sense that a crisis increases the risk of harm leads to a very stressful experience for carers: '*you want to know they're safe*'. Some carers discussed fearing for their loved ones or being fearful of them. Carers tried to make sense of acts of violence that they perceived as out of character; they said: '*we didn't understand why else he would be violent, other than being afraid*'. For some, violence can lead to criminal conviction and '*ending up in the forensic system*'. In itself this situation increases the complexity, of crisis, due to managing clinical and forensic needs and the impact that a criminal history can have as regards recovery and re-establishing life post-crisis. In these difficult situations carers discussed feeling responsible for risk management and any outcome. With little to no support or training about how to monitor and how to respond to these difficulties carers described not knowing what to do for the best.

Coping responses during crisis and attempts at resolution

Coping resources, and the ability to access and make use of coping resources, was commonly reflected on during the interviews. There were three sub-categories of responses to the crisis experience; help seeking, withdrawal, and a frustrated approach. There was the sense that resolution could be positive, with developed resilience and new ways of managing. One participant commented, '*maybe tolerance levels go up with each crisis*' and another said '*sometimes it can make you more resilient*'. However, on the contrary, there was also the sense that the impact on the person after crisis can be negative with the crisis experience as damaging. People discussed how the '*the knowledge of what happened makes you more sensitive*', and that '*the preoccupation with getting ill can sometimes induce a crisis*'.

Continued ineffective attempts at resolution. When people couldn't develop new ways of managing or increasing resilience, participants referred to continual reliance and use on maladaptive coping responses. Some people noted '*drinking more than they should be, taking drugs*' or being '*not concordant with their medication*', and how these maladaptive coping responses '*made it all so much worse*'. This reflected a circular pattern of trying to cope but, in effect, exacerbated the crisis situation. Some people discussed maladaptive responses not as attempts to cope but as avoidance strategies: '*you can resort to extreme behaviours to try and nullify or distract from it*'.

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Withdrawal. Some responses to the crisis experience were described as withdrawal, such as '*I revert into myself and shy away from the world*'. Carers described how their loved ones '*ignored the support*' from services and that '*the barriers would go up*'. Although some participants talked about people being '*resistant*' to treatment, others described how the impact of crisis rendered them unable to engage. This suggests withdrawal and disengagement may not be a willing and conscious process. Some people related this to the emotional experience of crisis making them '*vacant*' and how they had '*no sense of what was going on outside of myself*'. This withdrawal relates both to service support and sometimes to families too: '*he shuts out his family, doesn't want us near him*' which can be particularly distressing for carers and presents a difficult task for services regards engagement. Some people talked about withdrawal resulting from barriers to accessing services. One participant felt that her son could not help seek due to fear, commenting '*he was afraid of what might happen to him if people knew how he was feeling*'.

Help seeking. Other people feel compelled to seek help and commented, '*you need contact*' and '*we couldn't not react*'. This response seems to come from an expectation that contact with services or other people is helpful: '*knowing there is support takes a huge pressure off*'. Help seeking from attendance at A&E, going to their doctor or seeing their family more were sighted as the usual modes of help seeking.

Frustrated approach. The frustrated approach is characterised by wanting contact/support but there being nobody there to provide it. This category has a sense of rejection and invalidation of their experience: '*no-one listens to you, nobody cares*' and the sense that some people do not have anyone to support them: '*they haven't got anyone to talk to*'. There was also some indication that trying to access help from services was difficult and unhelpful: '*I was at the GP surgery every two minutes, in the end I had a massive panic attack in the surgery and they said I needed help*'.

3.2 Results: Phase Two

Considering differentiating statements. The interpretation of the factor arrays yielded two narrative descriptions which were identified within the journal paper. However, during this process the statements that differentiated Factor one and Factor two were considered, as shown in Table 10. This output was considered subsequent to

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factor interpretation as a method of checking the interpretation and constructed factor narratives. The statements appear to correspond with overarching themes of altered awareness and perception (Factor one) and emotional devastation, anxiety and debilitation (Factor two).

As can be seen from the differentiating statements, Factor one was more associated with reduced functioning and the sense of feeling unsafe but also acting in ways that could increase risk of harm. Factor one was also differentiated from Factor two by the statement that refers to ending life. This suggests that suicide risk may be understood as more related to perceptual and thinking changes, rather than the emotional experience of crisis. The findings could suggest that the emotional experience of crisis is understood as being more isolating than the perceptual and thinking changes. Statements regarding shutting yourself away and feeling like nobody understands you could influence this sense of isolation.

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Table 10

Statements that most differentiated the two factors

Statements that differentiated Factor One from Factor Two (presented as most>less differentiating)	Statements that differentiated Factor Two from Factor One (presented as most>less differentiating)
46 You are not aware of what is going on	38 Intense emotional pain
48 You can't take care of yourself, it's unsafe	74 Extreme anxiety, panic
44 You can't see reality	17 You stop talking to people, shut yourself away
25 You have no insight	7 You feel that nobody understands you
23 Thinking strange things, things that aren't real	62 You couldn't imagine things getting any worse
19 You stop taking your medication	64 You are totally overwhelmed by your emotions
59 You do outrageous things	77 It's like treading on eggshells
78 You feel so unsafe	47 You function, get up, work, eat and breathe, but you just go through the motions
42 It does something to me that is inexplicable	39 It's when distress goes beyond what is normal
40 Incomprehensible rage	57 You experience a level of distress that would not be expected
36 It's like you're screaming so loud and everyone seems to be just walking by	16 Unbearable restlessness
8 Dying seems like a way to stop the pain	10 You just can't cope anymore
51 You know that things are happening outside of yourself but you can't react	33 You feel totally shut off from everyone

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Unexpected and idiosyncratic findings in the factor narratives. The holistic approach taken in interpretation regarded each item in the array as a clue that leads to an understanding of the viewpoint (Watts & Stenner, 2012). During the process, there were some surprising findings that appeared idiosyncratic or contrary to the understanding of the developing factor narrative. Instead of disregarding them, these were highlighted for further consideration.

There were two emotion-related statements that were more strongly associated with Factor one; 'you can't see reality' than Factor two: 'emotional devastation, anxiety and debilitation'. These were 'incomprehensible rage' and 'absolute despair'. It seems that rage is less associated with the emotional experience of crisis, yet more commonly understood as being related to disturbances in perception. Further to rage, 'absolute despair' was also more highly associated with Factor one: 'emotional devastation, anxiety and debilitation'; therefore, this was another emotion-related statement that was more strongly associated with the impact of crisis on perception.

Furthermore, another statement that most differentiated Factor two from Factor one was; 'you feel totally shut off from everyone'. Therefore, those whose understanding of crisis was more synonymous with Factor two understood being shut off or disconnected from others as more like a crisis than those whose understandings were more synonymous with Factor one. From this we could hypothesise that the emotional devastation of crisis could make it very difficult for people to connect with people around them. Feeling shut off could relate to a felt isolation rather than a physical isolation, or a change in perception that elicits an experience of being separate or removed from reality. Indeed, the phrase 'shut off from everyone' implies a social or relational experience. These findings are discussed further in the discussion section.

Participant 11. An interesting finding in this study was that service users had the least shared variance with anyone else, including other service users. Their understandings of crisis were more diverse. In particular, Participant 11 did not load onto either of the factors that emerged. Furthermore, they had much lower shared variance with the rest of the participants. This led to further interpretation of the raw data and consideration of demographic information. Similarly to the interpretation of the factor arrays, the crib sheet method of holistic interpretation was used as

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Statements in the Factor two array ... [42]
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Deleted: As Watts and Stenner (2012) discuss, every statement is in its place for a reason. The findings that were regarded as idiosyncratic are presented in Table 11.
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recommended by Watts and Stenner (2012). This process was applied again to the raw data from Participant 11 in order to aid qualitative considerations of the responses. See Figure 5 for the crib sheet that reflects the understanding of crisis constructed by Participant 11.

Interpretation of the crib sheet suggests that feeling dead and wanting to be dead were the statements most characteristic of crisis. They appear to associate being overpowered and the inability to cope as very characteristic of crisis, and feeling disengaged from the world and like nobody understands. Ineffectuality appears to feature, with the participant also rating feelings of worthlessness and feeling trapped with the crisis relatively highly. Least characteristic were statements relating to the experience being normal. It is possible that this participants understanding of crisis is more synonymous with understandings of crisis as associated with high risk. Although risk was not highlighted as a factor in its own right, the understanding of crisis offered by Participant 11 suggests that for some people risk might be a central and defining characteristic of crisis.

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Figure 5

Crib sheet of raw data (Participant 11)

Statements ranked at +6
60 It's like you're dead already
8 Dying seems like a way to stop the pain

Statements ranked at +5
36 It's like you're screaming so loud and everyone seems to be just walking by
71 An overwhelming feeling of not being able to cope
76 It completely overpowers you
62 You couldn't imagine things getting any worse

Statements ranked at +4
38 Intense emotional pain
7 You feel that nobody understands you
55 You feel totally disengaged from the world
22 It is so powerful
53 It's your worst nightmare times by a million

Statements ranked at +3
29 It's totally unpredictable
41 You feel totally worthless

67 Absolute despair
28 You're trapped with it
63 You feel numb
17 You stop talking to people, shut yourself away

Statements ranked at +2
5 It takes over your life
43 You can't see it coming
27 It blocks everything else out
59 You do outrageous things
74 Extreme anxiety, panic
73 Your life gets smashed
10 You just can't cope anymore
56 A total meltdown, falling to bits

Statements ranked at +1
21 It becomes bigger than you
39 It's when distress goes beyond what is normal
70 Your thoughts overtake you
16 Unbearable restlessness
48 You can't take care of yourself, it's unsafe
32 You can't see a future
57 You experience a level of distress that would not be expected
14 You just don't want to be here anymore
66 Chaos takes over ordered thinking

Statements ranked 0
50 You just can't function anymore
72 You feel like you're going crazy
65 It's frightening, very very frightening
37 Pure fear
46 You're not aware of what is going on
20 It's a medical problem
33 You feel totally shut off from everyone
30 You lose all hope
44 You can't see reality
68 The sense of totally losing control

Statements ranked at -1
49 You can't eat, can't sleep, can't work, can't do anything you used to
35 It's hard to explain, and hard to understand
64 You are totally overwhelmed by your emotions
52 You know when it's coming
12 It's very confusing, not knowing what to do, where to go
75 You're not 'you' during that time
42 It does something to me that is inexplicable
45 You usually know you're in crisis

6 It's restricting, something you can’t seem to move through

Statements ranked at -2
15 It's a bit like a wound
4 There is something wrong with you
40 Incomprehensible rage
25 You have no insight
19 You stop taking your medication
51 You know that things are happening outside of yourself, but you can’t react
2 It's very confusing, you just don’t know what to do
77 It's like treading on eggshells

Statements ranked at -3
54 You just need to be with people
23 Thinking strange things, things that aren’t real
26 You can understand your crisis
3 A very normal reaction
13 You want to do something to feel better, maybe drinking or drugs
9 You're not being normal; normally you would never be like that

Statements ranked at -4
31 Desperation to feel safe
18 A normal reaction to the circumstances
11 If you've been there before, you have a sense that things will get better
47 You function, get up, work, eat and breathe, but you just go through the motions
1 There is hope that things will get better

Statements ranked at -5
69 You don’t know why you are doing what you are doing
61 It's not about me or my personality
58 The barriers just go up
78 You feel so unsafe

Statements ranked at -6
34 It's a normal life experience
24 With the right amount of stress we would all feel that way

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4. Extended discussion

What are the understandings of crisis held by the people who experience it?

This research aims to develop our understanding of how people who experience crisis understand it, and secondly, to explore areas of consensus and potential difference between the understandings held by service users, carers and professionals.

Qualitative analysis generated four themes (and sub-themes) that represented understandings about the nature of crisis, the causes of crisis, the experience of crisis and recovery. Despite the ambiguity of the concept of crisis, the application of Q-methodology highlighted a common structure in the understandings of the crisis experience.

These understandings were organised around two main characteristics of the experience: the impact on perception ('you can't see reality') and the emotional experience ('emotional devastation, anxiety and debilitation').

The impact on perception 'you can't see reality'. This factor accounted for the majority of shared understandings of crisis. The factor related to the changes in perception and thinking that occur during a crisis that can make people feel out of control and very unsafe.

The impact on perception of reality has previously been linked to crisis (Caplan, 1964; Aguilera, 1998; Golan, 1998). Caplan (1964) described how, because crisis poses a threat to peoples fundamental needs, they feel intense distress from the realisation that there is no resolution. In the face of this, 'perceptual distortion' can be protective and adaptive; for example people could develop new ways of thinking about the problem or new ways of trying to solve it. Aguilera (1998) further described 'intrapsychic defensive mechanisms' that result from appraisals of the situation as too overwhelming, leading to a freeze response in the face of threat. These intrapsychic defensive mechanisms either repress or distort the reality of the situation. In this study, one participant disclosed feeling that he had been chosen by god and was special, which was protective in some sense as he was not connecting with the reality of the situation. Of course, defences

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Deleted: Within each of these themes there were subthemes, the crisis experience theme had eight subthemes alone. However,

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often serve a protective-avoidant function, in which the problem remains unresolved or worsens.

Also within this factor, people described feeling like they were going crazy, that they couldn't understand what was happening to them. This links back to one of the themes from the qualitative findings of the study 'confusion'. As regards clinical practice, these findings suggest that the perceptual and cognitive experiences of crisis might make it very difficult for people to take part in assessments, especially if they are being asked multiple questions or they are being given an abundance of new information. This finding is supported by service users' perspectives on what is helpful about crisis intervention. Service users identified that too much information was overwhelming (Clark et al., 2008, Goldsack et al., 2005). Mental health terminology and convoluted language can be confusing (Clark et al., 2008; Hopkins & Niemiec, 2007), and being given '*bits and pieces*' of information in general conversation (Goldsack et al., 2005) was accessible when someone is experiencing crisis. The altered perceptions of their abilities to resolve the crisis and their perception of the future also have implications for intervention and recovery. Caplan (1964) suggests that recovery is enabled both by meeting the unsatisfied need that is the cause of tension but also by locating the individual in a position of power and control over their recovery. This shifts the perception of self from being ineffective to being effective.

The emotional experience 'emotional devastation, anxiety and debilitation'.

This factor relates to the emotional experience of crisis as extreme anxiety, despair and debilitation. This finding supports the understandings offered by Crisis Theory literature (Lindemann, 1944; Caplan, 1964; Hoff, 2001). Caplan (1964) described crisis as a disruption to the emotional equilibrium that cannot be resolved and thus causes emotional tension, described as extreme anxiety, and 'hopelessness and ineffectuality' (Caplan, 1964, p.40). Hoff (2001) later defined crisis, this emotional experience, as 'acute' upset, and Lindemann (1944) first referred to 'emotional crises'. The findings of this study also suggest that the emotional experience of crisis is associated with a sense of being trapped and hopeless, unable to effect change. This is similar to the 'ineffectuality' described by Caplan (1964). The findings relating to the emotional experience of crisis support previous understandings of crisis (for example Caplan,

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Moved up [4]: It is understandable that working with people in intense emotional pain, in situations that can be highly variable and unpredictable, which may or may not lead to harm or death elicits an anxiety response.
Moved up [6]: it is possible policy, service organisation become deterministic and structured in order to provide some containment. This enables a 'task focused' approach to assessment that gives the sense of knowledge and direction enabling professionals to act.
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Moved up [3]: Although these findings differ from some (Tobitt & Kamboj, 2011; Department of Health, 2001), it is synonymous with other crisis literature suggesting it is important to distinguish crisis from emergency to ensure good clinical outcomes (Callahan, 1994; Callahan,1998; Brennaman, 2012).
Deleted: Risk. Although risk was not identified as a factor in its own right, holistic interpretation highlighted that it was a core feature within both factors. Furthermore, the interpretation of the Q-sort offered by Participant 11 demonstrates that risk may be central to the understandings of crisis for some people. As such, tthe findings suggest that although risk is related to crisis, the degree to which i ... [44]
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1964; Bridget & Polak, 2003; Hoff, 2001; Callahan, 2009). This is considered to be a response to the threat of fundamental needs not being met (Caplan, 1964). The qualitative findings suggest that, further to the understandings of emotional upset (Caplan, 1964; Hoff, 2001) or the categorisation of types of crisis based on emotion (Ball et al., 2005), the emotional experience of crisis is associated with experiencing multiple emotions at one time or rapid fluctuations in mood. People described making sense of these experiences as them 'going crazy' and being 'out of control' which potentially increased the sense of anxiety further.

Unexpected and idiosyncratic findings within the two factor model. There were some unexpected findings within the factor arrays. Two emotion-related statements; 'incomprehensible rage' and 'absolute despair', were more strongly associated with Factor one. Incomprehensible rage was a statement that best differentiated between the understandings. Therefore, rage was less associated with the emotional experience of crisis, and more commonly understood as being related to the disturbances in perception.

Considering this finding further, perhaps it makes sense that experiencing paranoid thoughts, believing that people are out to get you or wronging you in some way is more likely to be associated with rage than emotional devastation and debilitation. Caplan (1964) described how, because crisis poses a threat to people's fundamental needs, they feel intense distress from the realisation that there is no resolution; this continued experience can lead to 'complete disorganisation' of functioning and attempts at resolution. Perhaps it is understandable that being in a distressing situation from which there is no escape could lead to feelings of rage.

Further to rage, 'absolute despair' was also more highly associated with Factor one; again it is perhaps understandable that the perception of having no future and there being no resolution would lead to association with feelings of despair, as suggested in Crisis Theory (Caplan, 1964). It is understood that the event, perception and meaning-making, emotional distress and coping attempts are all interrelated (Caplan, 1964; Aguilera, 1998) and therefore that each part of the experience impacts on one another. Therefore, perhaps, although these findings first appear to not 'fit', they are reflective of the complex relationships between the different aspects of the crisis experience. This

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Deleted: There is debate within the understandings of distress in crisis about whether or not this is understood as an illness response. As discussed in the journal article, there is debate about this within professional's understandings of crisis (Tobitt & Kamboj, 2011). For some professionals to identify a crisis there must be a mental illness, whereas other professionals more widely consider emotional distress, irrespective of a diagnosis. This reflects an important debate that is central to crisis intervention in which some understand distress or mental illness as a potential consequence of crisis (Caplan, 1964), whereas others explicitly link crisis to severe and enduring mental illness (Ball et al. 2005) and potential organic origins (Tobitt & Kamboj, 2010). This debate has become somewhat more significant by definitions in CRHT policy and literature that propose the presence of mental illness as a pre-requisite for CRHT involvement (Department of Health, 2001). ... [45]

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Deleted: The theme of 'help seeking' suggested that people are motivated to find support and comfort from others in time of need. This is supported the understanding that during crisis people will use their social resources as a way to achieve resolution (Caplan, 1964; Bridett & Polak, 2003b). This reflects some attachment based understandings of achieving basic needs. Attachment theory suggests that we are all intrinsically motivated to seek out support from others, as we learn from birth that it is within these relationships that our fundamental needs get met (Bowlby, 1969). Caplan (1964) also discussed that recovery occurs within the context of the persons key relationships. This finding also reflects service user perspectives of helpful crisis intervention, that highlighted 'people being there' and the proximity and accessibility of support as enabling a sense of safety (Davies & Rennoldson, 2013). ... [46]

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finding suggests that understanding the crisis experience is complex, idiosyncratic and at times unexpected. Again, suggesting a case formulation approach may be more useful than deterministic definitions.

Risk. Although risk was not identified as a factor in its own right, holistic interpretation highlighted that it was a core feature within both factors. Furthermore, the interpretation of the Q-sort offered by Participant 11 demonstrates that risk may be central to the understandings of crisis for some people. As such, the findings suggest that, although risk is related to crisis, the degree to which it is central to the way people understand their experience varies. The way that risk statements featured within the two factor model presented further insight into the relationship between risk and crisis.

Risk appeared more strongly associated with perceptual changes than emotional distress. This may suggest that people understand increased risk as a result of impaired judgement, having no hope for the future, and seeing no way of resolving the crisis. Understanding risk as associated with perceptual changes, rather than a central characteristic of crisis in its own right, is not synonymous with other professional understandings of crisis in empirical literature (Tobitt & Kamboj, 2011) and definitions in CRHT policy (Department of Health, 2001) that suggest risk as a defining characteristic of crisis. The factor solution, therefore, presents an interesting perspective on existing understandings of crisis that influence clinical practice and service structure. Although risk was a core feature of both factors, it was also highlighted that people may not define their experience in this way. This highlights that, although it is important to attend to concerns about risk, it is equally important to attend to how individuals understand risk in relation to their experience of crisis. Although these findings differ from some (Tobitt & Kamboj, 2011; Department of Health, 2001), it is synonymous with other crisis literature suggesting it is important to distinguish crisis from emergency to ensure good clinical outcomes (Callahan, 1994; Callahan,1998; Brennaman, 2012). Callahan (1994) identified the need to distinguish psychiatric emergencies from crisis in order to guide action, as treating psychiatric emergency with crisis intervention could be harmful and likewise crisis does not warrant emergency care. Therefore, attending to how people make sense of risk in relation to their

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experiences of crisis could have benefits for determining appropriate interventions and achieving good clinical outcomes.

Defining risk as central to crisis within service structures may serve to manage professional anxieties. Menzies' (1960) landmark case study of a nursing team offers some interesting considerations about how professionals defend against anxiety. She describes how systems form 'social defences' against task anxiety when working with intense distress and the reality of mortality. Social defences are thought to occur when individuals align their defences with one another and with the structure and culture of an organisation (Jaques, 1953).

Within this theoretical perspective, is possible to understand the organisation of crisis services as serving to reduce anxieties elicited by managing people in the community who would previously have been admitted to hospital. Government concerns about risk and dangerousness have previously been highlighted as the main driving force behind policy (Peck & Parker, 1998). For example, the structure and deterministic nature of policy and service organisation could serve to provide containment, thereby enabling a 'task focused' approach in which professionals can act rather than becoming immobilised by the unpredictability of crisis. The prescriptive nature of referral criteria which encompass risk and the presence of a mental illness possibly serves a similar function, and could also serve to distance the professional from the possibility that they too could experience crisis.

Systemic approaches offer a further theoretical perspective from which to consider these findings. A structural approach, as developed by Salvador Minuchin and associates in the 1960s, proposes that distress can be caused, maintained and alleviated by the structures that develop within the system (Vetere, 2001). This theoretical perspective could offer further explanation about why structures, such as working definitions and referral criteria, develop in such a way. Within this approach, the organisation of the system acts as a metaphor for describing transactional patterns and relational contexts. Structures, such as rules and hierarchies, are created to set the context for needs to be met. In a system with high levels of unpredictability and anxiety, predictable and fixed structures would serve to contain anxiety and provide methods of 'protecting' members from threat. For example, fixed methods of assessment and recording of clinical notes

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could be understood as ways to protect individuals and teams from the fear of culpability. Furthermore, National Health Service 'banding' systems and distribution of responsibility could also be considered to create a necessary hierarchy that increases safety within the system. Hierarchies within systems allow for the distribution of power and roles to members. However, the theory proposes that structures can be both functional and dysfunctional, depending on the system and the needs of its members. What serves one 'subsystem' (group identified by roles/qualities), such as professionals, may be problematic for other subsystems. Fixed rules and processes enforced by a commanding hierarchy may serve to organise service provision in the context of austerity, and may serve to contain professional anxiety in the context of unpredictability and potential risk of mortality. Therefore, the centrality of risk may have mediated the clinical, professional and economical needs that resulted from the deinstitutionalisation era. On the other hand, it may have the unintended consequence of limiting clinical flexibility and judgement, and limiting the possible ways of understanding crisis experiences that are responsive to the individual service user/carer.

If, as these research findings suggest, service level definitions of crisis (and referral criteria) were less deterministic and prescriptive, this may challenge social defences leading to increased professional anxieties. Good clinical support structures, such as clinical supervision and reflective practice opportunities could enable new ways of managing to develop. In doing so, this could allow professionals to process the challenges of working within this context, thereby supporting staff wellbeing and learning/development, and reducing burnout (Edward & Hercelinskyj, 2007). Empirical findings suggest that reflective practice can have benefits of greater autonomy in decision making, more confidence in clinical judgments and a less rule-bound approach to practice (Platzer, Blake & Ashford, 2000), as well as the opportunity to improve clinical practice (Paget, 2001). This context could reduce the need for the social defence, and allow the openness for case-by-case sense making.

What are the areas of consensus and potential difference between the understandings held by service users, carers and professionals?

One of the main conclusions of the Q-methodological findings was that there was not much difference between the ways that groups of service users, carers or professionals understand crisis. For example, this suggests that a carer and professional could be just

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as likely to have different understandings of crisis as one professional with another. The important finding was that, irrespective of what 'group' someone belongs to, there is a lot of variability within the way different people understand crisis. Another important finding was that there was a lot more variance in service user understandings of crisis, than there was within carer understandings or professional understandings.

The findings also suggested that professionals' and carers' understandings of crisis were more likely to reflect both of the characteristics of crisis identified, whereas service users were more idiosyncratic and were more likely to reflect one or the other.

Therefore, there is more variability within the understandings held by service users, and their understanding may be more explicitly linked to one area of experience. It is possible that throughout their recovery, service users become aware of the parts of the crisis experience that are psychologically significant for them, maybe the 'symptoms' that were most salient or distressing or the aspects of crisis that impacted on areas of their life that they felt were the most important. The findings may suggest that professionals and carers are able to have greater distance in their perspective, therefore being able to attend to multiple aspects of the crisis. Professionals also have the advantage of drawing on multiple experiences of crisis, which may influence wider perspectives.

A further finding that supports the variability within people's understandings of crisis, is the understanding offered by Participant 11. This understanding was not associated with either factor that emerged from the data set as a whole. Furthermore, their understanding of crisis had very little shared variance with any other participant. This understanding appeared to reflect a greater similarity to some of the understandings of crisis held by crisis team professionals as regards the centrality of risk (Tobitt & Kamboj, 2011; Department of Health, 2001). This demonstrates that, although the findings of this study give a starting point for thinking about how people understand crisis, they are limited by the very nature of the crisis experience as variable. They are limited in that even within a relatively small sample these common understandings were not representative of everyone's understandings of the central characteristics of crisis.

Further to the Q-methodology findings, the findings of the qualitative analysis and other empirical literature also supported the variability between understandings. One theme

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was labelled 'it's different for everyone' which reflected a central characteristic of crisis as being its variability. Caplan (1964) also noted the variability of crisis, stating 'every crisis represents a novel situation in which novel forces, both internal and external, are involved' (p.41). These findings have important implications for recovery. They suggest that the crisis experience is so variable between individuals that a case-by-case formulation approach within a broad and flexible definition of crisis would be beneficial. In this context service users and carers could be assisted in defining their crisis and making decisions about their recovery. Weinstein (2010) discusses the importance of service users defining their own recovery and it seems logical to assume they should define their own crisis. The use of formulation could be helpful in this process. This also supports Caplan's (1964) ideas about positioning the individual in crisis in power and enabling them to effect change for themselves, which has built more momentum in more recent recovery literature (Slade, 2009; Weinstein, 2010).

As regards developing shared understandings, Tobitt and Kamboj (2011) referred to a period of confusion and debate, where professionals from the same crisis team struggled to come to a consensus. This leads me to consider a further theme from the qualitative analysis which was labelled 'hard to explain and hard to understand'. This finding noted something about the nature of communicating about crisis. This theme relates to both communicating with loved ones and families, but also professionals. This suggests that communicating about crisis can be challenging, and has implications for shared decision making. Shared decision making in mental health settings has been linked to better clinical outcomes and positive long term effects as well as being positively received by service users (Joosten, DeFuentes-Merillas, De Weert, Sensky, Van Der Staak & de Jong, 2008; Simon, Wills & Harter, 2009; Farrelly et al., 2015). Due to the potential complexities of communicating about crisis and reaching a point of mutual understanding it seems that overly deterministic and almost prescriptive definitions and models may further hinder these processes.

The variability of crisis was also linked to another theme from the qualitative analysis labelled 'crisis as temporal'. This theme highlighted that there was variance within how crises develop and progress and also as regards recovery. This theme is discussed in relation to variability, but also in relation to other research that has helped provide

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insight into these 'crisis trajectories' and how these understandings can influence clinical practice and policy.

Crisis as temporal. Another theme related to the nature of crisis, is that crisis is understood as temporal; it has a timeframe. Not only does it have a time frame, but its development through time has various characteristics. This theme is synonymous with crisis literature to some extent. Caplan (1964) identified that crisis usually lasts between four to six weeks, which has been frequently cited by other crisis theorists (Golan, 1998; Callahan, 1994; Brennaman, 2012), as well as in other crisis literature that has defined crisis as a 'temporary inability to cope (Hoff, 2001, p.4). Systemic understandings of crisis also describe 'brief reaction to stress' (Bridgett & Polak, 2003). The findings of the current research, along with this other empirical literature support the appropriateness of time limited interventions offered by CRHT (Department of Health, 2001). However, what differs in this study was the understanding of duration. In contrast to the timeframes offered by Caplan (1964) and frequently cited in crisis literature (Golan, 1998; Callahan, 1994; Brennaman 2012) the findings of this research suggest that people have a more generous understanding of the duration of crisis. Some participants talked about a crisis lasting days, to weeks to months. Of course, it is possible that they are considering recovery as part of this timeframe. Nevertheless, it is an important consideration that people might feel crisis requires time limited intervention, but that this timeframe needs to be responsive on a case-by-case basis. However, this is not to suggest long term crisis input. Callahan (2009) suggested the importance in distinguishing crisis responses to post traumatic stress responses and severe and enduring mental illness that require longer term treatment. This was also considered by Tobitt and Kamboj (2011) who identified 'clusters' of presentations referred to crisis services. Within these presentations were people with severe and enduring mental illness and people who were termed as 'emotionally unstable' or as having 'problematic personalities'. Despite the pejorative associations of these statements there appears to be a relevant implication for clinical practice. That is, crisis may present with or without other comorbidities and, as a result, would require a different approach. Whereas crisis intervention alone might be sufficient for some cases, crisis intervention alongside longer term psychological, social or medical interventions may be required (depending on the nature of the comorbidities).

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Further to its temporary nature, is the idea that crisis has various patterns of development that can be identified. Caplan (1964) also highlighted that 'the significance of crisis is in its temporal telescoping of development'. The findings of this study highlighted differences in the onset of crisis, for example rapid or slow, gradual progression or acute decline which reflects the onsets described in crisis theory (Caplan, 1964) and the understandings offered by Tobitt and Kamboj (2011). The findings also highlighted a tendency for crisis trajectories to fluctuate, therefore, possibly not reflecting a steady approach to recovery. Participants in this study appeared to understand crisis as having a 'crisis peak', therefore, a point at which it is at its worst before it starts to diminish. This is synonymous with previous crisis literature; for example Caplan (1964) refers to a 'breaking point', and Tobitt and Kamboj (2011) also refer to a peak. However, what was an important distinction in this research was between a crisis peak and an 'explosion'. Some participants felt that crisis can be misunderstood as having to have an emergency situation in which there is some threat to life or limb. The findings of this research suggest that some crises can resolve before this point, and that an 'explosion' should not be a necessary pre-requisite for crisis intervention. Some participants discussed that a crisis could be a crisis 'with or without an explosion'. This understanding is supported by crisis theory (Caplan, 1964) that suggests resolution can occur at any point up to the 'breaking point', as well as more recent findings by Tobitt and Kamboj (2011) that suggested the 'window of opportunity' for intervention was before 'explosion' or 'crisis point'.

Finally, regarding recovery, the findings of this research suggest that there can be a period of fluctuation and fragility; people talked about 'blips' and bad days. They also talked about bad days having 'more power'. These findings support previous empirical research (Tobitt & Kamboj, 2011) that highlighted variability in recovery, although some patterns of an 'instant effect' (dramatic improvement following contact with services) and a fluctuating recovery pattern. These findings are also supported by common reference to recovery 'blips' on various health related websites (Healthtalk, 2016) as well as self-help recovery literature (The National Health Service & The Centre for Mental Health Recovery, 2007). These understandings offer support for well-considered endings and a period of monitored stability before discharge from services.

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Additional findings. There were a number of additional themes that could not be captured in the Q-set, and that were not so explicitly linked to the Q-methodological findings. These were; understandings of crisis as a 'difference' from 'normal', the identified causes of crisis and discussions about coping and attempts at resolution.

'It's the difference, from them normally to them poorly' People understood part of the nature of crisis as 'the difference from them normally to them poorly'. Understanding crisis as a difference to 'normal' is synonymous with the concept of 'dis-equilibrium' within crisis theory (Caplan, 1964), in which crisis is defined as the deviation from the normal 'equilibrium'. Although dis-equilibrium refers to the emotional changes in crisis, the theory also highlights disequilibrium in psychosocial functioning. Furthermore, the person's ineffectuality at resolving the problem leads to 'disorganisation of functioning' which refers to the behaviours such as using alcohol or illicit substances or other desperate attempts to resolve their distress which may appear very out of character. Other crisis theories and literature also refer to 'changes' in mood and functioning (Caplan, 1964; Tobitt & Kamboj, 2011; Department of Health, 2001; JCPMH, 2012).

This understanding highlighted something about understandings of crisis that could be important to recovery. The tendency for people to attribute the difficulties to the crisis and not the person could be understood as 'splitting'. Splitting is a psychodynamic concept which suggests that the 'crisis self' or difficult aspects of behaviour or interpersonal interactions during crisis could be hard for the service user and carer to integrate into their former perceptions (Brown & Starkey, 2000). This could serve a protective function for both service users and carers. For service users, it may, in part, protect them from integrating some of the aspects of themselves during crisis, which may cause them to feel intense emotions such as guilt, shame or humiliation. These parts may be too difficult to integrate into their perception of self. Similarly for carers, splitting may be of benefit by protecting them from the full extent of the impact of some of the more difficult behaviours associated with some crises, such as violence and aggression at family members. For the system as a whole, this may serve the function of keeping relationships intact and allowing caring behaviours to continue post crisis. This

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way of understanding crisis as separate from the person could have benefits for recovery, as regards enabling them to resume their usual roles and positioning in the family.

Causes of crisis. The findings of this study support previous findings that people understand certain life experiences such as trauma and long standing difficulties with mental illness as influencing a 'vulnerability' to crisis. This is synonymous with previous crisis literature (Caplan, 1964; Callahan, 2009; Erikson, 1959). Tobitt and Kamboj (2011) discussed these factors and referred to the 'differential vulnerability' to crises, with some people being more vulnerable to crisis than others, again reflecting variability as part of the nature of crisis. Tobitt and Kamboj (2011) also go on to discuss the impact of developmental histories, trauma and problematic attachment relationships. They suggest that such difficulties 'set the stage' for crisis.

Some people understood that crisis can result from 'internal triggers', ; therefore, triggers of biological organic origin or heredity. This supports the inclusion of internal triggers as suggested by Ball et al. (2005). Further to internal triggers, relational triggers were identified as being a contributing factor for the development of crises. One participant said '*people cause crisis*'. This understanding is supported by systemic understandings of crisis that refer to 'internal conflict' within social systems (Bridgett & Polak, 2003a; 2003b) and other crisis literature that refers to the 'very large role' family difficulties have on developing a crisis (Johnson et al., 2008). Further to this is to revisit the origins of 'underlying vulnerability', many of which are interpersonal, for example abuse, neglect, domestic violence etc. (Caplan, 1964; Callahan, 2009; Erikson, 1959; Tobitt & Kamboj, 2011).

On a similar system level of understanding, participants in this study understood a potential trigger for crisis as social adversity and the cultural and social pressures associated with western society. This theme was labelled 'the impact of the world we live in'. This finding is synonymous with previous crisis theorising that has acknowledged situational and socio-cultural origins of crisis (Caplan, 1964; Bridgett and Polak, 2003a; Collins & Collins, 2005; Hoff, 2001). These factors can impact on how someone perceives themselves or the situation, the resources they have to deal with challenges/difficulties, and the impact of the crisis as regards the extent of impairment.

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Social adversity has been linked to the development of serious mental illness (Wicks, Hjern, Gunnell, Lewis & Dalman, 2005; Patel & Kleinman, 2003; Dohrenwend, 1998); although the links between crisis and illness are tenuous, this also highlights the importance of context and resources for responding to adversity and challenge.

Not only was social adversity discussed, but one participant also reflected on the impact of children being raised in generations of people who have not worked or taken part in meaningful activity. Psychological theories relating to ideas of the thwarted self and learned helplessness could offer insight into these contexts (Seligman, 1990).

Participants also talked about 'the straw that broke the camel's back' referring to the accumulation of stressors that can lead to a crisis, as an alternative to the presence of one major event. This is supported by previous crisis literature; for example Caplan (1964) describes a 'series of crises' and Bridgett and Polak (2003a) a 'connected series' pattern in which there can exist multiple unresolved crises that can span across social systems. Tobitt and Kamboj (2011) also discuss the presence of a seemingly 'mundane trigger'. Counter to some understandings of crisis as being a response to a major life event, this theme represents coping with stressors over a period of time resulting in feeling 'ground down', which appears to link to having lowered resilience. Considering how resilience becomes lowered, Caplan (1964) describes the impact of continued maladaptive coping which is ineffective at resolution, and therefore leads to a 'complete disorganization' of attempts to resolve the problems. He suggests that prolonged use of ineffective and maladaptive coping can 'damage' the individual and their contexts, which increases the likelihood of further crises. Furthermore, the continued 'ineffectuality' as described by Caplan (1964) could lead to changes in the way that people perceive their ability to resolve stressors leading to 'giving up'. Perception of one's ability to cope with it has been described as a key element in a person's vulnerability to crisis (Aguilera, 1998; Golan, 1998).

Attempts at resolution, coping and recovery. This theme represents some findings of the qualitative analysis that could not be included in the Q-set, yet may have some important implications both for clinical practice and future research. In general, some people referred to crisis as an opportunity to develop resilience that can lead to positive outcomes. Whereas others described how nothing good can come out of crisis,

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and that it can cause damage. Both of these understandings are reflected by Caplan (1964) who suggests that people can come out of crisis better or worse, depending on the ways in which they respond and cope with it.

Participants understood crisis as a situation in which you cannot cope alone, this was labelled 'the need for help'. This links to crisis literature that emphasises the inability to cope (Caplan, 1964; Tobitt & Kamboj; 2011; Bridgett & Polak, 2003a) but also that a crisis is rarely experienced alone. Caplan (1964) states 'a man does not usually face his crisis alone, but is helped or hindered by the people around him, by his family, his friends, neighbourhood, community, and even nation' (p.43).

This finding links to drawing on the resources available within the person's social network as also reflected in more contemporary crisis literature and approaches to intervention (Hoff, 2001; Bridgett & Polak, 2003b). Again there was some variability within this need for help, with qualitative findings suggesting that some people need more help than others or at different times, such as in the early hours of the morning. This relates to service user perspectives that identified the helpfulness of 24/7 access to crisis services (Davies & Rennoldson, 2013).

The qualitative findings of this study supported previous findings that in response to not being able to cope alone people will 'help seek' (Caplan, 1964; Ball et al., 2005; Callahan 1994) or try to manage alone (Ball et al., 2005). Managing alone appeared to be more akin to withdrawal. This could be related to immobilisation due to the inability to resolve the crisis (Caplan, 1964), intrapsychic defences to protect themselves from this (Aguilera, 1998) or possibly due to 'people being the cause of crisis', as identified within the qualitative findings of this study, as well as previous research that highlights the influence of interpersonal conflict (Caplan, 1964; Tobitt & Kamboj, 2011; Bridgett & Polak, 2003a). Caplan (1964) described that, within a crisis, distress can be directed inwards, which can lead to mental ill-health such as depression and negative self-perceptions associated with blame, loathing and guilt. Therefore, this characteristic response to crisis supports previous findings.

Despite the presence of support from services, Caplan (1964) noted the importance of personal relationships for recovery. He suggested that the people who can more strongly

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affect recovery are those who are most connected to the person in crisis through 'primary bonds of his basic needs for love and interaction and those who fit in with his needs for authority and dependence' (Caplan, 1964, p48). This again emphasises the importance of attachment relationships. However, an important finding within the qualitative analysis was the burden that this places on carers.

The impact of caring. Despite the importance of key relationships to recovery, the findings of this study suggest that carers endure an enormous strain that depletes their abilities to be able to offer adequate support, and may even impact on their own psychological wellbeing. Particularly, carers noted the fear that their loved ones would harm themselves, and a sense of confusion and not knowing what to do for the best was thought to be central to this distress. Caplan (1964) described how helping to resolve a loved one's crises can cause carers to develop mental illness. He describes how in reorganising to meet the needs of their loved ones, their own needs are threatened, therefore resolving the crisis at the expense of their own wellbeing. This may be more evident overtime. McCubbin and Patterson (1982) proposed an extension to the ABC-X model of family crisis (Hill, 1949; 1958) suggesting that it is not just what leads to crisis, but what leads from it which is important. They highlight the build-up of stressors and diminishing resources over time. Furthermore, Bridgett and Polak (2003a) suggested that crises span across social systems. They describe the individual as belonging to a series of overlapping systems of interactive human relationships. These social systems are vulnerable to internal conflict and external stress/pressures. Within these systems, people are interconnected. Actions by any person within the system changes the context for all of the others and, as such, the system develops and changes in a circular process. Therefore, these understandings suggest that carers and families can be vital in supporting recovery from crisis, but that in inhabiting this role they are at risk of significant stress and the risk of burnout. This is supported by literature in other clinical areas about the impact of the carer role (Ybema, Kuijer, Hagedoorn & Buunk, 2002; Murphy, Christian, Caplin & Young, 2007).

Caplan (1964) suggested that it is best not to understand the impact of crisis on mental health as regards the individual presenting to services, but to broaden our understandings and notice the impact of those involved in supporting crisis resolution.

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Therefore, Crisis Theory suggests not only working with the individual, but working in a systems approach. Bridgett and Polak (2003b) suggest a model for systems level assessment and intervention that targets systemic issues and incorporates 'system meetings' in a group/family therapy approach to crisis resolution. Other research has evaluated the benefits of group-based programmes (Mitchell, 2000) and carer support groups (Munn-Giddings & McVicar, 2007) suggest possible approaches to maintaining the wellbeing of carers, and the invaluable resource that they provide for recovery.

'Normal' response or mental illness. The introduction highlighted a debate within the literature about the degree to which crisis is linked to mental illness. This research was positioned as exploratory and, therefore, did not aim to argue for or against a link between crisis and mental illness. Some argue that mental illness can be one factor that contributes to a person's vulnerability to crisis, and that it can also be the bi-product of a crisis experience (Caplan, 1964; Johnson et al., 2008). However, others have more explicitly linked mental illness and crisis (Brennaman, 2012; Ball et al., 2005). This debate is unsurprising given the dominance of the medical model in crisis intervention. The Q-methodological findings suggested that people's understandings of crisis were structured around two factors: perceptual and cognitive changes and extreme emotional distress. This differs from understandings in policy (Department of Health, 2001), some professional understandings (Tobitt and Kamboj, 2011) and 'common sense' definitions used in empirical research (Johnson et al., 2005) which explicitly highlight the centrality of mental illness. However, the findings of this research do not rule out the helpfulness of mental illness narratives for some people.

The findings of this research suggest that the degree to which people understand mental illness as a factor in the development of crisis is variable. This finding was also reflected by Tobitt and Kamboj (2011) who suggested that professionals varied in the degree to which they understood crisis as related to mental illness, despite mental illness being central to service level eligibility criteria.

For some of the participants in this research, illness and mental ill-health narratives appeared to be valuable ways of making sense of their experience. Some people understood themselves as vulnerable to crisis due to their history of mental illness or a genetic predisposition. For some carers, the identification of a diagnosis and associated

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Moved up [7]: Returning to consideration of a further coping response, a further response that has not been explicated in previous research was termed the 'frustrated approach'. This approach was characterised with an approach-rejection pattern. People described a sense of invalidation from others when they were help-seeking, and a sense that nobody cares. This reflects findings that difficulties in accessing crisis services can exacerbate crisis (Middleton et al. 2011). Returning to the quote again, in which Caplan (1964) states 'a man does not usually face his crisis alone, but is helped or hindered by the people around him, by his family, his friends, neighbourhood, community, and even nation' (p43). Again, this reflects that the people who support an individual in crisis can either help or hinder.

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symptomology appeared to be helpful in monitoring when a crisis was coming. These understandings of illness and diagnoses, therefore, reflect one side of the debate (Tobitt & Kamboj, 2011; Ball et al., 2005). On the other hand, some participants understood crisis as a common and understandable response to the circumstances, and 'a dormant possibility for everyone'. Some people reflected that these understandings of crisis were helpful as they reassured them that they were 'normal'. Some people who understood crisis in this way appeared to defend themselves against pathology, for example one participant felt strongly that there was nothing implicitly wrong with him as a person. These findings reflected the alternative 'side' of the debate with a greater emphasis on their circumstantial struggles and hardships similar to that of crisis theory (Caplan, 1964) and systemic understandings (Bridgett & Polak, 2003).

To conclude, the findings of this research do not resolve this debate in favour of either viewpoint. Instead they highlight that there may be no need to debate the superiority of one perspective over the other. As discussed in the introduction, Hoff (2001) highlighted that illness is a subjective concept, and the findings of this research suggest that this, as a concept, may be more or less helpful depending on the individual. Rather than generalising one way of understanding crisis as helpful or 'right' and the other as unhelpful or 'wrong', what may be a more valuable feat is to try to understand the value of understandings for recovery. For example, a carer viewing their family member as 'ill' may initiate a caring response. This may be helpful for some people, drawing in resources and comfort. However, for others, being positioned as 'ill' may lead to them inhabiting a helpless role in which they have no power. Some people may view mental illness as indicating there is something wrong with them; for some this may be pathologising whereas for others this could be validating and provide relief. The research suggests that aiming to maintain an open, curious and accepting position could enable clinicians to understand the experience of people in crisis and to be responsive to what individuals and families find helpful and unhelpful.

The importance of these findings is that although illness-based understandings of crisis are well represented by the definitions that influence service provision (Department of Health, 2001) and the dominance of the medical model in crisis provision, not everyone understands crisis in this way. This offers further support for crisis being understood as

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Deleted: Rather than argue for the superiority of one way of understanding of crisis over another, what seems to be important is recognising the variability.Johnson et al. (2008) later define psychiatric emergencies as situations in the context of mental health illness which need immediate action due to high risk. In contrast, psychosocial crisis is a common human response to psychosocial stressors, and not a manifestation of illness. Therefore, this definition differs to those proposed by Ball et al. (2005) and Brennaman (2012) as it explicitly excludes illness. ... [48]

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idiographic and suggests that understanding crisis should steer towards a case-by-case formulation approach. This also has implications for policy, as it suggests that determining 'crisis' by the presence or absence of mental illness may limit other helpful perspectives.

Reflecting on the findings within broader psychological frameworks. The findings of this research can be located within broader psychological and philosophical frameworks, such as existential and humanist perspectives, psychological theories of stress and attachment theory.

Existential and humanist perspectives. The findings of this research highlighted that understandings of crisis are highly variable between individuals. As such, existential and humanistic perspectives may be a useful approach from which to consider the findings further.

Existential philosophy developed out of critique of systems of belief that promoted absolute idealism and the reduction of human experience to deterministic elements, and instead proposed that each person should be understood relative to their own unique experience. As such, each crisis is a unique expression of an individual's history, context and their experience of it. Within this approach, generalising is pointless.

The approach proposes that the inescapable struggles of life are the very nature of existence. Several of these inescapable struggles are highlighted, for example death, loss, separation and freedom and choice (Frankl, 2011; Frankl, 2005; Cooper, 2003)

Deurzen (2002) argues that human life is tough, unfair and filled with crises, failures and injustice. As such, it is inevitable that we will be faced with challenges and distress, due to the nature of human existence. This understanding was reflected within the findings of this research. Participants experienced various 'triggers' for crisis, many of which reflected existential ideas such as relationship breakdown, death, loss of homes, families and employment. This understanding was reflected within the findings of this research that deemed crisis inevitable in the context of the world we live in. Participants discussed societal pressures, deprivation and hardship, the strain of striving for more in life and the impact of loss. One participant discussed how austerity has challenged our very purpose in life stating '*we are not designed to do nothing, we have*

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to do things, to interact with people'. This comments on a fundamental part of existence that is becoming thwarted by social and economic factors; the participant understood this as leading to an increase in people experiencing crises.

The findings of this research suggested that some people view crisis as a challenge from which growth can appear. One participant discussed how their job was putting too much pressure on them and the crisis brought awareness to this and led to a change of circumstances. Another participant discussed how their husband had never dealt with the loss of their daughter. The crisis triggered a 'breakdown' during which he connected with this loss. However, there were also many understandings of crisis as destructive and damaging. Within existential and humanist perspectives people are considered to be orientated to the future (Cooper, 2003) and, as such, experiences that are 'forward moving' and 'growthful' are more valued than those perceived as restraining (Mearns & Thorne, 2000). Within this perspective, if a person can connect with some higher meaning, some learning or developmental purpose to the experience of crisis, they can move forward and experience the crisis as growthful rather than limiting. This may be easier for some life experiences than others; for example, losing a job may present new and exciting opportunities to change direction in life. The loss of a child or spouse may be harder to find meaning in.

A benefit of an existential perspective is the assumption of human freedom. As such, a person is understood as having the choice about what to do next. Working therapeutically within this perspective would, therefore, position the service user as effective and powerful. This position is counter to the findings of this research in which people described feeling powerless. This also links to Caplan's (1964) notion of 'ineffectuality' in crisis, which he described as a necessary target in intervention. Therefore, positioning the service user as effective and as having the power to make choices within their recovery could be beneficial. On the other hand, this approach may be less helpful to people who experience crisis as damaging and limiting. In these cases, the emphasis on choice could be perceived as invalidating and blaming. As such, an existential approach could be considered a middle-class model which assumes people have choices that could lead to a better future. In spite of the concept of 'thrownness' (see Cooper, 2003), which acknowledges that we cannot choose the context within

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which we are born, it overlooks that people may be limited to choices between bad situations or even worse situations. In this context, choice and freedom only equip people to the extent to which resources allow. Humanist approaches, such as Maslow's hierarchy of needs (see Poston, 2009) may offer a framework for understanding the impact of limiting contexts. Maslow observed that we are driven to fulfil needs within a hierarchical order: basic physiological needs are prioritised over safety needs; safety needs are prioritised over the need for belonging and love; which is then prioritised over esteem needs and self-actualisation (achieving one's full potential). The first four needs are 'deficit' needs. The central idea is that higher order needs cannot be prioritised or met until basic needs for warmth, sustenance and safety are achieved. When these needs are met, individuals are motivated to pursue other needs. Within this perspective, finding a greater meaning within crisis and making choices that move towards growth and recovery may not be appropriate. For example, some people experience crisis due to a deficit needs being unmet. This could be due to homelessness, having no money for food or living in circumstances within which their safety is threatened. This perspective offers a framework for considering crisis resolution with people who are limited by their circumstances. The findings of this research suggest that crisis is a time of feeling desperately unsafe. Therefore, even if basic needs are met people may find it difficult to meet safety needs and then move beyond this to relational or esteem needs. Although critiques of the model have highlighted that some people may value needs of belonging over some basic needs, the model offers a simple framework that could be useful for considering sequencing or prioritising interventions.

To conclude, although not without limitations, the findings of this research can be further contextualised within existential and humanist perspectives. In summary, the benefits of the approach are the emphasis on individual experience and subjective meaning making, and on positioning service users as having freedom and choice.

Theories of 'psychological stress'. Considering crisis from a broader understandings of distress as a 'normal' part of human existence brings me to consider further theoretical understandings of stress.

Lazarus' (1993) theory of psychological stress proposes that there are two concepts that are central to understanding human responses to stress: appraisals and coping. Within

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this theory, stress is regarded as the transaction between individual and environment, and not any pre-defined or specific internal or external cue or stimulus.

Folkman and Lazarus (1986) proposed that 'psychological stress refers to a relationship with the environment that the person appraises as significant for his or her well-being and in which the demands tax or exceed available coping resources' (p. 63). This is similar to the definition of crisis proposed by Caplan (1964) and also reflects the finding of this research with participants referring to accumulative triggers and diminishing resources. Khrone (2002) proposes that appraisals are central to understanding stress transactions as they determine the emotional experience associated with an experience. The theory proposes that appraisals determine the quality, intensity and duration of the emotional response, which could possibly be a framework for understanding the variability within crisis experience. Lazarus (1993) proposes two important appraisals: those related to the threat to well-being, and those related to coping. This understanding links to how people refer to perceiving their crisis, whether they see it as a challenge to be overcome, or whether they view it as insurmountable. The findings of this study also highlighted that people talked about the way that they perceived the crisis, their personal ability to cope with it and evaluated the resources available to them. Therefore, understanding the way that people make sense of the challenges they face and the predictions that they make about coping with it could offer insight into intervention. For example, increasing self-efficacy, bolstering contextual and social resources and positioning service users in a position of power could be valuable. However, although this theory gives a framework for understanding responses to stress, the findings in this research appear to differ somewhat. The two-factor model incorporates both perceptual and emotional factors and, therefore, could be understood as reflecting a stress response. However, what the findings appear to suggest is that crisis is a situation in which people struggle to make sense; participants described chaos in their thinking. As such, the emotional response associated with crisis is one of feeling overwhelmed and unsafe, to the extent that the person becomes debilitated. This distinguishes crises from stress responses somewhat, maybe not as a different concept altogether, yet as a transaction of environment and individual that falls to the most severe or extreme. This suggests that there is a limit to how much stress a person can endure and that this limit varies depending on our experiences and context.

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The interaction between the individual and environment appears to suggest a possible explanation for the variability within crisis. The stress vulnerability model (Zubin & Spring, 1977) proposes that we all have biological, psychological and social elements which act as either strengths or vulnerabilities in the face of stress. The model proposes that the development of mental illness depends on the degree of 'vulnerability' and the degree of stress experienced. The greater our vulnerabilities the less stress we need to experience crisis. The lower our vulnerabilities, the more resilient we are to stress. This model could offer some benefit to crisis intervention, yet also has some inherent drawbacks. The model captures an interaction of both environmental and individual factors, which reflects the wider qualitative findings of this research and previous theorising (Caplan, 1964; Ball et al., 2005; Tobitt & Kamboj, 2011; Bridgett & Polak, 2003a, 2003b). However, it could be argued that the model is too simplistic to be applied to crisis and the identification of vulnerability is somewhat deficit focused. Attending to vulnerabilities could arguably be either validating or disempowering depending on its execution in clinical practice. However, this caution is related to the way that the model is applied rather than the model itself. A further difficulty with this model would be its links to illness and disorder. This model is essentially a model of the development of psychiatric disorder and could, therefore, further strengthen the links between crisis and illness which may be unhelpful for some. However, the findings of this research indicate that narratives about illness may be helpful and valuable. Conversely, the model also emphasises strengths and could be adapted to reflect crisis in a broader sense, rather than illness. Although simplistic, its simplicity could be useful in clinical practice. The model provides some direction and structure for clinicians, while also providing adequate room for flexibility and individual sense making.

The findings of this research also highlighted that it is not just what leads to crisis, or how one copes with it, but the ongoing strain on the ability to cope. The findings of this study, and previous theorising (Caplan, 1964; Brennaman, 2012; Ball et al., 2005; Tobitt & Kamboj, 2011) have identified crisis as being temporal in nature, however the duration and trajectory of crisis is highly variable. The findings of this research also highlighted the impact that crisis can have over time, both on the individual and their contexts. As such, crisis can be destructive and can cause further problems for the person over time. The conservation of resources (COR) theory of stress (Hobfoll, 1989)

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suggests that stress/distress occurs when we lose resources, when our resources are threatened or when we invest resources without gain. This theory proposes that it is not the individual event that causes stress, but the loss of resources. The theory proposes that resources protect resources, and lack of resources leads to further deterioration of resources. Krohne (2002) gives the example of a woman with high self-esteem accessing social support, whereas a woman with low self-esteem might not. Similar to the findings of this research highlighting that crisis itself is destructive in the sense that it drains and corrodes existing coping resources, Hobfoll (1989) refers to this as 'depleted' resources.

The impact of crisis on 'depleting' resources was an important finding within this research. This related to both further loss as a consequence of crisis or the impact of the crisis on carers. This has been highlighted with regard to the anxiety experienced by professionals and the sheer panic and fear described by carers. These findings, and the understandings offered by the ROC theory, propose that if resources continue to deplete and no intervention is put in place, it is likely that the person/family would become increasingly vulnerable to further challenges or stressors. This highlights the importance of continual assessment of coping and resources, and the need to prioritise preservation of resources where possible. Furthermore, even in cases where the crisis experience appears to have expanded, this perspective would suggest that intervention aimed at strengthening resources would still be valuable with regard to relapse prevention.

Attachment theory. Attachment theory offers a framework for understanding distress and how we respond to it. As such, it may offer a framework for thinking about the patterns of coping and attempts at resolution that were highlighted within the findings.

Attachment theory developed from the work of John Bowlby who noted the emotional distress caused by separating children from their caregiver (Bowlby, 1969; 1988). This seminal theory has influenced the way that we understand how people respond to and regulate intense distress. The theory proposes that, through our early experiences of caregivers, we develop expectations of ourselves, others and the world (Ainsworth, Blehar, Waters & Wall, 1978). This framework, often referred to as the

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'internal working model' (IWM) influences how we respond in relationships and future challenges.

The developed 'internal working model' could serve as a framework from which to understand people's responses to crisis. Proximity to others increases the likelihood of safety and physical/emotional needs being met. Therefore, we develop 'attachment behaviours' that enable us to get our needs met. This study highlighted that people either respond to crisis by withdrawing, seeking help or with a frustrated response. These responses can be mapped onto the categories of 'attachment styles' developed by (Ainsworth et al., 1978) and the associated adaptive strategies (Mikulincer, Shaver & Pereg, 2003). For example, people who withdraw from services may predict that other people cannot help them. This is considered a 'deactivating strategy' as it is a reduction in attachment behaviours that deprives opportunities for resolution (Ehring, Tuschen-Caffier, Schnülle, Fischer & Gross, 2010).

The theme of 'help seeking' suggested that people are motivated to find support and comfort from others in time of need. This is supported by the understanding that, during crisis, people will use their social resources as a way to achieve resolution (Caplan, 1964; Bridgett & Polak, 2003b). This reflects some attachment based understandings of achieving basic needs (Bowlby, 1969). Returning to consideration of a further coping response, a further response that has not been explicated in previous research was termed the 'frustrated approach'. This approach was characterised with an approach-rejection pattern. People described a sense of invalidation from others when they were help-seeking and a sense that nobody cares. This reflects findings that difficulties in accessing crisis services can exacerbate crisis (Middleton et al., 2011). Returning to the quote again, in which Caplan (1964) states 'a man does not usually face his crisis alone, but is helped or hindered by the people around him, by his family, his friends, neighbourhood, community, and even nation' (p.43), again, this reflects that the people who support an individual in crisis can either help or hinder. People who respond with a frustrated approach may perceive themselves as unable to cope alone and in need of help, but may also view others as a threat or unwilling to help and, therefore, become stuck in a position that is impossible to resolve. This can result in a 'hyper-activating strategy' which is marked by increasing demands on others which can

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be difficult for services/carers to manage and can lead to rejection (Wei, Vogel, Ku & Zakalik, 2005). Attachment theory is a framework that could be useful in helping carers and professionals to understand their interactions with service users who present in this way, and could help them to modify their responses in order to build positive relationships. The importance of seeking proximity and support from others was also reflected in crisis theory (Caplan, 1964) which highlighted that recovery occurs within the context of key relationships. Furthermore, this is also reflected by service user perspectives of helpful crisis intervention which highlighted 'people being there' and the proximity and accessibility of support as enabling a sense of safety (Davies & Rennoldson, 2013).

Attachment theory also offers a framework for understanding the way that people perceive their crisis and their predictions about recovery. For example, people may perceive themselves as unable to cope and they may perceive the crisis as insurmountable. They may have developed beliefs that 'nothing ever goes right for me' or they may believe that everything happens for a reason and that things tend to work out in the end. These beliefs about self and the world could, therefore, mediate the intensity of their distress and whether or not they respond in an active or passive way. This view of self is similar to Caplan's (1964) notion of 'ineffectuality' and how they perceive the crisis and likely outcomes.

The findings of this research suggest that 'triggers' of crisis are often relational, for example, the loss of a loved one through death or separation. Attachment theory offers one way of conceptualising the associated impact on perception and emotional disturbance as a response to the threat of separation. This framework could be a useful way of exploring the impact of loss with service users and normalising their distress.

From an attachment perspective, when security cannot be obtained, it remains the priority and, as such, the individual remains in a threat response preoccupied with obtaining safety and security (Bowlby, 1965). While safety needs are unmet, other needs are thwarted; during crisis this could relate to qualitative findings that highlighted crisis as destructive, thereby placing further strains on resources and support systems. For example, preoccupation with the crisis can result in difficulties in sustaining employment and relationships/friendships. The preoccupation, although in some ways

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adaptive and necessary, maintains and further contributes to the problem. This is also reflected by humanist perspectives such as Maslow's hierarchy of needs as highlighted previously.

Clinical implications

The findings suggest that a case formulation approach would be useful in clinical practice as it takes into consideration the variability within understandings of crisis.

A case formulation approach could empower service users to define their own understanding of crisis which would enable the development of tailored support and interventions which could impact on clinical outcomes (Caplan, 1964; Slade, 2009; Weinstein, 2010; Joosten, DeFuentes-Merillas, De Weert, Sensky, Van Der Staak & de Jong, 2008; Simon, Wills & Harter, 2009; Farrelly et al., 2015). Furthermore, the qualitative analysis highlighted that crisis is temporal in nature. This adds further support to a case formulation approach, as formulation is constantly updated (Johnstone & Dallos, 2014), and, therefore would be responsive to change than more static approaches to understanding problems.

As regards implications for policy, the findings suggest that re-evaluating definitions of crisis in policy in order to encompass a wider range of understandings, including fewer prescribed determinants of crisis, could influence a more inclusive approach to crisis provision. Furthermore, findings about risk suggested that risk may not a defining characteristic within all understandings of crisis, which again questions the validity of the current understandings of crisis within policy and corresponding service structures. The findings suggest that it is difficult to have an absolute and fixed understanding of crisis and that a more fluid understanding that holds within it areas of debate, difference and variability might be more clinically useful.

Although implementing these changes could be clinically useful, this could present challenges to service providers and professionals, for example in relation to the impact of current political and economic pressures on service provision. Increased strain on resources is particularly worthy of note due to the impact of current political and economic pressures on service provision. Currently, deterministic definitions of crisis within policy serve the function of gate-keeping resources (for example by diagnosis).

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Deleted: A further implication was the potential for the two factor model to be used as a starting point or guide to assist in this process. Future research would be well placed to test the usefulness of this in practice, as well as determining if the Q-set tool could be developed into a clinical tool to assist with recovery processes.

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A more fluid and inclusive definition of crisis could impact on the number of people that meet referral criteria and thus service structures and processes may need further rethinking. Case formulation approaches may take longer to complete, and the change in approach may highlight training needs and the necessity for increased levels of clinical supervision. The two factor model may offer a useful framework that could offer some structure within the case formulation approach. The two factor model proposes that focusing on perceptual and cognitive changes and the emotional impact of crisis may be sufficiently broad to capture a range of perspectives yet structured enough to provide clinical guidance.

Findings suggest that crisis experiences are very variable, and this may or may not have implications with regard to risk. As such, clinicians who hold responsibility to keep people safe are under tremendous pressure to make the 'right' clinical decision. It was hypothesised that focusing on risk could function as a defence from the distress that this role may cause. This defence could have both functional (protective) but also dysfunctional (limiting) consequences. The use of reflective practice within crisis teams was suggested as a way of supporting the wellbeing of professionals and effective clinical practice. Furthermore, supporting clinicians to make use of multidisciplinary working and other support systems such as clinical supervision may be beneficial for seeking advice about decision making and also for emotional support.

The findings of this research suggest that an individual's perception of their ability to resolve the crisis could have important implications for recovery. The discussion located these findings within an existential and humanist perspective, and proposed that positioning a service user with the power to enable change is important. This relates to building efficacy and approaching goal-setting in a realistic manner, but also in attending to resources and context and ensuring that service users have what they need to make recovery based choices.

Qualitative findings highlighted significant strain on the families and carers of people in crisis. This finding suggests that involving them directly in family based therapeutic approaches could be helpful where possible. Alternatively, when this is not possible, group programmes aimed at supporting and developing resilience and carer led support groups could prove a helpful addition to crisis services.

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Qualitative findings also highlighted three patterns within the way people described relating to crisis support: 'help seeking', 'withdrawal' and 'frustrated-approach'. Although engaging people who 'help seek' may be less demanding on clinicians, engaging service users who relate to services within a 'frustrated-approach' or 'withdrawal' pattern may require more thought. These patterns of relating suggest that relational approaches such as attachment theory could be helpful in supporting staff to make sense of these patterns (Gumley, Taylor, Schwannauer & MacBeth, 2014). This could assist with engaging service users who may fear closeness to others, or who may distrust other people as being able to help and support. Again, supporting clinicians through clinical supervision and reflective practice could be invaluable in building relationships with service users who might be perceived as hard to engage.

Implications for Clinical Psychology

The findings of this study suggest that crisis is a complex and idiosyncratic experience. Furthermore, there is an underlying debate around crisis in terms of whether it is explicitly linked to mental illness or not. This suggests that clinical psychology has a key role to play through its ability to make sense of complex presentations, by drawing on a range of understandings that may fall outside the remit of the medical model. As psychological formulation is central to the role of a Clinical Psychologist, the profession is well placed to provide knowledge and guidance in this area.

The research provides a two factor model as a starting point or guide for crisis case formulation which furthers the theoretical foundation of crisis intervention.

Furthermore, working with crisis presents a challenging context for professionals that could be supported by a reflective practice or consultative model that draws on multiple theoretical frameworks such as systems theory and psychodynamic approaches in order to safeguard staff well-being and good clinical practice. Again, clinical psychology is well placed to provide such support.

Limitations

There were a number of limitations that could have impacted on this study. Firstly, all of the service users were recruited from a crisis team and, as such, it is likely that their perspectives will have been influenced to some extent by socialisation to professional

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and mental illness discourse. Due to ethical considerations all service user participants were identified by staff within the crisis team as being ready to discharge. These judgements about who to include, and potentially who not to include, could have influenced the perspectives gained. Furthermore, ethical considerations led to the inclusion of people who were in recovery. Although still a valid and helpful perspective, it could be argued that this retrospective understanding of crisis offers a different perspective to an understanding of crisis during the experience.

The number of times that people had been in crisis, and the number of times they had accessed crisis services was not captured in demographic data. Retrospectively, this information could have aided the interpretation of the results and offered an interesting insight into potential reasons for greater or lower shared understandings between professionals and service users/carers.

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Despite the potential insights that may have been gained from this data, the decision not to collect these details was informed by ethical considerations and consideration of the aims of this research. Firstly, we were keen to preserve the anonymity and confidentiality of a narrow pool of participants. Only three service user participants were recruited at each stage, and from one crisis service. Therefore, further details could have made participants identifiable.

Investigating the impact of multiple experiences of crisis, and the impact of time on the way that people understand crisis was not within the aims of this research. The aim of the research was to explore the ways that people understand crisis and if this differed due to their perspective as a service user, carer or professional. The aim was to open up new, and multiple ways of understanding crisis. Therefore, information regarding how many crises had been experienced, the duration of crisis, and the time that had passed since the last crisis was not considered to directly link to this specific endeavour. This information highlights something interesting about how time and experience might impact perspective, which could prove valuable research. Although not within the scope of this research project, the Q-sort tool developed within the current research could be valuable for future research aimed at exploring this research question. The tool is static which would be necessary in demonstrating change in perspectives over time. Therefore, although highlighted as a limitation, the development of the Q-sort is

considered to be a valuable outcome of this project that will contribute to further research in the area.

Furthermore, the research design was constructed with the aim of opening up multiple understandings of crisis and exploring differences between groups. As such, maximum variation sampling suited these aims. However, this inevitably led to smaller numbers of participants in each group which would have impacted on the generalisability of claims about how multiple experiences of crises could impact on their point of view. Future research that investigates the impact of multiple experiences of crisis and the passing of time since crisis on how people perceive and understand crisis would require a longitudinal design.

Although retrospectively collecting this data was considered in supervision, it was not considered ethical to pursue this. Collecting this data would either require crisis staff to contact the patient or the researcher to access patient records and contact them. This is not permitted under the current ethical approval granted and participants did not consent to being contacted for further information. Pragmatically, the transient nature of crisis services would complicate this pursuit.

The qualitative analysis of the data collected in Phase One of the project revealed a vast number of themes. Although they added to the thesis in their own right, in order to construct a manageable and effective Q-set the decision was made to limit Phase Two to the crisis experience themes. To some extent this was a strength, as it allowed participants the depth needed to effectively communicate their understandings of the crisis experience. However, it could be argued that the exclusion of the wider themes was a limitation. Retrospectively, it is likely that the questions that formed the interview schedule were more extensive than necessary which led to this difficulty. However, these findings remain a key part of the thesis and add to the empirical knowledge of crisis.

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Recommendations for future research

There is scope for exploring the usefulness of the two factor model as a guide for building idiographic understandings of crisis in practice. Such research would be well placed in identifying if the model is helpful in structuring conversations about meaning making within clinical assessments and how this differs from usual practice. It would be

important to measure satisfaction with this approach, from service user, carer and professional perspectives.

Further to the two factor model providing a 'starting point' there is the possibility that further research could serve to develop the Q-set into a more accessible and manageable clinical tool. Several participants commented that they felt they had a better understanding of their experience of crisis after completing the Q-sort process. Professionals also commented that the procedure could have benefits as a clinical tool for use in recovery and when planning discharge. It would be useful to explore how the Q-sort could be used qualitatively to mark progress and initiate reflection, as opposed to usual practice.

This research hypothesised that the variability within understandings of crisis could increase complexity and potentially lead to difficulties in forming shared understandings and practicing shared decision making. Further research that examines the processes involved in forming shared understandings and decision making in crisis services would be useful in supporting these endeavours. Although this research analysed the content and structure of understandings of crisis, the design placed less emphasis on the processes of communication in practice. It is possible that discourse analysis would be an appropriate method for highlighting the process of determining crisis within referral meetings or initial assessments. Further research in this vein could also highlight the socio-political and historical forces and structures which influence how we understand crisis. The method also allows attention to what is 'un-said' as well as said. The development of CRHTs was invariably a politically and economically driven change in service provision and, as such, it is hypothesised that a shift in language use was necessary. This greater focus on language could clarify some of the obscurity around crisis as a term, and could highlight the forces that designate what can be said about crisis and what cannot. This further research could explore another hypothesis that was highlighted by the SUCAP panel about the dominance of professional discourse. It is possible that talk about crisis is impacted on by power imbalances between professionals and service users.

Findings indicated that risk was not a factor within its own right, yet a core feature of both factors. It would be interesting to build upon the work of Callahan (1994) to

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further distinguish understandings of crisis from understandings or risk/emergency. It seems that may be a reason that risk is so commonly linked or misunderstood as crisis (and vice versa). Understanding how people talk about risk could highlight its function, both for the service user and for professionals and services. This research would also offer the opportunity to examine the impact of working with risk and the strategies that are used to cope with it.

One of the valuable outcomes of the Q-methodological approach is the production of the Q-sort as a research tool. This enables further research that could capture understandings of crisis on a wider scale. It is possible that within a larger sample more factors would emerge and some of the findings noted as idiosyncratic, such as the understandings held by Participant 11, could be further explored. It may be that there is a sub-population of people for whom risk is more central to crisis. If so, further exploration of demographic and contextual information may offer interesting insights.

Furthermore, as discussed in the limitations and clinical implications this research did not examine the impact of time or the number of crises experienced on people's understandings. The Q-sort tool could be a useful way of capturing changing perspectives over time, and how duration and frequency of crisis experiences might influence understandings.

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5. Reflections

This section details my reflections on the research process, namely my development as a scientist practitioner, and my reflections on my own position as a stakeholder of crisis.

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Reflecting on my development as a scientist-practitioner

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The training to become a Clinical Psychologist is influenced by the scientist-practitioner model, which aims to integrate both empirical study and clinical practice into the core role of psychologists. The model has been defined as 'an integrative approach to science and practice wherein each must continually inform the other. This model represents more than a summation of both parts. Scientist-practitioner psychologists embody a research orientation to their practice and practice relevance in their research' (Belar & Perry, 1992, p.72).

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At the start of the project, I perceived a split between my role as a trainee clinician and the requirement to undertake a research project. To some degree I inhabited the scientist-practitioner model; I was comfortable in drawing on research to influence my practice, yet I was less comfortable with the idea of 'being a researcher'. However, clinical training was requiring me to integrate both positions.

As I didn't perceive myself as 'a researcher', I found one of the major challenges was in gaining momentum. I found the beginning of the research process challenging; making decisions and developing study designs, applying for ethical approval and the thought of actually analysing my data felt overwhelming. This led to a slow start and much indecision on my part as regards methodology and study design. Beyond my lack of confidence was a limited understanding of the multitude of ways that the role of psychologist integrates both skill sets. This understanding developed over the course of the project, as explored further in the following reflections.

The use of 'clinical skills' in research

The first way that I felt my clinical skills advanced my development as a researcher was in considering ethical implications and study design when preparing the documents to request ethical approval. I felt my experience as a clinician allowed me a greater awareness of the challenges that participants might face during research in this context, and my understandings of capacity assessments supported the process of informed consent. I was able to reflect on the positioning of staff, as regards maybe the uncertainty of stability within the NHS and some possible suspicion about the level of confidentiality and what their interviews would be used for. I was able to reflect upon my understandings of mental illness, and my clinical experience gave me the skills to be able to identify, respond to and manage risk. As regards the process of qualitative data collection, I was able to draw on knowledge of building rapport, and I used clinical judgement to pace the interviews. I used therapeutic and assessment skills to explore people's experiences of crisis while also being mindful of maintaining a sense of safety, and being respectful and empathic towards their experiences. This is not to say that researchers without clinical training do not attend to these issues, just that it was an area that I felt was benefited by my clinical experience.

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My clinical experience also influenced the analysis of the qualitative data, the interpretation of the quantitative data and decision making processes throughout the research. Whilst analysing qualitative data I reflected on how the process felt like psychological formulation. I wondered to what extent my profession and my theoretical and clinical knowledge were influencing the analysis. Being aware of this influence and being reflective about how this might influence the analytic process and findings was helpful in making my positioning as a scientist-practitioner more explicit, and in recognising both the strengths and limitations that this offered. When interpreting data I found it more difficult to connect meaning to the quantitative data. My clinical experience helped me to reflect on what that would mean in 'real life', what that means for practice. This process enabled me to consider the clinical implications of my findings, both for policy, service provision and clinical practice.

The use of 'research skills' in practice

Similarly, I developed more of an applied sense of how research skills are core to the role of a clinical psychologist. I reflected on my ability to develop a study design that was appropriate for answering the research question, and I was able to apply both qualitative and quantitative analytic methods.

I have been able to apply these skills directly in my clinical practice. Drawing on my experience of constructing appropriate study designs, I was able to think about how I could effectively evaluate my own clinical practice but to conduct service evaluations and clinical audit. I was considering what tools would be useful, again looking at empirical literature to assess the validity and reliability of tools, and applying this information to the clinical setting as regards the limitations of use for the clinical problem, or population.

My developing understanding of crisis, both from my own research from theory and research, directly informed my thinking in clinical practice. Whilst working with looked after children I noticed that placements or foster carers were often described as 'in crisis'. Many decisions and interventions were initiated by social care in a way that was reactive to these 'crisis situations'. I was, therefore, able to draw on my understandings, for example of demands and difficulties exceeding coping resources and fluctuating recovery pathways, to help to make sense of a family's distress. I feel that the

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understanding of crisis as temporal, therefore as having a timescale, helped me to support carers to be present and to sustain the placement due to the reassurance that crises pass. Furthermore, including service users, carers and professionals in the study enabled me to be aware of holding all perspectives and working towards a negotiated understanding of the presenting difficulties.

For clarity, the influence of one position, or skill set, on another is discussed separately; however, in practice, the scientist-practitioner model is a much more integrated process. Therefore, in order to demonstrate this process as it occurred in the current research, an example is offered below.

Integrating both positions in decision making

When analysing the qualitative data, I felt that reducing the data set down to a manageable Q-set proved challenging. I was torn between my original aim to represent the whole concourse in the Q-set, and constructing a Q-set that was manageable in size yet still gave the participants enough scope of meaning within the statements to construct a representation of their subjective understanding. Defining a Q-set would either exchange depth for breadth, or alternatively exchange breadth for depth. I oscillated between 'researcher' and 'clinician' considerations. The observations of the data led me to look to at other empirical findings, in terms of what was less available. Many theories offer breadth (Caplan, 1964) and the understandings from professionals offer breadth (Tobitt & Kamboj, 2011), yet what I felt they lacked was a sense of the raw experience. I thought about the purpose of the Q-set and needing to provide adequate scope of meaning to participants. I then thought about ethical considerations and 'doing justice' to the people who participated in the interviews, and not wanting to disregard parts of their perspectives.

I considered my clinical practice, as regards what I would be considering in assessment and intervention. Breadth is good for determining where difficulties may arise and in considering what recovery might look like. Yet I would also want to understand the experienced distress, what the experience of crisis was like for them. I was considering what I would want or need to know more about as a clinician, what would be helpful for both the clinician, and the service users and carers. This led to the decision to focus the

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Q-set on the 'crisis experience' themes. The process of decision making was influenced by both practice considerations and considerations of empirical research and theory.

Reflecting on my own position as a stakeholder of crisis

My research identified several stakeholders of a crisis. As a Trainee Clinical Psychologist, I was aware that I also belonged within the 'professional' group. Therefore, I was possibly more aligned with this perspective which was something I was mindful of. Furthermore, the interest that led me to a mental health profession and my subsequent training and knowledge acquired were likely to have influenced the development of the research.

I spent some time in the crisis team, building relationships and considering the study design, procedure and the ethical implications required to complete the study protocol. Reflecting on this time, it is likely that my understanding of crisis, and how crisis teams work was likely to have started developing here. Although it is not easy to admit, I had some negative preconceptions of crisis teams that I reflected on in my diary. For example, I reflected that staff understandings would be bound by the arbitrary referral criteria. These preconceptions were not founded, with staff favouring a much wider understanding of crisis and displaying more flexibility and clinical judgement than I had predicted. On reflection, this time would have been well spent as a structured observation using ethnography which, again, could have added to crisis literature.

From a constructivist perspective, it is impossible to escape the influences that may have shaped my own understanding of crisis. As a clinician, it is likely that the interview questions were already guided by my own assumptions and understanding of what a crisis might be and my clinical training and, therefore, my clinical skills, my understandings of mental health, therapeutic approaches and theory and empirical literature. To some extent, the interview schedule assumed a trajectory; it assumed a recovery process and it assumed that there was difference between crises. Therefore, it would be naïve to propose a neutral position as a researcher. The benefit of a Q-methodological approach was that it generated some unexpected and idiosyncratic findings that possibly would not have been observed through the lens of my experience and influences. Furthermore, on reflection the interview schedule referred to the terms 'mental health crisis'. It is possible that this terminology could have influenced some

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use of use of mental health discourse within the data. The presence of the term ‘mental health crisis’ and the later shift to a preference for crisis reflects my own growth of understanding about crisis through the process of the research. This also reflects my professional position, and my assumed links between crisis and mental illness. It is interesting to reflect on my own position, particularly in the knowledge that I was unaware of this in the beginning. I have never particularly thought of myself as being influenced heavily by the medical model; however, this reflection brought awareness to the language that I use in clinical practice. In retrospect, the word crisis would have been sufficient and would have reflected a more balanced position.

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Appendix A: Journal submission guidelines

Instructions for Authors: Community Mental Health Journal

Manuscript Submission

Authors should submit their manuscripts online. Electronic submission substantially reduces the editorial processing and reviewing times and shortens overall publication times. Please follow the hyperlink "Submit online" on the right and upload all of your manuscript files following the instructions given on the screen. http://comh.edmgr.com

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Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

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• Use italics for emphasis
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All studies must be approved by human subjects committees (also known as institutional review boards). At the end of the Methods section, authors must state which human subject committee (institutional review board) approved the study.
The title page should include:
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Limit Articles to 16 pages of text, exclusive of references, tables, and figures. Brief Reports should be no longer than 10 pages of text, and should not include any tables or figures.
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References

List alphabetically, adhering strictly to APA style (Publication Manual of the American Psychological Association, 4th or 5th edition). Authors are responsible for providing accurate references.

Appendix B: Research Protocol



What is a mental health crisis?

The identification of subjective constructions of 'mental health crisis' in crisis services; feasibility of a Q-methodology approach.

Final version 2.0

02/07/2015

Short title: *What is a mental health crisis?*

IRAS Project ID: *152512*

Study Sponsor: University of Nottingham

Sponsor reference: *14112*

Funding Source: *University of Nottingham*

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Study Coordinating Centre:	Faculty of Medicine and Health Sciences

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SYNOPSIS

Title	What is a mental health crisis? The identification of subjective constructions of 'mental health crisis' in crisis services; feasibility of a Q-methodology approach.
Short title	What is a mental health crisis?
Chief Investigator	Thomas Schroder
Objectives	One: explore and identify the constructions of a mental health crisis, both in existing literature and in interviews with mental health professionals, service users and carers. Two: Develop a Q set that reflects the Q-concourse around 'mental health crisis'. A Q-set refers to a set of statements that reflect the Q-concourse (understandings of mental health crisis). Three: undertake a feasibility study using the Q-set that further identifies emerging constructions and establishes the usefulness of the tool for further research.
Study Configuration	The study will use an exploratory cross sectional design to investigate the constructions of mental health crisis within an adult mental health service. The study will use Q-methodology, and will consist of two phases. The researcher will also take an ethnographic stance to the research, using observation and reflections whilst learning about mental health crisis and crisis intervention. Phase I: Assembly of the initial Q-concourse (information and understandings of crisis) by searching existing literature and conducting one to one interviews. The statements to be included in the Q-set (set of statements about crisis) will be generated by the researchers and pre-existing university

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	based steering group. Phase II: A pilot of the Q-sort procedure and analysis to determine feasibility of Q-methodology.
Setting	Mansfield and Ashfield Crisis Resolution Home Treatment Team (CRHT) have agreed to support the research and aid sampling. This is conditional to ethical and trust approval.
Number of participants	Phase I: Estimated 10-20 one to one interviews. Phase II: estimated 10-30.
Eligibility criteria	Participants must be over the age of 18. Must be either: • A mental health professional working within a crisis team • A mental health professional who has referred a client to a crisis team • A service user who has previously accessed crisis services or identified themselves as being in crisis • A relative/carer of a service user who has previously accessed crisis services or identified themselves as being in crisis. Must be able to communicate in English. Service users **must not** be experiencing a current mental health crisis.
Description of interventions	This study is an observational study. The researcher will take an ethnographic stance as she becomes associated with the crisis team; through systematic observation and reflections on meetings and discussions within the team. Phase I: 20-30 minute one to one semi structured interviews.

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	Phase II: administration of the Q-sort procedure using the developed Q-set. The Q-sort procedure involves ranking statements about crisis according to how alike or not alike they are to the persons understanding of crisis.
Duration of study	This study will take place over a one year period. Proposed hand in date January 2016. Phase I: Participants will take part for a maximum of 70 minutes Consent procedures – up to 30 minutes Interview – up to 30 minutes Debrief – 5-10 minutes Phase II: Participants will take part for a maximum of 100 minutes Consent procedures – up to 30 minutes Q-sort procedure – up to 60 minutes Debrief – 5-10 minutes
Methods of analysis	Phase I: Data will be analysed using thematic analysis. A pre-existing university based steering group will be used to generate the final Q-set. Phase II: Analysis will follow the method proposed by Stephenson (1953) and McKeown and Thomas (1988), which is a manner akin to factor analysis. This method of analysis is in line with existing research using Q-methodology (McIntosh, Westbrook, Sheldrick, Surr & Hare, 2012; Butler, Hare, Walker, Wieck & Wittkowski, 2014). Q methodology permits people to give self-referent accounts. Data is analysed by person, rather than by tests, which allows subjective viewpoints to emerge from the data. This method will highlight commonalities or discrepancies between constructions of mental health crisis between participants.

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ABBREVIATIONS

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CI Chief Investigator overall

CRF Case Report Form

GCP Good Clinical Practice

NHS National Health Service

PI Principal Investigator at a local centre

PIS Participant Information Sheet

REC Research Ethics Committee

R&D Research and Development department

UoN University of Nottingham

CRHTs Crisis Resolution Home Treatment Teams

CMHTs Community Mental Health Teams

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STUDY BACKGROUND INFORMATION AND RATIONALE

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Crisis resolution teams (CRHTs) aim to provide the best treatment in the least restrictive environment and therefore advocate for home treatment where possible. CRHTs are multidisciplinary teams that deliver 24 hour support for people whom without support would require admission to hospital. They work in partnership with Community Mental Health Teams (CMHT's) providing rapid assessments, intensive monitoring, and frequent visits. Since their introduction in to the National Health Service (NHS) over a decade ago they have become available in all trusts across the country.

CRHTs were developed to deinstitutionalize mental health services. Vast numbers of psychiatric beds were reduced and a movement began towards home treatment. Detailed history and development of CRHTs is well documented (Johnson, 2013). Johnson, Needle, Bindman and Thornicroft (2008) conducted interviews with various leading professionals in the home treatment movement and outline key values underpinning CRHTs. CRHTs have a fundamental basis on ethical principles of respect for the dignity and autonomy of people with mental illness (Johnson *et al.* 2008, p.69). Home treatment options developed when people started to observe the negative impact of hospital admission, and the importance of social environments on the development of mental health crisis (Querido, 1968). Johnson et al. (2008) review the negative effects associated with hospital admissions such as loss of employment and status, and describe being hospitalized as alienating and unpleasant with damaging associated stigma. Also, they note that people are often dissatisfied with hospital admission. Due to the 'very large role' that social and family difficulties have on developing a crisis, community treatment is thought to give service users a chance to develop skills and insights in the context they are to be applied. Research has shown that this improves efficiency (Stein, 1980). Despite findings eluding to an overarching preference for home treatment this is not always the case. Some qualitative inquiries of service user perspectives highlight a preference for hospitalisation in some circumstances, and the benefits that this can have for carers and children (Khalifeh *et al.* 2009; Mind, 2011). This relates mostly to when a home context is contributing to the crisis, there are fears of risk to self or others, and when family members and children experience distress.

Despite much research and evidence for the treatment of mental health crisis at home, the definition of mental health crisis has been somewhat overlooked. In attempting to define mental health crisis Johnson *et al.* (2008) highlighted a conflict between definitions of psychosocial crisis and psychiatric emergencies. Psychiatric emergencies are situations in the context of mental health illness which need immediate action due to high risk. In contrast, psychosocial crisis is a common human response to psychosocial stressors, and not a manifestation of illness. Johnson *et al.* (2008) highlight that in CRHTs the boundaries between psychiatric emergencies and psychosocial crises are

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ambiguous, and they often co-occur. It is common for psychiatric emergencies to be preceded by psychosocial stressors and difficulties coping (Jones & Polak, 1968). Therefore it seems mental health crisis encapsulates both of these terms to some degree.

UK policy guidance instructs that CRHTs be available to people aged 16-65, with severe mental illness and 'with an acute psychiatric crisis of such severity that without involvement (of CRHTs), hospitalisation would be necessary (p.11, Department of Health, 2001). This definition does not add to an understanding of crisis, and its usefulness to clinicians and referrers is therefore limited. Attempts to define crisis and establish CRHT in a firm theoretical basis have been overlooked. CRHT policy and literature make little reference to complex conceptual difficulties. Whilst some propose the application of Crisis Theory to mental health settings is useful (Bridgett & Polak, 2003) others argue it is inappropriate (Ball, Links, Strike, & Boydell, 2005; Brennaman 2012). Due to the theoretical disputes, and the lack of empirical study into the concept of crisis in mental health settings remains ambiguous.

Recent research has begun to explore how the concept of crisis is understood in mental health settings. Tobitt & Kamboj (2011) investigated the understandings of professionals working in CRHTs. Analysis highlighted several origins of crisis, and factors regarded as identifying someone as 'in crisis' or not. Author's recommended further improvements to the clarity of the definition, would benefit communication with referrers and enable a better judgement of outcome. Clinical observations also reflect this. Clinicians discussed the ambiguity of the term, that 'crisis means different things in different areas' (M. Louwrens, personal communication, February 14, 2014) and is 'a term that is used a lot but is not necessarily clear about what it means' (L. Ball, personal communications, February 13, 2014) as well as the difficulties associated with receiving inappropriate referrals.

Current definitions are based largely on referral criteria for crisis services, which although necessary, neglects the voices and experiences of service users. During an interview with Dr Patrick Bracken, a former psychiatric consultant for home treatment, he stated 'the priority in our involvement with people is respect and dignity, how people view themselves, their thoughts, how they define what's happening to them' (Johnson et al. 2008, p70). There has been movement towards service user involvement in services, and involving service users in defining their own experiences of crisis is thought to be an important avenue for research. The inclusion of service users, staff members and carers allows attention to be given to the various stakeholders involved in identifying an experience a 'crisis', and the different perspectives are thought to offer a unique contribution to the definition of a crisis. This research aims to begin to develop an understanding of what a mental health crisis is from the perspectives of the people who experience it, both directly and indirectly.

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STUDY OBJECTIVES AND PURPOSE

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PURPOSE

The purpose of the study is to explore the constructions of a mental health crisis.

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PRIMARY OBJECTIVE

The primary objective of this study is to begin to develop a deeper understanding of the constructions of mental health crisis from the perspectives of service users, carers and mental health professionals, in order to contribute to an operationalised definition of mental health crisis.

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SECONDARY OBJECTIVES

The secondary objectives are:

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- To develop a set of statements (Q-set) representative of the Q-concourse of mental health crisis. A Q-set refers to a set of statements that reflect the Q-concourse (understandings of mental health crisis)
- To administer the Q-sort procedure, explore the taxonomy of shared subjective constructions and variations within the responses. The Q-sort procedure involves ranking statements about crisis according to how alike or not alike they are to the persons understanding of crisis.

- Establish feasibility of Q-methodology as a tool to explore constructions of mental health crisis. Q Methodology is a research method used to study subjective viewpoints. Analysis reflects an individual's understanding of a subject, and looks for correlations between the way different participants understand the subject.

STUDY DESIGN

STUDY CONFIGURATION

The study will use a cross-sectional design to investigate how service users, carers and professionals construe a mental health crisis. The study will gather the Q-concourse from existing literature and one to one interviews with participants. From this, a Q-set will be developed piloted to determine if Q-methodology is a feasible way of developing understanding of the phenomena on a larger scale. The study will take place in the Mansfield and Ashfield Crisis Team as well as services that refer to this crisis team and local carer groups.

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STUDY MANAGEMENT

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The Chief Investigator has overall responsibility for the study and shall oversee all study management.

The data custodian will be the Chief Investigator.

The researcher will collect and analyse data. They will also produce written reports of study outcomes as part of the Doctorate in Clinical Psychology.

DURATION OF THE STUDY AND PARTICIPANT INVOLVEMENT

Study Duration: Enrolment will begin once ethical and trust approval has been granted. This is expected to be January/February 2015. The study will end in January 2016, when it will be submitted for assessment.

Participant Duration:

Phase I: Participants will be participating in this phase for approximately 70 minutes.

Consent procedures – up to 30 minutes

Interview – up to 30 minutes

Debrief – 5-10 minutes

Phase II: Participants will be participating in this phase for approximately 100 minutes.

Consent procedures – up to 30 minutes

Q-sort procedure – up to 60 minutes

Debrief – 5-10 minutes

End of the Study

The end of the study will be the last Q-sort of the last participant. It is expected that this will be approximately July/August 2015.

SELECTION AND WITHDRAWAL OF PARTICIPANTS

Recruitment

NHS recruitment

Participants will be recruited from Mansfield and Ashfield Crisis Team and referring Community Mental Health Teams. This setting is appropriate as it allows the researcher to access participants from staff groups as well as service users. In line with Q-methodology research maximum variation sampling will be used to access diversity in points of view. Therefore participants will be recruited from various sub-sets described below. The approach to recruitment will be equivalent in each phase of research, but will vary between participant groups. Both phases will include participants from each group; staff, service users and carers.

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Mental Health Professionals

The researcher has made links with the CRHT team and CMHT based at [redacted] Mental Health Unit, [redacted]. The teams are willing to support the research (subject to ethical and trust approval). The researcher is currently training in Clinical Psychology (Trent Doctorate Programme). The links were made while the researcher was working on an adult mental health placement (in a neighbouring trust). The team was recommended as a suitable crisis team due to it being a stable team (regarding staffing levels) and Dr. Lisa Ball (Clinical Psychologist) expressed an interest in supporting research. The researcher will promote the research via a presentation at team meetings. Staff will be asked within the meetings to express interest in participation, and contact details will be taken to arrange interviews. All staff that refer to crisis teams, or experience of working within a crisis team will be approached to take part in the research.

Service Users

The initial approach will be from a member of the patient's usual care team. The researcher will not approach participants initially. Participants will be asked to express interest to the member of their care team. Only then will they be approached by the investigator.

This study specifically focuses on service users, as well as carers and mental health professionals. Service users who may have experienced a mental health crisis may be considered a vulnerable group. It is considered necessary to include service users in the study, so as their perspectives and experiences can be understood along with those professionals and carers. Gaining an understanding of how service users understand their previous mental health crisis may help to identify differences in the understandings of a mental health crisis. This could identify ways of improving services in the future.

Relatives/Carer's

There are a number of carers groups within the area that will be approached to take part in the research. The researcher has been in contact with the Mansfield and Ashfield Carer Support Group (Contact: Peter Robinson) and Nottinghamshire Carers Alliance (Contact: Judith Machin), who are keen to support the research subject to ethical approval. Service users who take part will also be asked to identify relatives and carer's who may be interested in participating.

The researcher will inform the participant of all aspects pertaining to participation in the study.

If needed, the usual hospital interpreter and translator services will be available to assist with discussion of the trial, the participant information sheets, and consent forms, but the consent forms and information sheets will not be available printed in other languages.

It will be explained to the potential participant that entry into the study is entirely voluntary and that their treatment and care will not be affected by their decision. It will also be explained that they can withdraw at any time but attempts will be made to avoid

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this occurrence. In the event of their withdrawal it will be explained that their data collected so far cannot be erased and we will seek consent to use the data in the final analyses where appropriate.

Third sector organisation recruitment
Recruitment will also take place in a third sector organisation called 'Self-help services'. This organisation has developed a crisis service called 'The Sanctuary' which offers support from professionals and volunteers with personal experiences of crisis. The Chief Executive of the organisation, Nicky Lidbetter, contacted the researcher due to their interest in participating. Recruitment will take place at the service located in Manchester. This service offers a different viewpoint to the research, as many service users are classified as not meeting criteria for CRHTs, and this service was set up in hope to fill this gap in service provision.

Staff
The chief executive, Nicky Lidbetter, will promote the research during a team meeting. Staff will be asked within the meetings to express interest in participation. Interviews will then be arranged via Nicky Lidbetter, but will be conducted by the researcher Kerry Davies in accordance to the protocol for all data collection.

Volunteers
In this service the volunteers who offer support have previously experienced their own crisis. This personal experience is considered vital to the Sanctuary model. Volunteers will recruited in the same manner as staff, due to their attendance at staff meetings.

Service Users
Current service users of the Sanctuary WILL NOT be asked to participate due to ethical considerations. However the Sanctuary has pre-existing anonymised data and consent to use this data in research. This data comes from a brief assessment of service users reasons for coming to the service.

Retention
The researcher will endeavour to promote retention of participants by promptly arranging appointments and offering appointments to suit participant's preferences and circumstances. Retention problems are not foreseen due to the study requiring one off participation. Participants take part in either phase of the research, independently from the other phase. There is no requirement to take part in both phases.

Eligibility criteria

Inclusion criteria

Mental Health Professionals	Service users	Carers
Have experience of referring	Have experienced a	Have a relative or loved

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to or working in a CRHT team	previous mental health crisis	one who has experienced a previous mental health crisis
Must be ages 18 – 65	Must be ages 18 – 65	Must be ages 18 – 65
Must be able to read and comprehend English language	Must be able to read and comprehend English language	Must be able to read and comprehend English language
Ability to give informed consent	Ability to give informed consent	Ability to give informed consent

The decision to include only participants over the age of 18 was made due to the research and development of CRHTs related to working age adults (18-65) (Johnson *et al,* 2008). Due to the research being based at a CRHT it is unlikely that it would attract any participants out of this age range. This is not to say that people outside of this age range do not experience mental health crises, yet including other populations was considered to be outside the scope of this individual research project.

Exclusion criteria

People experiencing a current mental health crisis.

Justification: People experiencing a current mental health crisis will be excluded as participation may adversely impact on their mental health. Experiencing a current mental health crisis may also impact on the ability to reflect on the experience. It is probable that some individuals when experiencing a mental health crisis would not have capacity to consent. Taken together these considerations influenced the decision not to include people experiencing a current mental health crisis.

Expected duration of participant participation

Phase I: Study participants will be participating in the study for a maximum of 70 minutes
Consent procedures – up to 30 minutes

Interview – up to 30 minutes

Debrief – 5-10 minutes

Phase II: Study participants (staff/service users/carers) will be participating in the study for a maximum of 100 minutes
Consent procedures – up to 30 minutes

Q-sort procedure – up to 60 minutes

Debrief – 5-10 minutes

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Participant Withdrawal

Participants may be withdrawn from the study either at their own request or at the discretion of the Investigator. The participants will be made aware that this will not affect their future care. Participants will be made aware (via the information sheet and consent form) that should they withdraw the data collected to date cannot be erased and may still be used in the final analysis.

Informed consent

Participants will be asked to opt-in to the study after reviewing the information about it given via their usual care team. All participants will provide written informed consent. The Consent Form will be signed and dated by the participant before they enter the study. The researcher will explain the details of the study and provide a Participant Information Sheet, ensuring that the participant has sufficient time to consider participating or not. The researcher will answer any questions that the participant has concerning study participation.

Informed consent will be collected from each participant before they undergo any interventions related to the study. One copy of this will be kept by the participant, one will be kept by the Investigator.

The investigators current training in clinical psychology assists with the consideration of informed consent, due to attending teaching on conducting ethical research, and other clinically relevant aspects such as capacity to consent. Advice from the Chief investigator will be sought when it is unclear if the participant has capacity to consent. Consideration will be given to the participants understanding of the purpose and nature of the research, the benefits and risks it may present, and the alternatives to taking part. Questions will be asked to ascertain if the participant can retain the information given, and consideration will be given to if they are capable at the time of participation to make that choice.

Should there be any subsequent amendment to the final protocol, which might affect a participant's participation in the study, continuing consent will be obtained using an amended Consent Form which will be signed by the participant.

STUDY REGIMEN

All procedures listed are not part of usual care, therefore are additional for the purpose of research.

Attendance at meetings to promote research: As the researcher will observe meetings and discussions within the team in the process of the research. She will make note of her observations and reflections, specifically relating to her own development of a definition of crisis. This phase is designed to contribute to the development of the Q-concourse as the researcher will be mindful of her own influence on data collection.

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This will also inform quality management in the analysis phase by identifying any preconceived ideas or biases of the investigator.

Phase I: A series of semi structured one to one interviews with service users, staff, referrers and carers.

- Informed consent will be obtained.
- Interview will be conducted by the researcher for approximately 30 minutes (see interview schedule).
- Interviews will be conducted on NHS premises, or the participant's home.
- Interviews will be audio recorded by the investigator.
- The researcher will conduct some transcribing, but transcription services will also be employed.
- All recordings will only be labelled with study numbers (no personally identifiable data)
- Recordings will be stored along with other source data in study archives. .

Phase II: Q-Sort procedure. The Q-sort procedure involves ranking statements about crisis according to how alike or not alike they are to the persons understanding of crisis. Rankings are recording and form the data to be analysed.

- Informed consent will be obtained
- The researcher will talk through the set of instructions (unless the participant would like to complete the task alone, in which case written instructions will be provided)
- Participants will be instructed to read each statement
- They will be asked to put the statements into three piles – 'most like', 'neutral' and 'least like'.
- Participants will be instructed to order/rank the statements according to how alike, or not alike a mental health crisis they are
- Participants will record their responses on a predetermined response sheet. See file 'response sheet'.

The researcher will discuss the debrief sheet with all participants.

Compliance

Acceptable compliance will be determined by completing an interview, or by completing the Q-sort task. Compliance will not be assessed regarding length of interview. Only completed Q-sort tasks will be included in analysis.

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Criteria for terminating the study

Phase I: Recruitment will end when interviews cease to add new perspectives to the data, or when the maximum number of interviews within the range considered feasible for the study (20) is reached.

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Phase II: Recruitment is estimated to cease by July/August 2015. As this phase is a feasibility study there is no required number of participants set, although the aim is to recruit between 10-30 participants.

The study will end in January 2016 when it will be submitted for assessment.

ANALYSES

Methods

Q methodology has been chosen because it generates diverse accounts of something that is not easily pre-defined, and can give insight into multiple perspectives of the phenomena which is important in crisis as there are many people involved with vested interests in the assessment. A purely qualitative approach was initially considered, nonetheless Q methodology has been chosen above other methods, because it maintains the benefits of openness to subjective accounts but combines this with more precise mapping of various accounts rather than finding convergent accounts as with other methodologies. This will allow the research to highlight various patterns of construing, with areas that may conflict or compliment. Baker, Thompson and Mannion (2006) suggest Q methodology is a useful approach for unfamiliar areas in health research as it combines 'eliciting structure from complex data whilst remaining mindful of subjectivity and personal interpretation' (p.18). It allows unexpected and potentially counterintuitive accounts to emerge. Semi-structured interviews will be included in the development of Q-concourse phase to supplement the limited amount of published work that directly addresses the research question. It was considered that this would result in a better quality Q-sort tool which could then be used in future research on a larger scale if feasible.

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The researcher will analyse all data. Mike Rennoldson and Thomas Schroder will oversee analysis.

Phase I: Thematic analysis will be structured using the six phase process outlined by Braun & Clark (2006). The transcripts will be read several times to develop familiarity and to allow similarities and differences to become apparent. Salient statements that represent mental health crisis will be coded, and then will be grouped into relevant themes/domains. The labelling and definition of the themes will be completed subsequent to Q-sort procedures and factor analyses. Transcription and thematic analysis will be undertaken at the investigators home, as no personally identifiable information will be included.

Statement selection

The following principles will be applied to statement selection:

· Duplications of statements will be removed.

· Examined for relevance

· Intelligibility

· Similarity with other statements

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Akin to the TA process statements will be grouped in to similar themes/domains. Statement phrasing will be based on the guidance outlined by Donner (2001).

Statement relevance and selection will be determined by the research steering group. This is expected to take no longer than two hours.

Phase II
Exploratory factor analysis as highlighted by Fabrigar and Wegener (2012) will be followed using SPSS computer package. The factors that emerge will indicate shared subjective viewpoints of mental health crisis. Factor interpretation is a hermeneutic process, to some extent remaining open and subjective. Analysis will be undertaken by the investigator. Data will be analysed on UoN computers.

Sample size and justification

Phase I

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It is estimated that 10-20 participants will interviewed in person or via the telephone. Maximum variation sampling will be used to elicit diversity of viewpoints, rather than aiming on a specific number of participants the concept of saturation will govern when data collection will cease. Saturation occurs when the diversity of sampling is exhausted and no new contributions are being made to the concourse.

Phase II

In Q methodology sample size is ultimately related the collection of a diverse range of viewpoints, and not to reflect any level of frequency in general populations. Willig and Stainton-Rogers (2007) suggests that a sample size of between 40-60 participants is typical, although with Q methodology small sample sizes, including single case studies, have been shown to be psychometrically acceptable (McKeown & Thomas, 1988). Due to this phase of research being intended to test feasibility of Q-methodology there is no specified limits for sample size, the researcher will conduct between 10-30 Q-sorts for this phase.

ADVERSE EVENTS

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The occurrence of an adverse event as a result of participation within this study is not expected and no adverse event data will be collected. Sensitive issues may be discussed within the interviews and statements will relate to previous adverse experiences. The researcher is equipped with skills to manage risk and distress due to current training and experience in clinical psychology. Involvement of service users usual care team in recruitment will ensure all participants have support available to them. Giving full information about the nature of the study and using an opt-in process will endeavour to attract participants who feel safe in discussing their mental health. In the event of distress participants will be signposted to their care team as well as national helpline numbers. In the event of disclosing risk to self or others Care teams and other relevant

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professionals will be informed, as deemed necessary by the researcher and the Chief investigator.

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ETHICAL AND REGULATORY ASPECTS

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Discussing distressing events.

It is possible that discussing previous experiences of crisis may cause some upset/distress. The risk may be increased by talking to someone new about these experiences, as opposed to a care provider whom participants have an established relationship with. Conversely, having no previous relationship with participants is thought to influence their responses less and will serve to ease concerns that their care after participation could be affected. The researcher will gain informed consent prior to participation, which is thought would enable some level of rapport building.

The risk will be discussed with clients during the process of gaining informed consent. It was considered that the risk of distress was minimised by asking participants to identify to their care team if they would like to take part, rather than being approached by the investigator. This would be more likely to attract participants who are willing to discuss their crisis It was considered that a shorter interview of 30 minutes, focused tightly on questions pertaining to crisis, would provide adequate depth of data whilst minimising the length of time the participant has to spend discussing potentially distressing events. All participants will be identified by their care team. This will make the care team aware of participation, should the participant contact for support or experience any adverse effects. The debrief sheet will be discussed after participation. It highlights where participants can go for support should they experience any adverse effects.

Breach of confidentiality due to risk of harm

It is possible that when talking about previous crisis participants may disclose current thoughts or feelings that indicate they could be at risk of harm. These could be thoughts/feelings that were previously unknown to other care professionals. In this case confidentiality may have to be broken to ensure the safety of the participant or other people. Asking care teams to identify people with previous experiences of crisis, yet not in current crisis, may help to reduce this risk. However it is acknowledged that this may occur.

The researcher is a Trainee Clinical Psychologist who has experience in both assessing risk of harm and also in discussing this with service users/ highlighting this to necessary clinicians to ensure safety. If such a disclosure is made, participation in the interview will stop. The researcher will discuss the need to breach confidentiality with the participant should this occur, unless doing so could raise risk to themselves or others. The researcher also has contact with the Chief Investigator to discuss concerns, as well

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as Dr. Lisa Ball, Clinical Psychologist, Mansfield and Ashfield Crisis Team. The researcher has attended safeguarding training and will therefore be in a good position to identify any concerning disclosures and act on them accordingly.

Lone Working

When interviews/Q-sort task is completed in the participant home the UoN Lone Working Policy will be adhered to.

ETHICS COMMITTEE AND REGULATORY APPROVALS

The study will not be initiated before the protocol, consent forms and participant information sheets have received approval / favourable opinion from the Research Ethics Committee (REC), and the respective National Health Service (NHS) Research & Development (R&D) department. Should a protocol amendment be made that requires REC approval, the changes in the protocol will not be instituted until the amendment and revised informed consent forms and participant information sheets have been reviewed and received approval / favourable opinion from the REC and R&D departments. A protocol amendment intended to eliminate an apparent immediate hazard to participants may be implemented immediately providing that the REC are notified as soon as possible and an approval is requested. Minor protocol amendments only for logistical or administrative changes may be implemented immediately; and the REC will be informed.

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The study will be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social care, 2005.

INFORMED CONSENT AND PARTICIPANT INFORMATION

The process for obtaining participant informed consent will be in accordance with the REC guidance, and Good Clinical Practice (GCP) and any other regulatory requirements that might be introduced. The researcher and the participant shall both sign and date the Consent Form before the person can participate in the study.

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Participants will be asked to opt-in to the study after reviewing the information about it given via their usual care team. All participants interviewed in person will provide written informed consent. Transcribed consent will be treated in the same way as written. Informed consent will be obtained for interviews and separately for the Q-sort task.

The participant will receive a copy of the signed and dated forms and the original will be retained in the Study records.

The decision regarding participation in the study is entirely voluntary. The researcher shall emphasize to them that consent regarding study participation may be withdrawn at any time without penalty or affecting the quality or quantity of their future medical care,

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or loss of benefits to which the participant is otherwise entitled. No study-specific interventions will be done before informed consent has been obtained.

If the Consent Form is amended during the study, the researcher shall follow all applicable regulatory requirements pertaining to approval of the amended Consent Form by the REC and use of the amended form.

RECORDS

Case Report Forms

All documents collected during the study will be treated as confidential documents and held securely in accordance with regulations and will be restricted to those personnel approved by the Chief Investigator.

Each participant will be assigned a study identity code number for use on forms and the electronic database. All forms, tapes and response sheets will be treated as confidential documents and held securely in accordance with regulations. The researcher will make a separate confidential record of the participant's name and contact details if they would like feedback on the study. All paper forms will be legible and will be filled in using black ballpoint pen. Errors shall be lined out but not obliterated by using correction fluid and the correction inserted, initialled and dated.

The Chief or local Investigator shall sign a declaration ensuring accuracy of data recorded in the record forms.

Source documents

Source documents shall be filed at the investigator's site and may include but are not limited to, consent forms, study records, field notes, interview transcriptions and audio records. A CRF may also completely serve as its own source data. Only study staff shall have access to study documentation other than the regulatory requirements listed below.

Direct access to source data / documents

The CRF and all source documents shall made be available at all times for review by the Chief Investigator, Sponsor's designee and inspection by relevant regulatory authorities.

DATA PROTECTION

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All study staff and investigators will endeavour to protect the rights of the study's participants to privacy and informed consent, and will adhere to the Data Protection Act, 1998. The CRF will only collect the minimum required information for the purposes of the study. CRFs will be held securely, in a locked room, or locked cupboard or cabinet. Access to the information will be limited to the study staff and investigators and any relevant regulatory authorities (see above). Computer held data including the study database will be held securely and password protected. All data will be stored on a secure dedicated web server. Access will be restricted by user identifiers and passwords (encrypted using a one way encryption method).

Electronic data will be backed up every 24 hours to both local and remote media in encrypted format.

Each participant will be assigned a study identity code number for use on all documents and the electronic database. No NHS case notes will be accessed by the investigator. All documents will only collect the minimum required information for the purposes of the trial. Documents will be held securely, in a locked room, in a locked cupboard or cabinet. Access to the information will be limited to the study staff and investigators and any relevant regulatory authorities. All access to CRFs will be on authorisation by the Chief Investigator only. The researcher will make a separate record of contact information should the participants request feedback of study outcomes, or should they wish to participate in a later phase. These records will be securely held at the University of Nottingham. It will be highlighted that disclosures during interviews relating to risk will have to be shared in order to protect the participant and others.

Computer held data will be held securely and password protected. Only the investigator, and study staff approved by the Chief Investigator will have access to the database. All data will be stored on a secure dedicated web server.

Professional transcription services recommended by UoN will be used to assist with transcription. A confidentiality for transcriber agreement will be obtained prior to transcription. Recordings will be labelled with the identity code number only.

Transportation of data

It is unavoidable that some data containing personally identifiable information will require transportation. Due to conducting consent/interviews/Q-sort on NHS premises or service user/carer homes the documents will need to be transported to the University of Nottingham for storage. The researcher will personally transport all study documents and transcripts by car.

QUALITY ASSURANCE & AUDIT

INSURANCE AND INDEMNITY

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Insurance and indemnity for clinical study participants and study staff is covered within the NHS Indemnity Arrangements for clinical negligence claims in the NHS, issued under cover of HSG (96)48. There are no special compensation arrangements, but study participants may have recourse through the NHS complaints procedures.

The University of Nottingham as research Sponsor indemnifies its staff, research participants and research protocols with both public liability insurance and clinical trials insurance. These policies include provision for indemnity in the event of a successful litigious claim for proven non-negligent harm.

STUDY CONDUCT

Study conduct may be subject to systems audit for inclusion of essential documents; permissions to conduct the study; CVs of study staff and training received; local document control procedures; consent procedures and recruitment logs; adherence to procedures defined in the protocol (e.g. inclusion / exclusion criteria, timeliness of visits); accountability of study materials and equipment calibration logs.

The Study Coordinator/Academic Supervisor, or where required, a nominated designee of the Sponsor, shall carry out a site systems audit at least yearly and an audit report shall be made.

STUDY DATA

Monitoring of study data shall include confirmation of informed consent; source data verification; data storage and data transfer procedures; local quality control checks and procedures, back-up and disaster recovery of any local databases and validation of data manipulation. The Study Coordinator/Academic Supervisor,, or where required, a nominated designee of the Sponsor, shall carry out monitoring of study data as an ongoing activity.

Entries on CRFs will be verified by inspection against the source data. A sample of CRFs (10% or as per the study risk assessment) will be checked on a regular basis for verification of all entries made. In addition the subsequent capture of the data on the study database will be checked. Where corrections are required these will carry a full audit trail and justification.

Study data and evidence of monitoring and systems audits will be made available for inspection by the REC as required.

RECORD RETENTION AND ARCHIVING

In compliance with the ICH/GCP guidelines, regulations and in accordance with the University of Nottingham Code of Research Conduct and Research Ethics, the Chief or local Principal Investigator will maintain all records and documents regarding the conduct of the study. These will be retained for at least 7 years or for longer if required.

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If the responsible investigator is no longer able to maintain the study records, a second person will be nominated to take over this responsibility.

The study documents held by the Chief Investigator on behalf of the Sponsor shall be finally archived at secure archive facilities at the University of Nottingham. This archive shall include all anonymised audio recordings, study databases and associated meta-data encryption codes.

DISCONTINUATION OF THE STUDY BY THE SPONSOR

The Sponsor reserves the right to discontinue this study at any time for failure to meet expected enrolment goals, for safety or any other administrative reasons. The Sponsor shall take advice as appropriate in making this decision.

STATEMENT OF CONFIDENTIALITY

Individual participant medical or personal information obtained as a result of this study are considered confidential and disclosure to third parties is prohibited with the exceptions noted above.

Participant confidentiality will be further ensured by utilising identification code numbers to correspond to treatment data in the computer files.

Such medical information may be given to the participant's medical team and all appropriate medical personnel responsible for the participant's welfare.

If information is disclosed during the study that could pose a risk of harm to the participant or others, the researcher will discuss this with the CI and where appropriate report accordingly.

Data generated as a result of this study will be available for inspection on request by the participating physicians, the University of Nottingham representatives, the REC, local R&D Departments and the regulatory authorities.

PUBLICATION AND DISSEMINATION POLICY

Participants will be asked if they would like to receive a summary of the findings, if so they will be sent this individually using the contact information they supplied during the consent procedure. Reports will also be sent to the participating teams in Nottinghamshire healthcare NHS trust. Further dissemination will be negotiated with the participating trust, regarding presentation at meetings if required. I also intend to submit this research to a British Journal. Participants will not be identified in any publications.

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USER AND PUBLIC INVOLVEMENT

Dave Barber (Service User and Carer Advisory Panel, SUCAP, member) will act as a consultant to the project. Dave Barber has consulted with the development of the research idea and proposal, he will also be involved in the development of the interview schedule, statement selection and piloting of the Q-sort.

STUDY FINANCES

Funding source

The study is funded as part of the Doctorate in Clinical Psychology.

Participant stipends and payments

Participants will not be paid to participate in the study.

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SIGNATURE PAGES

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Signatories to Protocol:

Chief Investigator: (name)_____

Signature:_____

Date: _____

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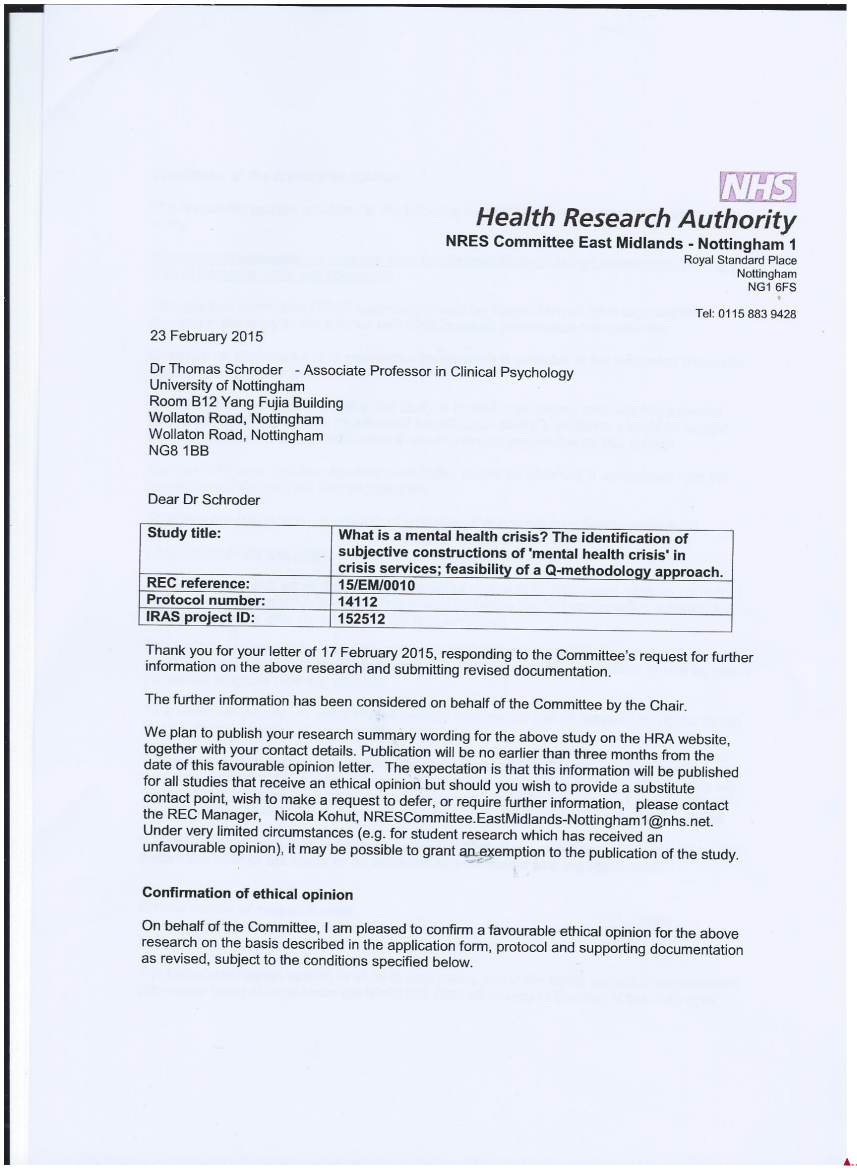
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Appendix C: Ethical approvals (including amendments)

Ethical Approval from NRES

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NHS
Health Research Authority
NRES Committee East Midlands - Nottingham 1
Royal Standard Place
Nottingham
NG1 6FS

Tel: 0115 883 9428

23 February 2015

Dr Thomas Schroder - Associate Professor in Clinical Psychology
University of Nottingham
Room B12 Yang Fujia Building
Wollaton Road, Nottingham
Wollaton Road, Nottingham
NG8 1BB

Dear Dr Schroder

Study title:	**What is a mental health crisis? The identification of subjective constructions of 'mental health crisis' in crisis services; feasibility of a Q-methodology approach.**
REC reference:	**15/EM/0010**
Protocol number:	**14112**
IRAS project ID:	**152512**

Thank you for your letter of 17 February 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Nicola Kohut, NRESCommittee.EastMidlands-Nottingham1@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see

"Conditions of the favourable opinion" below).

Non-NHS sites

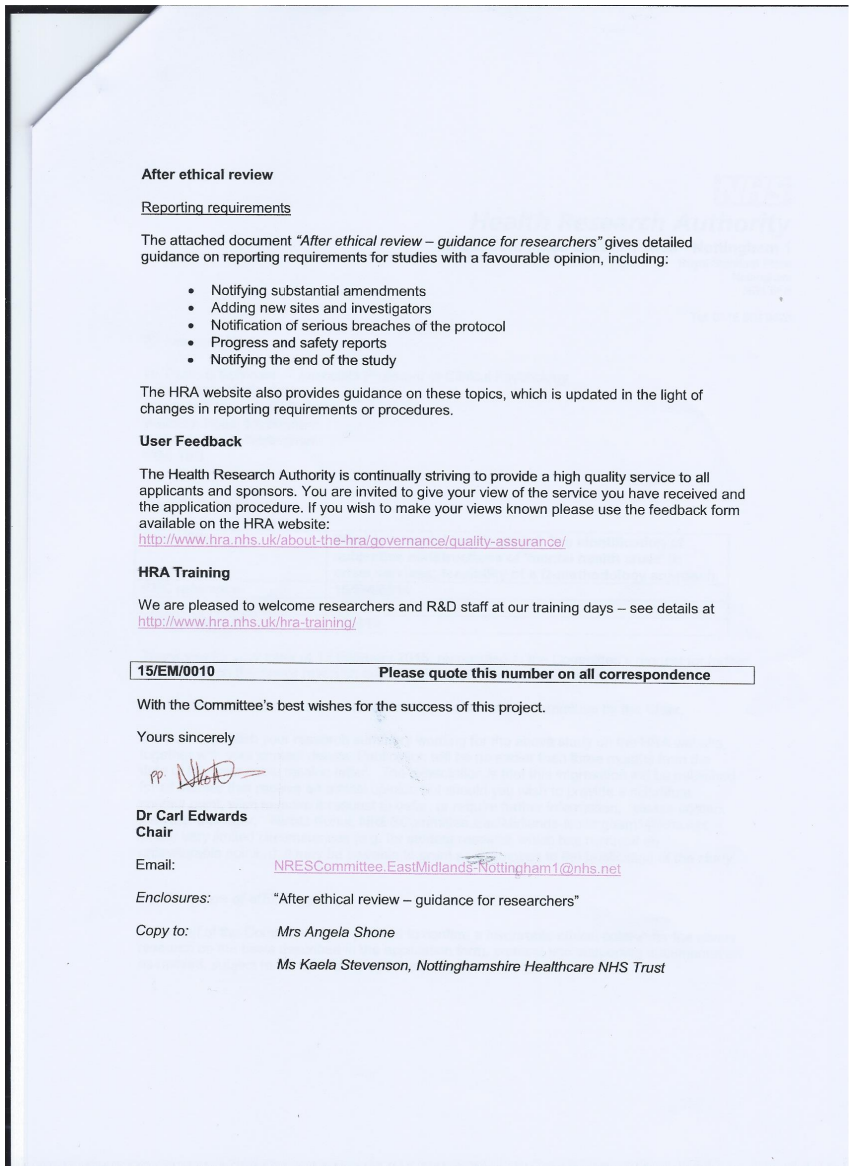
Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [insurance]		17 December 2014
Interview schedules or topic guides for participants [Interview questions]	Final version 1.0	19 December 2014
Interview schedules or topic guides for participants [Instruction sheet Q sort]		12 December 2014
IRAS Checklist XML [Checklist_17022015]		17 February 2015
Letter from sponsor [Sponsor letter]		17 December 2014
Other [Debrief sheet]	Final version 1.0	19 December 2014
Other [Example response sheet]		12 December 2014
Other [Staff Presentation]	Final version 1.0	19 December 2014
Other [Letter confiming changes to committee]		17 February 2015
Participant consent form [Carer/staff Phase I]	2	07 February 2015
Participant consent form [carer/staff Phase II]	2	07 February 2015
Participant consent form [service user Phase I]	2	07 February 2015
Participant consent form [service user Phase II]	2	07 February 2015
Participant information sheet (PIS) [Phase I Carers]	2	07 February 2015
Participant information sheet (PIS) [Phase I service users]	2	07 February 2015
Participant information sheet (PIS) [Phase I staff]	2	07 February 2015
Participant information sheet (PIS) [Phase II Carers]	2	07 February 2015
Participant information sheet (PIS) [Phase II service users]	2	07 February 2015
Participant information sheet (PIS) [Phase II Staff]	2	07 February 2015
REC Application Form [REC_Form_23122014]		23 December 2014
Research protocol or project proposal [Research protocol]	Final version 1.0	12 December 2014
Response to Request for Further Information [Documents uploaded to IRAS]		17 February 2015
Summary CV for Chief Investigator (CI) [CI CV]		12 December 2014
Summary CV for student [CV Student]		12 December 2014
Summary CV for supervisor (student research) [MR CV]		12 December 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.



After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/EM/0010 **Please quote this number on all correspondence**

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

Yours sincerely

pp

Dr Carl Edwards
Chair

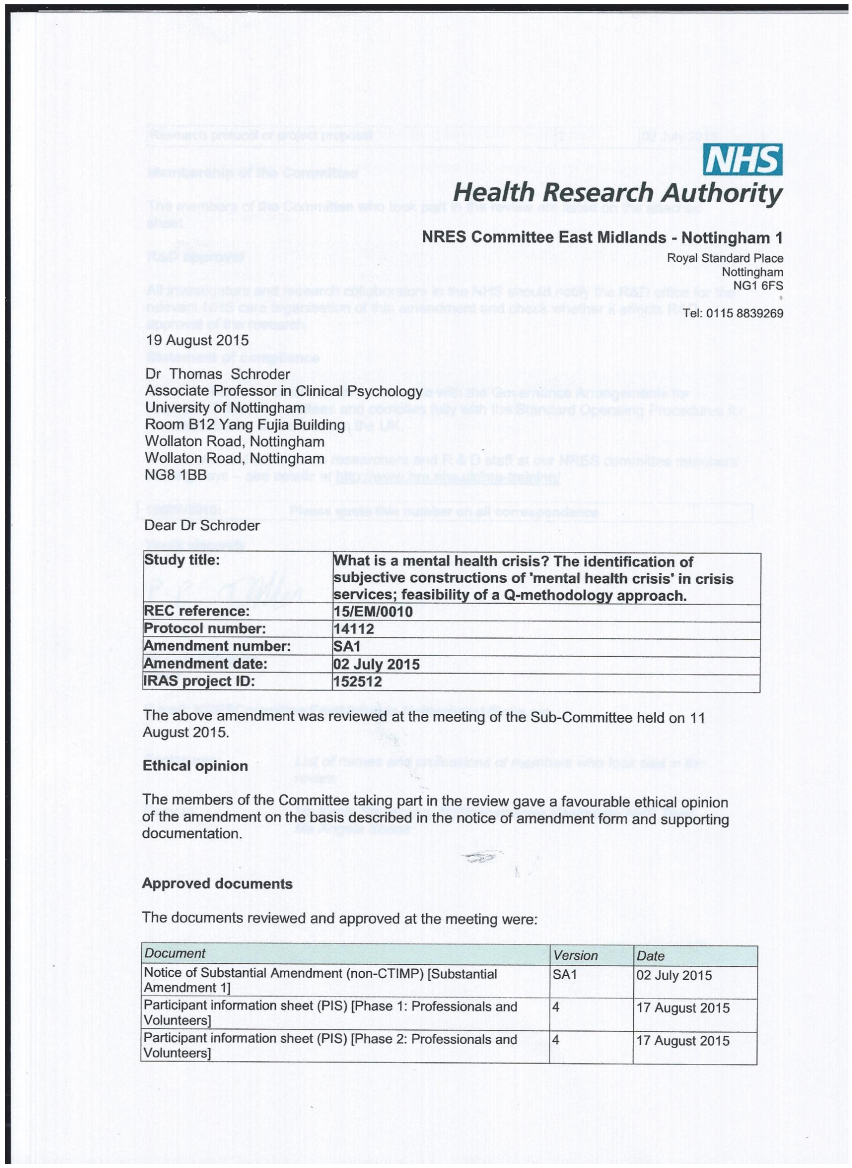
Email: NRESCommittee.EastMidlands-Nottingham1@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Mrs Angela Shone*

Ms Kaela Stevenson, Nottinghamshire Healthcare NHS Trust

Ethical approval from NRES: Amendment 1, for the inclusion of Self Help UK.



NHS
Health Research Authority

NRES Committee East Midlands - Nottingham 1
Royal Standard Place
Nottingham
NG1 6FS
Tel: 0115 8839269

19 August 2015

Dr Thomas Schroder
Associate Professor in Clinical Psychology
University of Nottingham
Room B12 Yang Fujia Building
Wollaton Road, Nottingham
Wollaton Road, Nottingham
NG8 1BB

Dear Dr Schroder

Study title:	**What is a mental health crisis? The identification of subjective constructions of 'mental health crisis' in crisis services; feasibility of a Q-methodology approach.**
REC reference:	**15/EM/0010**
Protocol number:	**14112**
Amendment number:	**SA1**
Amendment date:	**02 July 2015**
IRAS project ID:	**152512**

The above amendment was reviewed at the meeting of the Sub-Committee held on 11 August 2015.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Notice of Substantial Amendment (non-CTIMP) [Substantial Amendment 1]	SA1	02 July 2015
Participant information sheet (PIS) [Phase 1: Professionals and Volunteers]	4	17 August 2015
Participant information sheet (PIS) [Phase 2: Professionals and Volunteers]	4	17 August 2015

Research protocol or project proposal	2	02 July 2015

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

15/EM/0010:	**Please quote this number on all correspondence**

Yours sincerely

P.P

Dr Carl Edwards
Chair

E-mail: NRESCommittee.EastMidlands-Nottingham1@nhs.net

Enclosures:	*List of names and professions of members who took part in the review*
Copy to:	*Ms Kaela Stevenson, Nottinghamshire Healthcare NHS Trust* *Ms Angela Shone*

NRES Committee East Midlands - Nottingham 1

Attendance at Sub-Committee of the REC meeting on 11 August 2015

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr Carl Edwards (Chair)	Investment Advisor	Yes	
Reverend Keith Lackenby	Lay member	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Teagan Allen	REC Assistant
Nicola Kohut	REC Assistant

Ethical Approval: Amendment 2, review of the Q-set

NHS
Health Research Authority

East Midlands - Nottingham 1 Research Ethics Committee
Royal Standard Place
Nottingham
NG1 6FS

Tel: 0115 8839269

13 January 2016

Ms Angela Shone
Research and Graduate Services
King's Meadow Campus- Lenton Lane
Nottingham
NG7 2NR

Dear Ms Shone

Study title:	**What is a mental health crisis? The identification of subjective constructions of 'mental health crisis' in crisis services; feasibility of a Q-methodology approach.**
REC reference:	**15/EM/0010**
Protocol number:	**14112**
Amendment number:	**Substantial Amendment 2 14/12/2015**
IRAS project ID:	**152512**

The above amendment was reviewed on 12 January 2016 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Notice of Substantial Amendment (non-CTIMP)	Substantial Amendment 2 14/12/2015	
Other [List of Statements]	1	14 December 2015
Other [Pre and Post Questions]	1	14 December 2015
Participant information sheet (PIS) [NHS Staff]	3	14 December 2015
Participant information sheet (PIS) [NHS Service User]	3	14 December 2015
Participant information sheet (PIS) [Carer]	3	14 December 2015

Participant information sheet (PIS) [Self Help UK Staff]	4	14 December 2015
Participant information sheet (PIS) [Self Help UK Volunteer]	5	14 December 2015

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

15/EM/0010:	**Please quote this number on all correspondence**

Yours sincerely

P.P

Reverend Keith Lackenby
Chair

E-mail: NRESCommittee.EastMidlands-Nottingham1@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Ms Kaela Stevenson, Nottinghamshire Healthcare NHS Trust*
Dr Thomas Schroder , University of Nottingham

East Midlands - Nottingham 1 Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 12 January 2016

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr Glenys Caswell	Research Fellow in End of Life Care and Dementia	Yes	
Reverend Keith Lackenby (Chair)	Lay member	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Ms Teagan Allen	REC Assistant

Research and Development Department Approvals

positive ☑

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

E-mail: shirley.mitchell@nottshc.nhs.uk

Date of NHS Permission: 28/05/2015

Kerry Davies
Trainee Clinical Psychologist
Trent DClinPsy Programme
University of Nottingham
International House
Jubilee Campus
Nottingham
NG8 1BB

Dear Kerry,

Study title: What is a mental health crisis? The identification of subjective constructions of 'mental health crisis' in crisis services; feasibility of a Q methodology approach.
Sponsor: University of Nottingham
IRAS/REC ID: 15/EM/0010
Chief Investigator: Dr Thomas Schroder
Local Collaborator: Dr Lisa Ball
Recruitment target: 10-40
Service: CRHT team and CMHT based at Millbrook Mental Health Unit

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Foundation Trust's R&D Department. The project has now been given NHS permission by:

Dr Julie Hankin: R & D Director, on behalf of Nottinghamshire Healthcare NHS Foundation Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version	Date
Consent Form – Carer – Phase I	2.0	07/02/2015
Consent Form – Carer – Phase II	2.0	07/02/2015
Consent Form – Service User – Phase I	2.0	07/02/2015
Consent Form – Service User – Phase II	2.0	07/02/2015
Debrief	1.0	12/12/2014
Example Response Sheet	1.0	12/12/2014
Instruction Sheet	1.0	12/12/2014

Interview Schedule	1.0	12/12/2014
Participant Information Sheet – Carer - Phase I	2.0	07/02/2015
Participant Information Sheet – Service User – Phase I	2.0	07/02/2015
Participant Information Sheet – Staff – Phase I	2.0	07/02/2015
Participant Information Sheet – Carer – Phase II	2.0	07/02/2015
Participant Information Sheet – Service User – Phase II	2.0	07/02/2015
Participant Information Sheet – Staff – Phase II	2.0	07/02/2015
Study Protocol	3.0	09/12/2014

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

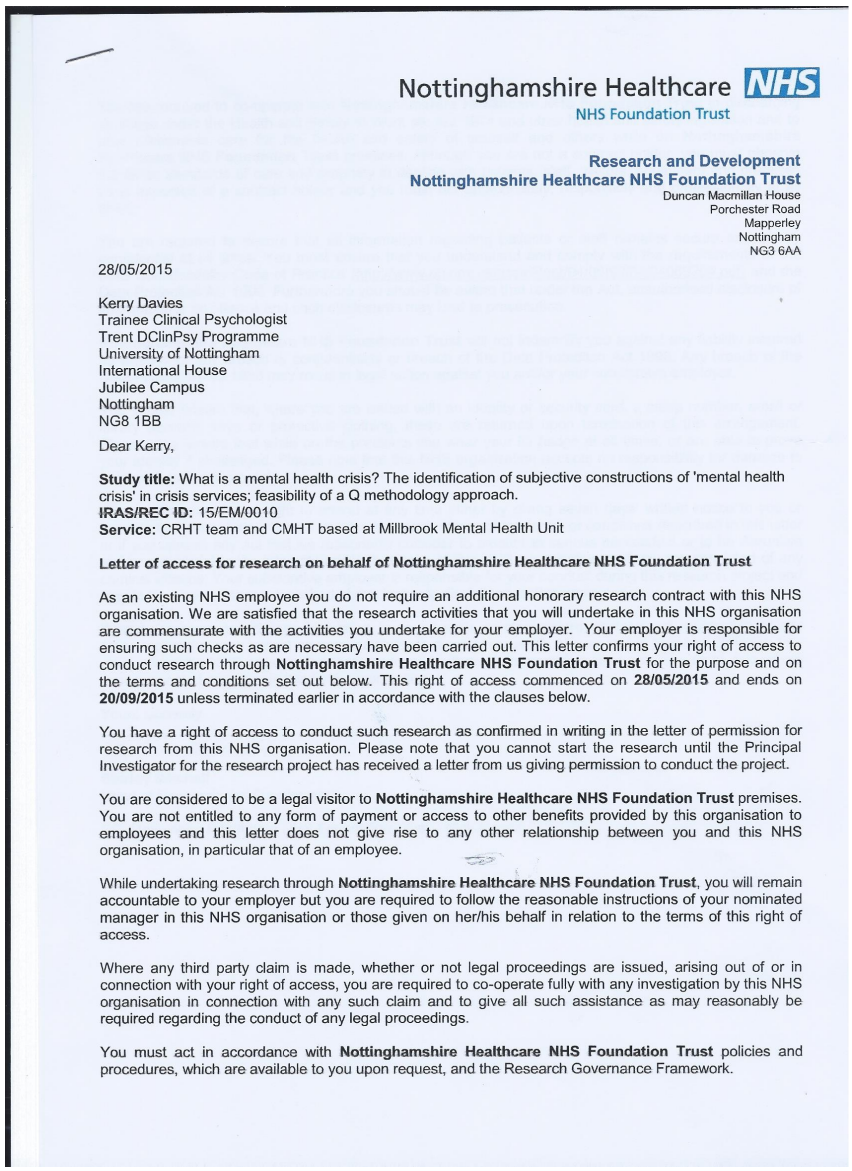
Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

Shirley Mitchell
Head of Research and Development

cc.
Chief Investigator
Academic Supervisor
Local Collaborator
Sponsor

Research and Development Department Approval: Letter of Access



Nottinghamshire Healthcare NHS
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

28/05/2015

Kerry Davies
Trainee Clinical Psychologist
Trent DClinPsy Programme
University of Nottingham
International House
Jubilee Campus
Nottingham
NG8 1BB

Dear Kerry,

Study title: What is a mental health crisis? The identification of subjective constructions of 'mental health crisis' in crisis services; feasibility of a Q methodology approach.
IRAS/REC ID: 15/EM/0010
Service: CRHT team and CMHT based at Millbrook Mental Health Unit

Letter of access for research on behalf of Nottinghamshire Healthcare NHS Foundation Trust

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is responsible for ensuring such checks as are necessary have been carried out. This letter confirms your right of access to conduct research through **Nottinghamshire Healthcare NHS Foundation Trust** for the purpose and on the terms and conditions set out below. This right of access commenced on **28/05/2015** and ends on **20/09/2015** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to **Nottinghamshire Healthcare NHS Foundation Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **Nottinghamshire Healthcare NHS Foundation Trust**, you will remain accountable to your employer but you are required to follow the reasonable instructions of your nominated manager in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **Nottinghamshire Healthcare NHS Foundation Trust** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **Nottinghamshire Healthcare NHS Foundation Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on **Nottinghamshire Healthcare NHS Foundation Trust** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Nottinghamshire Healthcare NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Shirley Mitchell
Head of Research and Development

CC: Derbyshire Healthcare NHS Foundation Trust – Nick Moore

Research and Development Department Approval: Letter of Access

NHS to NHS letter of access: proforma confirmation of pre-engagement checks
Version 1

For NHS researchers who have a substantive NHS contract of employment or clinical academics with an honorary clinical contract with an NHS organisation, and who need an NHS to NHS letter of access from an NHS organisation hosting their research

CONFIRMATION OF PRE-ENGAGEMENT CHECKS

To: R&D Office

Address of NHS site hosting the research

Re: **Researcher's name: Kerry Davies**

Job title: Trainee Clinical Psychologist

Contract end-date: 20 Sept 2015

Workplace and postal address:

Derbyshire Healthcare NHS Foundation Trust, Bramble House, Kingsway Site, Derby, DE22 3LZ

Electronic Staff Record number: 24113361

As the representative of the NHS employer[1] of the above-named person, I can confirm that s/he is employed by this organisation. I understand that the responsibility for ensuring that the appropriate pre-engagement checks have been undertaken rests with us as the individual's substantive employer. I can confirm that the appropriate pre-engagement checks have been completed, commensurate with her/his job description and proposed research role in your NHS organisation, and in line with NHS employment checks standards

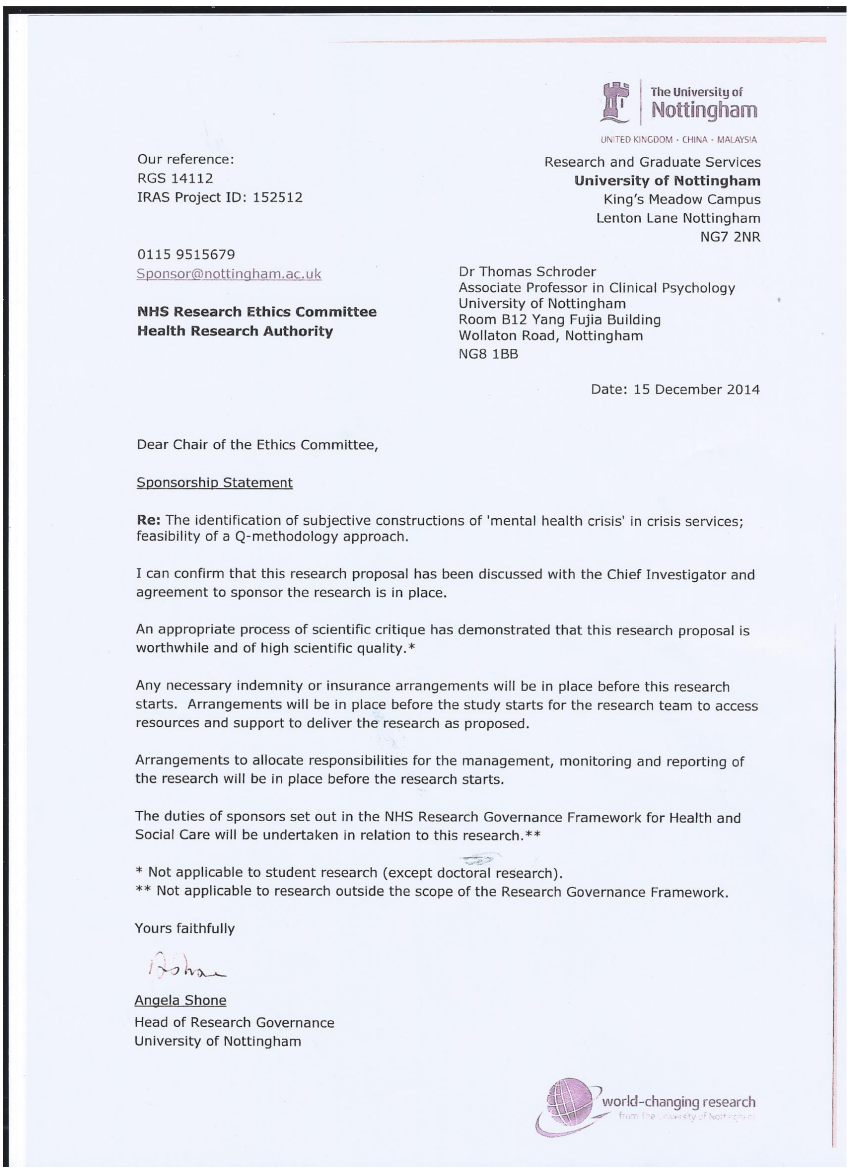
Name of employer's representative: Nick Moore

Job Title: Clinical Psychologist (DHCFT) / Senior Clinical Tutor
(Trent DClinPsy)

[1] For clinical academics, this would be a representative from their HEI employer

NHS to NHS letter of access: proforma confirmation of pre-engagement checks
Version 1, February 2010
Research in the NHS: HR Good Practice Resource Pack

University Sponsorship



The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Our reference:
RGS 14112
IRAS Project ID: 152512

Research and Graduate Services
University of Nottingham
King's Meadow Campus
Lenton Lane Nottingham
NG7 2NR

0115 9515679
Sponsor@nottingham.ac.uk

NHS Research Ethics Committee
Health Research Authority

Dr Thomas Schroder
Associate Professor in Clinical Psychology
University of Nottingham
Room B12 Yang Fujia Building
Wollaton Road, Nottingham
NG8 1BB

Date: 15 December 2014

Dear Chair of the Ethics Committee,

Sponsorship Statement

Re: The identification of subjective constructions of 'mental health crisis' in crisis services; feasibility of a Q-methodology approach.

I can confirm that this research proposal has been discussed with the Chief Investigator and agreement to sponsor the research is in place.

An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*

Any necessary indemnity or insurance arrangements will be in place before this research starts. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**

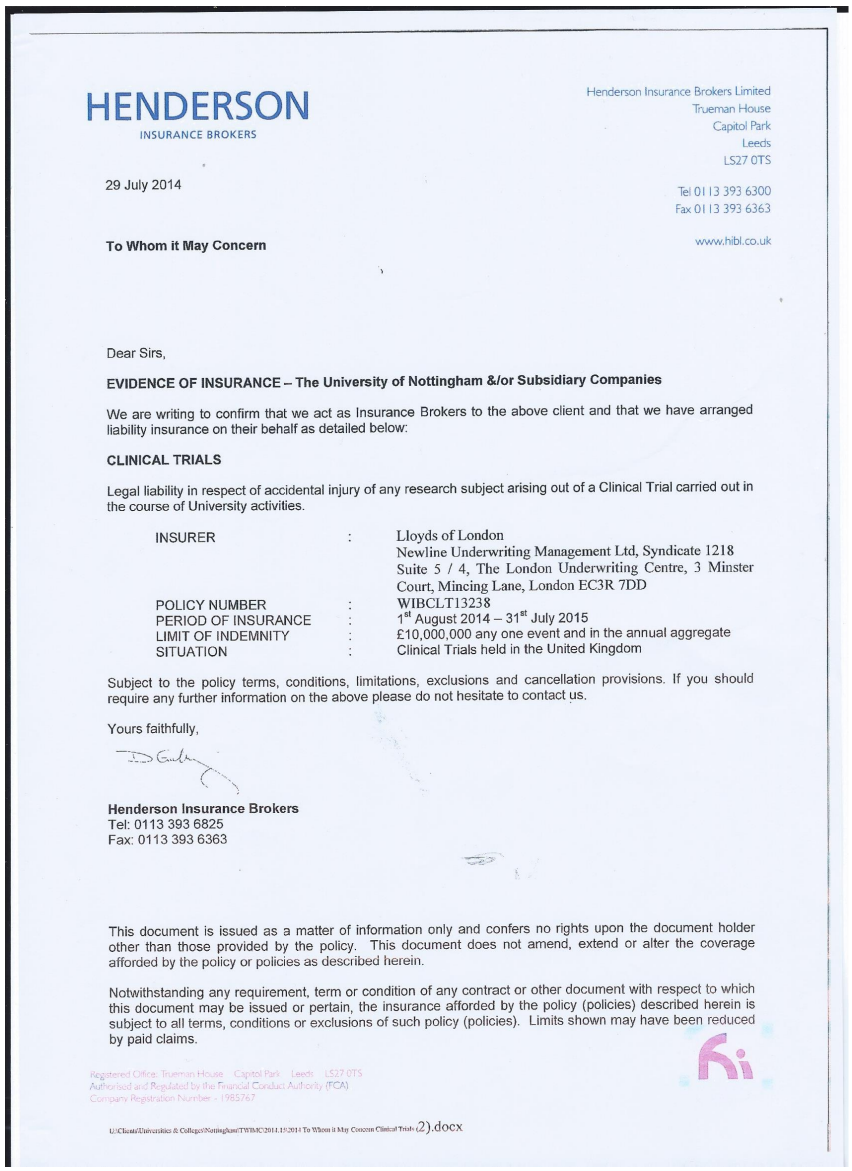
* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Yours faithfully

Angela Shone
Head of Research Governance
University of Nottingham

world-changing research
from the University of Nottingham

Insurance policy



HENDERSON
INSURANCE BROKERS

Henderson Insurance Brokers Limited
Trueman House
Capitol Park
Leeds
LS27 0TS

Tel 0113 393 6300
Fax 0113 393 6363

www.hibl.co.uk

29 July 2014

To Whom it May Concern

Dear Sirs,

EVIDENCE OF INSURANCE – The University of Nottingham &/or Subsidiary Companies

We are writing to confirm that we act as Insurance Brokers to the above client and that we have arranged liability insurance on their behalf as detailed below:

CLINICAL TRIALS

Legal liability in respect of accidental injury of any research subject arising out of a Clinical Trial carried out in the course of University activities.

INSURER	:	Lloyds of London Newline Underwriting Management Ltd, Syndicate 1218 Suite 5 / 4, The London Underwriting Centre, 3 Minster Court, Mincing Lane, London EC3R 7DD
POLICY NUMBER	:	WIBCLT13238
PERIOD OF INSURANCE	:	1st August 2014 – 31st July 2015
LIMIT OF INDEMNITY	:	£10,000,000 any one event and in the annual aggregate
SITUATION	:	Clinical Trials held in the United Kingdom

Subject to the policy terms, conditions, limitations, exclusions and cancellation provisions. If you should require any further information on the above please do not hesitate to contact us.

Yours faithfully,

Henderson Insurance Brokers
Tel: 0113 393 6825
Fax: 0113 393 6363

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Notwithstanding any requirement, term or condition of any contract or other document with respect to which this document may be issued or pertain, the insurance afforded by the policy (policies) described herein is subject to all terms, conditions or exclusions of such policy (policies). Limits shown may have been reduced by paid claims.

Registered Office: Trueman House Capitol Park Leeds LS27 0TS
Authorised and Regulated by the Financial Conduct Authority (FCA)
Company Registration Number - 1985767

Letter required by Self Help UK for file

Dear Sir/Madam

Formatted: Font:(Default) Times New Roman

I am writing to enquire if you would consider approving the involvement of Self Help Services and specifically, the Sanctuary project, with some research I am conducting into 'crisis'.

I was recently contacted by Nicky Lidbetter, Chief Officer of Self Help Services due to her interest in my current project. It seemed fitting to enquire about the possibility of recruiting from this service, therefore I thought I would provide you some further information about the research.

My research aims to explore the way that people understand a 'crisis'. The idea was raised by a service user, who noted that at times when they felt 'in crisis' they did not meet criteria needed in order to access crisis services. It seems that within mental health contexts 'crisis' as an experience is sometimes largely defined by referral criteria of corresponding services. It was questioned if this might limit our understanding of such a complex and multifaceted experience.

The research will be conducted in NHS services, and I hope that I could also involve Self Help Services Sanctuary (Manchester venue) service. My research has two phases. Phase one will use interviews to explore peoples understanding of crisis. Several groups of people will be interviewed; professionals, service users and carers. Regards Self Help Services, I will only be recruiting staff and volunteers. This is due to ethical considerations of interviewing people currently in crisis, which would make the service users of The Sanctuary not eligible in order to protect their recovery process and avoid further distress.

It may be useful to outline how I intend to work with Self Help Services, and the process of the research:

Firstly, I plan to meet with a few staff and volunteers (approximately 3-6) and conduct interviews that will last between 30-60 minutes, depending on how much they would like to say. I will only be interviewing staff and volunteers from the Manchester Sanctuary service.

This data will be anonymised, transcribed, and analysed using a qualitative research method called thematic analysis. This looks for common themes in the data. From this we will get a set of statements that are used to talk about crisis.

In the second phase of research people are asked to rate these statements, regarding how 'like' or 'not like' a crisis they are. This will take approximately 30-60 minutes.

This phase allows statistical analysis to highlight patterns of understandings, and to compare the understandings of different people. From this we will hopefully be able to draw conclusions about how professionals, service users, and carers think differently or

the same about crisis. It may also highlight new understandings of crisis that are currently neglected.

This research will form part of my Doctoral training in Clinical Psychology, of which I am just entering my final year. Therefore the research is sponsored by The University of Nottingham. As the research is being undertaken NHS services the protocol and corresponding documentation has been independently reviewed by the Research Ethics Committee to protect the interests of participants. This study has been reviewed and given favourable opinion by National Research Ethics Service Committee East Midlands – Nottingham 1. Further documentation regards this approval can be provided if necessary, along with the protocol, copies of participant information sheets and consent forms.

I am keen to get this service on board, as I feel the experiences of people who use it offer a different perspective to those who are deemed eligible for NHS crisis provision. Therefore this will allow us to form a broader understanding of the experience of crisis, without being constrained by current dominant understandings and referral procedures. The research will also be submitted to an academic journal for publication, and will hopefully be presented at conferences.

I am more than happy to provide any further information required by your organisation.

Yours Faithfully

Kerry Davies
Trainee Clinical Psychologist
Trent DClinpsych Programme
University of Nottingham

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

Appendix D: Crib sheets

Factor 1

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Statements ranked at +6
44 You can't see reality
46 You're not aware of what is going on

Statements ranked at +5
8 dying seems like a way to stop the pain
14 You just don't want to be here anymore
32 you can't see a future
48 You can't take care yourself, it's unsafe

Statements ranked at +4
23 Thinking strange things, things that aren't real
25 You have no insight
30 you lose all hope
49 You can't eat, can't sleep, can't work, can't do anything you used to

Statements ranked at +3
37 Pure fear
50 You just can't function anymore
59 you do outrageous things
66 Chaos takes over ordered thinking
67 Absolute despair
68 The sense of totally losing control

Statements ranked at +2
9 You're not being normal, normally you would never be like that
28 You're trapped with it
31 desperation to feel safe
51 you know that things are happening outside of yourself, but you can't react to it
53 Its your worst nightmare times by a million
55 you feel totally disengaged from the world
71 an overwhelming feeling of not being able to cope
78 you feel so unsafe

Statements ranked at +1
33 You feel totally shut off from everyone
36 Its like you're screaming so loud and everyone seems to be just walking by
41 you feel totally worthless
42 It does something to me that is inexplicable
60 It's like you're dead already
61 It's not about me or my personality
63 you feel numb
69 you don't know why you are doing what you are doing

72 you feel like you're going crazy

Statements ranked 0
6 Its restricting, something you can't seem to move through
16 unbearable restlessness
19 You stop taking your medication
40 Incomprehensible rage
43 You can't see it coming
56 A total meltdown, falling to bits
57 you experience a level of distress that would not be expected
74 extreme anxiety, panic
75 you're not 'you' during that time
76 It completely overpowers you

Statements ranked at -1
5 It takes over your life
10 you just can't cope anymore
21 It becomes bigger than you
22 It's so powerful
27 It blocks everything else out
29 Its totally unpredictable
35 Its hard to explain, and hard to understand
70 your thoughts overtake you
73 your life gets smashed

Statements ranked at -2
2 It's very confusing, you just don't know what to do
7 you feel that nobody understands you
20 It's a medical problem
38 Intense emotional pain
39 Its when distress goes beyond what is normal
45 You usually know you're in crisis
62 You couldn't imagine things getting any worse
64 You are totally overwhelmed by your emotions

Statements ranked at -3
12 it's very confusing, not knowing what to do, where to go
13 you want to do something to feel better, maybe drinking or drugs
17 You stop talking to people, shut yourself away
26 you can understand your crisis
47 You function, get up, work, eat and breathe, but you just go through the motions
58 The barriers just go up

Statements ranked at -4

4 there is something wrong with you
15 It's a bit like a wound
24 With the right amount of stress we would all feel that way
52 You know when it's coming
54 you just need to be with people
65 It's frightening, very very frightening

Statements ranked at -5
1 There is hope that things will get better
3 a very normal reaction
34 It's a normal life experience
77 It's like treading on eggshells

Statements ranked at -6
11 if you've been there before, you have a sense that things will get better
18 A normal reaction to the circumstances

Factor 2

Statements ranked at +6
38 Intense emotional pain
74 extreme anxiety, panic

Statements ranked at +5
33 You feel totally shut off from everyone
50 You just can't function anymore
57 You experience a level of distress that would not be expected
65 It's frightening, very very frightening

Statements ranked at +4
16 Unbearable restlessness
41 you feel totally worthless
49 You can't eat, can't sleep, can't work, can't do anything you used to do
56 A total meltdown, falling to bits
68 The sense of totally losing control

Statements ranked at +3
7 you feel that nobody understands you
10 You just can't cope anymore
17 You stop talking to people, shut yourself away
62 You couldn't imagine things getting any worse
64 You are totally overwhelmed by your emotions

Statements ranked at +2
2 Its very confusing, you just don't know what to do
14 you just don't want to be here anymore
32 you can't see a future
35 It's hard to explain, and hard to understand
39 It's when distress goes beyond what is normal
47 You function, get up, work, eat and breathe, but you just go with the motions
53 Its your worst nightmare times by a million
67 Absolute despair
71 An overwhelming feeling of not being able to cope

Statements ranked at +1
5 It takes over your life
8 Dying seems like a way to stop the pain
22 It is so powerful
30 You lose all hope
37 Pure fear
43 You can't see it coming
66 Chaos takes over ordered thinking
76 It completely overpowers you

Statements ranked at 0
9 You're not being normal, normally you would never be like that
29 Its totally unpredictable
44 You can't see reality
55 You feel totally disengaged from the world
58 The barriers just go up
60 It's like you're dead already
63 You feel numb
69 You don't know why you are doing what you are doing
70 your thoughts overtake you
72 You feel like you're going crazy

Statements ranked at -1
6 It restricting, something you can't seem to move through
12 Its very confusing, not knowing what to do, where to go
21 It becomes bigger than you
25 You have no insight
27 It blocks everything else out
28 You're trapped with it
31 desperation to feel safe
51 You know things are happening outside of yourself, but you can't react to it
75 You're not 'you' during that time
77 It's like treading on eggshells

Statements ranked at -2
23 Thinking strange things, things that aren't real
36 It's like you're screaming so loud and everyone seems to be just walking by
45 You usually know you're in crisis
46 You're not aware of what is going on
48 You can't take care of yourself, it's unsafe
59 You do outrageous things
61 It's not about me or my personality
73 Your life gets smashed

Statements ranked at -3
1 there is hope things get better
15 It's a bit like a wound
18 A normal reaction to the circumstances
20 It's a medical problem
42 It does something to me that is inexplicable
78 You feel so unsafe

Statements ranked at -4
4 There is something wrong with you

26 You can understand your crisis
40 Incomprehensible rage
54 You just need to be with people

Statements ranked at -5
3 A very normal reaction
11 If you've been there before, you have a sense that things will get better
24 With the right amount of stress we would all feel that way
34 It's a normal life experience
52 You know when it's coming

Statements ranked at -6
13 You want to do something to feel better, maybe drinking or drugs
19 you stop taking your medication

Appendix E: Further information about search strategy used in Systematic Literature Review (Davies & Rennoldson, 2013)

Inclusion and exclusion criteria. As a pragmatic minimum quality threshold, only peer-reviewed academic papers and policy papers were included; theses, conference papers, books and secondary literature (meta-analyses) were excluded. Both qualitative, mixed methods and quantitative studies that were available in English and were published between 1806 and 2014 were included. The lack of specificity regarding research methodology was in recognition of the broad methodologies employed to investigate service user perspectives of CRHTs and the lack of consensus on how best to evaluate service user perspectives. Studies were required to investigate (1) the perspectives (attitudes, views, evaluation) of adult men or women who had used crisis services (2) refer to CRHT as defined by the Sainsbury Centre for Mental Health (2006) as providing alternatives to hospitalisation; 24/7 support; care in the least restrictive environment. Studies that included participants under the age of 18 were excluded.

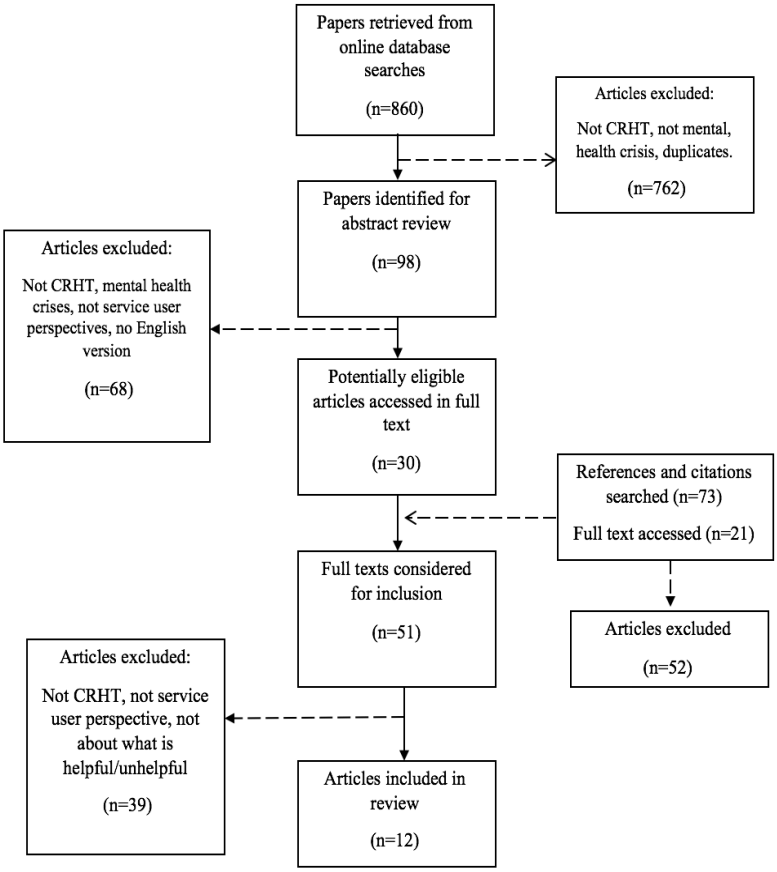
Selection. The initial search of electronic databases produced 860 potentially relevant studies. First, removal of duplicates and reviewing titles for relevance removed 762 studies. Inclusion and exclusion criteria were applied to all relevant studies, removing a further 68 studies. Thirty studies were eligible for full text review. A further 24 were excluded, six were included in the review. The bibliographies of full texts reviewed were searched, producing 18 further studies. Citation searching produced a

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further 55 studies. Of the 73 studies, a further 21 were reviewed in full text and 6 were included in the review. Twelve eligible studies were included in the review.

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Quorum diagram outlining the selection process.



Appendix F: Recruitment materials

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Participant Information Sheets

Phase One: Service user

Phase One

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Participant Information Sheet: Service Users
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

What is the purpose of the study?
We want to better understand what a crisis is in mental health settings. There are lots of different ways of understanding what a crisis is, we would like to know more about how you understand it.

Why have I been invited?
You are being invited to take part because we think you may have experienced a mental health crisis in the past. Between 20 and 50 people will be asked to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you can change your mind. If you change your mind after you have taken part, the information you have given already will still be used. You do not have to give a reason for changing your mind. This would not affect your legal rights or any care you receive in the future.

What will happen to me if I take part?
This is part one of the study. In this part you will take part in an interview. You will be asked some questions about your experiences of mental health crisis. This will be face to face with a researcher and is expected to take no longer than 30 minutes of your time. The interview will be recorded, and then later a professional service will transcribe it (write it out word by word), so that it can be analysed along with the other interviews.

You can also take part in part two of the study. Part two will involve a task that gets you to rank a number of statements about mental health crisis as to how 'like' or 'not like' a crisis they are. To take part in this you will have to leave your contact details on the

consent form. If you decide not to take part in stage two, your participation in part one will take no longer than the 30 minute interview.

I will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it. If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe. Taking part will take no more than 60 minutes of your time.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints.

Call: 0115 993 4542

Email: complaints@nottshc.nhs.uk

Write to:

Samantha Eagling
Service Liaison Manager
Service Liaison Department
Moorgreen House
Highbury Hospital
NG6 9DR

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NHS Complaints Advocacy Service

POhWER provide a free, independent and confidential advocacy service to support people with their NHS complaint.

Visit their website for more information:

http://www.pohwer.net/in-your-area/where-you-live/nottinghamshire

Or telephone: 0300 020 0093

The Patient Advice and Liaison Service (PALS) can offer further information and advice if you would like to talk to them about concerns.

Phone: 0800 015 3367

Email: PALS@nottshc.nhs.uk

Write to:

Patient Advice and Liaison Service
Moorgreen House
Highbury Hospital
NG6 9DR

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. These people all have a duty of confidentiality to you and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY - If you talk about wanting to harm yourself or anyone else the researcher will have to tell someone. It is their duty to make efforts to protect you (and other people).

We will only keep your contact details if you highlight on the consent form that:

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- You would like to participate in part two of the study
- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be very careful to maintain your confidentiality. Only the researcher, her supervisors, and regulatory bodies (people that check we are doing things properly) will have access to your personal data.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

Involvement of the Care Coordinator
You will have been told about this study by your care coordinator. If you would like to take part I will write to them to inform them of this. This is so they know you are taking part so that they can support you afterwards if you need it. The letter will tell them you are taking part, but they will not know what you have said.

The only time they might be told what you have said is if you say you want to harm yourself or anyone else. We have to tell them to help keep you/others safe.

What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Service Committee East Midlands - Nottingham 1.

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

Phase One: Professionals

Phase one
Participant Information Sheet: Professionals
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

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What is the purpose of the study?
We want to better understand what a crisis is in mental health settings. There are lots of different ways of understanding what a crisis is, we would like to know more about how you understand it.

Why have I been invited?
You are being invited to take part because you work with people who experience crisis. Between 20 and 50 people will be asked to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you can change your mind. If you change your mind after you have taken part, the information you have given already will still be used. You do not have to give a reason for changing your mind. This would not affect your legal rights or any care you receive in the future.

What will happen to me if I take part?
This is part one of the study. In this part you will take part in an interview. You will be asked some questions about your experiences of mental health crisis. This will be face to face with a researcher and is expected to take no longer than 30 minutes of your time. The interview will be recorded, and then later a professional service will transcribe it (write it out word by word), so that it can be analysed along with the other interviews.

You can also take part in part two of the study. Part two will involve a task that gets you to rank a number of statements about mental health crisis as to how 'like' or 'not like' a crisis they are. To take part in this you will have to leave your contact details on the consent form. If you decide not to take part in stage two, your participation in part one will take no longer than the 30 minute interview.

I will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it. If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe. Taking part will take no more than 60 minutes of your time.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints.

Call: 0115 993 4542

Email: complaints@nottshc.nhs.uk

Write to:

Samantha Eagling
Service Liaison Manager
Service Liaison Department
Moorgreen House
Highbury Hospital
NG6 9DR

NHS Complaints Advocacy Service

POhWER provide a free, independent and confidential advocacy service to support people with their NHS complaint.

Visit their website for more information:

http://www.pohwer.net/in-your-area/where-you-live/nottinghamshire

Or telephone: 0300 020 0093

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The Patient Advice and Liaison Service (PALS) can offer further information and advice if you would like to talk to them about concerns.

Phone: 0800 015 3367

Email: PALS@nottshc.nhs.uk

Write to:

Patient Advice and Liaison Service
Moorgreen House
Highbury Hospital
NG6 9DR

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. These people all have a duty of confidentiality to you and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY - The researcher has a duty to report any disclosure of malpractice.

We will only keep your contact details if you highlight on the consent form that:

- You would like to participate in part two of the study
- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be 1516, RPV, UofN: 4218235, UofL: 13451652, Research Portfolio & Viva, Page **228** of **306**

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very careful to maintain your confidentiality. Only the researcher, her supervisors, and regulatory bodies (people that check we are doing things properly) will have access to your personal data.

Will your managers find out what you say? No. Your participation is not being monitored by line managers, your decision to take part will not be highlighted to anyone. However if you mention wanting to harm yourself or anyone else we will have to tell someone to keep you/other people safe.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Service Committee East Midlands – Nottingham 1

Further information and contact details

Researcher: Kerry Davies.

Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

Carers

Phase One
Participant Information Sheet: Carers
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

What is the purpose of the study?
We want to better understand what a crisis is in mental health settings. There are lots of different ways of understanding what a crisis is, we would like to know more about how you understand it.

Why have I been invited?
You are being invited to take part because your family member or loved one has experienced a previous crisis. Between 20 and 50 people will be asked to take part.

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Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you can change your mind. If you change your mind after you have taken part, the information you have given already will still be used. You do not have to give a reason for changing your mind. This would not affect your legal rights or any care you receive in the future.

What will happen to me if I take part?
This is part one of the study. In this part you will take part in an interview. You will be asked some questions about your experiences of mental health crisis. This will be face to face with a researcher and is expected to take no longer than 30 minutes of your time. The interview will be recorded, and then later a professional service will transcribe it (write it out word by word), so that it can be analysed along with the other interviews.

You can also take part in part two of the study. Part two will involve a task that gets you to rank a number of statements about mental health crisis as to how 'like' or 'not like' a crisis they are. To take part in this you will have to leave your contact details on the consent form. If you decide not to take part in stage two, your participation in part one will take no longer than the 30 minute interview.

I will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?
Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it. If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe. Taking part will take no more than 60 minutes of your time.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints.

Call: 0115 993 4542

Email: complaints@nottshc.nhs.uk

Write to:

Samantha Eagling
Service Liaison Manager
Service Liaison Department
Moorgreen House
Highbury Hospital
NG6 9DR

NHS Complaints Advocacy Service

POhWER provide a free, independent and confidential advocacy service to support people with their NHS complaint.

Visit their website for more information:

http://www.pohwer.net/in-your-area/where-you-live/nottinghamshire

Or telephone: 0300 020 0093

The Patient Advice and Liaison Service (PALS) can offer further information and advice if you would like to talk to them about concerns.

Phone: 0800 015 3367

Email: PALS@nottshc.nhs.uk

Write to:

Patient Advice and Liaison Service
Moorgreen House

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Highbury Hospital
NG6 9DR

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. These people all have a duty of confidentiality to you and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY - If you talk about wanting to harm yourself or anyone else the researcher will have to tell someone. It is their duty to make efforts to protect you (and other people).

We will only keep your contact details if you highlight on the consent form that:

- You would like to participate in part two of the study
- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be very careful to maintain your confidentiality. Only the researcher, her supervisors, and regulatory bodies (people that check we are doing things properly) will have access to your personal data.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Service Committee East Midlands – Nottingham 1.

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

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Self Help UK

Phase one

Participant Information Sheet: Professionals and volunteers
(Final version 3.0: 03/07/15)

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Title of Study: What is a mental health crisis?

Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

What is the purpose of the study?
We want to better understand what a crisis is in mental health settings. There are lots of different ways of understanding what a crisis is, we would like to know more about how you understand it.

Why have I been invited?
You are being invited to take part because you work with people who experience crisis. Between 20 and 50 people will be asked to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you can change your mind. If you change your mind after you have taken part, the information you have given already will still be used. You do not have to give a reason for changing your mind. This would not affect your legal rights or any care you receive in the future.

What will happen to me if I take part?

This is part one of the study. In this part you will take part in an interview. You will be asked some questions about your experiences of mental health crisis. This will be face to face with a researcher and is expected to take no longer than 30 minutes of your time. The interview will be recorded, and then later a professional service will transcribe it (write it out word by word), so that it can be analysed along with the other interviews.

You can also take part in part two of the study. Part two will involve a task that gets you to rank a number of statements about mental health crisis as to how 'like' or 'not like' a crisis they are. To take part in this you will have to leave your contact details on the consent form. If you decide not to take part in stage two, your participation in part one will take no longer than the 30 minute interview.

I will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it. If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe. Taking part will take no more than 60 minutes of your time.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Joanne Harding, Specialist Services Manager, or Keith Smith.

Joanne.harding@selfhelpservices.org.uk

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Keith.smith@selfhelpservices.org.uk

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Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. These people all have a duty of confidentiality to you and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY - The researcher has a duty to report any disclosure of malpractice.

We will only keep your contact details if you highlight on the consent form that:

- You would like to participate in part two of the study
- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be very careful to maintain your confidentiality. Only the researcher, her supervisors, and regulatory bodies (people that check we are doing things properly) will have access to your personal data.

Will your managers find out what you say? No. Your participation is not being monitored by line managers, your decision to take part will not be highlighted to anyone. However if you mention wanting to harm yourself or anyone else we will have to tell someone to keep you/other people safe.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
This research is also being conducted in the NHS. Therefore it has been approved by an independent group of people, called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by National Research Ethics Service Committee East Midlands – Nottingham 1.

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

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Phase Two: Service Users

Phase Two
Participant Information Sheet: Service Users
(Final version 3.0: 14/12/15)

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Title of Study: What is a mental health crisis?

Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

What is the purpose of the study?
We want to better understand what a crisis is in mental health settings. There are lots of different ways of understanding what a crisis is, we would like to know more about how you understand it.

Why have I been invited?
You are being invited to take part because we think you may have experienced a mental health crisis in the past. Between 20 and 50 people will be asked to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you can change your mind. If you change your mind after you have taken part, the information you have given already will still be used. You do not have to give a reason for changing your mind. This would not affect your legal rights or any care you receive in the future.

What will happen to me if I take part?
You will be asked your age and gender before we start, you do not have to provide this information should you decide not to. This information helps us to communicate the demographics of our participants. You will be given a set of sentences that might describe a mental health crisis. You will be asked to rank the sentences, this means to place them in order, of how alike you think it is to a crisis or not. The researcher will be there to help you to know what to do and will note down/save your responses. **After you have ranked the statements, the researcher will ask you a few questions about how you found the task, if you felt there was anything missing, and will give you**

space to reflect on your ideas/thoughts about crisis. This will be recorded and used to help make sense of the findings of the study.

The researcher will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments
You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?
Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it. If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe. Taking part will take no more than 60 minutes of your time.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints.

Call: 0115 993 4542

Email: complaints@nottshc.nhs.uk

Write to:

Samantha Eagling
Service Liaison Manager
Service Liaison Department
Moorgreen House
Highbury Hospital
NG6 9DR

NHS Complaints Advocacy Service

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http://www.pohwer.net/in-your-area/where-you-live/nottinghamshire

Or telephone: 0300 020 0093

The Patient Advice and Liaison Service (PALS) can offer further information and advice if you would like to talk to them about concerns.

Phone: 0800 015 3367

Email: PALS@nottshc.nhs.uk

Write to:

Patient Advice and Liaison Service
Moorgreen House
Highbury Hospital
NG6 9DR

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. These people all have a duty of confidentiality to you and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY - If you talk about wanting to harm yourself or anyone else the researcher will have to tell someone. It is their duty to make efforts to protect you (and other people).

We will only keep your contact details if you highlight on the consent form that:

- You would like to receive information about the findings of the study.

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These details will then be deleted after the research is complete and the report has been sent to you.

All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be very careful to maintain your confidentiality. Only the researcher, her supervisors, and regulatory bodies (people that check we are doing things properly) will have access to your personal data.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

Involvement of the Care Coordinator
You will have been told about this study by your care coordinator. If you would like to take part I will write to them to inform them of this. This is so they know you are taking part so that they can support you afterwards if you need it. The letter will tell them you are taking part, but they will not know what you have said.

The only time they might be told what you have said is if you say you want to harm yourself or anyone else. We have to tell them to help keep you/others safe.
What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by National Research Ethics Service Committee East Midlands – Nottingham 1

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

Professionals

Phase Two
Participant Information Sheet: Professionals
(Final version 3.0: 14/12/15)

Title of Study: What is a mental health crisis?

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Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

What is the purpose of the study?
We want to better understand what a crisis is in mental health settings. There are lots of different ways of understanding what a crisis is, we would like to know more about how you understand it.

Why have I been invited?
You are being invited to take part because you work with people who experience crisis. Between 20 and 50 people will be asked to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you can change your mind. If you change your mind after you have taken part, the information you have given already will still be used. You do not have to give a reason for changing your mind. This would not affect your legal rights or any care you receive in the future.

What will happen to me if I take part?
You will be asked your age and gender before we start, you do not have to provide this information should you decide not to. This information helps us to communicate the demographics of our participants. You will be given a set of sentences that might describe a mental health crisis. You will be asked to rank the sentences, this means to place them in order, of how alike you think it is to a crisis or not. The researcher will be there to help you to know what to do and will note down/save your responses. **After you have ranked the statements, the researcher will ask you a few questions about how you found the task, if you felt there was anything missing, and will give you space to reflect on your ideas/thoughts about crisis. This will be recorded and used to help make sense of the findings of the study.**

The researcher will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments
You will not be paid to participate in the study.
What are the possible disadvantages and risks of taking part?

Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it. If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe. Taking part will take no more than 60 minutes of your time.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints.

Call: 0115 993 4542

Email: complaints@nottshc.nhs.uk

Write to:

Samantha Eagling
Service Liaison Manager
Service Liaison Department
Moorgreen House
Highbury Hospital
NG6 9DR

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Or telephone: 0300 020 0093

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The Patient Advice and Liaison Service (PALS) can offer further information and advice if you would like to talk to them about concerns.

Phone: 0800 015 3367

Email: PALS@nottshc.nhs.uk

Write to:

Patient Advice and Liaison Service
Moorgreen House
Highbury Hospital
NG6 9DR

Will my taking part in the study be kept confidential?
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All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY – The researcher has a duty to report any disclosure of malpractice.

We will only keep your contact details if you highlight on the consent form that:

- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be very careful to maintain your confidentiality. Only the researcher, her supervisors, and

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regulatory bodies (people that check we are doing things properly) will have access to your personal data.

Will your managers find out what you say? No. Your participation is not being monitored by line managers, your decision to take part will not be highlighted to anyone. However if you mention wanting to harm yourself or anyone else we will have to tell someone to keep you/other people safe.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by National Research Ethics Service Committee East Midlands – Nottingham 1.

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

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Phase Two
Participant Information Sheet: Carers
(Final Version 3.0:14/12/15)

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Title of Study: What is a mental health crisis?
Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

What is the purpose of the study?
We want to better understand what a crisis is in mental health settings. There are lots of different ways of understanding what a crisis is, we would like to know more about how you understand it.

Why have I been invited?
You are being invited to take part because one of your family members or loved ones has experienced a previous crisis. Between 20 and 50 people will be asked to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you can change your mind. If you change your mind after you have taken part, the information you have given already will still be used. You do not have to give a reason for changing your mind. This would not affect your legal rights or any care you receive in the future.

What will happen to me if I take part?
You will be asked your age and gender before we start, you do not have to provide this information should you decide not to. This information helps us to communicate the demographics of our participants. You will be given a set of sentences that might describe a mental health crisis. You will be asked to rank the sentences, this means to place them in order, of how alike you think it is to a crisis or not. The researcher will be there to help you to know what to do and will note down/save your responses. **After you have ranked the statements, the researcher will ask you a few questions about how you found the task, if you felt there was anything missing, and will give you space to reflect on your ideas/thoughts about crisis. This will be recorded and used to help make sense of the findings of the study.**

The researcher will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments
You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?
Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it. If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe. Taking part will take no more than 60 minutes of your time.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints.

Call: 0115 993 4542

Email: complaints@nottshc.nhs.uk

Write to:

Samantha Eagling
Service Liaison Manager
Service Liaison Department
Moorgreen House
Highbury Hospital
NG6 9DR

NHS Complaints Advocacy Service

POhWER provide a free, independent and confidential advocacy service to support people with their NHS complaint.

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Visit their website for more information:

http://www.pohwer.net/in-your-area/where-you-live/nottinghamshire

Or telephone: 0300 020 0093

The Patient Advice and Liaison Service (PALS) can offer further information and advice if you would like to talk to them about concerns.

Phone: 0800 015 3367

Email: PALS@nottshc.nhs.uk

Write to:

Patient Advice and Liaison Service
Moorgreen House
Highbury Hospital
NG6 9DR

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. These people all have a duty of confidentiality to you and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY - If you talk about wanting to harm yourself or anyone else the researcher will have to tell someone. It is their duty to make efforts to protect you (and other people).

We will only keep your contact details if you highlight on the consent form that:

- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

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All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be very careful to maintain your confidentiality. Only the researcher, her supervisors, and regulatory bodies (people that check we are doing things properly) will have access to your personal data.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by National Research Ethics Service Committee East Midlands – Nottingham 1.

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

Self Help UK

Phase Two
Participant Information Sheet: Professionals and volunteers
(Final version 4.0: 14/12/15)

Title of Study: What is a mental health crisis?

Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

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We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

What is the purpose of the study?
We want to better understand what a crisis is in mental health settings. There are lots of different ways of understanding what a crisis is, we would like to know more about how you understand it.

Why have I been invited?
You are being invited to take part because you work with people who experience crisis. Between 20 and 50 people will be asked to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you can change your mind. If you change your mind after you have taken part, the information you have given already will still be used. You do not have to give a reason for changing your mind. This would not affect your legal rights or any care you receive in the future.

What will happen to me if I take part?
You will be asked your age and gender before we start, you do not have to provide this information should you decide not to. This information helps us to communicate the demographics of our participants. You will be given a set of sentences that might describe a mental health crisis. You will be asked to rank the sentences, this means to place them in order, of how alike you think it is to a crisis or not. The researcher will be there to help you to know what to do and will note down/save your responses. **After you have ranked the statements, the researcher will ask you a few questions about how you found the task, if you felt there was anything missing, and will give you space to reflect on your ideas/thoughts about crisis. This will be recorded and used to help make sense of the findings of the study.**

The researcher will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments
You will not be paid to participate in the study.
What are the possible disadvantages and risks of taking part?
Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it. If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe. Taking part will take no more than 60 minutes of your time.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Joanne Harding, Specialist Services Manager, or Keith Smith.

Joanne.harding@selfhelpservices.org.uk

Keith.smith@selfhelpservices.org.uk

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. These people all have a duty of confidentiality to you and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY – The researcher has a duty to report any disclosure of malpractice.

We will only keep your contact details if you highlight on the consent form that:

- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

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All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be very careful to maintain your confidentiality. Only the researcher, her supervisors, and regulatory bodies (people that check we are doing things properly) will have access to your personal data.

Will your managers find out what you say? No. Your participation is not being monitored by line managers, your decision to take part will not be highlighted to anyone. However if you mention wanting to harm yourself or anyone else we will have to tell someone to keep you/other people safe.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
This research is also being conducted in the NHS. Therefore it has been approved by an independent group of people, called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by National Research Ethics Service Committee East Midlands – Nottingham 1.

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

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Self Help UK

Phase Two

Participant Information Sheet: Volunteers
(Final version 5.0: 14/12/2015)

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Title of Study: What is a mental health crisis?

Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Ask the researcher if you have any questions or if anything is not clear.

What is the purpose of the study?
We want to better understand what a crisis is. There are lots of different ways of understanding what a crisis is, we would like to know what you think.

Why have I been invited?
You are being invited to take part because you have experienced a crisis. Between 20 and 50 people will be asked to take part.

Do I have to take part?
It is up to you to decide whether or not to take part.

If you do decide to take part you will be asked to sign a consent form.

If you decide to take part you can change your mind.

What will happen to me if I take part?
You will be asked your age and gender before we start, you do not have to provide this information should you decide not to. This information helps us to communicate the demographics of our participants. You will be given a set of sentences that might describe a mental health crisis. You will be asked to rank the sentences, this means to place them in order, of how alike you think it is to a crisis or not. The researcher will be there to help you to know what to do and will note down/save your responses. **After you have ranked the statements, the researcher will ask you a few questions about how you found the task, if you felt there was anything missing, and will give you space to reflect on your ideas/thoughts about crisis. This will be recorded and used to help make sense of the findings of the study.**

The researcher will not have access to any of your personal information (apart from what you disclose) at any point of the research.

Expenses and payments
You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?
Thinking about difficult experiences can sometimes make people feel emotional. It is important to access support that is highlighted on the debrief sheet should you need it.

If you talk about wanting to harm yourself, or anyone else, the researcher will have to tell someone. This is to keep people safe.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to better understand crisis in the future. This could help to improve services and care.

What happens when the research study stops?
When the study stops the findings will be analysed and a report will be produced.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Joanne Harding, Specialist Services Manager, or Keith Smith.

Joanne.harding@selfhelpservices.org.uk

Keith.smith@selfhelpservices.org.uk

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with current data protection legislation. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

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If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly.

These people all have a duty of confidentiality to you and we will do our best to meet this duty.

LIMITS TO CONFIDENTIALITY – The researcher has a duty to report any disclosure of malpractice.

We will only keep your contact details if you highlight on the consent form that:

- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham Code of Research Conduct. During this time they will be very careful to maintain your confidentiality.

What will happen if I don't want to carry on with the study?
You do not have to take part. You can choose to stop taking part at any time, without giving a reason, and without your legal rights being affected.

If you stop taking part for any reason the information given so far cannot be erased and this information may still be used in the analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

If for any reason you lose capacity to consent during the study, the researchers will talk to you about this and will withdraw you from the study.

What will happen to the results of the research study
The results of the research will be written in a report and may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report.

The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings of the study please indicate this on your consent form and leave your contact details.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Nottingham.

Who has reviewed the study?
This research is also being conducted in the NHS. Therefore it has been approved by an independent group of people, called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by National Research Ethics Service Committee East Midlands – Nottingham 1.

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
Email Thomas.schroder@nottingham.ac.uk
Phone: 0115 8468181
Address: Yang Fujia Building, Jubilee Campus

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Service User

CONSENT FORM: Phase One
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

REC ref: 15/EM/0010

Name of Researcher: Kerry Davies

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 2.0 dated 7/2/15 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

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

6. I would like my contact details to be saved by the researcher so that I can be contacted to take part in the next stage of research as detailed on the information sheet. ☐

7. I would like my contact details to be saved by the researcher so that I can receive feedback and findings on the study ☐

8. I understand that if I say that I want to hurt myself or anyone else, the researcher will have to tell someone to keep me (or other people) safe. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

Carer and Professionals

CONSENT FORM: Phase One
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

REC ref: 15/EM/0010

Name of Researcher: Kerry Davies

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 2.0 dated 7/2/15 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

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

6. I would like my contact details to be saved by the researcher so that I can be contacted to take part in the next stage of research as detailed on the information sheet. ☐

7. I would like my contact details to be saved by the researcher so that I can receive feedback and findings on the study ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

Self Help UK

CONSENT FORM: Phase One
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

REC ref: 15/EM/0010

Name of Researcher: Kerry Davies

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 4.0 dated 17/8/15 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

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

6. I would like my contact details to be saved by the researcher so that I can be contacted to take part in the next stage of research as detailed on the information sheet. ☐

7. I would like my contact details to be saved by the researcher so that I can receive feedback and findings on the study ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

Service user

CONSENT FORM: Phase Two
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

REC ref: 15/EM/0010

Name of Researcher: Kerry Davies

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 3.0 dated 14/12/15 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that my responses will be recorded/saved and then analysed. I understand that this data will be anonymised (my name will not be on it). ☐

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

6. I would like my contact details to be saved by the researcher so that I can receive feedback and findings on the study ☐

7. I understand that if I say that I want to hurt myself or anyone else, the researcher will have to tell someone to keep me (or other people) safe. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

Professionals and carers

CONSENT FORM: Phase Two
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

REC ref: 15/EM/0010

Name of Researcher: Kerry Davies

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 3.0 dated 14/12/15 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that my responses will be recorded/saved and then analysed. I understand that this data will be anonymised (my name will not be on it). ☐

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

6. I would like my contact details to be saved by the researcher so that I can receive feedback and findings on the study ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

Self Help UK

CONSENT FORM: Phase Two
(Final version 2.0: 07/02/15)

Title of Study: What is a mental health crisis?

REC ref: 15/EM/0010

Name of Researcher: Kerry Davies

Name of Participant:

		Please initial box
1.	I confirm that I have read and understand the information sheet version number 4.0 dated 14/12/15 for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.	☐
3.	I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.	☐
4.	I understand that my responses will be recorded/saved and then analysed. I understand that this data will be anonymised (my name will not be on it).	☐
5.	I agree to take part in the above study.	☐
6.	I would like my contact details to be saved by the researcher so that I can receive feedback and findings on the study	☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

INSTRUCTIONS

Title of Project: **WHAT IS A MENTAL HEALTH CRISIS?**

Name of Researcher: **KERRY DAVIES**

INSTRUCTIONS:

1) Read through all the statements
2) Read through them again, and place them into three piles as below

Statements that are most uncharacteristic of crisis	Ones that I am not too sure about	Statements that are the most characteristic of crisis

3) Now that you have three piles. Put them above corresponding sides of distribution.

4) Spread out one pile to take another look. Start to sort out the cards again, placing one card on each space on the grid according to how characteristic or uncharacteristic it is. Place the cards you think are the most uncharacteristic towards the left, and the most characteristic towards the right.

(note down where there positive pile ends eg. Is it a big pile that ends at -1, mark it with a line on the distribution sheets)

5) Do the same thing with the most uncharacteristic pile. Then the neutral pile, and feel free to move the statements around until you are happy.

End of task. The researcher will now discuss what happens with your rankings, and will ask you a few questions about how you found the task.

Participant Debrief Sheet
(Final version 1.0: 13/3/14)

Title of Study: What is a mental health crisis?

Thank you for taking part in this study.

What are the possible disadvantages and risks of taking part?

Thinking about difficult experiences can sometimes make people feel emotional. If you feel upset after taking part in this research you can contact your care coordinator, or one of the following support agencies:

SANE is a national, out-of-hours mental health helpline offering specialist emotional support and information to anyone affected by mental illness, including family, friends and carers. They are open every day of the year from 6pm to 11pm.

Contact their helpline on 0845 767 8000.

MIND mental health support line 0300 123 3393.

SAMARITANS generic support line 08457 90 90 90.

What happens now?

The responses will be analysed and a report will be produced. The report may be published in an academic journal. This is most likely to be in 2016. You will not be identified in the report. The report will also be submitted as part of the researchers Doctoral training in Clinical Psychology (DClinpsy).

If you would like to receive feedback on the findings please leave your contact details here:

Name:_____

Address/email address:
_____

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database in accordance with the Data Protection Act 1998. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

LIMITS TO CONFIDENTIALITY - If you mention anything to the researcher that indicates you (or anyone else) may be at risk, such as plans to end your life, maltreatment of other people, the researcher is duty bound to make efforts to protect you (or others). This will include telling other people about the risks.

We will only keep your contact details if you highlight on the consent form that:

- You would like to participate in part two of the study
- You would like to receive information about the findings of the study.

These details will then be deleted after the research is complete and the report has been sent to you.

All other data (research data) will be kept securely for seven years at the University of Nottingham. After this time your data will be disposed of securely in accordance with the University of Nottingham's Code of Research Conduct. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw after your participation has ended then the information collected so far cannot be erased and this information may still be used in the project analysis. All contact details will be deleted and you will not be contacted to take part in further stages, or about the findings of the study.

Further information and contact details

Researcher: Kerry Davies.
Email lwxkad@nottingham.ac.uk

Chief Investigator: Dr. Thomas Schroder.
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Interview Schedule
(Final Version 1.0. Date: 21/11/14)

Title of Study: What is a mental health crisis?

Name of Researcher(s): Kerry Davies, Trainee Clinical Psychologist.

Range of questions that could be asked in interview:

How would you describe a mental health crisis to someone who has no experience of it?

From your experiences, what do you think a mental health crisis is?

How did you know you were in crisis? /How do you know when someone is in crisis?

What do you think causes mental health crises?

How do you think it changes over time? (Either developing, getting worse…or recovery)

What does it feel like to be in crisis? (Or what do you think it feels like)

What do you feel it is important for people to understand about mental health crises?

What were/are the signs of recovery from crisis?

Is there anything that you think gets mistaken as part of a crisis?

Professional specific questions:

What are the main commonalities in the crisis experience on your caseload?

What are the main differences in the crisis experience on your caseload?

Do you feel some of the people who are declined from CRHT – are in crisis?

If so, how is their crisis different?

How do you understand resolution of crisis to work?

Appendix H: Statements

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	Statement	Theme
1.	you're not aware of what is going on	Confusion
2.	you can't see reality	Perception: reality
3.	You can't see it coming	Perception crisis
4.	you know when it's coming	Perception crisis
5.	you usually know that you're in crisis	Perception crisis
6.	You don't know why you are doing what you're doing	Confusion
7.	it's like treading on egg shells	Highly variable
8.	your thoughts overtake you	Overwhelmed
9.	The sense of totally losing control	Out of control
10.	chaos takes over ordered thinking	Out of control
11.	it completely overpowers you	overwhelmed
12.	an overwhelming feeling of not being able to cope	Overwhelmed
13.	You're not 'you' during that time	Not functioning at baseline
14.	You experience a level of distress that would not be expected	Emotional response: disproportionate
15.	You feel so unsafe	Unsafe
16.	it's when distress goes beyond what is normal	Emotional response: disproportionate
17.	absolute despair	Emotional response: sadness
18.	It's frightening, very very frightening	Emotional response: fear
19.	You feel totally worthless	Perception: self
20.	incomprehensible rage	Emotional response: anger
21.	pure fear	Emotional response: fear
22.	You feel like you're going crazy	Perception: self
23.	intense emotional pain	Emotional response
24.	You feel numb	Emotional response: numbness
25.	extreme anxiety, panic	Emotional response: fear
26.	You are totally overwhelmed by your emotions	Overwhelmed
27.	it's like your dead already	Emotional response
28.	You couldn't imagine things getting any worse	Perception: crisis
29.	You do outrageous things	Not functioning to baseline
30.	It's not about me or my personality	Perception: crisis
31.	it's your worst nightmare times by a million	Perception: crisis
32.	a total meltdown, falling to bits	Destructive

33.	it’s like you're screaming so loud and everyone seems to be just walking by	Disconnected
34.	you know that things are happening outside of yourself, but you can’t react to it	Disconnected
35.	Your life gets smashed	Destructive
36.	the barriers just go up	Disconnected
37.	You feel totally disengaged from the world	Disconnected
38.	You just need to be with people	Disconnected
39.	You can’t eat, can’t sleep, can’t work, can’t do anything you used to	Not functioning to baseline
40.	You can’t take care of yourself, it’s unsafe	Risk
41.	You just can’t function anymore	Not functioning to baseline
42.	You function, you get up, you go to work, you eat and you breathe…but you just go through the motions	Not functioning to baseline
43.	It does something to me that is inexplicable	Help seeking
44.	it’s hard to explain, and hard to understand	Help seeking
45.	it’s totally unpredictable	Response is highly variable
46.	you can’t see a future	Perception of future
47.	you lose all hope	Perception of future
48.	desperation to feel safe	Unsafe
49.	You feel totally shut off from everyone	Disconnected
50.	it’s a normal life experience	Perception: crisis
51.	a normal reaction to the circumstances	Perception: crisis
52.	it’s very confusing, not knowing what to do, where to go	Confusion
53.	it is so powerful	Overwhelmed
54.	it takes over your life	Overwhelmed
55.	it blocks everything else out	Overwhelmed
56.	it becomes bigger than you	Overwhelmed
57.	its restricting, something you can’t seem to move through	Overwhelmed
58.	you're trapped with it	Overwhelmed
59.	you just don’t want to be here anymore	Risk
60.	dying seems like a way to stop the pain	Risk
61.	thinking strange things, things that aren’t real	Perception: reality
62.	unbearable restlessness	Physiological response
63.	You feel that nobody understands	Help seeking
64.	You can understand your crisis	Confusion
65.	You have no insight	Confusion
66.	There is something wrong with you	Perception: crisis
67.	You’re not being normal; normally you would never be	Not functioning to

	like that	baseline
68.	With the right amount of stress we would all feel that way	Perception of crisis
69.	A very normal reaction	Perception of crisis
70.	It's very confusing, you just don't know what to do	Confusion
71.	It's a medical problem	Perception of crisis
72.	It's a bit like a wound	Perception of crisis
73.	You lose all hope	Perception of future
74.	You want to do something to feel better, maybe drinking or drugs	Attempts to resolve
75.	You stop taking your medication	Attempts to resolve
76.	You stop talking to people, shut yourself away	Attempts to resolve
77.	You just can't cope anymore	Stress exceeds coping / perception of self
78.	If you've been there before, you have a sense that things will get better	Perception of future

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Meaning Units identified by Dr Simon Clarke: transcript 3009

Interviewer: Okay, so interview number 3009. I'm just going to leave that there, is that alright?

Respondent: Yeah, it's cool.

Interviewer: Okay, so the first question is really general, so how would you describe a mental health crisis to somebody who has no experience of it?

Respondent: Take your worst nightmare you've ever had, times it by a million and you're still not even close. That's how I'd put it.

Interviewer: Can you tell me a little bit more about that? What about the kind of, what was the nightmare like for you?

Respondent: Real. Very real. Depending on which I were going through, I'd either be depressed, I were low and then [?? 00:00:55], worst of my anxiety it were pure fear. Pure terror, horrible.

Interviewer: What do you think a crisis is?

Respondent: Just like having a meltdown, falling to bits, can't cope, do you know what I mean? That kind of thing.

Interviewer: And kind of, what do you think brought it on?

Respondent: Oh, loads of things. Loads of things. Past, bullying, my kids going, loads of things.

Interviewer: So loads of life things all going on at once?

Respondent: Yeah, deaths and all sorts.

Interviewer: And did that happen, kind of, quickly? Did you feel, did the crisis come on quickly?

Respondent: Yeah.

Interviewer: Or was it over quite a period?

Respondent: Yeah, it all come, it all come at once, mine did.

Interviewer: And do you think you were coping with that for a while and then it got more difficult?

Respondent: Well looking back now, I'd coped with anxiety for twenty odd years not knowing I'd got anxiety. I just thought it were me being me.

Interviewer: Okay.

Respondent: Yeah, until I came to the crisis team, that's when I knew I'd got a problem, do you know what I mean? I could see it looking back because I did a lot of thinking.

Interviewer: So maybe there was already, like, you'd struggled already with some things like anxiety and worrying.

Respondent: Yeah, I struggled with loads of things, loads of things. How I deal with situations and all sorts or inability to deal with them.

Interviewer: What's your, kind of, go to way of dealing with things do you think?

Respondent: To, well, it were get mad at first but then obviously as the depression kicked in, it was like either way and I just, I just don't want people around me, so that's how I go now, I just revert into myself and shy away from the world.

Interviewer: Did you have many people around you at the time?

Respondent: No.

Interviewer: During this crisis?

Respondent: I don't have many people around me.

Interviewer: Did you know that you were in a crisis at first?

Respondent: No. Well, I knew something were up but I didn't know what it were. I thought I were going mad.

Interviewer: What made you think something was up, do you think?

Respondent: Crying at work, panic attacks, wouldn't eat nought, couldn't sleep, shaking, my leg were twitching all the time, nervous, jumpy, that kind of thing.

Interviewer: Then at what point did you think, "Oh, I'm," did you think, "I'm in a crisis" or did somebody else, kind of…?

Respondent: No, I struggled on with it for two years and then just, things were just, well, I just couldn't take it anymore.

Interviewer: What happened at that point, then? Did somebody else kind of step in, or did somebody say…?

Respondent: I kept going down to the doctor's all the time, I were at doctor's every two minutes, and then I just had a massive panic attack at doctor's, and then they said, 'You need to see somebody' and then it went from there.

Interviewer: Did they get in touch with the crisis team then?

Respondent: Mmm.

Interviewer: Yeah.

Respondent: Straight away.

Interviewer: And then the crisis team came out?

Respondent: Yeah, every day.

Interviewer: Every day.

Respondent: For quite a while.

Interviewer: And was it seeing them that helped you to understand what was going on or…

Respondent: Yeah.

Interviewer: …understand it as a crisis?

Respondent: Yeah, they gave me, like, that I weren't going mad, it is normal, sort of thing, and what I was experiencing, what it meant because at the time I didn't have a clue, I just didn't, I fell to bits.

Interviewer: How do you think your crisis changed over time? Do you think it got worse? Did it go up and down, or was it always as bad? Was it kind of stable?

Respondent: It depends. It depends how I feel. One minute I'm depressed, one minute I'm feeling anxious, do you know what I mean? So I'm torn between the two, so one minute I'm all, well, it's never really gone away because I can't deal with certain things and situations, so these happen isn't it, a daily basis, they're never going to go away, do you know what I mean? So it just carries on. Some days it's less than others, some days it's worse than others, it's just how it rolls, what I'm going through.

Interviewer: Do you see yourself as, kind of, always in a crisis, or do you see yourself as always, kind of, struggling?

Respondent: I'll always struggle.

Interviewer: But then sometimes you're in a crisis and sometimes you're just…

Respondent: Yeah, well yeah, it's called a crisis when I go into meltdown.

Interviewer: So sometimes you're not in meltdown…

Respondent: No.

Interviewer: …but you're struggling.

Respondent: Struggling, yeah. I'll always struggle, always.

Interviewer: And then you have a meltdown and that's when you have…

Respondent: Mmm.

Interviewer: …that's when crisis comes, and then you kind of get back to the struggling level, would you say?

Respondent: I get to a point where obviously, if I take me meds, I can keep an even keel, sort of thing, depending on what gets thrown at me life-wise.

Interviewer: Yeah. So it tends to be life that triggers meltdown?

Respondent: Yeah, it's life, it's work, life, stress. Stress is the worst. Stress is the worst. It's key to it all.

Interviewer: What do you think are the main things that cause you stress?

Respondent: A lot because I don't get on with people very often because I see through people's bullshit, if you get me, their fakeness. Everyone's out to screw each other for a pound, nowadays. No one listens to you. No one cares. So I have a lot of big time dealing with people because they are just so fake.

Interviewer: And that's why, I guess, sometimes when you're in work things are difficult because you work around other people, do you?

Respondent: Yeah, I work around other people, and it's like, I work around a lot, they're kids, they're in their 20s, right, so they're kids, you work with a bunch of kids and it's like, my dad's bigger than your dad crap and I'm just too old for that crap.

Interviewer: Yeah.

Respondent: And I'm sick of hearing this, that and the other, so that's why I can't deal with them. Can't cope with them because they just irritate me.

Interviewer: Now that you feel like you're kind of getting back onto an even keel, is your sleeping better?

Respondent: Yeah, the Olanzapine's knocking me out at night.

Interviewer: And then what about your eating and things like that, that you were struggling with?

Respondent: Yeah, that's [?? 00:08:26] but that's good because I'm doing my weight, so I'm not bothered about that. That's an actual bonus of it, so keeping me on an even keel, I'm gaining weight and I'm sleeping more, so.

Interviewer: Does that make things feel a bit easier?

Respondent: A lot better because I were sleeping five hours a night. I'd been sleeping five hours a night for the last two years solid and doing a hard day's graft.

Interviewer: Yeah, yeah.

Respondent: And not eating a great deal, so it's took its toll on me.

Interviewer: Yeah, yeah.

Respondent: But it's getting back to normal if you, so to speak.

Interviewer: If you were to kind of describe what it feels like to be in a crisis, what would you say? What would be the words that you would choose? Maybe, like, some of the feelings, I know you said…

Respondent: Ah, well, someone asked me this a while ago and I turned around and said, "If you could manifest what you feel in a solid object…" I always see it as a smoky grey man. I don't know why, it's just, I had a really, I had bad flashes and stuff and I had weird dreams and that's what I kept dreaming, just this weird, you couldn't see his face, you couldn't see anything, just a smoky geezer but you just knew wherever he were it were bad, so I'd wake up sweating in a panic. That's how, that's the worst, that's the worst of anxiety, I suppose.

Interviewer: And that's how you feel, your crisis feels like this grey…

Respondent: Mmm but then again, when that, sort of, like, I feel like I'm going crazy, I could pull me skin off because just nobody listens, it's like

you're screaming, you're screaming that loud and everyone's just walking by and it's like no one hears you, it's like you're not even there, that's how frustrated you feel, do you know what I mean? It feels like everyone's rushing around and you're moving at a snail pace, a bit like they do on films…

Interviewer: So you've felt like…

Respondent: I've felt like that, just racing around, everyone's racing around and I'm just going like, what? Just like that. Like, a full day could flicker in front of me, like, do you know what I mean? It's like that kind of speed.

Interviewer: This, like, kind of grey man that you're talking about, kind of, do you feel like that, kind of, when things are bad, do you feel like that's, kind of, following you around all the time?

Respondent: Mmm.

Interviewer: Like it's…

Respondent: Yeah, mmm, like he's there taunting you, sort of thing.

Interviewer: And when you, kind of, are on an even keel, does that feel less present?

Respondent: Yeah, I don't see him when I, the meds are helping me. Without the meds, I would just go back to a bad place.

Interviewer: So that man, is that something that you see when you're kind of coming into a crisis?

Respondent: Mmm, yeah.

Interviewer: Something that you, kind of, you think is there?

Respondent: Yeah.

Interviewer: So then when you talked before about that kind of nightmare come true and that kind of fear, is that linked to that man?

Respondent: Yeah. That's, yeah. Yeah, it's just, I'm in a, well, I'm in a constant panic about everything. I worry about everything, so if I don't take my meds, I'll see him again, do you know what I mean? That's why I want to take my meds again because I don't want to see that bloke again.

Interviewer: And those worries, are they always around but then they get worse when the man's here?

Respondent: Yeah. Yeah, though, I've always got worries. I've always been a worrier, I've always, I look back now, it's my past, it's brought me to where I am now.

Interviewer: Even as, like, a little one, did you still worry, when you were a little one?

Respondent: No. When my dad left. When I was 10, it all…

Interviewer: So it's been since then?

Respondent: Mmm, it's been ever since then.

Interviewer: Okay. Do you feel like, so what do you think, in terms of things bringing on a crisis, I know we talked about life stress, does it tend to be, you know you said that you're on meds and that kind of keeps, when you're coming into a crisis, did you stop taking your meds…

Respondent: Yeah.

Interviewer: …or were you not on meds before?

Respondent: What it were, I were taking me meds for a while, from when I started seeing him and then when my ex took off two years ago and took my kids, it, like, sort of shocked me and I didn't take them. I was more bothered about seeing the kids.

Interviewer: Okay.

Respondent: And I just struggled on from then and tried to do it myself, tried to beat it myself but obviously I can't do it.

Interviewer: What do you think the signs are for you, when you're getting better? So when you're, kind of, coming out? I know you said about the sleeping and the eating is better but is there anything else that you think of when things start getting more even?

Respondent: I'll do things. I won't just sit in the house and do nothing, I'll tidy up a bit. This isn't tidied up a bit, you know when I look at it man it's, so I'll have it placed but…

Interviewer: I've got kids, it's tidier than mine.

Respondent: I do more, I'm trying to get back into things I enjoy, do you know what I mean? I suppose when I start enjoying them, I'll know I'm getting on right track.

Interviewer: Yeah but you feel a bit more motivated at the moment, it seems, to actually try and kind of get back into those.

Respondent: Yeah, yeah, yeah. Oh, I'm, yeah, because that's the reason why I've, even crisis team at first, because I didn't want to go back to a real bad place. I knew it were coming, so I did something about it.

Interviewer: Yeah. So do you think, when you've had previous crises, that now you kind of know when it's coming?

Respondent: Yeah, oh ah, yeah, you know when it's coming.

Interviewer: Do you think there was a moment when you thought, "Oh God, I need to ring the crisis team?"

Respondent: Yeah.

Interviewer: What was that moment? Can you remember?

Respondent: Yeah, bullying at work.

Interviewer: Okay.

Respondent: And it just, to be fair it's the lads who, you know, the lads who bullied me, when my ex took off, they terrorised me because I were working with them they knew I couldn't jack my job in, so they had me, like, over a barrel sort of thing and they terrorised me then and it just all, like, took me back two years and I just fell to bits.

Interviewer: Is there anything else that you think is important about crisis that we haven't spoken about?

Respondent: Yeah. Get people like my gaffer to, like, wake up to things like this. Do you know what I mean?

Interviewer: Did that make it worse then? Do you think, like, because…

Respondent: Yeah, yeah.

Interviewer: Okay.

Respondent: See, it makes me laugh, you've had, like, the gay and all that movements for the last 20 years rammed down his neck, yet I'm classed as a crackpot at work, yet, do you know what I mean? Where are we going with this, do you know what I mean? It's like, this happens to people, do you know what I mean? So…

Interviewer: And you think that's actually, kind of, made the crisis worse? Made that situation worse?

Respondent: Yeah, it does make things worse because my boss is, like, totally blind to it. It makes you laugh, a bloke will stand dressed up as a woman, no one bats an eyelid. Some youth, or a woman, whatever, has a bad time, you're classed as, you're a laughing stock and it's a joke. That's another thing that rubs me up the wrong way.

Interviewer: And I guess that's kind of added to the stress…

Respondent: Yeah.

Interviewer: …because you needed to keep your job at the same time.

Respondent: Yeah, and you've got to remember I work in the building trade, it's macho, do you know what I'm saying? It's all that all the time, "Oh, I'm bigger than you," crap, and you feel like you've got to conform to all that. You can't speak out and say things like this. "Hold off, pal, I'm having a panic attack at work"' because what do you think you're going to get? Do you know what I mean?

Interviewer: Do you think that kind of held you back from asking for help initially?

Respondent: The first time, yeah, not the second time because I don't give two craps because I know the score and I don't want to go back to a bad place.

Interviewer: Okay.

Respondent: So that's, you know.

Interviewer: Thank you, that's really helpful. Is there anything else you want to add, or…?

Respondent: No.

Interviewer: Okay, that's great, thank you.

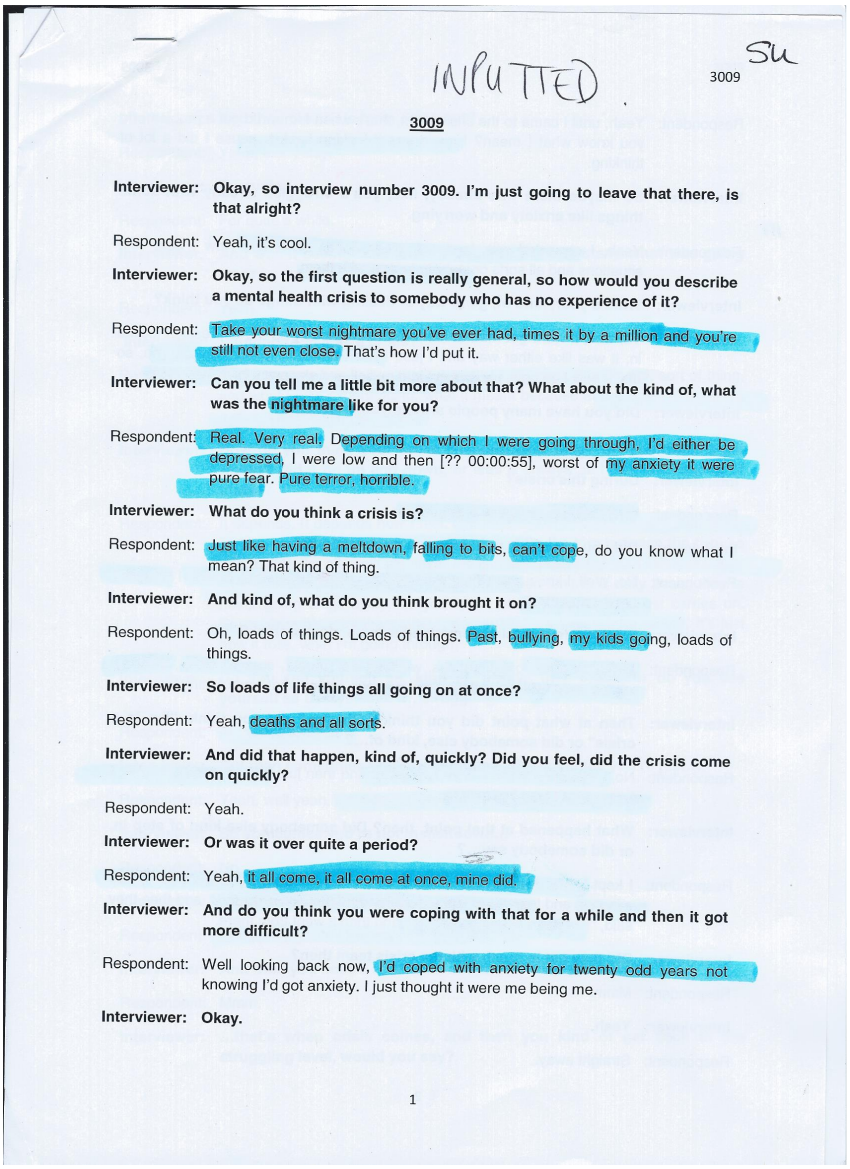
Respondent: No worries.

Interviewer: That's really helpful. Stop recording please, don't want to hear my voice too much.

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Meaning Units identified by Kerry Davies: transcript 3009



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3009

Interviewer: **Okay, so interview number 3009. I'm just going to leave that there, is that alright?**

Respondent: Yeah, it's cool.

Interviewer: **Okay, so the first question is really general, so how would you describe a mental health crisis to somebody who has no experience of it?**

Respondent: Take your worst nightmare you've ever had, times it by a million and you're still not even close. That's how I'd put it.

Interviewer: **Can you tell me a little bit more about that? What about the kind of, what was the nightmare like for you?**

Respondent: Real. Very real. Depending on which I were going through, I'd either be depressed, I were low and then [?? 00:00:55], worst of my anxiety it were pure fear. Pure terror, horrible.

Interviewer: **What do you think a crisis is?**

Respondent: Just like having a meltdown, falling to bits, can't cope, do you know what I mean? That kind of thing.

Interviewer: **And kind of, what do you think brought it on?**

Respondent: Oh, loads of things. Loads of things. Past, bullying, my kids going, loads of things.

Interviewer: **So loads of life things all going on at once?**

Respondent: Yeah, deaths and all sorts.

Interviewer: **And did that happen, kind of, quickly? Did you feel, did the crisis come on quickly?**

Respondent: Yeah.

Interviewer: **Or was it over quite a period?**

Respondent: Yeah, it all come, it all come at once, mine did.

Interviewer: **And do you think you were coping with that for a while and then it got more difficult?**

Respondent: Well looking back now, I'd coped with anxiety for twenty odd years not knowing I'd got anxiety. I just thought it were me being me.

Interviewer: **Okay.**

Respondent: Yeah, until I came to the crisis team, that's when I knew I'd got a problem, do you know what I mean? I could see it looking back because I did a lot of thinking.

Interviewer: So maybe there was already, like, you'd struggled already with some things like anxiety and worrying.

Respondent: Yeah, I struggled with loads of things, loads of things. How I deal with situations and all sorts or inability to deal with them.

Interviewer: What's your, kind of, go to way of dealing with things do you think?

Respondent: To, well, it were get mad at first but then obviously as the depression kicked in, it was like either way and I just, I just don't want people around me, so that's how I go now, I just revert into myself and shy away from the world.

Interviewer: Did you have many people around you at the time?

Respondent: No.

Interviewer: During this crisis?

Respondent: I don't have many people around me.

Interviewer: Did you know that you were in a crisis at first?

Respondent: No. Well, I knew something were up but I didn't know what it were. I thought I were going mad.

Interviewer: What made you think something was up, do you think?

Respondent: Crying at work, panic attacks, wouldn't eat nought, couldn't sleep, shaking, my leg were twitching all the time, nervous, jumpy, that kind of thing.

Interviewer: Then at what point did you think, "Oh, I'm," did you think, "I'm in a crisis" or did somebody else, kind of...?

Respondent: No, I struggled on with it for two years and then just, things were just, well, I just couldn't take it anymore.

Interviewer: What happened at that point, then? Did somebody else kind of step in, or did somebody say...?

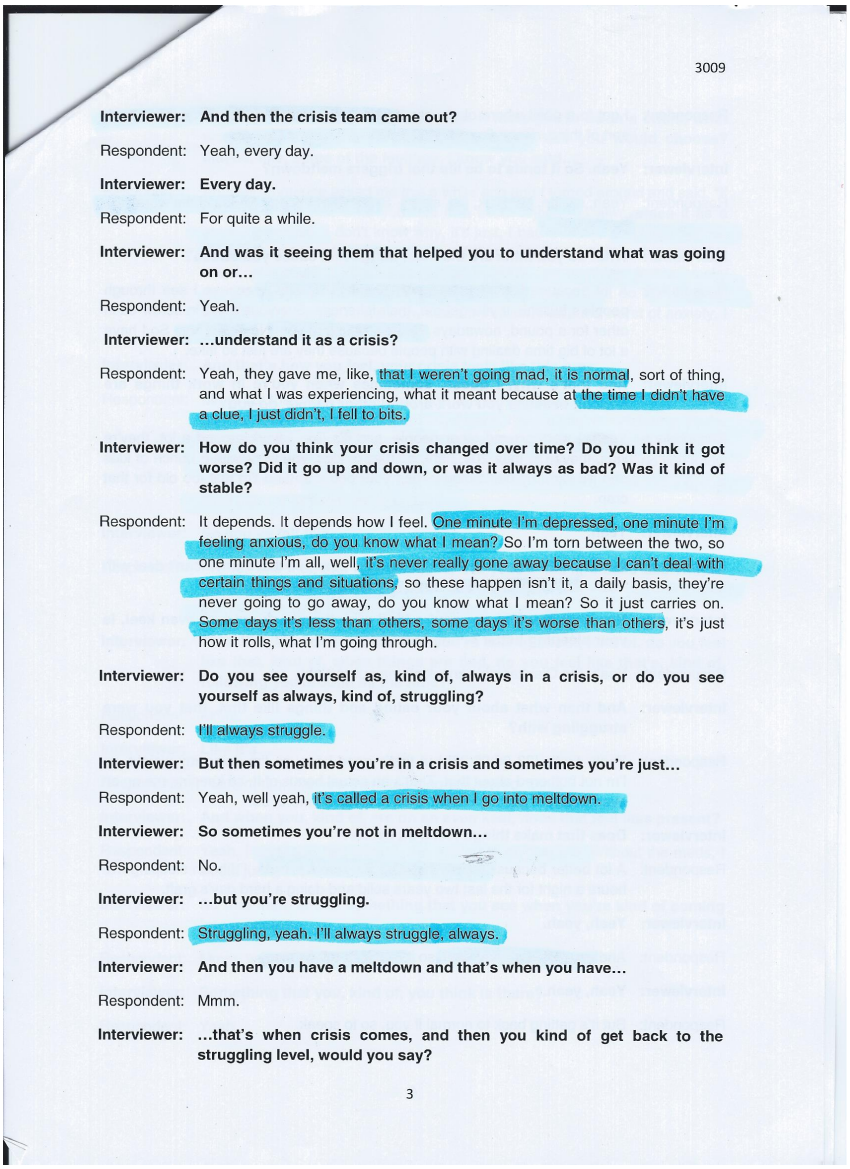
Respondent: I kept going down to the doctor's all the time, I were at doctor's every two minutes, and then I just had a massive panic attack at doctor's, and then they said, 'You need to see somebody' and then it went from there.

Interviewer: Did they get in touch with the crisis team then?

Respondent: Mmm.

Interviewer: Yeah.

Respondent: Straight away.



3009

Interviewer: **And then the crisis team came out?**

Respondent: Yeah, every day.

Interviewer: **Every day.**

Respondent: For quite a while.

Interviewer: **And was it seeing them that helped you to understand what was going on or…**

Respondent: Yeah.

Interviewer: **…understand it as a crisis?**

Respondent: Yeah, they gave me, like, that I weren't going mad, it is normal, sort of thing, and what I was experiencing, what it meant because at the time I didn't have a clue, I just didn't, I fell to bits.

Interviewer: **How do you think your crisis changed over time? Do you think it got worse? Did it go up and down, or was it always as bad? Was it kind of stable?**

Respondent: It depends. It depends how I feel. One minute I'm depressed, one minute I'm feeling anxious, do you know what I mean? So I'm torn between the two, so one minute I'm all, well, it's never really gone away because I can't deal with certain things and situations, so these happen isn't it, a daily basis, they're never going to go away, do you know what I mean? So it just carries on. Some days it's less than others, some days it's worse than others, it's just how it rolls, what I'm going through.

Interviewer: **Do you see yourself as, kind of, always in a crisis, or do you see yourself as always, kind of, struggling?**

Respondent: I'll always struggle.

Interviewer: **But then sometimes you're in a crisis and sometimes you're just…**

Respondent: Yeah, well yeah, it's called a crisis when I go into meltdown.

Interviewer: **So sometimes you're not in meltdown…**

Respondent: No.

Interviewer: **…but you're struggling.**

Respondent: Struggling, yeah. I'll always struggle, always.

Interviewer: **And then you have a meltdown and that's when you have…**

Respondent: Mmm.

Interviewer: **…that's when crisis comes, and then you kind of get back to the struggling level, would you say?**

3

Respondent: I get to a point where obviously, if I take me meds, I can keep an even keel, sort of thing, depending on what gets thrown at me life-wise.

Interviewer: Yeah. So it tends to be life that triggers meltdown?

Respondent: Yeah, it's life, it's work, life, stress. Stress is the worst. Stress is the worst. It's key to it all.

Interviewer: What do you think are the main things that cause you stress?

Respondent: A lot because I don't get on with people very often because I see through people's bullshit, if you get me, their fakeness. Everyone's out to screw each other for a pound, nowadays. No one listens to you. No one cares. So I have a lot of big time dealing with people because they are just so fake.

Interviewer: And that's why, I guess, sometimes when you're in work things are difficult because you work around other people, do you?

Respondent: Yeah, I work around other people, and it's like, I work around a lot, they're kids, they're in their 20s, right, so they're kids, you work with a bunch of kids and it's like, my dad's bigger than your dad crap and I'm just too old for that crap.

Interviewer: Yeah.

Respondent: And I'm sick of hearing this, that and the other, so that's why I can't deal with them. Can't cope with them because they just irritate me.

Interviewer: Now that you feel like you're kind of getting back onto an even keel, is your sleeping better?

Respondent: Yeah, the Olanzapine's knocking me out at night.

Interviewer: And then what about your eating and things like that, that you were struggling with?

Respondent: Yeah, that's [?? 00:08:26] but that's good because I'm doing my weight, so I'm not bothered about that. That's an actual bonus of it, so keeping me on an even keel, I'm gaining weight and I'm sleeping more, so.

Interviewer: Does that make things feel a bit easier?

Respondent: A lot better because I were sleeping five hours a night. I'd been sleeping five hours a night for the last two years solid and doing a hard day's graft.

Interviewer: Yeah, yeah.

Respondent: And not eating a great deal, so it's took its toll on me.

Interviewer: Yeah, yeah.

Respondent: But it's getting back to normal if you, so to speak.

Interviewer: **If you were to kind of describe what it feels like to be in a crisis, what would you say? What would be the words that you would choose? Maybe, like, some of the feelings, I know you said…**

Respondent: Ah, well, someone asked me this a while ago and I turned around and said, "If you could manifest what you feel in a solid object…" I always see it as a smoky grey man. I don't know why, it's just, I had a really, I had bad flashes and stuff and I had weird dreams and that's what I kept dreaming, just this weird, you couldn't see his face, you couldn't see anything, just a smoky geezer but you just knew wherever he were it were bad, so I'd wake up sweating in a panic. That's how, that's the worst, that's the worst of anxiety, I suppose.

Interviewer: **And that's how you feel, your crisis feels like this grey…**

Respondent: Mmm but then again, when that, sort of, like, I feel like I'm going crazy, I could pull me skin off because just nobody listens, it's like you're screaming, you're screaming that loud and everyone's just walking by and it's like no one hears you, it's like you're not even there, that's how frustrated you feel, do you know what I mean? It feels like everyone's rushing around and you're moving at a snail pace, a bit like they do on films…

Interviewer: **So you've felt like…**

Respondent: I've felt like that, just racing around, everyone's racing around and I'm just going like, what? Just like that. Like, a full day could flicker in front of me, like, do you know what I mean? It's like that kind of speed.

Interviewer: **This, like, kind of grey man that you're talking about, kind of, do you feel like that, kind of, when things are bad, do you feel like that's, kind of, following you around all the time?**

Respondent: Mmm.

Interviewer: **Like it's…**

Respondent: Yeah, mmm, like he's there taunting you, sort of thing.

Interviewer: **And when you, kind of, are on an even keel, does that feel less present?**

Respondent: Yeah, I don't see him when I, the meds are helping me. Without the meds, I would just go back to a bad place.

Interviewer: **So that man, is that something that you see when you're kind of coming into a crisis?**

Respondent: Mmm, yeah.

Interviewer: **Something that you, kind of, you think is there?**

Respondent: Yeah.

Interviewer: **So then when you talked before about that kind of nightmare come true and that kind of fear, is that linked to that man?**

Respondent: Yeah. That's, yeah. Yeah, it's just, I'm in a, well, I'm in a constant panic about everything. I worry about everything, so if I don't take my meds, I'll see him again, do you know what I mean? That's why I want to take my meds again because I don't want to see that bloke again.

Interviewer: **And those worries, are they always around but then they get worse when the man's here?**

Respondent: Yeah. Yeah, though, I've always got worries. I've always been a worrier. I've always, I look back now, it's my past, it's brought me to where I am now.

Interviewer: **Even as, like, a little one, did you still worry, when you were a little one?**

Respondent: No. When my dad left. When I was 10, it all…

Interviewer: **So it's been since then?**

Respondent: Mmm, it's been ever since then.

Interviewer: **Okay. Do you feel like, so what do you think, in terms of things bringing on a crisis, I know we talked about life stress, does it tend to be, you know you said that you're on meds and that kind of keeps, when you're coming into a crisis, did you stop taking your meds…**

Respondent: Yeah.

Interviewer: **…or were you not on meds before?**

Respondent: What it were, I were taking me meds for a while, from when I started seeing him and then when my ex took off two years ago and took my kids, it, like, sort of shocked me and I didn't take them. I was more bothered about seeing the kids.

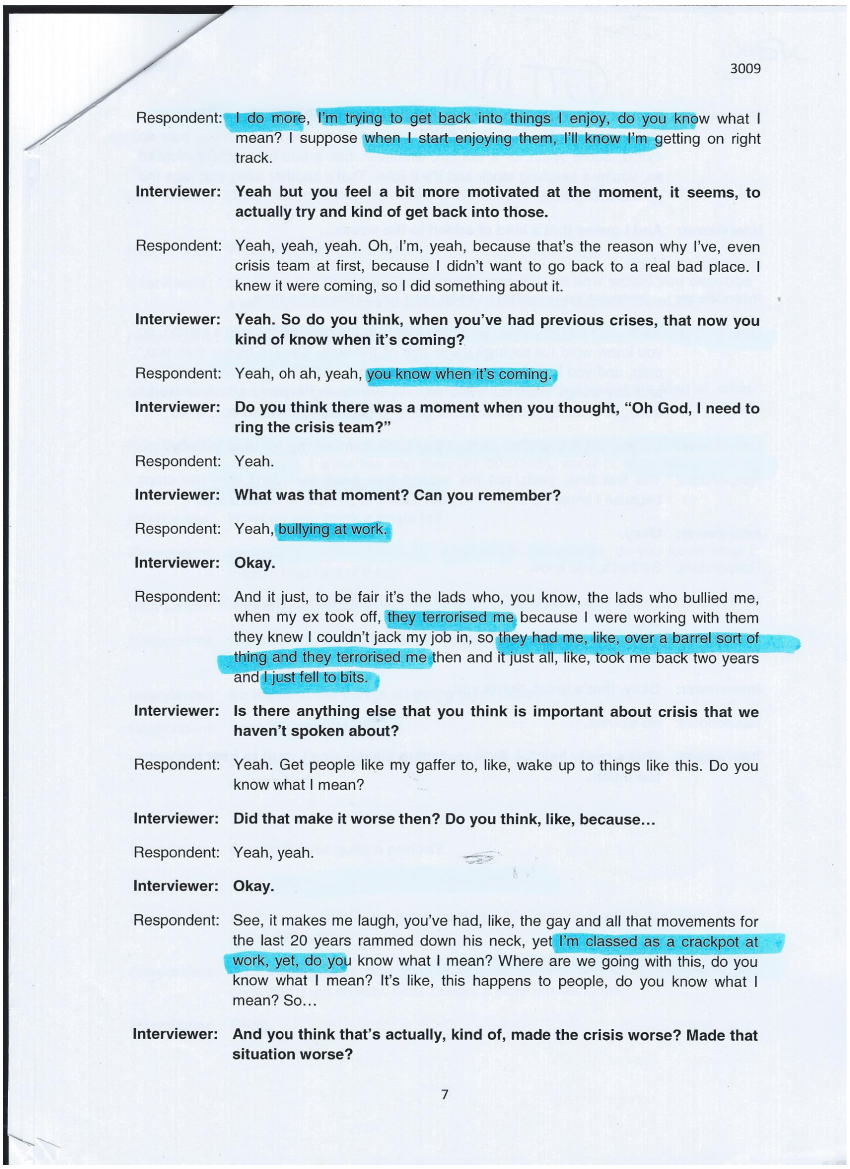
Interviewer: **Okay.**

Respondent: And I just struggled on from then and tried to do it myself, tried to beat it myself but obviously I can't do it.

Interviewer: **What do you think the signs are for you, when you're getting better? So when you're, kind of, coming out? I know you said about the sleeping and the eating is better but is there anything else that you think of when things start getting more even?**

Respondent: I'll do things. I won't just sit in the house and do nothing, I'll tidy up a bit. This isn't tidied up a bit, you know when I look at it man it's, so I'll have it placed but…

Interviewer: **I've got kids, it's tidier than mine.**



Respondent: I do more, I'm trying to get back into things I enjoy, do you know what I mean? I suppose when I start enjoying them, I'll know I'm getting on right track.

Interviewer: Yeah but you feel a bit more motivated at the moment, it seems, to actually try and kind of get back into those.

Respondent: Yeah, yeah, yeah. Oh, I'm, yeah, because that's the reason why I've, even crisis team at first, because I didn't want to go back to a real bad place. I knew it were coming, so I did something about it.

Interviewer: Yeah. So do you think, when you've had previous crises, that now you kind of know when it's coming?

Respondent: Yeah, oh ah, yeah, you know when it's coming.

Interviewer: Do you think there was a moment when you thought, "Oh God, I need to ring the crisis team?"

Respondent: Yeah.

Interviewer: What was that moment? Can you remember?

Respondent: Yeah, bullying at work.

Interviewer: Okay.

Respondent: And it just, to be fair it's the lads who, you know, the lads who bullied me, when my ex took off, they terrorised me because I were working with them they knew I couldn't jack my job in, so they had me, like, over a barrel sort of thing and they terrorised me then and it just all, like, took me back two years and I just fell to bits.

Interviewer: Is there anything else that you think is important about crisis that we haven't spoken about?

Respondent: Yeah. Get people like my gaffer to, like, wake up to things like this. Do you know what I mean?

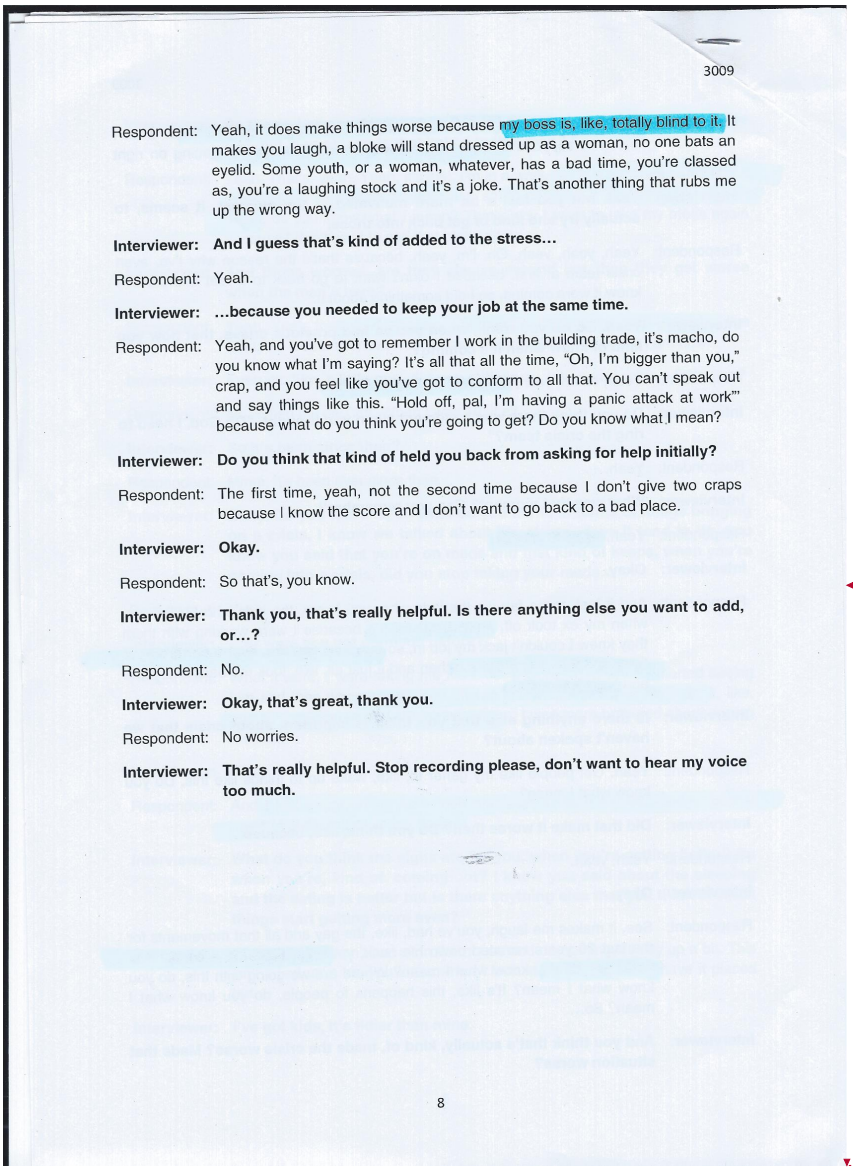
Interviewer: Did that make it worse then? Do you think, like, because…

Respondent: Yeah, yeah.

Interviewer: Okay.

Respondent: See, it makes me laugh, you've had, like, the gay and all that movements for the last 20 years rammed down his neck, yet I'm classed as a crackpot at work, yet, do you know what I mean? Where are we going with this, do you know what I mean? It's like, this happens to people, do you know what I mean? So…

Interviewer: And you think that's actually, kind of, made the crisis worse? Made that situation worse?



3009

Respondent: Yeah, it does make things worse because my boss is, like, totally blind to it. It makes you laugh, a bloke will stand dressed up as a woman, no one bats an eyelid. Some youth, or a woman, whatever, has a bad time, you're classed as, you're a laughing stock and it's a joke. That's another thing that rubs me up the wrong way.

Interviewer: And I guess that's kind of added to the stress…

Respondent: Yeah.

Interviewer: …because you needed to keep your job at the same time.

Respondent: Yeah, and you've got to remember I work in the building trade, it's macho, do you know what I'm saying? It's all that all the time, "Oh, I'm bigger than you," crap, and you feel like you've got to conform to all that. You can't speak out and say things like this. "Hold off, pal, I'm having a panic attack at work"' because what do you think you're going to get? Do you know what I mean?

Interviewer: Do you think that kind of held you back from asking for help initially?

Respondent: The first time, yeah, not the second time because I don't give two craps because I know the score and I don't want to go back to a bad place.

Interviewer: Okay.

Respondent: So that's, you know.

Interviewer: Thank you, that's really helpful. Is there anything else you want to add, or…?

Respondent: No.

Interviewer: Okay, that's great, thank you.

Respondent: No worries.

Interviewer: That's really helpful. Stop recording please, don't want to hear my voice too much.

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Interviewer: Okay, so interview number 3009. I'm just going to leave that there, is that alright?

Respondent: Yeah, it's cool.

Interviewer: Okay, so the first question is really general, so how would you describe a mental health crisis to somebody who has no experience of it?

Respondent: Take your worst nightmare you've ever had, times it by a million and you're still not even close. That's how I'd put it.

Interviewer: Can you tell me a little bit more about that? What about the kind of, what was the nightmare like for you?

Respondent: Real. Very real. Depending on which I were going through,

I'd either be depressed, I were low and then [?? 00:00:55],

worst of my anxiety it were pure fear. Pure terror, horrible.

Interviewer: What do you think a crisis is?

Respondent: Just like having a meltdown,

falling to bits,

can't cope, do you know what I mean? That kind of thing.

Interviewer: And kind of, what do you think brought it on?

Respondent: Oh, loads of things. Loads of things. Past,

bullying,

my kids going, loads of things.

Interviewer: So loads of life things all going on at once?

Respondent: Yeah, deaths and all sorts.

Interviewer: And did that happen, kind of, quickly? Did you feel, did the crisis come on quickly?

Respondent: Yeah.

Interviewer: Or was it over quite a period?

Respondent: Yeah, it all come, it all come at once, mine did.

Interviewer: And do you think you were coping with that for a while and then it got more difficult?

Respondent: Well looking back now, I'd coped with anxiety for twenty odd years not knowing I'd got anxiety. I just thought it were me being me.

Interviewer: Okay.

Respondent: Yeah, until I came to the crisis team, that's when I knew I'd got a problem, do you know what I mean? I could see it looking back because I did a lot of thinking.

Interviewer: So maybe there was already, like, you'd struggled already with some things like anxiety and worrying.

Respondent: Yeah, I struggled with loads of things, loads of things.

How I deal with situations and all sorts or inability to deal with them.

Interviewer: What's your, kind of, go to way of dealing with things do you think?

Respondent: To, well, it were get mad at first but then obviously as the depression kicked in, it was like either way and I just, I just don't want people around me, so that's how I go now, I just revert into myself and shy away from the world.

Interviewer: Did you have many people around you at the time?

Respondent: No.

Interviewer: During this crisis?

Respondent: I don't have many people around me.

Interviewer: Did you know that you were in a crisis at first?

Respondent: No. Well, I knew something were up but I didn't know what it were.

I thought I were going mad.

Interviewer: What made you think something was up, do you think?

Respondent: Crying at work,

panic attacks,

wouldn't eat nought,

couldn't sleep,

shaking,

my leg were twitching all the time,

nervous,

jumpy, that kind of thing.

Interviewer: Then at what point did you think, "Oh, I'm," did you think, "I'm in a crisis" or did somebody else, kind of…?

Respondent: No, I struggled on with it for two years and then just, things were just, well, I just couldn't take it anymore.

Interviewer: What happened at that point, then? Did somebody else kind of step in, or did somebody say…?

Respondent: I kept going down to the doctor's all the time, I were at doctor's every two minutes, and then

I just had a massive panic attack at doctor's, and then

they said, 'You need to see somebody' and then it went from there.

Interviewer: Did they get in touch with the crisis team then?

Respondent: Mmm.

Interviewer: Yeah.

Respondent: Straight away.

Interviewer: And then the crisis team came out?

Respondent: Yeah, every day.

Interviewer: Every day.

Respondent: For quite a while.

Interviewer: And was it seeing them that helped you to understand what was going on or…

Respondent: Yeah.

Interviewer: …understand it as a crisis?

Respondent: Yeah, they gave me, like, that I weren't going mad, it is normal, sort of thing, and what I was experiencing, what it meant because at the time

I didn't have a clue, I just didn't,

I fell to bits.

Interviewer: How do you think your crisis changed over time? Do you think it got worse? Did it go up and down, or was it always as bad? Was it kind of stable?

Respondent: It depends. It depends how I feel. One minute I'm depressed,

one minute I'm feeling anxious, do you know what I mean? So I'm torn between the two, so one minute I'm all, well, it's never really gone away because I can't deal with certain things and situations, so these happen isn't it, a daily basis, they're never going to go away, do you know what I mean? So it just carries on.

Some days it's less than others, some days it's worse than others, it's just how it rolls, what I'm going through.

Interviewer: Do you see yourself as, kind of, always in a crisis, or do you see yourself as always, kind of, struggling?

Respondent: I'll always struggle.

Interviewer: But then sometimes you're in a crisis and sometimes you're just…

Respondent: Yeah, well yeah, it's called a crisis when I go into meltdown.

Interviewer: So sometimes you're not in meltdown…

Respondent: No.

Interviewer: …but you're struggling.

Respondent: Struggling, yeah. I'll always struggle, always.

Interviewer: And then you have a meltdown and that's when you have…

Respondent: Mmm.

Interviewer: …that's when crisis comes, and then you kind of get back to the struggling level, would you say?

Respondent: I get to a point where obviously, if I take me meds, I can keep an even keel, sort of thing, depending on what gets thrown at me life-wise.

Interviewer: Yeah. So it tends to be life that triggers meltdown?

Respondent: Yeah, it's life, it's work, life, stress. Stress is the worst. Stress is the worst. It's key to it all.

Interviewer: What do you think are the main things that cause you stress?

Respondent: A lot because I don't get on with people very often because

I see through people's bullshit, if you get me, their fakeness.

Everyone's out to screw each other for a pound, nowadays.

No one listens to you.

No one cares.

So I have a lot of big time dealing with people because they are just so fake.

Interviewer: And that's why, I guess, sometimes when you're in work things are difficult because you work around other people, do you?

Respondent: Yeah, I work around other people, and it's like, I work around a lot, they're kids, they're in their 20s, right, so they're kids, you work with a bunch of kids and it's like, my dad's bigger than your dad crap and

I'm just too old for that crap.

Interviewer: Yeah.

Respondent: And I'm sick of hearing this, that and the other, so that's why I can't deal with them. Can't cope with them because they just irritate me.

Interviewer: Now that you feel like you're kind of getting back onto an even keel, is your sleeping better?

Respondent: Yeah, the Olanzapine's knocking me out at night.

Interviewer: And then what about your eating and things like that, that you were struggling with?

Respondent: Yeah, that's [?? 00:08:26] but that's good because I'm doing my weight, so I'm not bothered about that. That's an actual bonus of it, so keeping me on an even keel, I'm gaining weight and I'm sleeping more, so.

Interviewer: Does that make things feel a bit easier?

Respondent: A lot better because I were sleeping five hours a night. I'd been sleeping five hours a night for the last two years solid and doing a hard day's graft.

Interviewer: Yeah, yeah.

Respondent: And not eating a great deal, so it's took its toll on me.

Interviewer: Yeah, yeah.

Respondent: But it's getting back to normal if you, so to speak.

Interviewer: If you were to kind of describe what it feels like to be in a crisis, what would you say? What would be the words that you would choose? Maybe, like, some of the feelings, I know you said…

Respondent: Ah, well, someone asked me this a while ago and I turned around and said, "If you could manifest what you feel in a solid object…" I always see it as a smoky grey man.

I don't know why, it's just, I had a really, I had bad flashes and stuff and I had weird dreams and that's what I kept dreaming, just this weird, you couldn't see his face, you couldn't see anything, just a smoky geezer but you just knew wherever he were it were bad, so I'd wake up sweating in a panic. That's how, that's the worst, that's the worst of anxiety, I suppose.

Interviewer: And that's how you feel, your crisis feels like this grey…

Respondent: Mmm but then again, when that, sort of, like, I feel like I'm going crazy,

I could pull me skin off because just nobody listens,

it's like you're screaming, you're screaming that loud and everyone's just walking by

and it's like no one hears you,

it's like you're not even there,

that's how frustrated you feel, do you know what I mean? It feels like everyone's rushing around and you're moving at a snail pace, a bit like they do on films…

Interviewer: So you've felt like…

Respondent: I've felt like that, just racing around, everyone's racing around and

I'm just going like, what? Just like that. Like, a full day could flicker in front of me, like, do you know what I mean? It's like that kind of speed.

Interviewer: This, like, kind of grey man that you're talking about, kind of, do you feel like that, kind of, when things are bad, do you feel like that's, kind of, following you around all the time?

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Interviewer: Like it's…

Respondent: Yeah, mmm, like he's there taunting you, sort of thing.

Interviewer: And when you, kind of, are on an even keel, does that feel less present?

Respondent: Yeah, I don't see him when I, the meds are helping me. Without the meds, I would just go back to a bad place.

Interviewer: So that man, is that something that you see when you're kind of coming into a crisis?

Respondent: Mmm, yeah.

Interviewer: Something that you, kind of, you think is there?

Respondent: Yeah.

Interviewer: So then when you talked before about that kind of nightmare come true and that kind of fear, is that linked to that man?

Respondent: Yeah. That's, yeah. Yeah, it's just, I'm in a, well, I'm in a constant panic about everything. I worry about everything, so if I don't take my meds, I'll see him again, do you know what I mean? That's why I want to take my meds again because I don't want to see that bloke again.

Interviewer: And those worries, are they always around but then they get worse when the man's here?

Respondent: Yeah. Yeah, though, I've always got worries. I've always been a worrier, I've always, I look back now, it's my past, it's brought me to where I am now.

Interviewer: Even as, like, a little one, did you still worry, when you were a little one?

Respondent: No. When my dad left. When I was 10, it all…

Interviewer: So it's been since then?

Respondent: Mmm, it's been ever since then.

Interviewer: Okay. Do you feel like, so what do you think, in terms of things bringing on a crisis, I know we talked about life stress, does it tend to be, you know you said that you're on meds and that kind of keeps, when you're coming into a crisis, did you stop taking your meds…

Respondent: Yeah.

Interviewer: …or were you not on meds before?

Respondent: What it were, I were taking me meds for a while, from when I started seeing him and then when my ex took off two years ago and took my kids, it, like, sort of shocked me and I didn't take them. I was more bothered about seeing the kids.

Interviewer: Okay.

Respondent: And I just struggled on from then and tried to do it myself, tried to beat it myself but obviously I can't do it.

Interviewer: What do you think the signs are for you, when you're getting better? So when you're, kind of, coming out? I know you said about the sleeping and the eating is better but is there anything else that you think of when things start getting more even?

Respondent: I'll do things. I won't just sit in the house and do nothing, I'll tidy up a bit. This isn't tidied up a bit, you know when I look at it man it's, so I'll have it placed but…

Interviewer: I've got kids, it's tidier than mine.

Respondent: I do more, I'm trying to get back into things I enjoy, do you know what I mean? I suppose when I start enjoying them, I'll know I'm getting on right track.

Interviewer: Yeah but you feel a bit more motivated at the moment, it seems, to actually try and kind of get back into those.

Respondent: Yeah, yeah, yeah. Oh, I'm, yeah, because that's the reason why I've, even crisis team at first, because I didn't want to go back to a real bad place. I knew it were coming, so I did something about it.

Interviewer: Yeah. So do you think, when you've had previous crises, that now you kind of know when it's coming?

Respondent: Yeah, oh ah, yeah, you know when it's coming.

Interviewer: Do you think there was a moment when you thought, "Oh God, I need to ring the crisis team?"

Respondent: Yeah.

Interviewer: What was that moment? Can you remember?

Respondent: Yeah, bullying at work.

Interviewer: Okay.

Respondent: And it just, to be fair it's the lads who, you know, the lads who bullied me, when my ex took off, they terrorised me because I

were working with them they knew I couldn't jack my job in, so they had me, like, over a barrel sort of thing and they terrorised me then and it just all, like, took me back two years and I just fell to bits.

Interviewer: Is there anything else that you think is important about crisis that we haven't spoken about?

Respondent: Yeah. Get people like my gaffer to, like, wake up to things like this. Do you know what I mean?

Interviewer: Did that make it worse then? Do you think, like, because…

Respondent: Yeah, yeah.

Interviewer: Okay.

Respondent: See, it makes me laugh, you've had, like, the gay and all that movements for the last 20 years rammed down his neck, yet I'm classed as a crackpot at work, yet, do you know what I mean? Where are we going with this, do you know what I mean? It's like, this happens to people, do you know what I mean? So…

Interviewer: And you think that's actually, kind of, made the crisis worse? Made that situation worse?

Respondent: Yeah, it does make things worse because my boss is, like, totally blind to it. It makes you laugh, a bloke will stand dressed up as a woman, no one bats an eyelid. Some youth, or a woman, whatever, has a bad time, you're classed as, you're a laughing stock and it's a joke. That's another thing that rubs me up the wrong way.

Interviewer: And I guess that's kind of added to the stress…

Respondent: Yeah.

Interviewer: …because you needed to keep your job at the same time.

Respondent: Yeah, and you've got to remember I work in the building trade, it's macho, do you know what I'm saying? It's all that all the time, "Oh, I'm bigger than you," crap, and you feel like you've got to conform to all that. You can't speak out and say things like this. "Hold off, pal, I'm having a panic attack at work"' because what do you think you're going to get? Do you know what I mean?

Interviewer: Do you think that kind of held you back from asking for help initially?

Respondent: The first time, yeah, not the second time because I don't give two craps because I know the score and I don't want to go back to a bad place.

Interviewer: Okay.

Respondent: So that's, you know.

Interviewer: Thank you, that's really helpful. Is there anything else you want to add, or…?

Respondent: No.

Interviewer: Okay, that's great, thank you.

Respondent: No worries.

Interviewer: That's really helpful. Stop recording please, don't want to hear my voice too much.

Appendix J: Pre/Post Q sort questions

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PRE/POST Q-SORT QUESTIONS

VERSION 1: 14/12/2015

Confidential participant number:_____

Questions to be asked 'Pre' Q sort:

What is the participant's age: _____

What is the participant's gender: _____

Questions to be asked 'Pre' Q sort:

1) How did you find the process of sorting the statements?
2) Is there anything that could make the process better?
3) Do you think there were any statements missing?
4) Do you have any reflections on your rankings?
5) I noticed you put (insert statements ranked at extreme poles) as 'most'/'least' like a crisis, is there anything more you want to say about that?
6) Is there anything you want to say about crisis that you feel you didn't get to express in this task

Appendix K: Q sort distribution sheet

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most uncharacteristic of crisis _____most characteristic of crisis

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6

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Page 7: [2] Deleted	kerry davies	9/1/16 12:10:00 PM

Sampling the concourse and defining the Q-set. The first stage of a Q-methodological study is to define the concourse. The concourse is a set of statements that reflects all that is known of about a topic (Watts & Stenner, 2012). In this study a 'hybrid' method of assembling the concourse was used (McKeown & Thomas, 1988) which combines naturalistic (interview) methods with ready-made (literature) methods. A total of 16 participants were interviewed about their perspectives of crisis. After transcription of voice recordings key themes were identified. See extended paper for details of the analytic method.

Table 1
Themes and subthemes identified in the interview data

	The nature of crisis	Causes of crisis	The 'crisis' experience	Coping/attempts at resolution
Subthemes	'it's the difference, from them normally to them poorly'	'underlying vulnerability'	Emotional experience	Continued ineffective attempts at resolution
	'hard to explain, and hard to understand'	Internal trigger	Cognitive experience	Withdrawal
	'it's different for everyone'	'people cause crisis'	Perceptual changes	Help seeking
	'crisis as temporal'	'the impact of the world we live in'	Impact on functioning	The frustrated approach
	Understanding crisis	'the straw that broke the camel's back'	Confusion	
			Risk	
			The need for help	
			Carer burden	

Statements that represented the crisis experience theme were directly extracted to form the Q-set. The collection of statements was condensed by removing duplicated meaning and choosing statements that best reflected the theme as a whole. This process was assisted by the research team and service user input. As is common in Q-methodology, the statements from interviews were supplemented with statements generated from existing literature. A final Q-set of 78 statements was assembled to specifically examine the experience of crisis. Each statement was transcribed onto a set of numbered cards for use in the Q-sort procedure. For more information see extended paper.

Participants. In Q-methodology participants are often selected based on their knowledge or experience of the research topic (Chinnis, Debra & Stephen, 2001; Cordingley, Webb, & Hillier, 1997). Stratified sampling

was used in order to collect data from the population that represented the central stakeholders of the term 'crisis'. For more information see extended paper.

Participants (n=26) were all service users, carers, or professionals with experience of crisis. They were recruited from an NHS based CRHT, a carer support group, and a third sector organisation providing peer support and low intensity intervention. The participant group as a whole was made up of ten males and 16 females, with a mean age of 50.6 (SD=16.30). The demographics by groups are summarised in Table 2. All potential participants apart from service users were approached by the primary author. Service users were identified and approached by their usual care team due to ethical considerations. All participants gave written informed consent. For more information see extended paper.

Procedure. All Q-sorts were conducted in the participants' own home, place of work, or NHS site depending on their preference. Participants were asked to provide their age and gender. All participants were given an instruction sheet detailing how to complete the Q-sort process; the primary author was present to support this process. The process used followed guidance from Watts and Stenner (2012). Participants were asked to read the 78 statements. They were first asked to organise the statements into three piles 'mostly characteristic' of crisis, 'least characteristic' of crisis, and 'neutral/unsure'.

Participants then sorted the statements again. Participants were asked to begin with the most characteristic pile and lay all the statements out so they could be seen. They were asked to place the two statements that they thought were 'most characteristic' of crisis in the +6 column of the quasi-normal fixed response grid (as shown in figure 1) and to then continue placing statements in the other descending columns until all statements in the 'like' crisis pile were ordered along the distribution. Participants were then asked to continue the process with the other two piles, either continuing in the same direction with their neutral pile, or starting at the other side with their 'least characteristic pile'. Participants were given ample time to rearrange their responses. After indicating that their Q-sort was complete the number of each statement was recorded onto a corresponding response grid. On completing the Q-sort participants were asked a brief set of questions designed to elicit reflection on the statements and the Q-sort process and were subsequently debriefed.

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* indicates Q sorts that loaded significantly on Factor one only

** indicates Q sorts that loaded significantly on Factor two only

*** Q sorts that were confounding (loading significantly on both Factor one and two)

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This leaves an understanding that maybe that the crisis/emotional disturbance is ‘not something wrong with me, but it is not normal for me either’.

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The understandings offered by Crisis theory and the understandings of crisis in the contemporary CRHT model (Tobitt & Kamboj, 2010) bear some clear similarities. Both identify crisis as a period in time, both highlight the inherent variability in crisis responses and trajectory. Both highlight a potential underlying vulnerability, contextual triggers, and the imbalance between distress/difficulties and the ability to cope with them. Despite these similarities, some have argued that the contemporary CRHT model is an atheoretical approach to service provision (Johnson & Needle, 2008), due to the lack of explicit theoretical foundations. Some propose the application of Crisis Theory to mental health settings is useful (Bridgett & Polak, 2003) others argue have argued that it is inappropriate (Ball, Links, Strike, & Boydell, 2005; Brennaman 2012; Callahan, 1994), in part due to its lack of focus on mental illness. However, Callahan (2009) later proposed that consensus within contemporary understandings of crisis appear to be shifting to the traditional theories of the 1960s and 1970s (such as Caplan, 1964; Lindemann, 1944). This may in part suggest that suggesting that the CRHT model is atheoretical (Johnson & Needle, 2008) may not be a just critique, despite the seeming lack of efforts to explicate the theoretical foundations as hightlighted by Tobitt and Kamboj (2010).

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Tobitt and Kamboj (2011) recommended that further research into the understandings of service users and carers is vital due to the lack of empirical knowledge of their perspectives. The service user and carer panel that influenced the development of this research suggested that it was possible that service users, carers and professionals understood crisis differently and reflected on their experiences of this when using or attempting to access crisis services. These differences in understanding may have implications for goals of shared decision making in crisis intervention (Farrelly et al. 2015). This research is in line with current national drivers for service user involvement and participation in health care (NHS England, 2013). Involving service users in defining their own experiences of crisis is thought to be an important avenue for research for improving crisis service provision (Johnson et al. 2008).

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even within one crisis team there are some differences between how professionals understanding crisis

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Tobitt and Kamboj (2011) recommended that further research into the understandings of service users and carers is vital due to the lack of empirical knowledge of their perspectives.

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This research could help us to understand different perspectives, so that these differences can be better navigated, in order to promote positive engagement and avoid crisis situations being overlooked. This is particularly important due to the proposed distinction between crisis, psychiatric emergency and risk of harm, and the associated links to clinical outcome (Callahan, 1994; Brennaman, 2012). The importance of clarity in communication was also highlighted by Tobitt and Kamboj (2011) regards negotiating access to crisis services. They suggested that furthering our understanding of crisis could improve the clarity and appropriateness of the definitions that determine access to services and intervention type, this enabling better clinical judgement and outcome. The presence of service user perspectives within these definitions are particularly relevant given the increasing focus on the rights of patients experiencing acute mental health problems to access community treatment (Tobitt & Kamboj, 2011), and the legal responsibilities held by professionals such as Approved Mental Health Professionals (AMHP) and Responsible Clinicians (RCs).

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Epistemology is concerned with the nature of knowledge, and how we can acquire it (Snape & Spencer, 2003).

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Epistemology is concerned with the nature of knowledge, and how we can acquire it (Snape & Spencer, 2003). As Watts and Stenner (2012) discuss, Q methodology can be approached from constructivist or constructionist perspective. Constructivism proposes 'people do not passively see things as they are in any sort of unproblematic fashion, but are instead continually and actively selective in their attention' (Watts, 2009). Therefore people engage in a meaning making process determined by what they attend to and what they perceive as significant. This is a meaning making that is 'personally' meaningful. On the other hand constructionism generally refers to social aspects of this meaning making process. Rather than personal meaning, the meaning regards shared viewpoints, and social knowledge/discourses (McHoul & Grace, 1995). Therefore it is socially meaningful. Socially

constructed meanings and discourses tend to saturate the context of individuals, and become entangled with their own meaning making.

This study can be considered to assume both perspectives. The design incorporates both personally meaningful (self-referent) viewpoints yet it is expected that socially meaningful discourses will permeate the concourse. Each Q sort becomes a snapshot of personally meaningful and self-referent view of crisis. Yet when analysed as a multiple-participant study social viewpoints are likely to emerge. The grouped design allows differences within social viewpoints to be explored, highlighting areas of commonality and difference. Watts and Stenner (2012) explain that social constructionism offers insight into the common meanings that arise in the Q methodology process. They explain that despite the vast amount of variability that offered by the Q sort procedure, consensus is surprisingly common and in fact only three or four factors usually emerge (Stephenson, 1982, p216). Therefore the social viewpoints and messages that are imbedded in our environments from birth become 'object-like' knowledge structures that become a point of reference impossible to relinquish.

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As described by Watts and Stenner (2012) the equation for the $p<0.01$ significance level is:

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* indicates Q sorts that loaded significantly on Factor one only

** indicates Q sorts that loaded significantly on Factor two only

*** Q sorts that were confounding (loading significantly on both Factor one and two)

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Table 11

Findings highlighted as unexpected or idiosyncratic during interpretation

Statements in the Factor one array	Statements in the Factor two array	Differentiating statements
40 Incomprehensible rage (ranked 0)	40 Incomprehensible rage ranked (-4)	40 Incomprehensible rage (more strongly associated with Factor one)
67 Absolute despair (ranked +3)	13 You want to do something to feel better, maybe drinking or drugs (ranked -6) 19 You stop taking your medication	33 You feel totally shut off from everyone (more strongly associated with Factor two)

(ranked -6)

The advantages of the holistic approach and attending to the full configuration was the potential for further hypothesising about why the understandings manifest in such a way, which is consistent with a Q methodological approach that aims to generate infinite hypotheses and new insights. Table 11 shows that despite factor two representing the emotional devastation attributed to the crisis experience there were also two extreme emotion related statements that were ranked higher in factor one. In particular, 'incomprehensible rage' was s statement that most differentiated between the factors. Similarly, 'you feel totally shut off from everyone' was more associated with emotional disturbance rather than perceptual disturbance.

Two emotion related statements, 'incomprehensible rage' and 'absolute despair', were more strongly associated with factor one. Incomprehensible rage was a statement that best differentiated between the understandings. It seems that rage is less associated with the emotion experience of crisis, yet more commonly understood as being related to the disturbances in perception. Further to rage, 'absolute despair' was also more highly associated with Factor One, therefore another emotion related statement that was more strongly associated with the impact of crisis on perception. These findings are discussed further in the discussion section.

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Risk. Although risk was not identified as a factor in its own right, holistic interpretation highlighted that it was a core feature within both factors. Furthermore, the interpretation of the Q-sort offered by Participant 11 demonstrates that risk may be central to the understandings of crisis for some people. As such, tthe findings suggest that although risk is related to crisis, the degree to which it is central to the way people understand their experience varies. of The way that risk statements featured within the two factor model presented further insight into the relationship between risk and crisis. this research suggest that increased risk is not a central characteristic of crisis (as discussed in the journal paper), the findings did associate these changes in perception to increased risk

. In the face of no perceived future or resolution people described the risk of perceiving death as being the only way of escape.

Risk appearedwas more strongly associated with perceptual changesion than emotional distress. This may ; suggest thating people understand increased risk as a result of impaired judgement, having no hope for the future, and seeing no way of resolving the crisis. Understanding risk as associated to perceptual changes, rather than a central characteristic of crisis in its own right, is not synonymous with other professional understandings of crisis in empirical literature (Tobitt & Kamboj, 2011) and definitions in CRHT policy (Department of Health, 2001) that suggest risk as central a defining characteristic ofto crisis. The factor solution therefore presents an interesting perspectivedistinction onto existing definitions that influence clinical practice and service structure. Although risk was a core feature of both factors, it was also highlighted that people may not define their experience in this way. This highlights that although it is important to attend to concerns about risk, it is equally important to attend to how individuals understand risk in relation to their experience of crisis. Although these findings differ from some (Tobitt & Kamboj, 2011; Department of Health, 2001), it is

synonymous with other crisis literature suggesting it is important to distinguish crisis from emergency to ensure good clinical outcomes (Callahan, 1994; Callahan,1998; Brennaman, 2012). Therefore, attending to how people make sense of risk in relation to their experiences of crisis could have benefits for determining appropriate interventions and achieving good clinical outcomes.

Defining risk as central to crisis within service structures may serve to manage professional anxieties. Menzies (1960) landmark case study of a nursing team offers some interesting considerations for how professionals defend against anxiety. She describes how systems form a 'social defences' against task anxiety when working with intense distress and the reality of mortality. Social defences are thought to occur when individuals align their defences with one another and with the structure and culture of an organisation (Jaques, 1953).

Within this theoretical perspective, is possible to understand the organisation of crisis services as serving to the reduce anxieties elicited by managing people in the community who would previously have been admitted to hospital. Government concerns about risk and dangerousness have previously been highlighted as the main driving force behind policy (Peck & Parker, 1998). For example, the structure and deterministic nature ofit is possible policy and , service organisation become deterministic and structured in order tocould serve to provide some containment. Thereby is enablinges a 'task focused' approach to assessment that gives the sense of knowledge and direction enablingin which professionals canto act rather than becoming immobilised by the unpredictability of crisis. The prescriptive nature of referral criteria which encompass risk and the presence of a mental illness possibly serves a similar function, and could also serve to distance the professional from the possibility that they too could experience crisis. .Therefore, the centrality of risk may have mediated the clinical, professional and economical needs that resulted from the deinstitutionalisation era. If, This may suggest that services are organised in a way to manage anxieties that are elicited by people who experience crisis. Professionals may be more risk focussed because of the anxieties inherent in the task of caring for someone in such intense distress.It is understandable that working with people in intense emotional pain, in situations that can be highly variable and unpredictable, which may or may not lead to harm or death elicits an anxiety response. Menzies (1960) landmark case study of a nursing team offers some interesting considerations for how professionals defend against anxiety. She describes how systems form a 'social defence' against task anxiety when working with intense distress and the reality of mortality. Social defences are thought to occur when individuals align their defences with one another and with the structure and culture of an organisation (Jaques, 1953). It is understandable that working with people in intense emotional pain, in situations that can be highly variable and unpredictable, which may or may not lead to harm or death elicits an anxiety response. Considering social defences, it is possible policy, service

organisation become deterministic and structured in order to provide some containment. This enables a 'task focused' approach to assessment that gives the sense of knowledge and direction enabling professionals to act. The definitions centre around risk and the presence of mental illness, this possibly serves another function of distancing from the raw emotional distress that gives rise to anxiety. Government concerns about risk and dangerousness have previously been highlighted as the main driving force behind policy (Peck & Parker, 1998). Classifying as illness may help to distance from the possibility that we could all be vulnerable to experience crisis. Of course this is not to say that for some people risk is not associated with crisis, as the findings from Participant 11 suggest. as these research findings suggest, service level definitions of crisis (and referral criteria) were less deterministic and prescriptive, this may challenge social defences leading to increased professional anxieties. However, as the findings suggest that it is not a defining characteristic of crisis. Although these findings differ from some (Tobitt & Kamboj, 2011; Department of Health, 2001), it is synonymous with other crisis literature suggesting it is important to distinguish crisis from emergency to ensure good clinical outcomes (Callahan, 1994; Callahan,1998; Brennaman, 2012). Good clinical support structures, such as clinical supervision and reflective practice opportunities could enable a new way of containing anxietiesnew ways of managing to develop. In doing so , it provides the space for people to become aware of the anxieties that are elicited and the functional defences assumed, in doing so this cwould allow a processing of thisprofessionals to process the challenges of working within this context, thereby supporting that could support staff wellbeing and learning/development, and reducinge burnout (Edward & Hercelinskyj, 2007). , and it could provide a context for learning and development. Empirical findings suggest that reflective practice can have benefits of greater autonomy in decision making, more confidence in clinical judgments and a less rule-bound approach to practice (Platzer, Blake, & Ashford, 2000), as well as the opportunity to improve clinical practice (Paget, 2001). This context could reduce the need for the social defence, and allow the openness for case by case sense making.

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There is debate within the understandings of emotional distress in crisis about whether or not this is understood as an illness response. As discussed in the journal article, there is debate about this within professional's understandings of crisis (Tobitt & Kamboj, 2011). For some professionals to identify a crisis there must be a mental illness, whereas other professionals more widely consider emotional distress, irrespective of a diagnosis. This

reflects an important debate that is central to crisis intervention in which some understand distress or mental illness as a potential consequence of crisis (Caplan, 1964), whereas others explicitly link crisis to severe and enduring mental illness (Ball et al. 2005) and potential organic origins (Tobitt & Kamboj, 2010). This debate has become somewhat more significant by definitions in CRHT policy and literature that propose the presence of mental illness as a pre-requisite for CRHT involvement (Department of Health, 2001).

The findings of this study contribute to this debate. The Q-methodological findings suggested that understandings of crisis are better defined by the perceptual and cognitive changes and extreme emotional distress, rather than by risk of harm or mental illness. This is contrary to the definitions in policy (Department of Health, 2001), some professional understandings (Tobitt and Kamboj, 2011), and 'common sense' definitions used in empirical research (Johnson et al. 2005).

However, the findings of the qualitative analysis mirrored the debate. Some people referred to illness and diagnoses, therefore reflecting one side of the debate and illness based understandings (Tobitt & Kamboj, 2011; Ball et al. 2005) and also reflected in CRHT policy (Department of Health, 2001). On the other hand, some participants understood crisis as a common and understandable response to the circumstances, therefore reflecting other understandings from crisis theory (Caplan, 1964) and systemic understandings (Bridgett & Polak, 2003). Rather than argue for the superiority of one way of understanding of crisis over another, what seems to be important is recognising the variability.

The importance of these findings is that although illness based understandings of crisis are well represented by the definitions that influence service provision (Department of Health, 2001), not everyone understands crisis in this way. This suggests that understanding crisis should steer towards a case by case formulation approach, which positions the service user at the centre of sense making. This also has implications for policy, as it suggests that determining 'crisis' by the presence of mental illness is limiting.

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The theme of 'help seeking' suggested that people are motivated to find support and comfort from others in time of need. This is supported the understanding that during crisis people will use their social resources as a way to achieve resolution (Caplan, 1964; Bridett & Polak, 2003b). This reflects some attachment based understandings of achieving basic needs. Attachment theory suggests that we are all intrinsically motivated to seek out support from

others, as we learn from birth that it is within these relationships that our fundamental needs get met (Bowlby, 1969). Caplan (1964) also discussed that recovery occurs within the context of the persons key relationships. This finding also reflects service user perspectives of helpful crisis intervention, that highlighted 'people being there' and the proximity and accessibility of support as enabling a sense of safety (Davies & Rennoldson, 2013).

Returning to consideration of a further coping response, a further response that has not been explicated in previous research was termed the 'frustrated approach'. This approach was characterised with an approach-rejection pattern. People described a sense of invalidation from others when they were help-seeking, and a sense that nobody cares. This reflects findings that difficulties in accessing crisis services can exacerbate crisis (Middleton et al. 2011). Returning to the quote again, in which Caplan (1964) states 'a man does not usually face his crisis alone, but is helped or hindered by the people around him, by his family, his friends, neighbourhood, community, and even nation' (p43). Again, this reflects that the people who support an individual in crisis can either help or hinder.

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Rather than argue for the superiority of one way of understanding of crisis over another, what seems to be important is recognising the variability.Johnson et al. (2008) later define psychiatric emergencies as situations in the context of mental health illness which need immediate action due to high risk. In contrast, psychosocial crisis is a common human response to psychosocial stressors, and not a manifestation of illness. Therefore, this definition differs to those proposed by Ball et al. (2005) and Brennaman (2012) as it explicitly excludes illness.

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Furthermore, overly simplistic psychological models of stress, crisis and illness based on cause-effect logic can increase labelling and harmful narratives/unhelpful attitudes about presentations such as personality disorder (Hoff, 2001). Ball et al. (2005) seem to propose a link between severe and enduring mental illness and crisis without consideration of the

mechanisms that establish this link, and how these individuals would be better supported by services/families/communities due to this model

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However, the findings of the qualitative analysis mirrored the debate.

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An existential perspective is also useful for considering crisis as temporal, temporary and passing. From an existential perspective, alongside the unavoidable hardships of life people are also considered to be orientated to the future (Cooper, 2003), and as such experiences that are 'forward moving' and 'growthful' are more valued than those perceived as restraining (Mearns & Thorne, 2000). This may present a way of thinking about why described their crisis as a turning point, whereas others described it as destructive or limiting. Within this

perspective the challenge for supporting someone through crisis would be to provide the context within which they can make the choice to move forward??

The benefit of an existential perspective is the assumption of human freedom. As such, a person is understood as having the choice about what to do next. Working therapeutically within this perspective would therefore position the service user as powerful. This position is counter to the findings of this research in which people described feeling powerless, and also links to Caplan's (1964) notion of 'ineffectuality' in crisis. As such, positioning the service user in this way throughout intervention and recovery could be beneficial.

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For Heidegger (1962), another given of existence is 'thrownness': the fact that we are born into a particular social, historic and economic context that is not of our making or choosing. Hence, existential philosophers have argued that we can not determine our beginnings, can not determine our endings, and throughout our lives are rocked and swayed by a 'huge tide of accident' (Jaspers, 1932).

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From an existential standpoint, then, individuals who experience intense and enduring Maslow observed that we are driven to fulfil needs within a hierarchical order: basic physiological needs are prioritised over safety needs; safety needs are prioritised over the need for belonging and love; which is then prioritised over esteem needs and self-actualisation (achieving one's full potential). The first four needs are 'deficit' needs. The central idea is that higher order needs cannot be prioritised or met until basic needs for warmth, sustenance and safety are achieved. When these needs are met, individuals are motivated to pursue other needs. Within this perspective, finding a greater meaning within crisis and making choices that move towards growth and recovery may not be appropriate. For example, some people experience crisis due to a deficit needs being unmet. This could be due to homelessness, having no money for food or living in circumstances within which their safety is threatened. This perspective offers a framework for considering crisis resolution with people who are limited by their circumstances. The findings of this research suggest that crisis is a time of feeling desperately unsafe. Therefore, even if basic needs are met people

may find it difficult to meet safety needs and then move beyond this to relational or esteem needs. Although critiques of the model have highlighted that some people may value needs of belonging over some basic needs, the model offers a simple framework that could be useful for considering sequencing or prioritising interventions.

To conclude, although not without limitations, the findings of this research can be further contextualised within existential and humanist perspectives. In summary, the benefits of the approach are the emphasis on individual experience and subjective meaning making, and on positioning service users as having freedom and choice.

feelings of anxiety, regret or helplessness may not necessarily be suffering from some

form of pathology. Rather, they may be very much in touch with the realities of their – or human – life (Laing, 1965; Spinelli, 1994).

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– or human – life (Laing, 1965; Spinelli, 1994).

Existential thinking, then, throws
into question many our assumptions about what is 'dysfunctional', 'impaired', 'abnormal' or 'maladjusted'.

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The focus on risk in policy and potentially in teams/clinicians was questioned by the findings of this research. It was hypothesised that this focus could function as a social defence from the distress that working with people in crisis elicits, which could have both functional (protective) but also dysfunctional (limiting) consequences. The use of reflective practice within crisis teams was suggested as a way of supporting the wellbeing of professionals and effective clinical practice.

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