

Mental Health Crisis Resolution as Human Occupation: A Political and Professional Discourse

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Abstract

The aim of this thesis is to identify concepts of human occupation within the discourses surrounding Crisis Resolution Home Treatment Teams. The scope of the research covers specific Government policy and research related to the implementation of Crisis Resolution Home Treatment Teams in the United Kingdom, exploring theories of human occupation with the intent of proposing an additional perspective of mental health crisis. Drawing on Michel Foucault's ideas of governmentality and the influences of discourses within historical and political contexts, articles, research reports and government policy have been investigated. Documents reflecting the national context of a number of stakeholders and types of knowledge were subjected to a discourse analysis, mapping the development of mental health crisis as a discursive formation.

The main findings in Part One identify how overarching discourses of neo-liberal ideas privileges economic and managerial discursive practices in shaping the remit and measurement of efficacy of this service provision. As a result, these discourses influence the focus of research onto the economic efficacy of Crisis Teams and their role in performing a gatekeeper function to hospital admission. Part Two proposes that concepts of human occupation are implicit within recent Government policy strategies, and posits an additional perspective for exploring how concepts of human occupation manifest themselves in relation to other discourses and through the mode of governmentality. Links developed between policy rhetoric and service user discourse suggest an additional paradigm for the definition of crisis which draws upon the concepts of human occupation.

Future research that can investigate mental health crisis from additional perspectives will address power relations in mental health crisis response and redress the balance of a current economic and

managerial research focus in this area. Further investigation from a perspective of occupational disruption/deprivation will contribute to the development of responses to support recovery from mental health crisis, raising awareness of occupation in relation to increasing resilience and well-being. In addition, research exploring concepts of human occupation implicit within a range of social arenas will identify and look to address issues of occupational justice.

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Preface

The genesis of this thesis is rooted in my own experience as an occupational therapist working in a Crisis Resolution Home Treatment Team from 2006 to 2011. At the time of writing, in 2013, the team do not have an occupational therapist. The research documented here represents a complex, exhilarating and at times frustrating journey negotiating the numerous theories, perspectives, concepts and resultant discourses at play within current mental health service policy, provision and practice and its potential relevance to occupational science and occupational therapy. The term Crisis Resolution Home Treatment Teams refers to specific services that were introduced in England in response to Government targets. At times within this document the name is shortened to Crisis Team in order to ease reading of the text; crisis resolution is used to refer to the nature of the service and also to previous theories of crisis in mental health, and reflects the use of these terms in current literature on the subject.

This thesis is set out in such a way as to illustrate the journey from the initial review of literature and background history provided in chapter one to the proposed conclusions in the final chapter. These conclusions are drawn from the investigation in to how one policy guideline document has influenced the research and practice of a specific mental health service through analysis of the discourses present in relevant documents. The analysis findings, framed through the ideas and concepts in the work of Michel Foucault, are then further excavated to propose an additional perspective for consideration in the discursive construction of crisis, crisis resolution work and the relevance of human occupation concepts.

Part One of the thesis begins by charting the recent history of developments in mental health policy in the National Health

Service (NHS), and the background to one of these developments in the form of the introduction of Crisis Resolution Home Treatment Teams. In addition, chapter one introduces an overview of occupational science and the related professional discipline of occupational therapy, with examples of previously suggested links with crisis resolution approaches and services.

This research project is situated within the domain of the National Health Service, specifically mental health provision, and in particular excavating the representation of discreet concepts within the implementation of a relatively new service, Crisis Resolution Home Treatment Teams. As an area of research, this brings together a myriad of subjects, theoretical stances and concepts. A number of questions, approaches and methods could be proposed as relevant to specific issues in this area. Chapter four provides a discussion and critique of one approach to the study of the domains identified, the work of Michel Foucault. Through the lens of Foucault's writings on knowledge, power and the technologies of governmentality, a framework is proposed to analyse the discourses surrounding the introduction of Crisis Teams.

Chapters five and six give a rationale for the approach taken to research this area of investigation. From a social constructionist stance, this research is influenced by French philosopher Michel Foucault's concept of discourse as a way of thinking and talking about an aspect of reality that both shapes and reflects the cultural, political and social relations within the subject area at a given time. The method for analysis is informed by the theoretical and methodological approach adopted from the sphere of policy analysis (Bacchi 1999) and Carabine's guide to discourse analysis from a foucauldian perspective (Carabine 2001).

The formation of Crisis Resolution Services is put into context with an exploration of the policy documents and research literature that

underpin our current understanding of crisis as it is applied in the context of the National Health Service in England. Reflexive methodology is incorporated throughout the process of research to provide evidence of the decision trail, maintain relevance to the subject and promote an ethical approach to the study.

The development of Crisis as a mental health construct is mapped and the dominant policy and research documents identified. These documents are analysed, discursive constructs identified and practices extrapolated. From this, a process of reinterpretation based on Foucault's ideas of power/knowledge and framed within the concept of governmentality suggests the influence of dominant discourses on the generation of privileged knowledge, the identification of sites of power relations and tensions and resistances in discursive practices.

In Part Two concepts of human occupation are related to the identified themes through the lens of governmentality, illustrating a proposed relationship between crisis resolution work and human occupation as technology of the self. However the terminology of occupational science and occupational therapy itself limits its accessibility to others and it is subsumed by more dominant discourses.

Interpretation/Implications

The discourse analysis has revealed a number of dominant discursive practices that trace the construction of crisis teams as a service. The role of gatekeeper has emerged as an overarching construct of the remit of the Crisis Team. The implications for professional practice and education are explored.

Service user discourse identified within the documents, describes experience of a crisis through the use of emotional language and the impact on occupational activity. Service user discourse

suggests knowledge of the experience of a mental health crisis is partly defined through the paradigm of human occupation.

By reconstructing the experience of mental health crisis/emotional distress through the discursive practices of service users and human occupation, an alternative reality can be explored – changing the focus of research projects, generating new knowledge with the potential to increase status/power of the currently obscured human occupation discourse and influence service configuration. The conclusions proposed by this study suggest that concepts of human occupation are implicit within recent Government policy strategies, and posit an additional perspective for exploring how concepts of human occupation manifest themselves in relation to other discourses and through the modes of governmentality across a range social agencies and institutions.

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Thank you to all my friends, family and colleagues who have supported and encouraged me throughout this challenging process.

Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree

Signed:

Dated: 29th May 2014

PART ONE

Chapter One

Chapter One introduces the two main themes of this research project; the subject of this study of crisis resolution as an intervention in mental health provision, followed by an introduction to contemporary concepts of occupational science and related profession of occupational therapy.

Review of relevant literature provides an overview of the current context of modern mental health provision and the introduction of crisis resolution home treatment teams. The history and development of the discipline of occupational therapy within the health service is described. An introduction to core concepts of the occupational therapy profession and the discipline of occupational science is given as a foundation to later discussions illustrating findings and interpretations from the discourse analysis.

This chapter concludes with inclusions of reflective and reflexive descriptions of the research process which led to the research questions driving this investigation as a discourse analysis.

1.1 The Literature – Part One: Mental Health & current service provision

The provision of mental health services through the National Health Service is the subject of rapid and radical change, the like of which has not been seen probably since its inception. The main thrust of these changes appears to be to provide an efficient, quality service that provides value for money (DoH 1998, 1999, 2000, 2001, 2005, 2009). While these aims are laudable, the strategies adopted for implementing government requirements can be scrutinised in terms of their practical application and appropriateness. For instance, a report of the analysis of the current department of health requirements for service user

involvement in the planning and delivery of services, identified discrepancies in policy guidelines and perceived implementation (Hui & Stickley 2007). The report cited the significance of language, how subtle inferences can be drawn from the rhetorical language of policy and the implications for professional practice and therefore service delivery.

Among other changes to service configuration is an expansion of the availability of teams and services to offer 24 hour, 7 days a week access to community mental health provision, recommendations for people to receive treatment in the least restrictive environment and for people to have the option of a range of therapeutic interventions (DoH 2000). The creation of Crisis Resolution Home Treatment Teams is just one of the responses to these requirements and recommendations. Others are the introduction of early intervention teams, assertive outreach services, increased access to psychological therapies and greater involvement of independent agencies in service provision (DoH 1999, 2001, CSIP 2006).

The introduction of crisis teams across the country has developed rapidly in the preceding years. These teams aim to provide an alternative to psychiatric hospital admission, providing treatment at home with access 24 hours, 7 days a week. Various reports identify a myriad of discrepancies between policy guidelines and the implementation of crisis resolution home treatment teams, including conflicting opinions of the definition of a crisis and the name of such teams, who the service is for, and major differences in the variety of professions employed between teams (Garcia 2006, Morgan 2007, NAO 2007a). For example, on the latter point, DoH guidelines (2001) recommend the inclusion of occupational therapists within crisis teams. However audits suggest only 30% of teams have occupational therapy input (NAO 2007a), the role and

expectations of occupational therapists within these teams is not specified.

The results of the NAO (2007a) audit can be read as identifying that 70% of crisis teams do not include occupational therapy as an intervention option offered for treatment at home as an alternative to hospital. Prior to exploring further how or if occupational therapy or related concepts are included in the way that crisis resolution has been developed and implemented in UK health care, a description and overview of theories of human occupation and occupational therapy follows.

1.2 Concepts of Human Occupation

The term occupation has different meanings and uses; as a verb, to occupy time, space, attention; as an adjective and an object (Oxford English Dictionary 1996). The most common understanding of the term occupation, particularly in western cultures, refers to employment, work, a profession (Pollard 2011, Creek 2010). The wider sense of the word as applied by occupational therapists refers to the collective activities and tasks that people need and want to do, the how, when and why of specific activities, the relevance, meaning and purpose of the activity to the individual and also the meaning of activities within society as a whole (Wilcock 2006). Definitions of the term then are equally diverse, depending on the historical and contemporary context in which the word is being used or defined (Creek 2010). Occupational therapy and occupational science are two distinct but related disciplines that have concepts of human occupation at the centre of their endeavours. The differences and similarities between them will be explored further in Part Two of the thesis.

A performative description of occupation suggests a term that, in the context of occupational therapy, describes the array of activities and tasks that form the routine and patterns of daily life;

the performance of which includes a complex interaction of numerous physical, cognitive, psychological, social and emotional factors. This not only results in the completion of tasks, but incorporates the motivation, choices and feedback that initiate and maintain activity; also the form, habits and patterns of activity that make up daily life, a lifestyle and personal identity (Kielhofner 1995, Kielhofner 2002, Christiansen et al 2005,). Theories of human occupation posit that the motivation to engage in occupations can be viewed as an innate human drive, essential to life, and as such, opportunities to participate in meaningful and satisfying activities promotes well-being and can improve mental and physical health (Wilcock 2006, 1998). The relationship between activity and health has been traced back to Greek and Roman times and beyond (Turner 1992, Hagedorn 1995, Wilcock 2006). Theorists in the field of occupational therapy have developed models for practice, many of which were based on Systems Theory, from a structuralist epistemology (Kielhofner 1995, 2002; Law et al 1996).

As theories are extended and applied, the concept of occupation has diversified and expanded. Occupation has come to be seen as an overarching concept, separate from, but supported by groups of activities, which themselves may be constituted through a range of tasks (Creek 2010). Occupations are named and understood from the personal, spiritual and socio-cultural meaning attributed to them; occupation is the idea and is not observable; performance of the components/actions of occupation is observable (Creek 2010). The importance of the lived experience and narrative expression by individuals and groups has increased in research into the search to define and understand the meaning of occupation, both to individuals and to society as a whole (Asaba & Jackson 2011, Finlay & McKay 2004, Pollard 2011)

A relatively recent systematic review of the effects of occupation on health (Creek & Hughes 2008) found that while there is evidence of positive benefits to health from engaging in activities, there is also evidence that other activities can have a negative impact on health and well-being. The major conclusion, however, appears to be the confusion around terminology, multiple meanings in different contexts of the same words and the fact that much of the evidence for the benefits of occupation/activity on health is produced by disciplines other than occupational therapists. The issue of language use in occupational therapy is illustrated by Creek (2010), with the production of a framework which to all intents and purposes provides a translation of the everyday usage of specific terms into a description of their meanings to occupational therapists within the sphere of practice.

The concepts of occupation do not appear to be as straight forward as at first may be thought. The term occupation has a variety of meanings and uses in everyday language. In a clinical or scientific setting it can attempt to convey complex descriptions of human behaviour, drives and motivations within a social and cultural context (Creek 2010). Human beings can be viewed as possessing an innate drive to engage in occupational activity that not only results in provision of basic needs, but also provides a sense of control, mastery and identity in the world (Wilcock 2006).

If the things we do and the way we do them define us, then it is fair to say that occupation in all its forms and manifestations is a central tenet of human experience (Kielhofner 1995, Molineux 2009, Asaba & Jackson 2011). The opportunity to engage in meaningful occupations and related activities, with the ability to do so is recognised as a factor influencing physical and mental health and recovery from illness (Creek 2003, Kielhofner 1995). This is the primary focus of both theories informing proponents of occupational science and the driving force of the occupational

therapy profession. Equally, if occupation and activity can improve and maintain health, then the absence of them in significant forms could be viewed as unhealthy or leading to ill health (Wilcock 1998, 2006).

The overriding impression when looking to the nature of occupation is one of complexity, fluidity, where the mode and form of action is influenced and determined by a myriad of factors (Creek 2003, 2010). Philosophers over the years have recognised the nature of the human condition as not only the search and development of knowledge through analysis of thought and ideas but also the meaning of actions, behaviour and consequence (Sartre 1958, Foucault 1967). In fact, it is this combination of actions and behaviours and the seeking of meaning and knowledge that is the defining discrimination between human and animal occupation (Sartre 1958).

Proponents of occupational science have sought to expand and clarify the concept of human occupation. Occupational therapy is a specialist, focused treatment modality designed to ameliorate the consequences of illness and/or disability impacting on ability to engage in daily activities. Occupational science is seen as a field of study, utilising approaches from a wide range of disciplines and research methodologies that explores the nature of occupation and its relationship with health (Yerxa et al 1989).

1.3 Historical Context of Occupation Therapy

According to Wilcock (2006), the recognition of the influence of occupational performance, behaviour and balance on health has been identified in ancient cultures all over the world. However a formal movement to promote the use of activities as health related in Europe and western culture, is probably best illustrated in the involvement of moral treatment and the arts and crafts movement during the late 18th, 19th and early 20th centuries (Reed 1993).

In 1793, a French physician named Philippe Pinel advocated the humane treatment of people with mental illness as opposed to incarceration (Pinel 1962, cited by Reed 1993). Pinel's ideas were adopted and expanded in England. William Tuke founded The Retreat in York in 1796, where the daily routine for mentally ill patients/residents consisted of engaging in regular productive activities that not only occupied their time but also contributed to the maintenance of the Retreat itself and the well-being of its residents (Reed 1993).

However, consider the view of Foucault (1967), who cites the work of Pinel and Tuke as the foundation for the Asylum system and the rise of psychiatry as an authoritarian power base. In contrast to the widely held perception of this moral treatment as preferable and "right", Foucault suggests it was the implementation of a more subtle and socially acceptable form of control and containment. It is interesting to note that the work of Pinel and Tuke is generally credited as evidence of early forms of occupational therapy. Is this potentially where the groundwork for the professions long struggle with defining and justifying itself has its roots? If, as is often suggested, occupational therapy is a complex, fluid, subtle, person centred process aimed at enabling and empowering the individual in their pursuit of life enhancing occupational choice and performance (Creek 2003), then the constraints and power politics of the dominating medical model in modern health care has been at odds with the professions philosophy (Wilcock 2002, Pollard 2011).

A philosophy more compatible with that of occupational therapy is probably that of the Arts and Crafts Movement that emerged at the end of the 19th century. The arts and crafts movement developed in response to the increased mechanisation and industrialisation of working life. The requirements and environment of factory work

was seen to be harmful to health and eroding the practical skills of whole communities. The value of creativeness and personal achievement began to be recognised not only in the practical skills and end products produced, but also in the creative process itself and the influence on confidence, self esteem and the well-being of the wider community. During the First World War, injured soldiers who were given the opportunity to engage in purposeful activities appeared to recover more quickly and activities such as craft work were used in the rehabilitation process (Reed 1993).

Creativity as a human phenomenon is itself a complex, subtle and fluid process. As with the individual significance attributed to the meaningfulness of a particular form of occupation, creative activity takes many forms and will have meaning as ascribed by the individual (Silverstone 1997). The creative process is seen as therapeutic in and of itself and techniques such as art therapy, drama therapy and music therapy are used to address some of the difficulties experienced by people (Mental Health Foundation 2008). The practice of occupational therapy has a focus on the therapeutic use of activities as a treatment modality (Breines 1995)

To this end, occupational therapists have a tradition of utilising creative activities (Lloyd & Papas 1999), however the rationale and aim for their use has changed over the years. In the 1950's and 60's, art and creative activities were used as part of the assessment and diagnostic process in psychiatry. With the development of specific creative therapy disciplines into the 1970's and 80's, occupational therapists appear to have shifted the focus to a more diversional view, using the creative medium as a process for engaging the individual or group and facilitating social interaction and/or communication (Brock 1991, Lloyd & Papas 1999).

The origins of occupational therapy in the UK are best traced from the years between the first and second world wars. This is possibly also the origin of the stereotypical view of white middle class women using basket weaving as a fulfilling occupation to while away the time in a hospital bed (Blom-Cooper 1989). However, these pioneering women established the foundations of a profession and contributed to the development of its education programmes which continue to provide the grounding for future therapists today (Hagedorn 1995).

Dorset House, the first school devoted to this fledgling profession was opened by Dr Elizabeth Casson in 1930 (Casson 1955). 1932 saw the formation of the Scottish Association of Occupational Therapists, while the English Association of Occupational Therapy came into being four years later in 1936 (The two organisations became the British Association of Occupational Therapists in 1973). By the 1960's the formation of the Council for the Professions Supplementary to Medicine required the state registration of qualified practising Occupational Therapists. By the 1990's, academically, the profession had made the transition from pre-registration diploma to first degree level (Hagedorn 1995).

For the remainder of the 20th century, occupational therapy developed across the globe, with an accompanying debate within the growing profession as to the definition of occupational therapy and the direction it should take in the future. In his report on the profession of occupational therapy in 1989, Blom-Cooper noted that many therapists worked in isolation from their health care colleagues, contributing to the lack of understanding and appreciation of the potential benefits of this form of therapy by others outside of the profession (Blom-Cooper 1989). In fact, this lack of understanding and a perception of poor status is identified as a significant factor in the decision to leave the profession for many occupational therapists (Jenkins 1991). A further study

aiming to define occupational therapy concluded further research was needed in order for therapists to finally agree upon a definition (Taylor & Rubin 1999). Later that same year, Duncan (1999) suggested the profession, as it was in mental health at least, leave behind the quest for a definitive definition and get on with the job at hand.

1.4 Debates in Occupational Therapy

We are now in the 21st century and the outsider could be forgiven for wondering if occupational therapy is any nearer to consolidating its identity and direction. Ilott and Mounter (2000) advocate the use of occupational terminology to establish credibility and promote the role of the profession within multidisciplinary settings. However, eight years later, and occupational therapists are being urged to embrace change in the form of new opportunities and adapt the terminology to fit whichever audience /market /client group it is aimed at (Withers & Shann 2008). Creek (2003), continued with the search for a definition, concluding that occupational therapy is a complex intervention and further to this, that occupational therapy, based on complexity and chaos theory, is part of a complex system and measuring evidence of the effectiveness of interventions was problematic, if not virtually impossible. This position was challenged by Duncan et al (2007), who acknowledge the complexity of occupational therapy as an intervention while asserting the view that measuring and predicting outcomes of therapy may be difficult at times, but not impossible.

An exploration of professional literature and professional journals can trace the developments and initiatives that mirror/parallel the changes in society, technology (Goodacre 2008, Yerxa 2000). Issues within the profession have ranged from debates on the most appropriate terminology, to the tension between the pressure to fulfil generic health worker roles and maintain role specific skills (Illott & Mounter 2000, Harrison 2003, Harries & Gilhooly 2003).

Opinions are inconclusive, whether to embrace generic roles as the inevitable result of government policy and the move to a more cohesive service (Harrison 2003), or a challenge to the unique skills of a profession and yet more evidence of a lack of understanding by others (Ilott & Mounter 2000, Pollard 2011).

The range and complexity of occupational therapy in practice is illustrated, along with the accompanying struggles of a continuously developing profession, which in the UK, at present remains sited most predominantly within statutory health and social care systems. However, recent debate resonates with pleas and instructions for occupational therapists to assert their place in, and contribution to, future health care strategies (Christie & Goodacre 2007, Mackey 2007, 2011), to expand and explore alternative forms of practice outside of the traditional roles and organisations and to adapt to new ways of working while remaining faithful to the core philosophy of the profession (Kronenberg et al 2005, COT 2006, Withers & Shann 2008). It is yet to be seen whether the efforts to adapt and change will strengthen the position of the profession or ultimately weaken and dilute its current role to the detriment of its future.

Evidence which demonstrates some form of economic gain within health and social spheres will likely be given more credence by government policy makers (Morley 2010). A core philosophy of person centred and client led therapeutic aims may sit uncomfortably with a requirement to adhere to policy driven strategies and service delivery designed to meet a political agenda, however well-meaning the underlying sentiments informing the policies were originally. Equally, could the ghost of earlier views of occupational therapy as a type of craft based cottage industry that always recognised the value of engaging in meaningful and purposeful activity be the obstacle to a profession that is now being overtaken by evidence of the relationship between health and

activity coming from other spheres of human study such as psychology, psychiatry and social sciences (Molineux 2009).

Although the value and benefits of various forms of occupational activity may have been inferred and discussed over the years, and even the formation of a profession specifically focused on the therapeutic use of activity to treat a range of health conditions, the evidence in terms of scientifically researched outcomes on how activity actually works to improve and /or ameliorate ill health remains sketchy and inconsistent. The focus of government and social policy may shift priorities to strategies for demonstrating reductions in the cost of health and social security now and in the future. Therefore interventions that establish an ability to reduce government expenditure will attract more interest and gain access to public funding (Morley et al 2011).

1.5 Occupational Therapy in Crisis Resolution

Occupational therapists may possess many of the skills required to provide a range of generic interventions, such as mental health and risk assessment, planning/co-ordination of care packages, even arguably an ability to monitor medication concordance and side effects, although many may not feel confident of possessing an in-depth knowledge in this area (Miller & Robertson 1991, Harrison & Dewis 2008). In terms of interventions used in mental health by occupational therapists, Cook (2003) identified assessment, the development of leisure skills, social skills and life skills, as most frequently cited by occupational therapists working in community mental health teams. These results reflect the trend identified by Lloyd & Papas (1999), that many therapists are now frequently based in community settings, possibly accounting for the increased use of education and advice on coping strategies and life skills as occupational therapy interventions. Although these skills may contribute to an individuals' ability to engage in

occupations of choice, the cognitive behavioural roots of skills training does not limit its use to occupational therapists.

In America, Rosenfeld (1984) identified the lack of literature and training available in occupational therapy on crisis intervention, particularly education at under-graduate level. The situation does not appear to have improved a great deal since. Miller & Robertson (1991) proposed crisis intervention/prevention as a new and legitimate area of practice for occupational therapists in Australia. Despite acknowledging there were potential issues in that traditionally occupational therapists have not been solely responsible for the hospital admission and discharge of a client and do not usually have therapeutic contact with clients at the initial point of contact in a crisis, the report emphasised how the generic skills possessed by occupational therapists can be utilised. Recommendations in the report suggested that due to the clinical responsibility incumbent in crisis work, it is only suitable for occupational therapists with experience of working in mental health, particularly acute settings. The report cited one example of the assessment and possible intervention with an individual experiencing a crisis. The views of occupational therapists working in crisis teams were not included.

Rosenfeld (1984) suggested the use of a Nuclear Task Approach by occupational therapists working with people in crisis, by identifying activity that supports recovery or training in the skills required to complete tasks that compound/contributed to the crisis. Small vignettes are described to illustrate the use of this approach. However only one of the six examples appeared to have an identifiable mental health problem, the others would more likely be classed as situational or relationship difficulties. While these issues can still cause people great distress and result in an emotional crisis, as discussed earlier, it is debatable as to whether this is the target group for the service in the UK. Although Rosenfeld's study

is nearly 30 years old and uses a small number of case studies, it does highlight the primary tenet of occupational therapy, that of activity as therapeutic and health restoring.

The College of Occupational Therapists (COT) following consultation with the Sainsbury Centre for Mental Health published a 10 year strategy for occupational therapy in mental health (COT 2006). One of the issues included in this document refers to working practices and workforce development, including 7 day shift patterns. The inclusion of occupational therapists in Crisis Resolution Home Treatment teams is a new area of practice for this profession in the UK, and could provide the opportunities outlined in the strategy, that of valuing occupation and promoting an understanding of the relationship between occupation, occupational identity and mental health (COT 2006). Rigby et al (2007) describe the experiences of one group of occupational therapists working with a crisis resolution team and propose a model for occupational therapists in the form of an integrated care pathway with the crisis team and the day hospital. The occupational therapists do not appear to actually form part of the crisis team workforce, but offer a service which can be accessed by the team.

However, Crisis Resolution Teams have not been implemented in the same format across the country (Morgan 2007) and although the model described has the potential to be adapted, further information is required regarding the working practices of other teams and the expectations of the occupational therapists within them. Anecdotal evidence, and my own experience, suggests that if a Crisis Team has an occupational therapist at all, then they will only have one and the role may be more or less generic, depending on the nature of the team and the ability of the individual to maintain a core role focused on occupation (Kershaw et al 2008).

1.6 Summary

The opening chapter to this thesis has described recent changes and developments in the provision of mental health care in England in the form of Crisis Resolution Home Treatment Teams. It is noted that despite policy advocating the inclusion of occupational therapists, very few make up the workforce of these teams. In addition, the ideas and concepts of human occupation are introduced, with an overview of the discipline of occupational therapy and a discussion of the contemporary debates within the profession of occupational therapy. This chapter provides the background to this study. The following chapter traces the reflexive and reflective processes influencing decisions and the resulting questions and aims driving this research.

Chapter 2 - Research Decisions and Questions

As noted earlier, National Audit Office (2007a) figures suggest only 30% of crisis teams have an occupational therapist. It was this figure from the NAO audit that first triggered the impetus for the research focus described in this study at a time when I myself was employed as the single occupational therapist in a relatively newly formed crisis team. From this initial starting point, a series of enquiry, reflection and reflexive decision-making characterizes the research process. In order to contextualise the decisions made and trace the course of the investigation, the following section of this chapter gives an account of the concept of reflexive and reflective research practice with illustrations of how reflective/reflexive methodology has shaped the focus, methods and decisions in my own enquiry.

2.1 Reflexive/Reflective Research

Steier (1991) supported the notion that a purely scientific, objective mode of recording, writing was not necessarily the only acceptable format for disseminating findings through enquiry and that researchers were part of the process of constructing knowledge. The assumption, if accepted, that knowledge is socially constructed, demands then that the researcher acknowledge their own socio-cultural constructs, in particular in terms of the mode of data collection and analysis and specifically in relation to the interpretation of the results (Guba 1990, Ballinger 2004). Jasper (2005), proposes that the reflective accounts of the researcher are not only a requirement in terms of an audit trail to substantiate credibility and trustworthiness in qualitative research, but that these accounts are a valuable source of data within the research process itself and again calls for the wider acceptance of the inclusion of personal reflexive evidence in published reports. However, in practice this type of reflexive research practice can also be seen as detrimental, particularly where the research is tightly time bound or

sponsored by an organisation (May 1997). Mauthner & Doucet (2003) also acknowledged that much of the reflexive “knowing” and awareness of influences on thought, interpretation and actions can come after the research is finished and with hindsight.

The specific research under discussion here, as mentioned previously, is situated within the NHS. I, as the researcher, am employed by a NHS Trust and have first hand experience of working in the service in question. It would be naive to suggest I am completely detached and objective in my approach to the subject matter. However, a stance such as that required by action research or participative observation could be counter productive in some circumstances (Blaxter et al 2001, May 2003). As a clinician, my alternative role as researcher could be perceived as obstructive to clinical events; the day to day participation in the service may be compromised as colleagues struggle to know which “role” I am adopting at any specific time, particularly in crisis/emergency situations. Hammersley (1992) acknowledges that in deciding on a methodology, compromises may have to be made in order to be able to practically complete the research.

The notion of the insider researcher is true for me as an occupational therapist working in a crisis team; acknowledging the central role of the researcher, the subject/issue is likely to have some personal importance to the investigator/instigator of the research. The initial focus at the outset, and as the title suggests, relates to the position of human occupation within the service of crisis resolution & home treatment. This was of particular interest, due to my own position and also in view of the report identifying that 70% these teams did not receive any input from an occupational therapist (NAO 2007a). However, the process of embarking on an extended study into a new and developing area provides not only an exciting opportunity, but also the pitfalls and drawbacks of working in, and researching a specific section of the

rapidly changing landscape that is the national health care system in England.

2.2 Preliminary Research Decision

As the only occupational therapist in the team, working a shift pattern and with the requirements of shift co-ordinator to be met, it is often the case that I will only see some people on the caseload once and others I may never meet. Therefore it is not always practical or realistic to follow a traditional occupational therapy process of assess, plan, treat, evaluate and discharge. This generic process does form the basis of the team's approach, however parts of the process will be facilitated by different members of the team of different professions.

Department of Health policy suggests occupational therapists be one of the professions making up the workforce of Crisis Resolution Home Treatment Teams (DoH 2001). This would infer recognition of the integral part that occupational concepts play in an individual's mental health and recovery. However my own role within a Crisis Resolution Home Treatment Team limited the amount and level of occupational therapy interventions I could offer and the statistical suggestion that 70% of teams did not have any input that specifically explored issues from the perspective of an occupational therapist.

An initial research topic could have been to carry out a survey of occupational therapists working in Crisis Resolution Home Treatment Teams. However, research reports and discussion papers already exist on the generic nature of much of the current mental health occupational therapy posts. Also a survey of Crisis Resolution Home Treatment Teams with occupational therapists would not address the issue of what is happening in teams without an occupational therapist. In order to investigate this issue, aims were formulated for an exploration of the way individuals

understand and construct ideas about crisis and the place of occupational concepts during a crisis.

2.3 Service User Collaboration

In addition to changes in service configuration and delivery and the suggestion that service users and carers have increased say/control in service design (DoH 2000), is the drive for increased collaborative and user led research (INVOLVE 2007). Following NHS Trusts' guidance, I was able to contact colleagues in community mental health teams prior to application for ethics approval, who agreed to approach service users on my behalf with the view to establishing an advisory panel. Twelve people were identified with possible interest, four of whom eventually agreed to meet with me to discuss and advise on the development and design of this project. It was made clear that members of the panel would not be included in the research data, as per Trust guidelines.

The panel of service user volunteers and I met three times to discuss and ensure the relevance of research questions and the processes for gathering information. There was a consensus regarding the use of the term crisis and how differing ideas about how this is defined might influence responses from health professionals and services and expectations of service users. All of the panel members had experience of crisis teams and all were familiar with occupational therapy as a discipline, although not via a crisis team. Ideas about how or why occupational therapy may be a beneficial component of a crisis resolution service, or factors impacting on the lack of occupational therapists in crisis teams were deemed to be of interest. Several options and strategies were discussed for exploring, developing these ideas. Over the course of several meetings, a central theme emerged around the confusion about the term crisis, who decided what a crisis entailed and the remit of crisis teams. One panel member brought his understanding of Michel Foucault's ideas on the production of

discourses and knowledge formation to the discussions, other members of the panel expressed curiosity about this perspective and it was agreed this sort of approach may be worthy of consideration. A provisional plan devised was to analyse the discursive formations and practices of people using this service and the views of crisis team members through interviews and focus groups, and identify the relationship with the rhetoric of government policy documentation.

This plan also provided the potential option for exploring the way ideas about concepts of human occupation are constructed through the language used by service users and staff within the context of Crisis Resolution & Home Treatment Services. The rationale being that theories from occupational science would suggest that the inherent occupational nature of human beings would be a factor in not only how a mental health crisis is experienced, but also in how it might be resolved. Reflections on my role as a researcher offer a transparent description of the decisions and rationale utilised in this research process. Additional reflective extracts appear in italics within the discourse analysis phase.

Following a number of setbacks within a short space of time at a pivotal point in the research process, I came to the decision that in order to complete this study, I would need to adapt, refine and ultimately alter the direction of the enquiry. Thus the following study describes the processes and progress of an exploration into the discourses present in relevant documentation that contribute to the construction of knowledge about a service – Crisis Resolution Home Treatment Teams, the position of concepts of human occupation within the service discourse and potential implications for professionals, service users and future research.

2.4 Decision Process

As the processes of research progressed, I clarified my epistemological and ontological approach to enquiry and refined the ideas underpinning my initial research aims. Particularly the idea of discourse and its relationship with knowledge and power as developed by Foucault (1972) interested me and the implications for my area of research. During this process, and my own experiences of working and being immersed within the service's development, the potential influence and importance of the role of documents as an area for research became evident. Mental health services in the NHS, it could be argued, are constituted in and through an array of documents and the way they are utilised (Foucault 1972, Prior 2003). The idea that concepts of human occupation and the apparent lack of occupational therapists in Crisis Teams may be explored through the analysis of government and research documents as a basis for further study also took shape within this period. Several factors converging resulted in the decision to change the way in which I would attempt to address the issues I had identified.

My ability to proceed to the NHS ethics committee was hampered and delayed by events outside of my control, specifically a radical change in the research policy and procedures of my employing NHS Trust. The adverse effect on the research project is echoed in findings by Meenaghan et al (2007), who identified an increased level of bureaucracy and tensions between research ethics processes and local governance procedures, resulting in at time insurmountable obstacles to research projects within NHS mental services/Trusts. I then experienced several weeks, turning to months of ill health. Eventually, after numerous discussions with research supervisors, friends and colleagues, I decided to continue the research through the analysis of the very documents that formed the basis of the clinical area in which the research would be situated. These documents may be seen as constructing the

service. The language used within texts, documents, health literature can be viewed as illuminating the way concepts are understood and constructed within the policies and research that inform and shape this service and influence professional/clinical practice.

2.5 Research Decision

The struggle to improve the visibility of occupation, occupational therapy and occupational therapists has been discussed earlier, identifying difficulties in defining core concepts and articulating theory due to the various meanings attributed to the term occupation (Creek 2010, Illiot & Mounter 2000). The contested meaning of crisis and the different configuration of teams has also been introduced. The documents and text utilised within the day to day workings of the Crisis Resolution Home Treatment Team in which I am employed, provide the language, terminology and rationale for clinical, practice and organisational decision making, processes and procedures, and a recognisable discourse for communication within and between mental health teams and the wider mental health care system.

This collective language appeared to have developed rapidly and in my experience within the area in which I work, was taken for granted as the accepted use of terminology for this specialist service, Crisis Resolution Home Treatment Team. However, until this service, few of my colleagues in the team, nor I myself, had constructed the subjects within clinical practice in quite this way. Therefore, my interest in the power of a collected language, a discourse and the potential impact on professions, services, service users and practice development expanded my original starting point of occupational therapy as a minority professional presence.

2.5.1 Research Question:

How do contemporary discourses construct the objects and subjectivities of crisis in Crisis Resolution Home Treatment Teams?

How are concepts of human occupation constructed and represented in Government documents and related literature that describe and study the introduction of Crisis Resolution Home Treatment Teams in mental health?

2.5.2 Aims:

- To analyse relevant government policy documents and related published literature around Crisis Resolution Home Treatment Teams, using Foucault's concepts of discourse and governmentality.
- To explore the discursive constructs of mental health crisis and Crisis Resolution Home Treatment Teams.
- To identify the types of knowledge and sites of power relations present in discursive formations.
- To identify representations of concepts of human occupation within discourses.
- To develop an interpretation of identified discursive formations from a foucauldian perspective.
- To propose an alternative view of mental health crisis and the relevance of concepts of human occupation

2.5.3 Objectives:

- To excavate the language and terminology in literature that is used to explain the principles of, and interventions provided by Crisis Resolution Home Treatment Teams.

- To illustrate the discursive formations and privileged knowledge that forms the discourse of Crisis Resolution Home Treatment Teams.

- To identify potential challenges to the taken for granted view of Crisis Resolution Home Treatment Teams.

- To investigate the analysis of Crisis Resolution Home Treatment Team discourse for evidence of representations of human occupation concepts.

- To identify hidden discourses that may propose an additional discursive construction of crisis.

- To provide an interpretation from the results drawing on Foucault's concept of governmentality and propose expanded fields of enquiry for occupational science/therapy.

By utilising discourse analysis as an approach to the research data collection and analysis, the study positions itself as an investigation of a clinical, health care arena. As such, it is feasible to anticipate that the area of study will not be easily isolated from the wider discourses of current mental health issues, NHS and political issues and influence, necessitating acknowledgement of these influences and therefore identifying the research as a micro-analysis of the macro-discourse in which the service is situated. The view of discursive practices as products of the historical, institutional, professional, political context at any given time reflects Foucault's (1972) ideas of the nature of discourse and its

relationship to concepts of power, knowledge and social action. The action in this case could be seen as being the production of a specific service.

2.6 Ethical considerations

All research endeavours must have relevance and the intent to contribute meaningful knowledge to an area of study (Blaxter et al 2001). With regard to research in health and social care, this intent also refers to contribution to practice, whether it be the potential for new treatments and interventions, develop theory or to bring awareness of issues that have implications for current or future practice and/or the education of practitioners. Without this as a consideration at the outset of a research project, then the research will not meet even the basics of ethical requirements.

2.6.1 Relevance

The aims of the research concern a particular set of theories underpinning the notion of human occupation and how this may be represented in the policies and research that have thus far guided the implementation of a new service across England; Crisis Resolution Teams.

Concepts that have developed from theories within the field of occupational science include the idea of occupational justice and occupation rights as components of the principles of human rights (Townsend & Wilcock 2004). Principles of human rights contend that everyone is entitled to well-being by means of the abilities and conditions required to achieve purpose through action (Kallen 2004). A core assumption of occupational therapy is that engagement with meaningful forms of occupation influence wellbeing; so conditions impacting on opportunities and/or abilities to engage in occupations are connected with issues of human rights in the form of occupational rights (Hammell & Iwama 2012). Therefore, it is an ethical and moral imperative to take

opportunities to critically examine an occupational perspective of a range of human endeavours and contexts and where necessary identify and argue for occupational approaches to inequality, restrictions and injustices. That 70% of Crisis Teams are recorded as not having input from an occupational therapist may reasonably suggest that in this context, there are limitations to an occupational perspective on the impact of crisis and crisis team interventions for individuals in this context.

As described earlier (see 2.3), the relevance of the direction of this study was also supported by a panel of service users who were consulted in the early stages of the research process for their opinions and who informed the research question and methodology, as suggested by INVOLVE guidelines (2007). Although according to NHS Trust governance procedures, consulting with a number of service users prior to embarking on any research is a perquisite, the inclusion of the panels expressed specific views in the final research itself is restricted.

2.6.2 Contribution

As stated, the aims of this research project look to identify how concepts of human occupation are represented in the documents influencing and describing the implementation of Crisis Resolution Home Treatment Teams. By identifying how, or if, concepts of occupation are present within the ethos and practices of this service provision, the findings from this study will contribute to expanding a critical approach to occupational science, occupational therapy practice and issues of occupational justice. In addition, a discourse analysis of the texts spotlighting Crisis Teams in England, will provide a wider exploration of the rapid implementation of these services; opening up a space for critical dialogue and analysis of taken for granted assumptions and perspectives.

One aspect of research is to provide the basis for a forum to question and develop other lines of enquiry. The research described in this thesis, will contribute to the possibilities for future service provisions by engaging with the dialogue of policy and research (Wetherell 2001).

2.6.3 Ethics of using documents as data

There is very little literature on the ethical issues of using published documents as data in research (Grinyer 2009, Mogalakwe 2006). Documents and research published and in the public domain, including availability on-line, are open to critique, analysis and discussion which may not be related to the original purpose (Darlington & Scott 2002). With respect to inclusion of examples of service user opinions, this study has not sought to re-interpret their meaning, rather to compare descriptions of crisis with concepts of human occupation. The purpose here is to explore the representation of their comments with respect to Crisis Resolution Team service provision and explore the mechanisms of power relations in terms of how the service user discourse is recruited with respect to the implementation of Crisis Resolution Teams. Equally important is the ethical consideration of utilising the work of others. In analysing the discourses and discursive formations identified in this study, I am acknowledging the influence of dominant discourses on texts and practices from the perspective of Foucault (1972). I am not attempting to dismiss or disparage the authors of the works used as data, or the opinions therein. Mogalakwe (2006) suggests ethical use of documents in research should ensure the documents used are credible, representative and meaningful in relation to the topic. All the documents selected in this study are directly related to the subject of Crisis Teams and have recognised authorship.

The ethical issues concerning the use of secondary sources as data for analysis is an ambiguous and contested area (Mogalakwe

2006, Grinyer 2009). Confidentiality should be maintained within published research/audit findings. Use of individuals' quotes being used in research extended beyond the initial research once published or in the public domain is suggested by Grinyer (2009) as evidence of the value of their contribution and would generally be welcomed. The dissemination of research findings is also an ethical consideration, as research that is not disseminated can be viewed as unethical (Blaxter et al 2001).

This study in its original form received University ethics approval and all documentation was completed ready to submit for Local Trust Research Ethics and NHS Research Ethics Committee consideration. Following the decision and confirmation with the University to adapt the method of research, the employing NHS Trust Research Department confirmed it no longer required the research to be submitted locally or to NHS ethics committees. However, as the researcher I continue to uphold ethical and moral principles and to abide by the University code of practice and my own professional codes of conduct in completing this thesis.

2.7 Reflection on the Research Decision

The concept of reflective practice within the health professions is not new (Schon 1983), and researchers have a tradition of keeping a journal or log of thoughts, ideas, events throughout the research process (Koch 1994, Glaze 2001). However, the centrality of the researcher in the whole process has become an important issue, with suggestions on how reflexivity can be operationalised and influence the research and the data analysis process (Mauthner & Doucet 2003, Finlay 2003).

When considering the longer term implications for decisions on design methodologies and approaches, then the methods to be used become imperative to the likely success or otherwise of the project, and importantly can identify serious ethical and moral

issues. For example, a superficial consideration of the aims of this project may suggest the use of participative observation or action research strategies in order to observe and gather information within an ethnographic paradigm. However, the potential issues of role blurring and power relations between researcher and clinician (May 2003) and the implications in terms of trust in an arena that carries high levels of risk for both clinicians and service users negates the rationale for implementing this form of research.

By integrating reflexive principles into the research process from the earliest opportunity, then the role of the researcher and its potential implications can be identified and if necessary strategies adapted (Mauthner & Doucet 2003, Finlay 2003). A variety of issues, events and considerations can impact on decisions made within the research process, from philosophical debates to practical procedures or obstacles. Incorporating reflexive and reflective principles from the outset facilitates a fluid, flexible and adaptable research strategy. In this case, this has allowed for an alternative research method to be developed, in response to unforeseen circumstances, whilst remaining within congruent epistemological and ontological perspectives based on social constructionist theories.

In deciding against a methodology that has the potential to include those involved in a more explicit, collaborative way, I am compromising the opportunity to construct knowledge around the event with those participating. However, I am also acknowledging my own awareness of the political dimension of this area of research at this particular point in time, which also has implications for my own position within the organisation.

As an authentic way of illustrating the central role of the researcher in relation to the researched, the analysis of discourse explored in this thesis will reflect the documents, which in my own experience

and area of practice have shaped and influenced the service in question.

2.8 Potential Contribution to Professional & Service Knowledge

This study is exploring concepts of human occupation within the context of mental health crisis resolution teams, an area that at present has not been the subject of extensive research. The use of discourse analysis and in particular a Foucault inspired approach, as a method of exploration is little used in occupational science/therapy, with the exception of Mackey (2007) and Laliberte Rudman (2005, 2010). Therefore, I would hope to provide novel contributions to the knowledge base and literature of occupational science by making explicit the implicit concepts of human occupation in the subject of crisis resolution teams as a developing service.

Additionally, I hope to provide a basis for further research to explore and identify the impact of crisis resolution home treatment services in terms of professional and service user power relations, and to increase the profile of human occupation as an important element in the process of recovering from a mental health crisis. According to theories from the field of human occupation, engagement through occupations not only results in meeting basic needs, but also provides a sense of control, mastery and identity in the world, factors which may contribute to the amelioration of mental health crisis.

Chapter 3 - Crisis and Crisis Resolution

Chapter three provides an expanded exploration of the term crisis in the mental health context and subsequent formation of crisis resolution services. By tracing the origins of an underpinning theory and mapping policy and research, the discursive practices that construct the notion of mental health crisis and crisis resolution teams are illuminated. The context of clinical and organisational discourse within the National Health Service is illustrated, identifying the impact of recent policy directives and economic pressures on the roles of health professionals and service design. This process forms the basis and context of the genesis of the development or influence of particular discourses in the style of Foucault's genealogical approach to discourse analysis.

3.1 Literature Part Two: Context of Crisis Resolution in the NHS

An approach to research from a foucauldian perspective is addressing understandings and ideas that are historically, socially and culturally specific (Carabine 2001). Therefore, the formation of Crisis Resolution Home Treatment services will be put into context with an exploration of the ideas and research literature that appear to underpin our current understanding of crisis as it is applied in the context of the National Health Service in England.

Crisis Resolution Home Treatment Teams as a field of practice is a relatively new introduction within the National Health Service and there are several reports on the service in terms of its implementation, efficacy, problems and issues affecting the service (NAO 2007a, Onyett et al 2006). These reports/audits have been commissioned by the Department of Health and therefore could be open to criticism in terms of bias or a conflict of interest. Also, the current research on the service has focused on economic value and financial savings in comparison to traditional service provision,

not on any of the treatment modalities identified in Government Implementation Guidelines (DoH 2001) as being required to be offered by the service. Some of the research articles viewed in this case illustrate the tension present in the traditional acceptance that quantitative, statistically robust research, in particular Randomised Controlled Trials provide the most reliable and generalisable results (CRD 1996).

Further reading of qualitative research and also of reports and information from a variety of sources, such as letters, opinion pieces and conference presentations, have generated a more complex and controversial picture from sources of professional practice. Results gleaned from a quantitative, positivist approach to a research question, provide specific numerically measurable results. However, the subject area is comprised of such an array of human involvement, intervention and interpretation that these results could actually become irrelevant in the face of the lived experiences as expressed by those actually working in or in receipt of the service under scrutiny. The use of a variety of sources for information about a subject area, confirms that while certain levels of research may provide reliable statistical evidence of a specific factor, other qualitative, subjective or experiential information can put the phenomenon in context and may even challenge data. For Foucault and Alford, the impact such challenges may have is mediated by the dominant discourses of interest/stake holders with the power to influence notions of knowledge and truth in the specific arena (Foucault 1972, 1971, Alford 1975). One of the first elements of “truth” in the arena of Crisis Resolution services is the term “crisis”, how it is used and what meaning it is given within this context.

3.2 Definitions of Crisis and Trauma

The Oxford English Dictionary (1996) defines the word crisis as

“a crucial stage or turning point in the course of something.... In a sequence of events or a disease; an unstable period of extreme trouble or danger, especially in politics or economics; a sudden change for better or worse in the course of a disease” (p.377)

and trauma as

“a powerful shock that may have long-lasting effects” (p. 1638)

Recently, the term crisis has become synonymous with global financial disasters and more local economic hardship. From a social point of view, the word crisis is also the name of a nationally renowned charity which has supported the homeless for many years, particularly known for its advertising campaigns at Christmas. At the time of writing, a search using any internet search engine will bring forward results primarily concerned with financial, economic and property/housing issues.

The media database UK Newsstand provides an illustration of the frequency of the use of the word crisis in national and provisional press news coverage from 1980 to 2013; in the 1980's the word crisis appears rarely in print, once or twice a month, gradually increasing from the middle of the 1990's, with a significant increase in 2001 onwards. From 2007 this increases again, at a rate of over one hundred times a month, with never less than 80. A rudimentary analysis may infer a relationship between political events in the UK in the 80's and 90's, such as poll tax riots, the miner's strike and the collapse of the property market, with an increase in frequency from 2001, as wider global issues began to receive more attention and parts of the media became increasingly alarmist. The word crisis has been added as a suffix to describe a wide range of issues from tension in the Middle East to environmental topics, social problems and events in western financial sectors. The frequency of the term crisis in relation to mental health has

followed a similar trajectory over the same period of time, with the increase beginning later, from around 2004 onwards. Further investigation leads to specific news stories, several of which related to incidents where a Crisis Team had been part of the care package for an individual (East Anglian Times 2012, Daily Telegraph 2013).

For the purposes of identifying the remit of a Crisis Team, the Department of Health (DOH 2001) describe crisis in terms of an acute psychiatric episode that without the input of a Crisis Resolution Home Treatment Team would require the person to be admitted to hospital. The Sainsbury Centre for Mental Health (2001) expand on this description, where a crisis in terms of mental illness can be thought of as the inability of an individual to cope with situations, which may include the response to severe trauma. In Foucault's work analysing the development of the medical profession, he identifies a crisis in the progression of disease as the point at which the individual confronts the disease with the likely result that the medical profession intervenes and take control (Foucault 1980)

The definition from the Sainsbury Centre reflects some of the earlier uses of the term crisis in the context of mental illness. Caplan (1964), focused on an individuals emotional balance that can be disrupted by a perceived inability to cope with an event or situation. Caplan's work was the result of building on Lindeman's (1944) findings of treating individuals following traumatic experiences, specifically survivors of a fire. Caplan developed these ideas and described how they might be applied to survivors or witnesses to extreme weather events, natural disasters, violent crime, premature birth and other life events.

The theory developed consists of the notion that offering psychological and practical support at the time, in-situ or as near to

the event as possible, significantly increases the person's ability to process the event emotionally and psychologically, thus decreasing the likelihood of further mental health problems in the long term. In the United States, this theory of crisis continues to be utilised to provide support to people who have experienced shock, trauma, and is viewed as a preventative method to mediate against the development of post traumatic shock disorder (Roberts & Everly 2006). This crisis theory was not specifically aimed at the treatment of individuals who already had a history of mental health problems, but is more akin to a forerunner of current ideas of promoting well-being and resilience in the general population through community education and early intervention.

However, Ball et al (2005) suggest that those individuals with severe and enduring mental illness experience a crisis in the form of a recurrence of symptoms, feeling overwhelmed and out of control, but may not necessarily be in response to an event or situation. The onset or reoccurrence of distressing symptoms could be perceived as traumatic and therefore considered in the context of a crisis in mental health. In the United States, meanwhile, there has been much debate and research into the nature of crisis and trauma (Roberts 2000, Yeager & Roberts 2003, Dulmus & Hilarski 2003, Roberts & Everly 2006). Much of the work focuses on suicide prevention and as noted previously, symptoms of stress following severe traumatic events. The socio-cultural differences apparent in the United States, with higher levels of violence/gun crime, severe weather in the form of hurricanes/tornadoes and the increased fear of terrorism, influences the practical use of these terms, although provides interesting views and potential areas of reference.

Roberts (2000) proposed that an individual may experience crisis in the form of instability and disorganisation as a result of unresolved acute or chronic perceived stress. The outcome of perceived stress may lead to depression, anxiety, low self esteem,

depressed immune system and impaired cognitive abilities. Crisis may or may not result in pathology, with the development of defence mechanisms seen in the form of over activity or lethargy (Dulmus & Hilarski 2003). From this perspective, stress, trauma and crisis are viewed as a continuum, with responses and outcomes dependant on the individuals own experiences, resilience and perceptions. Trauma is described as a shattering of the person's worldview, challenging basic beliefs with a loss of meaning, control and lacking connection to a safe place or dependable individual (Roberts 2000). Referencing Maslow (1954), this can be seen as a violation of the basic needs of safety, thwarting growth and development, resulting in a perception of powerlessness.

The term crisis within the initial phase of this research project refers to the use of the word in the context of mental health services and policy in England.

The transformation of the generic term crisis into a taken-for-granted clinical/psychiatric and organisational description is a phenomenon that will be explored further through the analysis in this thesis. For the moment, however, the remainder of the chapter will explore the historical context of the introduction of Crisis Resolution Teams within NHS mental health provision in England.

3.3 Background to Crisis Resolution Home Treatment Teams

The 60's and 70's saw an increasing body of work expressing unease with the treatment and perception of mental illness (Scott 1973, Brown & Wing 1962, Braginsky et al 1973). In 1985, a review of the failings of psychiatric institutions was published (Martin 1985) identifying the geographical, structural and professional isolation engendered by the environment and culture of large psychiatric hospitals. According to Scull (1977), a process of de-institutionalisation gathered pace in the 70's with the advances in

psychotropic medication and an economic driver in response to changes in the welfare state and unsustainable costs of the large institutions. Prior (1991) contests this view of the reasons for the closure of large asylums and the move toward short term hospital care, citing a shift in the theoretical base informing psychiatry. Psychoanalytical theory and psycho-social concepts of mental health had an increased influence on the ideology, organisation and practices within psychiatry. The term mental health replaced mental illness as a generic description in policy and some areas of research.

Community care in the 1990's and early 21st century began to describe the organisation and practices for the treatment of mental illness, denoting the transfer of in-patient facilities to smaller, short-term, acute units/hospitals within local communities, community mental health teams staffed by health professionals from a number of disciplines (nursing, social work, occupational therapy) (Rogers & Pilgrim 2010). However, the acute ward system has come under scrutiny, facing charges of being non-therapeutic with increased incidence of aggression, substance misuse, boredom, low staff morale and high levels of patient dissatisfaction (Sainsbury Centre for Mental Health 1998, Lelliott & Quirk 2004, Norton 2004). According to Rogers & Pilgrim (2010) these units have become a form of custodial risk management, focusing on mental pathology rather than mental health.

One of the first Home Treatment services in England was introduced in Birmingham in the late 1980's (Dean & Gadd 1990). The evidence cited as rationale for the service, referenced studies of alternatives to admission by Stein & Test (1980) in America, Hault & Reynolds (1984) in Australia and Pai & Kapur (1982) in Bangalore. The service in Birmingham, was part of an expanded multi-disciplinary mental health drop-in centre. Although an evaluation of the service concluded that "home treatment is

feasible for most people with acute psychiatric illness” (Dean & Gadd 1990 p1021), it was also acknowledged that the geographical area served was very compact, easing the logistics of frequent home visits. Over a 12 month period 65 of the 99 people referred were treated at home. The description of the service, whilst highlighting it as an option to admission, was not gate-keeping all admissions to hospital. Interestingly, given the current ubiquitous use of the term crisis, this word is not mentioned within the report recounting the service evaluation. Whilst it has been agreed that there was a need for improvements for urgent responses within community mental service provision (Cold 1994), it has been contested that a reduction in bed use is advantageous for service users or carers (Pelosi & Jackson 2000, Burns 2004, Allen 2010).

Against a background of controversy and critique, the past decade has seen a raft of policy changes and Government guidelines introduced in relation to the delivery of mental health services and in the context of continued reduction of hospital beds (Department of Health 1998, 1999, 2000, 2001). The National Service Framework (NSF) for Mental Health (DOH 1999) recommends people are treated in the least restrictive environment, as close to home as possible. One response, Crisis Resolution Home Treatment Teams have been introduced by NHS Trusts across the country, with over 300 dedicated teams providing support to people deemed to be experiencing a crisis in mental health (Garcia 2006). The remit of these teams is to provide a therapeutic treatment programme at home, for individuals who would otherwise require hospital admission to a mental health in-patient unit (Johnson et al 2005, Garcia 2006).

Other responses to government policies include specialist teams that have been developed over the preceding years such as Assertive Outreach Teams and Early Intervention Services as part

of the NSF for mental health recommendations. In common with Crisis Resolution Home Treatment Teams, these services offer a multi-disciplinary team approach, with Assertive Outreach Teams (AOT) also having a remit to prevent hospital admissions (Wane et al 2007). These teams also have specific criteria for referrals and are developed in line with guidelines for a model of practice. The Assertive Outreach model is characterised by a multidisciplinary team approach to develop a consistent therapeutic relationship with individuals experiencing severe and enduring mental health problems with a history of poor or limited engagement with mental health services and who may also have a history of repeated hospital admissions (Sainsbury Centre for Mental Health 2001).

A critical evaluation of the literature on Assertive Outreach Teams by Wharne (2005) identified several factors that may contribute to making research into this type of service problematic; the multidisciplinary nature of the approach and possibly competing professional perspectives, the lack of literature defining the types of interventions offered and a focus on the economic/cost effectiveness at a service level in terms of reducing hospital bed occupancy. These factors are also evident in the current research literature surrounding Crisis Resolution Home treatment Teams. The literature evaluation was not a systematic review and did not provide any details of inclusion/exclusion criteria of literature. However, the paper does note a large proportion of AOT work involved “crisis management” in the form of support with financial problems, problem-solving, daily living tasks/issues, disputes with neighbours and family/relationship problems. As Wharne (2005) suggests, these types of interventions do not fit neatly into descriptions of evidence-based psychosocial treatments. It may be reasonable to consider that these interventions could also form the workload of Crisis Resolution Teams.

3.4 The Evidence Base

The development of Crisis Resolution Home Treatment Teams in the NHS has occurred across Trusts in England rapidly as a response to Government targets (DoH 2000). However, studies investigating the implementation and performance of Crisis Teams report differences in the format and make-up of teams, along with discrepancies between the remit and criteria of teams and the Department of Health (2001) Implementation Guidelines (Garcia 2006, NCMH 2004). This has implications for the reliability of research on the efficacy of Crisis Resolution Home Treatment Teams, as teams may not be treating similar clients groups or may be operating with differing remits.

Two studies that have reported on the probable efficacy of Crisis Resolution Home Treatment Teams in relation to reducing hospital admissions are Johnson et al (2005) and Glover et al (2006). Johnson et al (2005) describe a randomised controlled trial of mental health care in Islington and conclude the introduction of Crisis Resolution Teams (CRT) reduced hospital admissions from 71% prior to CRT existence to 49%, in the six weeks following a crisis. Although comparison was made between individuals with a similar diagnosis, the extent and severity of each crisis was not measured. The effect on involuntary admissions was not commented on, nor whether a reduction in suicide rates was noted, another factor identified as needing addressing in the NSF for Mental Health (DoH 1999). Although the study by Johnson et al (2005) used a robust methodology in the form of a random controlled trial (RCT), there may be a question of transferability if, as Garcia (2006) points out, many teams have been subject to change and in some areas remain in a high state of flux. The trial was also only conducted within one geographical team.

Wharne (2005) asserts in relation to Assertive Outreach Teams, randomised controlled trials in mental health service provision tend

to measure the service and do not necessarily identify or measure the specific clinical treatments or approaches, with the notable exception of the research on Cognitive Behavioural Therapy. It may also be suggested that Johnson et al's research poses more questions than answers; the use of an RCT in this instance is retrospective and utilises statistical data on hospital admissions and Crisis Team referrals which would rely heavily on the accuracy of the original data; how many of the prevented admissions were followed up by a crisis team and to what extent did service user preference have on decisions to admit or not to admit to hospital?

Glover et al (2006) completed an audit of 229 local health areas in England between 1989 and 2004. A reduction by 10% of hospital admissions in 34 of the areas examined was reported since the introduction of Crisis Resolution Home Treatment Teams in 2001, with a further 23% reduction in areas with 24 hour access to Crisis Resolution Home Treatment Teams. Although both of these studies purport to provide evidence to support the development of Crisis Resolution and Home Treatment as a separate entity, they cannot be said to provide conclusive evidence. Another possible explanation for the reduction in hospital admissions in, what has to be said, is a relatively small number of Trusts could also be the introduction of assertive outreach and early intervention teams, although the authors discount the impact of assertive outreach teams (Glover et al 2006). A further factor may be the "bed blocking" phenomenon. That is, hospital beds used for long stay patients, possibly in the absence of suitable accommodation to be discharged to, thus reducing beds available for individuals to be admitted into. Both studies are unclear in terms of what the Crisis service offered, although intensive support in the form of daily home visits and telephone contact appears to be a common feature of these teams. Both studies also rely heavily on statistical data produced by the NHS trusts and do not give any information

on whether there had been a reduction in bed availability during the timeframes under scrutiny.

Pelosi & Jackson (2000), suggest additional support is already available in Community Mental Health Teams with the exception of the ability to offer increased numbers of daily visits. Policy implementation guidelines also describe the service as a 24-hour, 7 days a week service for people experiencing an acute episode of mental illness, with staffing levels of 14 per 150,000 population. It is also suggested that the service is not appropriate or designed for individuals with a primary diagnosis of personality disorder, substance misuse or emotional distress derived solely from social/relationship problems (DOH 2001).

A recent report on behalf of the Care Services Improvement Partnership (CSIP) cites the personality disorder and substance misuse exclusion criteria as further promoting inequalities in health care provision and marginalising those who may already be disadvantaged in society (Clark 2008). This report cites the analysis of northwest regional NHS Trusts and Teams operational policies and telephone interviews of team members as data sources. The report describes the use of thematic analysis to identify current practice and areas for service development. The results focus on procedures for referral and availability of teams via telephone and the author appears to find some operational procedures, while in line with Department of Health guidelines (2001), incompatible with other government directives and/or lacking any identifiable evidence base.

Many teams are reported as finding a large proportion of referrals for Crisis Resolution Home Treatment input are for people experiencing severe emotional distress, commonly related to social or relationship difficulties, and may not otherwise be regarded as suffering from mental illness, also for individuals with a history of

deliberate self-harm (Garcia 2006, Morgan 2007). The discrepancy between the proposed target group for Crisis Resolution Home Treatment Teams and the actual people who are assessed and receiving the service is an initial and continued topic of debate and likely influenced by confusion over the term crisis and also teams focusing on their remit to provide an alternative to hospital admission, acting as the gatekeepers to in-patient units (Pelosi & Jackson 2000, Garcia 2006, Carpenter et al 2013). The risks associated with suicidality, provide an additional criteria in the decision to offer the service, yet suicidal ideation is not in itself always an indication of severe and enduring mental illness (Marsh 2010). Anderson (2006) also identified the numerous interpersonal processes and individual professional discretion at play in the acceptance of a referral by Crisis Resolution Home Treatment Teams.

The whole idea of Crisis Resolution Teams has been a subject of controversy and studies from America and Australia in the 1980's and 90's have been openly criticised, with the closure of the service in a number of areas cited as a reflection of the contrasting views as to the efficacy of Crisis Teams (Pelosi & Jackson 2000, Burns 2000). Pelosi & Jackson (2000) suggest that the evidence cited for the effectiveness of home treatment against in-patient care is out dated and community care in the U.K is much improved since publication of the original research. Comparison with American models of health care may not be helpful, in as much as the United States has a very different health care system. However, issues surrounding the prevalence, treatment or prevention of mental illness are pertinent across the globe.

With reference to approaches to mental health care in North America, the term Crisis Team and crisis models of practice refer to a service which includes Crisis Centres and a model which focuses on the aftermath of an emotional or traumatic event

(victims of crime, bereavement etc), not solely on those experiencing mental health problems. Guidelines for Crisis Resolution Home Treatment Teams in this country specifically exclude the provision for emotional and socially triggered issues, although as Pelosi & Jackson (2000) point out, it is precisely these people who are more likely to access the service in the first place. Burns et al (2002) carried out a systematic review of the differences in home treatment for mental health problems in Europe and the USA. Although admissions to hospital appeared to be reduced in America, with the introduction of home treatment teams, the authors' findings were inconclusive, with a variety of factors appearing to potentially influence results of research in specific countries, including the possibility that standard European community provision was already more robust and so contributed to a lesser demand for admission in the first place. The presence or not of specific professional disciplines such as occupational therapists or social workers was not seen as a significant contributory factor to the results.

In a systematic review in collaboration with The Cochrane Database, Joy et al (2006), found inconclusive evidence of a reduction in bed days, although acknowledged possible reduction in repeat admissions, however the presence of one particularly positive study was cited as potentially over-influencing the data. The review did not include studies which referred to people suffering depressive illness or drug-induced psychosis. Indeed, the review of only 5 studies, specifically focussed on reports of those experiencing a psychotic illness, a criteria possibly influenced by the original outline for extended service access being aimed at people classified with severe and enduring mental illness (DoH 1999). The results from the studies included were not specific to crisis intervention, but to the crisis-orientated part of a wider community-based package of care. The review also acknowledged

the difficulty in defining the meaning of crisis intervention and exactly what this entails.

Including the most recent audits and reports commissioned by the Department of Health and the National Audit Office, it would appear that research into the role of Crisis Resolution Home Treatment Teams has focused predominantly on effectiveness of reducing admissions to in-patient facilities (Johnson et al 2005, Onyett et al 2006, Glover et al 2006). Research has been quantitative in nature, using surveys and statistical analysis to measure service provision against numerical targets, with little or no information on the quality of the service, the views of those involved and what is actually offered to service users in order to prevent hospital admission and provide a viable alternative.

Due to the relatively recent introduction of specific, stand-alone Crisis Teams in this country, there is also a dearth of research on the longer term influence of these teams or on the actual clinical benefits and outcomes for the users of the service (Toot et al 2011, Carpenter et al 2013, Winness et al 2010). Equally, apart from occasional mention of multi-disciplinary teams and daily visits, very little information is forthcoming on what forms of intervention are available (Sjolie et al 2010). Toot et al (2011) report on the effectiveness of Crisis Teams for older adults and point out that the evidence base for this model is very weak. In their systematic review of the effectiveness in practice of Crisis Teams, Carpenter et al (2013) confirm findings of cost effectiveness, whilst also acknowledging a scarcity of robust evidence for psychosocial outcomes. Winness et al (2010) note the need for further exploration of the different understandings of the concept of crisis from the view of service users and providers.

Throughout the literature relating to Crisis Resolution Home Treatment Teams is the issue of the term "crisis". Although on a

personal level, individuals may have differing views of what constitutes a crisis, parts of an organisation, a team or a service are also likely to hold a variety of opinions (Tobitt & Kamboj 2011). According to Morgan (2007), this continues to impact on the perceived role and efficacy of Crisis Teams from the point of view of other parts of the health care system and the service users and carers involved. Much of the debate also appears to be anecdotal and conducted via the letters/opinion pages of professional journals, or descriptions of individual teams (Pelosi & Jackson 2000, Allen 2010, Hunt 2012). However, despite this, the central tenet of Crisis Resolution Home Treatment Teams is to provide an alternative option to hospital, as the name suggests; resolve a crisis and providing treatment for individuals at home.

At present it is unclear how and in what form this treatment is delivered; research papers, audits and reports predominantly describe the make-up, remit and policy driven development of Crisis Resolution Home Treatment Teams against a backdrop of complex organisational, professional and social interactions and change. In his work entitled "Street-level bureaucracy; Dilemmas of the individual in public services", Lipsky (1980) proposed that workers in public services, including the health sector, operate within a paradoxical framework consisting of their humanistic ideology from training, whilst working within a bureaucratic structure defined by performance management, rationing and service pressures. This appears to be supported by Anderson's study of two Crisis Teams, which highlighted the different perspectives of crisis held by nursing and social work professionals, influencing how a working definition of crisis is constructed and understood, and mediating the resultant responses (Anderson 2006).

Whilst not dismissing the elements and factors influencing Crisis Resolution Home Treatment Teams development, a core

consideration of enquiries into the nature of this service must include exploration of what these teams do (Sjoli et al 2010, Kingsford & Webber 2010). A hospital admission will entail access to nursing staff 24 hours a day, access to therapies and therapeutic group-work, including occupational therapy, counselling and psychology and separation or respite from their usual roles, routines and responsibilities. In view of the fact that users of the Crisis Resolution Home Treatment service remain at home during an acute episode of mental illness/crisis, then how individuals are supported with coping and engaging with their daily living/occupational responsibilities appears to be a fundamental question and one which occupational therapists would traditionally identify as a core concern for the profession. However, issues of professional role and remit are not solely a matter of interest for occupational therapists. The continuing changing landscape of mental health provision has implications for all those working in this area of health care (Rogers & Pilgrim 2010).

3.5 Team Work – Crisis Teams and the Professional Context

As with the provision of mental health services, government policies have, and continue, to implement changes, challenging the roles, working practices and professional boundaries of the workforce in the National Health Service and Social Care Services (DoH 2000, 2004).

Integral to the changes to the delivery of mental health services within the NHS has been the drive to dismantle the professional boundaries between health care workers (DoH 2000, Witz & Annandale 2006), best illustrated in the government Agenda for Change policy (DoH 2004). Proposed as a vehicle for the increase in collaborative, effective team working to ensure a comprehensive care package for the individual, it has also been seen as a cost saving exercise (Witz & Annandale 2006). In mental health, the demarcation of profession specific duties highlights the dichotomy

between rising to the challenge of change and the call to redefine and focus these professions in terms of their core philosophies and unique skills contribution (COT 2006, DoH 2009).

Aside from the change for Approved Social Workers in mental health, who are seeing one of their most fundamental and unique roles shared with professionals from other disciplines with the development of the Approved Mental Health Practitioner role (Barcham 2008). Another challenge appears to be for psychiatrists, nurses and occupational therapists (Jones 2006). Psychiatrists are witness to the shift of responsibility for hospital admissions from themselves to Crisis Teams (DoH 2001). Reeves & Summerfield-Mann (2004) point out the increasingly generic role required of occupational therapists in community mental health settings could be in danger of eroding the professions identity. Yet another report on the tension between generic and role specific demands was highlighted by Culverhouse & Bibby (2008), using vignettes to illustrate the complexities of care co-ordination and providing specific occupation therapy interventions. The report advocated for occupational therapists to provide more profession specific interventions and cited the College of Occupational Therapists (2006) 10 year strategy which calls for service commissioners to ensure service users have access to occupational therapy assessments and interventions.

Nursing education has moved from the practical, hospital based model into academic institutions, and has made the transition from vocation to profession (Witz & Annandale 2006), mirroring the progression of occupational therapy. What these two particular professions have in common it would appear is a dilemma of identity and justification of interventions (Jones 2006, Stark et al 2002). The introduction of Support, Time and Recovery workers in particular is seen as the development of a role once the domain of mental health nurses and occupational therapists (Jones 2006).

The overall impression of mental health and professional discourse is one of contradiction and some confusion on the future and current shape of practice.

In his study utilising an action research methodology to identify how a multi-disciplinary team developed a care pathway for individuals with a diagnosis of schizophrenia, Jones (2006) describes a number of issues arising within the team, which consisted of nurses, social workers, occupational therapists, psychologists and psychiatrists. Through the research process, issues of professional defensiveness came to the fore to the detriment of the development work. The use of specific terminology/language and the assertion of a professional signature over areas of work being identified as a defence of professional boundaries and roles. In particular, the need to use profession specific assessment tools was frequently cited as a reason to maintain separate pathways. Exploitation of perceived positions of power and the background dialogue from earlier student training appears to have become evident in disputes over ownership of areas of practice. The overall findings are suggested as being in contrast to the government drive toward inter-professional collaboration and role boundary blurring (Jones 2006). It was acknowledged that the research project itself possibly contributed to, or at least exacerbated tensions between team members. Due to the nature and methodology of the research, these tensions may have manifested themselves through professional identity issues as a safer way of expressing dissatisfaction with working practices or even personal differences.

Reporting from a 2 year research project in collaboration with the then English National Board for Nursing, Midwifery and Health Visiting, Stark et al (2002), also highlighted the dichotomy between the rhetoric of government and organisational policy, and the reality of team working and the delivery of mental health care

services in the NHS. The project took the form of a mixed method approach, collating data from document and literature analysis, focus groups, survey, and case studies. The 1800 participants included service users, carers, health care professionals, educators and students from across regions in England. Findings identified tensions and contradictions illustrated by the discourse at government and organisational level and the practicalities and realities as perceived by those using or working within mental health services. Examples included services users who preferred a distinct diagnostic title such as schizophrenia rather than terms such as severe and enduring mental illness.

Multidisciplinary team working was seen to fall victim to issues of power relations, status differences, role blurring, time constraints and resource limitations resulting in a perceived failure to attain policy aims and fuelling a blame culture within professions. The authors, whose focus was to provide guidance on health profession student training, suggest that future education of health care professions should include an understanding of the professional discourse of other disciplines, of how professions talk about and with other professionals and identify and justify their practice (Stark et al 2002).

Wodak (1996) has explored the wider influence of organisational and institutional discourse on language and action, while Potter & Wetherall (1987) suggest the existence of interpretive repertoires; a limited available number of discourses with specific ways of talking about a subject or problem, and how or why this use of language is rooted in a wider discourse.

Simpson (2007) also explored the impact of team working, specifically in community mental health teams. A multiple case study design compared the observed interactions of team members at team meetings and interviews with team members, to

identify patterns and themes. The longitudinal study took place over 2 years and included 15 community mental health teams. Although the research claims to illustrate the impact of team working on case management, all of the care co-ordinators were identified as nurses and the roles of social workers, occupational therapists and psychologists within the teams were not described. The findings reported tended to focus on the dynamics of communication styles in team meetings, with particular attention on the role of the consultant psychiatrists in the potential success or otherwise of collaborative team working. Service users were also interviewed, and carers, however this data is not discussed in the report.

Although over ten years old, a study by Boomsma et al (1999) of nursing interventions in crisis-oriented home care in the Netherlands identified 16 categories for the most frequently cited interventions. With the possible exception of medication management, the remaining categories are likely to be recognised by health care workers, other than nurses/doctors, in this country as pertinent to their own repertoire of interventions. In particular, the third most frequently used intervention was identified as “activity therapy”, which occupational therapists would immediately rate as their domain of expertise. However, it is important to recognise that the terminology being utilised to describe categories in a taxonomy of nursing interventions may not describe the same actions and approaches that the term would represent in an occupational therapy taxonomy or be transferable to another country/culture. As Stark et al (2002) concluded, it is important to recognise and become familiar with the discourse of other professions in order to facilitate better understanding. By identifying how terminology and language is being used, it may be possible to determine whether professional boundaries are being blurred or whether in fact individuals are providing unique skills and

interventions according to their specific professional approach, but describing it using a homogenous terminology.

A systematic review of the interventions delivered by nurses in the United Kingdom by Curran & Brooker (2007) identified cognitive behavioural therapy (CBT) as the most commonly evaluated effective intervention. Case management, education and problem-solving were also cited. Although all studies reviewed used a Randomised Controlled Trial method, it was acknowledged that a variety of factors are likely to influence the outcome of any interventions delivered in mental health, making conclusions regarding efficacy of a specific modality delivered by a specific profession problematic. Curran & Brooker (2007) also noted many of the studies measured interventions delivered by multidisciplinary teams, however the inclusion of these studies in a systematic review of nursing interventions was justified by the assumption that as nurses represent the highest proportion of health professionals in mental health, then nurses were likely to make up a large percentage of the clinicians in those teams.

Also of interest in the review results are terms such as case management, education and problem-solving, and their use in naming an intervention. Definitions are not provided for these interventions and there appears to be an assumption that these interventions can be delivered in a standardised way, which may not be the case, particularly between different professions, who may be approaching these types of interventions from subtly different perspectives. Another point here is that although CBT was identified as the most commonly cited effective intervention, some of the studies included specialist therapists delivering this particular approach. Studies were included where it was shown that outcome measurement tools had been used, however Curran & Brooker (2007) identified this as a possible limitation themselves, in that no studies utilised service user views as an outcome measure, a

factor at odds with current user led and service user inclusion policies (DoH 2005)

According to Jerome Frank (1989) in his review of psychotherapeutic techniques, there is evidence to suggest that the interaction and quality of engagement between worker and client is central to how the individual perceives and reacts to therapeutic intervention. This assertion is supported by findings described in a case study of two community teams (Hannigan & Allen 2011). The personal qualities, individual style and unique combination of skills were cited as pivotal in the treatment and support of a service user by their allocated case worker. The loss of this case worker was seen as having a negative impact by the service users' carer, with little chance of the service being able to find a replacement for the staff member with the same skills and personal qualities. The importance of rapport and development of a trusting relationship is demonstrated a central tenet of quality therapeutic engagement (Hannigan & Allen 2011)

Common features of therapeutic interventions that appear to be beneficial are cited as those where the therapist can convey a genuine interest in the person, is able to instil hope and strengthen a sense of self-efficacy (Frank 1989). Occupational therapists, nurses and social workers would all lay claim to including these qualities in their approach to the people they see, however, each discipline may view the issues and needs of an individual from differing perspectives and therefore utilise different terminology and language that can define them in a professional status and different from other disciplines

3.6 Summary

The number of Crisis Resolution Home Treatment Teams operating as part of the mental health service provision in England has increased greatly. A target of 335 teams by 2003 was set out

in the NHS Plan (DoH 2000). The Mental Health Policy Implementation Guidelines (DoH 2001) was published setting out a framework for criteria, workforce resources and general operating procedures. An overview of the evidence base and research published on the efficacy of Crisis Resolution Home Treatment teams and has highlighted some areas of debate and discussion. These include ambiguity concerning the application of the term crisis and how crisis is defined within the context of mental health service provision. In addition, the proposed nature of the service as a team approach, comprised of a number of health and social care disciplines is identified, along with examples of issues that may come with the territory of differing professional perspectives and language.

Chapter 4 - Foucault; Power; Knowledge

In his work *Madness & Civilization* (1967) Foucault proposed a history of the problematization of mental illness, of the construction of the subjectification of the mentally ill and confinement and surveillance as technologies to manage the problem, mediated through the power afforded the medical profession and later the rise of psychotherapy. Foucault was not alone in his critical appraisal of psychiatry; Szasz (1971) echoed similar concerns regarding the role of psychiatry as agent of social control. In America, Goffman (1961) wrote of the institutionalisation and de-humanising effects of the large asylums, or mental hospital. In England, Brown & Wing (1962) published a study describing social withdrawal, apathy and severe effects of institutionalisation, which could be reversed with the introduction of a stimulating work environment. A central theme in Foucault's work has been the production and circulation of knowledge and how some types of knowledge are privileged over others.

4.1 What is knowledge?

The answer to this question is culturally, historically, politically and contextually based (Burr 1995). Definitions of knowledge, the nature of knowledge and how it is acquired and utilised are at the heart of any research endeavour. Scheffler (1983), defined knowledge as including familiarity with people, places and subject, competency in a range of learned performance and the possession of truths held as fact and also matters of faith. Nonako (1994) derives a definition of knowledge, based on the work of Plato, as justified belief. Research is a means of knowledge creation (Carter & Little 2007).

Social constructionist theories of knowledge and knowledge acquisition suggest that knowledge is the result of social interaction and is particularly related to the patterns of language or discourses

used for a specific purpose (Burr 1995). A social constructionist paradigm questions the accepted knowledge frameworks and views knowledge creation as social, cultural and historically constructed understandings of the world.

Explicit knowledge may be defined as the processes, strategies and rules that can be described, explained and followed, whilst tacit knowledge is that which the individual believes to be true, is intuitive and/or based on experience, but is not easily communicated, described or shared (Newell et al 2002). Theories of explicit and tacit knowledge are not new. Particularly in terms of health and social care clinical practice, the role of tacit knowledge in clinical reasoning and decision making processes has influenced models of reflective practice and reflective learning (Schon 1983, Boud 1993, Johns 1993). Health care professionals have professional responsibility for continual professional development and learning (Health Care Professions Council 2011) and certain proponents of knowledge management theory have also adopted the fostering of an organisational culture for continuous learning as a prerequisite for success in the marketplace (Von Krogh et al 2000, Newell et al 2002). The ability of an organisation to ensure the identification of areas of tacit knowledge and to convert these to explicit knowledge through dissemination and widespread application is a key aspect of knowledge management (Dann & Barclay 2006).

4.2 Knowledge as Commodity

The concept of knowledge as commodity is a concept that appears to have developed in response to the economic, corporate and technological imperatives of the business world (McElroy 2000). Knowledge management includes the ideas of intellectual capital, business intelligence and corporate knowledge and is cited as an important model for innovation, competitiveness and business advantage (Stewart 1997, McElroy 2000, Von Krogh et al 2000).

Much of its own knowledge base appears to be derived from areas as diverse as psychology, sociology, systems theories. Distinctions are made within this concept between data, information and knowledge. Data can be viewed as a collection of figures, signs and/or observations that, once related to a specific context, becomes information (Newell et al 2002). For data and information to become useful and meaningful, it needs to be interpreted and applied, and so may become knowledge. However in order to be interpreted and applied appropriately, prior knowledge of the context, issue or situation may be required (Newell et al 2002).

If applied to the arena of research practice, then data collected through a research method becomes information as related to the context of the research question and subject. The analysis of this data, in conjunction with the information held by the researcher of the subject under research and their own understandings, then may become new knowledge in the form of a developing theory, a new insight or the identification and explanation of a phenomenon. For knowledge to be useful it must be applied and this is an area that knowledge management cites itself in promoting the furthering of organisational learning to encourage innovation and competitiveness. Knowledge management makes the distinction between explicit knowledge and tacit or implicit knowledge, and particularly the role these two concepts play in the creation, acceptance and integration of proposed new knowledge into practice (Von Krogh et al 2000).

Viewed from the perspective of aspects of knowledge management, the processes of creating, disseminating and applying knowledge for innovation and change within an organisation can be seen as fragile. Von Krogh et al (2000) acknowledge this and propose recognition of organisational and individual barriers to knowledge creation, sharing and implementation. The importance of a legitimate language to

communicate ideas and tacit knowledge is identified. Stories and metaphors may become a legitimate and more efficient way of disseminating knowledge (Girard & Lambert 2007). This is supported by social constructivist ideas of knowledge and theories of the role of language use in knowledge creation (Burr 1995).

However, this also raises the questions that interest researchers from a Foucauldian perspective, of how some knowledge may be deemed more legitimate than others, the positioning of “taken for granted” truths and the role of health professions in the construction, application and practice of knowledge, particularly in the context of the evidence-based practice culture promoted by policy and professional governing bodies (Bevir 2011).

4.3 Knowledge, Power and Professions

As research based on French philosopher Michel Foucault's concept of discourse, the view is taken of texts and practice as a way of thinking and talking about an aspect of reality that both shapes and reflects the cultural, political and social relations within the subject area at a given time. Foucault (1972) suggests that there are limitations to the way language is used within a particular discourse and this will be influenced by the current dominant organisational discourse of that time.

For Foucault, discursive formations provide a way of constructing a given topic in a particular way, with resulting discursive practices influencing outcomes and effects. These outcomes tend to relate to concepts of power and attribution of knowledge in relation to the objects within the specified topic. For example, Department of Health policy (DoH 2000) and guidelines (DoH 2001) on the implementation of crisis teams may be read as to imply an importance of occupational considerations, but without specifying what this entails other than the recommendation of an occupational therapist to be employed within the team. The absence of an

occupational therapist in a team does not mean people do not have needs that could be addressed through occupational therapy. Equally, it does not mean other health professions are not in possession of knowledge that could be used to address these needs. However, as the issues may not be articulated in the same language/terminology of occupational objects, then the intervention may not provide the focused approach to achieve the aims identified by an individual in crisis, therefore missing an opportunity to provide timely, effective outcomes and providing a quality service. This is a point that will be explored further from the resulting analysis of discourses within crisis resolution literature.

As indicated previously, mental health services employ a variety of health care professionals. The role of professions and specifically health professionals, has been the subject of much debate and analysis over the years (Illich 1977, Abel 1988, Oppenheimer 1975, Scull 1979, Rogers & Pilgrim 2010). Illich (1977) in particular has been very critical of the degree of power held by the medical profession and described health care workers as disabling those whom they purport to help. Equally, depending on the sociological and philosophical approach taken, health professionals can be viewed as seeking to dominate and exercise power over clients, junior ranks in their own profession and other work related groups (Abel 1988), to promote social cohesion.

Following Foucault's ideas on the changing nature of knowledge and with it the shifts in power relations, mental health professions are the site of competing and changing versions of knowledge, with challenges to professional identity, roles and status from a variety of reforms, government initiatives and social and technological changes (Rogers & Pilgrim 2010). With respect to the profession of occupational therapy, Mackey (2007, 2011) drew on foucauldian ideas of power, knowledge and identity to illustrate the potential opportunities for redefining the professional identity of occupational

therapists, in response to current challenges within health care redesign. The construction of professional identity through discursive practices illustrated the tensions and contradictions, between and within different discourses and how adaptations and compromises are made in order to rationalise and validate professional practice and identity (Mackey 2011).

Hui & Stickley (2007) conducted a review of literature and government health policy using a discourse analysis approach influenced by Foucault, to explore the concepts of service user empowerment in mental health nursing. The authors defined the approach as focusing on aspects of language that identify contradictions, repetitions, metaphor and dissociations of social reality, resulting in new versions of truth discovered in text, and themes are viewed as concepts. Results from the review and analysis concluded there are competing discourses identified in the language and rhetoric of service users and policy-makers. Tensions are evident between policy and practice and the issues of language, power and knowledge are complex but important factors to be considered in the relationship between mental health nurses and service users.

Foucault's views and ideas regarding the power/knowledge relationship have been recruited to explore recent developments in UK health policy, nursing practices and professional identities (Bacchi 1999, Shaw 2010, Crowe 2005, Mackey 2007, 2011, Roberts 2005, Fejes 2008). The concept of discourse as constructive of knowledge and the dominance of a specific discourse at certain points in history defining what may count as knowledge, and what may not, informs the work of Michel Foucault (1971, 1972). In particular, a Foucauldian approach to discourse and discourse analysis will look to shed light on the relationship between what counts as knowledge, creation of knowledge and power formations (Lines 2001).

The social and institutional agents that produce the dominant discourses are likely to be seen as providing the truth of the subject and making decisions about what is considered valid knowledge. Suppressed or hidden discourse practices may hold alternative versions of truth and may be considered knowledge that could be equally if not more valid and valuable. The focus of the research here concerns the discourses around the introduction of crisis teams as a result of Government policy, therefore incorporating a framework for analysis utilised within policy analysis that shares Foucauldian perspectives is a valid option for ensuring a robust process.

4.4 Governmentality

Foucault's thoughts on governmentality (based on ideas from Nietzsche) refer to the thoughts and actions by which agencies and the individual seek to shape and guide how the conduct of others and the self is governed (Foucault 1991, 2003b, Dean 1994, Rose 1999). Kendall & Wickham (2004) describe government as a particular way of thinking and doing in daily life; a way of conducting oneself. How conduct is seen is shaped and guided by dominant social and cultural discourses with the resultant technologies and practices. The production and dissemination of "truth" through dominant discourses promotes an understanding of what is to be governed and how (Kendall & Wickham 2004).

The technologies of governmentality include policies, legislation, media and academic texts. A major example of the influence of discourses on determining what is to be governed and how has been the shift from Keynesian-based welfare state to neo-liberal based policy reforms with a focus on greater individual responsibility and market-driven public services (O'Rand 2000, Flynn 2002, Bevir 2011).

Gordon (1991) described the rise of neo-liberal rationality of government in every day life, in the (at the time) political acceptability of mass unemployment which he attributed to

“..the wide diffusion of the notion of the individual as enterprise.....and that it is a part of the continuous business of living to make adequate provision for the preservation, reproduction and reconstruction of one’s own human capital. This is the ‘care of the self’ which government commends as the corrective to collective greed” (p44).

The state however, continues to exert power as custodian of and through the dissemination of preferred types of knowledge that will facilitate the mobilisation of human capital (Gordon 1991). Within health-care, discursive practices and technologies provide greater emphasis on personal responsibility for individuals’ own health/mental health, with increasing focus on health promotion through media advertising campaigns, adoption of the recovery paradigm from service user discourse (Deegan 1993, Craig 2008) and use of WRAP (wellness, recovery action plans; Copeland 1999). For health professionals, technologies of governmentality are identified within the practices of supervision, reflective practice and adherence to specific codes of conducts and through the introduction of clinical governance and evidence-based practice (Flynn 2002). Non-adherence to these practices would result in a failure to meet the expectations of the subjectivity of the health care professional.

Techniques for governing one’s own conduct, or technologies of the self, are a central theme in the concept of governmentality (Foucault 2003b). For Foucault, one of the fundamental technologies of the self is the role of the confession and its origins in the pastoral power of Christianity; in today’s secular societies and with the rise in power accorded to scientific sources of

knowledge, this has transformed into the techniques of verbalisation as a form of pastoral power in a variety of social and professional practices (Fejes 2008). Today, pastoral power as a technology of governmentality, focuses on the creation of the ideal, ethical self through the realisation of a good life (Foucault 2003b). Whereas Foucault's work gave greater significance to the techniques of the confession and verbalisation, particularly in relation to the discourse of the "psy" disciplines, his ideas and concepts can also be used to dissect the assumptions underlying theories of human occupation.

Laliberte Rudman (2005) proposed the concept of occupational possibilities, in that occupation is constructed through dominant discourses and participation in particular occupations as a means of attaining ideal subjectivities in the neo-liberalist form of responsible citizenship. Technologies of government are seen as acting through the construction of socially, morally and culturally preferred occupations and that performance or engagement in these occupations is done well and in the right way. For instance, in her studies of later life, the production through contemporary discourses of positive or successful aging were seen as dependant upon the engagement with consumer-based, physical activities and cultured occupations, thus attaining preferred outcomes within a neo-liberal framework of individualism and consumerism. Those individuals who do not have the health, financial or physical resources to participate in such occupations risk becoming marginalised (Laliberte Rudman 2005, 2010).

4.4.1 Policy as Governmentality

Policy analysts who draw on Foucault's theories and concepts of power, governmentality and discourse look to bring attention to the way governments and social actors construct and use knowledge/power in order to develop and implement policy and regulate practice (Bevir 2011, Dean 1999, Broer et al 2011). An

exploration of the “how” of governing across a range of sites and situations in society gives a focus from the micro-level, and an opportunity to reveal the practices and routines that come into being from the interpretation and application of a specific policy (Higgins 2004, Broer et al 2011). Therefore, a conceptual framework from the arena of policy implementation analysis which shares theoretical perspectives of Foucauldian discourse analysis – that is the relationship between construction of knowledge/power, power relations and the dominant discourse in the creation of objects and subjects – can be justified as a valid tool supporting the development of conclusions emerging from the analysis proposed here.

The topic of research is exploring the representation of concepts of human occupation within the mental health field of Crisis Resolution work. However, in order to provide the opportunity to explore this representation, the construction, evolution and evaluation of Crisis Resolution Home Treatment as an object must be traced, deconstructed and analysed. In this way, the research positions itself within the cultural, social and political arena of the research subject and makes transparent its philosophical stance in relation to identifying the role of language use in both constructing and obstructing notions of reality, knowledge, power and social relations.

4.5 Critique of a Foucauldian Perspective

The French philosopher Michel Foucault (1926-1984) produced a body work which has been influential on the thinking and approaches of the social sciences (McNay 2009). Foucault’s ideas on the inextricable relationship between the construction of knowledge and the production and sites of power, and therefore power relations, with the opportunities for resistance have influenced analysis of such social structures and technologies as the prison system and health care (Foucault 1980, 2003b).

However, his work and ideas are not without controversy or criticism (Bevir 2011, Ojankangas 2012, Gane 2012)

Foucault has been described as idiosyncratic (in his genealogy of neo-liberal discourse), elusive and possibly disingenuous (Bevir 2011). Some of these observations may stem from Foucault's reluctance to be categorised (Rabinow 1984), and the assertion that his work and consequent inquiry based on his perspectives and concepts, do not provide definitive answers, recommendation or offer solutions (Wetherell 2001, Sharp & Richardson 2001). However, others would suggest that Foucault exposes the taken-for-granted and offers the possibility of alternative constructions of an object and subsequent impact of discursive practices and technologies (Mackey 2007, Hui & Stickley 2007). Foucault has argued that a search for definitive truths is futile, asserting the presence of regimes of truth are representative of the power relations at play and therefore the solutions or recommendations for change must come from those involved and faced with the conflicts of power (Foucault 1980).

Ideas of a historically and politically constituted discourse that constructs others as subjects and maintains sites of power have drawn accusations of pessimism, with actors captive in the power relations consequent of power/knowledge dynamic (Horrocks & Jevtic 2001). Proponents of the use of foucauldian perspectives of discourse contest this view, suggesting that the exposing of discursive practices and power relations provides a challenge to the dominant discipline, opportunity for reflection and change (Roberts 2005, Mackey 2011). The presence of power relations and tensions indicates the presence of resistance, and the possibility for shifting power balance According to Foucault, the identification and exploration of problems and tensions in a given area of human activity can be illuminated and analysed using his approaches and ideas as tools for enquiry (Foucault 1980, 2003a).

Neo-liberalism is a term that was generally used to refer to the political and economic ideas and concepts seen in the 1980's and 90's and firstly is an economic discourse that proposes market-based solutions to economic problems (Bevir 2011, Flew 2012). In addition, neo-liberalism has variously been described as an ideology, a philosophy, a political project, a discourse or a set of discourses incorporating economics, managerialism, individual freedom and choice (Harvey 2005, Treanor 2005, Bourdieu 1998, Fairclough 2001). Choices are made viable through the structures offered through Government policies advancing free markets, free trade, property rights and promoting individual responsibility and entrepreneurial skills (Harvey 2005).

Foucault proposed a re-thinking of the term ideology as more useful from the view of regimes of truth; the taken for granted or common sense way of things, a way of representing ideas that sustains the interests of powerful groups; a system for the production, dissemination, regulation and operation of statements as truth in relation to systems of power (Foucault 1994). By taking this view of ideology, then discourses can be said to be used ideologically (Burr 2003). Although Foucault discussed neo-liberal ideas in his work on bio-politics, his focus was drawn from America and German examples (Flew 2012). Hall et al (2013) suggest neo-liberal ideas have become embedded in western thinking as the parameters of common sense and the taken for granted in public debate.

In order to ensure clarity, the use of the term neo-liberal/ism in the context of the findings from the analysis in this thesis refers to discourses that have been suggested as employed in pursuing the neo-liberal political project; economic, managerial, individualistic (Bourdieu 1998, Hall et al 2013, Shaw 2010).

4.6 Summary

The work of Michel Foucault has been explored with particular regard to his ideas on the relationship between knowledge, power and his concept of governmentality as a technology of knowledge/power mobilised through particular discourses and discursive practices. A link has been made between the generation and circulation of knowledge as enacted through dominant discourses and the relevance of these ideas to this research project. Governmentality and technologies of the self as concepts related to theories of human occupation have been introduced through the work of Laliberte Rudman (2005, 2010) in preparation for the framing of the discourse analysis of Crisis Resolution Home Treatment in Part One and in relating the findings to human occupation in Part Two of this thesis.

Chapter 5 – Methodology

Chapter five sets out the perspectives and approaches adopted as the methodological philosophy of this research project. The epistemological and ontological stance from which the investigation is approached is described and gives the rationale for method and analysis from a Foucauldian perspective. The contribution of Foucault's ideas of discourse as an agent of power through its construction of truth through accepted forms of knowledge is outlined as it relates to the structure of this research. A further critique of discourse analysis as method/methodology identifies the various approaches and differing strategies available, whilst also exploring the limitations and drawbacks of the particular approach utilised here.

5.1 Epistemological and Ontological Stance

The view that phenomena can be explained, can establish facts and that relationships can be discovered and scientific laws established, comes from a positivist ontological and epistemological standpoint that an external reality exists, independent of human behaviour, and this reality can be discovered, tested and known. Research methodologies in this tradition are generally referred to as quantitative research, where variables can be measured, subjectivity minimised or eradicated and results can be generalised, re-tested and are statistically reliable (Smith 1998).

Positivist philosophy stems from the period following the Enlightenment, when thinking and investigation moved away from the confines of religious teachings and toward the development and accumulation of scientific knowledge. Philosophers such as Comte and Hume in the 18th and 19th centuries, rejected any theories or "knowledge" that could not be objectively measured (Outhwaite 1987). There developed from this school of thought,

research strategies for collecting, measuring and analysing data which could be measured and tested numerically and statistically, providing a means to establish principles and laws about the phenomenon under scrutiny. Further to this, by the mid 20th century, positivists advocated reasoning through deductive thinking and developing predictions based on scientific principles which can then be tested through the use of research methods. The research methodologies and designs most associated with this philosophical approach are quantitative, experimental and would usually look to test a hypothesis (Outhwaite 1987).

However, not all phenomena lend themselves to the development of a hypothesis or to statistical testing and the measurable processes of a positivist approach to research methodology (Ayer 1969). Specifically, human behaviour, emotions and thoughts are notoriously difficult to measure and quantify and can be subject to an array of factors outside of the control of an objective observer (Parahoo 1997). The manipulation of variables to observe the effect and highlight causality in a specific set of circumstances raises questions of ethical considerations when applied to human beings (and arguably to any living creature). The limitations of the positivist, reductionist approach to research, particularly in the area of the social sciences was acknowledged by people such as Popper (1959) and Bronowski (1956), resulting in challenges to the traditionally held views of scientific knowledge and inquiry and alternative perspectives, collectively known as post-positivism and later developments in thought, coming under the approaches known as post-structuralism, critical realism and postmodernism.

Research within the tradition of post-structuralism does not aim to make claims about absolute truths or predictions, but to acknowledge the complexity of the social world and to explore meaning and/or significance (Blaxter et al 2001). Another premise is the view that truth is not fixed, but is that which is experienced by

the individual, although it will be shaped and influenced by social and cultural history, language and context reliant and with the potential to change. Therefore, any research and knowledge derived from research is the interpretation of the researcher filtered through their experiences of reality and bound by that individuals attitudes, believes and cultural influences. Research informed by these paradigms is generally qualitative in nature and methodologies associated with these approaches include ethnography, phenomenology and grounded theory (Stack & Trinidad 2007).

As a study into the constitutive nature of language and the historical, social and cultural origins of knowledge, this research is situated in the epistemological traditions of post-structuralism and social constructionism. The assertion that knowledge is fluid and not independent from the social and historical context is also connected to the ontological position of multiple truths and realities. Knowledge or findings from research is seen as partial, situated and relative (to the researcher's values). Some forms of discourse analysis are associated with these epistemological and ontological claims such as the methodological approaches of discursive psychology (Potter & Wetherell 1987), critical discourse analysis (Fairclough 1995) and analysis based on the ideas of Michel Foucault (Carabine 2001).

These approaches make claims to the constitutive nature of language and the relationship with social action, practices, politics and representations (Taylor 2001). The ontological stance of a foucauldian discourse analysis of specific documentation will not be claiming to identify the truth of the experience of the individual, or explain the views of a group; rather, to identify and explore the dominant discursive practices that construct specific ideas and concepts to such an extent and in such a way, that these ideas

have been accepted as knowledge, taken for granted truths in a specific context, at a specific moment in time (Foucault 1967).

5.2 Reflexive Decision Making

As suggested earlier (2.5), during the process of working in, and researching this area of the mental health services, I noted the importance of the contribution of texts and documents concerned with crisis resolution home treatment in the NHS. Many philosophers and thinkers have promoted the ideas of the influence of language, the written word and a collective discourse on accepted truths, knowledge and action. Most notably Derrida (1976) and Foucault (1972) provided the basis for exploration of the construction of objects through the analysis and deconstruction of texts.

From this stance, texts and discourse incorporate all the written, visual and auditory symbols that together form the object and provide the means for understanding and knowing that particular object (Derrida 1976). In this case the object – crisis resolution in mental health is constructed through the existence of specialist teams, policy documents naming and describing the teams, assumptions that people experiencing mental health problems are treated by specific health professions. Therefore, to take the written documents as the starting point for analysis, and deconstruction, can be argued as a valid exercise in seeking to show how they work in representing a particular view, and conversely hide or obstruct awareness of alternative or additional views.

5.3 Discourse Analysis – A Critique

The term Discourse Analysis may at first appear self explanatory – the study of words, talk, conversation, language? However, even a perfunctory glance through relevant literature will reveal an array of concepts and is variously described in terms of theory,

methodology, research method and a discipline in itself and as such is claimed by linguistics, psychology and a growing number of disciplines within the social sciences (Wetherell 2001). Early uses of the term were predominantly concerned with the structure and organisation of language (Harries 1952), although the probable origins of discourse analysis in its present forms stems from ethnomethodology and the ways in which people produce meaning and make sense of the social world (Garfinkel 1967). A general definition might suggest discourse analysis as an investigation or examination into the use of language within a social context (Wetherall et al 2001). The analysis of language use in a specific forum, arena or context can illuminate the strategies for creating and maintaining personal/group identities and political and social interactions (Stack & Trinidad 2007).

The complex variety of applications of the term discourse analysis relates to a number of different approaches, yet depending on the discipline within which an approach is applied, different names may be given to the broad approaches and further terminology applied to the specific concepts of methods attached. For example, schools of thought in psychology view conversation analysis and discourse analysis as specific entities of research method (Leech & Onwuegbuzie 2008). Yet other discourse analysis approaches are described from a methodological point of view due to their specific epistemological and ontological perspectives (Taylor 2001).

According to Wetherell et al (2001) as the field of discourse research has evolved, distinct yet at times overlapping traditions can be recognised. These include Discursive Psychology, talk as action, the role of cognition and in particular memory, on the construction of language (Edwards 1997, Potter 2000); Conversation Analysis, the activity and patterns of speech and language and its use in social interactions, including organisation/institutional settings (Heritage 2001); Critical

Discourse Analysis, an approach influenced by Foucauldian philosophy of power and representation, focuses on relationships of control, dominance and discrimination as manifested through language (Wodak & Meyer 2001, Fairclough 1995), and genealogical discourse analysis based more closely on Foucault's ideas of knowledge, power and representation (Carabine 2001).

The assumption, if accepted, that knowledge is socially constructed, demands then that the researcher acknowledge their own socio-cultural constructs, in particular in terms of the mode of data collection and analysis and specifically in relation to the interpretation of the results (Jasper 2007). Fairclough (2005) argues for a critical realist stance in his approach to discourse analysis, in as much as the array of systems and practices constituting discourse can include multiple truths that analysis will reveal. From a research point, this illustrates that the instigator of an area of research will approach from a particular epistemological and ontological framework, and further, any information will also be then analysed and interpreted through the socio-cultural constructs of the researcher (Proctor 1998).

Another element in the broad concept of discourse analysis, is the terminology or "language" itself. Differing approaches utilise similar terminology whilst referring to subtle, and sometimes not so subtle, or discrete differences in concepts or items. Much debate can be found on the meaning of the terms discourse, text and different approaches will include written, verbal, non-verbal and semiotic aspects of socio-cultural action/interaction as data for analysis, while others will concentrate on only the spoken word (Fairclough 1995, Wodak 1996, Potter & Wetherell 1987, Schlegoff 1998). Some authors will transfer certain concepts within the definition of a term and include it in an alternative term. So while the term semiotics can refer to the study of signs in a socio-cultural sense – images, music, sounds (Barthes 1964 cited by Chandler 2001:2),

Fairclough (1995) specifically refers to semiosis as including styles and genres of communication. The term “text”, can also be taken to mean all documents, policies, written, verbal, semiotic data, and therefore constitutes a discourse (Wetherell et al 2001).

For Foucault, discourse is the way systems of language represent ideas of knowledge, the production and control of knowledge, and therefore power, which perpetuates both power and the discourse in a given situation at a particular moment in time (McNay 1994, Foucault 1972). Written/documented forms of discourse were of great importance to Foucault, in terms of language use, author and audience in exploring discursive practices and social actions. The use of documents as data source for analysis and research (distinguishable from literature/systematic review) is promoted as a viable and feasible option by Prior (2003). Documents are seen as both a receptacle, of information, instructions and opinions, and as agents open to manipulation, suppression or as a resource and methods for producing social action, objects and knowledge. The authorship and intended audience are also part of the analysis, to determine the function of a document, how it is consumed, the circumstances of its production and generative properties (Prior 2003).

Documents are collective, social products that represent discursive practices and as such are utilised as allies or support in social, political and cultural change. The authenticity of a document, either through authorship or form of dissemination may be central to its acceptance into certain orders of discourse, such as the rhetoric of scientific or academic discourse (Foucault 1979). A document must have a consumer, a reader, who will also be active in the production process of the discourse. Without an audience the process stalls, although how the document is received, used or even ignored can not guarantee the implementation of the documents’ original intention (Prior 2003). How a document is

validated, appropriated and circulated is influenced by its consumers and forms another aspect for analysis (Foucault 1979).

5.4 Limitations of Discourse Analysis

Criticism of discourse analysis suggests that as a collection of theories and concepts borrowed from other areas of inquiry such as anthropology, psychology, philosophy it produces a circular debate and does not provide clear frameworks for the “doing” of discourse analysis in any consistent manner (Widdowson 2004, Burman 2003, Antaki et al 2002). Although the majority of approaches appear to concentrate on the linguistic strategies and tools of language, others do provide focus on categorising meanings and patterns and the relationship between themes, functions and consequences (Potter & Wetherall 1987). Antaki et al (2002) and Burman (2003) identify the potential pitfalls and common shortcomings often evident in the analysis of discourse such as under-analysis, circular analysis and de-contextualising. Predominantly, the issues appear to be an over reliance on quotes from raw data as an explanation of the ideas being offered, limited connection of the text with a wider discourse or ideology, failure to put the work in context from a historical, political or even organisational perspective and failure to clarify why the analysis is being done in the first place (Burman 2003).

Widdowson (2004) cites problems of relying on “borrowed” theoretical frameworks resulting in limitations of the operationalising of analytical methods. Fairclough in particular is noted as having adapted models and theories from other areas/disciplines in what Widdowson appears to find a rather unsatisfactory manner (Widowson 2004). Of those methods of analysis that are given illustration, their basis in an understanding and expertise in linguistics appears a prerequisite (Wodak 1996, Fairclough 1995). Norman Fairclough goes as far as to suggest that any research intending to utilise methods of discourse analysis

would do better to involve a linguist, as linguistics should also collaborate with experts from other fields of study, such as economists, sociologists (Fairclough 2005). However, Antaki et al (2002) and Burman (2003) acknowledge the wider interest that has developed in discourse analysis resulting in its increased use as a research method in a diverse range of disciplines and call for clearer guidelines and support for those entering into the discourse analysis arena from unconventional fields.

Additional criticism cites the hidden and often not so hidden bias of the researcher (Widdowson 2004, Schlegoff 1998), particularly in critical discourse analysis which positions itself by its very political and philosophical basis, as addressing predetermined issues of power, dominance, injustice. Van Dijk (1993) would argue that the role of the critical discourse analyst is one of a socio-political nature. It is a rather ironic argument, in that theories of discourse suggest that language, truth and knowledge are constructed by, and construct, the socio-cultural discourse surrounding a given scenario, organisation or individual (Wodak 1996, Potter & Wetherell 1987, Foucault 1972). Therefore, researchers, as individuals, are as much subject to the myriad of discourse texts/language around them as anyone else. As the majority of discourse analysis is associated with qualitative research, this does not assist an argument for the relevance of qualitative studies to be given the equivalent weight and validity as findings generated by quantitative research methods (Antaki et al 2002).

Further issues relating to criticism of discourse analysis as a methodology and method have been considered. Specifically, the limited cohesive agreement among differing disciplines regarding the process of analysis and conflicting approaches to discourse analysis which focus primarily on the linguistic features of discourse (Wetherell 2001). In response to these criticisms, this research is designed in line with foucauldian ideas of the

genealogy of discursive practices from a social constructivist point of view, rather than a linguistic process.

5.5 A Foucauldian Framework

The view of discursive practices as products of the historical, institutional, professional, political context at any given time reflects Foucault's (1972) ideas of the nature of discourse and its relationship to concepts of power, knowledge and social action. More significantly, in my opinion, are the issues of organisational and institutional discourse and professional identity as related to power and ownership of knowledge (Foucault 1972, Mackey 2007). I would also agree with the concept of multiple truths, the social construction of reality (Burr 1995) and that knowledge is a fluid concept capable of manipulation and being manipulated through discourse (Van Dijk 1993). As an employee in Crisis Resolution Home Treatment Team, I am surrounded by and influenced by the discourse of crisis work; I construct ideas about people and situations that I encounter in terms of the nature of crisis, contributing factors and options to resolve the crisis. However, this has not always been the case, therefore I am aware of alternative ways of understanding and constructing the ideas about the situations and people I meet, although I am currently subject to a dominant discourse.

This research is based on postmodernist French philosopher Michel Foucault's concept of discourse as a way of thinking and talking about an aspect of reality that both shapes and reflects the cultural, political and social/power relations within the subject area at a given time. Foucault suggests that there are limitations to the way language is used within a particular discourse and this will be influenced by the current dominant organisational discourse of that time. Foucault is cited as not being a discourse analyst and as such there is no definitive foucauldian discourse analysis method (Carabine 2001, Hui & Stickley 2007), However, by approaching a

specific subject, identifying its social, cultural and historical context and analysing the body of documentation that represents the subject, then the discursive formations and practices that construct the accepted truth of this subject through its documents and literature can be explored.

The reconfiguration of service delivery described through the introduction of Crisis Teams, represents the potential for a major shift in power relations for professionals and service users. Foucault's conceptual construction of the strategies of power through knowledge in the form of power relations provides a lens through which to analyse and identify the practices and technologies at play. This research project proposes to utilise Foucault's concept of discursive formations and practices to underpin the principles of discourse analysis as a research methodology. Methods for discourse analysis are dependant on the theoretical approach of the researcher, a foucauldian perspective does not bring a specific method/framework. Rather, Foucault advocated that his writings be accessed as a toolbox, to provide ideas, language and arguments as a reference point (Foucault 1980).

Discourse analysis from a foucauldian perspective is generally described as based on Foucault's writings as a method of archaeology or genealogy of a specific social arena (Carabine 2001, Rabinow 1984). However, more recent use of Foucault's work as a basis for discourse analysis, particularly in nursing and education, have focused on his ideas of power and knowledge through Foucault's concepts of governmentality and technologies of the self (Rolfe & Gardner 2006, Fejes 2008, Traynor 2006, Clouder & Sellars 2004).

The discourse analysis proposed and executed in this thesis is based on foucauldian concepts of governmentality and

technologies of the self (Foucault 2003b). To support and guide this analysis, a framework in the form of questions is suggested by Bacchi (1999) as utilised in policy analysis influenced by foucauldian thought. This, together with Carrabine's guide to discourse analysis from a foucauldian perspective will provide a structure to the process and method for analysis.

5.6 Questions of Quality and Rigour in Discourse Analysis

A structured approach to the data, documenting each phase of analysis and the explicit theoretical constructs underpinning the approach will provide a robust framework to illustrate the analysis along with a decision trail (Cheek 2004, Nixon & Power 2007, Ballinger 2004). Discourse analysis as a methodology does not seek to provide an undisputable answer or truth, but to provide a description of how a subject can be interpreted and to invite further interpretation, or an alternative discourse.

In order to establish rigor within the interpretative process, Crowe (2005) suggests;

- Links between the discourse and findings are adequately described
- Inclusion of verbatim text to support findings
- Links between the discourse and the interpretation should be plausible
- Linkages should be described and supported adequately
- Describe how findings are related to existing knowledge

The above strategies are included as part of the analysis process (chapter 7 onwards). In addition, to establish and demonstrate rigour within research utilising discourse analysis, Nixon & Power (2007), proposed a framework to ensure congruity between analysis, interpretation and the epistemological and ontological assumptions underpinning the research;

- Research question is appropriate for discourse analysis: *This study is exploring the national implementation of a new service, the generation of knowledge about the service and implications for a specific profession. Dominant discourses and discursive strategies can be identified within this process.*
- A definition of discourse analysis is given along with the specific approach to be used: *A review of the descriptions of differing ideas of discourse analysis has provided a working definition related to one particular perspective by Foucault, which is pertinent to this enquiry.*
- Theoretical framework congruent with clear epistemological and ontological position: *This enquiry sits within a post-structuralist/social constructionist paradigm which holds that there are different and conflicting views of reality and identity and that language creates individual understanding of reality. A framework based on Foucault's ideas of the constitutive nature of language and the role of discourse in the fluid connections between power, knowledge and social action is supported by post-structuralist/constructionist paradigm.*
- Clear method of analysis and theory applied to analysis: *A guide to the process of analysis using a foucauldian perspective is provided by Carabine (2001) supported by ideas from policy analysts from the foucauldian tradition*
- Rationale for selection of texts for analysis: *The dominant policy implementation guidelines and published documents selected represent the formation and knowledge generation describing the introduction of the Crisis Resolution services and are representative of the current body of knowledge and discourse.*

How much do we need to know about the position of the researcher from a philosophical and sometimes existential point of view as a rationale for conducting research that appears to have an inbuilt bias as the researcher has a moral, ethical and/or political point to prove? The possibility of a continual analysis of the discourse of the researchers' analysis and the researchers' reflections are cited as potential pitfalls that can undermine the use of discourse analysis as a research methodology. Wetherell (2001) proposes that there are indeed profound debates and questions to be posed as to the nature of the human experience and the social world, and discourse analysis in its many forms and approaches will have something of value to add to the discussion. In order to ameliorate the effects of a potential pitfall of continual analysis of reflections, an evaluation and illustration of how rigour and reflexivity were addressed is included in the concluding chapter of this thesis. This will provide a way of looking back at the implicit reflexivity of the analysis and research process and my role within it, without overpowering or obscuring the data, data analysis and discussions.

5.7 Alternative Approaches Considered

As the process of research and becoming immersed in the literature and documentation progresses, distinct strands appear – government & national organisation documents; professional research/service evaluation reports and service user perspectives. The emergence of what appears to be distinct categories in the literature may reflect Alford's (1975) theoretical political framework developed from his study in New York, of the failure of plans for reform to improve health service provision. This theory holds that health care planning and development incorporates the interests of three different groups; those of the clinicians, corporate rationalisers and patients (now more commonly referred to as service users). Corporate rationalisers are identified in terms of

bureaucrats, managers and academics. Underpinning the framework are the political concepts of vested interests and power; the theory being that groups/individuals have an interest or a stake in something that has the potential for social harm or benefit and that power is expressed through the ability to influence and effect interests positively or negatively.

More recently, this theoretical framework has been applied to the current trends for reform and change in the NHS. Government policy makers/civil servants and NHS managers are seen as the corporate rationalisers, whilst General Practitioners are classed as the clinicians. The interests of the service user (and therefore general public) are described as being so badly represented as to be barely visible at all (Williamson 2008). A further concept that could be included in this framework is that of discourse as the vehicle for expressing the interests and power of stakeholders through the historically and culturally defined notions of valid, acceptable knowledge. However, whilst this approach may be useful in illuminating issues of policy implementation difficulties and discrepancies, it will not provide the tools for a wider enquiry to uncover the presence of implicit knowledge and technologies.

Alternative theoretical frameworks were utilised by Bergen & White (2005), when exploring policy implementation in NHS mental health provision by community nurses. In their research, Bergen & White examined how Government policy is translated into practice, developing a framework based on implementation theory and Lipsky's concept of street-level bureaucracy (1980). However, the approaches described above are less useful when exploring the mechanisms of discourse in the generation and circulation of knowledge about a specific arena. Whilst both Alford's and Lipsky's work contribute to research in the area of policy implementation, the focus is on interpretation of policy by relevant players. The aims of this research seek to uncover the presence of specific

concepts that may be obscured due to the nature of dominant discourses.

5.8 Rationale for this Discourse analysis

Discourse analysis has been utilised increasingly to explore issues and provide alternative perspectives in health and policy research (Crowe 2005, Wharne 2007, Potter & Wetherall 1998). Clinical reasoning and service development requires access to different types of knowledge in order to ensure a deeper understanding of issues, needs and potential responses. Data generated through research via a range of methodologies, methods and perspectives provides the potential for greater depth and breadth of knowledge available for synthesis and application (Crowe 2005).

Particularly within nursing research, discourse analysis from foucauldian or derridean perspectives have been used due to their relevance in terms of exploring power/knowledge relations or the deconstruction of binary oppositions, respectively. A foucauldian approach may be seen as a form of social critique seeking to identify and map possible change and transformation (Crowe 2005). For this reason, Foucault's ideas and thoughts on social action, change and power relations have also been drawn upon by policy analysts, including analysis of UK health care policy (Bacchi 1999, Bevir 2011).

The analysis of discourse involves describing the context of the dominant discourse identified and links to other discourses, interpreting implications and the production and consumption of texts. Analysis of text includes identifying documents specific to the area of inquiry, the function of language used and representations of reality. Further to the analysis of text is then an analysis of the effects of the discourses revealed on practice, social and power relations and systems of knowledge (Prior 2003, Crowe 2005).

Discourse analysis as a research method is less common within occupational therapy or occupational science research literature. However, issues regarding language and terminology within the disciplines have been debated, including the effects these issues may have on the position and future of the occupational therapy profession (Creek 2003, 2010, Ilott and Mounter 2000, Withers & Shann 2008). The question driving this research focuses on the representation of concepts of human occupation in the implementation and practice of mental health crisis resolution services. Therefore a discourse analysis is chosen to explore the socio-political and historical context of the development of knowledge about crisis resolution and the influence this has on practice with a specific interest in relation to concepts of human occupation.

Discourse analysis from a Foucauldian perspective allows for an exploration of taken for granted forms of knowledge and sites of power with the possibility of revealing alternative views of reality and shifts in power relations. This is pertinent to the disciplines of occupational therapy/science as they continue to strive to maintain or establish a body of knowledge to underpin and secure a position as valid and vital contributors to the health and welfare of individuals and society as a whole (Christie & Goodacre 2007, Withers & Shann 2008, COT 2006, Yerxa 1998, Wilcock 2006).

If discourses are viewed as the vehicle for the production of knowledge and constructing a “true” understanding of reality, then the notion of governmentality, according to Foucault’s work, is enacted through the production and circulation of discourses (Laliberte Rudman 2010). Government, as distinct from the State, is the term utilised in reference to all undertakings aiming to shape or direct the conduct of one’s self and others (Foucault 1991) As some agencies can effect more power to influence the formation of certain discourses and resulting subjectivities, then these

discourses are seen as shaping the understanding of what is to be governed and how (Dean 1994). The concept of governmentality has been applied previously with respect to its influence on options for preferred, or identification of marginalised, occupations in society (Laliberte Rudmen 2010). Therefore, following on from the initial analysis that will be described in Chapter six, this thesis will then explore the findings from the discourses identified in relation to ideas of governmentality and technologies of the self, as the actions of governing one's conduct of the self.

5.9 Summary

The process of embarking on research into a specific area necessitates an exploration of the assumptions and beliefs of the researcher. The epistemological and ontological position of this research project has been illustrated, with a background to the philosophical ideas underpinning the methodology. An overview of the methods for carrying out the mode of research herein has been given, with a critique and rationale for a discourse analysis based on the works of Michel Foucault being the preferred approach to the questions posed.

Chapter 6 - Method: A Guide to this Discourse Analysis

The following chapter provides a description of the framework used to guide the gathering, interpretation and analysis of texts. As the project in this document is itself part of the discourse within both mental health and academia, definitions of the terms being used to describe the objects/subjects under scrutiny are given in the context of the discourses within which they are situated.

The method of discourse analysis referred to in this study is based on the perspectives of Michel Foucault (1926-1982). From my understanding of Foucault's writings, my interpretation of discourse analysis is as a way of defining the idea of discourse and its role in representing and shaping specific objects, in this case concepts within the literature on mental health crisis resolution home treatment. **This is not a form of content analysis, rather an examination of the production, dissemination and possible consequences of the way in which objects and subjects of knowledge are described and conceptualised and responded to within a specific area.**

Foucault sought, through his writings on madness, discipline and sexuality to challenge taken-for granted modes of thought and practices and to trace the ways authoritative knowledge comes to be produced and circulated. The results of these discourses are described in terms of regimes of truth and Foucault's critical analyses sought to map the "truth effects" of these discursive practices – the rules, technologies, actions, in relation to knowledge/power and the constitution of knowledge.

6.1 Terms of reference

The following terms are in common usage within this thesis:

6.1.1 Discourse/discursive formations; words, sentences, statements that form a unifying matrix of ideas and principles linked to systems of people and places and roles, buildings and institutions (Foucault 1972). In this study, the focus relates to the discourse of mental health care workers, crisis resolution home treatment teams in England, the home or hospital as place of treatment and recipients of that treatment, and mental health NHS Trusts, National Health Service, Department of Health, UK Government.

6.1.2 Human Occupation; An overarching term that refers to the meaningful and/or productive use of time in the form of activities, tasks and exercises constituting individual, community and societal roles, routines and identity (Wilcock 2006).

6.1.3 Crisis Resolution Home Treatment Teams;

A National Health Service mental health provision as an alternative option to hospital admission. The service is provided by teams of health professionals on an extended hour's, 7 day a week basis to individuals experiencing mental illness that would otherwise require admission to an in-patient hospital.

6.2 Sources for Discourse as Data

Although discourse analysis is not strictly a step by step method, the process should include

- Specifying the discourses being explored and relevant texts
- Identifying links to other discourses and possible implications
- Identifying social practices as consequence of text production and consumption (Carabine 2001, Crowe 2005)

The sources of discourse and discursive practices being examined here are derived from the literature review, as a map of the introduction of the idea and term of Crisis Resolution Home

Treatment Teams. Analysis of one policy guidance document – Mental Health Policy Implementation Guide (DoH 2001) directs the identification of further related texts for context and production of social action as a result of policy, specifically the production of research literature and publicly available texts that have a direct reference to the introduction of crisis resolution home treatment in mental health in England.

The following databases were accessed:

PsycINFO

CINAHL

MEDLINE

AMED

BNI

EMBASE

HEALTH BUSINESS ELITE

Document Search between 2007 and 2010 using combinations of key words;

Crisis, Resolution, Home Treatment, Service, Team, Mental Health - 151 reports found; of these 22 reports with limit of publication between 2001 and 2010.

Treatment Evaluation, Client, Service User, Attitudes, Crisis Resolution, mental health – 4 reports found

Crisis Resolution Home Treatment; Occupational therapy – 5 results

Accessed websites of organisations:

Department of Health

National Audit Office

SANE

MIND

Recover your life

Sainsbury Centre for Mental Health

National Mental Health Development Unit (now closed)

Patientopinion.org.uk

Acutecarepathway.org.uk

British Association of Occupational Therapy

Search engine: Google

The documents already identified in the initial literature review/search form the drivers for policy change and implementation, evidence-base and evaluation of the service implementation process, which was the result of the targeted introduction.

Literature and document searches identified texts whose main topic is crisis resolution home treatment teams in England; this literature was gathered and consulted as part of the research and literature review for the proposed study.

6.3 Document Selection Process

A purposive sample of documents identified in the literature review was selected, as representative of the current discourse of Crisis Resolution Home Treatment Teams. The documents identified but not included in the analysis phase were excluded for the primary reason that they were not related to the introduction of crisis teams in England as a result of the UK government policy. Reports on findings from teams outside of England are not a reflection of the UK policy implementation, which is the focus of this discourse analysis. Reports on teams in Scotland and Northern Ireland were not included, although part of the United Kingdom, both areas have additional local policy directives and implementation guidelines that are not used in England.

Also excluded are those articles that report on UK teams but were primarily literature reviews that reviewed primary research reports. Any articles or reports that described services that performed

aspects of crisis management but would not be classified as Crisis Resolution Home Treatment Teams, such as Assertive Outreach Teams or Early Intervention services, according to Department of Health policy guidelines (2001) were also excluded.

Of the five pieces of literature which included reference to occupational therapy in searches, two originated from the United States, one recounted a case in Australia and another formed part of an opinion piece on the roles for occupational therapists.

Only one report was the focus of occupational therapy within a Crisis Resolution Home Treatment Team in the UK. This report will be included in the latter part of this thesis, as the initial focus is on exploring the discursive construction of crisis and crisis resolution and the presence, or not, of concepts of human occupation in policy and related documents.

The documents selected for analysis were identified as representative of primary reports and research mapping the introduction of the service as a result of Government policy in 2000. Therefore, documents published before 2001 were discounted. The government policy implementation document (DoH 2001) is recognised and referenced within the documents sourced as the basis for the current Crisis Resolution Home Treatment Teams, in the specific time frame relating to the target for introduction of teams in England. Documents that have been published in full either as hard copy or electronically are included as representative of mechanisms for the production, circulation and dissemination of types of knowledge at a given point in time. As would be expected when exploring a specific arena, much of the content in the documents recovered is similar and the discourses consistent across certain domains. Therefore documents were chosen from the available evidence to provide examples of the current discourses on Crisis Resolution Home Treatment Teams

from a number of agencies and perspectives. For full details of documents selected see Appendix.

6.4 Reflexive Decision Making in Document Selection

Much of the literature identified through searches and referenced within documents is repetitious; reference the same studies/policies and utilise the same terminology – this is to be expected in terms of the identification of an overarching discourse of crisis resolution services.

Therefore the decision was made to gather together through a purposive sample of the literature, of illustrating the specific analysis after Foucault, those documents that constituted.

- a) The referenced policy guideline document from Department of Health.
- b) Audit and evaluation surveys by or on behalf of Government bodies.
- c) Research/literature from prominent professional journals.
- d) Service-user examples and reports from statutory and non-statutory organisations.

These types of documents reflect the knowledge management strategies used to disseminate information generated by statutory organisations, to generate and apply knowledge through professional discourse and also potential alternative perspectives, within the context of policy implementation in England and strategies for applying evidence-based practice (Rogers & Pilgrim 2010).

6.5 Guide for Analysis

The following guide for analysis is based on a description of a foucauldian discourse analysis by Carabine (2001) broken down into discrete phases;

Texts selection; know the data; identify themes; discourse inter-relationships; identify discursive strategies; absences and silences; identify resistances; identify effects; outline the context/background issues; situate in context of power/knowledge networks; awareness of limitations of the research, data, sources.

As a starting point, this provided guidance on organising the literature. However, as I worked through the phases, the documents themselves and my own reflexive emersion in the discourse of Crisis Resolution provided points of interest, conflict and directions. Foucault himself stated that he did not follow any specific method or technique in his studies, rather on completion of writing, reflected back on the process and extrapolates the method he could have used. (Foucault 2003a). For the processes of modern academic study, and as an example of the dominant discursive practices of scientific knowledge generation and academic discourses, this approach would not be necessarily deemed rigorous or legitimate.

In exploring the documents, analysis is the process of making links between language and text in practice, proposing alternative possibilities and original thoughts. Results of analysis will add something to the text, the subject, providing insights and alternative interpretations through the lens of foucauldian principles; identifying assumptions, knowledge/power dynamics, discourse as practice/action. The analysis and identified/proposed conclusions will be recorded along with extracts from my own reflective accounts, decision trail, with a view to providing further clarity of process and identifying my own position and discourse within the research project.

The policy analysis approach developed from Bacchi (1999) also has value in contributing to the analytical framework. This “What’s

the problem?’ approach sits within a social constructionist paradigm and opposes the notion of problems that sit outside human and political engagement (Shaw 2010). Rather, Bacchi is concerned with problems as a consequence of positioning issues within a knowledge–power context and therefore provides additional support for the Foucauldian theoretical framework underpinning of this discourse analysis. As the starting point of this research is positioned within the implementation of a specific policy in mental health, then utilising a conceptual framework from the arena of policy analysis can add to the rigor of method. Nixon & Power (2007) acknowledge that combining approaches to discourse analysis is permissible, whilst Wood & Kroger (2000) advocate the application of combined approaches. (See chapter 12 for evaluation of rigor within this discourse analysis)

Bacchi (1999) suggests framing the approach to analysis in the form of the following questions:

“What is the problem represented to be, in either a specific policy debate or in a specific policy proposal?

What presuppositions or assumptions underlie this representation?

What effects are produced by this representation?

How are subjects constituted within it?

What is likely to change? What is likely to remain the same?

Who is likely to benefit from this representation?

What is left unproblematic in this representation?

How would “responses” differ if the “problem” were thought about or represented differently?” (p. 12)

6.6 Summary

The introduction of crisis resolution home treatment teams across the country are the result of Government policy. A method for analysing the discourses related to this introduction of a new type of service has been developed from the area of policy analysis,

underpinned by Foucauldian concepts of power/knowledge and governmentality. Inclusion of an approach from theories of policy analysis contextualises crisis teams as part of a response to a problem as defined through the policy. This thesis also aims to explore how concepts from the knowledge base of a particular discipline are represented within policy and related texts as products of the policy. Concepts from occupational science and occupational therapy may provide an alternative representation, offering options for additional or alternative responses and will be explored further in Part Two.

Chapter 7 - Analytical process; Mapping Crisis Resolution Home Treatment

The following is a process of discourse analysis from a Foucauldian perspective, using a method developed from Carabine (2001) and supported by Bacchi's (1999) approach to policy/discourse analysis. These approaches are also supported by Prior (2003) for the analysis of documents as a valuable source of research data. Contemporary documents are used to explore the evolution of Crisis Resolution and Home Treatment services through discursive formations within policy and research domains. Through the deconstruction of the dominant discourse, an investigation can begin into the possibility of the presence of concepts of human occupation within the discourse of Crisis Resolution.

As suggested by Carabine (2001), the aim of discourse analysis from a Foucauldian perspective, is not an exhaustive search for literature and analysis of the subject, rather to identify the main, dominant documents, literature, text and context. This will then provide the source, constructs and formations that form the discursive practices and actions. Analysis is framed through my own understanding of Foucault's ideas and concepts of the power/knowledge dynamic, power relations and governmentality; identifying where these concepts are present and mobilised through dominant discourses and provide a space for reflection on the influence on social practices (Foucault 1972, 1980). This chapter maps the process of analysing specific documentation in order to begin the development of emerging themes. The themes proposed will then be analysed further in subsequent chapters utilising Foucauldian perspectives as a framework.

The dominant document within the arena of Crisis Resolution Home Treatment as a service is the Department of Health: Mental Health Policy Implementation Guidelines (2001). This document

sets out recommendations for the configuration and remit of a service that reflects the rhetoric of improvements in choice and accessibility in mental health service provision, identified in the National Service Framework for mental health (1999) and the NHS Plan (2000) as described in chapter 3. The guidelines in this document represent the first use of a target for introduction of the service nationally and identify who the service is for and why.

7.1 Policy

7.1.1 The Mental Health Policy Implementation Guide (DoH 2001)

This policy guideline document set out the target of 335 crisis teams to be operational by 2004. The term Crisis Resolution Home Treatment Team appeared in the NHS plan (DoH 2000) and was identified as a means of implementing service improvements described in the National Service Framework for mental health (1999), where the need for more readily accessible mental health support was included as one of the priorities from consultations with service users and carers.

The Mental Health Policy Implementation Guide (7.1.1) is in the form of a report, a policy guideline that describes the rationale, role, design, implementation and development of crisis teams in England. The target audience is predominantly managers, policy makers and commissioners. The report forms the main reference points for Mental Health Trusts and health care Commissioners in identifying, developing and auditing the service. The document claims authority from its stated objective as a guide to implementation of Government policy, which itself claims authority from the process of policy development and the inclusion of consultation process and collaboration with a range of stakeholders (Bevir 2011).

An excerpt from the Mental Health Policy Implementation Guide (7.1.1) is reproduced below, giving an introduction into the background and the future of mental health services;

“The task of improving our mental health services requires both vision and commitment. The Mental Health National Service Framework for mental health (MHNSF), published in 1999, sets out a vision of a better service in its seven standards, spanning the full range of mental health care. It is a ten year strategy.

The NHS Plan, published in 2000, demonstrated a commitment to working towards this vision. Major investment is being made in the new models of service: crisis resolution; assertive outreach, early intervention in psychosis; primary care and gateway workers. Services are being redesigned to ensure the availability of women-only services, and additional staff are being recruited to increase the breaks available for carers, and to strengthen carer support networks. There is significant investment in secure accommodation, personality disorder and prison in-reach. As services are developed they should be evaluated over time and if necessary adapted to local circumstances. The long-neglected infrastructure of mental health care - our workforce, facilities and information systems - is now being given the attention it merits. (MHPIG 2001;p5)

“Such a comprehensive programme of change cannot be achieved by a single agency or a single profession working in isolation. One of the defining characteristics of mental health services is the range of disciplines who frequently need to be involved in the care plan of a single individual; suitable accommodation, adequate income, meaningful occupation, and family support all play a part alongside competent diagnosis, treatment and care.”(p7).

The “problem” is viewed as a structure that no longer meets the needs of the individual or their families, one which requires a

number of stakeholders and social actors to engage with in order to facilitate change on behalf the government/state. An additional problem may also be inferred, is that of the individual experiencing mental illness. Mental illness is framed through the rhetorical device of mental health and also indicates a shared responsibility for the care of those identified/diagnosed with the rest of society and its structures of employment, housing and family. Policy analysts have tracked the formation of policy discourse representing ideological aims and promoting the practice of decentralisation and devolving control and therefore power, to local agents (Bevir 2011).

The development of the crisis resolution home treatment model is described as rooted in the concept of preventative psychiatry, reducing stigma and improving quality and outcomes (Caplan 1964). The implementation of these teams is also cited as the result of preferences identified by service users and carers for wider choice and alternatives to hospital admissions. The language is rhetorical, of a procedural, business and corporate nature, with the aims of providing guidance and descriptions of the purpose of a crisis team, staffing levels, including professional/skill mix, criteria for access, performance measures and possible obstacles to the development of a fully functioning team.

“People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care.” (7.1.1 pg11)

Assumptions are evident here which infer inpatient care as a negative experience; that hospital is restrictive and disrupts lives, making assumptions that unrestrictive environments can equate to minimum disruption. Whilst the statement refers to a range of

settings being available for treatment, the use of the term home treatment sets up the possibility that this is a specific modality, a form of treatment. Providing this care is described with the word home, indicating this as the probable venue for a specific treatment. The word “should” also indicates that not only is this alternative desirable, it is an imperative.

The guidelines also identify specific groups that the service is being provided for – those experiencing severe mental health difficulties. An assumption implied here is that mild and moderate mental health problems will not require this service. Indeed, several categories of mental health problems are cited in the document as being outside of the remit for crisis resolution home treatment services;

“This service is not usually appropriate for individuals with:

- *Mild anxiety disorders*
- *Primary diagnosis of alcohol or other substance misuse*
- *Brain damage or other organic disorders including dementia*
- *Learning disabilities*
- *Exclusive diagnosis of personality disorder*
- *Recent history of self harm but not suffering from a psychotic illness or severe depressive illness*
- *Crisis related solely to relationship issues” (pg11)*

The criteria and exclusion criteria for the service are framed in medical/psychiatric terminology and sets up clear parameters for how the service is positioned in relation to service users. As a service, it is only available to a specific category of people, those who meet the requirements of psychiatric diagnosis, and particularly who fall within the range of major (severe and enduring) mental illness.

The language used illustrates the view that Crisis Resolution Home Treatment Teams are “an alternative to hospital” in terms of their role as a tool for saving money and reducing the need for hospital as a resource. The government guidelines (7.1.1) describes Crisis Teams as the gatekeeper to mental health services, suggesting the role as more of a rapid assessment option to identify timely and effective treatment from a range of potential providers;

“(CRHTT’s)...Act as a ‘gatekeeper’ to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service” (7.1.1 p11).

The individual with acute mental health problems becomes the subject, a category requiring designation and allocation to a place in the overall mental health service structure. The document does not make explicit the strategies for the role of gate-keeper, leaving an assumption that the workforce employed within teams will have the necessary knowledge and skills to make the assessment and the resources available to refer onto.

This document is consistently referenced in subsequent reports, literature and texts relating to Crisis Resolution Home Treatment Teams. It is positioned as the authoritative voice of the implementation of Government policy developed from the National Service Framework for Mental Health (DoH 1999) and The NHS Plan (DoH 2000). As such, the text has identified what is to be governed (access to mental health services and particularly admission to hospital); who is to be governed (individuals experiencing severe mental illness); how this government will be enacted (through the introduction of Crisis Resolution Home Treatment Teams) and the technology of government through the development of the gatekeeper role. The aspect of governmentality implicit within the discourse, but not articulated, is the assumption

that the individual will govern their own conduct in the absence of the containment and control subsequent to a hospital admission.

This Policy Implementation Guide holds a high degree of power and through the discursive practice of Policy as knowledge base has constructed a “true” understanding of the subjectivity of a person experiencing crisis as mental illness. The circulation of this discourse is promoted through the practice of audit and evaluation, and will be illustrated in the following section.

7.2 Audit

As a consequence of the target for implementation of this policy guideline, new services have been formed, or existing teams reconfigured, with a resultant mental health crisis discourse developing and evident in subsequent research, audit and evaluation literature. The identification of related texts in the form of audit reports on the implementation of the policy guideline document demonstrates how the document has been utilised as a source of knowledge, and therefore power, to construct discursive practices in the form of Crisis Resolution Home Treatment Teams (Crisis Resolution Home Treatment Teams). As such these documents represent discursive practices in generating a further basis for the building of a knowledge and evidence base to constructing the crisis resolution service provision.

The continuation of this discourse analysis identified two documents that relate to the implementation of Crisis Resolution Home Treatment Teams as constituted by the Mental Health Policy Implementation Guidelines (7.1.1). These documents were chosen as they are the core documents describing the background, purpose, concept, implementation and initial monitoring/auditing of the service, as it was proposed in the mental health component of the NHS Plan (DoH 2000);

7.2.1 Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment Teams. (National Audit Office Report 2007a)

7.2.2 Guidance Statement on fidelity and best practice for crisis services. (Compton & Daniel 2006)

The language used in these documents illustrates the view that Crisis Resolution Home Treatment Teams are “an alternative to hospital” in terms of their role as a tool for saving money and reducing the need for hospital as a resource. The economic focus has become increasingly predominant during the time span covered by these reports; the government guidelines (7.1.1) describes Crisis Teams as the gatekeeper to mental health services, suggesting the role as more of a rapid assessment option to identify timely and effective treatment from a range of potential providers;

“Successful CRHT teams have:

- *Met their targets for numbers of home treatment episodes*
- *By the same token, avoided costly and disruptive inpatient admissions for large numbers of service users.*

Allowed mental health providers and local commissioners to refocus resources from inpatient to community based care.” (7.2.2 p3)

Again, discursive formations utilise the term disruptive, however in this context it is unclear who or what it disrupts. It can be read as to suggest inpatient admission is disruptive to the organisation, as the line also includes the need to avoid the costs of admission. An economic focus has become increasingly predominant during the time span covered by these reports since the publication of the original policy guidelines in 2001 (7.1.1).

The NAO report (7.2.1) identifies the lack of reference to therapeutic/clinical benefits in policy and guideline documents. The service is now described as a model with a framework in operating and organisational terms; access, criteria, staff levels, pathways, wider system integration, numbers of treatment episodes and economic implications. The discourse most evident in the National Audit Office document is economic, describing Crisis Resolution Teams in terms of their value for money and cost saving role within the NHS.

“...we estimated a potential for savings to the NHS of around £12million per year. Even greater savings may be possible from further increasing gatekeeping, potentially saving up to £50million a year if the gatekeeping rate could be raised to 90%” (7.2.1 pg 28).

“We estimate that increasing CRHT resources to at least 14 care staff per 150,000 of weighted population in every region using mental health nurses alone would cost the NHS between £10 million and £17million per year.....However, if this additional expenditure resulted in more effective CRHT services as intended, it would also be likely to generate cost savings through improved gate-keeping and avoided admissions” (7.2.1 pg 16).

The fidelity report (7.2.2) was authored in collaboration with the Care Services Improvement Partnership and Department of Health. The report documents how the gate-keeping role of Crisis Teams has become a central theme and primarily refers to access to hospital.

“Particular attention should be paid to impact and especially in relation to hitting target trajectories in relation to episodes in comparison to having a positive effect on in-patient occupancy. Teams that hit trajectory targets without a subsequent impact on

the 'whole system' (reducing occupancy primarily) need to address targeting issues raised in this document."

"Research has shown that areas with CRHT teams operating in 2002 had a 10% lower admission rate than areas without CRHT teams. If the CRHT team was operating 24 hours a day 7 days a week there was a further 22% reduction" (7.2.2 p3).

This is an interesting distinction and implies awareness that "keeping people out of hospital" is still the primary goal. Gate-keeping and the criteria for treatment by a crisis team become discursive practices that denote the rules for accessing care. People must qualify for care, their crisis must be one that fits the definition and rules set by the policy, which in turn has been developed by those with access to that which is accepted as truth; the knowledge and accepted truth of crisis as mental illness and vice versa. This then is what can now be determined as an alternative to traditional treatment in hospital.

Health professionals are constituted within the discursive formations in terms of a team, not as individuals, that act as gatekeeper to acute mental health services. This has the potential to change the focus of professional practice and influence the perception of others. The NAO report also suggests the costs and potential savings in the case of crisis teams being staffed by nurses alone (7.2.1 p16). Although this can be seen as an example of costs, the inference may be drawn that crisis teams do not necessarily need additional professional disciplines, in contrast to Department of Health guidelines.

Although the object of the discourse may be Crisis Resolution, the vested interests of the author/organisation can be detected in the discursive practices of other discourses or the absence of expected discourses. Despite the notion of recovery becoming

increasingly prevalent in other areas of policy and practice (Pilgrim 2008, Lillehet 2002), there is no reference to recovery as an approach, model or preferable terminology.

These documents are not primarily aimed at clinicians, however 7.2.1 the NAO report itself, cites a lack of reference to clinical outcomes/evidence within the guidelines and other government documents. The Fidelity report (7.2.2) identifies specific treatment approaches that should be utilised due their robust evidence base, however the evidence for these (CBT, DBT, STORM) are not clearly linked to their use within Crisis Teams and would rely on the recruitment of staff competent in their use. Without clear reference to clinical or therapeutic outcomes, the possibility of not fulfilling these recruitment needs is left unexplored.

Risk management is mentioned briefly as a task to be done (7.2.1: 7.2.2). As documents designed to propose, describe and evaluate the implementation of a new service, the day to day practical elements of providing treatment in the home for acutely unwell patients does not appear, however a clear criteria of who will deliver the service and who the service is/is not for is described in detail.

Other discourses identified include economic, political, procedural, and system management. These discourses construct crisis teams as a tool for implementing the political agenda. The proposed consequence of the introduction of Crisis Resolution Home Treatment Teams is a reduction in costs to the NHS through the prevention of hospital admission. The service has a very specific aim and is targeted at a specific care group and subsequent procedures are described as a result of meeting inclusion criteria (7.2.1; 7.2.3). Whole systems working (operating systems, strategic development, pathways) is identified with high levels of importance are placed on the potential positive impact of Crisis

Resolution Home Treatment Teams across mental health services; these documents both refer to other government policies that have laid out plans for changes in delivery, commissioning and planning of mental health services

The Department of Health (DoH) is the overarching institution by which knowledge about delivery of health care is circulated. Knowledge may also be said to be generated and produced through this organisation and in the context of its relationships with other health related governing bodies and organisations. Research is identified and supported through these organisations; decisions and policy are made as a result of the relationships within this network. The Department of Health document (7.1.1) is proposed as organisational and procedural, in that referring to Crisis Resolution Home Treatment in terms of the systems needed to implement and operationalise teams; the numbers of staff and professional skill mix recommended and provides numbers of teams and people treated as targets to measure achievement.

The construction of health provision in response to mental illness is formed within the politics of health; the state as a mediator of public choice, of situating treatment of mental illness within the individuals home, of recruiting the wider community in the care of those experiencing mental health problems. There is a tension here also, in that government rhetoric in health policies cites choice and quality, yet the reality as described through the construction of Crisis team discourse infers an economic imperative and a service as possessing the power to decide who can and cannot access alternative services (7.2.1).

There is controversy and disagreement regarding the clinical, research evidence underpinning the model for implementing crisis resolution home treatment in the UK, as it is described in documents 7.1.1; 7.2.2; 7.2.3 (Hubberling & Bertram 2012). The

model for teams is cited as that developed by Hoult & Reynolds (1984) in Australia. The primary ethos on which the whole idea of crisis resolution teams is based – Caplan’s preventative psychiatry, is a theory of urgent clinical response to individuals following traumatic events. This approach was not exclusively aimed at those individuals experiencing mental health problems, but rather a proposed intervention for people who did not have mental health problems, to prevent the emotional aftermath of a traumatic event leading to longer term health issues (such as post traumatic stress disorder). It appears that Caplan’s most significant contribution to the concept of crisis resolution in the context of mental health in England, is the idea that a crisis is time-limited to around four to six weeks. Figures in policy and guidelines all refer to the time-bound nature of the service in terms of weeks.

The two documents explored in the audit section (7.2.1; 7.2.2) have taken as their main reference point the Mental Health Policy Implementation Guide (7.1.1). This document has subsequently become the most commonly referenced within research studies and has influenced the direction, focus and priorities of research into Crisis Resolution Home Treatment Teams. The following section looks at the additional production of knowledge in the way the service is understood, measured and the knowledge disseminated through publication in medical and health professions journals.

7.3 Research: Crisis Resolution Home Treatment Teams

The following section maps the discursive practices resulting from the government policy guidelines and policy implementation audit. The documents in this next section are comprised of research articles and surveys describing research into the effectiveness of crisis resolution home treatment teams and the transformation of policy into practice. Documents, articles and reports analysed here describe a variety of research and evaluation projects focused on

Crisis Resolution Teams. These documents include a range of research methodology using quantitative and qualitative methods. These papers also represent the primary attempts at evaluation of the effectiveness Crisis Team services. They may be considered as the foundation of the evidence base for current and future services of this nature.

7.3.1 National Survey of CRHT's in England. (Onyett et al 2006)

7.3.2 Crisis resolution /home treatment teams and psychiatric admission rates in England. (Glover et al 2006)

7.3.3 Randomised Controlled Trial of acute mental health care by a crisis resolution team: The North Islington study. (Johnson et al 2005)

7.3.4 Leading the way in times of crisis. (Garcia 2006)

7.3.5 Crisis Resolution: A service response to mental distress. (Morton 2009)

7.3.6 Social Deprivation and the outcomes of crisis resolution and home treatment teams for people with mental health problems; a historical cohort study. (Kingsford & Webber 2010)

The first of these research papers (7.3.1) describes the progress of the implementation of Crisis Resolution Home Treatment Teams compared to the recommendations and guidance put forward in the policy document explored earlier.

The remaining reports and articles appeared in professional journals, 7.3.2 and 7.3.3 were published in medical journals, being

reports on quantitative research studies. Paper 7.3.4 was published in Mental Health practice journal, whilst 7.3.5 appears in a Social Care practice journal and 7.3.6 was published in Health and Social Care in the Community. All are descriptions of the processes and professional practices incorporated in implementing Crisis Teams and provide examples of how these have been or can be developed.

These documents are aimed at a professional audience and authored by members of the health, social care and/or academic professions. Within the health and social care field, these documents may be viewed as technologies of governmentality, in providing the mechanism for the circulation of power/knowledge constituted through discourse and producing effects in the form the practice of Crisis Resolution Home Treatment Teams and the subjectivity of the individual, both as person in crisis, and also crisis team members.

In this section analysing the discourse of research and evaluation papers, the term crisis is defined in medical terms of illness – “mental health crisis”. As such, crisis is constructed as an element of mental illness that is treated within the realms of psychiatry. Research is based on measuring how teams operate against policy implementation guidelines (7.1.1) as an alternative to admission. Research papers 7.3.5 and 7.3.6 also aim to bring to the fore the social factors involved in the provision of Crisis Resolution Home Treatment services.

Crisis Resolution Home Treatment Teams are again constructed in terms of their use as an alternative to another resource, their ability, or not, to meet the targets and adhere to guidelines. The survey report (7.3.1) acknowledges the role of teamwork, the importance of professional expertise as identified by those teams

that have been operational for a length of time and lists examples of tasks performed;

“The most widely and intensively provided interventions post assessment were risk assessment, monitoring of mental state, help with self-help strategies, delivering psychosocial interventions and administering medication” (7.3.1 p5)

However, some conflict is evident within the discourse between stakeholders, in how the success of the gate-keeping function is defined – government organisations construct success in terms of reduced admissions; academic auditors describe the inclusion/consultation of the crisis team in the decision process as meeting the requirements of the CRHTT role;

“It is important to note that gate-keeping in this context refers to whether the team was involved in decisions to admit or not, not whether they were successful in keeping people out of hospital” (7.3.1 p37)

The term “alternative to admission” would imply some choice in the matter, however dominant discursive formations reveal that the agenda is clearly to prevent admission wherever possible in order to provide evidence of the economic and organisational effectiveness of the introduction of Crisis Resolution Home Treatment Teams. The term “gate-keeping” is used to describe the role of crisis teams in assessing all requests for hospital admission, although this is not without problems;

“The interviews revealed that team leaders thought one of the requirements of gate-keeping was that everyone who signed up to it ...understood and acknowledged his or her role.....Gate-keeping and referral processes are clearly very important issues, our

survey has revealed there is still more to be done to improve these processes” (7.3.4 p23)

and team leaders feeling:

“under pressure to demonstrate bed occupancy reduction” (p22)

Gate-keeper infers a custodial role, guarding the access to a service/facility – a confrontational, adversarial stance? Is this not at odds with the identities of the so-called caring professions?

“the gate-keeping role looks good on paper but in practice is not easy” (7.3.4 p22).

Tensions were evident in the descriptions of teams deemed not to be adhering to the “model” and policy guidelines. The discourse of economics and procedure are being resisted by the clinical discourses of professionals who are at the front line of the process in the decision to admit or not, where emotional, social and risk factors constitute a crisis.

“targets had distorted what was trying to be accomplished.....leaving the CRT to manage users who should be in hospital but (for whom) inpatient care is unavailable” (7.3.5 p22).

“a range of diagnoses listed in the characteristics of patient being treated by both the experimental and the control group, with substance misuse making up the greatest number of patients in both groups” (7.3.3) - (policy guidelines identify primary substance misuse as an exclusion criteria for Crisis Resolution Home Treatment Teams.)

“There are a significant number of people who would not fit the narrow definition of acute psychiatric crisis (on the CRHTT caseloads)” (7.4.5 p147).

“The disparity between the effect on admissions and bed use was an important finding. Our study could not indicate whether this was because short hospital admissions of less severely ill people were the most preventable..” (7.3.2 p445).

It is evident by the discursive formations that this is constructed in terms of failure to meet model fidelity requirements; individuals in emotional and/or social crisis are being taken onto crisis team caseloads in larger numbers than those with a “major psychiatric diagnosis”, for whom policy states the service is designed for, therefore inferring failure to meet requirements.

The use of the term “disparity” (7.3.2 p445) indicates that whilst this particular study (and by implication, other similar research/findings) found a reduction in hospital admissions, which is attributed the presence of Crisis Resolution Home Treatment Teams, this is not the whole the story. Bed use and length of stay had not reduced.

The discursive formations being used to construct knowledge, identifies the role of a crisis team as a guardian of the access to acute services, whose primary goal is an economic one – to reduce expenditure and secondly, to abide by policy guidelines on the service model fidelity. The original socio-political driver to alternative to admission, to reduce stigma and in response to service-user preference may have become the taken for granted understanding to the point where it no longer needs to be mentioned. The implication of these dominant discourses, which are an extension of those within the original policy documents, is the continued promotion of the emphasis on economic and

organisational performance. This is a political imperative. The risk of this emphasis is dilution and deterioration of clinical standards, improvements and developments due to a focus on economic performance. The language of targets, model fidelity and service criteria encourage a focus on economic and procedural performance management. This does not necessarily relate to clinical excellence and assumptions are made that teams can and will base their “home treatment” on evidence based practice requirements.

The exception to the procedural, economic imperative nature of the discourses in the documents, are documents 7.3.5 and 7.3.6. This may be explained by the focus from a specific professional perspective, of social worker. Report 7.3.5 is authored by a member of the social work profession and its conclusions are critical of the dominance of medical interventions and the narrow definition/criteria of crisis resolution. The professional discourse is most dominant here, identifying the range of presentations, factors and interventions that are the practicalities of the work within a crisis team.

“Coping difficulties are viewed most frequently as contributing to a crisis (by staff)...Chronic social problems and life events also feature...there seemed to be range of difficulties which pushed people to the point of crisis” (7.3.5 p153).

“Overwhelmingly staff said “emotional support” was the most important element of their involvement” (p153).

“Interventions were skewed to health (mental not physical). There were 63 psychological/emotional interventionsHowever it was noticeable that there were relatively few interventions dealing with typical social issues such as accommodation, liaison with day-time activity and supporting social interaction” (p155).

Risk is also identified as major factor in assessment, although little reference is made to management. This article utilised wider social discursive practices in its construction of the notion of crisis, reflecting Potter & Wetherall's theory of interpretive repertoires (1987). The research was conducted by a member of the social work profession and reports the descriptions given by staff of people on the team caseload and interventions provided. The dominance of the biological and medical discourse within crisis resolution was identified by this study, and explained by the predominance of health care staff within teams. A suggested area for future research in paper 7.3.5 includes an exploration of the construction of the idea of crisis through the perspective of Foucault's notion of discourse, power, truth and knowledge.

Authors of the paper 7.3.6, propose that social deprivation can be a factor that impacts on Crisis Team outcomes, where admission is more likely and is identified as an unsuccessful outcome. In their study of one Crisis Resolution Home Treatment Team, the team's key performance indicators and operational policy were used to define "unsuccessful outcome", and referred to admission whilst under the care of the team or within 28 days of discharge, this included cases where an individual was referred back and accepted by the crisis team within 28 days. Although this still reflects the discourse of policy and earlier research, the authors also assert the importance of social deprivation as a factor that has not been given due consideration (7.3.6).

"People with enhanced mental health needs were more likely to live in deprived areas, have a lower socioeconomic status with decreased access to resources and less ability to participate in mainstream society and have significant social needs in areas such as housing, employment, education, health and finances."
(7.3.6 p462)

and as a result....

“Those with the most severe and enduring mental health problems were not only more vulnerable to admission, but were more likely to be in hospital for longer periods. It is also a concern that a reduced effectiveness with this group can have the consequence that admission is delayed by unsuccessful CRHT interventions ...” (p462).

7.3.6; people referred to the crisis team who were deemed to have received a successful outcome were those not admitted to hospital and where the crisis was resolved. The definition or parameters of what constitutes a resolved crisis are not explained further. Women made up the greater number of referrals and were judged to have better outcomes. Although social deprivation is cited as influencing outcomes negatively, this did not equate to living alone. Living alone was not associated with an unsuccessful outcome, although breakdown of a person’s support network did appear to contribute to referral and higher likelihood of admission.

Both 7.3.5 and 7.3.6 contain the dominant discursive formations constructing crisis within the psychiatric paradigm and the crisis service as a team whose existence prevents hospital admission. However, both utilise this discourse to also contest and challenge the discursive practices developed. The author of 7.3.5 contests that teams are providing interventions for people who may not fit policy criteria. The study findings in 7.3.6 have demonstrated that the people identified in original policies as those for whom prevention of hospital admission is most desirable to prevent stigma and revolving door re-admissions, are not the people who make up the majority of a Crisis Teams case-load.

The discursive formations utilised in the papers in this section can be identified by the focus of the article and the elements of the Crisis Resolution service being measured/researched: A medical discourse is predominant in 7.3.1; 7.3.2; 7.3.3 with a focus on hospital admission rates, morbidity and diagnosis. Economic discourse is also evident with the identification of financial implications, references to value for money and the resultant discursive practice to modulate the financial imperatives in the form of the gate-keeping function (7.3.1; 7.3.2; 7.3.4; 7.3.5; 7.3.6)

Discursive formations construct Crisis Teams in terms of their ability to meet procedural requirements and the level of fidelity to practice model as set out in policy document 7.1.1. In addition, academic discursive practices dictate the layout of reports, use of research and academic terminology to provide rationale for topic, methods of investigation and evaluation. The reports represent the discursive construction of the development of a rationale and evidence base for Crisis Resolution Home Treatment Teams.

The inclusion of service user perspectives and service led research is proposed as an integral part of health and social care research by the Department of Health, yet a representation of service users, other than the target subject within the service, is absent. Reference to the philosophy of recovery is not evident, yet this is a paradigm cited elsewhere in policy documents (DoH 2011) and professional literature (COT 2006, Craig 2008).

Also, the research papers analysed here have not explored the issues of managing risks within the home environment. The subject of risk assessment is noted as a significant part of the role within the service (7.3.5; 7.3.6). However, one might reasonably expect research on the operation of these teams to give this a higher profile, given the shift of emphasis from contained hospital environment to home and community for people who according to

the policy guidelines would otherwise need hospital admission. However, it may also be evidence of the taken-for-granted understanding of the nature of mental health services, that staff will be familiar with and experts in, risk assessment and management.

The discursive practices and discourses identified in this category can be seen in the context of a response to Government policy. Whilst potentially providing a critique of the implementation of a new service, much of the evident discourse echoes that contained within policy rhetoric. As dominant discourses are viewed as the mechanism through which power and authority is invoked and practiced, then the continuation of the discursive formations used in policy is to be expected. Papers 7.3.5 and 7.3.6 provided an additional context in the form of a discussion on the potential impact of dominant health and economic discourse on professional practices and the place of specific professions within an evolving health service. Paper 7.3.5 also questioned the narrow definition of crisis constructed within mental health professional and political discourse.

As a relatively new area for research, it may be anticipated that challenges to the initial research findings and an expansion of the domains and direction of research into mental health crisis and Crisis Resolution Teams will be forthcoming. Foucault saw positions or power and areas of tension as sites of struggle, always with the possibility of transformation aided by the fluid nature of power/knowledge (Foucault 1997).

The final section of this chapter presents the possibility of challenge and transformation, through the introduction of additional discursive formations around the generation of knowledge about crisis and Crisis Resolution Home Treatment Teams. Although the use of the term crisis continues to reflect some of the origins from the policy guide (7.1.1) and subsequent discourse, the following

texts provide a broader range of discursive strategies, reflecting alternative perspectives from those of the political and professional.

7.4 Additional Discourses of Crisis

The next section explores texts and documents that purport to represent service user views and experience of crisis and crisis resolution teams. Very few of the literature/research documents sourced have included the perspectives of users of the service. Two reports, one generated by Bristol MIND (2004) through the User Focused Monitoring initiative, and an evaluation of service user feedback (Brennan 2007) were found to relate to mental health crisis and service responses. Documents and literature that have not been generated by service users but have contributions from, or examples of, service user perspectives are also included here:

- 7.4.1** Mental health crisis and respite services; service user and carer aspirations. (Lyons et al 2009)
- 7.4.2** Crisis Resolution Teams and the role of the service user development worker. (Armitage & Lange 2006)
- 7.4.3** Crisis.....what crisis? The experiences of being in a crisis in Bristol. (Bristol MIND 2004)
- 7.4.4** A Service-user Focused Evaluation of the crisis resolution home treatment team of Leeds mental health trust. (Brennan 2007)
- 7.4.5** Crisis resolution and home treatment: The service user and carer experience (NAO 2007b)

7.4.1 and 7.4.2: These documents are both published in professional journals and are the result of qualitative research studies carried out by research/academic professionals who are also qualified mental health nurses. Document 7.4.2 describes how one specific crisis team employed a service user in a service development role. This report includes a description of the experience by the service user and is co-authored by the service user and a senior lead professional (nurse). All of the documents in this section purport to provide a view of crisis resolution home treatment services from the perspective of service users (including carers) and include quotes from service users and carers. All utilise a formal academic style of language and presentation.

As 7.4.1 and 7.4.2 are published in mental health professional journals, then the target audience can be assumed to be health professionals, practicing in mental health. The circulation of knowledge, ideas and opinions by and through health professionals and professional media sources can be seen to infer greater legitimacy is granted to knowledge that is constituted through professional discourse (Prior 2003, Foucault 1988).

The document published by MIND 7.4.3, is a report describing a survey of people who had experienced a mental health crisis and the services they had used at that time. The study was a user-led research project undertaken in order to improve the quality of the mental health services in the Bristol area and was supported by a commissioning Primary Care NHS Trust. The primary aim of this document is described as contributing to the development of local services. The report includes user's views on all services that they may have accessed during a crisis, such as the General Practitioner, Accident & Emergency, ambulance, police, as well as mental health services and/or crisis teams.

The report documenting the evaluation by service users in Leeds, 7.4.4, was available online via Google, through the University of Leeds website and research link. This report represents the findings of a service evaluation of a local crisis team, with the focus on the feedback gained from 108 people who had used the service within the twelve months from April 2006.

Although the report from the National Audit Office 7.4.5 could arguably be categorised with the earlier audit reports analysed, it is included here as it describes the experience of Crisis Resolution Home Treatment Teams from the perspective of service users and carers gathered from focus groups and questionnaires.

Paper 7.4.2; clinical and academic/research discursive practices are inter-related, providing mutual support to the construction of an identity of the health professional as a provider, generator and user of knowledge for the benefit of recipients – service users, colleagues, organisations. This also then infers a degree of power, of “knowing” about crisis, of providing the expertise to improve services. The service user development worker is able to advise on service improvements as he is part of the Crisis Team. Academics, researchers and health professionals are able to generate reports on research through the privileges afforded their positions, such as access to the resources needed, funding and databases of knowledge. Service user discourse is revealed and facilitated via professional and academic pursuits. Two reports, 7.4.3 and 7.4.4 are available online, although do not appear to have been reproduced in any other journals or formats, which may restrict their circulation and availability to a wider audience, thus potentially limiting application of the knowledge produced through the service user discourse. However, internet search engines are a common tool for locating information of all types and forms, therefore the two reports available online may actually be more accessible, as they do not require subscription or membership. A prominent

theme within all of these documents is the construction of the definition of Crisis in mental health;

“Service users and carers described the distressing impact of crisis in terms of the emotions that the situation evoked and the experience of finding oneself in such a situation. Feelings of fear, desperation and extreme distress were commonly reported. As one participant explained, ‘you feel like you are in a big black hole, feeling desperate and completely alone’. Participants linked these emotions with experiences of being unable to cope or being out of control. Participants found themselves in situations that they were unprepared for and had no idea of what they could do or who could help. The same participant described it as ‘finding yourself in the situation where you believe there is nobody to help or support you. You just don’t know where to turn’.

This situation was often exacerbated by professionals. For participants, the experience of crisis was a very individual phenomenon that was not always regarded as such by professionals. A common example cited by a number of service users was when they started to be unable to cope with daily living as a result of an increase in mental illness symptoms, such as sleeping problems. This contrasts with several staff who stated that a crisis is where a service user rapidly deteriorates and becomes acutely unwell. Paradoxically, many staff privately disagreed with this but were constrained by the more stringent admission criteria of the crisis service.” (7.4.1 p428)

“feeling out of control...powerless....” (7.4.3 p16)

The term crisis in the context of mental health is a construct being utilised to define a service and access to the service. Individuals experiencing distress, desperation, voices, anxiety; describe their experience through identification of feelings, functioning and

impact on themselves and/or others. Findings in paper 7.4.1 cite conflict between the expectations of service users and the organisational definition of crisis which results in specific criteria for access.

“The issue of most concern for many participants related to the stringent access criteria for crisis intervention home treatment services, inpatient admission. Participants described how an individual’s condition often needs to reach a predetermined level of severity before services can be accessed. There seemed to be complicated ‘rules’ (word coined by service users to describe access criteria) about accessing services, but little in the way of alternatives if an individual was not taken on by the service. The ‘rules’ were especially obscure and difficult to navigate for people with no previous contact with the system.” (7.4.1 p429)

Foucault proposed that the construction of the subject (people in crisis) within a dominant discourse will produce actions in practice. Individuals experiencing mental distress may now recognise the notion of mental health crisis due to the existence of crisis resolution teams. 7.4.1: Health professionals are identified as complying with organisational definitions of a crisis for access to crisis resolution services despite privately/clinically disagreeing with the stringent criteria.

Tensions and resistances are evident in the view of service criteria described as “rules” by a service user, implying a need to know the rules in order to be able to follow or succeed in complying and access the service. The idea that a dominant discourse becomes accepted practice is illustrated within the examples from research report 7.4.1; people with no previous contact with the service, and therefore unfamiliar with the discourse, were identified as finding these rules particularly difficult to understand and struggled to get help from professionals and services.

“Risk of harm (to oneself or others) or neglect was identified as a frequent and defining feature of crisis. Descriptions ranged from not being able to cope and ‘doing things I don’t usually do’ to being desperate, suicidal and having a ‘negative frame of mind, self destructive’. These descriptions start to articulate a sense of reaching a ‘breaking point’ or being unable to continue. They also imply an expectation that something has to be done to stop or change the situation. Participants also pointed out that a crisis could be ‘sudden or gradually creep up’. (7.4.1 p429)

and

“Service users and carers reported that they were unable to access timely support to prevent the escalation into crisis” (p428)

The prevention of crisis is an interesting point – who decides when a situation becomes a crisis? There is also the potential that if a crisis is prevented, then would that person meet the criteria for accessing a crisis resolution team? This denotes a tension between competing priorities. Individuals would perhaps prefer not to get to the point of crisis, whereas Crisis Resolution discourse is focused on “resolving” the crisis; political discourse is concerned with the object as an economic benefit.

The short quotes utilised in the research studies predominantly constructed a picture of requests for something or someone to take responsibility for an individual at a specific point – the point of crisis;

“.....of desperation...someone to ride to the rescue and solve the trigger problem” (7.4.1 p429)

Implications of the discursive practices identified here highlight a continuing gap between the expectations of individuals accessing services and the assumptions of service providers and professionals. The idea of someone riding to the rescue suggests a need for someone (anyone?) to take over responsibility, to solve the problem and thereby resolve the crisis. Whereas the discursive practices employed within policy documents describing least restrictive and minimal disruption can be seen as promoting the individual to maintain responsibility.

A disparity between the perceptions of the function and motives of a clinical service and the expectations of the recipients of that service is evident; 7.4.4 noted the discrepancies between service user expectations and the reality of service provision.

“Service users often saw multiple members of staff; they were unable to establish therapeutic relationships and disliked having to retell their story on each visit” (7.4.4 pg15)

“Most of the respondents reported receiving emotional support and help with medication but other types of support were sparse, with service users requesting more practical support in particular” (pg 15)

For example, a suggestion to improve the service from one respondent;

“More one to one time, and practical help with shopping” (pg8)

supported by another comment (it is not made explicit whether these related comments were made by the same person);

“Nobody actually saw to it that I had food in my cupboards” (pg12)

Discursive formations in 7.4.5 bring to the fore the importance of establishing a therapeutic relationship with staff is also highlighted

“The feedback examined here reflects a strong relationship between satisfaction with service provision and the level of personal engagement received. Service users most frequently express their appreciation of CRHT teams in terms of qualities in their relationship with staff such as approachability, friendliness and receptivity” (pg5).

The following excerpt identifies the tension between professional discourse and discursive practices and the central role of the change in context of treatment from hospital to home;

“There are trade-offs between staying longer to be friendly and ask follow-up questions, and moving on to cover the case load and provide help to others. However, in addition to consideration of teams’ caseload and resourcing needs, there is also scope for future research to explore how different care settings influence service users’, carers’ and workers’ expectations of helping relationships. For example, service users may associate inpatient wards more with medico-professional than with social interaction, whereas the home setting may have a stronger association with informal and social visits, thus making the personal element more dominant.” (7.4.5:pg8)

The shift of care from hospital to home is also recognised in the impact on social networks

“Beyond carers’ ongoing responsibilities for day-to-day care, service users in the acute phase of their illness require more intensive input and support. Providing this care through the CRHT service model - in which people who would previously have been

hospitalised remain at home – can have considerable implications for carers. Many emphasise the benefits of their loved one remaining within the family environment, providing these are fully realised through sufficient support and expertise on the part of the team”(pg12)

“The carer is often the person most in tune with the service user and aware of their behaviours, their needs and their relative states of mental health. A carer can offer the CRHT team a great deal of knowledge based on this close understanding and experience, and carers feel that teams should make the most of this extra insight whenever they can” (pg13)

Document 7.4.5 notes the importance of additional and alternative types of knowledge is also recognised here, although the subjectivity of the person in crisis remains, it is expanded with the acknowledgement of an identity outside the boundaries Crisis Team.

The documents in this category reflect a greater focus on the actual practice of the Crisis Resolution Home Treatment Teams. Although research in the previous category focused on the success of Crisis Teams from an economic stance, the documents in this category give a mixed and much more complex view. This can then impact on how and what is identified for an area of research which then influences the development of services. A further implication is that research evidence, based on narrow enquiry topics, may not be providing the key elements of knowledge and understanding that service provision, treatment and professional education is founded upon.

Professional, medical and academic discourses are prominent within the papers and reports in this section. The individual is constructed as mental health service user, as someone requiring

help. Subjectivities of service users and carers as recipients of a service once criteria has been met are embedded in the discourses.

Definitions of “crisis” are constructed through service user discourse as an individual experience, as a combination of physical and emotional feelings and measured in relation to feeling unsafe, unable to regulate emotions, loss or change in ability to participate in usual activities and respond to demands of usual roles.

Crisis resolution is related to the experience of “the crisis”; to the removal or solution of the trigger/cause; to practical problem solving and relief from intense emotions. Expectations by service users of the service reveal the tension between organisational and service user discourse through the perceived difficulty in accessing services when needed and the practical support available. Illness and recovery are described by service users in terms of how illness and recovery are experienced through the individuals’ practices; daily living activity, future goals and occupational routines

Economic considerations are not at the forefront of the discussions or views expressed through service user’s discourse in these documents.

The articles in this section differ from those in other sections in that they seek to explore the service user perspective of Crisis Teams. Much of the literature in the earlier section of this chapter, focuses on their potential economic impact within the health service, the viability as an alternative to admission and the fidelity to implementation of service model.

7.5 Limitations of analysis

The documents analysed here can be viewed as a response to the relatively rapid introduction of a new service nationwide. Each

article outlines the government directives, legislation and guidelines that underpin the development of Crisis resolution home treatment teams at the outset as a rationale for the subsequent report/study.

The documents in the sections 7.1 and 7.2 are aimed at providing the rationale, framework and guidance for the introduction of crisis teams across the UK. Therefore it could be expected that the language use would be of a corporate, procedural nature. Although not all of the government papers that refer to the introduction of crisis teams are included in the analysis here, they are part of the contextual background and utilise the same discursive practices. The discourse may not be a surprise in that it utilises political rhetoric and economic practices, therefore the analysis runs the risk of circular debate and an acceptance of knowledge constructed through this version of the object. (Burnham 2002).

Some of the documents in section 7.4, (7.4.2, 7.4.1) relating to service users have limited descriptions of service user perspectives in their own words. Therefore it could be argued, that the perspectives provided are done so using the professional discourse of the clinical and research professional. However, the reports did include some quotes from service users, utilising their own words. Of note, 7.4.3 describes a project that was carried out by service users interviewing individuals who had experienced a mental health crisis. In addition 7.4.4 provides a service-user evaluation of one Crisis Resolution Home Treatment Team, which takes its data from the feedback given by 102 individuals (representing a 27% response rate).

Each reading of the literature can provide new interpretations, leading to continuous analysis, at which does the researcher stop, and what impact will this have on the final analysis?

As the process of an in depth research can take several years, the historical, political and personal context surrounding the researcher will change, sometimes dramatically. This is likely to once again impact on the process of analysis, and the interpretations and decisions made. Therefore the interpretations leading to conclusions and implications drawn from this study can only be attributed to the perspectives of a specific moment in time.

7.6 Reflections

Taken as a group, these documents map the introduction and development of crisis teams across the country. They form the basis on which subsequent research and reports are justified, providing the rationale and often the starting point for research questions.

The language and definitions contained in these documents are cited in the paperwork, forms, procedures and protocols utilised in the service I work in every day. I am aware also on a daily basis that the terminology is not always familiar to or used by other health workers or individuals accessing the service. The Government policy and audit reports are often quoted or cited by Crisis Resolution Home Treatment staff and managers, when decisions are made and explained, particularly criteria driven subjectivity. What is interesting from the process of embarking on this research, the theories and history of crisis work which are described as the basis of the Crisis Resolution Home Treatment model are not widely known or acknowledged in practice. The discourse of Crisis Resolution has become one of care restricted by diagnostic criteria and time limited, representing the dominance of an economic imperative subsuming the original ethos of Crisis Resolution.

7.6.1 Reflexive Decisions

A search of mainstream literature did provide further modes of service user discourse in the form of internet discussion forums,

blogs, and websites. However, on reflection, I did not feel inclusion of these would be ethical, as those individuals who posted their thoughts and experiences on the websites and discussions forums did so to share with others, but not necessarily to be used in a research project. Although the internet provides open access and individuals often use pseudonyms to protect their own identity (or just from preference), the purpose of a particular forum can be very intimate and personal.

A fourth report (Ball et al 2005) exploring a theory of crisis drawn from service users' descriptions was not included in the analysis as it originates from Canada. Similarly, a literature review of service users' experiences of support from crisis resolution teams (Winness et al 2010) included studies and research projects from outside the UK. Therefore, cultural and contextual settings could influence any discourse identified from these documents.

7.7 Summary

This chapter has provided a guide to the initial stages of this discourse analysis, mapping the policy discursive strategies and influences on resultant discursive practices through examination of specific relevant documents. The construction of crisis as a mental health psychiatric pathology has been identified, along with the gatekeeper role of crisis teams; these two discursive formations give rise to the practices of measuring crisis in terms of its fit with a set of criteria and the effectiveness of the crisis team in terms of preventing admission to hospital.

The “problems” of crisis and prevention of admission have been constructed in such a way as to be dependant on one another – a crisis is an indicator of need for admission and hospital admission is a disruption to be avoided in a crisis. A number of dominant discursive formations and practices have begun to reveal themselves; gate-keeping as role and function; crisis as psychiatric construct; the generation of knowledge through policy

implementation; tensions between knowledge generated, privileged and other types of knowledge.

The following chapter explores the proposition of these formations as themes coming to the fore through ongoing analytical consideration of the documents made of discourses that constitute the object of Crisis Resolution and the subsequent practice of the development of Crisis Teams. These themes will be identified and examined through the lens of Foucault's concepts of power/knowledge, power relations, governmentality and resultant practices and technologies as operated through Crisis Teams. The consideration of Foucault's technologies of the self will also be applied with particular reference to occupational concepts and ideas from occupational therapy as they relate to the discourse of Crisis Resolution

Chapter 8 - Discursive Formations and Practices

The past decade and more, particularly since 2000, has seen the production of many government papers/legislation aimed at identifying improvements and driving changes in how the NHS delivers its services. Mental health provision has been the focus of much of these proposed changes, a culmination of a shift in approaches to mental illness that can be traced to late 20th century. The move to provide the majority of treatment within the community as apposed to hospital has gathered pace, to the extent where individuals experiencing even the most serious of mental illnesses can be considered for treatment at home (DoH 2000, 2009).

As a result of this process of discourse analysis, my own immersion in the data and the text of Crisis Resolution Home Treatment, prominent themes are beginning to emerge through analysis of discursive practices.

Michel Foucault's work explores how power structures within social systems and related institutions are established and maintained over the course of time, through use of language and discursive practices. Foucault did not utilise a specific method or framework in this endeavour, rather, by investigating texts, technologies and environments, the whole context is considered to establish the construction of subjects through the identification of dominant discourses. How and why these become and maintain a dominant position whilst others are hidden or marginalised is now explored further.

The discourse analysis begun here has revealed a number of dominant discursive formations that trace the construction of crisis teams as a service. The policy and Government rhetoric describes a service providing a viable choice to people requiring hospital

admission. The research literature continues to draw on this rhetoric, however the overriding economic imperatives of health service management dominates the subsequent discursive practices, resulting in a focus within the research of reduced admissions and concurrent savings as a measure of successful outcomes, rather than improved health and well-being, although that is not say that health and well-being have not improved. The findings from 7.4.5 and the 7.4.4 service-user evaluation report, both concluded that the majority of people who accessed the Crisis Resolution Home Treatment did find it beneficial and were satisfied with the service. The aim has not been to identify whether Crisis Resolution Home Treatment Teams “work”, but more to open up a space for interrogating the accepted “truth” of mental health crisis and Crisis service with a view to expanding valid areas for research.

The following interpretations are represented with subheadings to illustrate how discursive formations identified within analysis have produced discursive practices shaping the way ideas about people experiencing mental health problems are constructed along with the constitutive effect of language in producing knowledge about the service developed. An alternative reading can propose that knowledge is constructed to produce the service and ideas about mental health crisis have been shaped by the service.

8.1 Power Relations and the function of Crisis Resolution Home Treatment Teams

The introduction of Crisis Resolution Home Treatment Teams when viewed through the lens of governmentality can be seen as a technology of the state, via the agency of the National Health Service, to govern the conduct of others in relation to how and when admission to hospital may be prevented or accepted. Psychiatric and economic knowledge has been invoked to define the parameters and criteria of the service, producing and

circulating discourses promoting an understanding of what a crisis is and how it can be managed, or governed.

Through the deconstruction of the term gate-keeper, a role emerges designed to protect the resources of the institutional organisation, and ensuring a service that is beneficial, preferential and value for money according to specific targets which have been based on economic factors (7.1.1;7.2.1;7.2.2;.7.3.1;7.3.2;7.3.3). The idea of services being guarded is also described within the service user perspective – the awareness that there are rules, and that an individual has to fit with a pre-determined set of rules before being allowed access to a service (7.4.1; 7.4.3;7.4.4;.7.4.5).

The use of the term gate-keeping signals a major transfer of power from consultant psychiatrists to a separate entity – a team of, or an individual, health care professional, regardless of their profession specific discipline. Within the context of recent government policy, this places the service at the forefront of the removal of professional hierarchy/boundaries (DoH 2004, 2009). The function of gatekeeper also produces specific forms of conduct for the health professional and also for those referring to the Crisis Team.

The concept of gate-keeping is constructed within these documents as a cost saving tool, criteria driven procedure to ensure or deny access to treatment modalities and environments. By constructing this role as being a major remit of the crisis team, it becomes a legitimate role for all health and social care professionals working within a crisis team. In this way, the discourse within other government policy documents (DoH 2004) describing a generic workforce defined by its knowledge and skills, not specific professional disciplines, is linked and illustrated as a truth.

The effects can be viewed through Foucault's "regimes of truth"; that the knowledge produced and circulated forms accepted truths that then become practice. In this case, the description of a service becomes a reality as a "cost saving" product by restricting access to an expensive alternative; success/effectiveness is measured by the ability to meet this expectation. According to a Foucauldian perspective, the dominant discourse is revealed as a managerial and economic discourse and this has had a wider impact in constructing the meaning of Crisis Resolution Home Treatment teams. The rise of managerialism is seen as an effect of neo-liberal discursive influences in the provision of health services in the UK, as public sector services became the site of market principles (Bevir 2011).

Castel (1991) proposed the increased administrative function of managerialism in the form of categorising the subject in mental health as a series of factors and potential risks would diminish the therapeutic relationship. One of the criticisms by service users of Crisis Teams has been the variety of staff members visiting, resulting in the need to repeat their story and feeling unable to establish a connection with anyone (7.4.5). This has been attributed to the 24 hour nature of teams necessitating shift patterns. However, the directive to provide a 24 hour service in order to prevent hospital admission and the measurement of success in these terms has gained priority over the previously privileged discourse of the therapeutic alliance and is replaced by the mechanistic strategies of weighing up information against a set of predetermined criteria (Castel 1991)

The gate-keeping role of Crisis Teams is seen as central to their success as a service, and this role would require a high degree of professional expertise and knowledge as defined by the psychiatric construction of crisis as mental illness. This dominant discursive construct and practice may offer an insight into the limited

presence of occupational therapists within Crisis Teams. Both managers and occupational therapists themselves may not view the profession as possessing sufficient degrees or depth of this type of knowledge to be able to perform the role of gate-keeper. It could be argued, that when viewed from anything other than a medical/psychiatric perspective, whether anyone, other than the person “in crisis” has the knowledge and expertise to judge what response is necessary.

The ambiguity of the term crisis and how it is constructed as mental health crisis is another theme brought to the fore through this discourse analysis from chapter 7 and is now explored further.

8.2 Discursive Constructs of Crisis

Crisis is defined within policy guidelines using psychiatric terms and categories of mental illness. This definition is then carried through into the audit, evaluation and research documents to denote the relationship with the text to policy. At times the limitations of this definition are acknowledged with the all encompassing “unable to cope” used as a clinical phrase to expand on the need for other specific issues to be evident in addition to the presence of an identified mental illness (7.3.5;7.3.1). From the discursive formations highlighted by service users, the concept of mental health crisis is described in emotional terms and often citing the disruption to usual ways of being and acting.

The term crisis is itself a discursive construct, which is now closely linked to financial and economic ideas due to recent global events resulting in the widespread use of terms such as financial crisis, economic crisis. Crisis within a social context was historically describing the breakdown of coping skills in response to an event outside the individual’s experience (Caplan 1964, Roberts 2000). The term as used in mental health is now dominated by a psychiatric definition of acute mental distress, relapse of severe

mental illness and which, according to policy guidelines, excludes stress and emotional responses to social events.

However the studies analysed here also identify the reality of the service, in that teams are seeing individuals in “social and emotional” crisis (7.3.5). The reasons for this may include the power of discourse; how the word crisis is interpreted, the influence of the economic imperative to prevent admissions which have included those with emotional responses to social problems due their level of risk to self or others. The tensions identified from the descriptions of teams being accessed by those for which the service was not intended can be viewed through the lens of the foucauldian notion of the productive elements of power and resistance (Mackey 2011); that of service users and the resistance to a narrow definition of crisis, also the resistance of health professionals in their assessment of the needs of someone in contrast to the stated remit and narrow definition of crisis as criteria for access to crisis resolution teams.

For health professionals, as with anyone else, beliefs and understanding of their own ethical and moral conduct are influenced by the discourses which constitute their subjectivity (Mackey 2007, 2011); technologies of governmentality, such as reflective practice and supervision promote the identity of health professionals and along with personal experiences, provide the space for challenging or even discounting the discourse of policy and research. Lipsky (1980) also sought to explain how health professionals make decisions that may run contrary to policy directives. Following on from this theory, Ellis (2007) recorded the discretionary actions of social workers in response to policy and resource management strategies with regard to the introduction of direct payments for social care.

However, this theory, supported by findings from Ellis' study, tends to support the idea of discretion being used negatively and as a defence against the erosion of professional expertise. Whereas in the case of Crisis Team workers the, albeit limited, evidence so far suggests discretion is used more positively (depending on your perspective), in making available a resource that in strict policy terms would not be offered in those circumstances. As the majority, if not all, qualified staff working in a Crisis Team will have been influenced by their own profession's discourse for significantly longer than the relatively new discourse of crisis resolution, then they are more likely to act in accordance with how they understand and think about themselves and their conduct as a health professional.

The difficulty of applying consistent definitions of crisis is a factor identified in the documentation analysed (7.3.5; 7.2.1; 7.3.4; 7.4.5). The result is identified within reports as variously; confusion between referrers and within teams leading to "inappropriate" admissions to the Crisis Resolution Home Treatment Team; service user frustration and dissatisfaction at perceived "rationing" and exclusion from assistance.

The overriding discourse may be described as procedural, managerial and economic. Crisis Teams are "known" in terms of their economic value and numbers, percentages and quantities are utilised in describing how they look, operate and exist. Is there a resistance to describing the concept of a crisis in emotional language and the cost in human terms of distress, impact on family and social networks? A discourse that includes emotional and functional implications of a mental health crisis would also require the acknowledgement of a complex response to an infinite range of issues which may not lend itself to the reductionist approach of quantifying performance within a set of targets measuring procedural/organisational achievements. Crisis has become a site

of contested priorities and power struggles. Individuals define crisis from a personal, experiential view, yet the crisis is constructed by the service in as much as it must fit the criteria to warrant classification as such and therefore access to the service.

The findings from this discourse analysis have identified tensions and discrepancies between differing discursive practices. Government guidelines and implementation reports construct “crisis” within narrow specific mental health/psychiatric terms; the role of the Crisis Resolution Home Treatment Team is described as an alternative to hospital and research literature consolidates the identity of crisis teams as the “gatekeepers” of services and their effect is to save money by reducing hospital admissions. Service users utilise very different discursive practices, resulting in a much wider and varied definition of crisis in terms of emotional distress, impact on functioning and an expectation of rapid, flexible solutions.

Foucault described the objectification and subjectivity of the mentally ill and technologies of confinement and control in his work “Madness & Civilization” (1967). Terminology has evolved, however the term service user continues to identify people as subjects within the mental health discourse and subject to criteria and structures of mental health services. “Service user” would suggest an element of choice, using a rhetorical device that evokes a market dynamic of a product/service that the individual as consumer has made an informed decision to purchase or use. The use of this language throughout most of the literature then gives the illusion of power or empowerment. This is further sustained through the discourse, where choice is given as one of the defining elements of the introduction of crisis teams. However, tension becomes evident and “choice” can be contested when research and audit subsequent to policy implementation constructs crisis teams as the mechanism for preventing admission and their

success is measured as such. The option for admission to hospital as a preference is silenced.

The introduction of crisis teams can be seen as the culmination in a process that has gathered pace in the past twenty years – that of increasing the provision of health care in the community. The increase of this type of provision is conversely aimed at reducing the demand for in-patient hospital admission. The historical and political context can be traced back to the inception of the National Health Service and beyond. The context of the political and organisational imperatives can be seen to have influenced the focus of subsequent research into the introduction of crisis teams at the moment.

The service user movement in mental health is driving for greater involvement and inclusion of service user perspectives in the development and provision of services – concepts of human occupation appear to be a large component of this perspective. Service user knowledge is gaining recognition and power (Campbell 2005), however in the forum of crisis resolution teams, the power to focus the direction, development and delivery of this service appears to lie within the dominant medical, political and economic discourses, therefore held by medical/nursing professions and the governing bodies that devise and implement health policy.

Service user discourse may provide a link with concepts of human occupation and a state of crisis resulting in seeking access to mental health services. This would then suggest that areas for research into crisis teams, human occupation and treatment options may focus on; the concept of occupational identity and its relationship to the identity of self in the crisis context; identify additional concepts of human occupation within service user discourse and how these are constructed and/or utilised to

construct experiences. An increase in the profile of the construction of service user knowledge of crisis has the potential to transfer the balance of power.

8.3 Knowledge Constructed through Policy Implementation

Through the analysis, and my own experience within the research process, there have appeared contradictions between and within the discourses present in literature concerning Crisis Resolution Home Treatment Teams.

The documents analysed here were predominantly published for organisational, professional or academic use; therefore discursive practices will also be organisational, professional and academic. However, all three of these discourses use political rhetoric to espouse not only the importance of the inclusion of service user perspectives, but the ideal of service user led research, development and design.

The discursive practices within the policy and evaluation documents analysed, constructed the notion of Crisis Resolution Home Treatment teams as an alternative to hospital admission; the rhetoric of political discourse describes this as a clinical improvement, increasing quality and choice. However, the analysis traces the economic drive behind the alternative to admission. The crisis team is constructed in terms of saving money by reducing hospital admissions and becoming “the gate-keeper” to acute (and expensive) services.

The National Health Service is the stage for competing political ideologies vying for dominance. Since its inception, medical, political, professional and economic discursive practices have produced and shaped the system and organisation at every level. The 1980’s in particular saw government agenda impose a capitalist market driven business model onto the service, and there

have been successive attempts to reform, reconfigure and regenerate the structure and organisation of the National Health Service (Turner 1995, Rogers & Pilgrim 2010). Each one has constructed its own knowledge and regimes of truth about the Service through its particular ideologically driven discourse.

Improvements and reforms have been proposed under the guise of improving efficiency and quality, whilst also acknowledging the need for strategies to manage the future of the service in light of the fact that with an aging population, the resulting demographics in the UK will impact on the economic viability of a “free at point of delivery” health service.

The most recent raft of government papers and policy guidelines construct ideas about the health service in terms of quality, choice, efficiency and value. In this way, the services and organisation are constructed through the discursive practices of management, economics and marketing (Bevir 2011). Medical and professional discourses compete with the discourse of business and economics. Medical and professional evidence-based practice describes the production and dissemination of the knowledge that is utilised within health services, however quality, value, efficiency and choice are cited as the drivers to service development and provision. Also within these competing discourses, the service user discourse is recruited to support the respective constructs of knowledge and truth (DoH 2000, 2001, Morton 2010).

Government policy and guidelines infer the preference of service users for alternatives to hospital admission (DoH 2001, 2005). Other evaluation reports include service user discourse to illustrate the varied experiences and definitions of mental health crisis, challenging the perceived narrow definitions in service discourse and the resultant criteria being utilised to protect access to services. The rhetoric in policy describes choice, whereas the

reality described by users of the service is of a series of rules and obstacles to be negotiated in order to access any type of help (7.4.3, 7.4.1, 7.4.4).

Crisis Teams were identified in Government papers and guidelines, as offering treatment choice and an alternative to hospital admission (DoH 2001). Whilst choice and alternative may denote the influence of service user preference and is described based on medical and clinical evidence, the dominant discourse comes from an economic perspective (7.2.1). Hospital admission is seen as the expensive option, and NHS Trusts (mental health) have followed a programme of ward and hospital closures, which has gathered pace since the introduction of the care in the community model in 1990's (Turner 1995). Initial research projects appear to have been influenced by the representation of Crisis Resolution Home Treatment Teams as gatekeepers and much of the research focuses on this function to reduce hospital admission, with less attention paid to the home treatment aspect. Later research has started to explore the home treatment function in more depth and from other perspectives (7.4.4, 7.3.5, 7.3.6)

This research project included the ideas, views and suggestions of a panel of service users. However the realities of organisational, academic requirements and time lines have overshadowed their voice. A Foucauldian perspective would suggest dominant discourses at play, whilst Alford (1975) could cite the influence of professional and institutional interests. The experience of engaging in this research resonates with the analysis of discourse in Crisis Team literature. Individual service user experiences and concepts of human occupation share elements of a discourse, however both are subjugated by professional, academic discourse and have been co-opted by the rhetoric of political and economic discourse. Meenaghan et al (2007) identified the then recent implementation of Government guidelines for conducting research, as resulting in a

level of bureaucracy threatening areas of research that underpinned policy and service development. Their conclusions also included recognition of the obstacles to research posed by tensions between research ethics committees and local NHS trust governance procedures, reflecting my own experiences and the impact on this research project.

From the basis of this study, the concept of discursive practices constructing knowledge and accepted reality about a given object; mental health crisis, is evident within the context of crisis team literature. The rhetoric of political, managerial discourse provides the truth that the least restrictive place of treatment will be the home, thereby inferring that this is beneficial to the individual. Is this because remaining at home with all that entails in terms of occupational roles, routine and environmental opportunities is also being recognised as inherently beneficial to the individual? Is the assumption that the naming of occupational therapists as a profession to be included will ensure the reality of inherent benefits of remaining at home is optimised?

8.4 Discursive Tensions and Resistance

The examination of contemporary documents reinforces the context of a system under pressure, with the introduction of new services and changes to professional focus. Documents 7.1.1, 7.2.1 and 7.2.2 describe the proposal and implementation of a new service and a radical change to the historical procedures and processes of acute mental health service access and delivery. Clinicians are now the “gatekeepers” to services. The discourse of service access is identified as managerial and economic; it is fair to suggest that these are not familiar forms of discourse for the majority of clinical staff and are potentially in conflict with clinical/professional discourse and knowledge. Foucault proposed that dominant discourses impact on power/knowledge relations and effect social actions, practice.

The limited research or discussion on clinical benefits, interventions and outcomes reflects the overwhelming influence of an economic perspective. Also the environmental cues of hospitals, asylums and buildings within an organisation contribute to an overall discourse and crisis teams are sometimes referred to as a ward without walls or ward on wheels. The fluid, unstable view these descriptions may imply does not fit with a medical, clinical discourse of hospital where treatments are supervised, monitored and measured. Turner (1995) described this phenomenon as the Foucault paradox – independence and deregulation requires increased control and surveillance. The onus on control and surveillance is then turned to the individual, family, friends and wider community.

The tension between the clinical, professional and managerial/economic discourses suggests further unintended consequences – that of clinician in the role of resource/service manager. Through the dominance of the economic discursive practices, the clinician of whichever professional discipline, has become the guardian of the access to resources. This suggests discursive practices constitute and maintain power balances and promote the interests of specific groups/stakeholders by constructing forms of knowledge which are privileged over others.

The survey of the introduction of Crisis Teams, 7.3.1 touched on this issue with respect to the predominant practice of Team managers providing supervision to the majority of Crisis Resolution Home Treatment clinical staff. This is in contrast to an earlier survey by Onyett (2003) of Community Mental Health Teams, where clinical supervision structures favour peer supervision and profession specific supervision. The idea that clinicians operating within Crisis Resolution as gatekeepers to sources of treatment and receiving clinical supervision from the service manager

suggests a major conflict of interest. Professional discourse constructs a clinical role that favours client led care, evidence-based therapeutic interventions and acting in the best interest of the service user.

There is little mention within the literature regarding the view of individuals who may prefer admission. The exploration and inclusion of such views could be construed as a threat to the discourse of Crisis Resolution Home Treatment Teams and its rhetorical construction as a choice in the prevention of admission, thereby challenging the target of reduction of in-patient costs.

8.5 Reflections

My own experience as an occupational therapist working within a Crisis Resolution Team influences my perception of the subject area through my own discourse. As an occupational therapist, I view the daily activities, interests, routines and environment of an individual as possessing inherent possibilities for therapeutic gain and improving health and wellbeing. However, I acknowledge also the potential for these same components in triggering or maintaining illness, maladaptive coping mechanisms and impacting on wellbeing. I am questioning the concept of crisis resolution with very limited explanations of the measure of a resolved crisis – whilst at the same time I am being asked to achieve targets based on the number of “contacts” the team has with each individual “in a crisis”; no reference is made as to the content of that contact, the outcome or the value. Within the team, each team member has their own definition of “crisis” and many people that we visit express alarm that they are considered to be “in a crisis”; indicated by contact with a service called Crisis Resolution; others wonder how we can resolve their crisis if it is linked to a loss, bereavement or long term struggles with past issues and events and yet others are disappointed when they are discharged from the Crisis Resolution Team feeling that their issues, crisis, problems have not

been resolved or they are not “cured”. We all appear to have different ideas and notions of what is and is not “a crisis”, different expectations of “resolution” and different approaches. Whilst this is to be expected within a multidisciplinary team, the apparent focus on the financial and organisational remit of crisis teams may be overshadowing a major component of the crisis resolution home treatment model – people will be treated in their own homes during a time of distress and potentially high levels of risk; this involves a vast array of considerations, from the dynamics of others living in the home to the shift in power relations between health worker, service user, relatives and wider support network, community .

8.6 Discussion of Findings

The discursive formation of crisis as an element of mental illness described in this document so far produces a response in the form of the Crisis Team service. The resulting practice of treating people who, according to policy criteria would otherwise be treated in hospital, at home becomes a truth, constructed and authorised through Government directives. Knowledge is produced, managed and circulated through a network of academic/scientific and professional journals claiming authority via the self-evident publication in said journals, utilising accepted forms of research method and citing Government policy stated remit as the measure of success.

Although the issue of integrating government policy into practice is not a new one, the themes emerging from this study shed light on very specific elements. That is, the notion of crisis constituted through the discourse of policy and research, with practices and strategies as a response. From the process of discourse analysis described thus far, dominant discourses, practices and actions have been identified. Within the analytical process, and from the resulting interpretations, inferences may be proposed relating to alternative discursive formations and practices. The inferences

identified within government policy discourse and subsequent monitoring and research, relate to concepts of human occupation, and bring to the fore alternative constructions of the notion of mental health crisis.

Exploration of these inferences and the alternative and additional discourse available through concepts of human occupation may provide an alternative construction of mental health crisis and service/professional responses. With an increased awareness of the human occupation element of crisis and crisis resolution come implications for the practice of occupational therapy. The remaining section of this thesis will now give an illustration of occupational concepts and propose an alternative reading of crisis resolution discourse, implications and possible responses.

Preliminary analysis of mental health crisis resolution discourse through the primary documents described the formation, implementation and evaluation of mental health crisis resolution services and identified the following;

- Links to other discourses – economic, managerial, medical.
- Claims to authority – previous theories of crisis, professional and academic authorship, Government directives.
- Practices – Crisis Teams as an alternative to admission, gate keeping as a function to reduce admissions, evaluating performance against model fidelity and targets, definitions of crisis as a criteria for accessing crisis resolution service

Initial analysis of the specified documents identifies discursive formations, with examples of text, links to other discourses and interpretations suggesting resultant discursive practices (ie construction of the role of gate keeper). Continuation of the process of analysis is now described taking the crisis resolution

discourse as a whole and offering further support for interpretations underpinned by Foucault's theoretical concepts of power/knowledge and governmentality.

8.6.1 Knowledge/power and hidden discourse

For Foucault, power and knowledge are inextricably linked, situated and shifting depending on historical and societal context. Policy-as-discourse theoretical views also acknowledge the socio-political and historical position of policy design (Bacchi 2001). Policy makers do not exist separate from current political ideology and social context (Shaw 2010).

The creation and implementation of crisis resolution home treatment teams from the beginning of the 21st century are the result of government policy (DoH 1999, 2000). The discursive formations, in 7.1.1 constituting the implementation of the policy through teams that are described in terms of criteria that can be measured promotes further construction of crisis teams in terms of economic success, through the production of research/evaluation practices in 7.3.3, 7.3.2.

The description of the economic success of crisis teams in terms of reducing hospital admissions can also be interpreted as an illustration of the power relations situated at the interface between professional as gatekeeper and individuals accessing the service. The crisis team (and therefore staff member) is in the position of possessing knowledge of criteria for admission to the service or to hospital and, as identified in findings from the discourse analysis, may have a definition of crisis which differs from the person contacting the team (7.4.3). This has the potential for putting the crisis team at an advantage in the power relation dynamic. To date, there is no published description or evaluation of the discussion or decision making process between crisis team staff members and individuals referring to/contacting the service.

However, Foucault's notion of power recognises the fluidity of shifting power relations within and between situations and contexts. Policy analysts have traced the movement of the delivery of mental health care from the institution to the community, from a Foucauldian perspective of governmentality and neo-liberal discourses (Bevir 2011, Bacchi 2001, Shaw 2010), suggesting that the more recent government policy strategies have ensured the selective use of evidence to reinforce the economising discourse in health care and promote a neo-liberal project of reduced state control and increased social empowerment.

The development of Crisis Teams illustrates the political discourse as a means to transfer the situated context of power from the hospital/clinic, and by inference the medical profession, to the individual, their home and a wider social network. The rhetorical strategies initially found in the earlier National Service Framework for Mental Health (1999) policy described the introduction of 24 hour access to community services and alternatives to admission as providing wider choice for service users. Over the next five years the language use has changed subtly to describe the remit of Crisis Teams as preventing admission (7.2.1, 7.2.2) and research and evaluation has focused on the economic value of this service (7.3.3, 7.3.2). The NAO (7.2.1) report illustrates what has become known as the Foucault effect – greater self governance resulting in increased monitoring and control (Gordon 1991). Through targets, specified criteria and quantifiable (economic) measures, services designed to promote choice and empowerment have been monitored and success measured in terms not directly related to service user experience.

Equally, by placing the service user in crisis, at home, technologies of self-surveillance are implied, as no Crisis Teams are reported as spending 24 hours a day with someone, therefore long periods of

time are spent in self management, possibly, but not necessarily, with support from relatives/carer. The restrictions, containment, routine and supervision of a hospital ward have been replaced by self determined restrictions and routines, whether by choice or in response to a need to manage the feelings/symptoms of the individual's experience of crisis. Mattingley et al (2011) identify a similar phenomenon in the United States with the movement of health care from clinic to home-based management of chronic health conditions, resulting in greater expectations for patients and families to be responsible for tasks previously carried out by healthcare professionals.

Individual descriptions of crisis from service users, places the experience within an emotional and practical, lived context (7.4.3, 7.4.4). However, the examples of service user opinions are small and it has been recognised that defining crisis in terms of mental health is problematic (7.3.5, 7.3.4). What is recognised, through mental health policy, research, evaluation and service user contribution, is that there is a need for services to respond to the needs of individuals at times of acute mental and emotional distress. However, the nature of dominant discourses is seen to be constitutive, influencing how, when and why services respond. Alternative or hidden discourses can resist the assumptions and taken for granted knowledge of a subject, in this case an individual with a mental health crisis, providing a discursive space to explore the beginnings of additional knowledge and practices.

8.7 Summary

The process of discourse analysis thus far had reflected the dominant discourses at play around the construction of crisis resolution home treatment teams, those of economic, managerial, political and organisational. The discursive strategies, practices and technologies have been identified, mapping the consequences, intended or not, of these dominant discourses.

Through the gradual exploration of the levels of discourse, a hidden discourse of the experience of crisis, how subjectivities come to be governed is beginning to be revealed. Although the voice of the individual is heard/documentated at times within the texts, it is through the analysis of discourses that practices and technologies can start to come to the fore, providing an option to explore additional obscured discourses and open up a space to explore alternative strategies for constructing mental health crisis.

The second part of this thesis will explore one of those alternatives – concepts of human occupation in relation to mental health crisis and Crisis Resolution Home Treatment Teams.

PART TWO

Chapter 9 – Introduction

The preceding chapters of this thesis have focused on Government policy and documents related to a specific area of mental health care practice. An analysis of the discursive practices employed within the documents traces the construction of the notion of crisis within mental health as pathology, with a resultant service developed to respond to/resolve the crisis. However, closer inspection reveals the ongoing wider remit of cost saving and transference of the clinical domain from hospital to the home/community environment

This section describes some of the theories and concepts underpinning the practice of occupational therapy and the perspective of occupational science in order to elucidate the relationship between constructs identified through the earlier discourse analysis and concepts of human occupation through the use of Foucault's concept of governmentality. By bringing to the fore hidden discourses, exploring the taken for granted views of mental health crisis and drawing links with concepts of human occupation, an alternative of view of crisis in mental health and crisis resolution can be interpreted through the paradigm of occupational science and occupation as technology of governmentality.

To begin this second section, descriptions and definitions of the two distinct but related disciplines are given. Identification of specific concepts is provided and these will be explored further within this second section to provide an illustration of the relationship with earlier discursive practices and propose the possibility of an alternative view of mental health crisis and practices through the lens of occupational science.

9.1 Discourse of Occupational Therapy

Occupational therapy includes in its knowledge base, theory and evidence from a range of disciplines, including biological, social and behavioural sciences. As such, the discourse of occupational therapy is a site of competing ideas and struggle (MacKey 2007). The latter part of the 20th century saw the development of occupational specific theories and models of practice, such as Adaptation through Occupation (Reed & Sanderson 1992), the Model of Human Occupation (Kielhofner 1985, 1995, 2002), Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists 1997), Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko 2007) and the Person-Environment-Occupation Model (Law et al 1996).

Occupational therapy is described as the use of meaningful activities to restore and/or maintain health. The focus of how and why this is implemented varies; activities may be encouraged for their own sake, to engage the mind and body, to provide structure to time, to imbue a sense of involvement, to provide enjoyment and relaxation; the activities may be used to increase skills, to increase ability, strength or endurance and to measure improvement (Reed 1993).

“Occupational therapists view people as occupational beings. People are intrinsically active and creative, needing to engage in a balanced range of activities in their daily lives in order to maintain health and wellbeing. People shape, and are shaped by, their experiences and interactions with their environments. They create identity and meaning through what they do and have the capacity to transform themselves through premeditated and autonomous action” (COT 2009).

What all occupational therapy models have in common is a focus on providing a framework of the components that make up concepts of occupational therapy to guide practice. Many identify human occupation in terms of activities divided into themed areas such as self-care activities, leisure/play and productive/work tasks; the skills, abilities and performance requirements necessary to engage in and complete the range of tasks and activities which make up a persons daily life, and the impact of environmental, cultural and contextual factors. Therapists are likely to intervene in the event of illness and/or disability limiting the individuals' ability to engage in any or all of the occupations that make up their daily lifestyle. This may be in the form of increasing skills, education and exploration of adapting and grading activities and/or the performance of activities to achieve success; it may be in the form of making adaptations to environmental barriers or provision of tools/equipment to facilitate the completion of specific tasks (Hagedorn 1997).

However, a growing body of academic literature has begun to challenge these assumptions and definitions of human occupation and occupational therapy practice in particular. Mocellin (1995) criticised the profession's acceptance of the formation of knowledge about occupational therapy based on the writings of a small number of central figures without supporting evidence. Hammell (2004, 2009a) challenged the assumption that everyone has the opportunity to positively influence their well-being through occupations and demonstrated that the meaning ascribed to an occupation by an individual may be just as much negative and futile, as positive and purposeful. The common practice of classifying activities using the categories of self-care, productivity/work and leisure has also been contested, accused of being value-laden, simplistic and de-contextualised (Pierce 2001). Further criticism has highlighted the western-centric nature of occupational therapy theory and practice, asserting that western,

middle-class assumptions dominate the profession (Iwama 2011, Hammell 2009b, Suto 2004). The alignment with medicine is seen as responsible for the limitations on practice in the workplace, where occupational therapists comply with and are constrained by, dominant structures and a biomedical focus (Whiteford & Townsend 2011)

Reading through professional journal research articles, Kielhofner's Model of Human Occupation appears to have become the practice model of choice for many therapists (Goren 2002). This model has been refined and amassed a research base in terms of the development of its related assessment tools and its theoretical components (Keilhofner 1985). However it is by no means a unanimous agreement on a definitive model for practice, it may simply be that the inclusion of several specific assessment tools within the model has led to its use in studies as they provide opportunities for measuring outcomes. Equally it may be that the people who use it have a higher tendency to reporting their findings as the author himself encouraged feedback on the experiences of therapists utilising the published tools.

However, the profession of occupational therapy is renowned within its own sphere of failing to produce evidence of the efficacy of its interventions (Bannigan et al 2007, Mairs 2003, Goren 2002). In the resulting "knowledge gap", and in the face of a shift in social and political awareness of the link between health and "doing" (DoH 2005, Schafer 2000, ODPM 2004) there is a growing body of research and evidence describing the benefits of meaningful activity to physical and mental health and overall well-being of the individual and the community as a whole (Biddle & Mutrie 2001, Everitt & Hamilton 2003, Faulkner & Taylor 2005, Merli 2002).

9.1.1 Generating Knowledge

In terms of activity as a clinical intervention, studies such as that of Faulkner & Sparkes (1999) and Daley (2002) describe improvement in self-esteem, and sleep patterns for people with schizophrenia and reduction in depressive symptoms for an individual with clinical depression respectively, following participation in exercise/sport programmes. Teall (2007) describes the experiences of mental health service users involved in a project using arts and horticulture. Individuals variously report benefits ranging from increased confidence and self-esteem to being able to form a positive identity and improved quality of life. Secker (2007) reports on the findings from a study commissioned by the Department for Culture, Media and Sport and the Department of Health to investigate the benefits of participating in creative arts projects for people experiencing mental health problems. The arts as forms of activity included painting, mosaic work, performance art, creative writing and photography. The report, including data gathered from 62 participants over 20 separate projects, suggests individuals experienced benefits ranging from increased feelings of self-worth, well-being and social acceptance, to a decrease in feelings of social isolation and risks of self-harm. It was acknowledged that those participants who lived alone experienced fewer benefits in the longer term.

The influence of factors such as ongoing social support and financial and environmental considerations cannot be disregarded in terms of mental health recovery (Jacobson & Greenley 2001). The particular studies cited above did not include any mention of occupational therapy, although they do claim to illustrate the concept of engaging in activity as of benefit. These studies, however also illustrate some of the limitations in terms of drawing comprehensive conclusions in that other factors influencing well-being may also be of significance, such as medication regimes or an increase in support from health professionals/family. Although

there are difficulties in isolating the definitive factors involved in psychosocial improvements, any subjective progress and benefit as experienced by the person with mental health problems could be viewed as a positive outcome and an indication of the effectiveness of the interaction (Duncan et al 2007).

The role of art in the recovery process in mental health has recently been highlighted in a report on the Girrebala art project in Australia (Lloyd et al 2007). The project has been in existence for over a decade organised by both artists and an occupational therapist, and participants describe their experience of the project as one that fosters feelings of hope, regaining control, increased confidence and acceptance. The use of art as an assessment tool by occupational therapists in a mental health in-patient unit, has also been reported (Mitchell & Neish 2007). However, the need for the use of additional assessment strategies to provide comprehensive information was acknowledged.

In terms of other interventions used in mental health by occupational therapists, Cook (2003) identified assessment, the development of leisure skills, social skills and life skills, as most frequently cited by occupational therapists working in community mental health teams. These results reflect a trend identified by Lloyd & Papas (1999), that many therapists are now frequently based in community settings, possibly accounting for the increased use of education and advice on coping strategies and life skills as occupational therapy interventions. However, Mairs & Bradshaw (2004) point out the less than favourable outcome of the efficacy of occupational therapy when compared to psychosocial interventions such as life skills and social skills training as used by other professional disciplines. Although these skills may contribute to an individuals' ability to engage in occupations of choice, the cognitive behavioural roots of skills training does not limit its use to occupational therapists.

Whatever the debate over what occupational therapists do or do not in terms of their work with people experiencing mental health problems, the notion that occupational engagement, in its widest sense, and the ability and opportunity to pursue meaningful activities is accepted as innately human, a human right and therefore will continue to contribute to an increased sense of well-being (Creek 2003, Wilcock 2006, Yerxa et al 1989). Other disciplines in the health field also recognise the importance of engaging in activity, although framed in different terms and for different reasons. In particular Cognitive Behavioural Therapy approaches, which can be utilised by nurses, psychologists, psychiatrists and occupational therapists, advocates the use of activity scheduling to increase positive feedback opportunities, thereby increasing self-esteem, confidence and also linking mood to levels of inactivity or activity and types of activity (Clarke 1986, Williams 2001).

At present, with continued calls for research to support occupational therapy interventions (Hampson 2007, McQueen 2008, Bannigan et al 2008) there can appear to be sporadic evidence of specific occupational therapy outcomes in mental health. However, occupation as it relates to a range of different activities within employment, sport, creative endeavours, horticulture, baking and housework is described in an array of studies, reports and government initiatives in terms of the positive relationship with health and health promotion (Biddle & Mutrie 2001, Faulkner & Taylor 2005, Everitt & Hamilton 2003, Haley & McKay 2004, Merli 2002).

It is the limitations of a cogent theoretical and research base for the profession of occupational therapy that is cited as the driver behind the development of occupational science.

9.1.2 Occupational Science

The origins of occupational science as a discipline are attributed to academics in California, USA during the 1980's. Proponents of occupational science have sought to expand and clarify the concept of human occupation. Occupational therapy is a specialist, focused treatment modality designed to ameliorate the consequences of illness and/or disability impacting on ability to engage in daily activities. Occupational science is seen as a field of study, utilising approaches from a wide range of disciplines and research methodologies that explores the nature of occupation and its relationship with health (Yerxa et al 1989).

Occupational science is a field of study whose purpose and focus is the study of human occupation, its nature, structure and the relationship between occupation and health (Molineux 2004). As a science, it is seen as dealing with the broader questions and ideas of occupation, as opposed to the application of therapeutic strategies with individuals/groups of individuals. Occupational science continues to draw on a range of disciplines and approaches; biology, psychology, sociology and environmental theories.

In her work within the sphere of occupational science, Ann Wilcock (2006) cites ancient civilisations, Greek philosophy and anthropological studies to illustrate the history and nature of human occupation and theories of health and illness. The influence of ruling regimes, government policy, societal/cultural norms and environmental factors are discussed at length in providing a theoretical perspective on the relationship between human occupation and the promotion of health and the prevention of ill health. Although Wilcock cites Marxist influences in the development of occupational therapy and an understanding of the centrality of occupation to the endeavours human beings, so too can a perspective of governmentality be brought to an exploration

of both the centrality and the marginalisation of concepts of human occupation.

9.2 Occupation and Governmentality

The term occupation has different meanings and uses; as a verb, to occupy time, space, attention; as an adjective and an object. Definitions of the term then are equally diverse, depending on the context in which the word is being used or defined. Particularly in western culture, the predominant understanding and use of the term occupation refers specifically to employment, work, career and profession. The wider sense of the word as applied to human behaviour refers to the collective activities and tasks that people need and want to do, the how, when and why of specific activities, the relevance, meaning and purpose of the activity to the individual and also the meaning of activities within society as a whole (Wilcock 2006).

Theories of governmentality emphasize that through the production and circulation of dominant discourses, particular kinds of subjectivity are constructed as ideal and act upon a person's sense of individual and social identity, this in turns promotes understanding of idealised ways of thinking and acting and comes to governs one's conduct in relation the self and others (Rose 1999, Dean 1999, 1994). Work is seen a technology of governmentality consistent with the ideal objectivities of social authorities, where work is not only an economic contract, but also a psychological need for self-organisation and promotion of individual and civic responsibility (Donzelot 1991).

9.2.1 The Nature of Occupation

By viewing human beings as having an innate need, drive and motivation to engage with their environments and situations through complex structures of activities, occupational science describes humans as occupational beings;

“...a self-organising system who responds to specific environmental challenges with occupation, creating an adaptive response. Successful self-organisation creates skills, which will be available in the face of new, unknown challenges” (Yerxa 2000, p197).

The animal world may be generally viewed as consisting of living things which have an innate drive to survive and procreate, therefore subsequent actions and activities are developed to best achieve these ends. According to Maslow (1954), human beings also have fundamental survival needs, however once these are met, humans will go on to pursue other activities to achieve and gain further satisfaction and knowledge. It could also be argued that humans will continue to strive to fulfil occupational, emotional and intellectual needs even when basic needs are not being met. A possible example may be cited in certain religious followers, where fasting, self-denial and an ascetic lifestyle are viewed as a prerequisite to spiritual achievement, although occupational patterns of ritualised behaviour continue. Wilcock (2006) proposed that occupations encompass the ways through which humans develop across the lifespan, as being, doing and becoming.

The evolution of mankind demonstrates the development of increasingly complex forms of occupation to fulfil survival, emotional and intellectual needs, from the increasingly intricate decoration of pots and utensils to production of abstract art forms; the early written recordings of human history to the development of plays and film; the progression from hunter-gatherer tribes, through the implementation of agricultural settlements, the industrial revolution and to the current technological age (Bronowski 1973, Statt 1994). Embedded in this evolution is the language we have come to use to define ourselves and our occupations. Particularly in western cultures, people are often described and even introduce

themselves in terms of what they do as a work role i.e. their occupation (Statt 1994).

The area of paid work, employment, in particular has become central to the status and lifestyle aspirations of large parts of society. The type of work and the leisure pursuits one engages in are used as a social and often moral barometer. Opinions regarding someone's values, intelligence and status can be made solely on the evidence of their occupations (Statt 1994, Wilcock 2006). As described earlier, the term occupation and its definition is context and culturally based, in current culturally defined terms occupation is widely understood to refer specifically to employment and the work role. The importance assigned to work, work roles and the changing form of work in the 20th and 21st centuries has seen an increase in theories and studies of work-related stress (Collings & Murray 1996, Jackson & Maslach 1982, Tee & Ashforth 1996).

Donzelot (1991) also traced the transformation of the idealised view of work through its relation to the emphasis in health policies in France from the 1970's onwards on the re-training and rehabilitating those who had previously been seen as unable or unfit for work. This included changes to the named categorisation of subjects such as the abolition of the term "handicapped". Donzelot (1991), in the context of governmentality, describes the use of occupational therapy (ergotherapy) in conjunction with the medical profession in the use of graduated activities to prepare the individual for work, and so reduce the burden of welfare payments. However, Donzelot (1991) also explored the nature of work in the context of the psychopathology of work, where absenteeism is seen as directly related to the level of meaningfulness, or lack of, that work has for the individual. Possibly in an attempt to ensure that occupation can be defined as far more than paid employment,

occupational therapy literature appears to have limited examples of research into formal work/employment domains.

The implications for occupational therapists in practice of not considering the things people do that may not promote wellbeing or health but provide a sense of wellbeing need to be considered (Twinley 2013)

9.3 Occupational Science Discourse; Humans as Occupational Beings

The following concepts are examples of occupational science discourse and demonstrate the reliance on the notions of value, meaning and purpose in the definitions of occupation used within the spheres of occupational science and occupational therapy. The value, meaning, priority and importance of occupations are individual to each person, although will be influence by social, cultural, economic and psychological factors (Creek 2010).

9.3.1 Occupations, activity, tasks:

Occupation refers to the network of factors at play in the organisation of what people do, how time is used in organising daily life and how a range of activities and tasks provide meaning and purpose across the lifespan, formed by the requirements of specific roles adopted or imposed and organised through routines and habits (Harvey & Pentland 2011, Brienens 1995). Activities are defined as occupational when they hold particular value, meaning and importance to an individual and/or society. The meaning and value are subjective experiences of the individual and occupations are socio-cultural constructs (Turpin & Iwama 2011, Jarman 2011).

The categories suggested above, which are also referred to as representing the domains of occupational therapy in the form of self-care, productivity and leisure (Creek 2010) can also be interpreted through the lens of governmentality. Conduct is seen as

governed and influenced by the individual's own understanding of how to govern the self, through the technologies and practices of social authorities and agencies. Health care systems, schools, the media and families are seen as some of the main institutions and agencies through which authority and discursive practices are invoked to construct ways of being and doing that are termed practices of the self (Foucault 2003b). The occupations and activities that might be variously sited within these categories are deemed to be socio-cultural constructs. However occupations can also be viewed as the construct of dominant discourses.

For example, the representation through mass media advertising of domestic and household tasks promotes the use of a myriad of cleaning, disinfecting and anti-bacterial products, suggesting that the "right" and "best" way to fulfil the obligations of domestic occupations is as a consumer of a range of different products, each with a specific target area within the home. The inference being that not engaging with consumer-based conduct implies a lack of responsibility for the health and welfare of the family and visitors to the home, by failure to protect them from the dirt and germs inherent in the home environment.

Drawing on the work of Foucault and others in relation to governmentality, Laliberte Rudman (2005) proposes the concept of occupational possibilities, referring to occupations as the regular activities people take for granted and that some occupations are supported or promoted by the wider systems and social structures in which they live. Whilst technologies of government do not deny us the freedom to pursue our own desires and ambitions, they are seen as establishing an ethic of the responsible self in line with neo-liberal objectives of individualism, self-reliance and consumerism (Rose 1999)

9.3.2 Occupation and time use:

Humans are seen as organising time through an array of routines and rituals made up of activities with varying degrees of value and importance to the individual. In many societies around the world, paid employment makes up the tasks and activities that constitute the occupational forms of many adults and consequently dictates the routine and time use for the individual, family, community and wider society. Many other occupational forms are inextricably linked to a common work timetable – schools, shops, banks, services, once again dictating the organisation of many activities and routines. An individual optimum distribution of occupational categories and time use, resulting in occupational balance, is identified as promoting health and long term wellbeing (Harvey & Pentland 2011).

The rate of change in the field of Information Technology will also have/is having an impact on time use and routines, as boundaries between actual and virtual spaces is eroded. As noted by Iwama (2011) and Hammell (2009a,b), explanations of occupational routines and forms have historically taken a middle class perspective and also assumed that people have a choice in having a balanced routine, which may not be the case. Too much time, with little directed activity leading to boredom has been related to poor mental health (Jonsson et al 2000, Csikszentmihalyi 2008).

In terms of the government of occupations, Foucault and governmentality theorists would suggest that choice is indeed contestable, given the power of dominant discourses and practices to influence what comes to be understood as the “right” or “ideal” mode of action at given times and in particular contexts (Foucault 2003b, Dean 1999). Time, and its central part in the organisation of social structures and institutional timetables contributes to the framework by which individuals may measure their conduct and the conduct of others.

9.3.3 Occupation and context/place:

The activities and occupational behaviours undertaken by individuals, communities and societies shape and are shaped by, the places, environments in which they are performed (Hamilton 2011). Places are identified as possessing important and symbolic meaning, socially constructed meaning related to the activities they support. Place provides the context for occupational forms and can also limit occupational opportunity or engagement. Finding or creating a place of safety and security is viewed as instinctual and necessary for health and wellbeing (Maslow 1954, Brienes 1995, Hamilton 2011).

Buildings, place and structures are conceptualised by Foucault as practices and technologies of the dominant discourses in society; hospitals being an obvious example for Foucault, as the symbol of medical discourse, power and knowledge (Foucault 1967). Discursive practices and technologies indicate the acceptability of where specific activities and occupations can and can not be performed. They are also indicators of who may have power in a particular context and contribute to the construction of particular subjectivities, such as patient, pupil, prisoner (hospital, school, prison). These subjectivities are fluid and can change with the context, place, dependent on the occupational identity and role to be performed. However, there will still be socially constructed limitations to the how, when and where these roles are enacted.

9.3.4 Occupational Risk;

Townsend & Wilcock (2004) defined the terms of occupational marginalisation, occupational deprivation and occupational alienation under the umbrella of the concept of occupational risks. This is an attempt to highlight the global and wider socio-cultural importance of the concept of occupation as an inherent human need and right. Occupational deprivation is identified as a prolonged period of restricted access to valued or meaningful

occupations due to factors beyond an individual's control. These could be environmental, social or cultural (ie Prison; stigma; religious restrictions; war).

A related idea is occupational disruption, described in relation to occupational deprivation, but distinct from. Disruption is seen as shorter in duration, temporary or transient and the individual has some degree of control in terms of choice to make adaptations. Occupational disruption may be a result of illness, life events or accident. It is envisaged that with supportive circumstances the disruption will be resolved (Wilcock 2006).

A Foucauldian reading of occupational deprivation and disruption may suggest the dominance of particular discourses and mechanisms of governmentality will marginalise certain groups in society; or that an inability to participate in "ideal" occupational forms may represent a transgression on the part of the individual to fulfil obligations to care of the self. The mobilisation of support is dependant on the technologies available to the individual in their socio-economic circumstances. Laliberte Rudman (2010) also proposed that occupational scientists begin to explore how contemporary discourses and the mechanisms of governmentality may come to marginalise certain types of occupations and subjects.

9.4 Summary

The field of Occupational Science has endeavoured to encapsulate the components covered in other academic arenas and translate the whole in terms of the phenomenon of human occupation (Wilcock 2006). Occupational Science promotes the development of theories and concepts for a paradigm of living, extending beyond the realms of a therapeutic treatment modality (Molineux 2009).

Occupational participation and inherent properties of activities that engage the individual on cognitive, emotional, physical and/or intellectual levels is deemed to provide therapeutic, cathartic or empowering experiences with the potential to instil hope, increase confidence and improve performance (Csikszentmihalyi 2008, Kielhofner 1995). It is the role of the therapist to facilitate the opportunities to engage in activities that will encourage success and achievement and foster a positive occupational identity through occupational participation (Creek 2010).

The ideas promoted by occupational therapy and occupational science have been described and illustrated so far to provide as is possible within the confines of this thesis. A link has been proposed between occupation as conceptualised by authors within occupational science and occupational therapy and the work of governmentality theorists. The remainder of this work will draw links between the analysis of Crisis Resolution Home Treatment Team discourse and the concepts of human occupation constructed by both occupational science and occupational therapy. These links are drawn within the historical context of the health service in England and one professional discipline. As such this is a snapshot of the discursive practices and power/knowledge strategies at play exemplified through one type of service in a wider socio-political domain.

Chapter 10 – Discourses; Crisis; Human Occupation

This chapter explores the construction of concepts of human occupation and how they can become evident in the discourses identified in Part One. From this, tensions and difficulties are explored through the lens of a Foucauldian perspective.

The identification and introduction of a service designed to provide an alternative to hospital has been described and instigated by Government policy (DoH 1999, 2000, 2001). As an overt example of state power, this draws on the taken-for-granted knowledge base of medical science and the bio-psychosocial paradigm. Power is then shifted to the organisational institutions that make up the NHS as implementers of the state through the strategies and technologies of mental health Trusts. Professional disciplines are mobilised through workforce designs in the form of, in this case, a specific service as a multidisciplinary team (Bevir 2011).

Discourses have been recruited from service user feedback and mental health research promoting the alternative to hospital as a viable and preferable option. However, a Foucauldian reading of the outcome of this policy identifies a complex interaction between the taken-for-granted, or regime of truth, and consequent practices and actions of governmentality, as experienced by staff and users of the service. From a Foucauldian analysis of the history of the present discourse, the increased dominance of an economic, performance-based way of knowing and measuring this service suggests unintended consequences have developed as a result. The individual who is at once the subject as mental health service user is also a person in crisis, unable to cope, suggesting an absence of control and power. The gate-keeping role of these teams has promoted a sense of referral and individuals needing to meet and navigate a set of unseen rules and criteria in order to prove they are experiencing a crisis and therefore are eligible to receive the

service. An unfortunate confrontation between service user, family/friends and the service could see an increase in risk to self (or others) in response to a perceived need to meet the criteria. The realities of practice as opposed to the rhetoric of policy may explain why reports suggest that the strict criteria of policy is not always applied (Stark et al 2002)

In the power/knowledge scenario, an individual will “know” they are in crisis but lack the technical knowledge of the crisis team member regarding the remit, criteria and service model which is influencing clinical decisions. Some of the discursive strategies utilised by service users identified within the literature describe feelings which resulted in accessing the Crisis Resolution service as those of being out of control, unable to cope and needing help. By definition, the individual is treated at home by the Crisis Team and so the assumption is made that the balance of power remains with the service user.

Each reading and re-reading of the documents identified and gathered to form the basis of this discourse analysis revealed inferences and allusions to concepts of human occupation. These interpretations will be given further exploration here. The themes developed from the earlier discourse analysis will now be considered in relation to concepts of occupational science.

10.1 Power Relations Identified through Discourse Analysis

From the initial analytical phase in chapter 7 and themes explored in chapter 8, the function of a gate-keeper became clear as constructed within the discourse of crisis teams. Interpretation then formulated further discursive practices emerging that places health care professionals in the role of protecting the resources of the institutional organisation in the form of preventing admissions that has been measured as beneficial based on economic factors (Johnson et al 2005, Garcia 2005). The idea of services being

guarded is also described within the service user perspective – the awareness that there are rules, and that an individual has to fit with a pre-determined set of criteria before being allowed access to a service. The gate-keeping function is predominantly aimed at protecting the best interests of the organisation and the team manager is tasked to implement and monitor this function of the team. Crisis Resolution Teams are a significant example of how the future of health care and the role of clinicians are affected by Government agendas (DoH 2000, 2004)

The concept of gate-keeping is constructed within these documents as a cost saving tool, criteria driven procedure to ensure or deny access to treatment modalities and environments. By constructing this role as being a major remit of the crisis team, it becomes a legitimate role for all health and social care professionals working within a crisis team. The professional identity of health care workers has been an area for discussion and debate across a range disciplines, from philosophical perspectives to profession specific studies (Foucault 1967, Crowe 2005, Mackey 2007, Illich 1974).

From an occupational science perspective, the professional health care role can be viewed as encompassing demands, challenges, technical skill and hold specific meaning, status and cultural and social significance (Wilcock 2006). Historically these roles have also been referred to as the helping professions and since the 1990's in mental health, have been providers of a systematic and monitored mode of practice referred to as the Care Plan Approach (DoH 1990). It may be fair to say that health care professionals would consider themselves to be first and foremost caring individuals. However this has been contested in the area of in-patient practice and in connection to the Mental Health Act (1983, 2003), where staff are viewed as having a custodial role (Rogers & Pilgrim 2010).

As a member of a Crisis Resolution Team, the occupational identity of health professional as clinician, therapist, advocate, health/social care worker may be challenged or at least adapted to assimilate the expectations of the gate-keeper role. This may necessitate learning new skills/procedures, modifying practice or even attitude. Throughout the literature on the introduction of Crisis Teams, their remit, purpose and actions are constructed in terms of a team identity. As a discursive strategy, the consequent discursive practice from an occupational science view also contributes to a homogenous identity as Crisis Team member. This latter possibility has also been explored by Nelson et al (2008) and Wharne (2005), with both studies highlighting the team approach adopted by specialist services (Crisis Teams and Assertive Outreach Teams specifically).

In the study by Nelson et al (2008), the support of a cohesive team and clearly defined service role was cited as one of the factors for increased job satisfaction and reduced stress levels among Crisis Resolution Team staff members. According to proponents of the benefits of occupation to health and well-being, satisfaction and reduced stress can be viewed as potential evidence of the positive influence of the nature of specific aspects of occupational engagement and performance. Within the field of occupational therapy, perceived satisfaction with occupational roles and performance is assessed as a measure for identifying areas of discord and limitations impacting on health (Kielhofner 2002; Law et al 1999)

Another discursive practice that may contribute to increased job satisfaction relates to the perceived strict criteria and short-term nature of Crisis Team provision (Nelson et al 2008). Whilst users of the service may find these two elements frustrating or obstructive, it provides clinical staff with a clear focus and rationale to support

decision-making. As an element of the activity of performing the role of health professional in a Crisis Team it provides implicit knowledge to be utilised and drawn upon, effecting a perception of mastery and meaning to the occupation of Crisis Team health professional. Mastery and meaning are cited as major components of positive occupational engagement and as contributing to learning and development across the lifespan (Wilcock 1998, Brienes 1995).

Alongside mastery as a related concept is that of expertise and the perception of the health professional as expert, bringing to the fore the power relations at work with the encounters between Crisis Team staff member and service user. As noted during the discourse analysis phase of this thesis, a person accessing the Crisis Team is constructed as an individual in crisis and requiring the services of a specialist team, both to provide support and also as the alternative/prevention to hospital admission. The service user becomes the subject within their own crisis, given the role of person in crisis. With this role comes the expectation for performance of specific activities – to meet with and talk to Crisis Team staff, to take medication as prescribed, to follow advice and suggestions for self-help techniques and building coping skills (Morton 2010, Rigby et al 2007).

The meeting with the health professional is likely to be in the person's home, a central place and context for the performance and engagement of a myriad of occupational roles through routines of needed and preferred activities (Harvey & Pentland 2011, Hocking 2009). This meeting has socially and culturally constructed purpose and meaning; health professionals hold a certain status and recognised role in society, the meeting occurs due to the response to a referral and the expectations of both parties. Expectations for the person to be "in crisis" and the health professional to "resolve" the crisis by engaging in the joint work of

crisis resolution, are met through the technologies and practices of the Crisis Resolution Home Treatment Team and human occupations.

From an occupational science paradigm, both parties are participating in purposeful, meaningful actions, constructed together through their respective expectations. Additional cultural and social rituals are also playing a part in that Team members need to be invited into the person's home and will need to respect individual customs (such as taking off shoes on entering the home).

“Service users from the CRHT client group may already be suffering from low self-esteem, and having a team member stay and give them company helps them feel valued and improves personal engagement. Local survey respondents repeatedly emphasized how they value the time taken for the team member to sit and have a cup of tea, for example, and not convey a sense of haste to their visit.” (7.4.5)

Within this scenario is situated the dynamics of power relations that illustrate Foucault's assertion of the shifting, productive nature of power. However, for the service user this balance of power and their options for utilising it may seem at best transient and at worst none existent. Rather than inviting the Team member/s into their home, the view of the Crisis Team as possessing the power of decision based on unknown criteria (Lloyd et al 2004) may feel more akin to an invasion, as inferences in the example above highlight that this is the person's home, where individual cultural and social customs are to be respected.

A link can also be made to concepts of human occupation – the professional identity and all that status infers is expanded through the paradigm of human occupation. The status, satisfaction,

routines and roles attributed to the health professional is challenged through the introduction of a potentially competing and conflicting function and identity as gatekeeper.

10.2 Crisis as Discursive Construct

From the basis of this study, the concept of discursive practices constructing knowledge and accepted reality about a given object; mental health crisis, is evident within the context of crisis team literature. The rhetoric of political, managerial discourse promotes the regime of truth that the least restrictive place of treatment will be the home, thereby inferring that this is beneficial to the individual. Is this because remaining at home with all that entails in terms of occupational roles, routine and environmental opportunities is also being recognised as inherently beneficial to the individual?

In identifying Crisis Resolution Home Treatment Teams as an alternative to hospital, the same reference is made to “the least restrictive environment” and to teams assisting with practical needs such as transport to appointments and shopping, in all the documents. Some acknowledgement is given to the fact that an individual will most likely be treated at home, where daily activities and social networks are accessible. These short references can be identified as constituting some basic concepts of human occupation, as situated in the personal environment of an individual, where occupational endeavours provide a sense of control, mastery, identity and potentially a sense of wellbeing.

The most explicit references to human occupation objects come in the form of short quotes from service users in document 7.4.5; being able to maintain roles and routine within the family; continuing with important daily activities and avoiding the stigma and disruption of hospital admission.

“Those who find the home a less stressful environment and associate the home with safety, comfort and well-being prefer being treated at home and appreciate that the CRHT service allows them to do this. A large number of local survey respondents reported the benefits of not ‘being away from the reality of my life’ and not ‘having to enter the alien atmosphere of hospital’. (7.4.5)

In the main body of the texts in these documents, concepts of human occupation do not obviously form part of the knowledge base or truth about how Crisis Resolution Home Treatment Teams are developed or operate. Yet the focus of individuals utilising the service is on their identity as an occupational being and their social and built environment. A relationship may be seen with theoretical concepts within occupational science and the discourse of service users.

Within the literature of research and evaluation (7.3/1/2/3/4/5/6), there is very little reference to concepts of human occupation, per se. However, the discourse of occupational therapy and occupational science may be described as elitist and representative of power/knowledge structures in the development and maintenance of a professional identity and scientific discipline. The dominant discourses in policy and research documents related to Crisis Resolution Teams are medical, economic and organisational. The documents in section 7.3 are predominantly by and for the medical and nursing professions, however, this would not usually imply that no consideration is given to social functioning, relationships (roles) and activity levels. Again, the exception to this was the report 7.3.6, where the focus was on identifying the social factors influencing Crisis Resolution Team outcomes. In addition, paper 7.3.5 also employed a different perspective to Crisis Team work. As a consequence, the search for alternatives to a medical response allowed for the identification of the possibility of a wider construction of mental health and crisis.

However, this was in the form of acknowledgement that very few interventions described, dealt with daily activities, routine and social interaction, despite the study including the views and experiences of an occupational therapist in a Crisis Resolution Home Treatment Team.

The construction of definitions of a crisis and of crisis resolution within the organisational/clinical/academic discourse rely on the medical and bio-psychosocial terminology of acute mental illness, rapid deterioration, increased symptoms, medication, coping strategies and social support networks. However an alternative discourse is evident in the service user category, displaying elements of the construction of crisis from a different perspective and incorporating the domains of human occupation. The organisational discursive practices contrast sharply with descriptions quoted from service users, where a crisis was defined by the inability to engage in usual daily activities, neglect of personal care, “not able to go out” and more emotive use of language such as “being desperate”, “reaching breaking point” and being “completely alone”.

Service users quoted in these studies are more likely to construct an idea of crisis by incorporating their own experiences in terms of the emotional impact on their ability to continue or maintain occupational performance in their daily lives. Equally, crisis resolution is described through the reinstating of previously valued activities, routines and an ability to perform occupational tasks to a satisfactory level, sometimes equated to a decrease in negative symptoms or emotions.

“...healthy eating and exercise” 7.4.2 p17

How a resolution to the crisis was achieved is also described through the use of ideas of human occupation – by engaging in

calming or focused activities, being supported to manage household finances and looking to future options of employment or education

“.....a range of practical help such as assistance with housing...enrolment on college courses”

“The study showed that most respondents preferred home treatment to an admission as they felt more in control in their own homes.....attention of visiting staff more beneficial than being on an acute ward where they had very little to do all day” 7.4.2 p17

The discursive practices within the service user's quotes, incorporate concepts of human occupation as a way of constructing ideas and theories of their own experiences of mental health crisis and crisis resolution. The notion of home as a foundation for control – of self and others? – indicating the importance of environment on a perception of one's ability to engage with social and personal demands. Technologies of the self, the conduct of the self may find its point of origin in the home

A crisis is described in terms of disengaging from daily activities, disruption to routine and degeneration of skills. The discursive practices identified in the service user category of this analysis uncovered an alternative way of perceiving a mental health crisis. The subject of crisis was described, and therefore experienced, as an emotional response, often to a social trigger. The impact on routine and function in daily activities were elements of the consequence of a crisis. This is in contrast to the medical and professional discursive practices used to define the term crisis, also identified by Winness et al (2010). However, the consequence of providing an alternative to admission results in an individual being engaged by, and with the demands of their personal, social

and built environments – these are elements also described within the concepts of human occupation (Wilcock 2006, Kielhofner 1995)

As such, this has the potential to expose the differing agenda's and aims of the operation of crisis teams from the people using the service. It also has implications for the interventions offered – i.e the medical treatment of pathology, neglecting the practical, social, emotional and occupational needs that may be contributing to a crisis or could promote recovery from a crisis.

10.3 Knowledge Construction in Policy Implementation

Governments over the past decades have incorporated increasingly neo-liberal, market driven ideas to inform policy (Bevir 2011, Turner 1995). The resulting shift of many public sector services to private sector business has been generally overt and public. In the case of the National Health Service, this is less so (Rogers & Pilgrim 2010).

Overt references to concepts of human occupation are in the form of the inclusion of occupational therapists as a profession to be included in the multi-disciplinary make up of a crisis team, (7.1.1, 7.2.1, 7.3.1). Other than this listing in the desired skill mix, there is very little that might be initially construed as the construction of human occupation concepts. However, a crisis is defined in terms of a relapse in mental illness and/or an inability to cope – although no specific examples of how this may manifest itself, there is an inference that the inability to cope with symptoms, stress, emotions will impact on functioning in daily living requirements.

The inclusion in the policies and audit (7.1.1, 7.2.1) of occupational therapists as potential crisis team worker is interesting, given that no further reference or rationale as to how this profession is specifically relevant to crisis work. Psychiatrists, nurses, social workers and support workers have some additional discursive

references which imply acknowledgement of a specific responsibility and/or role within this type of service; - medication, mental state assessment, practical support/life experiences, social circumstances, carers support. In view of the fact that users of the Crisis Resolution Home Treatment service remain at home during an acute episode of mental illness/crisis, then how individuals are supported with coping and engaging with their daily living/occupational responsibilities appears to be a fundamental question and one which occupational therapists would traditionally identify as a core concern for the profession.

Service user discourse describes experience of a crisis through the use of emotional language and the impact on occupational activity. Some organisational discursive practices contain inferences to occupational ideas, although these are utilised to describe social and economic outcomes of the implementation of crisis teams, as noted in the policy and audit/evaluation sections of the initial analysis.

Occupational therapists are identified as one of the professions that should make up the workforce of a crisis resolution home treatment team. The statistical evidence that occupational therapists are not included in the workforce of the majority of crisis teams suggests organisational processes are at odds with the DoH guidelines. However, service user discourse suggests knowledge of the experience of a mental health crisis is partly defined through the paradigm of occupation.

The relationship between service user discourse and that of human occupation is potentially the most relevant to all of the themes as it employs the lay language of occupational concepts more visibly. This has the potential to provide the framework for generating knowledge about the experience of the onset, presentation and resolution of the object as mental health crisis. By revealing the

common components of service user discourse and human occupation, one discourse recruits another to increase the potential credibility of the knowledge base, influence research priorities and shape policy.

As a discourse in itself, the knowledge generated and circulated through the literature of Crisis Resolution Home Treatment has created subjectivities that become the target for technologies of governmentality. The person in crisis and the Crisis Team member as gate-keeper are organised within the dominant discursive formations of economic imperatives and management of resources in NHS mental health service provision. The concept of occupations as technologies for organising and governing populations and the self may be seen as embedded in the policy mechanisms of the state to govern at a distance, by promoting individual responsibility in managing at home through collaborative creation of occupational devices to resolve/manage the crisis.

10.4 Tensions and Resistances: Occupational Discourse

The discourse surrounding Crisis Resolution Teams has been revealed as utilising knowledge from earlier areas of study and discourse to construct ideas about a service and the concept of mental health crisis that include taken for granted “regimes of truth”. These include the idea of alternative to hospital that has been actually identified as a practice to prevent admission and save money. The historical idea of reducing state run mental health institutions can be related to the notion of governmentality in promoting the self-management of health, self regulation and individualism (Bevir 2011, Turner 2005).

The identified aim of occupational therapy in much of the discipline’s literature refers to maintaining, increasing and/or promoting individual independence (Hagedorn 1995, Kielhofner 2002). The mechanistic phase of the 1970’s and 80’s identified in

the profession's development is credited/criticised for placing functional independence at the forefront of the role and remit of occupational therapy (Hammell 2009a, Iwama 2011). Parallels with the concept of governmentality can be drawn with this stated philosophy and may go some way to illuminating the rationale for occupational therapy to be included in government policies on health care reform (DoH 1999, 2000, 2001, 2011). However, this focus on independence can be resisted and has been shown to hold less importance from a socio-cultural viewpoint, setting up a dichotomy between the stated aims of promoting independence through occupational therapy and the concerns for culturally and socially meaningful occupations, including occupational identity through roles, routines and social expectations which may value interdependence or induce dependence (Hammell 2009b, Molineux 2007, Iwama 2011).

In addition, more recently the profession of occupational therapy, taking a lead from occupational science literature, has begun to put occupation, the nature of occupation and its meanings to individuals, society and populations at the centre of its practice (Molineux 2007, Wilcock 2002). This can shift the focus from the increasing functional performance and independence, to an emphasis on participation, which may actually mean the need for support and development of support networks to facilitate engagement in chosen/preferred occupational activities (Chugg & Craik 2002, Mee et al 2004). As the profession develops its own core conceptual knowledge base, service development in mental health are moving at great pace.

10.5 The Relationships and Effects of Discourses

The relationship between discourses was a concern explored in Michel Foucault's work, particularly with regard to a power/knowledge mechanism. The discourse of occupational therapy and occupational science overlap, both in the use of a

shared terminology and in their stated focus on the centrality of human occupation as inherent in the organisation of human actions and participation in day to day roles, routines and engagement with social, cultural and built environments. The primacy of occupation as the expression of the lived experience of individuals, community and societies is explicit within both disciplines. Occupational science discourse also becomes a point of tension in its critical reflection on occupational therapy practice, often citing practice as too narrow, western-centric and culturally biased (Hammell & Iwama 2012).

However, the discourse of occupational science has developed additional vocabulary and concepts to describe a wider application of the occupational perspective to political, social and global issues. The discourse of occupational science that has also been explored in this study to begin to challenge the dominance of discourses identified in documents relating the implementation of Crisis Resolution Home Treatment Teams. Concepts of occupational justice and occupational disruption provide a critical lens with which to view the policy and research related to Crisis Teams and to the notion of mental health crisis.

The interpretations outlined in this thesis have identified dominant discourses in the literature related to Crisis Resolution Teams. Economic, managerial/organisational and medical discourses are foremost in the policy and research documents. The influence of economic discourse can be seen most prominently in its effect on early research studies that focused on the financial savings of Crisis Teams as a measure of efficacy as apposed to health, social or occupational outcomes for individuals. The dominance of economic and managerial discourses also outweighed biomedical discursive practices as exploration of clinical outcomes is not visible in research on the introduction of Crisis Teams across England. Information technology also plays a part in the focus of

research into Crisis Teams, in that organisational and financial statistics are relatively more easily obtained and collated than almost any other data.

It is possible that there may be longer term effects of the dominance of managerial/organisational and economic discourses in the arena of acute care provision for mental health. The funding made available to the NHS with the accompanying target for NHS Trusts to implement Crisis Teams by 2003 has resulted in the introduction of over 300 teams. However, as financial pressures on public sector organisations continue to increase, the potential detrimental effect on other services within the organisation and on hospital wards particularly has already begun to be seen (Rogers & Pilgrim 2010). In turn, the dominance of managerial and economic discourses is the result of an overarching political discourse of neo-liberal ideas (Bevir 2011) (see figure 1).

The dominance of managerial and economic discourses, with the addition of a medical discourse in particular can also be viewed as providing the objects of resistance in subsequent responses in the literature concerning Crisis Teams, most notably in the contested use and meaning of the term crisis. Service user and professional discourses utilise a wider range of concepts to describe and make judgements about what and how crisis manifests and is experienced (Morton 2009, Brennan 2007, Kingsford & Webber 2010). As discussed in chapter 8, with regard to the policy and audit focus on Crisis Teams, crisis is used as way of naming criteria for access to services and/or admission to hospital, functioning as a tool for rationing service responses. Here the biomedical discursive practices of categorizing through diagnosis are to the fore and have been recruited by economic discursive practices to gate keep resources. Analysis of the documents in this study identifies resistances in the form of professional decisions

made on the basis of distress and risk, rather than criteria outlined in Department of Health policy (see figure 1).

10.5.1 Discourse: Occupational Theory

Theories of human occupation purport to foreground the centrality of occupation in the lives of individuals, communities and society. However, it is the very central nature of this concept that brings tension, struggle and disparity to the practice of occupational therapy. From a medical perspective, the treatment and alleviation of biological symptoms, would improve a patient's ability to engage with the demands of daily life, therefore a separate theoretical perspective may not always be viewed as necessary.

Occupational therapists continue to be employed predominantly in statutory services in the UK. Within the NHS, this entails a requirement to practice within the structures dominated historically by a biomedical approach to illness. In mental health services, the structures for practice are defined by Government policy, management and psychiatry. As service provision looks to reducing the reliance on NHS and length of treatment time, this is illustrated in reduction in hospital beds and shorter stays (Rogers & Pilgrim 2010). The discursive practices of occupational theories consider the meaning and availability of occupational forms within socio-cultural settings as well as individual and environmental demands and obstacles to participation. Foucault's view of the power of a dominant biomedical discourse privileges the potentially reductionist medical treatment and solution which may sit more comfortably with the current demands for time bound interventions in acute care. Psychotropic medications can have a myriad of side effects which actually impact on an ability to engage satisfactorily with valued occupations.

In the clinical arena occupational therapy practice is influenced by medical discourse and managerial practices (Fortune 2000). For

example, the OT process described by Creek (2010) continues to follow the medical model process of referral/presentation, assessment, treatment, evaluation and discharge. Occupational therapy theory and education are informed by theories and research from a range of sciences (such as biology, psychology, sociology) and as such has many points of overlapping discursive formations and constructs. As a distinct science, occupational science is not universally accepted, even within the field of occupational therapy (Whiteford & Townsend 2011). However, occupational science has developed a wider theoretical knowledge base concerned with concepts of human occupation from a cultural and global perspective in an attempt to extend the practical application of occupational therapy from an allied health profession to social entrepreneurship (Kronenberg et al 2011).

The explicit political dimensions of occupational science acknowledge the influence of neo-liberal discourses in western societies on not only occupational therapy practice, but perhaps more importantly, on the choices of acceptable occupational forms and opportunities for occupational participation. This thesis has sought to explore and illuminate the relationship between the political neo-liberal discourse of policy and the formation of service provision (Crisis Teams) with concepts of human occupation through the notion of governmentality and the possibility of an occupation-based definition of crisis in the field of mental health.

The discourses of human occupation theory overlap with neo-liberal discourses of individual responsibility and self management in the form of occupational roles, routines and structures in daily life that provide order, moral and ethical behaviours. Tensions arise at the points where equitable access to meaningful occupation, balanced occupational demands and conditions to promote well-being through occupational participation are

overlooked or minimised as a result of policy, socio-cultural inequalities or economic pressures.

The findings drawn from interpretations of the discourses identified in this study identify the privileged status afforded to an economic construct of Crisis Teams, promoting this version as evidence of efficacy. The narrow definitions of crisis (in the context of Crisis Teams), also draw attention to the dominant discursive practices of managerialism and bio-medical approaches to mental health service provision, resulting in criteria for access to services that is resisted and contested by service users and professionals through their own discursive constructs of the meaning of crisis (Freeman et al 2012). Without the points of tension and resistance however, a critical reflexive exploration of the introduction of Crisis Teams would be less fruitful and it is these productive possibilities of resistance to the power relations inherent in dominant discourses that a Foucauldian inspired discourse analysis brings to light.

Figure 1 illustrates the discourses identified in this study and maps the effects, points of resistance and tensions and relationships as proposed by interpretations of the discourse analysis of documents related to Crisis Resolution Home Treatment Teams. In addition, the relationship between theories of occupation, occupational therapy and dominant discourses suggests the tensions evident in discursive practices and the limited presence of occupational therapy discourse in the implementation and practices of Crisis Resolution Home Treatment Teams.

Although reports are made of greater service user satisfaction with Crisis services than previous options, there is also evidence in service user discourse of resistance to the criteria driven gate keeping function of Crisis Teams and narrow definitions of crisis. Occupational therapists are also influenced by discursive constructions of narrow criteria driven service function as

economic, managerial and bio-medical practices constrain occupational therapy practice possibilities (Whiteford & Townsend 2011). The vast majority of Crisis Teams do not employ an occupational therapist and this thesis contends that this is in large part due to the effects of dominant discourses. The professional discourse of occupational therapy itself has also contributed to the limitations of occupational practice.

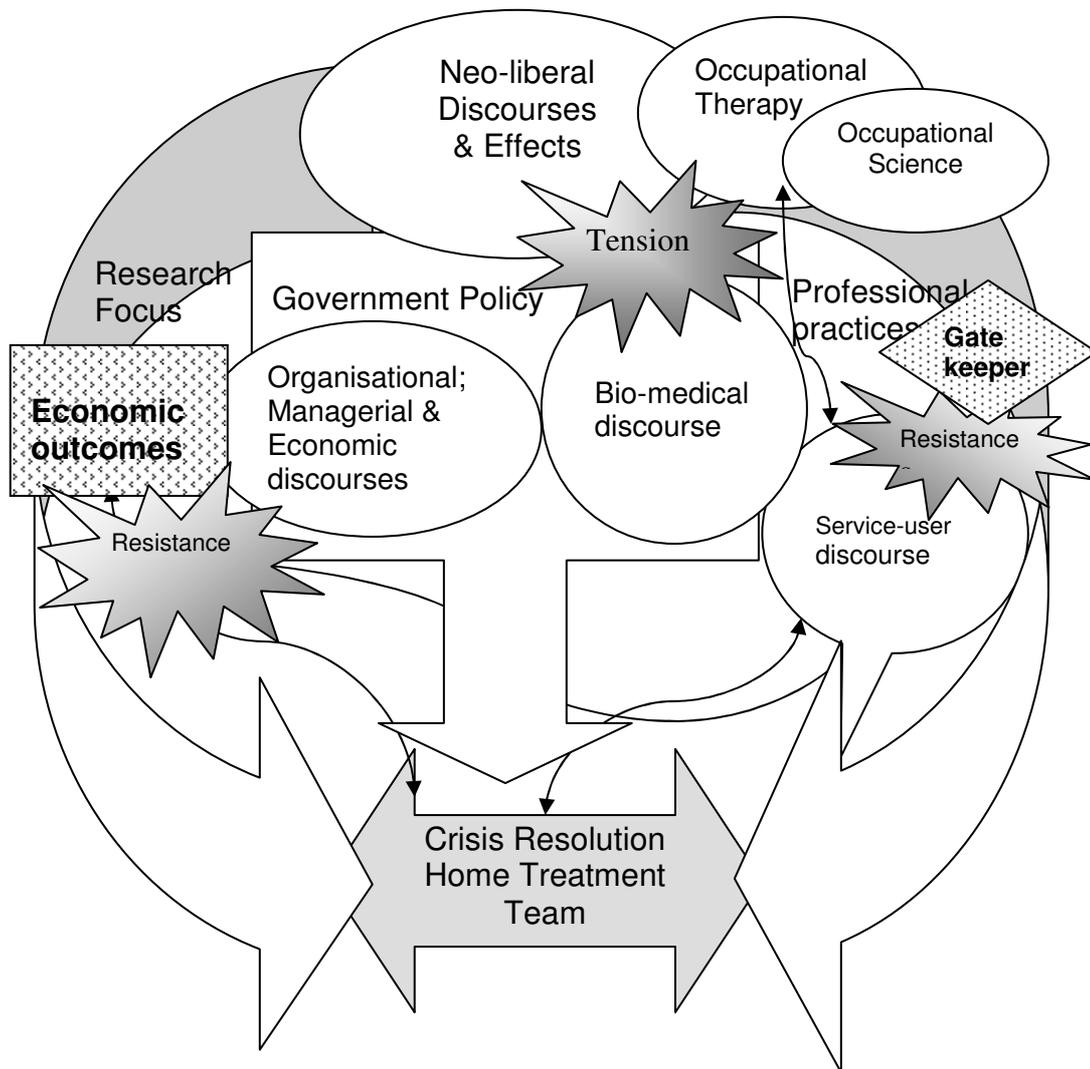


Figure1: The relationships and effects of discourses

10.6 Summary

The implication of the dominant economic, managerial discourses may distract focus from clinical standards, user-led priorities and the practical issues, including risk management, of transferring treatment from in-patient establishments to the home environment. The rhetoric of political policy is at odds with a service that is designed to provide an alternative to hospital admission to people at a time when issues of risks to self or others, risks of neglect and vulnerability will be at the forefront of clinical decision-making. The tension and resistances for occupational therapists may be an explanation for the limited number of occupational therapists working in Crisis Teams and also reflect factors that indicate managers are not considering occupational therapists as necessary to the functioning of a Crisis Resolution Team.

The next chapter develops further the proposition that occupational factors and concepts inform discursive formations in policy and discursive practices of Crisis Resolution Teams. An example from the limited literature on occupational therapy as a discipline contributing to Crisis Resolution services is given, illuminating the influence of how knowledge constructed through policy and research has been assimilated and circulated. Following on from this, an additional perspective on crisis and human occupation is drawn from the discursive space created through the findings from the preceding discourse analysis.

Chapter 11 – Occupation in Crisis

The issues of rhetorical discourse and the professional identity tensions already described in these emerging themes also contribute to an illustration of the contribution of occupational concepts to the discourse of Crisis Resolution and surrounding issues explored up to this point. Inferences and allusions to concepts of human occupation can be drawn from analysis of the selected documents in the discourse framework described earlier. One report on the role of occupational therapy in a crisis resolution team identified in the initial literature review phase of this research will be described next to give one example of the discipline of occupational therapy within a Crisis Resolution service.

11.1 Role of occupational therapy in a Crisis Resolution Team

One article by Rigby et al (2007) specifically focuses on the role of occupational therapy for service users accessing a crisis team. However, the paper is primarily a description of a procedural/organisational aspect of the role of this profession as an adjunct to the crisis team; an integrated referral pathway.

“ICP (intergrated care pathway) can optimise the “flow” of clients through a service”

“to ensure that service users are aware of the process of their care”

Discursive formations reflect the language and focus of the wider contextual documents in which crisis teams as a service were introduced. This could suggest that as a profession, occupational therapists in crisis teams (and the wider NHS context) are influenced by or adapt to the dominant discursive practices. This may be a conscious strategy for specific intentions. However, given the limited inclusion of discursive formations in the crisis team discourses of explicit concepts of human occupation, it could also

be an illustration of the power of the dominant “medical” knowledge and political economic focus.

Within the Foucauldian perspective, the dominant organisational discourse can be viewed as producing practices. The procedural aspect becomes the taken-for-granted truth effect and influences the discourse and actions of a specific profession.

However this document does provide a table depicting the interventions offered by the occupational team and frequency of use. These are listed as follows, although no further description is given to provide explanation of what each intervention entails:

“Coping Strategy enhancement - 4
Graded exposure approaches - 11
Goal setting/behavioural therapy - 37
Activity remediation strategies/planning - 23
Introduction to community facilities/rehabilitation - 23
Social skills training - 5
Environmental adaptation - 0
Re-motivation process (model of human occupation) – 2
Relaxation training - 1” (p531)

The evidence cited in the report for these interventions was primarily based on cognitive behavioural therapy strategies and research from outside of the occupational therapy domain. This report is published in an occupational therapy professional journal, therefore the limited explanation or descriptions of the interventions cited may stem from an assumption that the reader, being an occupational therapist, will know and understand.

The document gives reference to the remit of the crisis team – as an alternative to admission and to reduce in-patient admission. An account of the referral system is given, with 45 people (37%) from

the crisis team caseload being referred to the occupational therapy service over a 12 month period. The occupational therapy service appears to be an adjunct to the main crisis team, operating within an existing day hospital and expanding the service role on the formation of a crisis team.

11.2 Reflections on an Occupational Therapist in a Crisis Resolution Home Treatment Team

The College of Occupational Therapists (COT) following consultation with the Sainsbury Centre for Mental Health, published a 10 year strategy for occupational therapy in mental health (COT 2006). One of the issues included in this document refers to working practices and workforce development, including 7 day shift patterns. The inclusion of occupational therapists in Crisis Resolution Home Treatment teams is a new area of practice for this profession and could provide the opportunities outlined in the strategy for valuing occupation and promoting an understanding of the relationship between occupation, occupational identity and mental health (COT 2006).

As a member of the Crisis Resolution Team, I screen referrals to the team and complete Acute Initial Assessments of mental state and risk with people experiencing acute mental health problems. Along with the rest of the team, I work shift patterns to cover a 7 day service and act as shift leader and co-ordinator on a rota basis as a senior team member.

My duties include assessing level of immediate or imminent risk and mental health needs with responsibility for admitting to the Crisis Team or hospital as appropriate. The post requires a high proportion of generic mental health skills such as developing 72 hour care plans with individuals on behalf of the Team, monitoring medication compliance/side-effects, developing risk management/reduction strategies, and identifying positive risk

management plans in collaboration with clients, carers and the Crisis Team. As shift leader/co-ordinator, I allocate clinical work to colleagues, supervise junior team members and co-ordinate and prioritise workloads based on urgency of incoming referrals and/or emergencies. All contacts with clients have to be recorded on a computerised system to ensure team activity levels can be monitored and meet monthly/quarterly targets.

I endeavour to approach my work from an occupational therapy perspective and identify occupations that can either support or may impede individual recovery and incorporate occupational therapy strategies within the wider care plan. These strategies include using activities to distract or ground individuals experiencing intrusive thoughts; utilising an individuals usual routines and rituals to ameliorate distressing symptoms. Where appropriate I provide specific relevant Occupational Therapy assessments, particularly in relation to the impact of the work environment and roles on emotional and psychosocial well-being. I liaise with and refer to relevant agencies, professionals and employers to facilitate achieving client aims and recovery. I also consider part of my role includes advising colleagues on the occupational needs and aspects of care with individuals involved with the Crisis Team.

The role described above differs from the way the role of occupational therapy is integrated into a referral/care pathway as reported by Rigby et al (2007). This is probably a reflection of the various ways that crisis teams have been developed, an anomaly identified by Garcia (2006). Also evident is the difference in terminology/language used to describe the actual interventions or practice. The subject of professional terminology will now be discussed further. Occupational Science and the discipline of occupational therapy continue to struggle with the nature of language in trying to describe, label and explain the concepts

underpinning and driving the theme of occupation as a central human condition.

11.3 Professional Terminology in Occupational Therapy

The terminology utilised within academic text, professional practice and research in the sphere of occupational science and therapy has a myriad of subtle alternative and nuanced meanings in everyday use. These alternative and common parlance uses of technical terminology can create obstacles to the sharing of ideas and concepts and creating understanding, both between disciplines, within the profession and with wider societies. The different terms used in a variety of practice models, theoretical approaches and changes of focus over time potentially provide a larger obstacle to agreement and understanding within the profession of occupational therapy.

In an effort to resolve some of these difficulties, Creek (2010) sought to describe the core concepts of occupational therapy, utilising an agreed collection of universal terminology. Based upon the work of the ENOTHE (European Network of Occupational Therapy in Higher Education) Terminology project, a framework of concepts as applied to occupational therapy practice is illustrated. Other members of the network produced similar frameworks utilising the agreed terminology in each European language. The sphere of occupational science on the other hand, may have the vocabulary to describe wide ranging concepts that do attempt to describe human experiences from the view of occupation as human imperative. It is through this lens that the construct of crisis and crisis resolution in mental health may be described from an occupational standpoint.

If human occupation, from a western cultural perspective, is the framework by which humans seek to control, master and organise their global, local and inner environments (Wilcock 2006), then a

crisis may be conceptualised as an inability to control, master or organise said environments. As proposed in chapter 9, these concepts may be viewed from a Foucauldian perspective, through the lens of governmentality.

11.4 Occupational Concepts and Crisis

The discipline of occupational science continues to identify and develop concepts of the meaning and nature of occupation. To maintain the focus of this work, the concepts briefly described in chapter 9, of time use, occupation in context/place and occupational deprivation/disruption are expanded here. The rationale for this decision is the wider, more globally applicable nature of these concepts in relation to individuals; all occupational activity is performed within a time frame and is situated in place. The nature of crisis has been suggested as causing disruption and an inability to manage experiences outside of usual coping strategies (Caplan 1964). Policy documents identify admission to hospital as a potential cause of occupational disruption; restricting or preventing meaningful occupational routines; causes of stigma and social exclusion (DoH 2001).

The concepts related to specific occupations, activities, tasks and performance describe the meaning, choice and engagement with the activity as although socially and culturally situated, they are unique to the individual and incorporate a wide range of differences, adaptations and ways of doing. Therefore these will not be the focus of this discussion, but may be drawn upon as a tool to illustrate the practical application of the ideas developed.

11.4.1 Crisis Resolution as Human Occupation

Discursive formations and subsequent themes identified in chapters 7 and 8 are explored with the view to illustrate how concepts of human occupation may be interpreted within the

discourse as embedded and taken for granted human technologies and techniques.

From the Policy category of the discourse analysis, the concept of occupational disruption can be brought to the fore. Using the examples from the analysis, an alternative construct of crisis and crisis resolution is developed.

“People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care.” (7.1; p11)

Caplan (1964) devised four stages to describe his theory on crisis intervention, the second and fourth stages relating to increasing disorganisation and then major disorganisation. By this definition, then a crisis may be viewed as disruptive and so it does not automatically follow that treatment at home will be the least disruptive option. What can be inferred from this passage is that treatment at home will facilitate a continuation of daily contact with those aspects of life that are linked to the home and local community environment (Hamilton 2011) – family, possessions, friends, the familiar objects of home and environment; these are all things which contribute to, support and drive the notions of occupational roles, routines through the necessary and committed tasks and activities related to family, personal care, social demands (Wilcock 2006).

A lack of access to the resources, cultural, social and environmental aspects that promote the development of roles, routines and activities that constitute the construct of occupation are also cited as contributing to aetiology of mental and physical ill health, through the concept of occupational deprivation (Wilcock

2006). By avoiding admission to hospital through the use of crisis teams, government policy implies that the stigma of mental illness can be ameliorated and the impact of social exclusion limited. In reality, far more factors are at play and need to be addressed for the stigma of mental illness to be eradicated (Social Exclusion Unit 2004).

Professional and academic discourse provides further alternative constructions of crisis from a human occupation perspective;

“Coping difficulties are viewed most frequently as contributing to a crisis (by staff)...Chronic social problems and life events also feature...there seemed to be range of difficulties which pushed people to the point of crisis” (7.3.5; p153).

The report cited here did not specify what “coping difficulties” actually means – this is possibly one of the most important concepts of the construction of the notion of crisis and specifically mental health crisis, as the inability to cope is cited in several definitions (Caplan 1964, Ball et al 2005, Sainsbury Centre for Mental Health 2001). Inability to cope with emotions, symptoms may be inferred but as illustrated within the service user literature (7.4), the result of a crisis is also an inability to cope with daily activities, with environmental and social demands.

“In a black hole... desperate and completely alone... unable to cope with daily living....sleeping problems” (7.4.1; p428)

“feeling out of control...powerless....” (7.4.3; p16)

“a range of practical help such as assistance with housing...enrolment on college courses” (7.4.3; p18)

There are also implications that being distanced from the home and social environment, with its associated roles and routines is identified as negative, leaving people with a lack of purpose and feeling bored;

“The study showed that most respondents preferred home treatment to an admission as they felt more in control in their own homes.....attention of visiting staff more beneficial than being on an acute ward where they had very little to do all day” (7.4.2; p17)

As illustrated through the analysis contained in this thesis, the term crisis within the context of mental health literature has become a legitimate way of describing an episode of mental illness and/or emotional distress requiring intervention by mental health services.

From a human occupation perspective, a crisis is characterised as **disorganised**, the individual becomes **disengaged** from usual activities and routines and ability to perform/function within usual parameters is **disrupted**, possibly to the point of loss of occupational identity due to inability to perform tasks related to life roles.

Crisis resolution teams exist because the assumption is communicated via policy and research documents that people experiencing identifiable mental health problems (including risk to self) and require hospital admission for treatment may be better served by receiving treatment at home. The mental health episode becomes visible, an identifiable problem when the person is deemed unable to manage their daily life needs to a socially acceptable level and/or they are unable to maintain their own or others safety. The individual or family/friends may have identified these problems, or health/social care professionals or possibly police.

The assertion that occupation is an innate human drive (Wilcock 2006) infers that everyone will have their own experience of meaningful and purposeful engagement in structured activity. The implication here is that all those involved in delivering health care can have their own experiences of the positive and possibly negative impact of daily living activities on health. The nature of human occupation being so inherent may have the consequence that the inclusion of an additional, specialist professional to attend to these issues is not considered – it is in the tacit knowledge of all humans. Therefore nurses, psychiatrists, social workers and individuals accessing a Crisis Resolution service will be able to describe the consequences of the crisis in terms of impact on occupational participation, however it is unlikely any will name it in those terms. In this way, occupation can be seen as a taken for taken element of daily life, a way of governing the self and others and as a way of striving to live an ethical, moral and good life mediated through the concept of governmentality and enacted via technologies of the self and the authority of social agencies (Gordon 1991, Rose 1999)

11.5 Summary

The representation of occupational therapists within Crisis Resolution services is made visible in the two descriptions at the beginning of this chapter. The variations in role and remit are illustrated in these two accounts and serve to give context to the development of additional perspectives of crisis and human occupation. Concepts of human occupation are brought to the fore as elements of the experience of mental health crisis and of the practice of crisis resolution.

The final chapter will draw together the components of this thesis and summarise the propositions developed in formulating a novel perspective of mental crisis and human occupation.

Chapter 12 – Concluding Discussions

From the earlier exploration of the notion of occupational therapy and occupational science, a picture of the development of a profession and related theoretical perspective has built, which presents a field of study and discipline founded on core assumptions and taken for granted truths (Mocellin 1995, Hammell 2009a, Molineux 2009). Through the process of analysis of the discourse surrounding Crisis Resolution Teams, it has become apparent that both crisis resolution discourse, as related to the service development in England, and the disciplines of occupational therapy and occupational science are constructed based on assumptions that have become taken for granted truths. In the case of crisis resolution, the assumptions come from theory and studies that have not been fully explored in the context of mental health service provision and the assumption that a separate service operating in the community will provide a comprehensive, feasible clinical alternative to hospital. To date the majority of evidence for this service is based on economic benefits rather than clinical outcomes or patient feedback (Morton 2009, 2010 Garcia 2006, Allen 2010).

12.1 Taken for Granted Truths of Occupation

Debate within the sphere of occupational science/therapy highlights the lack of critical reflexivity in the continued use of theory and a philosophical stand point that does not reflect the experiences of the wider, global population and are based on western, middle class assumptions of preferable lifestyle choices (Hammell 2009b, Mocellin 1995, Iwama 2011). As suggested earlier, the core assumptions of occupational science and occupational therapy rest on over arching themes of the positive, health related benefits of participating in occupations; that a range of occupations give a balanced lifestyle that promotes good physical and mental health; factors that limit the ability or

opportunity to engage in a range of occupations impact on physical and/or mental well-being; that for occupations to be beneficial in maintaining or restoring health, they must be purposeful and meaningful (Yerxa et al 1989, Keilhofner 2002, Wilcock 2006). The determinants of what constitutes purposeful and meaningful are political, and socio-culturally driven and likely to be measured by the extent to which occupational participation is productive. However, individuals may engage in activity that may not be perceived as productive, purposeful or meaningful in the wider application to society, but may have personal meaning and/or derive from the purpose of gaining relief from specific situations, feelings or thoughts, for example self harming behaviour and potentially the most powerful of meaningful and purposeful actions – suicide (Marsh 2010).

In these assumptions, what is not always articulated is a preference for socially and culturally acceptable occupations – that is the idea that some occupations may be deemed bad and others are good (Laliberte Rudman 2010). Yet this is precisely the case; smoking may be purposeful and meaningful to some individuals but it is unlikely to be included in the repertoire of suggested activities of an occupational therapist. Similarly, alcohol in some cultures is socially acceptable and may be an important part in the rituals and celebrations within society. With some exceptions (Helbig & McKay 2003, Twinley 2013), the literature and academic teaching of the occupational therapy profession rarely addresses the how and why of occupational activity that may be harmful to health. Rather, the discourse of occupational science and occupational therapy tends to an assumption that people will automatically adapt, alter and accept the professions views, reflecting the power/knowledge strategies proposed by Foucault.

12.2 Governmentality, Crisis and Occupational Theory

Foucault's work has been the subject of much debate, interpretation and critique (McNay 1994, Bevir 2011, Rabinow 1984). The study of Crisis Resolution as a phenomenon in mental health service provision recounted here has sought to explore and illuminate the discursive formations and resultant practices through the lens of a foucauldian analysis. The generation of knowledge and its adoption and application in the form of policy guidelines, audit and research have been mapped and alternative modes of knowledge from service users and occupational science shed light on the consequent situated power relations. The centrality of language in the formation of subjectivities has been demonstrated. Through the excavation of a body of knowledge as represented in the literature of Crisis Resolution services, discursive formations, practices and technologies have come to the fore, enabling a comparison with conceptual ideas of human occupation.

The notion of governmentality can be applied to the production of knowledge of mental health crisis as it has been invoked by policy, research literature and NHS structures in the form of a specific service. Understandings and therefore "truths" constructed in the form of the discourse of mental health crisis and the development of teams which have drawn upon the service user discourse to promote the alternative to hospital. Crisis Resolution Home Treatment has come to be understood by individuals and professionals as the preferred option for the treatment of mental illness and has expanded to include severe emotional distress. The individual in crisis, may also be viewed using concepts of human occupation; disruption to roles/daily routine, reduced activity levels, reduction in enjoyment or satisfaction with usual activities and their immediate social network must utilise their own occupational roles and routines to contain and manage the crisis at home.

12.2.1 The Role of Discourse

Taking a view from Foucault's concepts of governmentality, power/knowledge and technologies of the self, additional discursive formations and practices may be illuminated within the construction of the crisis resolution object. Governance of the self, in the form of self management of the mental health crisis is embedded within the policy reform of mental health service provision. By transferring the site of treatment to the home, the individual, family and wider social network are placed at the forefront of managing the consequences of a crisis. This has become a taken for granted truth, with little mention of what this might entail within the documents recording the introduction and implementation of crisis teams. Mental health service managers maintain the power, partly now through the knowledge generated about crisis teams, of structuring the responses to individuals presenting to services such as A&E, GP or coming into contact with the police once they are identified/categorized as suffering from a mental illness.

However, from a foucauldian perspective, the knowledge supporting this shift continues to be generated and implemented through the dominant discourse of psychiatry and more recently the increasing influence of managerial discursive practices, with targets and specified criteria the strategies for measuring and accessing services. Knowledge generated through research into crisis teams continues to be framed through managerial discourse, constructing the efficacy and remit of crisis teams within terms of fidelity to criteria and achievement of targets to reduce hospital admission.

The analysis described here has explored the generation and dissemination of knowledge in the form of the discursive construction of mental health crisis and crisis resolution home treatment teams. The move from the hospitalisation, or as defined

by Michel Foucault, the containment and segregation of the mentally ill, has gathered pace and now mental health issues are viewed as situated within society and to be treated within society. Neo-liberal discourses influence policies and have increased the focus from state provision to the individual. The development of pharmacological treatments, adoption of ideas from preventative psychiatry and the recovery movement has promoted the shift of responsibility from hospital-based treatment to the community and in the case of crisis teams, specifically to within the home.

Concepts of human occupation in the literature concerned with Crisis Resolution Home Treatment Teams, as described through the discourse of occupational therapy and occupational science are not immediately evident. The discursive formations developed over many years by these two disciplines have bracketed the concept of occupation, separating it from the every day language of wider social agencies. However, by drawing on the ideas set out by Michel Foucault and subsequent theorists inspired by his work, this thesis has set out to illustrate the inherent nature of human occupation. By excavating the dominant discourses, practices and technologies at play within the texts recounting the implementation of Crisis Resolution Home Treatment Teams, the analysis and application of governmentality theories, brings to the fore the presence of concepts of human occupation as implicit technologies in the government of conduct of the self and others.

12.3 Evaluating Rigour and Reflexivity

Guided by Ballinger (2006) and Crowe (2005), rigour is demonstrated by describing how the epistemological and ontological perspectives of the research methodology are embedded in the discourse analysis through reflexive strategies congruent with the post-structuralist, relativist paradigm informing the research question and aims.

The research has been conducted through a systematic, careful process of transparency, describing the strategies, decisions and practices used to meet the aims of the research and interpret the discourses identified in documents relevant to the area of research. Examples of verbatim text from documents, extracts from reflective journal and notes and feedback from other audiences are used to make the links between interpretations, findings and discussions. In the concluding discussions of Part One and Part Two, interpretations have been linked to existing knowledge or theories to promote plausible, convincing and relevant arguments within the areas of crisis resolution teams and occupational science and propose contributions, so addressing the potential utility of the knowledge generated by this research (Ballinger 2004).

12.3.1 Rigour through Reflexivity

Throughout this thesis, my role as researcher is acknowledged and my insider perspective, with its accompanying advantages and pitfalls, has been illustrated below through processes of reflexivity.

Reflexivity is a process that happens within the workings of qualitative research methods, but can only be called so and identified when the researcher acknowledges and engages with this process in a complex and intertwined set of tasks, so “developing” their reflexivity. Ballinger (2006) cites four considerations in focusing reflection for researchers. These are described in terms of coherence; systematic and careful research conduct; convincing/relevant interpretation and the role played by the researcher. They may also be seen to complement the framework and suggestions to ensure rigour set out by Nixon & Power (2007) and Crowe (2005) respectively (see chapter 5).

The epistemological and ontological basis of this research demands a reflexive stance with regard to the approach to the subject and data analysis. A social constructionist perspective

inherent within a Foucauldian discourse analysis recognises the centrality of the researcher/analyst in the construction of interpretations and how subsequent findings are represented. However, the very nature of this implicit construction of the research means that without foregrounding the thought processes and decision making that led to the discussions set down, the credibility and plausibility of the project can be lost (Ballinger 2006).

12.3.2 Demonstrating Rigour

Ballinger's (2004, 2006) suggestions are taken as a focus to evaluating the rigour of this research through reflective and reflexive methods; coherence, evidence of systematic research conduct, convincing and relevant interpretation, sensitivity to the role of the researcher.

- **Coherence**

The research aims and methodology are consistent with a post-structuralist and social-constructionist epistemology and ontology utilising a Foucauldian inspired approach. I am not claiming to uncover specific facts or truths, but to explore the taken for granted and look to construct additional interpretations.

- **Systematic, careful research conduct**

In practical terms, I went about the analysis by laying out hard copies of all of the chosen documents on the floor of my spare room (aka Study Room). Around the edge of the room I placed all other related articles, journals and books by subject/focus, with some overlapping.

Following a framework informed by Carabine (2001) and Bacchi (1999)(see ch.6; section 6.5), I read and re-read the main documents, highlighting and notating recurrent terms, themes and phrases, identifying relationships, contradictions and cross referencing to each other, identifying prominent discourses,

practices and effects guided by the questions posed using the approach by Bacchi (1999). I built up a folder for each document of the points of interest, context and authors, recurring terms and statements; then began to compare and contrast the contents, identifying discursive constructs as themes and referring back to the original documents.

Carabine's approach to foucauldian discourse analysis was utilised to select and organise the documents, to identify the themes, categories and objects of the discourses present (Carabine 2001). The term theme is utilised in this discourse analysis to describe discursive constructs and strategies to add to the context and mapping of the effects of discursive practices. The questions proposed by Bacchi (1999) provided a guide to the analysis and interrogation of the texts, with points of reference giving form to resultant interpretations and discussions. Combining the two approaches provided a framework by way of a foucauldian lens with which to analyse data in a dynamic process of interpretation, re-interpretation and ensures methodological consistency and rigor. The proposed findings and discussions mapped the effects of the discursive formations and practices and the inter-relationship between discourses identified by the themes, categories and objects emerging from the data analysis.

Guide to how this discourse analysis was informed by Carabine (2001);

- *Choose the topic: Scan documents for relevance;* the main focus of this thesis is the introduction of mental health crisis resolution home treatment in England as a result of government policy and how it relates to concepts of human occupation. This was part of the original literature review and also part of my own practice in developing awareness of the evidence base for the service I was employed within on a daily basis. The documents chosen were all

published within the last 10 years, reflecting the introduction of the service in response to Government targets and its evolution.

- *Positioning, know the data - identify the authors/source, the context and timing, audience/consumer of the document, what is the aim or purpose? identify any assumptions, is there an identifiable prominent discourse evident and the discursive strategies employed?* The articles are aimed at a population involved in different levels and aspects of mental health services; from NHS directors, managers, commissioners', to health workers, health researchers, academics and potentially users of the service. Policy and audit documents aim to guide implementation of Crisis Teams and measure efficacy against the policy model. An economic discourse was identified as prominent in policy, further reflected in the audit and research papers (Chapter 7 & 8).
- *Identify themes - categories and objects of discourse;* Crisis, gate-keeping, service implementation, and economic evidence as knowledge emerged as categories and objects of discourse (see Chapters 7 & 8). Through the deconstruction of texts, by noting repetition of terms, changes to terminology, the context, the presentation and solutions, then discursive practices were identified and may be challenged to provide an additional or alternative way of viewing the object and its proposed actions and truths. For instance, the initial policy concern was the need for an *alternative* to admission, subsequent discursive formations evolved, with Crisis Teams spoken of as gate-keepers to *prevent* admission. Chapter 8 illustrates how themes and objects of discourse were then interpreted and their effects described in terms of; power relations; discursive constructs of the term crisis; generation and circulation of knowledge through policy; tensions and resistance.

- *Continue analysis; identify any inter-relationships, societal or professional representations, other discourses present, omissions.* Although the object of the discourse may be Crisis Resolution, the vested interests of the author/organisation can be detected in the discursive formations and practices of other discourses (economic; managerial) or the absence of expected discourses, such as overt references to themes of recovery or concepts of human occupation (Chapter 7 & 8).
- *Identify effects of discourse in terms of power relations, knowledge construction, appropriation, circulation, dissemination; resistances, rhetoric versus reality?* The formation and construction of crisis as a concept in mental health services and site of resistance, power relations and generation/circulation of knowledge is identified, mapped and discussed throughout chapters 7 and 8 with further exploration and illustration of the effects of discourses with respect to human occupation in chapters 10 and 12.
- *Analysis of the documents feeds back into the process of analysis* – the documents are listed within separate categories as an illustration of the analytical process in chapter 7. Subsequent exploration of findings and emerging themes of discursive practices draws upon insights from the process of analysis, supported by the questions from Bacchi and are discussed in chapter 8 under headings to illustrate the discursive strategies and effects of the discourses identified in policy, audit, research and literature focused on Crisis Resolution Home Treatment Teams.
- *Propose inferences and conclusions yielded from analysis – societal and professional representations and implications;* As the process of repeated reading and analysis progressed, my interpretations were refined using questions from my own reflections and Bacchi (1999), with inferences and implications

discussed under headings in chapter 8. From the conclusions suggested, I then progressed the analysis further with a re-interpretation of sections from the perspective of human occupation theories

- *Re-read sections with references to human occupation; are there references to concepts of human occupation within the text (concepts described within occupational science literature/discourse); are there references to concepts of human occupation within the text (concepts described within occupational science literature/discourse). Identify context in relation to whole of document; identify nature of references in terms of actual or potential action and practice, environmental considerations, relationship to other concepts evident. Utilising my own alternative professional discourse – of human occupation principles – I provide an alternative reading of the literature and propose a human occupation perspective of crisis, relating discourses of human occupation to strategies of governmentality in chapters 9, 10 & 11.*

- *Context – does the analysis and potential conclusions relate to wider social, historical and political issues? The findings and conclusions proposed are linked and related to previous and current issues through discussions and with references to literature published since the analysis began (see chapters 8, 9 & 12)*

- *Limitations of analysis – some limitations are identified and included within the analysis chapters. Analysis is limited to texts published via statutory or academic media (see also section 12.8 for further discussion)*

Questions posed by Bacchi (1999) are reproduced below with explanation of how these informed the basis of the construction of

proposed inferences and conclusions from the interpretation of discursive strategies and effects;

“What is the problem represented to be, in either a specific policy debate or in a specific policy proposal? – mental illness is represented as a problem and particularly mental illness as crisis, with mental health service provision previously seen as inadequate and unable to meet demands, specifically in times of emergency and out side of traditional office hours. Discursive strategies construct crisis within mental illness and this is taken forward through policy and research (see sections 7.1, 8.1 & 8.3)

What presuppositions or assumptions underlie this representation? That mental health is primarily a medical issue; institutional structures and organisation constitute service provision; hospital admission is disruptive and treatment at home is the only option/alternative; hospital admission is expensive. In this way, the policy problem generates and circulates types of knowledge which are taken for granted truths (see 7.1, 7.2, 7.3 & 8.1)

What effects are produced by this representation? Crisis is constructed as an element of mental illness. Service provision is a limited resource and therefore economic strategies are needed to resolve the problem; Complex social and emotional problems become simplified and paradoxically the term crisis becomes part of a medical discourse, potentially increasing demand for the service. The effects of discursive representations produce actions and practices - Research and audit becomes focused on the economic value of crisis teams. (see 7.2, 7.3, 7.4, 8.1, 8.3 & 8.2)

How are subjects constituted within it? Individuals become both consumer (service user) and subject of medical discourse; crisis team workers are constituted as gatekeepers of resources. (see 7.2, 7.3, 8.1, 8.2 & 8.4)

What is likely to change? Shift in power relations from institution as provider, to health professional as point of access to service; individual, family and social network take increased responsibility for managing acute distress/risk. (8.3 & 8.4)

What is likely to remain the same? How the form and availability of the service is provided remains the decision of institution and policy. Economic and managerial knowledge is privileged (see 7.1, 7.3, 8.1 & 8.6)

Who is likely to benefit from this representation? Institutions save money/meet policy objectives. (see 8.1, 8.2 & 8.3)

What is left unproblematic in this representation? The underlying social factors contributing to mental illness, and in particular those that can bring an individual to the point of emotional crisis are silenced – evidenced by the criteria cited in policy for exclusion to access to the service; implications for family/carers and social network in terms of increased responsibility for risks; professional identities and competing professional discourses come to the fore from responses to the policy and subsequent research. (see 7.3, 7.4, 8.4 & 8.6)

How would “responses” differ if the “problem” were thought about or represented differently? If the problem were represented from the perspective of emotional and occupational impact on the individual and family/social network from mental distress, research for crisis teams would prioritise how the service meets the needs of individuals and carers. A shift in the focus of early research and audit would then have the potential for improving the quality and sustainability of service provision and identify whether this configuration is the optimum response both in terms of individual

outcomes and resource allocation. (see 8.2, 8.4, 8.6, chapters 9 & 10).

The above review of the data analysis and subsequent construction of findings and discussions does not represent stages in a step by step process. Some of the processes occurred simultaneously, whilst at other times, additional information is added at a later stage (Carabine 2001). Examples of this appear below and further in the account of reflexive strategies, demonstrating how the process of analysis can not be separated completely from the experiences and actions of the researcher.

- **Convincing/relevant interpretations**

As emerging themes were identified from discursive strategies and constructions, I made links with the wider literature or went in search of further information or theories related to my findings, discussed developments with supervisors and spent many hours reading, reflecting and writing down or discarding threads, as suggested by Carabine (2001). During this process, some ideas were discarded or explored then re-traced, as I endeavoured to keep within the aims, objectives and philosophical parameters of the project. Regularly re-visiting the aims and objectives by copying and pasting at the beginning of sections during the write-up of the thesis (then deleting) became a useful strategy to ensure findings were plausible and knowledge generated could contribute to the fields of study.

- **Sensitivity to role of the researcher**

As discussed in chapter 2, reflexivity has its own literature and research base and as a concept is subject to the same arguments and analysis as any research methodology (Guba 1990, Finlay 2003, Jasper 2005, Ballinger 2006). The research project undertaken and represented in this thesis includes sections referencing the social, personal and political influences on decisions taken and

potential consequences to the finished study. In this section, I describe in more detail the actual strategies and practices recruited and how they contributed to the development of the analysis, discussions and findings.

12.4 Making the Reflexive Process Explicit

Ballinger (2003) identified four reflexive strategies utilised in her research studies; research diary, presenting work to peers, asking difficult questions and reflecting on unexpected findings. Ballinger's work was based on discourse analysis of texts in the health care setting, and below I describe how my use of similar strategies and practices produced consequences and influences on both the research process and the outcomes, linking the data, data analysis and discussion of findings. As outlined in chapter 5, establishing rigour within the interpretative process, relies on establishing plausibility between the discourse identified and author interpretations (Crowe 2005). The following extracts illustrate my position as the researcher in relation not only to the texts and my analysis, but also from within the clinical and political arena being researched.

- **Research diary/journal**

From the outset, the subject of my research has been problematic – is it crisis resolution teams or occupational therapy? In part this has been dictated by the requirement of the post I was employed in when I set out on my research journey; an occupational therapist/researcher in a crisis resolution team. My view of the research requirement, and in turn the focus of research aims, was coloured by the initial challenge of how my clinical and researcher roles would be realised in the absence of any service guidelines or job description. This was resolved pragmatically after 12 months in post, through informal agreement with a new team manager to organise my shift patterns in order to facilitate periods of study. The process and discussions during this 12 month period are

documented in professional supervision forms, emails between myself, team manager and service directors. These texts were collated and provided the beginnings of my own reflective journal, made of several notepads and various sheets/scraps of paper where I had obviously felt the need write down a sudden or unexpected idea/thought.

The consequence of this initial 12 month delay generated a shift in my original intention due to a clearer appreciation for the complexity of the notion “crisis”. As a result of my immersion within the work of a crisis team, day to day encounters with people using the service, referrers and colleagues, I was increasingly aware of a shared way of talking about, of taken for granted truths about “crisis”. Also a dawning realisation that the working processes of the team I was part of did not always correlate with the policies, theories, research or guidelines on Crisis Resolution Teams. I began to feel as though I was putting “the cart before the horse” and this nigging thought was given credence in later discussions with a panel of service users who acted in advisory capacity. It was no longer a “simple” case of researching occupational therapists in Crisis Teams – I had become concerned with much wider deliberations regarding the power of policy rhetoric on practice, on research focus and reporting and the missing links. Therefore, I became aware that my research is itself a subject of and subject to dominant discourses.

In this development of the changing direction of my research project, I acknowledge the political, personal and pragmatic influences and biases on the construction of my research aims and how I proceeded with my research within an epistemological perspective, social constructionist paradigm.

- **Linking data and data analysis to findings**

The choice of reports and articles forming the basis of my analysis was not arbitrary. The policy and audit documents were a constant presence through the focus of the meetings held by managers to communicate the priorities and targets for the team. However, they were not referenced specifically by managers, but as part of my initial literature search and review, I was very familiar with the content of these documents and began to hear the terminology repeated at work as the discourse of policy and audit filtered into the workplace.

Extract from journal 28.11.08:

“We have been told that as of tomorrow we will be “gate-keeping” all admissions to hospital. No-one knows what this means – its an alien term to many of the team. When it was explained that all requests for admissions would be directed to the team and whoever took the call would need to determine whether the request was appropriate, and to decide whether we could prevent the admission and offer the crisis team instead - chaos and protest ensued! Up to now people have referred to us because they have already made the decision whether the person needs admission or could be supported by the team – many people, myself too, felt uncomfortable at the prospect of questioning fellow professionals clinical reasoning – and how will the consultants take the news!?”

As I later progressed through a systematic analysis of the documents for this study, I would refer back to notes and reflections in my numerous pads and files, whenever I identified a theme or category, or a tension emerging from the discourse analysis, to look for any insights or thoughts that bore relation to my interpretations. The extract above is an example of how reflections from the workplace described “new terms” entering the vocabulary of the team (gate keeping) and also the conflict that this engendered as a new and extended role for staff was implemented

without clear guidelines or rationale. Themes of policy and knowledge construction, power relations and resistances can be seen developing within this extract. However, this also brings up the question of how much my experiences influenced what I “went looking for” or how I am interpreting texts. I have made no secret of my insider stance, my epistemological perspective is explicit; I am not trying to “pull something new out of the hat”, but rather illuminate the taken for granted and provide space for reflection and potential options.

Extract from journal 15.10.10

“who decides when or what becomes a crisis? We are all using the word like it’s a legitimate measurement of something..... is this right? Papers and research reports all use the word as some kind of short hand; at work we have protracted discussions (arguments?) with each other and with people referring – is this a crisis? Do they need to be in hospital?... I wonder - can only people “in crisis” need hospital? (that sounds like Sex & the City) Why has this word become so ubiquitous, so accepted as a clinical term? I can’t remember anyone I have met who described themselves as “in crisis” – they might be having a crisis, lost their job, debts, divorce – but the MHPIG says reactions to these “social problems” aren’t the remit of crisis teams. Does it mean hopeless? Does it mean suicidal? Does it mean paranoid, floridly psychotic? – all of the above?? In reality I think we make decisions based on risk and impact on the persons life and family, level of distress I know I do.”

The preceding extract gives a flavour of some of the questions I posed and how they related to the analytical phase described above using the approaches of Carabine (2001) and Bacchi (1999), demonstrating the interconnectedness of researcher and worker. From these and the questions posed by Bacchi, came the interrogation of the texts and how the concept of crisis was being

constructed in policy and research documents in addition to the tensions and resistances from service users and professionals.

- **Presenting to audiences**

The prolonged period of study at times meant that focus could be lost, learning and development can bring up areas of scholarship and ideas not previously considered and so fundamentally change one's world view. One of the most valuable reflexive strategies I found was the annual presentation to research peers, academics and students of my work in progress. I also presented my work to colleagues and managers at work at different points during the process.

The act of designing a presentation both re-focused and challenged my current thinking, decisions and relevance of the study. Even during the presentation, new revelations and or developments of ideas would come to the fore as I sought to verbalise and explain the present status and nature of my enquiries. Questions from the floor provided further opportunities to clarify or interrogate my own conclusions or directions. These presentations and their power point representations, provide another record of the progress and process of the whole research project, refining the interpretations from analysis by clarifying the presence and functions of discourses and discursive practices.

From the first presentation to the second, my direction is focused on finding the occupational therapist in crisis teams. Then by the third, a shift to concerns around philosophical and methodological paradigms comes to the fore as the "bigger picture" became clearer through the practical struggles with time frames and Trust procedures. Personal issues also impacted on decisions and confirm that research and scholarly endeavour can not happen in a vacuum, but must be acknowledged and their influences recognised. In particular, the need to repeatedly define the term

crisis at the beginning of presentations, or at least how it related to Crisis Resolution Teams and was constructed in policy and research gave credence to the decision to generate data from documents describing the introduction and subsequent research into Crisis Resolution Teams.

During the latest presentation, a question from an academic in the audience queried why I made no reference to The Recovery Approach – a question that was easy to answer but raises an important point relevant to my whole research enquiry and findings. The answer; there is no reference to recovery as an approach or a concept in any of the documents analysed and very little in any crisis resolution related literature. The point being that political, economic and organisational discourses dominate the literature around the introduction of crisis resolution teams in the UK, posing another question – has The Recovery Approach become a rhetorical device and a construct within the NHS that provides a framework for shifting responsibility for longer term care provision to the individual?

In addition, I have shared elements of the thesis with friends who are not employed within the NHS or health and social care. What is interesting from feedback is the different interpretations – “when do you solve the problem and give the answer, it’s a bit negative without a solution” – this friend was a journalist and more recently working in PR, where the focus is on finding the positive slant in every scenario. The lack of definitive solutions is a criticism levelled at Foucault’s work and therefore reflects one of the difficulties in approaching the work from this perspective. I did question whether the work would be more credible if I had taken a different approach. However, I think this would have been to “gloss over” the underlying discursive strategies at play and left fundamental problems hidden. Another friend suggested that although I may not be able to provide definitive solutions, the questions posed by the

process and my interpretations form the basis of further research and a reference point for others in the field of crisis resolution and occupational science.

- **Discussions with supervisors**

Another of the most useful and fruitful reflexive practices during the progression of my research were the regular meetings with my research supervisors. Again, the process of discussing and explaining where I was going/been increased clarity for me and identified gaps in knowledge.

Another interesting aspect of this process is also the discourses and experiences of the supervisors. Their individual perspectives could present an interesting slant or focus that took me in another direction or exploring an additional theory or area of research. For the majority, this was beneficial and enriched my understanding of specific topics. However, on occasion, it also led me into areas, that whilst related or posing potential future research questions, could obscure the intent of the study. Two directions in particular were explored in some depth; professional identity and influences on policy implementation. Revisiting the research question and aims again, along with the preparation for presentations of work in progress became pivotal in keeping a focus. However, this process demonstrates that the same data sources can produce different interpretations and multiple understandings, even by the same person at different times and is congruent with my relativist approach to this research.

- **Reading/reflecting/questioning**

Reading around the subject areas, reading the specified documents for data generation and reading seemingly unrelated articles and chapters promoted ongoing reflection and questioning and is recommended by Carabine (2001) in order to get to know the data and become immersed in the data and related sources.. A

wide reading of Foucault and the many areas his work has been utilised to explore a range of problems and events, although at times daunting, enabled me to gain confidence in my own version of a foucauldian discourse analysis. Equally, at times it caused me to feel overwhelmed and paralysed;

Extract from journal 23.7.12 “... *I have no idea where I am going with this, every time I think I have isolated the crux of how occupation/occupational science/therapy are inherent in the notion of how crisis is experienced and the policy inference of the implicit benefits of remaining at home, a whole other literature strand comes into play as I try to explain and justify.....*”

and 8.3.12 “*an occupational definition of crisis; how OT theories are implicated in neo-liberal policy drivers – these are the concepts that I have identified/constructed/developed?, that have been shrouded within the dominant discourses of politics, economics and professional power plays; how to illustrate and reveal this? I look to Foucault and governmentality – and it feels as though when I look back, they have retreated back behind a veil of words and accepted practice...what am I implying, that occupation does not need OT?*”

12.5 A Retrospective Word

The element of my thesis that I was not expecting, was how difficult and contradictory the occupational science and occupational therapy theories/discourses would be to synthesise with the analysis of crisis resolution team documents in order to produce a coherent summary of findings and implications for practice. However, on reflection now, after completing the draft for submission I realise that this is one of the findings and an implication for practice – “*occupational therapy discourse is disconnected from a meaningful dialogue in the political arena; occupational science is distancing itself from the historical places of OT practice and in an attempt to develop a discourse of*

occupation, is at risk of becoming self-referential and impenetrable”.

Throughout the research process and in structuring the final thesis my insider perspective has influenced the way I have approached the enquiry and constructed the themes and findings. As I begin to move on from this initial study I find my thoughts, views and understanding of both Crisis Resolution Teams and occupational therapy/science have developed and expanded. From these new insights and understandings I am able to take forward ideas for further research and into my approach to practice. Particularly a deeper understanding of how occupation and the focus of occupational science theories, once analysed and dissected then applied to my own experience, through my own discourses and the discursive practices I am influenced by, can provide support to critical reflection. My hope is that this will continue in order to find or build a path for the future of occupational therapy in mental health service provision.

12.6 Summary of Findings

This thesis represents a journey of investigation into how concepts of human occupation are represented within the discourses surrounding the development and implementation of Crisis Resolution Home Treatment Teams. The literature review posed questions regarding the nature of knowledge creation, dissemination and language in the configuration of, and subsequent research into Crisis Teams.

The interpretations described in this study identify a hierarchy of discourses influencing the configuration of mental health services, specifically the introduction of Crisis Resolution Home Treatment Teams. The overarching discourses of neo-liberalism privileges economic and managerial discursive practices in shaping the remit and measurement of efficacy of this service provision. As a result,

these discourses have been constitutive in producing social actions and effects; influencing the focus of research on the economic efficacy of Crisis Teams thereby constructing the Crisis Team as a cost saving function with the gatekeeper role as a tool for rationing services

From the analysis I propose that the term crisis (in mental health) has become a discursive construct – the term has been utilised in policy to frame a set of criteria for the rationing of mental health service provision, specifically to reduce hospital admissions. Subsequent research has perpetuated the economic focus as a legitimate rationale for CRHTT provision. Crisis has become a term inferring pathology, placing individuals as the subject within psychiatric practices and maintaining power relations within the health professions despite the rhetoric of service user choice/involvement and recovery.

Sites of tension and challenges to the discourses identified have been revealed in the service user discourse and in examples of professionals/teams redefining the definition of crisis from a set of diagnostic criteria to a range of psychosocial factors, particularly as an emotional response and the impact on daily life activities. Previous theories of crisis are related to emotional and psychological distress and identified as a continuum of severity, not specifically related to psychiatric conditions (Caplan 1964, Roberts 2000). However, Crisis Teams have been implemented using psychiatric diagnostic criteria, demonstrating how dominant discursive practices influence the generation and dissemination of knowledge.

Concepts of human occupation are identified through the discourse analysis as being implicit in policy drivers and neo-liberal discourses to continue the shift from state to individual responsibility in the form of managing ones own safety and well-

being at home. Despite the absence of occupational terminology in policy, research and as a presence in Teams, the interpretations from the discourse analysis are utilised to develop links between policy rhetoric and service user discourse to suggest an additional paradigm for the definition of crisis which draws on the concepts of human occupation. Crisis theory and theories of human occupation are revealed to have points of contact. As a result, crisis, in the context of mental health and/or emotional distress is described in terms of disruption to occupational identity, roles, routines and performance, disorganisation of occupational forms, behaviour and environment and dis-engagement from usual occupational activity, participation and demands.

12.7 Implications

The results proposed by this research add to the growing knowledge base of Crisis resolution in the UK by providing a wider construct of mental health crisis; opening up a space for reflective and critical analysis of practice and service provision. Through the identification of discursive practices and situated power relations, practitioners and researchers are asked to acknowledge individual and social agency and to challenge the knowledge base and basis of the criteria for Crisis Teams.

Alternative views of crisis and additional sources of knowledge open up spaces not only to challenge, but to consider different forms of managing/resolving crisis. A separate service targeting a narrow definition runs the risk of diluting and restricting the options for service and clinical responses, including the potential to prevent crisis and/or minimise the impact. Ironically, the prevention of crisis in terms of ameliorating effects/onset of mental illness was the focus of the work on which modern day crisis resolutions teams are cited as being based upon. This requires a wider perspective of the concept of mental health crisis with an

imperative to explore the social, cultural and political triggers, aspects and solutions to emotional and mental distress.

Prevention of mental distress can be viewed from the aspect of public health. A longer term view of developing programmes of education and support to increase emotional resilience and stress management skills could be argued in terms of economic practice to invest now for future gains in the form of savings on acute crisis response services. As with other public health programmes, the view is taken that educating and promoting healthy lifestyles will reduce health care costs in the future.

Although the findings posited do not provide the immediate answer to what should now be done or propose definitive changes to the provision of a particular service, there are potential implications and propositions that may be drawn. The limitations of the accessibility of occupational therapy/science discourse to other disciplines are proposed here as masking the implicit inferences in policy strategies to concepts of human occupation as technologies for mobilising the changes to service delivery. This raises the possibilities of a number of options in the education and development of mental health professions, other than occupational therapists.

By framing occupational concepts from the perspective of Foucault's governmentality, they become visible as related to daily lives and become accessible to the understanding of others. Academic literature and research in the Nursing profession have utilised Foucault's ideas on discourse, power relations and governmentality (Crowe 2005, Fejes 2008, Hiu & Stickley 2007, Nixon & Power 2007). Therefore it may be reasonably claimed that the nursing profession has some familiarity with this approach to topics and the discourse of Foucault. Incorporating an introduction to concepts of human occupation from a foucauldian perspective

into the under and post graduate education programmes for mental health nurses and other health and social care professions, may increase an understanding of the centrality of occupation in daily lives and its potential in the recovery process. By introducing other professions to the discourse of occupation through a mode already familiar, may also increase the communication and collaborative potentials within the already multi-disciplinary culture of mental health in the NHS, through increased awareness of other professional discourses, as advocated by Stark et al (2002).

There has already been much written on the nature of occupational therapy language, acknowledgement of problematics and differing opinions of how to address its use in daily practice (Illiot & Mounter 2000, Brown & Bourke-Taylor 2012, Creek 2010). Nevertheless, it remains an area of debate without concrete solution, if one is needed. The proposed findings of this thesis suggest that rather than the terminology, a greater focus on how concepts of human occupation manifest themselves in other discourses and through the modes of governance by social agencies and institutions may be beneficial. Further research into the roles of occupational therapists who are working in Crisis Teams is indicated. The findings from this study can provide a basis for approaching such research from a number of perspectives with options to explore a range of questions. These may include issues of power relations or how occupational therapists approach work in Crisis Teams and utilise occupational theories.

The option of developing a mental health specialty pathway in undergraduate training for occupational therapists has been proposed by Bannigan et al (2011) in recognition of the rapid and unprecedented changes in mental health service provision. In terms of equipping students for the requirements of generic practice in mental health, this may go a long way to preparing

future occupational therapists with the knowledge and expertise expected of the mental health workforce. However, it is also acknowledged that there is a high attrition rate for therapists leaving practice in mental health, and only a third of registered occupational therapists work in mental health (Craig et al 1998). This may have been a reflection at that time of the lack of confidence in graduates feeling ready to work in mental health.

There is clearly not a quick and simple solution to the issues affecting occupational therapy education and practice at this time. The formulations developed in this study for an additional perspective of occupational concepts, at least within one type of service, are presented as support for occupation being recognised as inherent across a range of contexts, discourses and practices, whilst also contributing to the debate and development of the future of occupational science and occupational therapy.

Further research in the area of Crisis Resolution services is needed in relation to the individual experience of crisis, causes and impact. The original theories of crisis include ideas of crisis as an opportunity for learning and development of increased coping and relapse prevention skills. Implications exist for occupational therapy and occupational science in terms of building on a definition of crisis that includes the factors contributing to and prolonging a mental health crisis and possible resolution. Occupational factors may include loss of roles through redundancy, bereavement, retirement or divorce; lack of opportunity to participate in meaningful occupation due to stigma, social isolation, unemployment, financial or physical/psychological limitations due to illness. Bio-medical responses may alleviate symptoms related to a crisis, such as anxiety, depression, psychosis but are inadequate in relation to the impact on occupational function and meaning. Research that can investigate crisis from an occupational perspective of disruption or deprivation

will support the development of occupational responses to support recovery from mental health crisis, facilitating awareness of the importance of occupational forms, identity and engagement in increasing resilience and well-being.

By relating notions of governmentality – the conduct of conduct; surveillance and confession – to concepts of human occupation, theory can be developed further through taken for granted modes of occupation to live a moral and ethical and aesthetic life – using the routines and demands of daily life to restructure and organise in the midst of a mental health crisis. Bringing occupation to the fore within the discursive practices of policy, research, audit and implementation in crisis work can increase the options for prevention and resolution.

The context of this research also promotes an appreciation of the political dimensions of concepts of human occupation and the role of occupational science and occupational therapy in neo-liberal discourses by increasing the occupational therapy profession's capacity to understand, identify and if needed, to resist discourses to which we are subject. Thus providing a basis for exploring strategies for raising the profile of occupation on a local and national level by engaging with and being embedded in dominant discourses. Occupational science and the profession of occupational therapy can be called in to question in terms of its ability to acknowledge the complicity of ideas of independence and productivity inherent in theories of both disciplines to the current political landscape. This is an example of foucauldian power/knowledge concepts – power is not fixed or necessarily oppressive, but can be productive and creative.

12.8 Limitations

Initial limitations of this thesis must relate to criticism of discourse analysis as a methodology and method. Specifically the limited

cohesive agreement among differing disciplines regarding the process of analysis and conflicting approaches to discourse analysis which focus primarily on the linguistic features of discourse (Wetherell 2001).

I have endeavoured to frame the work within a recognised epistemological and ontological perspective, utilising perspectives that have been adopted by others within similar areas of research into mental health issues as a format to give credence to my approach. As a qualitative work, the analysis and my conclusions are interpretations based on my own experience and understanding, therefore they can be contested and challenged. Interpretations are contextual and historically situated; the process of writing and revisiting texts throughout this research process has highlighted the multiple possibilities for re-interpretation and to draw different conclusions.

Critics of Foucault and studies based on his ideas cite the limits of any definitive conclusions and lack of solutions provided by this approach. The discourse analysis described in this project has only provided a basis for the proposition of conclusions to be drawn and does not offer an answer to problems identified. In this way, issues of ethical considerations can be directed at the study in terms of the limits to making improvements to the care and treatment of individuals accessing mental health services. Nevertheless, the generation of a fresh point of view can be supported as promoting and provoking new and alternative course of actions and fields of study. The use of texts as a source of data is not uncommon (Prior 2003). However the recruitment of individuals and groups to provide views and experiences would give a richer and more immediate picture of the domains explored in this study. The findings presented here can be utilised as a basis and justification for further research to include those who are or have been involved with Crisis Resolution Home Treatment Teams.

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Appendix
Documents contributing to a Discourse of Mental Health Crisis

Title	Type	Overview	Published
Department of Health (2001) The Mental Health Policy Implementation Guide. Department of Health.	Government paper	Outlines guidelines and targets for implementing reforms/service models as proposed in NHS Plan	Department of Health
Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment Teams. (2007a) National Audit Office	Report from Government Body	Audit of number of teams in operation nationally; workforce and professions employed by teams; relationship between DoH guidelines and operating procedures	National Audit Office
Guidance Statement on fidelity and best practice for crisis services. (2006) N. Compton & D. Daniel.	Report in Partnership with Dept. of Health and CSIP	Recommendations for skill mix; training and disciplines to included in team workforce; included likely length of input; out of hours pathway and place of Crisis Teams in relation to whole of Mental Health system of care provision	Department of Health
National Survey of CRHT's in England. (2006) S.Onyett, K. Linde, G. Glover, S. Floyd, S. Bradley, H. Middleton.	Research funded by Department of Health and National Institute for Mental Health in England	Results of survey of team members/managers in Crisis Teams; caseloads; success or obstacles to meeting gate-keeping function; working patterns and pathways within care systems	National Institute for Mental Health in England
Randomised Controlled Trial of acute mental health care by a crisis resolution team:The North Islington study. (2005). S. Johnson, F. Nolan, S.Pilling, A. Sander, J. Hault, N. McKenzie I.R. White, M. Thompson and P. Bebbington	RCT research project	Describes effect of introduction of one CRT on rate of admissions to hospital	British Medical Journal

Leading the way in times of crisis. (2006) I. Garcia	Article in professional journal	Description of development of crisis teams in UK.	Mental Health Practice
Crisis resolution /home treatment teams and psychiatric admission rates in England. (2006) G. Glover, G. Arts and K.S. Babu	Report of quantitative research project	Review of research studies measuring effect of introduction of CRT's on admission rates to hospital	British Journal of Psychiatry
Mental health crisis and respite services; service user and carer aspirations. (2009) C.Lyons, P. Hopley and J. Horrocks	Report on research study	Views of service users on experience crisis team referral and treatment using qualitative data.	Journal of Psychiatric and Mental Health Nursing
Crisis Resolution Teams and the role of the service user development worker. (2006) C. Armitage and Lange	Article	Review of the implementation of one Team and feedback from service users	Mental Health Practice
Crisis.....what crisis? The experiences of being in a crisis in Bristol. (2004) Bristol MIND	Report by Mental Health Charity	Overview and history of local crisis teams with examples of interviews with service users.	Online
A Service-user Focused Evaluation of the crisis resolution home treatment team of Leeds Mental Health Trust. (2007) C. Brennan	Report	Quantitative and qualitative data on local Crisis Team with feedback comments by service users	Online
Crisis resolution and home treatment: The service user and carer experience (2007b) National Audit Office	Report on behalf of Government body	Extensive study with data collected through focus groups and survey of service user/carers experiences of accessing and treatment by Crisis Teams nationally	NAO website

<p>Crisis Resolution: A service response to mental distress. (2009)</p> <p>J. Morton</p>	<p>Report on study</p>	<p>Quantitative research project; exploring who used the service and interventions received</p>	<p>Journal of Social Work Practice</p>
<p>Social Deprivation and the outcomes of crisis resolution and home treatment teams for people with mental health problems; a historical cohort study. (2010)</p> <p>R. Kingsford, M Webber</p>	<p>Report on study</p>	<p>Quantitative research using referral data measured against operational policy.</p>	<p>Health and Social Care in the Community</p>