

Telephone Street Triage: A Service Users Perspective

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CONTENTS:

Chapter 1 - Introduction and Background

Introduction.....	Page 2
The management of mental illness.....	Page 3
1.21 The History of asylums.....	Page 3
1.22 Legislation through the ages.....	Page 7
1.23 Mental Health Law and the Police.....	Page 8
Modern Day Mental Health Services.....	Page 10
The Crisis Care Concordat (2014)	Page 11
Models of Street Triage.....	Page 13
The service user voice.....	Page 15
1.61 History of service user involvement.....	Page 15
1.7 The Local Context.....	Page 17
1.8 Personal Statement.....	Page 19
1.9 Research aims and objectives.....	Page 20

Chapter 2 - Literature review

2.1 Introduction.....	Page 22
2.2 Search Strategy.....	Page 23
2.3 Critical Appraisal.....	Page 26
2.4 Analysis.....	Page 28
2.5 Findings of the literature review.....	Page 29
2.51 Service User perspective and police attitudes and actions	Page 29

2.52 Summary of the studies	Page 35
2.53 Street Triage Models and police attitudes and actions	Page 35
2.54 Summary of the studies	Page 44
2.6 Overall summary of the chapter and conclusion	Page 44
Chapter 3 - Methodology	
3.1 Quantative Research	Page 47
3.2 Qualitative Research	Page 48
3.3 Choosing the paradigm	Page 49
3.4 Paradigms and assumptions	Page 50
3.5 Study, design and approach	Page 53
3.6 Ethics	Page 59
3.7 Participants and recruitment	Page 61
3.8 Data Collection	Page 64
3.9 Data Analysis	Page 66
3.10 Rigour. Authenticity and Trustworthiness.	Page 71
Chapter 4 Findings: Carmel's story	
4.1 The Story of Carmel: A survivor	Page 73
4.2 Perceptions, rejections and trauma	Page 74
4.3 Trust, mistrust and insightful thoughts	Page 78
4.4 The thin blue line	Page 80
4.5 Street Triage and other new experiences	Page 83
4.6 Future possibilities	Page 86
4.7 Themes	Page 87

4.8 Critical reflection.....	Page 88
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Chapter 5 Findings: Tim's story

5.1 The story of Tim: Rock bottom to new beginnings.....	Page 91
5.2 Searching for reasons	Page 95
5.3 Reluctant absent father.....	Page 97
5.4 Team spirit	Page 100
5.5 It's okay to not be okay.....	Page 102
5.6 Themes	Page 107
5.7 Critical Reflection.....	Page 108

Chapter 6 Sam's Story

6.1 When the tables are turned.	Page 111
6.2 You can't choose your family.....	Page 114
6.3 The straw that broke the camel's back.....	Page 117
6.4 Tiredness, work, childcare and other pressures.....	Page 120
6.5 Recovery, hope and the future.....	Page 122
6.6 Themes	Page 123
6.7 Critical reflection	Page 124

Chapter 7 – Cross Narrative Commonalities

7.1 Different and unique	Page 129
7.2 Shared Experiences.....	Page 131
7.3 Learning from Experiences.....	Page 132
7.4 Blue light interactions.....	Page 133
7.5 Interaction with the Street Triage Team.....	Page 135

7.6 Follow up support	Page 137
7.7 Conclusion of findings	Page 139
Chapter 8: Discussion	
Aim	Page 141
Objective 1.....	Page 141
Objective 2.....	Page 146
Objective 3.....	Page 149
Objective 4.....	Page 149
Chapter 9: Conclusion and Recommendations	
9.1 Limitations to the study	Page 160
9.2 Recommendations	Page 161
9.3 Unique contribution and new knowledge	Page 162
References.....	Page 163
Appendices.....	Page 183
Appendix 1: Synthesis table.....	Page 183
Appendix 2: Ethics Application University.....	Page 196
Ethics approval University.....	Page 212
IRAS application and approval.....	Page 213
Appendix 3: Participant letter.....	Page 215
Appendix 4: Participant Information Sheet.....	Page 216
Appendix 5: Consent Form.....	Page 219
Appendix 6: Transcript Carmel.....	Page 221

List of Tables and diagrams:

Table 1:	Alternative phrases used in the search ...Page 24
Table 2:	Results of database search.....Page 25
Table 3:	Categorisation of papers.....Page 27
Table 4:	Reasons for selecting a paradigmPage 49
Diagram 1:	Cross commonalities extrapolated from individual narrativesPage 127

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ABSTRACT:

In the last fifteen years Accident and Emergency (A & E) departments have become the default environment for service users seeking help during a mental health crisis. Simultaneously, the Police have reported concerns about the expectations placed on their officers in dealing with the rising numbers of people experiencing a mental health crisis. In 2014 the Home Office launched The Crisis Care Concordat requiring statutory and non-statutory organisations to make a commitment to work together to ensure a seamless pathway for anyone who experiences a mental health crisis, regardless of their first contact with services. To facilitate this many new initiatives were developed, Street Triage being one. This allows the police immediate access to a mental health professional when they find themselves attending an incident or event that has a mental health component. Whilst there is an emerging body of research focusing on the organisational and financial benefits to such services, there is limited research regarding the experience of the service user utilising such services. The aim of this study was to explore and understand the experiences of service users, who when experiencing a mental health crisis were treated by the Street Triage Service. Qualitative research, using a narrative approach was used to address this aim. Data were collected through one to one narrative interviews with three service users. Interview transcripts were initially analysed as individual stories, and then as a collective, recognising the nuances of each narrative and also exploring the cross commonalities. While each narrative had its own unique themes some, shared commonalities were also identified. These included; (1) Learning from their own experiences, (2) Perceiving and interacting with blue light services and (3) Interacting with the Street Triage team. Individuals who have experienced a mental health crisis and used the Street Triage service offer a wealth of knowledge that not only contributes to the emerging body of research in this area, but also enables the development of such services in better meeting the needs of those who may require such services in the future

CHAPTER 1 INTRODUCTION AND BACKGROUND

1.1 Introduction:

Around the turn of the millennium Accident and Emergency (A & E) departments had become the default environment for service users seeking help during a mental health crisis (Hughs & Clarke, 2002). This coincided with the Police reporting their own concerns about the expectations placed on their officers to deal with the rising numbers of people presenting with mental health problems in their everyday work (Lamb et al., 2002). Since 2002 this situation appears to have worsened, with A and E departments reporting consistently being at, or above, capacity (NHSE 2016).

In 2015 the House of Commons Home Affairs Committee published a report on Policing and Mental Health. The report highlighted how the police are often the first contact with people in a Mental Health Crisis and often struggle to manage such individuals. The report suggested that this was due to; the police having limited access to mental health services, especially out of hours, a lack of their own awareness and knowledge of how to manage such situations, as well as what Norman Lamb, Rt Hon Minister of State for Care and Support at the time, called “*dysfunctional and fragmented*” Mental Health services (House of Commons Publication, 2015). In the same report, Sir Peter Fahy, Chief Constable for Greater Manchester Police, estimated that frontline police officers spent 20-40% of their time involved in situations in which mental ill-health was either a cause or an element. The report concluded that the “*police were being asked to do things they are not trained to do*” and that the “*police cannot be expected to fill in the gaps in mental health service provision*” (House of Commons Publication, 2015).

In 2006-7 the NHS in England spent over £8 Billion on mental health, reportedly more than any other single health problem in the country (National Audit Office 2007). The majority of this money was spent investing in Primary Care Mental Health Teams, with a less substantive amount being directed to acute inpatient services. Evident gaps in service provision between Primary Care and in-patient settings for those with a severe mental illness led to the development of ‘crisis services’, the fore runner of these being Crisis Resolution Home Treatment Teams (CRHTTS). Such teams were developed to offer an alternative to inpatient admission and the earlier discharge for those already in that setting (Johnson et al.,

2008). Since the inception of CRHTTS additional crisis models have also developed; namely the separation of CRHTTs into 'Access and Crisis teams' and 'Home Treatment Teams' and the subsequent emergence of the Rapid Assessment Intervention and Discharge (RAID) model, the latter offering dedicated mental health services to A and E departments for those experiencing a severe mental health crisis (Tadros et al., 2013).

The Police have acknowledged that they are managing vulnerable mentally unwell people in a setting not suited to their needs (Adebolawe, 2013). As untrained mental health professionals, the police are not the best placed service to manage such vulnerable people in a mental health crisis and in trying to ensure the safety of those involved often use their powers under the Mental Health Act (1983), often because they are unaware of any alternative pathways.

The Mental Health Act (1983) clearly states that a person detained under Section 136 of the Act by the police "*should be taken to a health based place of safety and only in exceptional circumstances should this be a police cell*". Hampson (2011, pg. No 82), stated that such exceptional circumstances should only occur when the person "*is too disturbed*" to be safely managed anywhere else. Nationally such cell based detentions occur on average in 36% of all Section 136 detentions (HSCIC 2015). Over a third of all police detentions under the Mental Health Act (1983) managed in this way do not denote "*exceptional circumstances*", but indicate this to be a routine management practice. The above situation has been widely documented in many NHS and Home Office publications, as untenable for service users and professionals alike.

1.2 The management of mental illness

1.21 History of asylums

Bethlem Royal Hospital in London has the auspicious title of being the first recorded lunatic asylum in Europe, dating back to 1247 (Winston, 1994). Originally built as a Priory it is known to have admitted its first mentally ill patients in 1407. It is often referred to as 'Bedlam', hence the colloquialism associated with this word. This was over three centuries before the introduction of the Mad House Act (1774) and, as such, asylums such as Bethlem treated the 'insane' by use of non-licensed

practitioners who saw such institutions as commercial opportunities rather than caring environments for those unfortunate enough to be incarcerated within them. The Mad House Act (1774), despite its derogatory title, was implemented in an attempt to regulate such institutions by ensuring they had licensed practitioners and underwent an annual inspection process. This appears to be an early attempt at providing a therapeutic and safe place for such individuals, rather than simply containment for a fee.

Subsequent to the Mad House Act (1774), in 1792 Quaker, William Tuke founded the York Retreat. This Retreat is commonly viewed as the first institution built to ensure the humane treatment of those individuals suffering from a mental illness (Porter, 2006). The main developments the York Retreat instigated were the removal of mechanical restraints, although still sadly used in some European countries today, and the promotion of a more therapeutic model of engagement through the use of sport, leisure and work activities.

Building on this approach, in 1808 the County Asylums Act was passed. The main principal within this Act was the ability for Counties to impose a local tax to raise funds to support the development of local county asylums that would adopt the therapeutic approach of the York Retreat. It was envisaged that those experiencing mental illness who were incarcerated in the workhouses could be removed and treated more appropriately in these 'new' county asylums. This was an early attempt to develop a local care system for the benefit of those with a mental illness in the local society. The County Asylums Act (1808), as well intentioned as it was, failed to deliver this on the scale it was envisaged and as a result only 20 such County asylums were built (Parry-Jones, 1972).

By the mid-1920s many asylum physicians claimed they had a cure for mental illness and in fact were experimenting on such unfortunate people with lobotomies and electro-convulsive therapy. Whilst for some this did work, for many more the damage was irreversible. Treatments such as strait jacket restraint, seclusion and bromide were the norm and many of those incarcerated only ever left the asylums in coffins (Foucault, 2006).

Turner et al. (1999) discussed how since 1890 psychiatrists had been complaining about Mental Health Legislation. They reported that the profession felt there were

delays caused by paperwork and bureaucracy, placing an imposition on them and their clinical practice that other medical professions did not have to endure. The first concession to this can be seen in the Mental Treatment Act (1930) where there is clear encouragement to offer treatment as an outpatient or on a voluntary basis (Jones, 1993). With the introduction of the Mental Health Act (1959) came the removal of the courts for routine detentions, these being replaced by a medical centric decision making framework that also allowed the support of the rights of those detained (Jones, 1993).

At the same time as the legislative developments were occurring, advances in treatments for severe mental illnesses were also taking place. In 1950, whilst developing medications with anti-histamine properties, French pharmacologists discovered Chlorpromazine, known as Thorazine or Largactil, it was the first known anti-psychotic drug. This discovery was, and still is, seen as the “*greatest advance in the history of psychiatry*” (Ban, 2007, pg. 42.). Used to treat severe mental illnesses such as schizophrenia, this drug enabled some people, who had been detained and incarcerated for many years, to have their symptoms managed more effectively and for them to move into less restrictive environments (Turner, 2007). There were many side effects associated with this drug; dry mouth, weight gain, sedation, acute movement disorder (tardive dyskinesia), Parkinson like symptoms and decreases in blood pressure. However, as a breakthrough, and forming the basis of all future anti-psychotic drug developments, this is a crucial tipping point in the care and treatment of those with a severe and enduring mental illness (Ban, 2007), not least the fact that such people could now feasibly be treated in the community, and with this new treatment option came the evolution of the community mental health nurse.

The drive towards community care began as far back as 1959 when Russell Barton wrote about the effects of institutionalisation on people in his book ‘Institutional Neuroses’. In it he described how many of the symptoms of mental illness, in particular psychosis, were a result of the institutionalisation process and the removal of “psychological crutches” and how continued incarceration was not beneficial to the sufferer (Barton, 1959). In 1961, Erving Goffman published his seminal book ‘Asylums: Essays on the social situations of the mental patients and other inmates.’ Composed of four essays, the first three focused on the experiences

of patients within a mental health asylum told through their own eyes. The essays explore the effects of what is termed 'total institutionalisation' from the perspective of the person experiencing this. This powerful book, alongside Barton's earlier work and the recent discovery of new medication options, help to propel the changes and reforms in mental health services, to reduce the number of large mental health hospitals and to initiate the development of care away from hospital and into the community (Smith, 2002). This new knowledge, coupled with the new found anti-psychotic medication, provided the motivation to move those experiencing mental illness out of the institutions that many now believed caused more problems than they solved, and prompted the development of the early community mental health teams (Grob, 1994).

With patient numbers reducing, during the 1970s and 80s there was a continued growing concern regarding the upkeep of the asylums in terms of cost to the NHS and a real recognition of the need for people to live in communities rather than being incarcerated in institutions. The 1980s saw the introduction of legislation which would give the mentally ill more rights. In particular, the Mental Health Act (1983), clearly outlined the rights of people admitted formally to Mental hospitals, and processes that would allow them better access to appeal against their committal should they wish. This supported the continuing agenda to keep people out of mental health hospitals and being cared for within their own home or other community settings. However, by the mid-1980s concerns were being expressed about what was termed '*care in the community*', following a few high profile killings by people with mental health problems. For example, in 1984 the murder of social worker, Isabel Schwarz by a former client, prompted a government inquiry into community care. (Griffiths, 1988). His report, 'Community Care: Agenda for Action' (1988) is seen as one of the forerunners to the Community Care Act (1990), a piece of major legislation which sets out the basis for community care as it is recognised today in modern mental health services.

Legislation has evolved over the ages to uphold the rights of the mentally ill. As attitudes, behaviours and treatments of such people have evolved the required legislative framework has worked to support this evolution. As such this evolution of care for those who become mentally ill can be seen through the history of the

asylums from the early days of Bedlam (Bethlem) through to the therapeutic endeavours of the York Retreat and the County Asylum system, and more recently the closure of large institutions and the move to care in the community. It would appear the Government has attempted to regulate the management of the mentally unwell in society with a legislative framework, designed at the time to try to protect the public as well as the individuals experiencing all forms of mental illness. Understanding this context allows the reader of this thesis to understand the current policy for the management and protection of the mentally ill, as well as not only some of the powers professionals have, but also the limitations they encounter through their given responsibilities. For example police officers have the authority to detain a person suspected of having a mental illness in order to protect them, yet no training is given to such professionals on how mental illness manifests. The current legislative framework took over two centuries to achieve. The following section provides a summary of this legislative evolution, and in doing so, identifies the current framework and how the service in this study uses this to help improve the quality of the care delivered to those who need it when in a mental health crisis.

1.22 Legislation through the ages.

As discussed in the previous section, the first law, Regulations of the Mad House Act (1774), was designed to ensure that unscrupulous individuals did not take advantage of this vulnerable group of people. However, the amount of inspections required to enforce it compromised its success, apart from such places as the York Retreat and their forward thinking approaches to care and treatment. Following the County Asylum Act (1808) was the Mad House Act (1828), and this was quickly followed by the Lunacy Act (1845). All of these Acts were attempting to ensure public awareness of and support for the plight of those deemed to be mentally ill and for the humane treatment of this group of people. In 1886 the Idiots Act was introduced, again to consider better ways to manage these people, with a move away from simply incarcerating and restraining them.

At the start of the 20th century the Mental Deficiency Act (1913) was introduced with recognition of some of the successful treatments emerging from more scrupulous institutions. The Mental Deficiency Act (1913) was superseded by the Mental Treatment Act (1930) which was later replaced by the first Mental Health Act (1959).

This was the first real framework that aimed to ensure the rights of those experiencing mental illness were fully recognised. The 1959 Act was criticised mainly for its deficiency in protecting those it was designed to protect, and to allow the potential abuse of power to those designed to offer this protection (Grounds, 2001). The 1959 Act was replaced with the Mental Health Act (1983).

The main changes in the new Mental Health Act (1983) were to strengthen patients' rights and ensure an independent review of their care and treatment could take place. The guiding principles of the 1983 Act were for people to be cared for in the least restrictive environment and to ensure that any formal detention allows for a full independent review of the care and treatment being received. The Mental Health Act (1983) was further updated in 2007. Whilst the 1983 Act focussed on the rights of the service user, the 2007 Act included a focus on the rights of the public and introduced Community Treatment Orders, making it compulsory for service users to comply with their treatment plans or be recalled to hospital. The purpose of this is to ensure compliance with treatment and reduce the likelihood of a relapse that could place the individual and/or members of the public at risk (DoH, 2007).

Alongside the Mental Health Act (1983/2007) the Mental Capacity Act (2005) was introduced, providing a framework for adults who do not have capacity to independently make decisions. The Act, not introduced in England and Wales until 2007, defines mental capacity; proposes best practice guidance for assessing capacity; introduced new safeguards for people at risk of abuse and introduced a new criminal offence for ill-treatment or wilful neglect of people lacking capacity to make independent decisions (Lesley & Pritchard, 2009). In the main it is these two legal frameworks that currently govern Mental Health services.

1.23 Mental Health Law and the Police.

The Mental Health Act (1959) introduced Section 136, the section giving the police detention powers. This section is still in existence today. While introduced in the 1959 Act, Section 136 was retained in the 1983 Act and the subsequent revised Act of 2007. Recent changes have also been agreed, with a new holding time for those detained under this section being introduced in June 2017.

This power, written into law since 1959, gives the police the power to remove a person from a public place if they feel that person is, or could be, suffering from a mental illness. Under this power the police can detain the individual and take them to an agreed place of safety. Whilst many Mental Health services have designated 136 suites for this purpose, many do not, and this leaves the police with limited options for conveyance of such individuals, usually resulting in the person being taken to either A and E or a police cell.

The fundamental flaw with this power under the Act was that it was not coupled with any specialist training packages for the police and there was, and still is, an expectation that the police understand and recognise mental illness and are able to make an informed decision regarding the correct destination for the person in their care. Whilst many local mental health services do deliver basic mental health training to the police, this is evidently insufficient (Home Affairs Report, 2015), and over the years this has been reiterated through many reports from service user groups, such as MIND and RETHINK (House of Commons, 2015).

As previously identified, the current iteration of The Community Care Act (1990) was introduced with the underlying principle that care should be delivered in the Community and as near to home as possible and, away from institutions such as hospitals, as is safe to do so. It was envisaged this initiative would support those with severe mental illness in living in the community. Embedded within the Community Care Act (1990) was The Care Programme Approach (CPA) this being the framework that underpins mental health care for all service users in specialist mental health settings. The CPA was introduced in 1992 as the approach to be used for the care of people with mental health needs in England and Wales. In 1999, the CPA was revised and integrated with local authority care management to form a single care coordination approach for adults of working age with mental health needs. This was to be used as the format for assessment, care planning and review of care by health and social care staff in all settings.

CPA was subsequently reviewed in 2008 (DoH, 2008) as it was recognised that the approach needed to be more patient-centred and have an appropriate workforce available to support it. The document also focuses on quality outcomes for those

subject to CPA and is less concerned about the infra-structure to deliver this, putting greater emphasis on the service user.

1.3 Modern Day Mental Health Services.

To support the principle of care away from hospital the National Service Framework (NSF) for Mental Health was introduced in 1999 (DoH, 1999). The money identified to support the NSF was used to develop new teams, designed to be able to manage severely unwell mentally ill people in a community setting. These teams were known as Assertive Outreach teams, Early Intervention Teams and Crisis Resolution Home Treatment Teams. The former was designed to identify and manage new cases of psychosis in individuals aged 14-35; while the latter offered an alternative to admission by delivering intensive intervention to keep people safe in their own environments whilst experiencing a mental health crisis and who would have traditionally been admitted to an inpatient bed. These teams also supported an earlier discharge pathway for people coming out of acute inpatient ward settings. It was inevitable that in conjunction with the implementation of these new teams, many in-patient adult acute beds were closed.

Public Health England, in their publication 'Better Mental Health for All' (2016) focused on prevention and the need to develop Primary Care Mental Health Services. Coupled with the earlier Health and Social Care Act (2008), this became integral to service developments and with it a drive to build on an emerging programme called Improving Access to Psychological Therapies (IAPT). There was heavy investment in these new developments and the provision of target driven services for those individuals with a mild to moderate mental illness (Monitor, 2015). Whilst this was a much welcomed move for the huge numbers of people who suffered from anxiety and mild to moderate depression, and even now for more complex psychological presentations, for those with a severe and enduring mental illness, such as schizophrenia or other psychotic illnesses, these services did not really offer them anything (Clarke et al., 2008). These individuals would still require specialist secondary care mental health services not only to maintain control over their symptoms and help ensure they kept well, but also to be able to access a crisis response when they relapsed and required urgent and immediate help and support.

However, with the constant reduction in investment in real terms, and the yearly rounds of Cost Improvement Plans implemented by many Trusts, many services have seen funding for core, non-target driven services, such as wards and Community Mental Health Teams (CMHTs) cut. Such teams as those that serve the A and E have secured additional investment to deliver the four hour breach target (NHS England, 2004) and whilst this has been welcomed, it has inevitably come at a cost, namely by reducing spending in other areas such as CMHTs. This has often meant a reduction in the numbers of staff available, whilst there is an ever growing increase in demand for mental health resources (Kings Fund, 2015). This has led to a re-design of many services and one such scheme was to develop A and E liaison teams known as Rapid Assessment, Intervention and Discharge (RAID) teams (Tadros, 2013). These services offer experienced frontline practitioners in A and E to support and manage those who present to these environments in a mental health crisis. The reality was that such teams were very successful and able to effectively manage a person attending A and E in a mental health crisis. These services then had become the default teams for people to access when in a crisis because there was limited crisis intervention services available in local areas to assist a person experiencing a mental health crisis. By replacing the development of such early crisis intervention services with such teams as RAID in A and E, had actually seen an escalation of numbers coming to A and E in a crisis. To address the issue of a lack of crisis intervention services to prevent a crisis escalating, the Crisis Care Concordat (2014) was developed.

1.31 The Crisis Care Concordat (2014).

To understand the origins of the Crisis Care Concordat and the context in which it was developed, it is useful to understand what a Mental Health Crisis is, how they have traditionally been managed, both effectively and ineffectively, and how the Concordat aims to address these issues.

A mental health crisis is defined as occurring when a person is in '*distress or despair emotionally or mentally and requires immediate help*' (Mind, 2010). This normally manifests itself in a suicidal state, as people in such despair often feel there are no other options available to them. Feeling pre-occupied with death, talking about death or suicide, being depressed or feeling hopeless, increased use of drugs or

alcohol, having a low self-esteem, being recently bereaved or having a recent relationship break up, changes in behaviour, getting affairs in order or being socially isolated are all typical of someone experiencing a Mental Health Crisis (MIND, 2010).

Following episodes of self-harm some of these people will come to the attention of the ambulance services, while other may attempt to take their own lives in public places, such as bridges, and come to the attention of the police, or seek help by attending the A and E department. If the deterioration occurs in 'office hours' and the person is known to mental health services they may seek help from that service. However, all too often the crisis does not happen in 'office hours' or the service is not able to respond effectively to such crisis presentations due to demand and capacity, and in fact on many occasions direct such cases to the A and E departments.

It is evident that the nature of a mental health crisis places high demand on the Police and Ambulance services, and the lines of intervention outlined above are often inappropriate responses to a person experiencing such a crisis. Many service users report that how sitting in the A and E department when waiting for an x-ray or to see a member of the medical staff when you have a broken bone is difficult enough, but being asked to sit there when in such distress that you are contemplating taking your own life is absolutely not the right environment to be in, and in fact increases that distress (Cooper et al, 2011). Many such people leave before being seen and in fact do complete suicide, whilst others become so distressed they require security or the police to be called and some require high doses of medication they may not have needed if attended to at an earlier stage (RCPsych, 2015). This long established and ever increasing issue has placed obvious pressure on blue light services, such as the police and ambulance services, the consequence of which has been a negative experience for both service users and their carer's. Addressing this issue is not the sole responsibility of one agency, but one requiring all agencies such as health, police, ambulance, local authority, third sector providers, housing agencies and probation, to name but a few, to come together to provide an appropriate and immediate response wherever and whenever such a crisis emerges.

The Mental Health Crisis Care Concordat (2014), is a policy document, involving over 20 organisations declaring a commitment to work together to improve the care and treatment of the vulnerable, mentally unwell service user, identifying what they will and should receive when they are in a crisis. The concordat is inclusive of a multi-agency approach to collaboratively develop more local responsive crisis services. Such responses have included the development of 'Crisis Cafes', where people can go when in distress and talk to a trained practitioner or peer support worker, and be in a safe place whilst the crisis is averted. Other initiatives have included helplines or extended Home Treatment Team provision. However, one of the new and most innovative services that emerged from the Crisis Care Concordat (2014) is a service now commonly known as 'Street Triage'.

1.32 Models of Street Triage

Triage is a well-established concept that is in regular use within both the nursing and medical professions. Most well-known is triage within the A and E departments which involves registering at reception and then seeing a nurse within 10 minutes of this registration to be 'triaged'. This is a screening assessment process that aims to gather immediate information to inform the sign posting and next steps of the care pathway required. This allows for the most efficient use of resources available and should ensure better patient outcomes as the care that is required is what is received (Broadbent, 2002). Evidence suggests that such an approach in A and E does not meet the requirements of a mental health crisis, as described above (Clarke et al., 2007). Such cases are all referred to psychiatry in the absence of really knowing what else is available or might be more appropriate at that time. Many service users report dissatisfaction with the services they receive when they attend such an environment, but continue to attend when a future crisis occurs as they have no suitable or appropriate alternative in which to go to (Clarke, 2007).

Taking the concept of triage in the context of people who come to the attention of blue light services, such as the police, and using the principles within the Crisis Care Concordat (2014), services have been directed to develop models of care that encompass this concept, to assist both the organisations involved, but more importantly the service users in crisis. By having a combined approach, each service is able to contribute to the triage process, offering their own expertise rather

than a professional who is not trained in mental health working in a pressured A and E Department, and who is unaware of what other services are available to support service users at that specific time.

The underpinning premise of Street Triage is for differing organisations to work together for the benefit of the person experiencing a mental health crisis. For example, Morabito (2007) describes how the police decision making process is very complex and takes into account many variables at the time, such as the environment, current resources, their own training and understanding, and previous experiences. As the police generally have little training regarding mental illness, being able to access a trained mental health practitioner who they can make aware of the environment and presenting issues, and in turn s/he is able to synthesise this information with their own knowledge, skills and expertise, allows for a more rounded and appropriate decision making process. This is more likely to result in the best pathway for the individual in a crisis and better service user outcomes. It is this model that the Crisis Care Concordat (2014) was tasked to achieve.

There are many different models of Street Triage that have emerged since the introduction of the Crisis Care Concordat (2014). In 2015 the Department of Health launched five new pilot Street Triage schemes with supported funding aimed at improving the way people with mental health problems are treated during such emergencies. These pilots were announced by the then Care and Support Minister Norman Lamb and were seen as the start of addressing the issues identified between police and health care services. These five pilot schemes were based on the original pilot sites launched in 2012 in Leicestershire and Cleveland police departments. These original pilot Street Triage schemes were fully funded by the Department of Health and delivered a model in which a mental health nurse would accompany police officers to incidents where police believed the people involved needed immediate mental health support. The initial reports from the more established Street Triage schemes in Leicestershire and Cleveland showed that such an approach could help to keep people out of custodial settings and reduce the demands on valuable police time. Over recent years many different models of Street Triage have been developed based on need, available resources, and local agreements. Such models include: Control room and advice line; Control room and advice line and mobile capability; Mobile mental health professional being available;

Mobile mental health professional and police officer available; Mobile mental health professional and police officer and paramedic available. The overall aim of all these services is to improve the experience and outcomes to service users and to enable the more efficient and safe allocation of health and emergency services resources (DoH, 2016).

Cummins and Edmondson (2016) undertook a review of the many differing models of Street Triage and new service developments. This review looked at the current state of play within the UK and, with particular relevance to this study, the Greater Manchester area, highlighting how in this area alone there are 160 mental health related incidents each day. The review also explored the recent use of section 136 of the Mental Health Act (1983) and the ongoing debate, regarding cells versus health based places of safety. Having explored the many different approaches to the principles of Street Triage the authors conclude that regardless of the scheme in place, the essential principles of a successful model are improved liaison between blue light services and healthcare professionals, and training for those who are not mental health specialists by background (Cummins & Edmondson, 2016). The review does note to date there has been limited research regarding service user experiences of accessing professional help via the police when in a mental health crisis, and this is a gap in the literature which this study aims to address.

1.4 The Service User Voice

1.41 History of service user involvement

Within recent years there have been proactive calls for service user involvement when developing any new provision of health and social care (Mind, 2010). In 1991 the World Health Organisation stated that involving patients by promoting participation and empowerment would ensure their “*voice is heard and not assumed*” (WHO, 1991). For those who have experienced mental illness, the concept of service user involvement is not new. As early as 1620 the ‘*poor distracted people in the house of Bedlam*’ seemingly petitioned the House of Lords asking to be treated humanely. Further, in 1845 John Perceval, son of the Prime Minister Spencer Perceval, founded a service user group after his release from a lunatic asylum. The ‘*Alleged Lunatics Friends Society*’ argued for their own voice to be heard with regard to their care and treatment (Russell, 1996). In 1957 the first

British television programme, entitled 'The Hurt Mind', featuring the mentally unwell, was shown. It began to show the plight and needs of this group of service users. In 1969 the People Not Psychiatry (PNP) group formed to offer support and friendship to service users who had experienced the same problems and treatments. Further groups were established, and in 1972 the Scottish Union of Mental Patients Group was formed, with London and Manchester following suit in 1973 and 1974 respectively. Since 1985 many service user networks and groups have been established including; Survivors Speak Out in 1986, Mad Pride in 1999 and National Survivor Network in 2007. These groups have been supported by national organisations such as MIND as well as at a political level. For example, the central theme of the NHS in England's modernisation programme was the involvement of patients in service development, research and professional education (Warne & McAndrew, 2007).

In 2008 the Health and Social Care Act was published and central to this was the need to pay '*proper regard to the views expressed by service users and carers.*' Beresford (2002) had earlier identified the part service users could play in research and evaluation of services, as well as education programmes for healthcare professionals. When the 2010 White Paper, 'Equity and Excellence: Liberating the NHS' was published, it coined the phrase '*no decisions about me without me*' and affirmed the need to ensure '*proper regard*' was paid to the views of those using the service and ensure they are involved in all decisions being made about the services they receive. As a result today the service user voice and the need to meaningfully involve this group of people in the development of new service models, policies and practice has become the expectation rather than the exception.

Within the above sections (1.1, 1.2 and 1.3) the history of asylums, the move to care in the community and legislation surrounding mental illness have been presented. Such factual information facilitates an understanding of why and how current models of care have been developed to manage people with long term severe and enduring mental illness. In addition, the presentation and management of people who experience a mental health crisis and the traditional routes of care delivered as a result were discussed. The advent of the Crisis Care Concordat (2014) and its innovative approach to crisis responses has given rise to many Street Triage models throughout the country. While some of the identified benefits of these

models have been explored, this has not included the impact this has had on the local context, Pennine Care NHS Foundation Trust (PCFT) and the RAID team operating in the A and E department that serves the people of Heywood Middleton and Rochdale (HMR) and Bury Boroughs. It is this element that needs further explanation and exploration.

1.5 Local Context

Pennine Care NHS Foundation Trust delivers Mental Health services to the five Boroughs of Oldham, Bury, HMR, Tameside and Stockport. The Trust serves a total population of approximately 1.2 million people, with many areas having high deprivation, high unemployment, high drug and alcohol use, poor health outcomes and high prevalence of severe mental illness. Many areas within PCFT footprint also have high crime rates and the combination of these issues giving rise to an increased pressure on blue light services and mental health responses, with services being stretched to meet an ever increasing demand with an ever diminishing resource.

Within the footprint there are four A and E departments operated by the local Acute Trusts of Pennine Acute, Tameside Acute and Stockport Foundation Trust. Interestingly, HMR does not have a dedicated A and E department and service users from these geographical areas attend either Bury or Oldham A and E. Each of these A and E departments have a dedicated Mental Health RAID A and E liaison team. As previously discussed, over recent years there has been a reported high use of A and E departments by those experiencing a mental health crisis. Likewise, there has also been a reported rise in the number of cases dealt with by the police that feature an aspect of mental illness (Sainsbury Centre, 2009). This combination has at times led to the relationship between the police and health professionals being fraught, with each blaming the other for the pressures they face. For service users this has resulted in long waits in A and E, or in a worst case scenario, detention in a police cell for a mentally unwell individual.

As already explored the Crisis Care Concordat (2014) is the framework that has been designed to address such isolative, blame enriched practices and bring services together to deliver a coordinated, collaborative response in such circumstances. The Concordat, being the agreed national framework, facilitated the

development of Street Triage services nationally including services being developed within PCFT. Locally, this enabled the Boroughs of HMR and Bury to develop their model of Street Triage as a way of addressing the principles contained in the Concordat.

The local model:

The Street Triage team in the Boroughs of HMR and Bury is an additional function added onto the existing RAID team. The local Oldham Commissioner from Greater Manchester Police funded additional posts, as an initial pilot, to ensure the RAID team always had two practitioners on duty at any one time. This ensured there was always a practitioner available to answer calls from the police when they required help and assistance in dealing with a potential or actual mental health crisis in the community.

The RAID team consists of highly experienced and specialist nurses and social workers, all skilled in the care of the mentally unwell individual arriving at A and E in a crisis. This team now provides a telephone Street Triage Service, offering the police and ambulance service the opportunity to access the team's expert knowledge and skills before deciding on a course of action. Any police officer (and more recently paramedics) is able to ring the Street Triage telephone line and access advice, information and sign posting as required from highly experienced and informed practitioners 24 hours a day, seven days a week. It is believed such early discussion and engagement with specialist services enables a better outcome for the service user involved and, as a result, provides a more appropriate care pathway (Broadbent, 2002). Since its inception in December 2014, the service has taken an average of 20-25 calls a week from the police and 10-15 from the ambulance service. These are mainly in the twilight hours from 6pm to 3am and on Friday and Saturday nights, with Tuesday also being another busy time.

The service records data on how many calls were received, how long the calls lasted, and the reason for the call, what the outcomes were, and what time and day they took place on. This raft of quantitative data has been used to undertake a cost benefit analysis and prove the ongoing worth of the service investment to both Health and Police chiefs. However, what is missing from the data is how the service is experienced by the service user. To date, there is very little research regarding

the perspectives of service users on these new models of crisis care (Cummins & Edmondson, 2016). Likewise, none of the teams that exist within the PCFT footprint, and in particular the team that operates out of the Bury A and E department serving the population of HMR and Bury residents, have sought such information from those using their service. The aim of this Doctoral study is to address this gap and in doing so will initiate a body of knowledge that to date is non-existent.

1.6 Personal Statement

The following section explores my personal driver for choosing this subject and why it is important to me. When undertaking a project such as a Professional Doctorate the best advice I received was to choose a subject that interests me, that I feel passionate about, and that I really feel will help achieve my personal goals. To me that is hearing the service user voice and, in particular, what would help such people when they are in their most desperate hours.

As a Mental Health nurse my main driver has always been trying to offer the very best service I can to the service users in my care, this has been directly as a 'hands on nurse' mainly working on in-patient acute wards, and more latterly on service developments and quality standards in roles such as service manager, and now as an Associate Director at a large Trust. It was inevitable for me that my thesis would be based on the voice of the service user, as it is what I am most passionate about and, alongside the new development of Street Triage, it was a unique opportunity for me to combine these two areas for the subject of my research.

I have been involved in the very early development of the Street Triage service within PCFT and have overseen its development into a service that now offers, directly or indirectly, the services of a dedicated mental health team, previously identified as an enhancer of user experience (Eales et al., 2006). However, due to its developmental infancy and range of approaches, there is limited research on the service user experience of utilising a Street Triage service when in a mental health crisis. Capturing service user perspectives on how the police and healthcare professionals treated them when they accessed this new service could help to inform future models and attain a sustainable service that better meets the needs of those who most need it.

The service user voice is important here, as in many aspects of health and social care services, as it is the true reflection of a service from one who has experienced it. This is not an assumption made by bystanders looking in, but the real experience of those utilising services designed to meet their needs. Gaining an account from such service users in relation to these services will give a unique insight into how it is received. I am aware that gaining the service user voice in relation to using crisis services has its challenges, and it is such challenges that undoubtedly contribute to the service user voice being absent from the literature regarding this specific topic. However, the challenges can and should be addressed to ensure the service user voice is heard and in turn enable a better understanding of how the mental health care we are delivering is being received by those who need it.

Gaining this level of understanding is my personal motivation for undertaking this research and the thing that has maintain my enthusiasm and passion throughout this research project. Of course feedback from the service users may not be positive and could challenge the organisation. Whilst the data I collect may be critical of aspects of the service, my role has been to ensure the findings are utilised to improve the service model and to ensure my skills as a manager and leader take the findings forward as a learning and development opportunity and not a criticism of the Organisation. More importantly, I am hopeful the end result will ultimately give a positive outcome for those service users who require our help when in a crisis.

1.7 Research aim and objectives

The aim of this study was to explore and understand the experiences of service users, who have had a mental health crisis and were treated using the Street Triage Service in Bury and HMR.

The objectives of the study were:

- To explore the perspectives of service users regarding their experiences of using the Street Triage service in Bury and HMR.
- To ascertain which, if any, aspects service users found to be beneficial

- To identify any aspects of the service that from a service user perspective could be changed
- To enhance knowledge regarding initiatives for addressing mental health crisis situations.

The following chapter will explore the relevant literature in relation to the aim and objectives of this study and identify how the research in this study will offer new knowledge to the existing body of knowledge.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction:

Undertaking a thorough literature review is the starting point to ensuring the planned area of study is unique or able to offer something new to the existing body of knowledge (Wolcott, 2001). In doing so the researcher also gains a deeper insight into the field of study and becomes more acquainted with the existing research relating to the topic. By undertaking this process, gaps in the available evidence can be seen and will help to inform the area of study, finalise the research question/s and offer assurance that what is being planned is not actually just a repeat of something that has already been undertaken (Greenhalgh, 1997). Greenhalgh (1997) clearly sets out the purpose of this literature review, in that it seeks to gain a better insight into the research available in this subject area. In doing so it will ensure the aims and objectives set out in chapter one are met through the generation of unique data. The best way of approaching this task was to plan a search strategy and use a systematic approach to reviewing the literature to ensure all related areas are explored.

There are many different approaches to a review of the literature. Since the 1990s and the emergence of Evidence Based Practice (EBP) in Health Care research, some confusion has evolved in relation to the reviewing of literature (Grant & Brett, 2009). Grant and Brett (2009) highlighted how the “rise of the review” dates further back than the 1990s, in fact to the 18th Century. In their paper they report the case of James Lind reflecting on his previously published paper on scurvy, quoting him as stating “*before the subject could be set in a clear and proper light, it was necessary to remove a great deal of rubbish.*” This “*gathering of the research*” and “*getting rid of the rubbish*” is what Grant and Brett (2009, pg. 81) believe truly captures the principles of a systematic review.

Systematic reviews aim to find as much as possible of the research relevant to the particular research questions, and use explicit methods to identify what can reliably be said on the basis of these studies. Methods of retrieving the literature should not only be explicit, but systematic, with the aim of producing varied and reliable results. Such reviews then go on to synthesise research findings and can reduce the bias

which can occur in other approaches to reviewing research evidence. This synthesis will result in a full understanding of the literature and subsequently being able to identify a unique focus of study that will add to, and extend, the available body of research based knowledge.

A systematic review is considered the gold standard in research (Greenhalgh, 1997), as it involves a defined criteria that details a systematic search, appraisal and synthesis of the research evidence from different papers. However, in this thesis I have used a systematised approach to review the papers in line with a narrative research approach.

2.2 Search Strategy

In order to inform the search strategy and therefore the literature review itself, it is important to identify keywords in the proposed study, as well as both an inclusion and exclusion criteria and the method by which the literature will be reviewed. The aim and purpose of this literature search was to systematically search for research papers by using the key words or phrases identified in the aims and objectives of the study. Initially the following key words/phrases identified were; 'Mental Health Crisis', 'Mental Health Service User Perspective', and 'Street Triage'.

Using these key phrases the search then utilised recognised electronic data bases for the main source of literature. This approach is recognised as the most efficient search tool due to the large numbers of articles contained within such databases, allowing a robust search to be undertaken in a timely and efficient manner (Holloway & Freshwater, 2007). By looking at the key words in the given research question, and then breaking these down, the researcher is able to achieve a search that is both wide and thorough. The search also used Boolean operators (Grant & Brett, 2003) which are words such as 'AND' or 'OR' to link words together to see if any research exists that contain all key aspects included in the area of study. It is acknowledged that differing databases have differing 'biases' such as towards nursing research or medical research (Aveyard, 2007), and as such a selection of these databases should be used to ensure a thorough relevant literature search is undertaken.

The search began by identifying the relevant databases to search. A starting point in undertaking the literature review was with PubMed/Medline, as these databases have access to over 19 million citations on biomedical and nursing subjects. This was followed by an exploration of CINAHL, as in the main this covers nursing subjects, but also includes allied health professionals. As Street Triage includes a range of professionals, such as social workers, it was felt searching CINAHL would ensure inclusiveness of a range of publications from multifarious professional journals. The Cochrane library was also searched, as it is the premier database for evidence based papers in the hierarchy of research, concentrating on randomised control trials (Sibbald & Martin, 1998). Finally Psych Info, as the specialist database for mental health research was explored, as was the Royal College of Nursing (RCN) database to ensure the search was robust and thorough.

The search was initiated with the key phrases identified above. The use of Boolean operators (Crombie, 2016), especially 'and' was then employed to 'link' each key phrase together with a view to narrowing the search.

Table 1 below shows the phrases used in the search and the alternatives substituted to ensure the search was as thorough as possible.

Original phrase used	Alternative phrase	Alternative phrase	Alternative phrase
Mental Health Crisis	Psychiatric crisis	Psychiatric emergency	Mental illness/breakdown
Service user	Patient	Consumer	
Police	Custody	Cells	Blue Light Services
Street triage	Sign posting	Police models	
Service user Perspective	Patient perspective	Patient experience	Consumer perspective/experience

Table 1: Alternative phrases used in the search

To ensure the accuracy of this result, the use of alternative phrases/words for those identified above was employed. This involved using alternatives for each key phrase, for example using 'patient' for 'service user' or 'experience' for 'perspective'. A table of the results gained (with Boolean operator phrases included) from each of the databases used is shown below in (Table 2):

	Mental Health service user perspective	Mental Health Crisis	Street Triage	Mental Health Crisis and Street Triage	Mental health Crisis and street triage and service user perspective
Cochrane	0	9581	0	0	0
Medline/ PubMed	135	4081	354	17	0
EMBASE	820	726	9	3	0
CINAHL	843	683	6	12	0
Psych Info	278	1259	37	35	0
RCN Database	312	1789	276	12	0

Table 2: Results of Database search including Boolean operator phrases.

This overall process resulted in identifying 67 relevant papers, after removing duplicates. This included using the reference lists of relevant papers and excluding those that were not relevant. These final 67 papers were then read and included or excluded based on the following:

Inclusion Criteria:

- Written in English
- Published from 1990 onwards. This was to allow for the Community Care Act (1990) and for the launch of the National Service Framework (NSF) and the implementation of Crisis Home Treatment Teams in 1999 as per the background context in chapter one.

- Papers presenting primary research

Exclusion Criteria:

- Not written in English
- Published before 1990
- Grey literature

Having undertaken the search as identified above and generated the papers thought relevant to this study based on the inclusion and exclusion criteria, as well as the key words and phrases shown, the next section explores how these papers were critically appraised in more detail to be included or excluded from the final analysis of the literature.

2.3 Critical Appraisal:

Critical appraisal is defined by Crombie (1996, pg. 14) as *“not just a fault finding exercise. It is a process of reviewing a paper to identify its value.”* In order to critically appraise the papers to ascertain their value, the Crombie Critical Appraisal tools (1996) were adopted and used when reviewing the remaining 67 articles, with abstracts being reviewed for prima facie relevance to the study. The Crombie tools are separated to facilitate a focused review of qualitative/quantitative and mixed methods papers. Each of the tools allows a systematic appraisal of a research paper, identifying its strengths and weaknesses and consequently its usefulness and validity. By taking the appraiser through an evaluation of the study design with regard to the research question/s asked and an assessment of the methodology used, it allows a judgment to be made of the interpretation of the findings and their usefulness (Crombie, 2016).

Many other tools exist that purport to assist in the systematic yet critical appraisal of various research papers. They are tailored to the varied types of research methods published in the plethora of journals available to the consumer. These include quantitative and qualitative appraisal tools such as the CASP (Critical Appraisal Skills Programme) that was developed by the Public Health Resource Unit at the Institute of Health in Oxford. Other tools have been developed by researchers such as Greenhalgh (1997) and Crombie (1996) as easy to use

checklists for a wide variety of research methods, including clinical guidelines and meta-analysis.

Following the initial critical appraisal of the 67 papers first identified in the literature review, 10 papers were identified as relevant to the study in question. Of the 10 papers identified, four were qualitative, one quantitative, three systematic reviews and two mixed methods. This reduction of 67 to 10 papers was based on the use of the checklists (Crombie, 1996) and the relevance each paper had to my study. As discussed, the parameters for the search for this study were articles written in the English language that dated from 1990 to the present day, allowing for the evolution of crisis services from the early years of the Community Care Act (1990) and the NSF for Mental Health (1999) to the present day service delivery through RAID teams and Street Triage models, instigated since the advent of the Crisis Care Concordat (2014). When applying such parameters after the Crombie Critical Appraisal review the 10 papers identified as relevant to the study, for the most part, fell into one of three categories as outlined in Table 3.

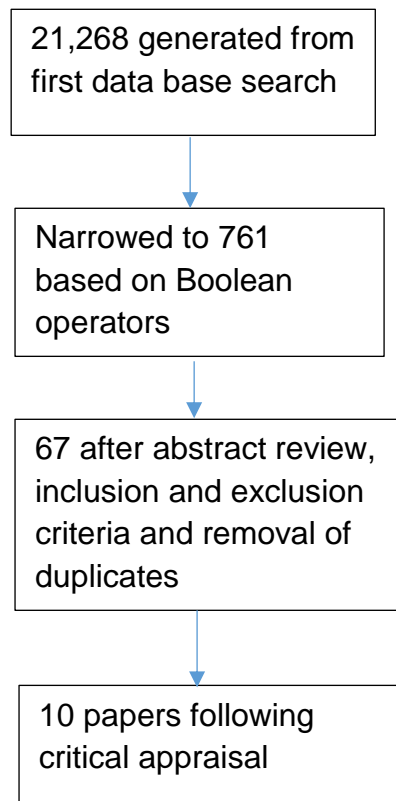
Identified Category	Number of Papers
Reported experiences of mental health interventions when in a crisis from the perspective of service users.	4
Papers relating to the attitudes and/or behaviours towards service users from blue light professionals.	5
The Street Triage Models	1

Table 3: Categorisation of The Papers reviewed

(These papers are presented in the full synthesis table in Appendix 1.)

While it was difficult to extrapolate attitudes from the studies as a distinct category, this particular theme permeated throughout all the papers.

Literature review process:



2.4 Analysis:

The 10 papers generated via the above process were all focused on the service user perspective and street triage models. The relatively low number of papers highlighted the lack of research in this area, but the papers that were generated were closely aligned with the aims and objectives of this study. From the 10 papers identified, four were qualitative research (Jones & Mason, 2002; Riley et al 2011; Canada & Watson, 2012; Clarke et al 2007), one was quantitative (Hails & Borum, 2003), three were systematic reviews (Compton et al, 2008; Reuland et al, 2009; Watson et al 2008) and two (Sands et al 2013; Franz & Borum, 2010) were mixed method studies. Each approach taken in the papers in the literature review carry both positive aspects and limitations that need to be considered when using the literature to inform the work in this thesis.

From the ten papers reviewed, the majority, six, were from the USA (Canada et al., 2012; Compton et al., 2008; Franz & Borum, 2010; Reuland et al. 2009; Watson et al., 2008), two from the UK (Jones & Mason, 2002; Riley et al., 2011) and one each from Canada (Clarke et al., 2007) and Australia (Sands et al., 2013). The papers

covering the service user experience were mainly from the UK, concentrating on what it felt like to have a mental health crisis that was managed by the police. The Australian paper considered how staff dealt with a mental health crisis over the telephone in remote rural areas in the Australian outback. The Canadian paper explores the role of a new Psychiatric Emergency Nurse based in the emergency department (ED) and how this impacts on the experience of service users who attend this facility. The USA papers covered a wide variety of relevant aspects of the topic; such as models of Crisis Intervention Teams that have been set up with specialist mental health trained police officers, what policy is in place to support the development of these teams, a review of training programmes, and the roles of these police officers and the impact they are having. The themes emerging from the papers are as reflected in table 3 above and include the attitude and actions of the police in dealing with a mental health crisis, the interventions available, mainly the ED but also street triage models, and the interventions such services offer, and finally the importance of understanding the personal experience as reported by the service user. Emergent themes from the literature are discussed in the following sections and evidence the gap that the proposed research study aims to address.

2.5 Findings of the Literature Review

Having reviewed the literature as described previously, it was evident that there were clear themes that permeated through all the papers. The service user perspective when in a mental health crisis is central to the overall aim of this study, as is their experience of the interventions they have received, from the Street Triage service I am interested in. As such the following section will present a review of the papers under these headings. The third theme identified, that of the actions and attitudes of the police, is woven into each of the headings as they are inextricably linked in all of the themes rather than a clearly identifiable distinct and separate standalone theme.

2.51. Service user perspectives and police attitudes and actions.

Limited research is available on service user experiences of services offered when in a Mental Health Crisis, with only three studies being identified, (Clarke et al., 2007; Jones & Mason 2002; Riley et al., 2011). Jones and Mason (2002) carried out a qualitative study, utilising a grounded theory approach, involving structured

interviews with 16 service users who had been treated under Section 136 of the Mental Health Act (1983) and held in a police cell for up to 72 hours. This study explored the relationship between what service users expect to happen, how professionals actually responded and finally the experience that was gained as a result of this complex interaction. The paper discusses how service users expect police officers to be '*custodial*' and as such, when they are, this does not impact on their reported experiences in that they remain neither positive nor negative about it, as they assumed that would happen. However, when police officers took service users to the ED, they reported an unexpected response from police officers. The response involved unexpected kindness and understanding to their plight, resulting in service users noticeably reporting this experience as very positive. Conversely service users quite rightly expected mental health nursing professionals to be responsive to their needs and to show a compassionate and understanding attitude to their plight. When this was not what happened the experience service users' reported was far worse than when police officers showed them the same attitude. This raised debate regarding service user expectations and professionals' attitudes towards people experiencing mental distress. Jones and Mason (2002) concluded in their proposed theoretical model on the interpersonal relationships between service user experience and professional attitudes, was optimum experience is reported when both the police officer and the health professional showed the person in crisis understanding and demonstrated a positive attitude. Whilst this might seem obvious to the majority, within the healthcare setting it is noted that it is the combination of everyone involved in that pathway that equates to a better experience for the service user (Jones & Mason, 2002).

This is important when examining a system such as telephone Street Triage as this is a pathway that covers more than one professional and the required training and attitudes sits with all involved and not just one single agency. Jones and Mason (2002) acknowledges the limitations of their study, and the appraisal process affirms this to be the case. Limitations identified as part of the critical appraisal process include all 16 subjects being male, thus not allowing any exploration of gender similarities or differences. This criticism aside, the study does remain useful in offering insight into aspects of service user perceptions regarding their management during a mental health crisis. While the exploration of 'blue light'

attitudes is further considered later in this literature review, Jones and Mason (2002) emphasise the experiences of service users includes a combination of treatment settings such as a police cell, hospital or a community base, as well as professionals and their attitudes towards the distress being experienced. This multi-faceted complex situation needs to be understood to enable the development of services that take into account factors that influence the experience for the service user, both positively and negatively. In relation to this study such a complex situation needs to be considered when undertaking data collection and understanding the context within which the narrative is being delivered. The perspectives of participants may vary dependent on their own personal experience. For example, their experience might be influenced by where they were taken, to a cell, a hospital or a dedicated place, who took them, who talked to them. All of these aspects will have an influence on the perspective of the service user and consideration needs to be attended to this issue during analysis.

The principle aim of this study is to explore the perceptions of the service user when being cared for using the Telephone Street Triage process and, as such, Jones and Mason's (2002) paper will aid in understanding the perceptions such people may have of different professionals and in what context, to fully understand that experience they are narrating. Riley et al. (2011) built on the study by Jones and Mason (2002) and also interviewed individuals who had been taken to the police cells following detention under Section 136 of the Mental Health Act (1983). In this study the perceptions of 18 participants, both male and female were sought. Limitations of this study were its geographical area (only confined to the Gloucestershire area of the UK) and its lack of reflection of the local community. The latter relates to the local population, such as gender, ethnicity, unemployment rates, and level of deprivation that would help the reader to establish if those taking part were representative of this local population, leading to a better understanding of the findings. With regard to the strengths of the paper, it did take into account the views of carer's as well as service users, and does offer meaningful insight into the experiences of those involved in, or actually detained, under Section 136 of the Mental Health Act 1983. An overarching theme emerging from Riley et al.'s study was one of participants finding their experiences of being treated via a place of safety at the police station were '*extremely distressing*'. Some of the participants

reported their detention in a police station made them feel like '*criminals*', and in some cases the process itself made their mental health condition worsen. They reported feeling unsafe and agitated and that the police had not been helpful. They felt that their emotional distress was increased, especially when put in a cell alone whilst not fully understanding what was going on.

In the same study, carers reported they too were not communicated with and that no information was given to them by the police, leaving them feeling alone and frightened (Riley et al., 2011). The paper also discusses how police do want to access places of safety that are not police cells and highlighted their desire to have access to trained healthcare professionals, as they acknowledged their own limitations in such situations. Interestingly, the carers and service users in the study all felt that the police tried their best, but did not have the skills to do what was required and that a specialist place should be available and attached to a hospital where trained staff could look after their needs. While such places do now exist in most hospitals, the use of police cells remains a concerning issue within mainstream mental health services.

Riley et al.'s (2011) study does affirm the findings of Jones and Mason's (2002) earlier study and helps to build an emerging evidence base of service user perspectives whilst being cared for in these particular custodial settings by non-mental health trained staff. Riley et al.'s (2011) paper does, however, lack further exploration of what service users would find beneficial in such circumstances and how understanding this could help inform service development to better meet their needs. Having insight into what service users believe would be beneficial is the essence of this study and as such these areas are in keeping with the core components of the overall objectives of the study.

The underlying principle issues raised in both these studies are also mirrored in Clarke et al.'s (2007) study. This study, based in Canada, explored the self-reported experiences of service users who attended the ED for intervention during their mental health crisis. Using focus groups and thematic analysis the study aimed to determine a level of satisfaction from service users and their families on the care received in an ED and, in particular, the role of the new Psychiatric Emergency Nurse (PEN). The paper highlighted how presentations to the ED are often vague

and as such access to a specialist practitioner is sometimes difficult. The ED staff is not always equipped to manage such presentations and this can, and does, lead to tensions between mental health and non-mental health professionals within the ED. Previous studies (Smart et al., 1999) evidenced long waits and a lack of understanding and compassion for such service users and their carer's. To address this, the Canadian Government put the new PEN into EDs. This study used eight focus groups; five involving service users, one involving carers, one engaging community and third sector agencies, and one mixed with family members and service users. This gave a total of 27 service users as well as seven carer's and five community and third sector providers taking part in this study. The service users were more or less equally represented with male and female participants being 13 and 14 respectively. Limited somewhat by its numbers and the population being urban centric and not reflective of the large rural population the organisation serves, the study still offers meaningful insights into the levels of satisfaction and reasons for these within this given setting. Once the focus groups had been completed the analysis generated six themes that were dominant in the study, of which the following five are relevant to this study:

Waiting in the ED: Service users reported feeling like they were left to the last after triage. Long waits, sometimes up to 10 hours, were reported, but this was much shorter when a PEN was available or if they were accompanied by a carer or a professional. Service users also stated they felt abandoned, and that their basic needs, such as food and water, were not met and some, as a result of this, gave up and left. ***Attitudes:*** Service users reported how they were made to feel bad or criminal for going to the ED, but did report some positive experiences if seen by the PEN. ***Nowhere else to go:*** Despite concerns about attending the ED they reported the need to continue to use it as they have no other choice out of hours. ***Family's needs:*** Carers reported how they would like written information or crisis numbers, much like carer's who participated in Riley et al.'s (2011) study. ***Wish List:*** Most service users and carer's stated they would like PENs 24/7 and to target more mental health awareness for all ED staff as well as the police. The paper concludes that the way in which people are treated in the ED shapes people's perceptions of the health care system as a whole, and their future interface with it.

In the study discussed earlier by Jones and Mason (2002), and the inter-relationship between how the police and health care professionals treat an individual in mental distress, the service users in Clarke et al.'s (2007) study also had expectations next time they used the service based on their original experience. If this experience was negative they expected this to be the same when subsequently using the service. This places an immediate pressure on all parties and may act as a barrier to any relationship being formed before it has even had a chance to flourish. Health care professionals need to be mindful of this when dealing with people attending the ED in mental distress. Much like the old saying 'first impressions last' these studies support the fact that 'first experience lasts' and services need to be developed and supported to offer an experience that is both positive and therapeutic from inception, enabling trust to be developed and better outcomes to be achieved by the service user, carer and the organisation.

The findings offered by Clarke et al. (2007) are not just a Canadian issue. The paper offers an interesting discussion on the success of an ED visit, whereby a patient reported an expectation they would be admitted, even though it was not what they really wanted to happen. It found when staff were able to find an alternative to admission, such as positively engaging the service user and their family in finding a different solution to their current problem, the expectation of an outcome in an ED attendance could change. All participants in the study felt there needed to be a range of alternatives available to allow alternative care options to be offered. In the absence of this service users were left dissatisfied, but not surprised by the experience they had when attending an ED.

Service users reported being managed by staff who were not trained in mental health and the findings from the study revealed an overwhelming disappointment with the service received. However, in the absence of any alternative, there was acknowledgement these service users would have to return to the ED if the same situation should occur (Clarke et al., 2007). What the paper did not explore in any depth is what such service users would have liked to have happened, what they felt could have helped at that time and how services could develop to better meet their needs.

2.52. Summary of the studies:

Overall these three studies show that, despite criticisms being levied regarding the numbers of participants and the subsequent inability to draw any significant conclusions, the evidence does suggest that the service user and carer perspective of 'traditional' forms of management, such as the use of EDs or cells, when in a mental health crisis, are less than desirable. In light of this, services need to consider fundamental changes to improve the service user experience when such a crisis occurs.

2.53. Street Triage Models and police attitudes and actions:

Sands et al. (2013) studied the use of telephone triage services to manage mental health crisis presentations within psychiatric services in Australia. Using a mixed methods approach, both quantitative and qualitative, the study used an observational design with wireless headsets being used to observe 197 occasions of Mental Health Telephone Triage interactions. Of the 197 calls in the study, 70 were deemed to be of a 'crisis' nature requiring a psychiatric assessment, with the remaining 127 being for secondary consultation or clinical information.

The study was based in a 350 bedded tertiary hospital in a large urban setting in Australia. The study used the recognised Mental Health Triage Government scale to identify the level of service required for the service user. This is a 58 item observation tool derived from the National Guidelines attached to the Mental Health Triage Scale (Broadbent et al., 2002). The study used standard descriptive analysis for quantitative data such as frequency of calls and outcomes. Qualitative data were analysed using content analysis of the calls received.

The quantitative data revealed that the majority of the calls from the 197 were for advice. 70 calls were classed as crisis or a Psychiatric Emergency (PE). Of these 70 calls 28.6% were related to suicide, 21.4% were concerned with psychotic episodes and 60% had comorbidity with drugs and or alcohol. The study findings highlighted issues with risk assessment completeness due to lack of availability of information and also not being able to talk to carers or family members when required. The study findings also showed that the Mental Health Telephone Triage team, answering the calls, looked for community support first rather than hospital

admission. The most frequently used intervention was supportive counselling. In a PE, the most frequently used intervention was de-escalation. The timely use of interventions and use of non-coercive techniques was also evident (Sands et al., 2013).

Sands et al. (2013) study does recognise its limitations in terms of the small sample size. This is of course is relative to the overall number of calls received and the number that were actually PEs, which were less than half the total calls taken. Other limitations included the study only being based at one hospital, in an urban setting and as such findings from the quantitative aspect of the study cannot be extrapolated to the general population. However, what it does demonstrate is brief crisis intervention via the telephone can be useful in rapidly stabilising a PE.

In light of these results it would appear the use of telephone triage for people in a crisis enabled their crisis to be managed in a manner that allowed de-escalation and prevention of needing to attend hospital, a model that might be appropriate for the use of blue light service personnel. The combination of effective use of resources, coupled with better clinical decision making and improved outcomes have helped to inform the developing model of Telephone Street Triage in PCFT, across the UK and worldwide.

Sands et al. (2013) study reflected how a telephone based triage service can have its use and place within a care pathway of a person experiencing a mental health crisis. This is regardless of environment and geography, and demonstrates how good interpersonal de-escalation skills can help resolve and/or divert a crisis. The paper highlighted the use of access to an expert clinician in such circumstances and this is one of the essential principles that can be found in the Crisis Intervention Team (CIT) models in America, These teams, especially those which have been in place much longer, such as the original team from Memphis, can offer a wider evidence base in which to discuss and explore the future developments of models within the UK. Such approaches are useful to be able to consider as part of the development of this project and in addressing the overall objectives contained within it.

In 1988, Memphis police shot dead a man who was in fact suffering from a psychotic illness they had failed to recognise. The resulting inquiry and review gave rise to

the development of the first Crisis Intervention Team (CIT), an initiative from which all subsequent crisis services have evolved (Compton et al., 2008). As a result of the Memphis case the USA does seem to have led the way in research exploring the benefits of having specialist police officers trained in the recognition and management of mental illness (Kellie et al., 2012). Watson et al. (2008) undertook a qualitative research study based in Chicago, designed to compare the response tactics utilised by CIT officers trained in Mental Health and working within an identified CIT and the tactics used by the police officers who were not trained and not attached to a CIT. The study, acknowledging its own limitations of size and a constrained population, did outline the fact that the CIT officers were able to more effectively resolve encounters with '*citizens with mental illness*' than the officers with no training and not attached to a CIT. One of the key factors to the success of such teams is the fact that police officers feel confident in the situations they are dealing with (Watson et al., 2008). Regardless of limitations, this study needs to be considered in the design of this professional doctorate study. The way a person feels they are managed by blue light and health care services is evidently influenced by the attitude, competence and behaviours of those professionals, and this issue needs further exploration in relation to a service user perspective on what is beneficial in such circumstances in order to evidence this further.

To become a police officer in the CIT, an individual must undergo intensive training in the recognition and management of mental illness and offer direct work within the team, as well as adopting support and advice roles to other officers on call throughout the area. The papers identified in this literature review, including; Canada et al. (2012), Compton et al. (2008), Franz and Borum (2010), Hails and Borum (2003), Reuland et al. (2009) and Watson et al. (2008) all identified how there is no set model on the training requirements of CIT officers. Compton et al. (2008) suggested 40 hours as the minimum such specialist training should require. The core principles of CIT teams have been identified as appropriate training for police officers involved in recognising and managing mental illness, how to work with their partners such as accessing health service personnel when required, and to be a role model within the wider police force to begin to challenge stigma around mental illness.

Canada et al. (2012) further explored how specialised training of police officers in a CIT, alongside access to specialist practitioners at health based services, could affect the responses of the trained police officers compared to those who have not been exposed to the training and never access support from such expert practitioners. Canada et al.'s (2003) study used a mixed methods research approach by utilising surveys of trained police officers in CIT services and those police officers who were neither trained or working in a CIT team. As well as the survey, the researchers then followed this up with face to face interviews with both sets of police officers. Using a grounded theory approach the study aimed to explore the differences in effectiveness of responses and the resulting implications this could have for policy.

As already identified above a CIT has three core components, training, partnerships with community providers, and the ability to take on the new leadership and role modelling of the service in the wider police department. The first point to note is that all three of these principles underpin the core components required within a Street Triage model. As outlined in the Crisis Care Concordat (2014) (See Chapter 1) regardless of the model of delivery, be that one of telephone triage, custody based or nurses in a car, these principles remain the same.

Canada et al. (2012) reported how trained CIT officers felt more prepared for calls with a mental health component and as a result were more aware of their own attitude whilst taking the call. In addition, they felt they had an increased knowledge base and more patience with the service user involved, with better links to local mental health services and an overall feeling of being more confident within such situations. This finding is in keeping with that of Jones and Mason (2002), discussed earlier, in that they found that the better the attitude of the blue light professional the more positive the experience by the service user. Such schemes as CITs in the USA and, more latterly, Street Triage services in the UK, hope to embrace such a finding and ensure better trained professionals are available to meet the service users and carer's needs when a mental health crisis occurs.

By having specially trained police officers who understand the stigma of mental illness out on the streets, their influence and attitude towards such issues could have a positive effect on those they come into contact with, be that members of the

community itself, other police officers, and/or other blue light professionals. As a result CIT trained teams could help reduce stigma in the community as a whole as well as within the police department itself.

Although the study accepts its limitations; such as it being purely a Chicago based study, it does reveal the differences in links to services between CIT and non CIT trained officers. The study reported that 60% of police officers who had completed CIT training described their responses to scenarios very differently than non CIT trained officers in relations to assessment, response tactics and the disposition of the person identified as being involved in the call (Canada et al., 2012). The study explored how people with mental illness do not respond well to control and command techniques and, as such, CIT trained officers are able to offer a better response to such situations (Canada et al., 2012). Interestingly CIT training is a voluntary programme, as such it could be argued that those who volunteer are already predisposed to more positive views on mental illness and innately better candidates to undertake such a programme. With this in mind it could be indicative of a more positive attitude and therefore, with relevant training, the service user is likely to have an even better experience.

Watson et al. (2008) undertook a systematic review of the literature regarding CITs with a view to identifying a conceptual model of police responses to persons with a mental illness that takes into account the officer themselves, the organisations and the Mental Health System in place, as well as the community as a whole. Watson et al. (2008) described the literature on CITs at that time as '*limited*', but their study identified what they found to be relevant to all 400 CITs. This resulted in 12 more studies. Two on responses by CIT teams; one study focusing on police officer perceptions, one on arrest rates, four on outcomes of the CIT training programme and four on the broader context of CIT models. These 12 studies collectively examined aspects of all 400 CITs across the USA. The outcome of Watson et al.'s (2008) study found that there was no core curriculum for the training of officers in each CIT. Variances in approaches existed, the researchers identifying how there is currently no rich evidence to suggest which training module or course was best. Watson et al. (2000) study highlighted how CIT is more than just training, it links to organisational and treatment offers in the community, as well as the interactions

between police officers. Most importantly in this study the implementation processes was found to be key to a successful model of CIT.

Reuland et al. (2009) commissioned by the USA State Department, published their Policy on Law Enforcement and the responses to people with a mental illness. Using a systematic review, the policy highlights some of the evidenced based solutions to the issue of policing and mental illness, suggesting that such approaches as CIT services are the key to success. However, Reuland et al. (2009) does add a caution, this being teams should use local research to develop sustainable local models that are fit for purpose in the community they serve. The USA, like the UK, has many varied populations, geographical areas, diverse social economic backgrounds and one size training and teams would not suit all.

To further explore the role a CIT trained officer could have in the better management of a person experiencing a mental health crisis, Franz and Borum (2010), using a mixed methods approach, examined the arrest rates of people with mental illness and the number of arrests that it was felt might have been prevented as a result of the implementation of a CIT programme in a large county in Florida, USA. The Franz and Borum (2010) study took the overall arrest rate before the CIT programme was implemented and then the overall arrest rate after to ascertain if the implementation of a CIT training programme and development of a team did in fact make a difference to how such people, traditionally arrested, may have been managed differently. The study used a quantitative approach in looking at the total number of calls to CIT as the potential arrest rate and then divided this by the actual number of arrests made. The qualitative element of the study was the numbers of prevented arrests, based on the police officers opinion of those calls, who they believe were not arrested after the CIT programme was implemented, but who would have been before a CIT team was present. This number, generated by informed opinion, was then divided by the total number of calls.

This data comparison allowed for an informed view on the impact on actual arrest rate of this service before and after the implementation of a CIT programme with the aim of demonstrating any reduction would be due to the fact that other strategies were deployed for some people in mental distress who would have traditionally been arrested. The result shows that calls to the team over five years remained

static, but the arrest rate within the CIT team reduced, whilst the estimated number of arrests in the non-CIT teams actually rose. These results suggest that people with a mental illness are less likely to be arrested when CIT officers are involved and alternative strategies are sought. Furthermore, Franz and Borum (2010) also note that after implementation of a CIT model, arrest rates also reduced for offenders with mental illness, claiming further evidences that CIT programs may indeed be useful in this area as well.

The report highlighted how 7-10% of all police contacts in the USA have a mental health component and the arrest rate is disproportionate to this and, as a result, some anecdotal reports of the criminalisation of mental illness have emerged (Franz & Borum, 2010). The study was limited in that it only concentrated on two key variables, the arrest and disposal of people the arrests prevented. However, these two key areas are able to show a pattern that demonstrates a difference between the two teams, CIT and Non CIT. A major criticism of this study is the fact that the number of diverted arrests is based on police opinion alone. These are police officers who have invested their time in the training and have an evident aptitude towards this area of work and, as such, one would question the objectivity of the results. As a result the evidence generated in Franz and Borum's (2010) study needs to be taken within the context it was generated. It is limited by the pre-CIT data and a lack of knowledge of the details of all the overall calls to the police, not just the CIT calls, also the police officers were asked what they might have done if they had not had the training. That said, it does offer a discussion on what impact CIT trained officers can have on the management of the person with a mental illness who is in distress in the community. If considered in a wider context it does raise the issue of the impact of specially trained officers, or access to professionally trained healthcare workers, and how this could inform future practice and research.

In contrast to the Jones and Mason (2002) study on the perceptions of service users when being dealt with by the police, Hails and Borum (2003) used a quantitative survey to explore the impact of police specialist training on their responses to people with a mental illness. The given context of the study was the identification that many communities in the USA had experienced high profile cases of police interactions with people with mental illness that had resulted in poor outcomes. Such cases had led to major criticisms and litigation, and this was one of the main

drivers behind the development of CITs. A similar issue is reflected in UK society, with many high profile cases of people experiencing mental illness and policing incidents being reported in the media on a regular basis. Cases such as Duncan Tomlin, Sean Rigg, Terry Smith, Carl Bibby and Nuno Cardoso all resulted in death and involved restraint and interventions by the police whilst the individual involved was experiencing a mental health crisis. Given this background, Hails and Borum (2003) found that the first generation training delivered to the original CIT officers was good, but limited. They found that the training did not fundamentally address attitudes and there was little evidence of an increase in knowledge of how to manage people with mental illness; the second generation training programmes do, however, now address this.

The study identified training for CIT officers in mental illness, and the ability for them to be able to deal effectively with such calls, ranged from 1 to 6 hours across the country. This was in contrast with the recommendation from the Reuland et al. (2009) study regarding Policy on Law Enforcement as discussed earlier. They recommend that such training should be a minimum of 16 hours for basic training and at least 40 hours of specialist training to give the full outcomes required from such a team. Furthermore, while Reuland et al. (2009) identified the length of training for both levels of basic and specialist training and the variances across the country, they failed to explore this further. Future studies should include the differences in impact limited training versus more rounded in depth training could have on the outcomes of those people in mental distress dealt with by these teams.

Compton et al. (2008) reviewed the literature and critically analysed the available research relating to CITs. The review was also designed to examine what issues, components and key elements existed that enabled the development of a successful team in terms of meeting the needs of their local population, impact on attitudes and responses, and providing better service user outcomes. Conversely they also explored what issues, components and key elements restricted this and caused a hindrance within such teams. The main finding of the study seems to be simplistic, but was in fact the identification of CITs bringing together the police and health services in a more joined up and cohesive way. This finding showed that communication and streamlined pathways to the person who most knowledgeable of the circumstances being faced was key to providing better care. CIT officers

described how they felt more confident knowing, should they need to, they had an expert available to them to help guide their decision making and outcomes. Crompton et al. (2008) stated that due to their specialist training and increased knowledge base and understanding, such trained police officers could, and in fact now act, as an advocate for the local community and ensure that issues such as stigma and vulnerability were highlighted and tackled. They also identified that there are two key models in existence in the USA; CITs and Co-responders, the latter being the next phase on from traditional CIT teams, by engaging both CITs and health teams, working and responding together from a joint base and having integrated team structure. This is much like the differing street triage models in the UK. Some teams have excellent links between the local police forces and health care professionals, who the former can call when advice and support is required. Some Street Triage teams have nurses based in custody suites who again can be called on when help or advice is needed, and some have fully integrated services where the police and healthcare staff work from the same base and to the same operational standards. Each has its differing key points, both positive and negative, and the remit of this study is designed to illicit what these are and which offer the best service from a service user's perspective.

Reuland et al. (2009) literature review informing the development of the USA Policy Guidance on Law Enforcement, describes how one of the models demonstrating the better outcomes overall is based in Vancouver, Canada. However, it needs to be noted that Reuland et al. (2009) study is limited in the fact that the better outcomes it describes are from the view of the service and not the service user. The study does not explore how the service user felt about this intervention, or if the outcomes were positive from their perspective. The project Reuland et al. (2009) looked at is known as Car 87, it was funded jointly from both health and police organisations and offers a combination of both a physical presence of a specialist nurse if required, coupled with the ability to ring a telephone triage response from a specialist nurse 24/7. The study looked at the numbers of calls to the line and number of incident attended by the specialist nurse and what the outcomes of such incidents were. The results highlighted a number of positive outcomes including service users being diverted from the ED departments to more appropriate settings,

as well as a high number of service users being able to remain safely in their home (Reuland et al., 2009).

Crompton et al. (2008) study reviewed 20 research papers that were directly regulated to CITs and 12 reports that contained empirical research on the teams. The review identified future research needs including the need to look at the link between officer led outcomes and service user led outcomes. In particular, Crompton et al. (2008) identified the difference between outcomes for these two groups of people and was able to identify what the best model of care is for meeting all of these needs. Future studies also need to consider the best model in relation to where a person is taken when they are in mental distress; cells, A and E or a dedicated place of safety, what that should look like, and what should happen within it. These findings overall are interesting in that they reflect the developments in the UK with health based places of safety, street triage models and the need to implement the principles within the Crisis Care Concordat (2014). Crompton et al. (2008) study also evidenced how the underlying principles of the objectives set out within this study; mainly the identification of the service user perspective, what is beneficial and how can this inform future service developments, are required to enhance the overall body of knowledge to achieve a service that meets the needs of those who they are designed to help.

2.54. Summary of the studies:

Overall these seven studies show that, despite their criticisms, the CITs developed as a result of the Memphis tragedy in 1988, have had a major impact on both the service user and the police officers out on the streets. The principles of specialist training and access to a trained healthcare professional underpin these services. In addition, the ability for the specialist trained practitioner to be able to triage the calls and make a judgment on how best to proceed is also imperative and plays a huge part in the management and sign posting of the individual in crisis.

2.6. Overall summary of the chapter and conclusion:

It is evident from the literature reviewed that the provision of joint police and mental health services are at an embryonic stage within the UK, but this is not necessarily

the case in places such as the USA and Canada. The synthesis of the literature reviewed has shown that in these countries such teams, called Crisis Intervention teams (CITs), are more established in the USA, their implementation being over two decades ahead of the emerging Street Triage teams here in the UK. The literature review does highlight that such service delivery in the USA is not limited to one model, but rather reflects local needs, resources and geographical areas, for example rural and urban communities and communities with differing socio-economic backgrounds (Hails & Borum, 2003). In contrast, in the UK two of the most used models are that of nurses' physically being in cars with the police and nurses being available via telephone street triage lines (Crisis Care Concordat, 2014).

The positive outcomes from the studies presented, such as Reuland et al. (2009), demonstrate an alternative care route for service users in distress equates to better outcomes for the professionals, as long waits in the ED with a distressed person were alleviated and there were no referrals onwards as service users were able to stay safely at home. However, there is no evidence to suggest these positive outcomes were shared by the service user. This is a gap identified throughout the literature review and points towards the need for further research to build on the current body of knowledge in this field.

The focus within the literature review has been on street triage models, triage as a principle and the perceptions of service users' whilst experiencing a mental health crisis. The research in this literature review has looked at telephone triage and specialist nurse advice at the point of crisis, due to the fact that police officers in the UK are not equipped to deal with mental illness in the same way as trained specialist nurses are. The literature review has also explored the many studies looking at CIT models based on the initial model established in 1988 in Memphis, USA. Ongoing research continues to demonstrate the positive impact these services are having on reducing arrest rates of people with mental illnesses and better outcomes being reported for individuals involved (Franz & Borum, 2011).

Although the majority of the research studies in this literature review are from the USA and Canada, and are not directly concerned with the service user perspective, they do help to inform the overall exploration of the development of Street Triage

services and illustrate an important gap in the available literature. While only a total of 10 studies have been presented in this section of the thesis, they have been critically reviewed and synthesised in great detail and show that although limited in number they offer the best evidence available that contributes to the aims and objectives of this study. Furthermore, the synthesis and analysis of this available literature has highlighted the fact that there appears to be a gap in the research in relation to the service user perspective. This gap, in relation to the exploration of the service user perspective of being treated through a Telephone Street Triage process in the UK, is addressed within this study.

Undertaking the literature review and identifying the limited research available regarding the service user perspective of street triage models, has helped to influence the research methods to be adopted in this study. Identifying how difficult it is to gain this perspective from a vulnerable, hard to reach group means that the approach used needed to optimise the data collected in order to be able to fully answer the aims and objectives of the study.

The following chapter explores this further and identifies how the literature review and overall aims and objectives of the study have influenced the choice of research methods used.

CHAPTER 3 METHODOLOGY:

In order to gain a richer understanding of the service user experience and perspective of using Street Triage when in a mental health crisis, as per the aim of this study, qualitative research using a narrative methodology was used (Holloway, 1997). Within this chapter I have explored the two main approaches, or paradigms, in research; that of qualitative and quantitative, and justified why the method and approach used in this research was selected. This exploration includes aspects that directed the choice of paradigm and explores my own position further affirming the philosophy, methodology and methods selected. To set the context for this discussion the following is a brief overview of each of the two main research paradigms.

3.1. Quantitative Research:

Quantitative research, sometimes referred to as positivism, looks to achieve the ultimate truth. Aliaga and Gunderson (2003, pg. 2) described it as a way of; *“Explaining phenomena by collecting numerical data that are analysed using mathematically based methods (in particular statistics).”* The quantitative paradigm develops theories using deductive reasoning to generate specific hypotheses. Facts are obtained through objective observation and measured independently from the observer. These observations are reduced to a numerical measure using a recognised statistical test. It is a formal, systematic, objective process in which numerical data is utilised to obtain information about the world. It removes the researcher from what is being studied and provides hard data to study the relationship of the variables being measured. It is systematic in approach, objective, deductive, contains high numbers and is able to be generalised to the target population (Long, 2014). Such approaches often manipulate one variable whilst measuring another; the ultimate aim being to bring together observed findings into a meaningful pattern. Quantitative research has an ability to make predictions, for example drinking certain amounts of alcohol will affect a person’s ability to drive. An example of this positive approach is a Randomised Control Trial.

3.2. Qualitative research:

Qualitative research is an approach that aims to understand phenomena in its natural environment (Creswell, 2011). It is systematic in approach, subjective, inductive, and is not generalisable (Marshall & Rossman, 1987).

“Qualitative methods are often regarded as providing rich data about real life people and situations and being more able to make sense of behaviour and to understand behaviour within its wider context. However, qualitative research is often criticised for lacking generalisability, being too reliant on the subjective interpretations of researchers and being incapable of replication by subsequent researchers” (William, 2005, p.5).

Human beings have a choice about their behaviour and this approach aims to understand such behaviour and individual choices. It aims to understand the interpretations and motivations of the subjects, rather than simple cause and effect relationships. Qualitative approaches do not start with a pre-conceived idea, but attempt to understand the world from the participant's perspective. The main approaches used in qualitative research are ethnography, phenomenology, grounded theory and narrative (Holloway, 1997). These approaches are explored in more depth later in this chapter, but firstly it is important to understand why I chose the qualitative paradigm for this research. Each paradigm offers a different view on a set of criteria, is dependent on the position of the researcher and the topic of investigation. To highlight this, Table 4 compares the two main paradigms of research, quantitative and qualitative, and offers the underpinning reason why I selected the qualitative paradigm for this study against the criteria identified.

Criteria	Quantitative Paradigm	Qualitative Paradigm
Researcher's worldview	A researchers comfort with the ontological, epistemological, axiological, rhetorical and methodological assumptions of the quantitative paradigm	A researchers comfort with the ontological, epistemological, axiological, rhetorical and methodological assumptions of the qualitative paradigm
Training and experience of the researcher	Technical writing skills, computer statistical skills, library skills	Literary writing skills, text-analysis skills, library skills
Researchers Psychological attributes	Comfort with rules and guidelines for conducting research, low tolerance for ambiguity	Comfort with lack of specific rules and procedures for conducting research, high tolerance for ambiguity.
Nature of the problem	Previously studied by other researchers so that body of literature exists, known variables, existing theories	Exploratory research, variables unknown, context important, may lack theory base for study.
Audience for the study (such as journal or thesis)	Individuals accustomed to/supportive of quantitative studies	Individuals accustomed to/supportive of qualitative studies.

Table 4: Reasons for selecting a paradigm Source: Creswell (2011 pg. 9).

3.3. Choosing the paradigm:

Using the table above it is clear that my research sits within a qualitative paradigm. Although my training and experience could be adapted to either paradigm it is mainly my personal psychological attributes that motivated me to utilise a qualitative approach. A comfort that sits better with a lack of specific rules that allows freedom to inquire and explore real stories with real human beings is what personally drives my interest and therefore this study. It enabled me to have a “tolerance of

ambiguity”, as the voice of the service user is what is important to me and the unpredictability of what that might be is, for me, the excitement in the discovery. The context of the study was important as it needed to be about the service user and their own unique and special experiences in order to frame the study and allow inquiry to move and flow as the data collection necessitated.

3.4. Paradigms and assumptions:

As already explored the two main paradigms in research are that of quantitative and qualitative approaches (Creswell, 2011) and these paradigms have a range of assumptions that direct the design of all stages of the research project. These assumptions are ontological, epistemological, axiological, rhetorical and methodological. Each assumption manifests itself differently in each paradigm, depending on the answer to key questions about the research process. It is the answers to such questions that guide the researcher to design a study within either a quantitative or qualitative paradigm (Creswell, 2011). In exploring what paradigm to choose for the research design I needed to understand the assumptions that underpin each paradigm and examine my own position within these assumptions.

In relation to my ontological position the qualitative paradigm indicates an assumption that I hold, there are multiple realities and each of these are subjective. This requires me, as a researcher, to use my skills and ability to listen to and accept the realities for those who have experienced what the phenomenon under investigation is like, in this case service users’ who have had a mental health crisis and used the Street Triage service. In addition, it is important to me to present those realities, exactly as it was reiterated by the participants.

In contrast an ontological position consistent with a quantitative paradigm would require complete independence of the researcher from the subject being researched, normally by controlled experiments or objective observations or questionnaires; and a belief in there being only one reality or truth. This approach is not conducive to eliciting the differing experiences/realities of service users, rather it is constructed, measured and bounded in approach and would not easily allow the freedom of speech and honesty I desire to seek in this study.

Collaborative approaches in research are an area that helps to demonstrate a qualitative ontological position. The Service user group advising on research (SUGAR) that works with, amongst others, the research department at the University of London, have demonstrated that involving their views in all aspects of the research design, from setting the question, designing the implementation of the study, being involved in collecting and analysing data and participating in writing up the study findings has added value to the project. As an example, SUGAR members may be asked their view on how to recruit participants from a particular vulnerable group or asked their view on jargon busting leaflets and information sheets. Collaborating in this way gives equal footing to both the researcher and service user, shifting the power balance to reflect that equality, empowering service users to openly express their views (Miller et al., 2006). This study did not include the use of service users in its design, in a small way, as they reviewed the Patient Information Sheet I had designed and incorporated their views into the final version. This study is primarily designed to ensure the service users are empowered to express their views and that the findings accurately reflect their experiences. As such this research clearly lends itself to a qualitative ontological approach.

In relation to epistemological assumptions, my position is very much aligned to my ontological view, in that interacting with that which is being researched is as important as the actual study design itself. Epistemology, defined as 'The theory of knowledge' (Sensky, 2002) is concerned with the nature and grounds of knowledge itself. Sensky (2002) goes on to discuss how there are three main elements to knowledge; firstly theoretical knowledge, self-explanatory in relation to theories that underpin the knowledge; secondly tacit knowledge or the unwritten, unspoken knowledge, harder to gain, but containing relevant experiences and insights. Finally expert by experience, again self-explanatory, is the knowledge those who have experienced the area under study and as such contain the expertise desired to answer the research questions posed. It is mainly this knowledge this study aimed to elicit.

The richness of data that can be generated as a result of being with a participant is far more valuable than could be achieved through approaches found in a

quantitative paradigm, such as questionnaires that are designed to give fixed responses rather than answers that allow free text and can be freely decided upon by the participants. By designing a project that elicits fixed responses it may encompass the researchers own biases and theories and does not allow participants to share the knowledge and expertise they have developed through their experiences. Through the inter-personal encounter with participants and their willingness to share their expertise I have been able to ensure their voice is heard, a voice which will extend the current, albeit limited, knowledge base regarding Street Triage.

My axiological position would again be in keeping with a qualitative paradigm as I have found 'comfort' in the study being value-laden and biased. While for some this might be controversial, using this approach will enable the service user voice to be heard, and as such reach a wider audience thus benefitting the wider service user population. My 'comfort' therefore is about being able to achieve this end goal whilst acknowledging my bias in the process. I am comfortable with acknowledging my bias within the study design and how this will impact the outcomes. This aspect has been analysed and presented in the discussion chapter of this study. Critics of quantitative research have questioned whether or not such approaches can really be value free. Researchers have of course got their own value base and opinions, and failure to acknowledge these when undertaking research could lead to a less objective approach than is desired. In qualitative approaches, such as this study, there is an acknowledgement of these values and the use of reflexivity to reflect on these has minimised their impact on the findings (Given, 2008).

Furthermore my rhetoric position means I feel comfortable, in fact encourage, using the personal voice and being more informal in approach to facilitate the telling of the service users' experiences to be heard and represented in this thesis. Being qualitative in methodological assumptions also means the service user voice can be authenticated and validated for its trustworthiness, through accurate representation of their narratives, within the context of the study subject. By understanding my position within the assumptions of ontology, epistemology, axiology and rhetoric, helps to understand why the paradigm of qualitative research

was chosen for this study and my own position within that research paradigm that underpins my choice of study design.

My beliefs about research are that it is a framework that can be used to effectively gain knowledge of the service user experience and is able to represent such through a rigorously designed research study, minimising existing bias inherent in my own views, passions and beliefs. Using reflexivity in this process enabled me to understand my position by reflecting on my own views and reasons for undertaking this study and why, out of all the topics and designs I could have chosen, I chose this study. Once the research paradigm and assumptions have been identified the next stage was to identify which approach within the qualitative paradigm would best be utilised to generate and analyse the data required within this study design.

3.5. Study Design and approach:

As discussed above, qualitative research seeks to understand the experience of the service users' perspectives through their discourse and is a "*form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live*" (Holloway, 1997, Pg. 3). As such, utilising a narrative methodology lends itself perfectly to the focus of this study. Taking a narrative approach ensured that I, as the researcher, could elicit experiences and perspectives as recounted by those who have used the Street Triage service and the meanings they associate with them (Holloway & Freshwater, 2007). Besides narrative the other three popular approaches in qualitative research are phenomenology, ethnography and grounded theory.

Phenomenology lends itself to the use of multiple in-depth interviews to gain access to a number of individuals' experiences which then seeks to establish commonalities between them by fragmenting and then reconstructing the data. This is opposed to focusing on the unique experience of each individual in its entirety (Creswell, 2011). Phenomenology is described as a philosophy, used as a method of research to explore the lived experience of individuals, much like the intention of this study. Streubert and Carpenter (1995) stated that phenomenology as a research methodology, is particularly useful in studying areas such as health and illness and being able to understand such areas from the perspective of those

experiencing it. While this could be seen as being relevant to this study, it is the difference in the analytic process that is important. In a narrative approach the researcher is interested in the whole story, whereas in phenomenology interest lays in particular aspects, hidden agendas and “*going beneath the surface and beyond appearances*” (Holloway, 1997 pg. 119). Colaizzi (1978) devised a seven step process for the analysis of a narrative using phenomenology. This approach fragments the narrative and, whilst useful in some qualitative research, it is not what I desired in this study. The main objective of this study was to illicit the service users’ individual stories of their own experience of being cared for using the Street Triage model. It does not seek to solely ascertain common themes, although these may emerge, but rather identify what was unique and beneficial to the individual’s experience. As such a phenomenological approach was not adopted for this study.

Another approach in qualitative research is that of ethnography (Reeves & Hodges, 2008). An ethnographical approach requires the researcher to be ‘living amongst’ the participant group to observe their behaviour and immerse themselves in their culture. Described as the research method of anthropology, it is used to give direct descriptions of a culture. Atkinson (1992) described how ethnography is the oldest of the qualitative methods, even quoting its use in Greek and Roman times when writings were discovered that described these cultures and their travels and battles. More recently Sarantakos (1994) and Thomas (1993) described two types of methods used in ethnography; descriptive (or conventional) and critical. The former, descriptive, focuses on describing the cultures and examining patterns, types and categories within it, whereas the latter, critical ethnography, looks more at the relationships in relation to power and hidden agendas within the culture. As the target group in this study was those who had experienced the use of Street Triage during a mental health crisis, living among these people whilst waiting for them to have another mental health crisis and then observing their behaviour when they did, was neither ethical nor feasible and would have been wholly inappropriate (Creswell 2011). As a nurse, as well as a researcher, I would not be able to ignore the signs of a mental health crisis occurring in those I was observing and to then intervene in their best interest. This would of course enable the person to gain help sooner and negate the need to access the very service I wished to observe them interacting

with. This interference would be inappropriate as at a specific time it could negate the viability of a much needed service.

Finally, in this quartet of qualitative approaches, is grounded theory (Bryant & Charmaz, 2007). Grounded Theory, derived from sociology, was first put forward by Glaser and Strauss in 1967. A grounded theorist would systematically look at data such as transcripts or protocols and aim to generate a theory based on it. This was also ruled out as an approach in this instance, as the study does not seek to generate a theory. It will hopefully ultimately give voice to those service users who have experienced Street Triage services to help improve that service. This will be done by acknowledging and accepting their experiences so as to be able to benefit a larger group of service users and professionals alike. As grounded theory is an evolving process the research does not begin with a theory, but develops one as the research findings emerge. This is known as an inductive approach. The researcher will sample data, analyse data and develop a theory all in parallel, not in distinct steps, and then repeat each one as many times as required to explain the phenomenon under study. The advantages of such an approach are it offers a systematic and rigorous procedure and generates a richness of data based on the experiences of individuals. Whilst this is useful, this study does not seek to generate a theory that can then be applied to all who use the Street Triage service (Pope & Mays, 1995). This study also aims to generate evidence to enable the development of the service to benefit all of its stakeholders, including the police and other blue light professionals. Grounded theory does not offer a framework for this type of study and, as already stated, is more focussed on the generation of a theory rather than the ideas and perspectives that are sought to address the overall aim of this study (Holloway, 1997).

In light of the above, I identified the narrative approach as the most appropriate to generate the information desired for this study. Grounded overall in hermeneutics, phenomenology, and ethnography, and literary analysis, narrative research aims to explore and conceptualise human experiences as they are represented in textual form (Charmaz, 2011). Narratives, or stories, are oral versions of personal experiences' and the primary catalyst by which human experience is made meaningful (Labov & Waletzky, 1967; Polkinghorne, 1988). Narrative research has been used by many researchers over recent years. Plummer (1991) stated that part

of being human involves narrating stories to ourselves and others. It is also said that through the retelling of narratives, people are representing their own identities and the societies they live in (Brunt, 2001). Most importantly for me is that narratives are said to be able to authorise the stories that 'ordinary' people tell (Gubreim & Holstein, 1995; McCabe & Bliss, 2003), this being exactly what I wished to achieve from undertaking this research.

Richmond (2002) used the narrative approach to understand the lives of learners in a Tennessee University, and how those experiences could help others. Using a case study approach the paper provides a rich data set that enables effective changes to be made. Narrative research is also reported to be useful in understanding those who have a mental illness, and again helpful to achieve the aims of this study. Hall and Powell (2011) used narrative research to develop a framework that helped nurses to better understand someone with a mental illness. Again using the narrative approach it demonstrated how by asking "how did this come about for you", rather than the more direct 'why' question, made the person who was unwell feel more at ease and more likely to engage. Other examples of narrative include, Powell (2011) who also drew on Nelson (2004) and his work using the narrative approach on self-narratives in the mentally ill; Stone's (1988) work on illness narratives, using a case study approach, and finally Franks (2007) work on trauma narratives, again using the approach with the vulnerable mentally unwell person. This wide range of papers and works demonstrates how narrative research can be used to extract a richness of data that tells the story of experience from such a unique position that cannot easily be captured through the other qualitative methods outlined above. Understanding the use of narrative, particularly when studying the mentally unwell, has influenced my choice in using this approach for my study and has further affirmed its alignment to my own philosophical position.

Narrative research dates back to 1967 when William Labov and Joshua Waletzky presented their six point model of structuring personal experience and described how this model could be used to analyse the narratives of people's experiences (Labov & Waletzky, 1972). Whilst such an approach is seen as an excellent way to give structure to an experience and allow a detailed and rich analysis of the discourse, its critics challenge the ability to use this method for complicated experiences that do not follow a structured 'tale telling' approach and can over

complicate the analysis required. Labov and Waletzky (1972) assumes an individual tells an experience in a structured manner, with a start, middle and end, when in reality those reliving such experiences involving trauma, as is the case in this study, do not follow a structure in this way. Trying to make the codes Labov and Waletzky (1972) proposed fit could in fact impair and lose some of the richness each participant's experience can offer.

Over the years many new approaches to the collating and analysing of narratives have emerged. These include the approach to understand the events people are narrating and to understand the experience of the person themselves. In this study the undeniable need is to understand the individual's experience of being cared for when using the telephone street triage service and so identifying what approach to use was crucial. Squire (2008) discussed how experience-centred narrative analysis assumes several issues; the narratives are sequential and meaningful, definitely human, 'they re-present' an experience and display a transformation or change for the subject. Whilst offering a framework that can help to focus on the power of the narrative and its meaning for the individual, its critics focus on the over complicated process of analysis and over-interpretation, suggesting both these activities risks losing the essence of the experience.

Many examples exist, such as Frank (1995) and Goffman (1967), on how to produce and analyse narratives told by those who have experienced events, and how such experiences can help inform and develop actions, institutions, services and a whole manner of processes. Such examples include the interpretations of the experiences of illness in Franks book 'The Wounded Storyteller' or Goffman's seminal work on his essays about experiences of human beings in a variety of institutional settings, such as prisons or hospitals in his book 'Asylums'. It is also reported that narrative researchers, elect to use interviews because they wish to delve beneath statistically driven generalisations that are made, but also because they have the potential to validate the knowledge of 'ordinary' people (Benmayor, 1991).

This appealed to me as it would give me the rich data I desired to gain as part of the process. By entering into dialogue with others, narrative interviewers may unearth hidden or subordinated ideas (Anderson & Jack, 1991) and the findings

produced may also lead to the development of new theories that resonate more with people's lives (Hyden, 1994). By engaging participants in relatively informal and friendly ways can sometimes produce stories and comments that do not appear to be immediately relevant (Coates, 1996). Blurring the boundaries between speakers and listeners, narrative research allows care to be taken during the telling of the narrative and not rushing those speaking (McCabe & Bliss, 2003). Taking the time to really listen, allows narrative researchers to plan the outline of an interview schedule, but not to be governed by it (Anderson & Jack, 1991). In doing this it enables the story telling process to be more responsive to the idiosyncrasies of each conversation.

Narrative interviews are then 'interviewee-orientated' rather than 'instrument-orientated' (Reinharz, 1992). Questions such as 'how did it begin' and 'then what happened' may be used to invite participants to translate their personal experiences into stories (Hyden, 1994). Little energy is usually expended trying to create the 'right' questions because it is more important to concentrate on the 'narrator's self-evaluative comments, meta-statements and the overall logic of the narrative (Berger Gluck & Patai, 1991). This continues to underpin why such an approach was chosen for this study. Whilst appreciating that personal stories are often circular, overlapping and 'slightly chaotic' utterances (Coates, 1996), narrative interviews also allow connectedness, appreciate uncertainty and do not follow a linear format. This is especially useful when discussing matters of a 'personal nature' (Harrison, 1996) as is the case in this study.

It was interesting to note that of the 10 studies identified in the literature review, none of them used the narrative approach to generate their findings. This was another motivating factor for me to utilise narrative, again making it this study unique in its approach. The ability to use this approach and keep the stories whole, as well as being able to de-constructed and re-constructed each narrative to produce a story spanning the collective narratives appealed to me particularly in my quest for authenticity.

Within this study a series of individual and unique experiences, told in narrative form were collected. The focus has been on people who have used the telephone street triage service in PCFT, and what those experiences were like from a service user

perspective, the purpose being to use such information to help develop and improve future services better placed to more effectively meet the needs of other service users. The narrative approach as a framework allows for this, however choosing the right analysis of the experiences recalled is key to ensuring the richness of the data is maximised and interpreted in a manner that achieves authenticity and trustworthiness. The analysis of the narratives is explored later in the chapter.

3.6. Ethics:

In any research study the issue of ethics needs to be considered. Harris (1985) in his book 'The Value of Life' explored the ethical dilemmas faced by contemporary medical practitioners and researchers. Relating these to other areas such as philosophy and social and healthcare research, Harris (1985) identified how all studies should ensure that the person, or subject, being researched is "*capable of valuing their own lives*" and as such no study should be designed that does not uphold this view and indeed cause harm to any group in society. To ensure this was the case for this study, it was subjected to ethical approval via the University of Salford's Post-Graduate Research Ethics panel as well as the National Research Ethics Service (Now part of the Health Research Authority): (both applications and approvals can be found in appendix 2). No recruitment of participants or data collection was undertaken until this approval had been sought and granted.

Whilst considering ethics within this study, I needed to take account of it involving a particularly vulnerable group of service users, namely the mentally unwell service user who had experienced a recent mental health crisis. To militate against the potential risks of engaging this group in the study and to ensure all ethical considerations were in place, in the first instance each participant received a letter of invitation (appendix 3), a participant information sheet (appendix 4), and a consent form (appendix 5). Each participant also had the opportunity to discuss the process with myself before they agreed to be involved. In addition, I ensured that they were fully aware of the process of data collection and the support they would receive during and immediately after the interview, and in the longer term if required. As a registered mental health nurse with 30 years' experience, I was aware of the vulnerability of this group, and in light of this I ensured due consideration was built into the interview process. This was achieved through offering breaks as and when

necessary during the interview, reminding the participant they could stop and withdraw their participation at any time and by offering a short debriefing time at the end of the interview. The latter formed no part of the data collection. I was also able to recognise if the participant was becoming distressed during the interview and would have stopped the process and dealt with any distress in a professional appropriate manner, such as seeking alternative help, accessing existing support from professionals involved or any other process required.

An interesting challenge for me in undertaking this study was the nurse-researcher role and to use it as an advantage rather than an issue in the research process. Whilst wanting to ensure the vulnerable service users participating in the study were kept safe during the process, as described above, it was also noted that the role of being a nurse and the consequent benefit participants could gain from being part of this study, should also be acknowledged. Lakeman et al (2012) discussed how participants in studies, such as this one, benefit from the therapeutic interactions they had from a nurse practitioner undertaking such research. By being open about the benefits to those participating and recognising the positive effects of volunteering to be part of the process, also helps to inform ethics committees of the positive aspects of engaging vulnerable service user groups, rather than raising negative issues which often act as a barrier to them engaging in such activities.

When each interview was completed I offered a 15-20 minute none recorded debrief to ensure the participant was able to leave safely and that there were no residual requirements to access a care package before I left. In none of the three interviews undertaken in this study was this required. Whilst there were some welfare checks made by me during the interviews I did not actually have to stop any of the interviews due to a need to seek clinical help. The offer of support and access to appropriate longer term support did still remain open to all participants after the interview should they have wished to access this and this was made clear to them before I left. I also left contact numbers they may require, such as the crisis helpline, Healthy Minds Primary Care Mental Health and the Home Treatment team.

All data collected was anonymised and it was ensured that during the interviews I avoided using names. It was recognised that at times the participants forgot to do

this, however, on transcribing the digital recording I ensured all names and any other identifying data was removed.

3.7. Participant Recruitment:

Goodwin et al. (1999) described how the views of the mentally unwell are not always considered, as many feel such a voice is ill-informed, unrepresentative and indeed unsophisticated. Sadly this view continues to permeate in some corners of mental health services (Juritzen et al., 2011), but in not seeking the views of those who use the services risks the delivery of services that do not meet the needs of the target population, possibly resulting in worsening the problem. Thirty years ago Shields et al. (1988) discussed how it is morally right that the views of service users in vulnerable groups, such as those with a mental illness, should be collated, as not only is it a moral obligation to do so, but such views will inform services that will be effective in outcome and subsequently be more cost efficient.

The body of research available that has examined the ways in which to collect the views of vulnerable mentally unwell people are divided in terms of the most effective way versus the ways in which more useful data can be gained, but can often be more time consuming and laborious. The use of surveys when seeking the views of mental health service users who have recently used in-patient mental health services is one proposed approach (Bond et al., 1990). Generating much information, such surveys were criticised for the generalised information they produced (Myers et al., 1990). Whilst this is acknowledged as the aim of such surveys they did not actually then capture information that was in-depth or informative from a service development perspective and also it did not really capture the feelings of the service users involved (Roger et al., 2015). Rapley (1995) used structured interviews with a group of recent users of in-patient mental health services, and the richness of the data this produced has been recognised (Wood & Pistrang, 2004). However, interviews can be time consuming and issues of power between interviewer and interviewee could compromise the research. A further tool that has been useful in the collection of service user perspectives is the focus group. Identified as useful to generate information and the wider views of a greater number of people, focus groups are also criticised for not being objective, representative or indeed generating information that the participants' feel the leader of the group

wants to hear, rather than their own experiences (Traynor, 2015). It is acknowledged that the target group for this study are potentially difficult to recruit. They are service users who have had a mental health crisis, and who had been cared for via the Street Telephone Triage pilot delivered by PCFT and Greater Manchester Police (GMP). By definition they are vulnerable people who may not have wanted to be identified and who may have been reluctant to participate.

The advantage of being a practitioner-researcher within the NHS, in this case working within PCFT at the start and during the data collection period of this study, is the access this brings to, amongst other resources, the Trust-Wide Service User group. This is a group of service users who represent the views of those who use the services delivered by PCFT. Access was available to local forums attended by service users in the Boroughs of Bury and Rochdale, which also encompassed people in the project's target population. Attendance at these forums allowed me, as the researcher, an opportunity to discuss the research with service users who might meet the criteria for the study or be able to pass the information on to other potential participants. My intention was, with permission, to attend such forums and to explain the purpose of the project and leave a short letter inviting people to contact me to find out more about participating in the study (appendix 3). The letter contained my contact details as the researcher should anyone wish to learn more about the study (written and verbal) which would help them to decide whether or not to participate. In taking this approach it was hoped that relevant service users who had experienced the Street Telephone Triage service would contact me. I also utilised opportunities such as drop in sessions at support and volunteer groups to leave the information. This was again to generate more interest and potential participant interest.

When participants contacted me, arrangements were made to give them a participant information sheet (appendix 4), either by meeting with them at a venue suitable to both parties or by posting the information to them. Once they had a chance to read the information they were contacted again to ensure they understood all of the information and to ascertain if they were still interested in participating. If they were still interested a time and place for the interview was agreed and prior to the interview starting the consent form was explained to the

participant which they were asked to sign if they agreed to participate in the study (appendix 5).

It was acknowledged that it might have been difficult to recruit participants due to the sensitive nature of the topic. The process outlined above may only have generated a very small number of participants and this further validated the use of a narrative approach (Creswell, 2011). Such narrative methods have been criticised as being 'intrinsic and limited' (Stake, 1994), but it is argued that they can also produce a richness of data and information that can be very valuable in informing local developments, promoting an understanding of local experiences and aid future research and possible service development (Hamersley, 1992). This could be the case if the recruitment numbers had been as little as only one.

Due to the sensitive nature of the project and potential difficulties in the recruitment of participants, the intention was for the study to recruit a minimum of one and a maximum of six. This was to allow a narrative analysis approach to take place whilst ensuring the project is manageable and elicits the desired depth of data (Reissman, 1993). Due to the sensitive nature of the project and potential difficulties in the recruitment of participants, the intention was for the study to recruit a minimum of one and a maximum of six people. This was to allow a narrative analysis approach to take place whilst ensuring the project is manageable and elicits the desired depth of data (Reissman, 1993). However, other narrative researchers looking at sensitive topics, such as suicide, also chose a narrative approach for their methodology and, although also only gained limited numbers of participants, generated a richness of data that uniquely contributed to the wider body of knowledge on sensitive areas. For example, research such as that of McAndrew (2008) in her study on gay men and suicidality clearly demonstrate this.

I did actually recruit three participants through the process outlined above, one female aged 57, Carmel, one male aged 25, Tim, and finally one female aged 39, Sam. These names are pseudonyms given to each of the participants in order to protect their anonymity.

3.8. Data Collection.

Data collection in the qualitative paradigm involves the purposeful selection of participants that allow for the best answer to be given to the question asked in the study (Miles & Huberman, 1994). Within the selection process consideration need to be given to the parameters of the study including; the setting, where the data collection will take place and how to ensure those who participate have had the lived experience required to be able to meaningfully contribute to the study, (Creswell, 2011).

In the case of this study the participants are those service users who had recently experienced a mental health crisis and had their needs cared for via the Street Triage service. These participants were therefore purposefully selected as they had the answers to the questions needed to be asked.

Whilst qualitative data can be collected through various mediums, for example, observations, interviews and visual images, data for this study was collected via face to face narrative interviews. This was the most effective method of data collection for the study design, as given the sensitivity of the topic and the potential vulnerability of the participants. The evidence suggests would be the best approach to generate rich and diverse data that would serve to answer the question raised in the study.

The face to face narrative interviews were undertaken at a venue agreed between the participant and the researcher. This was agreed based on the participant's wishes, but also the risk assessment of the individual and the safety needs of me, as a lone researcher. It was planned that interviews would last around one hour, with a short, off the record, debriefing opportunity at the end of each interview. As already stated the debrief was to give an opportunity for the participant to say how they were feeling after the interview, and to offer advice as to where they might access help in the longer term if required and desired. With the participants' permission the one hour interviews were audio-taped and transcribed at a later date.

The actual audio taping was done by use of a small Dictaphone, no bigger than a smartphone device so as not to be too imposing or threatening, when placed

between myself and the participant in the interview. The Dictaphone is then linked to a computer system called Big Hand. This is an encrypted system that allows the taped interview to be safely uploaded to a secure NHS computer and downloaded only by those with relevant and agreed access. In this case this was my secretarial support, an NHS employee bound by the confidentiality policies in place within the NHS. She was able to transcribe the conversations held, but did not know who the participant was or any details other than a pseudonym allocated to each person I interviewed. She would have heard names of nurses and some places, but is bound by confidentiality much the same as if she was typing my confidential reports. Once typed these were emailed back to me for analysis, again using the safe NHS email system. To further protect the identity of the participants each was given a different name, randomly selected by me, and all identification of services used was also removed.

Narrative interviewing facilitates the telling of a person's story and prior to the interview starting each participant was reminded that what is important to the researcher is hearing their experiences of the Street Triage service. Participants were given the following starter statement;

'Tell me about your experience of the street telephone triage service'

However, it was acknowledged that for some this could be difficult, as it may have been too vague. Likewise, some participants were unaware that the service they had used was actually called the Street Telephone Triage service. Where this was the case an alternative question was used that was more structured.

In this instance the following question was used:

'Think back to when you have used street triage, when the police talked to you – describe what it was like for you'

At the start of each interview, participants were reminded they could take a break at any time and if they wished to discontinue their participation that this would not be a problem and no part of the story they had given up to that point would be used in the research.

At the end of the interview the audio-recording equipment was turned off and they were each offered a 15-20 minute debrief to check on their wellbeing, to ascertain if they had any outstanding queries, but more importantly to ensure they had not been distressed by the process and were safe and settled before I left. It is noted that none of the participants in the study required this, but they all already had been given the crisis numbers and knew who to contact if they required it. They were then thanked for their contribution and, if they wished, I offered to send them a brief summary of the findings of the research once completed.

Each of the interviews had gone well and I felt the three participants had been keen to be engaged and contribute their narratives to the research.

The next section will explore data analysis in narrative research and discuss how the data collected in this study was analysed.

3.9. Data Analysis.

As previously discussed in this chapter approaches to analysing data in a narrative framework are essential, yet often criticised. Reissman (1993) discussed how, as researchers, we '*don't have direct access to another's experience*' (pg.8), but what narrative research tries to achieve is an accurate representation of that experience and then to share this. Within qualitative research using a narrative approach it was not possible to be neutral and objective, as accepted in my own epistemological and ontological position (Peller, 1987). This involved accepting the value-laden biased approach inherent in this framework. Acknowledging such biases and values and taking these into account was important when representing and interpreting the experiences being recalled during the data collection process. According to Squire et al. (2008, pg. 1); "*Narrative research offers no overall rules about suitable material or modes of investigation*". This is how the service user voice is heard.

Reissman (1993) suggests the telling, then transcribing and the analysing of a story, told by another, maybe considered a simple linear process, but it does not offer a clear framework despite its simplicity. Smaller studies, such as this one, have involved analysing sections of narratives and may have also incorporated the highly detailed material that comes from analysing stories line by line. Fraser (2004, pg. 23) stated; "*narrative analysis is not meant to be governed by formulas or recipes.*"

Having said this, Fraser did describe a seven phase approach that she suggested can be used when undertaking a narrative analysis. The phases are designed to give a line by line analysis of each narrative told to optimise the rich data they contain. Using Fraser's (2004) seven phases enabled me to take the narratives collected in this study and maximise the unique and rich data each contributed to achieving the aims of this study.

The seven phases described by Fraser (2004) enabled me to describe the narratives in the study in a manner I wanted them to be read, both in their entirety as distinct individual and personal narratives, as well as looking for themes across all the participants' narratives in this study. This approach is designed to enable the reader to gain a better understanding of the experience, and help inform developments through gaining new insights. By retelling and understanding the participants' experiences and what it means within the wider social context, it is hoped that the reader will appreciate the narratives presented and really 'hear' the participants' stories. Fraser (2004) described the seven phases as:

1. Hearing the stories, experiencing each other's emotions

During and after interviews have been conducted the first phase of the analysis involves hearing the stories narrated and experiencing the emotions of participants and researcher. In this study this process was aided through the use of a reflective diary capturing the emotional content soon after each interview had been undertaken.

Fraser (2004) suggests using a journal to describe the feelings that emerge. I did indeed make notes in a diary after each interview and, in this thesis use them in a reflection section after each narrative has been told. Fraser (2004) stated that this process of taking notes about the time, place and emotional climates of the interviews might prove useful. Anderson and Jack (1991) also stated that such notes are likely to affect the subsequent interpretations made, as they help to remind the researcher of the narrative, the emotions it gave and gives rise to, and again to really hear what has been said. This phase appealed to me as it satisfied my own interest of listening to the service user voice and to make that visible in the research and articulating this to a wider audience through this study.

2. Transcribing the material

In the second phase Fraser (2004) describes how the interview material is transcribed. Transcriptions are necessary for researchers who hope to analyse the stories line by line. Whilst time consuming, transcribing the interviews carries many benefits, the main one being how close you are able to get to the stories. Whilst wanting to transcribe my own interviews, this was not practical due to time constraints, but I did keep the notes made in my diary, as well as the tapes made during the interviews. This allowed me to go through the transcriptions line by line while listening to the tapes and using my notes to check for the emotional content during my interactions with participants. Undertaking this process enabled me to embed the narrative in my mind, as well as recall the emotions that were felt before and after the interview (mine) and during (mine and the participants).

3. Interpreting individual transcripts

In the third phase of the analysis, Fraser (2004) states that researchers may want to note some of the specificities of each transcript. She describes how one of the main challenges of this phase, is trying to disaggregate long chunks of talk into specific stories or segments of narratives. Sometimes this is difficult to do because one story ebbs seamlessly into another, this being the case in this study.

One way to manage this is to divide the talk into sets of ideas expressed and make sense of which different plot lines unfold. This again appealed to me as it was in keeping with how I wanted to set out each narrative. By taking the narrative as a whole and then breaking it down into 'chunks' it enabled me to pick out the plots, sometimes referred to as themes, and to interpret what I thought was important to the storyteller. Fraser (2004) also suggested naming each part of the narrative to help recall the set of ideas clearer. I have done this in my retelling of each narrative to underline the plots (or themes) in that part of the narrative, as well as to help break the whole narrative into meaningful 'chunks'.

4. Scanning across different domains of experience

Phase four of Fraser (2004) seven point phases discusses ways to prevent researchers from fixating on one dimension of life. She suggests how narrative researchers should scan stories in each study for different domains of experience

(McCabe & Bliss 2003; Segal, 1999). This phase helps to unearth insights about how different people interact with different dimensions of a similar environment or situation, in this case a mental health crisis and their experience of the Street Triage team. These dimensions can be intrapersonal, interpersonal and cultural (Gagnon & Simon 1974; Simon, 1996). Using this phase ensured that each narrative was examined for different 'themes' that indicated different experiences in the narrative and not just being fixated on anything to do with just the Street Triage team

5. Linking the personal with the political

During this phase attention is deliberately given to references made to popular discourses used in everyday life. Such examples are evident when people speak of 'falling in love' (Ellwood 1996; Westlund, 1999) or 'coming out' (Plummer, 1995). Trauma narratives, such as those in this study, contain popular metaphors of the 'aftermath' 'recovery' and 'rebuilding' (Herman, 1992; Plummer, 1995). Metaphors are a shorthand way of constructing meanings through speech patterns that have already been established in popular vernacular. This phase helped to identify what the metaphors were in each narrative and to interpret these. This allowed for an exploration of my interpretation and discussion of the theories and the analysis this generated. In the narratives in the study, one participant used the phrase '*boy to a man*' when talking about how his therapy had made him feel. In the given context, such phrases enabled me to explore what that meant, how I interpreted this and if it was supported by current evidence and/or theory.

6. Looking for commonalities and differences among participants

If it has not already occurred this phase involves researchers examining the transcripts for commonalities and differences that exist among and between participants. Patterns may surface that are worth exploring. Differences and similarities of themes is another aspect of the analytic process. While considering how stories align with the initial assumptions of the research, narrative researchers may also want to note 'findings' that are inconsistent, counter-intuitive, surprising and or anomalous (Worthington, 1996). It might also involve exploring ideas that are confronting and/or unpopular, such as suicide or child hood traumas. Using this approach helped this to be achieved and forms part of the discussion in Chapter seven of this study that looks at the commonalities in all three of the narratives and

explores what these mean for the future service development of the Street Triage service and further research ideas.

7. Writing academic narratives about personal stories

Narrative researchers are aware that in the process of pulling together threads of others stories, we will be telling stories of our own (Ellerman 1998; Ezzy 1998; Solas, 1995). As such a central part of the writing process is honing the analyses. Rather than hoping to produce 'the right' knowledge, narrative researchers realise that there are multiple possibilities for representing stories. For research to be coherent and credible, narrative analysts may want to keep checking that the written analyses they produce correspond to the stories told, as well as to the objectives of the research. This process ensured that the way the story was narrated in written form within this thesis captured the actual verbal narrative told and was true to that original process. In doing so I was able to accurately offer the authentic voice of the service users who participated in this study. Narratives are not always told in a simple linear fashion, but by using Fraser's (2004) seven phases of narrative analysis, the data has been analysed and presented in such a way that the participants' voices are foregrounded and their experiences made meaningful to the reader.

As such data will be presented in distinct individual chapters, each one dedicated to the narrator of that story, who gave not only their time, but a real insight into their own experiences so others could ultimately benefit. Each chapter will be presented with key events, themes, and actions extracted, quoted and represented to allow the reader to understand the perspective of the narrator in the context in which they told their story. Each chapter will also contain a reflexivity section allowing the reader to understand my own thoughts and feelings before, during and after the interview, and how my subsequent actions might have impacted on each of the interviews undertaken.

The final chapter regarding findings is the drawing together of any themes that have occurred across each of the individual stories. Presenting the analysis in this way ensures that the service user voice and their individual perceptions of their own experiences is not lost in 'reducing' their narrative down to a code or a category,

and the richness of the data in each interview is able to be utilised in the discussion, final and recommendation chapters.

3.10. Rigour, Authenticity and Trustworthiness:

Qualitative research is often criticised for lacking scientific rigour (Mays & Pope, 1995). Scientific knowledge, as generated by quantitative research, is seen as the gold standard of knowledge in that it is generated from what is considered the most thorough research processes available. The most common criticisms against the rigour of qualitative research are it is just a 'collection of anecdotes' from participants that cannot be reproduced and it lacks generalisation (Mays & Pope, 1995).

Despite such criticisms, qualitative research can, and does, offer new and unique knowledge that can develop the overall body of knowledge and make a real impact in and contribution to the research world (Golafshani, 2003). The purpose of many qualitative studies, this one included, is not to create a 'single truth' that can be generalised to a wider population, but to identify its rigour and authenticity from a particular set of individuals who have experienced a unique situation, such as being a service user in a mental health crisis who was treated using a particular Street Triage service. In this instance the rigour is demonstrated in the thoroughness of the approach and study design, and the ability for this to demonstrate its own 'truth value' as described by Holloway 1997; '*Validity is the scientific concept of the everyday notion of truth*' (Pg. 159).

In this study the transcripts of each participant were shared with both supervisors independently to review for themes and differences. This process was also undertaken by myself. We then used supervision to discuss differences and similarities; debate the academic literature that informed the themes identified and discussed the interpretations one could derive as a result. This richness of discussion and independent views generated from this process also added to the validity and rigour of the analytic process as a whole.

Authenticity is seen as the more important strand of qualitative research, as this includes the research representing participant's perceptions and, as is the case in this study, their narratives. This representation is the evidence that ensures what is

being portrayed in the study is authentic. This is demonstrated in the transcribed transcripts and the representation of these in the finished thesis. This process should stand up to scrutiny and clearly demonstrate the evidence behind the representation. Being able to do this ensures the study has rigour (Holloway, 1997).

The concept of trustworthiness is therefore important in qualitative research, being seen as; '*the qualitative researcher's alternative to validity*' (Holloway 1997, Pg. 160) and it is trustworthiness that demonstrates the value of the research. According to Holloway (1997, pg.160) '*Qualitative research is trustworthy when it reflects the reality and ideas of the participants*'. The study design in this research is such that it provides rigour in its thoroughness of design and implementation, its authenticity in its demonstration of the participants' voices within the study and its trustworthiness in that it reflects the reality and ideas that the participants contributed.

The following chapters (4, 5, and 6) will present the narratives of each individual who participated in this study, reflecting the phases outlined by Fraser (2004). In doing so, the reader will experience each narrative from the unique perspective of the person telling it. In addition it will demonstrate the approach taken in this study is rigorous, authentic and trustworthy.

CHAPTER 4 FINDINGS: CARMEL'S STORY

Within the next three chapters, individual narratives will be presented, each with my own analytic interpretation throughout the narration. This analysis will be presented as described in the previous Chapter (section 3.9), embracing the seven phases as set out by Fraser (2004). Each narrative will be concluded with my own reflections on the process and interactions following each participant interview.

As discussed in Chapter 3, section 3.5, each participant has been given a randomly generated name to protect their identity and all references to services used have also been either redacted or anonymised. In this chapter I will articulate how I heard the narrative, how I interpreted the transcript, the '*domains of experience*' I identified from the stories within the overall narrative, reflect on how the narrative links to popular discourses and theories, and provide an overall analysis of the narrative told by a service user I have called Carmel.

Carmel is a 54 years old female, who lives alone and experiences severe anxiety. Carmel has been known to mental health services for many years and often moves from one mental health team to another as her symptoms dictate, frequently entering a crisis situation. This narrative explores one such time in which the police attended her house following a call for help from Carmel and how this event was managed using the Street Triage Team, part of the overall RAID service, from her perspective.

The Story of Carmel: A Survivor.

4.1. Introduction

Carmel was interviewed in her own home at her request as she experiences severe anxiety and struggles to leave her house without making this worse. Carmel is well known to secondary care mental health services and her most recent risk assessment, updated the night of the incident that she describes in her narrative, indicated that there would be no problems with the interview taking place in this environment. The information regarding the study had already been given to her prior to her agreeing to participate, but it was re-read to her at the start of the interview before she signed the consent form. I ensured that reassurance was clearly given to support her from the moment I arrived at the house and once she

indicated she was ready to start I turned on the recording equipment. (A full transcript of the interview can be found in appendix 6). The interview began with the single opening question of *“you were looked after by the police speaking to the nurses at the hospital, can you tell me all about this and what was that like?”*

This is Carmel’s narrative:

4.2 Perceptions, rejections and trauma:

In telling her story, Carmel began with a short history of how her illness manifests itself, what usually happens and the situation she constantly finds herself in. The remarks Carmel made very early on in her narrative, and throughout the telling of her whole story, were indicative of her perception of health services and how, at times, this influences her decision making;

“I have been left in despair so many times anyway with no support I am not able to leave the house to get the assessment done you see. Even then it takes 2 weeks if I do get to Casualty for the assessment. There’s nobody mentally health trained up there which is ridiculous. There was years ago, but not anymore so we have to come from Bury to sit there for 6 to 8 hours in anxiety it’s too much. So I tend to just cope myself, but I can’t anymore.” (Page 1, line 12).

For me the above quotation demonstrates resignation on Carmel’s part. Those with mental health issues who have previously experienced a poor service often expect that they will be received with poor attitudes and are likely to have to wait a long time before being attended to (Chadwick et al., 2012). While some may continue to access such services feeling they have no other choice, others, like Carmel, try to manage alone. In a further statement Carmel highlights the problem inherent in such situations;

“Yes that’s why I don’t even bother contacting them anymore. Because I don’t know what you have to do to get them now. Whether it’s because I can’t any longer get up there I don’t know maybe that’s the reason. assessment (mmm) I shouldn’t be left 2 weeks. So I’ve not been assessed because I’m not well enough.” (Page 8, page 14)

In the above quotation Carmel is able to articulate the risible nature of her experience, suggesting that because she is unwell she is not able to have an

assessment. Carmel blames herself for not being able to access treatment and hints that in light of this she has been rejected by services. Feelings of rejection is a common thread throughout Carmel's narrative: Rejection from her family, as well as rejection from services she believes should help her.

Feelings of love and belonging have been recognised as a fundamental layer of human motivation (Maslow, 1954). The ability to give and receive such affection is central to the psychological health of an individual. People who feel they did not belong socially, or who have experienced rejection in any form; relationship, familial or social, is at risk of poor mental health, increased anxiety and prone to depressive illnesses (Baumeister & Rice, 1996). Unfortunately Carmel had experienced rejection in each of the categories specified, perhaps culminating in her poor mental health which is characterised by anxiety and depression.

As Carmel told her narrative, it became clear to me that she felt rejected by services and, as a result, viewed them negatively. This perception could be what drives her actions when in a crisis, meaning at times she does not seek the help she needs as she feels it will not be available to her;

"Because I always used to ask for help, but not anymore no. You're on your own." (Page 12, line 184)

A study by Twenge et al. (2002) indicated how rejection can lead to self-defeating behaviour, with the thoughts of the rejected individual, as appears to be the case with Carmel, creating a fixed perception of a situation. For Carmel this appeared to manifest as the negative perception she associated with accessing mental health services.

It was clear from her words, as well as the non-verbal manner in which Carmel narrated her story, that she had experienced trauma. Her traumatic experiences appeared to have influenced her view of mental health services and inevitably affected her trust in others. Carmel did comment on her childhood experiences and this part of her narrative is very traumatic;

"From being born I was brought up and went into the nuns they used to wake me up when they wanted to lay out the dead bodies. I was only 6/7 years of age. That was traumatic in itself I had to see a Psychiatrist at age 7 because I started rebelling by then. They said I was maladjusted at 7 so I had been mislabelled all my life. Hence why I cannot judge anyone because I know how

it feels to be misjudged.”I’ve tried so hard to help myself as much as I can do, but I attract madness. I don’t know why, well I do know why, because I had no guidance as a child, raped by daddy, and all his friends, and being until nearly 7 ummm and then any psychology I’ve read over the years, ‘show me the child I will give you the adult.’ Show me the child at 5 and I will give you the adult.” (Page 11, line 170)

Many studies, have demonstrated how the effects of psychological trauma and experiences, particularly in childhood, can result in a vulnerability in adulthood, with an increased risk of anxiety and depression (Jeronimus et al., 2013; Read & Bentall, 2012; Kessler et al., 2010).

However, noticeably, the tone in which Carmel described these events was very ‘matter-of-fact’ and seemingly detached, but this may have been the result of her mistrust in others;

“Yes but I mean I have had years when I didn’t feel believed (mmm) I had one GP, I’d never met her before and she ran out of the room, so I looked at the monitor while she ran out and it said schizophrenia, well I now actually think I am schizophrenic. You know because I’ve had so much trauma since then (mmm) it’s one of the main causes.” (Page 19, line 170)

“I can’t stand anybody who’s not efficient, I’m not being funny erm but I haven’t got patience when I’m having a breakdown for somebody asking me what should happen, do you know, what’s best for me, you know. I had one lady come and she sat there and fell asleep, I said excuse me am I boring you. Disgusting -- that’s not long ago.” (Page 6, line 86)

Bowlby’s (1973) attachment theory describes how adults who have not had positive experiences in childhood often learn to detach themselves as a way of self-protection. Such detachment can lead to mental health problems in later life. It appears from Carmel’s narrative that her early experiences as a child, and the rejection evident in her later life, have manifested in her current vulnerability and mental health issues. It is not surprising that such vulnerability exists given the traumatic details reiterated in excerpts of her narrative presented above, yet Carmel seemed very detached from most of the trauma and indeed re-told it with little or no emotion. This is clearly how Carmel copes with the past events she has experienced, in psychoanalytical terms such detachment is seen as a defence mechanism (Bowlby, 1973).

Carmel's resilience and her defence mechanisms are clearly evident throughout her narrative. On many occasions Carmel described how 'useless' services were and that she stopped engaging as a result. Carmel clearly did not like rejection and if challenged by professionals on her thinking or behaviours, she appears to use her own form of rejection to cope with the feelings this invokes. For Carmel this usually took the form of walking away from services who she then views as 'useless';

"I couldn't look at my GP because he had two heads the other day and he was awful with me and I walked out on him. Because I don't know whetherbut I won't be abused by anybody willingly and he was abusive, so I refuse to see him anymore. Got a nice lady now and she knows how to be with me, if somebody doesn't get me I can't relate to them, I don't care how professional they are, I've had so many abusive treatments over the years and treated like a piece of crap on the floor that I won't be treated willingly, abused by anybody. Because I got same rights as anyone else and respect is a two-way thing just because he's a qualified doctor doesn't give him the right to treat me as bad as I have been treated over the years." (Page 3, line 43)

Carmel appears to be resilient, but her resilience does not seem to have facilitated the attainment of a positive happy fulfilling life, but rather it allows her to cope with her experiences and deal with them in her own way. Pecillo (2016, Pg. 64,) defined psychological resilience as *"an individual's ability to successfully adapt to life tasks in the face of social disadvantage or other highly adverse conditions."* In a longitudinal study, Werner (1971) identified resilience as being a set of positive attributes developed by individuals, and despite experiencing highly adverse situations being resilient can enable a positive attitude, set of behaviours and the ability to live a fulfilling and happy life regardless of any earlier experiences. Carmel's coping mechanisms appear to allow her to deal with the traumatic events she experienced in childhood and the rejections she has encountered in adulthood, but her resilience has not led to her living a happy fulfilling life. Perhaps this might only be achieved if she was able to address the trauma and rejection she has experienced through undertaking psychological therapy. However, Carmel has tried a number of psychological approaches to addressing these issues, including counselling, cognitive behavioural therapy and had also been referred for psychoanalytical therapy, but never went to the initial appointment. She discussed how she thought it was all *'not working for her'*. It could be suggested that therapy might have actually been too traumatic for her, and she was not ready for such

exposure of the events and she had managed to deal with in her own way all these years. Carmel's inability to engage with therapy led to her being under the care of the home treatment team, but it was short term, only until her crisis had averted. Once Carmel had become stable she was moved on to the care of a psychiatrist, but she was evidently unhappy with this.

Carmel's behaviour could be considered in terms of Transactional Analysis (TA) theory and in particular the 'yes, but' game (Berne, 1964). Eric Berne (1964), in his seminal book 'Games People Play,' describes the 'yes but' game as people saying yes I could do that, but this is why I do not do it. In this instance Carmel could be saying yes I have tried counselling (or other therapy), but it did not work for me as I found it too traumatic; or yes I tried home treatment team, but no that did not work for me as it was too short. In terms of wider TA theory this could be interpreted as Carmel wanting to stay in a safe place; that is being safe by harbouring old, but familiar feelings. Staying in the same emotional place is safe even though not always the best place to be (Berne, 1964). As Carmel could not cope with the experience of therapy she defaulted to her natural coping mechanism of rejecting others before she is rejected, thus disengaging from the process and blaming others for her negative experience;

"Yes, maybe it would cure me, but I don't want to take that risk, a lot of people do say that....and I had so much shit counsellors anyway, I have walked out many a times because they are crap. You need a rapport with a counsellor, you need trust, especially, I'm not being funny I've only had one decent one, and she bloody left half way through I could have told her mmm but she left half way through my treatment so I didn't go again." (Page 12, line 182)

4.3 Trust, mistrust and insightful thoughts.

Despite her experiences and their impact on her mental wellbeing, Carmel had a remarkable amount of insight, evident in many statements throughout her narrative;

"I knew I was suicidal I don't doubt when I'm suicidal, I don't have any doubt at all, I have different stages of despair but when I'm suicidal I actually am, do you know what I mean, I don't just say it for sayings sake." (Page 2, line 20)

"You see there isn't any madness in me, mines trauma; my issues are through trauma" (Page 2, line 28).

Her ability to understand how her illness can manifest itself, as well as why it is present, may offer some assurances to Carmel that help her to understand why she feels as she does. However, although insightful in terms of understanding, her narrative does suggest she also feels at times that her situation is helpless and she may as well give up;

“I’m not functioning at all. The pain is so bad. It does hurt you know. I have deep pain. It’s not surface pain mine, I’ve had so much counselling, nothing works. I end up OD’ing at the end of it. Do you understand me, so nothing actually eases my deep trauma and knowing that is why it is easy for me to go to sleep. Because I know, I know I will never heal, I know that. I have been trying all my life to heal but there is so much to heal, if I could just get away from here, it’s a start and sometimes I could just go to sleep it would be so much easier.” (Page 11, line 168).

Regardless of her words above, Carmel’s narrative does provide some understanding as to why she does not in fact give up. Her wish not to be defeated by those she thinks have harmed her in the past, seems to help her to keep trying;

“I thought zero tolerance, I am not having this anymore.” (Page 4, line 26).

Her deep rooted mistrust of health services is very clear throughout her narrative and maybe linked to her marriage and the fact that her ex-husband was a nurse;

“He drove me to suicide within 3 weeks of marriage, cheating on me, that was my first big OD and because he was a charge nurse he came into hospital and took me out before a psychiatrist, before I got to tell anybody that it was him that drove me to it.” (Page 2, line 26).

Trust in any relationship is important, but it for Carmel positive relationships have not been evident with those she should have been able to trust; her father, her ex-husband, her children, her one friend and professionals. While trust is paramount in order for all relationships to develop (Batch & Grant, 2011), trust in a therapeutic relationship is essential. The nurse-patient relationship is said to be predicated on empathy, respect, trust and good communication (Arnold & Boggs, 2007). These essential components of a trusting relationships were absent from Carmel’s narrative, rather she describes her relationships as;

"I was in fear and I couldn't report it [domestic violence] at the time because I was in fear and trapped with the kids and I didn't know there were refuges, I didn't know there was any escape from him, I was in fear of him daily, hourly. Absolute mad man." (Page 2, line 28).

"Respect is a two way thing just because he's a qualified doctor doesn't give him the right to treat me as bad as I have been treated over the years." (Page 4, line 53)

"I'm not I'm the good one, and I hurt so much. I don't regret having them (children); I just regret having them with him. But they don't care anyway because I've had no contact in 6 years, which hurts every day. So I have very little to live for I'm being honest. They were my whole world. We didn't go in a refuge because he was a nice man did we!" (Page 11, line 68)

"Only one friend and her family is in intensive care at the moment so I won't even attempt to bother her, you know, and to be honest she not right much help because she got an idyllic life so she doesn't understand me suicidal." (Page 1, line 18).

Despite many examples of receiving poor treatment and a lack of positive relationships within her life, Carmel still retains the ability to place her trust in others, showing resilience in a manner that has positive implications for Carmel;

*"I have no complaints about ***** police and again they are like family." (Page 9, line 144)*

4.4. The thin blue line:

It is difficult to understand how, despite all the traumatic experiences Carmel has described; the circumstances of her ex-husband's behaviour towards her, her experience of rape both as a child and as an adult, she still has trust in the police.

Carmel clearly appeared to have a lot of respect and time for the police officers she has come into contact with. One reason for this might be the fact that many of them have supported her in some of her darkest moments and, despite her words to the contrary, it felt to me Carmel did want to be alive;

"So we have a bit of a banter going. He gets upset because he's seen me twice since. Come on – you know I've seen you dead and it was them words that shocked me into getting into that ambulance. He made me come too." (Page 9, line 166)

“Police are lovely with me because they know that we’ve tried to prosecute a few times and they know I’ve ended up taking suicidal thoughts with the stress of not being able to prosecute, right, so they know, they can’t do enough for me.” (Page 7, line 108).

It would perhaps be expected that a survivor of rape, both as a child and an adult, may be mistrusting of males, making Carmel’s evident trust in male police officers all the more interesting. Rape Trauma Syndrome (RTS), similar to Post Traumatic Syndrome, was a theory first put forward by Ann Wolbert Burgess, a psychiatrist, and Lynda Lytle Holmstrom, a sociologist in 1974. RTS describes the psychological trauma that is often experienced by victims of rape, such as could be seen in Carmel’s life as she continued to narrate her story. Regardless of the physical trauma, RTS describes changes in lifestyle adopted by rape victims particularly due to feeling unsafe and insecure, including hesitancy in making new relationships and developing phobias such as being in crowds or going out.

What is interesting in Carmel’s narrative is the fact that the police were male. It might be expected that given her traumatic background in relation to her father, ex-husband and an ex-partner, she may not have felt comfortable with them. However, she clearly was at ease with the policemen who attended to her when she was in crisis, perhaps due to the safety their uniform portrays, giving them recognition of being someone she feels able to trust, and/or it might relate to the level of authority and standing they have in society that she intrinsically still believes in. She genuinely felt that the policemen attending were a big help to her when she was in crisis, even being a little jovial and flirty in manner when describing them;

“Yes because he was well fit (laugh). So oh good. Fair enough then (laughing). So we have a bit of a banter going.” (Page 11, line 166).

What was noticeable throughout her narrative was that although Carmel evidently had positive thoughts about some people and professions that had helped her, such as the police and members of the crisis team, it was as if she had to immediately take the positive away and return to her negative thinking;

“Crisis Home Treatment Team, I knew them all by name, they were like family” (Page 10, line 160).

“Sometimes I used to sack them (Crisis Home Treatment team), you know if they weren’t any good”. (Page 10, line 164).

From the way in which Carmel told her narrative it appeared to be difficult for her to give up her negative thought processes. It could be suggested Carmel did not wish to give this up, as it appeared to serve as a coping mechanism, becoming the way she deals with difficult situations in her life, as opposed to addressing them through direct confrontation.

Coping mechanisms have been identified by many psychoanalysts over the years as 'Mechanisms of Defence' (Holmes & Bateman, 1995). Indeed Freud in 1937 in relation to defence mechanisms, talked about how "*the ego makes use of various procedures for fulfilling its task*". (Freud, 1937, pg. 235). The concept of defence explores how the interaction between ones wishes (id) and reality (super-ego) can cause the individual to become tense and anxious. This in turn causes internal conflicts within the mind (ego) and can trigger adaptive behaviours to be able to then cope with this inner turmoil. Such adaptive behaviours or defence mechanisms. For example, the defence mechanism of repression involves a person pushing the unacceptable away from their own consciousness. There are three main types of mechanisms of defence namely primitive/immature, such as being passive aggressive, or neurotic, such as being in denial or finally mature, such as using humour (Holmes & Bateman, 1995).

Carmel appeared to me to exhibit, at times, both primitive and neurotic mechanisms of defence as a way of coping with her past traumas and her current situation. In particular I noted the immature defence mechanism of devaluation in which others around her are dismissed as not being of value to her and that somehow she is not bothered by the situation. This could be particularly seen when she talked about no longer seeing her daughters. The neurotic defence mechanism observed in Carmel was repression, described as the primary mechanism of defence (Holmes & Bateman, 1995) this behaviour in essence removes a traumatic event from the conscious so the person in effect is ignoring its existence. Carmel talked about the multiple sexual assaults she had experienced in a very 'matter-of-fact' way as if these events did not happen to her, but to someone else.

This behaviour could also be a manifestation of her acute anxiety and feeling the people there to help her were causing her more anxiety. Likewise, when experiencing high anxiety she might have less patience than she would when she

is well. It's a double edged sword and typical of people experiencing acute anxiety (Varcarolis, 2010).

4.5 Street Triage and other new experiences:

In the telling of her narrative Carmel was prompted to explore her experience with street triage and how this compared to her previous experiences when she had a mental health crisis. From Carmel's narrative it was obvious she had little regard for the Mental Health services she had received in the past, and she readily talked about her negative experiences when she had engaged with services at the local hospital;

"And even mental health torture me when I go up there, I have to go through the 54 years of abuse every single time I go up there and I think you got that big bible there why do I have to keep reiterating everything, and how's that supposed to help me when I'm suicidal you know, how's that supposed to help me." (Page 4, line 44).

This part of the conversation indicated that Carmel did not really trust the Crisis team and had little time for their input. This could possibly be because the Crisis team represented all that is 'health' and 'mental health' and these agencies have failed to meet her needs in the past. Carmel puts her trust in the police, perhaps because she sees the police as dealing with the person who did her harm, such as the man that raped her, while the Crisis team focus on her current mental illness and presenting crisis, and keep asking her about her past and how she has become unwell. This is interesting to me as it links back to the earlier discussion on mechanisms of defence and in particular Carmel's use of repression. Continually being asked to repeat details of her past at a time when she is feeling particularly vulnerable is clearly not easy for Carmel and as such she does not find this helpful.

Carmel's narrative also demonstrated her long term relationship with health services, at times evident in the phrases she used, reflecting those she would have heard in the health settings had contact with;

"I thought zero tolerance I'm having no more." (Page 2, line 26)

The use of the term 'zero tolerance' was particularly interesting as it showed her close links to the language of the health workers who had cared for her, yet clearly not liking or trusting their input into her wellbeing.

As previously discussed in her narrative, Carmel had already formed a perception of crisis services that perhaps impacted her engagement with the Street Triage team which she found difficult. Some of Carmel's previous experiences lead her to believe she would be taken away, assessed after hours, be kept waiting for long periods of time and then left to get home on her own with no money;

"So I was bit annoyed at the police in a way because they rang RAID and first of all they said to me mmm we can get you help today – I said no there's no point there's never any help." (Page 4, line 53).

"I've taken to hospital so many times and just dumped there and you end up being sent home in the middle of the night on my own. £15 taxi home on benefits you know. They get you there by police car or ambulance but they don't think to let you get back safely, when you're vulnerable as well. So I try and avoid going to anywhere at all costs, because I have difficulty leaving the house anyway." (Page 4, line 54).

Her narrative regarding the interaction with the street triage process was interesting in that her preconceived ideas of what would happen when the police arrived did not transpire as expected, and Carmel appeared to have experienced some positive benefit from this interaction. Carmel was evidently not aware that the service she had used was that of Street Triage, but what she described depicted this perfectly. She talked about how the police contacted the Street Triage team, and, although Carmel knows she has the number to talk to the Street Triage team directly, she does not use it, probably due to her negative perception of the service she would receive. Carmel appeared to consider contacting the Street Triage team as a failure, but conversely she was more than happy to ring the police.

When the police did arrive, on the evening she described, her narrative indicated she expected them to take her to A and E and she did not want to go. Carmel was willing to speak to the Street Triage worker using the police officers phone when she realised this was an option. Carmel spoke to a practitioner from the Street Triage team from her home, and felt this benefited her and allowed her to become more settled;

“She was very nice but I can’t remember what she said. She was very nice anyway and I think she asked if I could get there and I said no I’m not going there no, I’m staying at home, you know, I’ll be alright, and I was weary and I was desperate just for some sleep.” (Page 5, line 57).

“I hadn’t slept for about 4 nights and erm yes so then I chatted to xxxxxx and she did calm me down, I think she must have known something on me I don’t know, I didn’t recognise her name but I must be on file mustn’t I?” (Page 5, line 53).

Carmel was evidently happy that the Street Triage team, in this case the practitioner she named, had information on her at hand and she did not have to give her details or retell her entire history at a time when she felt very vulnerable. She described the information held on her as ‘like a bible’, yet somehow she has to keep repeating herself as though she is new to the services. She described a time when she saw the same psychiatrist twice, which she had previously never experienced, and how having this continuity was such an improved experience for her;

“She’s [the Psychiatrist] the only one I’ve never had to go through everything with. It was such a relief.” (Page 4, line 44).

Reflecting on this it was clear from her description of the call that night to Street Triage that she felt she had been listened to, that services had information on her and knew her history. This made Carmel feel listened to and believed, and it struck me at this point in the narrative how important being believed was to someone like Carmel. She had evidently experienced horrendous and traumatic incidents in her life and needed the affirmation from others that what happened to her was real. Much like those who have experienced Child Sexual Exploitation, or other such terrible, usually hidden events, the importance of affirming the authenticity of their experiences is central to their healing process (Anderson et al., 2004).

Despite Carmel evidently feeling that Street Triage had dealt with her that night in a way she had not experienced before, and that she had benefitted from this, she then continued to discuss how frustrated she felt that every time she went to see her GP, mental health worker, or a psychiatrist, she had to continually retell her “54 years of abuse every single time”. This was a theme throughout her interview in that

having to constantly repeat her history and re-live all her significant traumatic life events was very distressing for her.

Carmel said how she and the Street Triage practitioner discussed options as she was not happy about leaving the house at that time. This was a new experience for Carmel as she was used to having care done 'to her', rather than her being part of the decision making process;

“she asked if I could get there and I said no I’m not going there no, I’m staying at home, you know, I’ll be alright, and I was weary and I was desperate just for some sleep, I didn’t want to be going up there for 8 hours and mmm I forgot what she said, think she said she’d refer me to Hospital”. (Page 5, line 57).

The ethos of ensuring care decisions are done in conjunction with those receiving care is what underpins Government policy, *‘liberating the NHS: No Decisions about me without me’* (DH, 2012). This was evidently a new, but welcomed experience for Carmel and she appeared happy about this now being an option, knowing she could still seek a resolution to her crisis without having to repeat her previous experiences.

4.6 Future possibilities:

Throughout the telling of her story Carmel was negative about her past experiences and the actions of professionals whose care she had been under. Such experiences encompassed the psychiatrist, her GP, the Home Treatment Team and her counsellor, yet in the main she remained positive regarding her experience with Street Triage. Carmel described how, in her view, no matter what she did, she will never be truly happy and free;

“I won’t ever function how I used to be able to function.” (Page 13, line 191).

“I am decent and kind but not very successful at life.” (Page 13, line 192).

Carmel may never be free of this burden of mental illness or be able to function as she did in the past. However, when listening to Carmel’s story I felt there was an acceptance of her situation; as she talked about her mental illness and not being able to function, but still knowing that she is a ‘*decent and kind*’ person, just not as successful in relation to others.

Carmel might be frightened to believe too much in herself, hence the negative comments following her acknowledgment of the positive aspects of self. These thoughts and ideas may have been reinforced throughout her adult life with partners who abused her and health staff who indicated they did not believe her or her story. Despite all this negativity however, she remained happy with the police and their ability to contact street triage when she is in crisis and, in amongst all her discourse on psychopaths, rapes, madness and trauma, they clearly were a positive resource in her life.

Carmel liked that the person she spoke to in the Street Triage team clearly had information about her and that she did not have to tell her whole tale again. Carmel also appreciated being able to arrange to see someone in less than 24 hours without having to call anyone else or go for an assessment at A and E to get further help. This interaction was of definite benefit to Carmel and, although she was unable to consistently acknowledge this was a good intervention, overall she had nothing but positive things to say about how the police, in conjunction with the Street Triage team, dealt with her crisis that night.

4.7 Themes:

Phase six of Fraser's (2004) analytic framework includes looking for themes or patterns within the individual narratives and then looking for commonalities between all the narratives. The first step in this process is to identify the emergent themes in this narrative, with a view that each narrative will produce its own emergent themes and generate an overall chapter in which the themes across all narratives can be considered and discussed.

The themes that I have highlighted from Carmel's narrative are:

- The meeting and not meeting of expectations
- Learning to protect oneself
- Trust, mistrust and rejection.
- Finding the positive in unexpected places

These themes will be considered with those that emerge from the remaining narratives and form the overall discussion and conclusion chapters of this thesis.

4.8 Critical Reflection:

Throughout the narrative I have reflected on each of the themes, outlining why I chose these particular quotations. This section is a critical reflection on my overall feelings regarding the process of hearing Carmel's narrative.

This was my first interview and I was acutely aware I was slightly anxious to ensure this was done well and that I did not cause any unnecessary distress to Carmel. I was also worried that the equipment was working properly, despite my numerous test runs on my children at home, and that I did indeed capture all the information I required as there would not be a second opportunity to do this.

My desire to only ask one question and allow Carmel to just talk was not realised and it was probably naïve of me to assume that I would not need to ask prompting questions to keep the conversation flowing. It is hard for even the chattiest of people to deliver a soliloquy for an hour.

I had some limited knowledge of Carmel from a previous role when I was a ward nurse, but realised that was many years ago and my first thoughts when I saw her again was how she had changed and, after chatting for a while, how many terrible life events had beset her since we last met. I did feel an overwhelming sadness for her in relation to this, as it did not reflect my own life circumstances, especially losing contact with her now adult children. This resonated in me and my thoughts were about how devastated I would be if my own two daughters did not contact me for six years and I had never met their children.

Whilst Carmel was genuinely warm and engaging, she did talk about how she *“didn't like any fuss or any attention at all”*, but I was unsure if this was actually the case, as she appeared to have contacted the police on a number of occasions and attended A and E via ambulance services a similar amount of times. It is probably harsh or unfair of me to question her not liking *‘fuss’* as she clearly experiences anxiety and, at times, has difficulty in managing this in an effective manner. However, it could be construed that Carmel has, over time, learnt her own way to call for help at times of crises. It was encouraging and reassuring that despite the terrible events Carmel had evidently experienced in life, she remained positive and had a plan to move and get a dog to help her get out more. It demonstrated the

resilience people can develop; despite some testing challenges they face in being able to achieve this.

As is often the case, non-verbal communication was as telling as the verbal, and her hand gestures, closed and open body language, silent tears and pauses, such as when she showed me the photograph of her daughters, were as useful in the interview, as the transcripts evidencing the spoken words.

I felt that the part of the narrative where Carmel was discussing her perceptions of the services she had received in the past and how the traumas she had experienced had influenced her wishes and actions when in crisis, were important to pull out and discuss. For me these things were relevant to note as they linked back to the aims and objectives of the study and also made me think that any training package for the blue light services should include information on trauma and how it can manifest itself in some people. It is easy to mistake the inaction of someone as 'attention seeking' or 'nothing wrong with her'. It struck me that having a level of understanding about such issues would inevitably have an impact on attitudes and approaches, and would hopefully lead to a more positive interaction between those providing and those in need of services.

The skill of being a mental health practitioner was certainly useful during the interview, especially in being able to keep a conversation going whilst managing distress and ensuring Carmel was comfortable and happy to continue. I believe this enabled a rounded and robust interview that allowed rich data to be collected. I felt it was this skill set, and my ability to recognise distress and manage it in an empathic manner that enabled Carmel to develop a trust in me that allowed her to be as open and honest as she was. I was grateful for this as it allowed a very full and rich story to be told, truly informing the research process.

Carmel was very happy to have contributed to the research and felt that if she is able to, in some small way, help others like her then she would be happy. I felt that Carmel was truly being altruistic as she had nothing to personally gain from giving up her time and discussing some very personal and traumatic events with me. Carmel did genuinely appear to want to help others. I believe the notion of altruism could be easily applied to Carmel though I doubt she would truly accept this to be the case.

CHAPTER 5 FINDINGS: TIM'S STORY

As in the previous chapter, Tim's narrative will be presented again with my own interpretation and analysis being made evident throughout the narration. This analysis will be presented as described in Chapter 3, embracing the seven phases as set out by Fraser (2004), and it will conclude with my own reflections on this participant's interview.

As discussed in Chapter 3, each participant has been given a pseudonym to protect their identity and all references to services used are either redacted or anonymised. As in chapter 4, in this chapter I will articulate how I heard the narrative, how I interpreted the transcript, the '*domains of experience*' how I identified from the stories within the overall narrative, reflect on how the narrative links to popular discourse and theories, and provide an overall analysis of the narrative told by a service user I have called Tim. Tim is a 25 year old male, who lives with his mother and girlfriend in a rented property in a local village, and had recently experienced a severe episode of depression and suicidal ideation.

Tim is an active member of the local rugby club and usually trains twice a week as well as playing every Saturday afternoon. He has a good job and a caring girlfriend with whom he has a very happy relationship. He has a young child from a previous relationship, and this seems to be a trigger for some of Tim's recent issues as he has a poor relationship with the mother of the child, at times manifesting through the limited and sometimes non-existent access to his son.

Tim was not known to Mental Health services before the incident discussed in his interview and never thought this could happen to him. This narrative explores a time in which the police and Street Triage Team were involved in a crisis situation when Tim took himself to a dam with the intention of taking his own life.

Tim was interviewed in his own home at his request as he did not want to come to the local hospital as it made him feel like he was a '*patient*' and he had got to a turning point in his recovery where he wanted to put that thought behind him. Tim had only recently had a full risk assessment completed on him by the Street Triage team and it showed no problems or risks with the interview taking place in his home environment.

The information regarding the project had already been given to Tim prior to agreeing to undertake the interview, but it was re-read to him at the start of the interview and he signed the consent form. I ensured that reassurance was clearly given to support him from the moment I arrived at the house and once he indicated he was ready to start I turned on the recording equipment. The interview again began with the single opening question of *'you were looked after by the police speaking to the nurses at the hospital, can you tell me all about this and what that was like for you?'*

This is Tim's story.

The story of Tim: Rock bottom to new beginnings.

5.1 Setting the scene:

As stated in chapter 3, Labov and Waletzky (1972) assume an individual tells an experience in a structured manner, with a start, middle and end. Labov and Waletzky (1972) also explored how personal narratives told by participants, such as those in this study, are not recalled and retold in such a linear manner and this was certainly the case for Tim.

Tim was very open and honest and certainly did not feel the need to set the scene or build up to the incident in which he considered taking his own life on the top of a dam. Following my initial question regarding what happened when he came into contact with the police and Street Triage team that night, he answered this directly;

"Just lost my temper, OK, I got upset. I had a lot of stuff going on and then obviously I went up to the dam and wanted to jump off." (**Page 1, line 5**).

Tim then stopped quite abruptly, as if to wait for questions. In essence this was his narrative. I encouraged him to just tell me more about what had happened that night. This was enough to prompt Tim to discuss how he had not *"been himself for a while"* and how he had put this down to issues with access to his young son from a previous relationship. Tim believed he was dealing with this okay, but explained how on the occasion he found himself on the dam it all felt different than previously experienced;

“This time it was just totally different. Never gone to the stage of that before but I got stopped seeing my kid, weren’t allowed to see him, think that had a big part in it.” (Page 3, Line 46).

Tim is a young man, in my opinion much younger than his 25 years, and he had already been a father for 2 years, separated, in a new relationship and about to move in with his new girlfriend. Just one of these events in a young man’s life could be considerable stressful, but to have several significant events to manage whilst feeling as distressed as he described himself that night, must have left Tim vulnerable, feeling overwhelmed, and struggling to cope. Holmes and Rahe (1967) developed a scale based on 43 significant life events, all of which had a positive correlation with an increase in anxiety. Each event was assigned a numerical weighting, indicating the level of stress each event might cause; the higher the weighting, the more likely the event would be to cause stress. Two of the highest scores relate to bereavement and divorce, making a person vulnerable to high levels of stress and possibly mental illness. Tim’s circumstances and recent events certainly seem to have been in the higher risk category.

Tim then described what he was feeling whilst he was actually stood on the dam and, although he found it difficult to recall, maybe because he did not want to or perhaps because he was not able to, he did describe what he called ‘the voices’ he experienced at that time;

“I just didn’t want to be here, I was hearing voices though telling me to jump. But it was like my voice, but not just thinking it was actually talking.” (Page 3, line 49).

Tim did not seem to be distressed by this recollection, he did not describe the voices as an ongoing phenomenon or something he was frightened of. Instead he rather saw this as a one off experience that happened at his most distressed whilst stood on the dam. He described this as his own voice, but not a ‘thinking voice’. He knew it was different and he knew the situation he was in was different. He also knew that taking his own life was not what he actually wanted to do.

Tim described how it was his girlfriend who had rang the police when he had earlier left the house in a temper and acting in a way she reported she had never seen him do before. It was the police who had tracked him to the dam. For context, the dam

is well known to be a local 'suicide hotspot' for that area and is one of the first places the police will look if they receive such calls.

Tim described how he had decided he did not want to jump off the dam despite what the 'voices' were saying and the next thing he recalled was the police being present with him. He did not know at the time why they were there, but did know after that his girlfriend had rang them in a distressed state. Tim did recall the police speaking to him, and how they then gave him the phone so he could speak to a nurse from the mental health team he now knows was the Street Triage team;

"The police rang the Street Triage and they spoke with me and then I went there and then spoke to them and that helped because I could get everything off my chest." (Page 1, Line 10).

His detail of the interaction with the police was actually minimal; he offered no opinion if they were good or not, but merely as the conduit that got him to speak with the Street Triage team which he was very grateful for. It is likely this gratitude, and subsequent positive interaction with the nurses at Street Triage, that has left Tim with a more enthusiastic opinion of the Street Triage team and a more indifferent opinion towards the police. Having stated this Tim was not disparaging of the police in any way, in fact he talked about how they had stayed with him and took him home after his conversation with the Street Triage team;

"The police ended up coming picking me up and taking me home. Stayed with me, so, it was good though, it did help a lot. They rang the RAID people." (Page 7, Line 106).

He then talked about how the police did give him some numbers and made sure he was safe before they left;

"Well they had numbers on do you know, if you didn't want to ring that number; a different number – other routes to take if you want to like – yes it was good. It helped – it did help." (Page 7, Line 109).

That said Tim's enthusiasm for the help he had received from the Street Triage team was clear. He talked about the practitioner he talked to that night and it was the same practitioner who then saw him later that day at the hospital. He had genuine warmth for this nurse and evidently saw her as someone who had truly helped him in his darkest time;

“She was good. She did not make it awkward; it was like she made it laughable. You know – not at what had happened but she made me feel comfortable. In fact she helped a lot coz I didn’t know her and just got everything off my chest, stuff from years ago that I didn’t think was up with me, but that obviously must have been coz once I told her I felt alright; not alright but a lot better.” (Page 8, Line 118).

This warmth and respect for the interaction from Street Triage team continued throughout Tim’s narrative and reaffirmed how interventions they use, can have a positive impact on people experiencing a mental health crisis. Kanel (2007) described how brief therapy in a crisis situation can be just as effective, if done correctly, as any long term therapy. Structured solution focussed approaches, such as the approach described by Tim in his narrative, can mean the difference between ‘renewed coping and prolonged damage’ (Hamaoka et al., 2007 pg. 4);

“You could just open up about everything. Even things from like when I was a kid. Getting that off my chest, obviously something must have been triggering it and getting everything off, every bad thing that has ever happened to me I just told her and it felt so good. I felt like a new man.” (Page 18, Line 267).

Gustafson (2014) wrote about the positive effects of talking and not holding ones emotions in. She stated that ‘Anger and sadness are an important part of life, accepting such emotions are vital to our mental health’ (pg1). Tim had evidently really benefited from talking about his emotions and felt as though this was a new experience for him and one he gained a lot from, even describing it as ‘enjoyable’;

“I enjoyed it. ‘Enjoyed’ I know is a weird word, but I get what you mean, kind of that actually somebody is really listening to my deepest, darkest, horrible thoughts, and not judging me.” (Page 19, Line 298).

One important aspect of the interaction, evident from Tim’s experience, was the attention he felt he had received from the practitioner. The nurse had not rushed him, she made him feel she was interested in his experience and ensured the room was quiet and the telephone did not disturb their interaction, and this clearly meant a lot to Tim;

“She wasn’t like you know, I have heard this before, she was interested, it was in a quiet room, no phone or anything, it felt like she was really bothered about me, yeah it was good.” (Page 12, line 186).

The main components of a therapeutic nurse-patient relationship, especially in mental health situations, are trust, respect, genuine interest and empathy (Dziopa & Ahern, 2009). From the narrative told by Tim it was evident that his interaction with the practitioner in Street Triage showed all these components. The impact that this interaction had on Tim can be best summarised in his quote at the end of his interview;

“I went in a boy came out a man.” (Page 18, Line 270).

Tim evidently felt that the experience had helped him to understand his feelings and not to see them as a weakness, but to see that he was not alone in feeling like this. Tim had to talk about his feelings and tackle them in order for him to move on with his life. I believe it is this maturation in thinking that underlined the above quotation and made Tim feel he really had become a man because of this experience.

5.2 Searching for reasons.

Throughout the narrative, Tim appeared to be looking for reasons for his incident to have occurred. He talked about how his life felt different at that time. He described coming home from work and going straight to bed, waking up early and not sleeping properly and then going back to work again;

“Well I’d go to work, come home, and go to bed – wasn’t doing anything. Playing rugby on Saturdays just because I’d played for that long and it was just habit, but wasn’t enjoying anything, just having the curtains shut all the time. It made it worse when I was on my own.” (Page 2, line 32).

He described a “*going through the motions*” approach to how he dealt with his mental state at that time. Things he previously really enjoyed, such as rugby, were now clearly just things he did because he should do, rather than because he actually wanted to participate.

It was very noticeable how animated and emotional Tim was when he talked about his son and how he thought the fact he had been recently denied access to him, by the mother of his son, had been the cause of his final actions of going to the dam;

“No didn’t care – obviously I’d go to work coz I needed to, but just doing what I needed to at work and coming home. Doing nothing, not speaking to anyone,

never gone to the stage of that before, but I got stopped seeing my kid, weren't allowed to see him, think that had a big part in it." **(Page 2, line 35).**

He did acknowledge that he had felt like this previously, never as bad as recently, but for a long time he had experienced periods of being low and wanting to just work and go home to sleep. He described how, in the past, he would just drink more alcohol for a while, until his low feelings passed. This is typical of those experiencing depression. MIND (2018) describe how depression can manifest itself in people; feeling down or upset, restless and agitated, guilty or worthless, empty and numb, isolated, finding no pleasure in life or giving up things you previously enjoyed, having low self-esteem, hopelessness or feeling suicidal are all typical signs. However, all of these could be seen in the narrative told by Tim about his own experience. It is also not untypical for those experiencing depression to turn to other coping mechanisms such as avoidance behaviour, self-harming or suicidal behaviour or increase their use of drugs or alcohol. This certainly could be seen in the narrative told by Tim;

"I just went and got a crate." **(Page 6, Line 96).**

Alcohol can often initially elate the mood, however, this can soon be replaced by over dependence on alcohol which, if used long term, leads to a lowering of mood and an increased risk of impulsive acts such as self-harming behaviour or suicide (Muneer, 2018). Tim recognised his own increased alcohol intake during this period of time. He discussed how since the incident on the dam he had learnt that there are so many other people who have felt depressed and down as he had and also who had put themselves in vulnerable positions such as going up on the dam in the same way he had. In particular, he realised that such feelings are indiscriminate and do not just happen to people such as him;

"I know a lot of people that have said to me they have felt like that and it's mad how many people actually go through it." **(Page 5, line 77).**

"It makes no difference if you're rich or poor does it?" **(Page 6, Line 99).**

This realisation seemed to help Tim frame his own experience and make him not feel as alone and more able to talk about his feelings. He talked about how he now knows what triggers to look out for;

“I definitely wouldn’t let it build up. Even if it was just that much that I couldn’t just cope with it, I’d do it so that I would have the help, get it all off my chest and hopefully be fine again.” (Page 13, line 205).

The above quotation indicates Tim now has insight into his illness. For people who experience depression insight is seen as an indicator of them being on the road to recovery (Repper & Perkins, 2006). Being able to recognise the symptoms of depression returning and ensuring positive coping mechanism are employed, are key to managing the symptoms of depression and preventing the illness returning (Khan et al., 2012). Tim talked about how he had been able to do this after his recent crisis;

“A few nights after it, I started hearing the voices again and I picked my phone up to ring that number and it just went, I know it sounds weird but it just went and I thought right put the phone down and they’ll come back in a minute and managed to sleep.” (Page 12, line 188).

His recent interaction with the Street Triage team has meant he now knows he has a support number he can ring at any time should he wish to talk to someone. Tim believed he would never have to use the number again, as he knew he needed to talk to those around him, but he also believed just knowing the Street Triage service was there was enough to help him cope if he was feeling low. This prophylactic system appeared to give Tim a degree of safety he had not had before his interaction with the Street Triage service, and coupled with his positive experience of the practitioner from this team, this appeared to be of great comfort and help in Tim’s recovery process.

However, within Tim’s narrative it was also evident that while he had experienced a positive interface with mental health services at the time of his crisis, he had been offered little follow up to maintain his improved mental wellbeing. Ongoing support to ensure Tim recovers and is able to manage and cope with any changes in his mental state is essential, but it felt as though Tim had received care that effectively managed his crisis, but further support to ensure he did not reach this crisis point again in future was unavailable.

5.3 Reluctant absent father:

One of the distinct features evident throughout Tim’s narrative was his obvious love for his son and his clear distress at recent events that denied him the access he

had previously enjoyed. Tim talked a lot in his narrative about how he had a strained relationship with the mother of his son and that at times this had meant a temporary stop to access. In the past such episodes had been short lived. The time of crisis described in this narrative was evidently different from previous times when Tim had been denied access, and, as a result, he linked this event to his subsequent actions;

“Never gone to the stage of that before but I got stopped seeing my kid, weren’t allowed to see him, think that had a big part in it.” (Page 3, line 53).

Access to his son was a strong theme throughout his narrative. The negative impact on mental health experienced by fathers separated from their children is well documented (Shaw & Lohan, 2012; Fitzgerald et al., 2015). For fathers’ such impact could result in poorer; physical health, psychological and emotional wellbeing, social relationships, and finances, and could subsequently result in poorer relationships with their children. A number of these impacts could be seen throughout Tim’s narrative, not as a distinct separate theme, but rather contained in many threads of his story. For example, discussions about his current situation with his girlfriend or what he thinks might help in future, all led back to a discussion about the current situation with his son;

“She didn’t put me on the birth certificate so there’s not much legally I can do. My friend, he got stopped seeing his kid, he paid £7K in court to get access, she stopped him again after 2 weeks and the court can’t do nothing so it’s just going to be a waste of money if I go.” (Page 14, line 225).

It seemed that his tale of a friend, and his terrible experience, seemed to justify why Tim was not legally pursuing his case. Tim did then state “*She’ll come back*” (Pg. 14), in reference to his child’s mother, as more of a reassurance to himself that this will be the case and assurance that he will resume his fatherly role.

At this point in the narrative Tim was very emotional when he talked about his son, and it was clear he did need time to talk through his current situation regarding access to his son. As stated earlier in Chapter 3, Labov and Waletzky (1972) described how a narrative maybe assumed to be told in a linear way but it does not always follow such a structured path. Tim’s narrative did indeed become chaotic when he tried to explain why he did not want to go and see his son when he visited

his granddad (Tim's dad) once a month. As much as Tim was torn between wanting to see his son, he felt by visiting his son when he was at his father's house could risk his dad then having his rights to access to his grandson denied;

"My dad's been having him. Erm once a month and he said I can go over and stay, but I'm not going doing it to see him once a month and then once she finds out she'll stop him [dad] seeing him [son]." **(Page 14, line 229).**

Tim was clearly still very upset by the situation and he talked about the financial support he was offering his son. He self-reported that he had very little money and worked long hours to earn as much as he could. Tim also made it clear he knew he had a financial responsibility to his son, but he personally felt that with this payment should come access, and when this was not the case it had caused him some stress he has not managed as effectively as he would have liked;

"She's like you've not paid your maintenance, I said I know I've not and I won't be doing, I didn't put it this way, but it's like saying would you buy a couch and not sit on it." **(Page 15, line 244).**

Once Tim had stated this he immediately validated it by explaining what he was doing instead;

"I know that you shouldn't put it that way, but the money I should have given her has just gone into his bank account." **(Page 15, line 249).**

Hawkins et al. (2007) noted that fathers needed to be valued too. McKeown (2001) described how separated families do not have to result in negative impacts on the children. Fathers that remain heavily involved in their children's life can result in the child having more friendships, fewer behavioural problems, lower criminality and less likely to have any substance abuse issues, higher educational achievements with higher self-esteem and greater life satisfaction (McKeown, 2001). It was clear from Tim's narrative that these were all the things he wanted for his son. This current situation was evidently a major stressor in Tim's life, and whilst it was not resolved following the event on the dam, he had clearly worked out a way of being able to deal with this stress, by setting up a bank account for his son's future, allowing him

to still feel like he is caring for his son during the period of time he has been denied access to him.

5.4 Team Spirit:

Throughout the interview Tim talked with much affection about his local rugby club and a really good friend of his he knew through playing there. Tim had played rugby from being 5 years old and had played in a league team based at the local community school up until 4 years ago when he joined the club he is now at as a first team player. Evidence suggests sport can have a positive benefit on a participant's physical and mental wellbeing (Biddle et al., 2015). This is further underlined by exercise and exercise classes now being prescribed socially due to its benefits on mental wellbeing (Fredli & Watson, 2004). Until recent events these benefits were clear in Tim's narrative, as was his love of rugby and being part of the local club. Tim talked with much enthusiasm about his affiliation with the club and in particular the good friends he had made whilst playing there. Being part of a sports club, such as the rugby club Tim belonged to, can have a positive impact on one's mental wellbeing (Breslin et al., 2017).

Being part of the club and having a good friend supporting him were obviously key aspects in Tim's life, and his warmth and care when talking about these people was clearly explicated. Tim summarised this aspect of his life well when he reflected on what being part of a team, such as his rugby team, was like for him and why it was so important in his recovery;

"But it is part of playing in the game isn't it and being part of the team and psychologically it is so good to have that as an outlet so yes I am glad I have it." (Page 17, line 228).

Tim placed much value on the actions of one particular friend, who he knew through playing rugby, and who he attributes to helping him hugely in his recovery process;

"He checked on me all the time. Every day, he comes and gets me out of the house. He made me go to the gym with him." (Page 6, line 101).

Tim explained how his friend had been in the army and been in an incident, whilst he was on tour to Afghanistan; the Taliban had attacked the compound he had been

guarding. Two of Tim's friend's colleagues had been shot and killed in front of him and the friend in question also received a gunshot wound, but survived. Tim knew this about his friend, and the subsequent battle he then had with what was described by Tim as Post Traumatic Stress Disorder (PTSD). PTSD can mirror some of the symptoms experienced by people who are depressed, such as low mood and suicidal ideation, but is marked by features of flashbacks or nightmares regarding the original traumatic event (Bisson et al., .2015). Tim felt it was this experience that meant his friend understood him and where he was coming from as he also had experienced mental ill health. This seemed to have been used by his friend as a means to help Tim;

"So that's the sort of person he is, though isn't it. He always wants to..... I think, it does, like I said, he has been there, seeing your mates killed and you get out, it's hard to handle, but he did and now you know he's been through it himself so he just knew what to say and how to help me." (Page11, line 165).

Tim talked about how tenacious this friend was and despite him continuously saying he was alright and he did not need any help, Tim's friend could clearly see he did and he did not give up on him;

"Because I was like I don't need help, he was like you need help, I was like I don't, I don't and then he said you do, and I thought give it a go and see if it works." (Page 11, line 168).

Tim was notably grateful at the intervention of his friend and talked about him in an affectionate manner. Tim was not concerned at showing love for a friend that obviously had such a positive impact on his life at the time of his distress, and continues to do so to this current day. Friendships have been cited as a major facet of a coping strategy when dealing with mental illness (Leamy et al., 2011). The friendship Tim evidently has with the friend he described in his narrative clearly aided in his own personal recovery journey;

"I'm still here so it must have done something." (Page 11, line 170).

Another key coping mechanism for Tim was the rugby club he belonged to. It is not unusual for people to report the mental health benefits of taking part in sport and rugby was clearly an important part of Tim's life and had been from a very early

age. Even when he was not feeling well Tim still played rugby, describing it as a ‘*habit*’ and that he was not “*enjoying it*”, but it remained a key feature that kept him going at that time. This can be seen in the following quote from Tim;

“I didn’t stay up, I’d only come and play and then I’d go home straight away, like normally I stay up there, but then I wasn’t, I was just going playing, coming home, but now I can’t get away from there.” (Page 20, Line 311).

When Tim talked about how the club helped him after the incident on the dam he identified how, when he does not play at the weekend he “*hates it*”, but that it is because he gets so much out of being a member of the club, as described earlier. A feeling of being part of something, like the rugby club, is an element of what Tim described as keeping him well;

“It’s a family based club as well, it’s not one of them clubs where it’s not just about the open age it’s about everyone who goes and who plays or not.” (Page 22, line 355).

Tim clearly saw his own family as part of that setting and the telling of this aspect of his story triggered him to move the narrative back to his son. He described how many generations of families have played at the club and now some dads are playing with their own sons at the rugby club and he would never ‘*hang his boots up*’ until his own son was doing the same with him.

“Oh I won’t be stopping. I always get told to hang your boots up, come home injured, hang your boots up; I won’t be, not until my son’s over 18 so he can play.” (Page 22, Line 357).

Within this statement Tim offers evidence of a positive outlook about his future demonstrating how far he had come from the night on the dam to the current stage of his recovery.

5.5 It’s okay to not be okay:

Tim had evidently spent time reflecting on his experience of being in a mental health crisis and, as previously discussed in section 5.4, took comfort in the fact he was not alone in his feelings and experience. He had realised that illnesses, such as his,

did not discriminate and that regardless of who you are or what your life is like such illnesses could still affect you;

“If something’s not right then something’s not right no matter how good your life.” (Page 6, Line 102).

This appeared to be important to Tim, as it demonstrated to him that he better understood his experience and he had acted in the way he did as he was unwell and not because he ‘was mad’. He described how he felt like he was a failure and this was the punishment. These are not unusual thoughts for people experiencing depression, but what was positive is the fact Tim seemed to understand these thoughts and feelings were the result of his current mental state and gained comfort from knowing it was not his fault;

“Obviously, people are worse off than me, I felt pathetic, but I was then like you’re not pathetic, it happens, and can happen to anyone.” (Page 9, line 133).

As a young man Tim evidently used the internet as an everyday part of his life. This included social media platforms such as Facebook and Twitter. Within his narrative he described how the internet could be a good, as well as a bad thing when you feel low as Tim did. He talked about an incident in which he had been having physical pains in his stomach for a few days and convinced himself he was very ill. As such he used the Google search engine to ascertain what was wrong with him;

“I’ve had belly ache and I put something on the internet and it told me I was pregnant.” (Page 10, line 161).

Whilst this was a very amusing moment in his narrative, Tim used it to demonstrate how the internet can take the reader to all kinds of conclusions. The dangers of self-diagnosis on the internet, and how this can lead to either false assurances or anxiety provoking situations with little or no supportive evidence are well documented (Pillay, 2015). Tim did however talk about recent positive social media campaigns which had actually helped him to move from being embarrassed about his mental illness to talking about it. This was a good example of how the internet could be a useful tool for people experiencing such problems. Tim felt that by seeing

others talking about their mental illness he was able to understand it more and, as a result, was able to feel more accepted, by society;

“I was just bothered about people judging me, but I’m not bothered anymore. I know and all the stuff that has happened recently as well with high profile campaigns and all the And the state of mind and that, it’s become a bit more acceptable isn’t it, it’s alright, Well I always thought it just a weakness but it’s not.” (Page 11, line 177).

The use of such social media platforms have evidently been positive for Tim and, whilst he had little if any understanding of this before his recent illness and crisis, he talked with passion about how these campaigns have been a good source of help for him. He described how when he was very unwell he had not talked to anyone and hid his feelings for a couple of reasons; firstly due to his fear of being judged and secondly that he might lose his job;

“Scared of being judged; but I’ve not been judged.” (Page 24, line 414).

“Work has been good with me, they keep checking me, and making sure I am alright.” (Page 20, line 396).

Tim had taken his experience and reflected on it, talking about how people are more accepting of such illnesses and how that in itself aids in the recovery process. Tim was able to recognise how not having to hide his feelings and being able to be open and honest no matter what, is very cathartic and therapeutic, and Tim was obviously grateful that this was the era he now lived in. This was reassuring to hear, as stigma is a well-documented issue with regard to mental illness and its impact on mental wellbeing (Thornicroft et al., 2008; Corrigan & Watson, 2002). Byrne (2000, pg. 47) described stigma in relation to mental illness as being *“a sign of disgrace and discredit that sets a person away from others.”* Stigma in itself impacts negatively on mental illness and serves only to compound the issue. It was good to hear in Tim’s narrative that this was not his experience;

“The majority of people from like work know what’s gone on and that, but they don’t judge me, don’t treat me any different. It’s a different world now I think, years ago it would have been a different story but now there is a lot more people going through it and so they understand, it’s much better.” (Page 24, line 420).

Tim was reflective when telling his narrative, he did have a beginning, middle and an end to his story (Labov & Wavelsky, 1972), but these were not told in a linear manner. Tim talked about things he would do in the future, interspersed throughout all his narrative. This to me showed hope. Watts and Higgins (2017) talked about hope as an integral part of the recovery process and how it should be considered a 'powerful ingredient' in achieving a full and positive recovery. When talking about the night he decided to go to the dam, Tim counterbalanced this by talking about how he would not do that in future, but rather talk and get help instead. This showed a positive outlook on his future and to me was hopeful;

"I definitely wouldn't let it build up. Even if it was just that much that I couldn't just cope with it, I'd do it so that I would have the help, get it all off my chest and hopefully be fine again. It might mean I have to ring people or RAID a lot, but it's better than going there isn't it?" (Page 13, line 210).

This was a theme for Tim and one he discussed on a number of occasions. The need to talk was clear for him and he was comfortable in discussing this throughout his whole narrative. Carrigan (2004) talked about how some people hide their mental illness or worries and do not seek help for fear they may be judged by others. As discussed earlier, stigma can cause people to suffer unnecessarily due to their perceptions of how others are likely to view them. Luckily this did not seem to be the case for Tim and he was happy to talk about the need to be open and seek help;

"If I went through it again I'd know to talk a lot". (Page 2, line 36).

Tim was also reflective when talking about being a 'sufferer of depression'. He accepted this to be the case and did not try to hide from it or be embarrassed by it. He had explored how he had seen this being talked about on social media and with high profile people who had the exact same illness as he did. As discussed above, this appeared to have helped him accept his illness and be able to move on with his life and help others in the same position if he was able to, much like his own good friend had done for him;

"I suffer from depression and I have thought there is no such thing, but now I have been through it I know, so I would always listen if people needed to talk to me." (Page 2, line 41).

One of the most important aspects of Tim's story was his relationship with his current girlfriend. She had been the one who called the police the night of his suicidal thinking and she was clearly an important part of Tim's life. He had explained how they were planning on moving in together later that month and that they had been saving up money, buying items for their new house and planning a future together. He described her as someone he could '*really rely on*' and evidently saw her as central to his own life. Major protective factors in mental health are recognised as being families, especially partners and children, as they offer a reason to keep safe and not to act impulsively (Werner & Smith, 1992). It was evident that Tim saw his girlfriend as just such a protective factor for him;

"I never thought I'd be happy buying knives and toasters, it's a next phase in your life I think and that's the exciting part and knives and toasters kind of say that don't they." (Page 20, line 245).

"If something pisses me off at work I come home and tell her straight away, she probably doesn't want to hear it anymore now." (Page 14, line 222).

Tim evidently felt supported by his girlfriend as he knew that he could talk to her. It did seem that he was happy with this situation, as it meant he did not ruminate too long before he moved on. In some way being able to talk to his girlfriend in a more open way contained his emotions and made him address them. Reflecting this back to the discussion earlier in this section on triggers and coping mechanisms, this was a good example of how Tim can recognise when he needs to talk and how by doing just that it helps him to manage his emotional state.

Tim also realised that depression was not necessarily a '*one off*' experience and that he would always be prone to feeling low in mood. However, he did believe that his experience of talking to the RAID team taught him that talking was the key. From that experience Tim learnt not to hold his emotions inside because of shame and feeling "*pathetic*", or somehow protecting those he loved from the truth. He knew holding on to such emotions was not the right way to deal with his low mood and identified how he will, and has, actually dealt with a recent minor recurrence of feeling low;

"Yes definitely, definitely, I think there's been one incident since I started feeling well where I didn't want to do anything and I just got up and made

myself do something. I'm not sure if I just came down and made tea for everyone, or something like that, it was something simple and I felt fine then. Not letting things eat away at me. Just got to realise haven't you." (Page 1, line 275).

The future for Tim seemed to be positive; he talked very excitedly about his relationship with his girlfriend now after the recent crisis event;

*"Me and C***** get on better now as well because obviously when I was going through it I was just snapping at her for nothing, but now we get on mint, I suppose talking to her as well so she understands is so great." (Page 21, line 323).*

Tim was also planning on a short holiday with his girlfriend and seemed to be planning a future with her that did not entail him thinking about taking his own life again;

"We are putting money away. We want to go away in November." (Page 19, line 312).

The retelling of his narrative did end on a positive note and it felt, similar to Carmel in Chapter 4, the process of being interviewed for this research study appeared to have helped Tim. He appeared pleased that it could possibly help others too which was important to him, maybe in some small way he saw this as a way of giving back to others as a thank you for those who gave to him.

5.6 Themes:

In keeping with Fraser (2004) framework, the themes emerging were

- Learning from the lived experience
- Insight, understanding, and future hope
- Recovery and the need to talk
- The role of fatherhood
- Camaraderie and the impact of sport

5.7 Critical Reflection:

I was feeling much more relaxed and confident before I started this interview. As it was my second interview, I especially had less anxiety about the equipment failing and losing my one chance to capture the narrative. I was not prepared, however, for Tim to leave the TV on during the interview and he made no attempt to turn this off, although he did get up to turn it down. This indicated to me he wanted it on, maybe to ensure there was no silence or as a comfort to him as he turned it down, but not off, and I did not feel it was my place, in someone else's house, to ask him to turn it off. I was then concerned that the Dictaphone would not pick up the conversation over the TV noise and so I moved closer to Tim asking if it was alright to sit on either side of the three seated sofa. He did not seem unhappy with this and so I was then able to place the Dictaphone between us.

I did, however, check the recording as soon as I got in the car as I thought the conversation may not be audible over Coronation Street! Luckily it was and my anxiety was short-lived. There was a lesson learned for me in this, about needing a quiet environment and if this was not possible be prepared to move seats, as I think I assumed most people would not have background noise. Many people with a mental illness use background noise to help them cope with such situations and, as such, I knew I needed to be prepared for this to happen again in future interviews.

When I first arranged the date and time for the interview I had no knowledge at all of Tim. I was very reliant on his risk assessment being completed accurately and that he did not pose any risks to my safety. I must have been a little less than 100% sure of this as I was very aware of following the procedure I had built into the study to protect my safety as a lone researcher in this interview. I ensured I left the details of where I was visiting in a sealed envelope on the manager's desk. The instructions were only to open this if I did not ring in after the interview. When I did the envelope was destroyed unopened.

On reflection I was pleased I had built this into the study design as it allowed the mitigation of any risks to be addressed as it is a known safe process used on a daily basis in such teams as Home Treatment and Community Mental health Teams. This process afforded an additional level of safety for me without compromising the trust between myself and Tim as he was unaware that this process was in place.

As expected, though, the risk assessment was accurate and the safety envelope system was not required. There were no risks at the address or with Tim and I found him to be a very genuine and warm individual who brought out the 'mother' in me at times!

Tim was only a young man, in fact the same age as my eldest nephew, only Tim was already a father. He clearly found coping with not having access to his son very difficult and seemed to lack advice and guidance on what he could do about this other than to accept the situations. I did feel the need in the debrief session to offer him advice about where he could go to talk to someone about the practicalities of gaining access to his son and how it was important to continue to pay his maintenance even though it seemed unjust to do so when he could not then see his son. I was acutely aware this was actually none of my business, but as a practitioner with the knowledge of where this help could be sought, and as a mother, I felt I should offer this as advice if it could help him. I would do this for anyone else if they were a service user or not. As with Carmel, being a practitioner in a researcher role does not mean you stop being a practitioner. I felt that being both a researcher and a practitioner was actually an advantage and if I could offer some additional advice for him that would help alleviate some of his sadness regarding his son then I was willing to offer that.

I had a very easy rapport with Tim and found him engaging. We shared a mutual love of rugby that allowed our conversation to be both difficult when exploring his suicide attempt, but light hearted when we talked about the rugby community and some mutual people we both knew. I was surprised at his honesty regarding the night he tried to take his own life and glad he recalled it as an event he never wanted to repeat. He had hope and optimism with a future planned that he was excited about and it did make me feel proud that a service I was a part of was able to achieve that.

CHAPTER 6 FINDINGS: SAM'S STORY

As described in chapters 4 and 5, the next narrative will be presented, again with my own interpretation and analysis throughout the narration of Sam's story. This analysis will be presented as described in Chapter 3, embracing the seven phases as set out by Fraser (2004). Again this narrative will be concluded with my own reflections on this participant's interview.

As discussed in Chapter 3, each participant has been given a pseudonym to protect their identity and all references to services used have either been redacted or anonymised. As in chapters 4 and 5, in this chapter I will again articulate how I heard the narrative and how I interpreted the transcript, the 'domains of experience' I identified from the stories within the overall narrative, reflect on how the narrative links to popular discourses and theories, and provide an overall analysis of the narrative told by a service user I have called Sam.

Sam was not known to mental health services before the incident she describes in her narrative. She had, however, been discussing some of her anxieties and worries about her son with her GP who had suggested a referral to mental health services for support. Sam had not accepted this request at the time of the incident. Sam was interviewed for this study at her own home, at her request, as she said she did not want to be seen walking into the 'bottom block' (a local term for the mental health unit). I did offer an alternative venue, but she was happy to meet at her home address. Sam had a recent, up to date, full and comprehensive risk assessment in place that did not identify any risks to the interview taking place at her venue of choice.

Sam is a married, 39 year old woman who is a general adult nurse, who works in the local hospital on a busy medical ward. She has been married for 22 years and has two sons, one aged 17 and currently studying for his 'A' levels, the other is eight years old and has a severe form of autism that Sam describes as challenging. Her husband works long hours and is often away. Sam works shifts and relies on family for childcare support for her eight year old son.

One night, Sam found herself on a motorway bridge in her local town, a known suicide hot spot, with the intention of jumping off. The police attended and Street Triage became involved, who talked her down and brought her back to the hospital.

The information regarding the project had already been given to her prior to agreeing to participate in an interview, but it was re-read to her at the start of the interview and she signed the consent form. I ensured that reassurance was clearly given to support her from the moment I arrived at the house and once she indicated she was ready to start I turned on the recording equipment. The interview again began with the single opening question of *'you were looked after by the police speaking to the nurses at the hospital, can you tell me all about this and what was that like for you?'*

This is Sam's story.

The story of Sam:

6.1. When the tables are turned:

What was evident from the start of Sam telling her narrative is her seemingly avoidant way of talking about the actual incident that night. To evidence this she started the telling of her narrative by ensuring I was aware of her professional background;

"I am a nurse you know, have been for ages, and this wasn't me that night."
(Page 1, line 6).

Rather than telling her narrative in a structured manner, similar to the other two participants, Sam circumvented a linear structure and appeared to go straight to the exact point she wanted me to know about.

It was very 'clinical' in approach in that Sam was engaging in an interview about herself in a manner that reminded me of a clinical assessment, formal and awaiting to be questioned on facts of an illness/symptoms, rather than an interview in which it was expected she would recall her own feelings and experience of the night in question. I had re-iterated the aims and objectives of the research before we had commenced the interview, as part of the process for signing the consent form, and

discussed how the research study was about gaining a view from her about what it was like to have been treated using the Street Triage Team at a time of her crisis. In her opening statement to the interview, telling me she was a nurse and the incident on the bridge was not her “*normal presentation*” appeared to be defensive.

The theory of the ‘defended subject’ originates from a psychoanalytical standpoint. Klein (1988) talked about how the self, in this case Sam, can act in a manner that defends against the feelings of anxiety. Klein (1988) talked about how subjects in studies, or even clinical interviews, can embellish or ‘idealise’ their narratives so as not to have to recall the trauma of the real incident (Pg. 19). Anxiety itself can be caused by what a person perceives to be a threat and for Sam this could have been recalling the events of the night in question. As a consequence Sam avoided actually talking about her crisis, but rather, as described above, adopted a more traditional approach to an interview as she would know it, as a nurse, and as such it felt ‘clinical’.

Holloway and Jefferson (2000) discussed how to produce data with such defended subjects as Sam appeared to be. Such techniques as open ended questions, avoiding the why questions and prompting to elicit stories are all approaches discussed and were all approaches I adopted in order to try to gain insight into Sam’s experiences of Street Triage when in a crisis. On my part I needed the interview to meet the aims and objectives of the research and not for this to be a therapeutic session, although I was aware Sam had willingly engaged in this process but in doing so it was also making her anxious and creating an internal dilemma for her.

The aspect of Sam’s narrative that appeared to be causing her a dilemma was the fact she was a nurse. As nurses we are all bound by our professional Code of Conduct and regulated by the Nursing and Midwifery Council (NMC) and our ‘Fitness to Practice’ and it was as if she was telling me she was still safe to be a nurse and the incident in question would not happen again. It felt as though Sam struggled with being as open as she may have wanted to be. This could have been due to her professional background and being a nurse creating a barrier to her being honest about her mental health. Also, as a nurse, or a mother, she may have felt a need to be ‘strong’ and advocate and care for those around her and in doing so

could not admit that she had contemplated doing what she had done, in what she may consider now as a moment of weakness;

“I couldn’t tell you why I ended up there that night, it all gets too much sometimes doesn’t it, and maybe it was lack of sleep or something.....who knows eh?” (Page 8, line 121).

The avoidance of recalling the incident as well as the attempts to minimise this as a moment of weakness or tiredness, could be construed as a defence mechanism. Discussed in Chapter 5, Freud (1938) talked about how such mechanisms are deployed by our unconsciousness as a way of managing the anxiety caused by the situation. A neurotic mechanism of defence is rationalisation (Holmes & Bateman, 1995) in which a person will unconsciously rationalise behaviour in a way that is more socially acceptable. For Sam this was being tired and thus resulting in her actions that night. Sam could have been rationalising her actions of that night rather than accepting that she may be stressed and in need of help from others.

The reason for Sam’s defence mechanisms coming into play could be explained by Lazarus’s theory of psychological stress. Lazarus (1991) argues that stress occurs as a result of the relationship between the individual and their environment, and how one interacts with this can cause stress. Exploring Sam’s narrative, it is evident that Sam is stressed and one such reason for this could be how she is interacting with her environment. Within her interview Sam was keen to discuss her role as a staff nurse on a very busy medical ward. She described how difficult she found the shift patterns, especially as she has a young son with autism and a husband who works away a lot;

“It’s tiring you know, coming home at gone 10 and back again at 7, the little one has to stay at my mums or she comes here, he doesn’t like it but I can’t do a 9 to 5, doesn’t pay the same does it?” (Page 6, line 94).

Shift work within the health profession has been reported as being problematic impacting on nurse’s physical, psychological and social wellbeing (Wilson, 2002). In relation to Sam, she worked a combination of shift patterns in a monthly cycle. This included some early and late shifts in the same week and then a weeklong section of night shifts. Dunham (1997) found that there was a critical window or a

specific time in the day that, when worked, had the most negative impact on work life balance. This timeframe was 4pm to midnight, hours regularly worked by Sam. Whilst nurses are aware that taking a role on a ward requires them to work shifts, it is the choice of which shifts they work that enables the negative impact of such work patterns to be lessened (Barton et al., 1993). Some of the consequences of working shifts that are imposed and not chosen, such as night shifts, are poor sleep, poor eating patterns, and disjointed social patterns, as well as mental health problems (Fossey, 1990). Indeed as early as 1988, Coffey et al. highlighted how there are high levels of neurotic and depressive type illnesses among nurses working shift patterns.

It has been suggested that those who work shifts should engage in compensatory behaviours, such as having a 'nap', exercising or going out socially, to counter the negative impacts of shift work (Clancy & McVicar, 1994). However, for Sam there appears little opportunity to engage in such compensatory behaviour due to the demands of her home life and role as main carer for her young, disabled son. Instead Sam appears to adopt defence mechanisms that help her cope with her stress. These mechanisms, repression and rationalisation, whilst serving in the short term to help Sam deal with her anxiety and stress, do place her at ongoing risk of mental illness and ongoing stress and anxiety if left unresolved in the unconscious (Bateman & Holmes, 1995).

6.2. You can't choose your family:

Throughout the narrative one of the observations I noted was that Sam seemed to have a '*resigned acceptance*' to her situation regarding her marriage, children, job and the roles she takes on in her life. This again could be interpreted as further evidence of her defence mechanisms through her drive to try to cope with her stress (Holmes & Bateman, 1995). Repression of the reality of her situation and rationalisation of it are evident throughout her narrative;

"I just get tired easily I think." **(Page 5, Line 76)**

"He can't help having to work away, we need the money." **(Page 7, line 107)**

Sam was notably very proud of her eldest son who appeared to be a high achiever, doing well at his studies and having plans to go to university to study chemistry. It was also evident that whenever Sam said anything positive about her eldest son, she had to follow this up with a supportive sentence regarding her youngest son;

“The eldest has his A levels this year, it’s tough at that age isn’t it, but you know he is doing well and wants to go to [university] to do chemistry, he is very clever, wants to be a scientist.....the youngest is clever in his own way, it’s just different, you know?” (Page 13, line 202).

Sam evidently struggled with the dichotomy her sons presented her with. From the way she spoke about them, verbally, tone of voice and facial expression, she clearly had love for both of them, but was tearful when talking about her youngest son who has a severe form of autism. Autism, or Autistic Spectrum Disorder (ASD), is the umbrella term for a range of conditions that affect how the person communicates, behaves and interacts with others. (NHS Choices, 2018). The range of conditions from those that have minimal impact on a person, with such people living full and independent lives with minimal adaptations to debilitating symptoms which not only impact on their own lives, but also on those around them (Ducan & Patel, 2012). Sam’s youngest son unfortunately sits at this latter end of the ASD spectrum.

Sam described her son as ‘*challenging*’ and how his behaviour at times can be difficult. One of the difficulties Sam struggled with was the need for her son to have a routine;

“He likes order, you know, me not being there when its bedtime sends him into a meltdown. I can’t make my mum deal with that, you know, it’s not fair on her or him. I just tell her to leave him ‘til I get back.” (Page 9, line 135).

This need for a routine is known as ‘*ritualistic behaviour*’ (Noens et al., 2006) requiring those diagnosed with ADS to have a daily, unchanging, pattern of activities that if interrupted could result in distressed and uncontrollable behaviour, such as tantrums or violence. The impact of Sam being present for some of the activities on some of the days, and not being able to be there at other times, was stressful for both Sam and her son, further impacting on her current mental wellbeing.

Communication is another common issue for those with autism (Lam & Aman, 2007). In severe cases, such as Sam's son, he is not able to effectively communicate either his daily needs or how the changes in his routine are making him feel. Unfortunately this manifests in either disruptive and challenging behaviour or complete withdrawal. This of course causes more stress for Sam as she feels guilty that whilst her son is distressed she is having to work:

"When I do lates, he sometimes won't talk to me, he doesn't look at me anyway, but on those nights he just sits alone, you know, it's not nice." (Page 11, Line 166).

It is evident within Sam's narrative that the added pressure of being a carer for her son, as well as working shift patterns, was impacting on her mental wellbeing. As discussed earlier, Lazarus Theory of Stress (1991) was concerned with how the individual interacts with their environment. In this case Sam is interacting in the only way she can, given her circumstances, such as having to work shifts and having to rely on her mother for help, neither of which she wants to do and both of which cause her a great deal of stress.

Within her narrative Sam also discussed her marriage and in particular the support she gets from her husband in relation to her youngest son. What was stark in her narrative was when she spoke about her husband she felt the need to ensure I knew that as a couple they had given birth to a 'normal' child, as well as a child with autism;

"It was a shock, you know, when we found out XXXX had an autistic condition, I mean XXXX is such a normal teenage lad, going to get a great job and stuff, his dad is so proud of him, we all are, so with XXXX and his needs it's been hard, we didn't have these worries with the eldest you know." (Page 13, Line 211).

Sam talked about how her husband has a very important job and needs to work away a lot as a result. Sam acknowledges the importance of her husband's work in terms of their finances, but she struggles as a result being the sole care giver for her youngest son without a break, other than when she goes to work. She did have support from her mother, who seemed to help as much as she could, but Sam felt guilty about this and believed as his mother, she should be taking care of him;

“What can you do? I have to work and it’s not fair to leave XXXX to look after his brother, so my mum helps, but she has done her time hasn’t she? I guess it would be okay if he wasn’t so challenging, but he is and hates me leaving him.” (Page 5, line 78).

Having extended family help in childcare is now an acceptable way to manage the demands of a modern working family. Taylor et al. (2015) suggest it can offer a positive protective factor against conditions such as major depression. Their study showed how support from good, close family members can increase the satisfaction of a parent in relation to being able to still achieve their personal goals. Conversely, this study found that it may be less protective if the relationship with the extended family is critical and judgemental with regard to either choices to work or parenting style and decisions (Taylor et al., 2015). Whilst Sam did not criticise her mother’s help, she was evidently grateful for it, but she did not see this support as positive. This, I felt, was more the demands of her son’s condition and the burden this places on her mother, rather than any criticisms her mother may have made regarding Sam’s choices and/or parenting style.

6.3.The straw that broke the camel’s back:

As discussed earlier, what was noticeable throughout the telling of her narrative was Sam did not explicitly talk about the actual incident on the bridge. The defended subject, was evident in Sam’s narrative (Holloway & Jefferson, 2000; Klein, 1988), however, the actual incident was referred to indirectly or as an event that happened to a different Sam. Throughout the narrative, her thoughts and feelings about the incident were interspersed, but not actually discussed as a whole story within a story;

“When I was up there I can only recall thinking its quiet here” (Page 14, Line 220).

“You know that night is a blur, I still think it was just tiredness, it can make you do daft things can’t it?” (Page 14, Line 221).

“It won’t happen again, it was just a daft thing that I did for some stupid reason.” (Page 15, Line 236).

For me the above indicated Sam had not really explored the incident in any depth. She referred to it almost in the third person, as if it was something that was not really connected to her. Again Bateman and Holmes (1995) describe such behaviour as a neurotic mechanism of defence; a way of coping with the trauma caused by recalling the event from the unconscious to the conscious, thereby, having to actually think about it. By dissociating with the event in this way it enabled Sam to cope with the trauma and stress this caused her.

Trauma can be caused by many different events, each affecting an individual differently. Examples of events leading to trauma include; systematic verbal, physical, sexual or emotional abuse, being attacked, witnessing an attack or a distressing situation; the latter can also include witnessing such events on the television (Moroz, 2005). Once the event has passed and an individual is then 'safe' a wide range of psychological symptoms may manifest. These, if left unchecked, can cause major mental health problems, including major depression and suicidal ideation (Black & Trickey, 2000). The night Sam found herself on the bridge could have been the manifestation of her trauma that had built up over time. If such trauma continues to be untreated the psychological impact will affect her mental wellbeing and Sam would remain at risk of major depression and suicidal behaviour (Rothschild, 2000).

When in her the narrative Sam got specifically to the night of the incident, unaware at the time, I used techniques described by Bateman and Holmes (1995) that would enable me to gain data from defended subjects. I realised I needed to ask her a direct prompt question as Sam was talking around the actual event without talking about the police attending and how the Street Triage team became involved. I asked her directly if the police had attended and what happened next. She noticeably took a deep breath at this point which made me feel this part of her narrative was difficult for her to articulate. I was acutely aware of this and ensured she had enough time and space to retell this part of the narrative at her own pace;

"I can't quite recall how they arrived, but there was one female police lady stood at the side of me and another just up the road. She was nice and that, just said are you cold up here, I wasn't, and like what's the matter and stuff."
(Page 14, Line 223).

“I don’t know what I said to them, but I must have said I would sit in the police car with them, they were nice you know, only young both of them, and then one of them passed me a phone and I spoke to a nurse at the mental team, the ones based in A and E, I didn’t know her, but she was nice and that.” (Page 15, Line 241).

Sam agreed to go to the hospital that night to see the nurses on the Street Triage team. She recalls going to the hospital and being very worried someone she knew might see her. I was unsure if this was fear of being stigmatised for being in a police car, having a mental health problem, or simply that she was seeking help and that somehow this made her look as though she was unable to cope. The fear that people would think she has an inability to cope was a recurring theme throughout Sam’s narrative;

“I was a bit embarrassed you know, back of a police car going to the bottom block, it’s not the sort of thing you want folk to see is it? Like I can’t cope or something, it was just one of them things you know, tiredness, bit of stress, who knows?” (Page 15, Line 247).

It was at this point in her narrative Sam revealed that the ward she worked on was undergoing an organisational change and her role may have to change as part of the redesign of services. Such change within the work environment has also been identified as stressful. In a systematic review of the evidence available on the impact of organisational change on a person’s mental health, 17 studies reported a link between organisational change and the negative impact on mental health. These included a lack of engagement with staff during the change process increasing the risk of poor mental health and introducing too many changes at once or too quickly (Bamberger et al., 2012). However, this a sudden change in topic initiated by Sam during the telling of her narrative could again be seen as defensive. Sam had just got to the part in her narrative where she was describing the incident of being on the bridge and how she felt the police had interacted with her, when she shut down and retreated into her coping mechanisms of repression and rationalisation, perhaps being mindful that she had revealed ‘enough’ (Bateman & Holmes, 1995). At this point Sam opted to describe another stressful situation in her life, perhaps indicating her personal hierarchy of stress whereby talking about the latter (organisational change) is less stressful than her suicide attempt.

It was evident Sam had various stressors in her life that had resulted in her suicidal ideation and her going to the bridge, not all of which she wanted to talk about or was able to talk about. What appeared to be avoidance in recall or the retelling of that part of her narrative was more likely to be the way Sam was coping with such events.

6.4. Tiredness, work, childcare and other associated pressures:

Although Sam did not seem to want to retell details of the reasons she was on the bridge that night, or what it felt like during that time, she did talk about the help she received, which was in keeping with the aims and objectives of the study. She was noticeably grateful to the police, somewhat in a surprised way for Sam. This part of the narrative was reminiscent of the Jones and Mason (2002) study reviewed in Chapter 2, section 2.51, whereby the expectations of the service user in a mental health crisis versus the reality when being looked after by the police were explored. Interestingly the service users in the Jones and Mason (2002) study reported that they expected the police to be negative towards them and were surprised when this was not in fact the case. Sam confirmed this, showing genuine surprise that the police officers who managed her situation that night were kind and concerned about her wellbeing. Sam's surprise and gratitude is demonstrated in the following quotation;

"They were actually really kind, both of them. Said stuff like about stress and that and it can happen to anyone. They were the ones that rang the mental team, I didn't know they could do that, but yeah it was lucky really 'cos they were bothered you know." (Page 14, line 229).

Although Sam talked about mental illness she never said the word depression or suicide at any time in her narrative. Instead she described signs and symptoms of both when describing how she ended up standing on the bridge that night. She used tiredness, work stress, childcare pressures as ways to explain how she became so desperate. It was as if accepting she had depression might be interpreted as being weak, but being able to explain this event by offering 'normal' reasons was more acceptable. Again this can be interpreted as rationalisation, but appears to be more of a denial in this instance.

It is not unusual for a person experiencing a severe mental illness to deny the existence of such. Denial is another unconscious neurotic defence mechanism that aims to remove an aspect of reality from consciousness (Freud, 1940). Denial can also be defined as '*A refusal to believe an uncomfortable truth.*' (Thompson, 2008). It does serve a purpose in that the individual experiencing denial uses it to help with detaching their emotions from an event. Freud (1940) described this process as 'splitting' in that the person may cognitively accept the issue and the pain this causes, but repudiates the associated emotions. In doing so the person protects their ego (or self) from further stress and anxiety. This state of denial can become harmful if the person does not seek the help and treatment required to address the issue being denied (Thompson, 2008). In extreme cases a person may have what is termed 'anosognosia' which is more than a refusal to face the truth, it is a complete inability to believe their illness is real (Grohol, 2016). This could be the case for Sam in terms of her accepting she had a mental illness.

During Sam's narrative it was evident that she was uncomfortable with talking about the events of that night and adapted many defence mechanisms to be able to cope with her anxiety and discomfort. As explored previously, this was possibly due to her being a nurse and believing she was the one who looked after people when they are ill, rather than the person who became ill. Likewise, it could be denial due to embarrassment of having a mental illness, not wanting to let her family down, or a whole range of reasons that she did not discuss. What was clear was Sam tried to rationalise how she felt rather than having an inability to realise she was ill. I felt she knew she was ill, but did not want to accept this to be the case and therefore never used the words depression or suicide in relation to herself, instead choosing terms such as tiredness and stress to describe her mental state;

"Sometimes you can get that stressed you do daft things don't you? Being tired doesn't help either" (Page 6, Line 95)

Denial seemed to be a coping mechanism for Sam and if being able to explain her actions by her own acceptable reasons is fine, unless of course she denies herself the right treatment as a result. Sam did mention medication and talking therapy which the nurses on the Street Triage team have been giving her following their initial assessment the night of the incident, and although she never said the

interventions helped her, she continues to attend all her appointments. Sam is waiting to be allocated a CPN, so one assumes she is accepting of, and engaging with, her current care plan;

“They (Street Triage) started me on some tablets and that. I see one of them weekly now and can ring when I need to. They talk to me about my life and stuff I have to do, you know being so busy and that, I need to sort this work move out and my shifts, that will help I know it will.” (Page 19, Line 301)

6.5. Recovery, hope and the future:

It was difficult from the narrative to ascertain what Sam wanted for her future. She was guarded in some respects and I wondered if this was linked to her being a nurse and not wanting to really express herself as openly as she might. She did say she was waiting to be allocated a CPN and that this might help her with practical things;

“I assume they know better than me about what help I might be able to get for the little one, I can’t keep asking my mum it’s not fair”. (Page 19, Line 305).

She continues to see the Street Triage team weekly whilst awaiting allocation of a CPN. This does indicate Sam remains in need of support for her mental health present, and this seemed like a plan Sam was happy with, although it appeared she had been waiting several weeks. Sam did not seem to mind about this and laughed it off by showing her understanding of the pressures the NHS is facing;

“I guess it’s like any service in the NHS isn’t it, too many patients not enough staff and you just have to wait your turn don’t you. What can you do, its fine” (Page 20, Line 310).

This links back to the earlier discussion of resigned acceptance. Sam knows she requires a service, but as a nurse her understanding of waiting list pressures in the NHS and staff demands and capacity has led to her acceptance of having to wait. Overall I felt as though Sam was accepting of anything asked of her. She had been asked by the Street Triage team to attend a peer support session as part of her treatment, and although she attended she was unsure why it had been suggested. It was at that session she had been presented with information about this research

and had agreed to participate. I was very grateful she had, but felt this was more about her core values and principles of being a nurse and wanting to help others than for her own benefit. This was a value I admired in Sam, but also felt it was one that meant everyone, and everything else in her life was number one. This left Sam vulnerable and perhaps contributed to the night described in her narrative.

Sam was being supported whilst waiting for her CPN, which I was pleased about as it would keep her safe and she did seem to have hope for the future, even though it was somewhat muted it was evident in her narrative;

“Hubby is back at weekend, he is looking at other roles now as he knows he needs to be home more now. Maybe we can even have a bit of a holiday, it will have to be in England as XXX won’t get on a plane, but that would be fine. Just need to get some good sleep and stuff. It will be alright.” (Page 21, Line 315).

The interview ended on this positive note and like Carmel and Tim, the process of being interviewed in this research study had helped Sam. As a nurse she holds value in helping others and this appears central to her actions. By engaging in this process she was able to verbalise her own narrative whilst achieving her value of helping others. This appeared to be cathartic for Sam and boosted her self-esteem at a time in her life when this was clearly needed.

The interview was then concluded and the tape turned off.

6.6. Themes:

As per Chapter 4 and 5, using the Fraser (2004) framework the following themes were identified:

- The values of being a nurse
- Impact of work on mental wellbeing
- Role of carer and mental wellbeing
- Denial, coping mechanisms and their effects
- Ongoing support needs and recovery

6.7. Critical Reflection:

This was my third and final interview as part of this research. I was much more relaxed in terms of the equipment and noise levels given my other experiences, but was nervous for a different reason.

I knew Sam was a nurse and for some reason this made me nervous. I was unsure if that was because I did not know if she was going to be angry, maybe at the NHS or the police, or even me as being affiliated with those delivering Street Triage. I was also concerned as to whether or not she would engage in the narrative process. I had no idea why I felt like this as I had no information to base these judgements on, until I realised they are judgements being made by me based on my own unfounded ideas.

These thoughts surprised me. I made a judgement here based solely on the fact I knew Sam was a nurse. I reflected on this after the interview, and thought it was more likely my own view of the NHS that was being transferred onto Sam. I do get angry at the fact that people who desperately need services, for example being allocated a CPN, have to wait because there is not enough to go round, or services that should be there to support severely disabled children are being cut because the government does not have enough money for this provision. This was also the third participant who had mentioned having to 'wait' for something else and this may have compounded my own feelings at this point.

I recognised this in myself during the interview and after it had ended, and it made me reflect on my role as Director in the NHS and a person who has some influence over such policies and contracting. It made me reflect on that role and my day to day tasks and to check that the driving principle behind all of this should be for the service user. Whilst that is often said I am not sure how much it is done.

The interview itself was less warm than the previous two and Sam was guarded throughout the process, she turned off the TV, actually sat at the dining table, opposite where she placed me, and it felt much more formal than the other interviews. I am not sure if that was for Sam's or my benefit, but she was in control of the environmental arrangements I assumed she was happy with this. This did result in a much shorter interview than the other two, and for me it had a very clinical feel. Sam did not cry or get visibly upset at any point during the interview apart from

only once when talking about her son, even then her emotions were controlled and held back.

I knew, from being a mental health nurse that Sam was not fully recovered and the plan for her to have input from a CPN was the right one. I also knew that Sam needed to take her medication and engage with Street Triage whilst she waited, but as she stated she was doing these things it did not feel as though it was my place to tell her she was right to do so. I did not want to patronise her, Sam knew what she needed to do even though she did not always retell this in her narrative.

The process of the narrative interview with Sam did unearth feelings in me about my own circumstances. How lucky I am in some respects that both my children are healthy and do not have the issues described by Sam in her youngest son. I feel I am in a stable senior role in an organisation and have a settled and supportive group of family and friends. This element of the reflection, whilst making me feel lucky, reminded me that others are not as fortunate and this being one of the reasons why I became a nurse in the first place, why I volunteer at the local community rugby club and why I am a Trustee for a Charity.

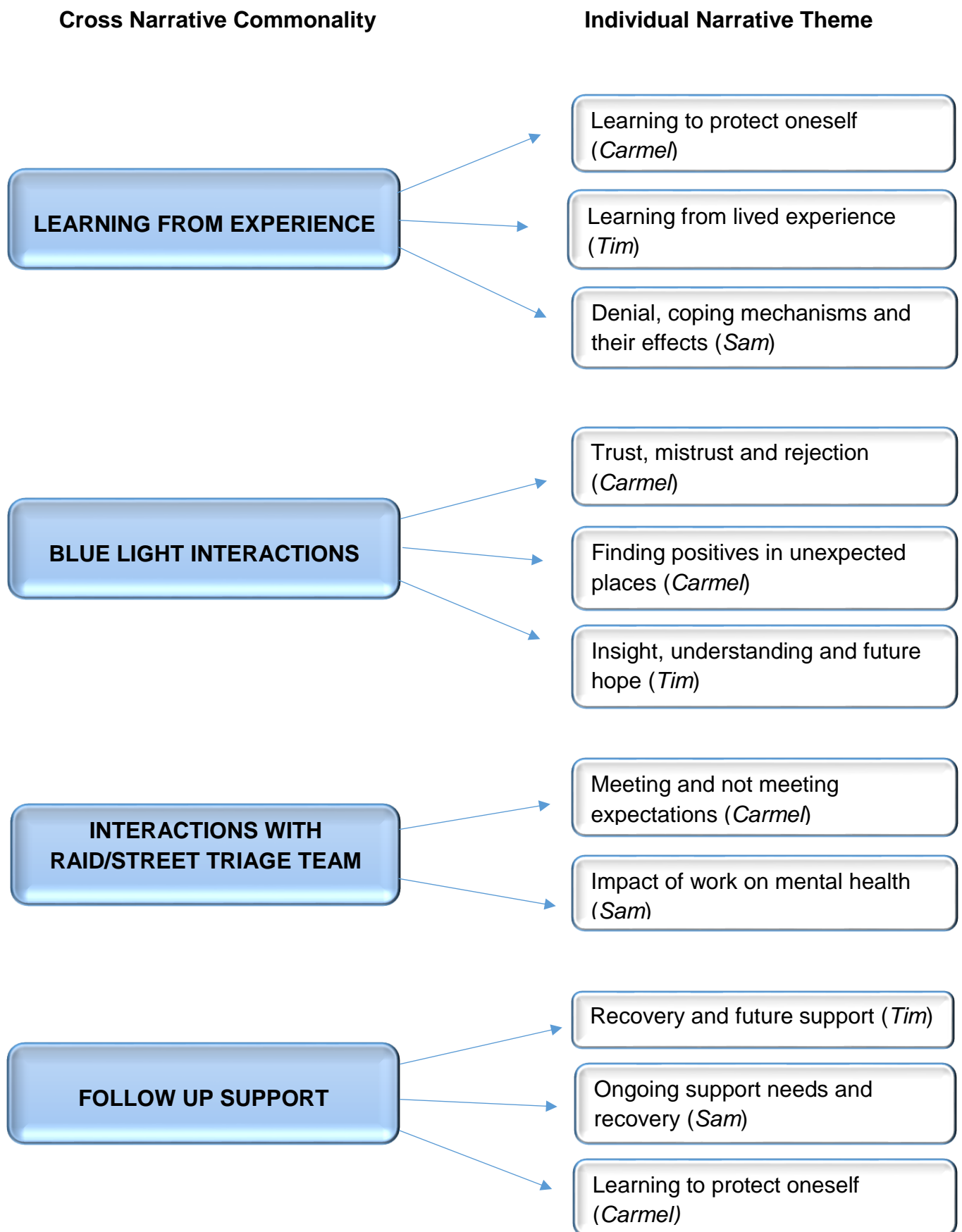
Having said all this in this reflection, I did not feel sorry for Sam as I did not think this is what she would want me to feel. Sam was very likeable in relation to her dedication to her children, her work and holding her family together and that was a lovely feature she demonstrated within all threads in her narrative. One can only admire her dedication and love, not only to her family, but to the patients she looks after.

CHAPTER 7: CROSS NARRATIVE COMMONALITIES

In being cogniscent of the importance of authenticity and trustworthiness within qualitative research when designing this study I was careful to articulate each individual narrative so as to retain the uniqueness of the participants' voice. I wanted to use a framework that allowed the retelling of such narratives in its entirety, whilst also being able to look for themes occurring across all three narratives. As discussed in Chapter 3 section 3.9, the framework I used to support this approach was the seven phases of narrative analysis as described by Fraser (2004). In phase six of this approach it is suggested the researcher looks for commonalities and differences among participants' narratives, as in doing so patterns could emerge that are worthy of further exploration (Fraser, 2004). Within this chapter I will present the commonalities evident in the narratives of Carmel, Tim and Sam, who, on first exploration, appear to have very little in common. All three participants are different ages, have different backgrounds, lifestyles and relationships. They all also have a different lived experience of mental illness with Carmel being in receipt of services over a long time period, Tim having had this one event and now waiting for ongoing care and Sam, despite her short experience, is still receiving regular support. Despite this, they all do share the commonality of having experienced a mental health crisis that involved the intervention of the Street Triage team.

In each narrative, I have used phases one to four of Fraser's (2004) framework and analysed each individual narrative for different '*domains of experience*.' This generated a series of 'domains' or 'themes' in each individual narrative that I extrapolated, explored and highlighted at the conclusion of each narrative chapter. Each narrative had a series of themes unique to that participant, but when examined as a whole across all three narratives four commonalities became apparent to me. Shown in diagram 1 below, are the commonalties identified from across all three narratives, with related themes from each individual narrative set against them. It is evident that not all themes from all narratives are aligned to a common theme and this in itself demonstrates the uniqueness of each narrative whilst allowing the commonalities to be seen across them as a whole.

Diagram 1: Cross commonalities extrapolated from individual narratives



As discussed above, looking at the diagram it can be seen that some of the 'domains of experience' identified in each individual narrative do not 'fit' into a cross commonality theme. These are offered as unique experiences to that participant, and although different, and specific to one individual, still offer valuable insight into how Street Triage service was experienced by those in a mental health crisis.

The aims and objectives of this study were to explore and understand the experiences of service users, who have had a mental health crisis and were treated using the Street Triage Service.

The objectives of the study are:

- To explore the perspectives of service users regarding their experiences of using the Street Triage service in Bury and HMR.
- To ascertain which, if any, aspects service users found to be beneficial
- To identify any aspects of the service that from a service user perspective could be changed
- To enhance knowledge regarding initiatives for addressing mental health crisis situations.

By undertaking phase six of Frasers (2004) framework and identifying the cross commonality themes, I am able to identify what is unique to each participant, as well as identifying commonalities, and how each of these contribute towards meeting the aim and objectives of the study. To achieve this the following sections will explore both the individual themes, from each narrative, followed by the common themes, as identified in the diagram above. In the final section of this chapter findings across the narratives will be linked back to the original aim and objectives of the study, set out above, in preparation for the presentation of the final two chapters of this thesis which will be the discussion and conclusion chapters respectively.

7.1. Different and Unique:

In telling the narratives of service users it was important that the uniqueness of each story was captured and made available to the reader. Fraser's (2004) framework allowed me as a researcher to look for themes within the narratives rather than focusing on looking for parts of the narrative that would link to any of the other narratives collected in the study. By using this approach I was able to identify what was unique and different to each participant in relation to the aim and objectives of this study.

Each narrative had their own themes in relation to the participant's individual experience. It would be expected that not all events happened exactly the same, to the exact same people with the exact same circumstances. As such each narrative did have a strong theme in relation to that participants own experience and own mental health issue.

To highlight this in Carmel's narrative rejection was a main theme. It was evident this rejection in her life had impacted on her current mental state;

"you know I'm an honest, decent person mmm can't even image doing anything wrong or wish to do you know what I mean, so not sure why people can't be as nice to me." (Carmel, Page 2, line 20).

For Tim, however, one of the main themes running through his narrative was that of sport and the importance this has on his life and mental wellbeing;

"It's dominated by males at the rugby club, but you know every one of them has your back." (Tim, Page 12, line 284).

Whereas the main theme evident throughout Sam's narrative was work/life balance and the challenges of having a severely disabled son;

"I have to work, you know, but when I am at work I need to be at home and vice versa really." (Sam, Page 4, page 45).

When considering the objectives of this study there are also some unique experiences each participant has to offer. The first objective is to explore the perspectives of service users regarding their experiences of using the Street Triage

service in Bury and HMR. Whilst commonalities do exist, as shown in Diagram one and to be discussed later in this chapter, each participant did have their own perspective on the Street Triage Team.

Carmel was more receptive to the police and dismissive of the nurses at Street Triage. Tim was apparently more thankful to the police, but overwhelmingly grateful to the nurses, whilst Sam was somewhat grateful to the police and is guarded about her feelings towards the nurses in the Street Triage Team;

“Police are lovely with me because they know me.” (Carmel, Page 7, line 108).

“She [nurse] helped a lot.” (Tim, Page 3, line 62).

“I see them [nurses] every week now, for a bit you know, not sure it helps but you know its fine, I just go.” (Sam, Page 21, line 345).

The second objective is that of looking to ascertain which, if any, aspects of Street Triage service users found beneficial. Again there are commonalities, discussed later, but uniquely Carmel found the ability to stay at home beneficial; Tim found the opportunity to speak to a nurse from a police officer’s phone beneficial; and Sam found not having to go to her local A and E of benefit to her. While each was beneficial to the participants involved, all of these unique situations may be beneficial to service users per se;

“They came to the house, you know, I can’t go out so they came to me.” (Carmel, page 6, line 97).

“He let me use his own phone, you know, it helped.” (Tim, Page 5, line 81).

“They took me to the bottom block so I didn’t have to go to A and E.” (Sam, Page 17, line 232).

The next objective is that of identifying anything that could be changed from the perspective of the service user. For Carmel this would be having easier access to the services at a time that suited her as she did not want to have to go to the local hospital as she found it difficult to get to. For Tim knowing about services and help that was available enabled him to prevent himself from becoming as unwell as he had been and for Sam this was harder to ascertain given her ‘defended self’

(Holmes & Bateman, 1995) approach to the interview, but I feel this could be access to a service that was not based in a hospital site;

“I don’t like going to the psychiatric place, it’s a fair distance and you never know who you might bump into.” (Carmel, Page 3, line 34).

“Yes and give me a number to ring if I need.” (Tim, Page 5, line 104).

“Yeah not going to A and E was better.” (Sam, Page 17, line 237).

The final objective in the study is to enhance knowledge regarding initiatives that could address mental health crisis situations. Carmel would say this would be to have access to her notes at the point of need so she would not have to repeat herself at a time when she is in a crisis. Tim would promote the idea of wider anti-stigma campaigns and more acceptance of mental illness in society, believing this would prevent a person’s mental health to deteriorate, and Sam would advocate, although probably say it was for others not herself, more social support for families with caring needs to prevent them becoming stressed and unwell themselves;

“She did calm me down, I think she did have notes on me.” (Carmel, Page 4, line 55).

“All the high profile campaigns, it’s become more acceptable.” (Tim, Page 9, line 219).

“More support from social services would help a lot of people wouldn’t it?” (Sam, Page 19, line 289)

The uniqueness and individuality of each narrative contribute towards meeting the overall aim and objectives of this study, whilst the cross narrative commonalities further build on the evidence presented above.

7.2. Shared Experiences:

As shown in diagram one, commonalities across all three narratives fell into four distinct areas: (1) learning from experience; (2) blue light interactions; (3) interactions with the Street Triage team and finally (4) follow up support. This section will explore each of these themes across the narratives and how they impacted each of the participants in the study and, in turn, the aim and objectives of the study.

7.3. Learning from experience:

The first common theme is that of learning from experience. All three narratives identify how, whilst the actual incident described individually was very distressing to the participant recalling it, each participant able to take that experience and used it to positive effect. In the case of Carmel she talked about ways in which she now protects herself, some of which were not very positive, such as staying at home and isolating herself, but she was also able to articulate how she had used previous experiences to stop herself from being back in the same place. Tim talked about learning from his experience and recognising the signs and symptoms of him becoming unwell again, thus being able to prevent deterioration of his mental state. Sam talked about her coping mechanisms and, although this was interlinked with some denial of her mental health problems, she did recognise she needed to seek help and support as she could not continue in the same way in the future.

In relation to the objectives of the study, these cross commonalities' show that by exploring the perspective of the service user in regards to their own unique experience it can reveal outcomes possibly not evidenced in the literature or identified by services. The service has been and is measured on standard Key Performance Indicators (KPIs) such as how many calls does the team take, how long did the call last, what was the outcome, all of which are beneficial to the organisation on how well the service is performing, but not very meaningful to people such as Carmel, Tim or Sam. Exploring their narratives and identifying common themes, such as learning from experience, provides richer detail to the outcomes of the service.

Whilst common across all narratives, the actual learning differed in each participant's narratives. The most successful learning appeared to be in Tim's narrative. His ability to be able to recognise the signs and symptoms of his illness and deploy tactics to prevent him ending up as unwell as he had been in the past:

"When I come home now I sit down for an hour and talk you know, I don't just go to bed anymore" (Tim, Page 4, line 74).

Neither Carmel nor Sam's learning appeared to be quite as successful, but still helped each in turn in their own unique way. For Carmel this was avoiding

relationships with men who may treat her inappropriately and disrespectfully, and in doing so this keeps her feeling safe;

“You know it’s hard when you are alone but for me that’s better.” (Carmel, Page 12, line 84).

Sam, did not overtly acknowledge she had a mental illness, but in continuing to engage with the Street Triage team whilst awaiting allocation of a CPN, it did indicate she acknowledged she needed the support being offered;

“I go every week, it’s okay you know, they say having a nurse will help me get stuff for my son so its worth it isn’t it?.” (Sam, Page 22, line 389).

This cross commonality theme of learning from experience is often referred to as ‘lived experience’ (Bartova, 2014) and describes those, such as Carmel, Tim and Sam, who have experienced a mental health issue, from which they have or are recovering, and as such can offer a unique insight into what that experience felt like and what would have helped at the time. The first objective of this study was to capture this. Recovery Insights (Rethink, 2010), a publication by a national mental health charity, showed that those with lived experience of mental illness were able to learn from that experience, much like Carmel, Tim and Sam, and develop a wide range of new skills as a result. Such skills included; all treatments required are adhered to, taking responsibility for one’s own health and ensuring engagement in positive relationships. Developing such skills would hopefully keep a person well and better able to manage their mental health. This ability to learn from experience offers another layer of protection to each of the participants and is important in the recovery process of any individual in similar circumstances.

7.4. Blue light interactions:

The next cross narrative commonality theme identified is that of the interactions each participant had with the police. Not obvious at first, but the individual narrative themes I have identified in diagram one, ‘finding positives in unexpected places’ (Carmel), ‘Insight, understanding’ (Tim) and ‘ongoing support needs and recovery’ (Sam) all contain elements of interactions with blue light services within the individual narratives and were part of their ‘domains of experience’ (Fraser, 2004).

This to me was an interesting cross narrative commonality as it reinforces the findings of recent research showing that the police themselves report 20-25% of their work now has a mental health component to it and, as such, the chances of them dealing with someone in a mental health crisis in their everyday work is high (House of Commons report, 2015). It is probably not surprising that all three narratives in this study noted the role of the police within their own individual crisis.

Whilst the interactions and roles of the police in all three narratives were different, a prevailing theme across them all was that the police were both helpful and caring during their crisis. Carmel reported how she felt safe with the police and displayed genuine warmth when retelling how she believed they really did care about her and her safety;

“Police are like family.” (Carmel, Page 7, line 108).

Tim reported how the police had been the first on scene at the dam and had used their own phone so he could talk to a nurse from the Street Triage team. Sam talked about the two police officers who came to her aid the night she found herself on the bridge. She described them as ‘kind’ and how they took their time to listen and help her. These are all positive actions from police officers dealing with someone in a mental health crisis.

In terms of this study, these reported interactions with the police and the Street Triage team, had clear benefits to the three participants. Whilst none of the participants stated what they expected the police, or Street Triage nurses, to be like with them, they all expressed varying degrees of warmth and gratitude which would lead one onto conclude they did gain benefit from the interactions they had. The police as an organisation acknowledge that the officers on the street are not mental health experts, but are still expected to deal with many complex mental health situations (House of Commons Publication, 2015). The police officers discussed in each of the three narratives in this study appear to have dealt with the crisis they faced in a professional manner and, more importantly, in a way that was appreciated by the three service users experiencing that crisis.

Whilst unable to verify if any of the police officers in the narratives had any past mental health training, based on my local knowledge I am not aware of any

specialist mental health training programmes being available to the local police force. The actions of the police officers in each of the narratives do not appear to demonstrate anything other than good listening skills and a caring and kind approach to the people in distress. These are of course transferable skills that any human being, regardless of their professional background, could have as innate qualities. What the College of Policing and police officers themselves report is that they do not feel 'equipped' to deal with a mental health crisis presentation. That said all three participants reported in their narratives in this study that during their crisis this interaction with the police had a positive impact on their perspective of their experience. All three had benefited in different ways as a result of this interaction and such transferable skills clearly offer a basis on which to build specialist training. .

7.5. Interaction with the Street Triage Team:

The research previously discussed in Chapter 2, section 2.53, highlighted how access to immediate expert mental health advice improved the experience of those experiencing a mental health crisis and also the blue light officers dealing with such situations (Franz & Borum, 2010). This immediate access is the premise that the Street Triage service is based on. It was evident that immediate access to the Street Triage team was sought and gained by the police officers and that all three participants had benefited from this process. Carmel highlighted how she particularly benefited from not having to repeat her history when she initially spoke to the Street Triage practitioner;

“Nice you know when you don’t have to go through 54 years of it all over again.” (Carmel, Page 4, line 57).

It is noted that repeating traumatic events is not always beneficial to the service user (Repper & Perkins, 2003). Being asked to do so can impart a feeling of not having read background notes on the individual or not valuing what has been said previously enough to have recorded it for the future. This is more important when in a crisis as it can cause added stress for an individual having to recall traumatic events at a time they are feeling particularly vulnerable. As previously discussed in Chapter 6, mechanisms of defence, such as repression or denial, come into play

when a person in severe distress moves the traumatic event to their unconscious whilst externally denying any issues (Bateman & Holmes, 1995). Continually asking Carmel for such detail when she is in a crisis only serves to cause her more stress, leading her to deny and/or repress the event. This is concerning as outwardly she may appear to be well;

“Can’t get out of bed, can’t move, can’t wash or anything. Just in that deep bloody awful hole but I just tell people I am fine so they leave me alone.”
(Carmel, Page 16, line 237).

Carmel had a long history with local mental health services and as such had experienced what she would recognise as good and poor examples of interactions with them. She clearly felt that having to keep telling her story over and over again when she met someone new from the same service was frustrating. Carmel could not understand how modern day services, such as the mental health services in her local hospital, did not have notes on her that could be accessed whenever required so she did not have to keep reliving what she described as ‘*traumatic events*’ exactly at the time she was at her most vulnerable.

On the night of Carmel’s crisis the team had been able to access this information and this clearly influenced her reporting the interaction with the police and the Street Triage team to be positive, but she also described times when this had not been the case and this had resulted in her having less faith in these services and being dissatisfied with them. In a digital age and with the available technology in a modern day NHS, those simple tasks such as information sharing and information availability at the point of need seems to be a major issue for some services to master. Building Bridges (DoH, 1995), noted that an important element of the integration of services was the ability to share information so that it was available in a timely manner and at the point of need. Indeed in the follow up publication, ‘Still Building Bridges’ (1999) the DoH reported that more work was needed to ensure such access of information was achieved. The narratives of Carmel, Tim and Sam in this study took place in 2017 and it was still reported, through the perspective of her own experience, information was not readily available to those who need it.

All three participants noted how the practitioners from the Street Triage team they had spoken to had been very helpful, understood their situation, made them feel at ease and offered an intervention that addressed their own individual needs. Carmel did not like going out, particularly at night, and so arrangements were made for a practitioner to visit her at her own home. Tim needed to talk to someone who understood his situation and did not make him feel judged, and that was the intervention he reported to have received. Sam was engaged with the Street Triage team and continues to receive practical help and support from them;

“They should come to your home, and this time they did.” (Carmel, Page 5, line 60).

“She made it about me, like an individual.” (Tim, Page 6, line 158).

They have helped me fill forms in and stuff.” (Sam, Page 23, line 409)

Healthcare services are designed to offer practitioners who are skilled and able to respond to service users’ needs appropriately. All too often, though, this is reported not to be the case and service users are less than satisfied with the response they have received from the nursing and health care staff they believed should be able to help them (Clarke et al., 2007). The additional disappointment such inappropriate healthcare responses may cause and compound a person’s mental health crisis at a time where effective management is required (Riley et al., 2011). All three participants, in this study, did not report this to be the case.

Such experiences have evidently had a positive impact on the recovery of the participants in the study following their individual mental health crises. One of the objectives of this study was to ascertain if the interaction with the Street Triage team had any benefits to the service user from their own perspective. Whilst each participant appeared to be at a different point on their road to recovery, each had reported how they had benefitted and the part the Street Triage Team had in helping them along that road.

7.6. Follow up support:

Whilst the previous cross narrative commonalities had been positive in nature, the final theme does not reflect such a positive impact in any of the three narratives.

The last objective of this study is to enhance knowledge regarding initiatives for addressing mental health crisis situations. On exploring this further in Carmel, Tim and Sam's narratives, it was evident that follow up offered after their initial crisis management intervention was important to all three participants and yet all three were waiting for another part of the service to provide intervention;

"I am harmless, I need medication, need counselling, I am traumatised."
(Carmel, Page 17, line 255).

Ongoing management within a mental health crisis is important in ensuring a person fully recovers (Repper & Perkins, 2003). Mental Health crises do not disappear as soon as they occur; rather they are a pathway in which a person could relapse at any time dependent on stressors and triggers within their own cultural context (Foster, 2008). Whilst Carmel and Tim await ongoing management they remain at risk of a further crisis as a result.

Such teams as Home Based Treatment teams (HBT) or Crisis Intervention teams (CIT) recognise this fact (Johnson, 2003). These teams are designed to manage an individual's crisis from initial point of presentation and immediate safety management through the whole pathway and on to recovery. This means from the point of access, in the case of Carmel, Tim and Sam, through the Street Triage Team, other elements of the service dependant on their needs should have been readily available. These could be the Home Based Treatment Team, CMHT, Early Intervention teams or even teams that offer social support in the community. Such pathways include a multitude of interactions from each of the teams including; therapeutic interventions such as motivational interviewing, goal setting or problem solving approaches alongside medication reviews and management, as well as other meaningful activities like swimming or running (Repper & Perkins, 2003).

The role of teams, such as the Street Triage Service, is to manage the initial crisis to make sure a person is safe and then to enable the individual to work through their own pathway and on to recovery. In all three narratives in this study it was evident that the immediate management of the crisis was effective and seen as a positive interaction. Carmel, Tim and Sam talked about having the number for the service and felt that simply having the number available to them was enough to make them feel safe if they ever needed to ring it again. Whilst this was common across all

three narratives, the follow up support for each participant was very different. Sam was still regularly seeing the team whilst she awaited allocation of a CPN, Tim and Carmel were not offered the same service. Both Tim and Carmel were only given the numbers to ring when in a crisis rather than having anything meaningful in place to prevent that crisis from occurring.

What was also clear in each of the three narratives was that meaningful follow up services that would manage their long term recovery were not forthcoming. Carmel talked about needing more support, but believed services she had benefitted from previously, such as a CMHT or the home treatment team, were not as readily available to her now and she was facing a wait for allocation. Whilst she felt the police and the Street Triage team could help her should she feel suicidal again, I had a sense of her going back into a crisis whilst she was waiting and before any further interventions would occur. Tim reported that he also felt safe due to being able to ring the number anytime, but he also talked of his frustration at now having to wait for ongoing counselling and that he had been told it was a long waiting list, at best it would be at least six months before he would be seen. Long waiting lists for services such as counselling are not uncommon and is a reflection of high demand and low capacity within current mental health services (Rankine, 2015). Sam did appear to be faring better and whilst still not allocated to a specific CPN, she was still receiving regular supportive interventions from the Street Triage team to keep her safe until the longer term planned intervention can begin.

7.7. Conclusion of Findings:

The experiences of Carmel, Tim and Sam are unique and the retelling of their individual stories offers rich data as a result. It is important to ensure services listen to the experiences of those that use them as they offer a valuable and unique contribution not only to the service in question, but the wider existent literature.

The cross narrative commonalities between the experiences of Carmel, Tim and Sam, can help to guide discussions about future developments of the service and the mental health research agenda. The themes emerging across the three narratives demonstrate that learning from their experiences has benefited each participant and helped them to develop resilience to help prevent future episodes of mental illness and/or crisis. The cross narrative themes also show a positive

regard for the police and their attitudes during a mental health crisis. This finding was contrary to police concerns, raised by their own College of Policing, that their officers are not equipped to manage such situations (House of Commons Publication, 2015). This was not evident in the narratives in this study.

The participants all benefitted from a positive interaction with the Street Triage practitioner they initially spoke to and who they then had follow up interventions with. The immediacy of this was evident in having a positive impact on their experiences, as was the attitude of the practitioner/s and the way in which they were engaged therapeutically in their interactions. Access to information to engage the person in crisis was also noted and the shared information agreement in place within the team is obviously beneficial to the police, health staff and the service user, the latter being spared the trauma of having to retell a potential traumatic history when they are distressed.

All participants also described a feeling of safety by having a number they could ring at any time of day or night if they felt a need. Knowing that someone they now know they can trust will answer and help them appeared to be reassuring and helpful. Notably none of the participants had rang the number since the initial crisis, but all felt the benefit of just having the number, and therefore access to professional help, available to them.

Unfortunately all three participants were waiting for further service involvement to help continue their recovery. Carmel was waiting for some ongoing support she can access to keep maintaining her recovery process. Tim was on a waiting list for counselling and again Sam was waiting to be allocated a CPN. Whilst Sam was understanding about the need to wait, probably due to her knowledge of pressures in the NHS, Carmel and Tim were less tolerant. It was disappointing to hear that services which could aid recovery and prevent a further crisis reoccurring were not readily available to support the participants in this study.

Having now presented the composite themes from each of the narratives, the next chapter will explore and discuss these findings within the context of the literature review presented in chapter two, with the final chapter of this thesis revisiting the original aims and objectives, limitations of this study, recommendations for future service redesign and further research needs.

CHAPTER 8: DISCUSSION

This chapter will review and discuss the findings as set out in the previous chapters 4, 5, 6 and 7. These findings will be reviewed and discussed in relation to existing research highlighted in the literature review (Chapter 2) and the overall aims and objectives set out for this study in Chapter 1.

The data produced in this study and analysed using the Fraser (2004) framework has generated a number of findings as discussed in Chapters four to seven. In summary these are the fact that each participant's perception and experience of the Street Triage Team had both unique and different aspects, but also some commonalities. Each participant did report experiencing some benefit from being cared for by the service, but the benefits differed in all three individuals. The narratives identified aspects of care and the service that could be changed and the narratives also offered an insight into what sort of initiatives could be further developed that would potentially help others in a mental health crisis.

Given this brief summary of the findings, this chapter will present each objective of the study in turn, discuss the findings in relation to the overall study aim and the literature reviewed in Chapter 2, as well as any current research or theories that are relevant to that discussion. In pulling all these aspects together the chapter will generate a rounded discussion of the study's findings. The final chapter in this study will present the conclusion, including the unique contribution this research has made to the body of knowledge as a whole and offer recommendations for further research.

Aim: To explore and understand the experiences of service users, who have had a mental health crisis and were treated using the Street Triage Service.

Objective: To explore the perspectives of service users regarding their experiences of using the Street Triage service in Bury and HMR:

For me the most important element of this study is that the service user voice is heard and articulated. Almost 40 years ago The World Health Organisation (WHO) (1991) stated that health organisations should empower service users to be involved in the development of the services they provide. They said that this voice should be '*heard and not assumed*', and it is this statement that for me underpins

the essence of this study. It has been recognised that many service developments have purported to have gained service user participation, but this has been carried out in a very superficial manner and not one that has been meaningful (Warne & McAndrew, 2007; Beresford 2002). For example, this could involve; having one person in a focus group, but then not actually listening to what they have to say, not engaging them in the discussions, or having a survey and disregarding the results. All of these activities are meaningless and considered tokenistic (WHO, 1991). Recognising this type of poor engagement, the Health and Social Care Act (2008) stated that there was a need to pay '*proper regard to the views expressed by service users and carers*'. This '*proper regard*' is what the aim of this study set out to achieve, alongside the first objective set out above.

To achieve these in a meaningful way was both challenging and difficult at times. It is probably this challenge that has led to such tokenistic approaches in the past, with superficial engagement being easier to achieve (WHO, 1991). However, this study ensured that just because such views are difficult to gain it does not mean they should not be sought in a real and meaningful manner. To further reiterate this point it was noted that when exploring the existing research only three relevant studies were identified. These studies (Clarke et al 2007; Jones & Mason 2002; Riley et al 2011) explored service user experiences when in a mental health crisis.

When exploring the existent research in relation to the findings in this study interesting similarities and differences emerged. In the Jones and Mason (2002) qualitative study, 16 structured interviews with service users who had been treated under Section 136 of the Mental Health Act 1983 (2008) and held in police cells for up to 72 hours were undertaken. The interesting aspect of this study, in relation to this research and its aim and objectives, was the exploration of the attitude of both the police and health staff and the relationship between what service users expected to happen and what they reported actually did happen whilst they were in a crisis. In the Jones and Mason (2002) study, service users expected the police to be '*custodial*' and so when they behaved in this way service users did not see this as necessarily negative, as it was what they expected to happen. In some respects this could be construed as indifference and acceptance; judging a certain professional will behave in a certain way and they do, even if it is controlling and custodial, those in receipt of the behaviour do not report this as a poor or

unacceptable experience. However, when the police officers did not behave in this way, but were kind and understanding, which occurred mainly when not in the custody setting, it was unexpected from the service user perspective and, as a result, was viewed as a positive interaction by those who experienced it (Jones & Mason, 2002). This aspect of their study is reflected in all three narratives in this study. Carmel reported that she had a very positive relationship with the police and viewed them in a more positive light than she did the health staff. Carmel felt the police had actually '*saved her life*' and she had genuine warmth for them and their input when she was in a mental health crisis. This was based on her past experiences with both the police and health staff, as well as how the police had interacted with her on the night of her crisis, this being central to her story.

The Jones and Mason (2002) study also discussed how those in a mental health crisis expected staff, such as nurses, should be kind, caring, compassionate and understanding of the service user experience. On occasion when this did not happen the service users in their study reported this experience to be worse than when the same attitude was shown to them by the police, as they actually expected that to happen. Of course the optimum experience would be a positive attitude from both the police and healthcare staff and, whilst this seems obvious, sadly it appears not to always happen. In keeping with the findings of Jones and Mason (2002) in this study Carmel was less than favourable about the healthcare staff she had interacted with over the years. This included her GP, psychiatrist and a multitude of healthcare staff. Carmel believed they had not listened to her and she had to continuously repeat herself at every interaction. Within her narrative she described how this felt like the people she had seen before had '*not bothered to write anything down*', resulting in her feeling rejected.

Carmel was noticeably more favourable about the nurse she had spoken to on the night of her incident, but did express some wariness. This centred on the original intention of taking her to hospital and this not materialising, as she had not wanted to have to make her own way home in the middle of the night as had previously happened. This is out of keeping with the notion of a 'place of safety' and unacceptable practice in terms of compassionate care. It was evident from Carmel's narrative that such previous interactions, with both the police and health

staff, had influenced her overall perspective of what she could expect when she went into a mental health crisis.

In contrast, neither Tim nor Sam had previous personal experience in the same way as Carmel of a mental health crisis, and as such had nothing to judge their own experience against other than what they expected based on their own judgements and assumptions. Sam had a different perspective on what she expected from the nurses than both Tim and Carmel based on the fact that she is a nurse herself who, from her own narrative, showed a positive value base for delivering care for the service users she came into contact with. Tim had no previous interactions with mental health nurses and he reported his experience as positive, due mainly to the evidently therapeutic intervention he had received from the nurse in the Street Triage Team. The experiences of each of the participants would also be informed from a cultural context, attitudinal base, from the media, or from others recalling their experiences to our participants as well as a wide range of other sources. This could result in the participants stereotyping the professionals involved based on this wide range of sources, most of which is not personal experience and based on others opinions. This is interesting, as stereotyping is often discussed in terms of professional attitudes some staff have towards certain service users. This is captured in the 1972 book by Stockwell 'The unpopular patient' in which certain 'types' of patient were described and the attitudes of nurses towards them challenged.

In another study, reviewed in Chapter 2, Riley et al. (2011), 18 participants were interviewed, including carers as well as service users, to discuss their experiences when they were cared for under Section 136 of the Mental Health Act 1983. For many individuals in a mental health crisis this equated to being taken to the local '*place of safety*' designated for this purpose. Whilst many such places are purpose built suites linked to the local mental health services, many are not and can either be the local A and E department or, on some occasions, the police cells. Recent changes in legislation has meant the use of cells is now only ever an option as a last resort, but the use of busy A and E departments remains common place (Riley et al., 2011)

In this study none of the participants required removal to a place of safety which could be testament to the Street Triage service, but access to a safe facility was explored in all three narratives. In both Tim and Sam's narratives they accessed such safe settings at the hospital. Carmel had previous experience of being taken to A and E when in a crisis and, following assessment, had been left to make her own way home. She described the A and E as '*distressing*' due to the noise and the people who were there in the early hours of the morning. Carmel also told of how she was in fear of coming home alone in the early hours of the morning, as well as the cost to her due to the distance from the A and E to her home address.

Conversely, Tim was taken to the hospital by the police that night. As he had been expected by the Street Triage team he did not need to go through the processing procedure in the A and E department, but had access to a pathways which allowed him to go straight to be seen by the team. As the team were expecting him, they were able to welcome Tim immediately, put him at ease and use a safe therapeutic space to begin to work through his crisis with him. Tim evidently benefited from this approach, reinforcing Riley et al.'s (2011) findings regarding dedicated and safe environments being of central importance when managing an individual in a mental health crisis. For Tim this first impression helped to enhance his experience of mental health services. Williams (2013) developed a toolkit to aid services to 'walk around' their teams to ensure the impression given is what was desired. Known as the 15 step challenge, this approach recognises that how the service user experiences their first impression of a care setting can affect their perception of the whole care journey. For Tim this first impression appeared to be positive.

Sam was concerned about being taken to A and E the night of her crisis, not because of the busyness of the environment or feeling distressed by being there, but mainly because it was based at the hospital she worked and her anxiety was about being seen by anyone who she knew and worked with. Although Sam was taken to what is locally known as 'the bottom block' (the mental health unit) she was taken to a specially commissioned room meant to provide a safe space to those in crisis. Specially designed not to look like a 'hospital', the room is softly decorated and furnished with soft lighting to put the service users at ease. In 2011 the Royal College of Psychiatrists reported standards expected from in-patient mental health wards, the physical environment being included. Recommending these

environments to be fit for purpose, it went on to say that the environment itself, including its décor, should be considered as part of the service user's treatment. Use of soft colours and calming designs are all proven to have a positive impact on the service user in distress (Bjorkdahl et al., 2016). Unbeknown to them both, the room both Tim and Sam accessed the night of their crisis, was in fact the same one and, as Riley et al (2011) stated, environments in a crisis are essential, with the room used by the Street Triage team appearing to have achieved this therapeutic requirement.

Objective: To ascertain which, if any, aspects service users found to be beneficial:

There are aspects in all three narratives that identify what each participant felt was beneficial to them. They are interesting in both their similarities, as well as their differences. One of the striking similarities was each participant reported how they felt the police involved in their own personal incident were helpful to them at that time. Carmel was very grateful and talked almost affectionately about the officers who helped her that night. Tim was less affectionate, but still felt the police had been helpful and allowed him to use their equipment to talk to the nurse. Sam, again not as obvious in her narrative about her gratitude to the police that night, describing them as '*kind*' and '*supportive*.' Whilst it may seem obvious that those looking after an individual in a crisis situation to approach that person with kindness and support, it is sadly not always the case (Campbell, 2015). The service users in this study reported that the attitude of the police was very welcome, had a positive impact on their outcomes, allowed their crisis to be resolved by showing kindness and support, and, most importantly, demonstrated understanding and had the ability to access the right help. Whilst the approach of the police officers in each narrative varied, what was evident is the right attitude and support was beneficial to the outcomes for the service user. This is reflected in the literature reviewed and in particular the Jones and Mason (2002) in which the optimum experience for a service user is to have the right attitude shown towards them from both the blue light services and health professionals.

Tim and Sam were both taken to a safe dedicated room at the hospital where they both described seeing a mental health trained specialist nurse. Tim in particular

found that this part of the pathway was beneficial to him as he was able to talk to someone he felt safe with, who did not make him feel rushed or not worthy. The experience of being able to access such a team in a seamless way appeared to have a positive impact on the outcome for Tim. His reported experience demonstrates that this is a beneficial part of the service model. Many services have inclusion and exclusion criteria, referral processes that disjoint access and cause points of 'hand off' that mean the experience for the person going through this pathway can be affected (Spehar et al., 2005). Seamless pathways, such as described by Tim, enhance the experience of the service user and ensure they have a positive perspective of the care they are receiving.

Further underlying this aspect of the Street Triage model, Sam described how relieved she was that she did not have to attend the busy A and E with the police that night, not just because she may have been recognised by colleagues she worked with, but also because the environment itself is very loud at times and not necessarily conducive to a person in mental distress (Hughes & Clarke, 2001). As discussed in Sam's narrative, she was quite defensive in the telling of her incident, but she not only attended and accepted help on the night of her incident, but has continued to do so since this time which does indicate she found some benefit from this service.

In exploring this aim it is useful to link the findings to the final research study reviewed in Chapter 2, Clarke et al. (2007), in relation to the service user perspective of the care they had received. A Canadian based study, they explored the self-reported perceptions service users had when attending an ED when they were in a mental health crisis. The study was designed to examine a new role termed a Psychiatric Emergency Nurse (PEN). This role was designed to reduce distressing waits for service users when they attended in a mental health crisis, as well as to reduce tensions between the mental health and non-mental health staff working in the ED. This seemed to be akin to one of the principles by which the Street Triage team was established.

Clarke et al. (2007) used focus groups to explore the impact of this new role of PEN. Findings highlighted how the experiences in the ED can have either a positive or negative impact on those in a crisis dependant on what that experience entailed.

For example those being seen in a timely manner by a trained professional reported a more positive experience than those having to wait a long time and seeing less capable staff. The development of the PEN had impacted positively on this experience and, not only allowed a quicker response reducing the anxiety of waiting, but the intervention was by someone trained to deal with their mental health crisis.

This experience is reflected in the Street Triage model. The development of the service linked directly to the 'emergency' services such as the police and A and E staff, meaning service users in a crisis, as in the Clarke et al. (2007) study, get immediate access to a highly trained practitioner. This not only reduces service user distress due to there being a limited wait time, but also the intervention is evidence based and therapeutic (Hughes & Clarke 2001). This positive impact can be seen in all three narratives in this study. Carmel did not want to attend hospital as previously discussed, but she did talk to the practitioner from the Street Triage team directly using the police officer's telephone. This immediate access to a trained mental health professional allowed Carmel's anxieties and distress to be alleviated, while the next steps in her required interventions could be planned and implemented. Prior to the Street Triage team being in place the police would have taken Carmel to A and E or left her at home and reported their actions to the Public Protection Investigation Unit (PPIU). This team would then send referrals to the mental health services for review; a process that can take several days with limited outcomes due to information shared and service availability. The interaction Carmel received the night of her self-reported crisis, highlighted how the Street Triage team, with 24 hours, 7 day a week, access to trained mental health practitioners with flexible pathways at their disposal, was able to meet her needs much more effectively than she would have previously been offered before the Street Triage Team was in place.

Tim's narrative also demonstrated how the specialist role of dedicated practitioners in the Street Triage team can enhance the experience for the service user. Tim described how he was able to go straight to the team without having a distressing wait in A and E, and then received evidence based therapeutic interventions from a trained mental health practitioner who was skilled and competent to meet his

needs. This positive interaction from this new team appears to reinforce the findings of other studies (Clarke et al. 2007).

Whilst Clarke et al.'s (2007) study discussed what service users did not like about the ED, the authors did accept that the study failed to identify what service users would actually like to happen in a crisis. Whilst the role of the PEN was welcomed, I feel the data collected in this research study builds on the findings of Clarke et al. (2007) by identifying it is not only the specialist role that is essential to a better experience for the service user, but the team, flexible pathways and the interface with all other services is what provides the all-round support. The narratives of the participants' in this research demonstrated how they benefitted from their experience of the Street Triage team and how it has had a positive impact on their perceptions of the service.

Objective: To identify any aspects of the service that from a service user perspective could be changed

Objective: To enhance knowledge regarding initiatives for addressing a mental health crisis situation:

The reasons these two objectives are presented together are that each generated data that were inextricably linked and thus not able to be fragmented in their presentation. From a service user perspective of what was felt could be changed led onto what initiatives could be developed to address future crisis. Such initiatives were explored in the literature review presented in chapter 2, and included models of Street Triage and police attitudes and actions within this model of service delivery and how these aspects all influenced the experience of the participants' who received care through this service.

The Street Triage model in place in the Bury and HMR Boroughs of Pennine Care NHS Foundation Trust (PCFT) is based on a combination of telephone access and manpower resources. The latter affords mental health practitioners to attend an incident in which a person is experiencing a mental health crisis, with the police in attendance and requesting support. Sands et al.'s (2013) study explored one aspect of a similar model to the Street Triage team in Bury and HMR, used to manage mental health crisis presentations in Australia, namely telephone access, triage and

support. This study used a mixed methods approach, reviewing practitioners in the mental health team who took telephone calls from service users across a large geographical area which the team covered in Australia. This study found in a psychiatric emergency (or mental health crisis) the telephone interventions offered by the practitioners and non-coercive techniques they adopted were able to assist in the crisis whilst a suitable safe intervention was sought. This ability to rapidly stabilise the crisis by use of the telephone is one of the main principles of the local Street Triage team in PCFT.

The literature review in chapter 2, identified how the combination of telephone support, with an effective pathway to services for blue light teams such as the police to access, could be beneficial to those service users in a crisis (Sands et al., 2013). Indeed this was of particular note in both Sam and Tim's narratives of their individual experiences. On the night of Tim's incident, the police were able to contact the Street Triage Team directly and discuss their concerns for his safety directly with trained mental health practitioners. Although Tim was not known to mental health services before the night described in his narrative, and as such they had no previous notes or history on him, they did follow an evidence based triage tool. This tool is much like the 58 item observation tool (Broadbent et al., 2002) used by the team in Australia. This triage tool enables the practitioner to assess the immediate risk in order to offer a safety solution to the crisis situation, allowing Tim to have immediate access to the team for further assessment. In Sam's narrative much of what happened to Tim was reflected in her crisis. Sam did not fully recall, or recount, her discussion with the Street Triage team during her time on the bridge, but did highlight how the police officers took her to the hospital and she was able to access trained mental health practitioners immediately. This link from telephone triage to access to clinical pathways appears to be beneficial to the experiences reported by the participants' in this study.

While Carmel did not access the team in person, on the night of her crisis, it was an option she was immediately offered. Her ability to talk directly to the team that night and negotiate her next intervention, allowed her crisis to subside and for her to feel safe. In addition, Carmel had a plan for onward support agreed through the interface between herself, the police and mental health services. This flexibility within the

model allowed Carmel to receive care tailored to meet her own needs and, as such, enhanced the experience she had that night.

One of the ways in which the Street Triage Team in Bury and HMR could be improved, could be reflected in the work undertaken in America on the development of their Crisis Intervention Teams (CITs). These teams have police officers specially trained in mental illness deployed to assist in identified incidents that appeared to have a mental health component. Evolving from the death of a mentally ill man, shot by the Memphis police in 1988 who mistakenly thought this man's illness behaviour was a threat to them, the subsequent inquiry identified the need for police officers to have some level of mental health awareness, hence the first initiative of a CIT was developed (Crompton et al., 2008). Chapter 1 of this study discussed how, in 2015, the then Chief Constable of the Greater Manchester Police Force, Sir Peter Fahy, described how police officers in the UK spend between 20-40% of their time involved in situations in which mental health was a cause, without having any formal training. The additional combination of telephone access to a trained mental health practitioner, coupled with clinical pathways that support immediate access to such teams and services, led by police officers who have undertaken specialist mental health awareness training, could realise the optimum service model for service users' experience and outcomes.

As previously discussed, such specialist and extensive mental health training, as discussed by Canada et al. (2008) and Compton et al. (2008), does not currently exist for the police force in the UK and is not available as part of either probation training or basic training for new police recruits. This exposes such police officers to the risk of making the wrong decision when dealing with a mental health crisis, mainly due to being unaware of what those risks could be. By having access to both specialist training and a system that allows them immediate access to a specialist trained professional can only optimise the experience for both the professional and the service user and make the managing of risks presented more effective.

Locally, PCFT services do deliver basic mental health awareness training to officers in GMP. This training consists of a one hour session on the basic signs and symptoms of mental illness. It includes how to place a Section 136 on a person they are concerned about, and how to bring that person to a 'place of safety'. I believe

this minimalistic training is linked more to detention and restriction than managing a mental health crisis in a joined up and co-produced manner as advocated by the Crisis Care Concordat (2014). Whilst this training is limited, it is a start and not to be dismissed. However, this limited training in no way reflects the suggested models in the literature with, for example, Compton et al. (2008) suggesting 40 hours of specialist training being the minimum to ensure police officers have the skills to manage a mental health crisis in their daily working life.

One of the main impacts such training appears to have is the positive impact on the attitude and behaviours of the police officers who have received it. Jones and Mason (2002) stated the better the attitude of the police the more positive the experience for the service user. The study by Watson et al. (2008) looked at the difference in actions and attitudes of those officers specially trained in mental health awareness and those officers that had not had the training. Although the limitations of Watson et al.'s (2008) study were explored in chapter 2, it was evident that mental health trained police officers had more confidence in dealing with such situations. Being more confident enabled the police to portray a more positive attitude influencing the overall experience of the incident from the service user perspective.

The suggested correlation between police officers who are trained in mental health and positive attitudes towards those in crisis is interesting in terms of this research. None of the police officers discussed in the three narratives presented in this study had received specialist mental health training, but all of the participants reported them as being positive in their attitude, approach and behaviour towards them. Carmel was very positive about her interactions with the police, they evidently knew her well which could account for their confidence in managing the situation they were faced when they attended the night of her incident, but they would also have known the risks as well. Their decision to access the Street Triage team and keep Carmel safe whilst supporting and reassuring her had a positive impact on how Carmel viewed that interaction and her overall experience that night. Both Tim and Sam had similar experiences to Carmel. The model of Street Triage, described in this study, allowed the police, in both these high risk and critical cases, to have immediate access to a trained mental health practitioner, enabling the two participants to enter the clinical pathway without having to negotiate difficult barriers, for example having to go through A and E. Rather than specialist training,

it could be this seamless system that helps the police to feel more confident in such situations. Subsequently the confidence it instils could be what translates into positive attitudes and actions each officer was reported to have had when attending to the participants in this study.

It could be argued that the 40 hours of specialist training may not have any more impact on service user experience as the maximum one hour session police officers in the local police force have received. The attitude and behaviour towards the three participants in this study from the police officers were of a positive nature and one could argue this could be enough if such a response was garnered, especially given the cost that 40 hours of specialist training would attract.

Whilst Watson et al. (2008) discussed the need for specialist training for the police officers to assist in improving interactions when faced with a mental health incident, it did not show if this was in fact the case from the service user perspective. Indeed in this study, all three participants experience appeared to be positive and, as identified, the officers discussed in these narratives were unlikely to have received any such specialist training. Hails and Borum (2003) did explore this aspect of specialist training for police officers and their responses to people with mental illness. They then compared such responses to those officers who had not received such training. The responses and attitudes of those officers who had received training did demonstrate improved outcomes for service users. Building on this, Reuland et al (2009) looked at the link between the length of training, its contents and outcomes for the service users. It concluded that the 40 hours of training provided the optimum outcomes desired. Consideration needs to be given, however, as to whether the expensive 40 hours of specialist training is required rather than a more achievable focused training package that delivers the awareness and overview of, and how, to deal with a mental health crisis in the context of a system such as Street Triage. This would offer the police officers a basic understanding of mental illness and its presentations but also knowledge on who to contact and when, so they are not left feeling unable to deal with the situation. All three participants in this study felt the police attitude to them was '*kind*' or '*supportive*' and this had a positive impact on their experiences and outcomes. It could be argued that a good attitude is not something that can be taught, but using real life scenarios and discussing good communication techniques in the context of

someone in a mental health crisis, might provide insight in how to approach such situations.

Watson et al. (2008) highlighted more than just training as the key to a successful Crisis Intervention Team (CIT). Other key components identified as contributing to a successful team, included organisational structure and links to treatment offers. As is the case of the Street Triage team being explored in this study, if the links did not exist between health and police services, the latter having opportunity to offer those in a crisis a choice of treatment options, then the experiences recalled by all three participants in the study may well have been very different.

In Carmel's narrative, if the police had not been able to contact the Street Triage that night and enable Carmel to talk to the nurse to arrange a suitable time to be seen, the police would have had to either convince Carmel to go with them to A and E, leave her at home with no follow up in place, or access legal powers to forcibly remove her against her will to an agreed 'place of safety'. With both Sam and Tim, the police officers discussed in their narratives were able to seek advice from trained mental health professionals and to then take both participants to the safety of the hospital to access immediate help. If this had not been an option the police would have had to have made such decision alone. Much like with Carmel, this would mean they would either have had to convince both Sam and Tim to attend A and E with them and wait to be seen, or to detain them using their powers under the Mental Health Act 1983 (2008) and take them forcibly to hospital.

The Street Triage model in this study reflects that of the CITs discussed in detail in Chapter 2. The final element of a successful CIT identified by Watson et al. (2008) was the implementation of such teams into the community as a whole. It was evident from the three narratives in this study that the participants had never heard of the Street Triage Team. It was clear that my assumption that those using the service would know they had been treated by the new Street Triage team was wrong.

Engaging the public in the development of the service and then ensuring all stakeholders, such as the wider public, are fully aware of what the team is, who is involved, what they will be able to offer and why it is a beneficial service to those who may need it, is essential to its success. By ensuring the public recognise what

the term 'Street Triage' means could help to improve perceptions of both the police and mental health teams, as well as highlighting the availability of such a service for those that may need to access such services.

The importance of advertising Street Triage may go some way to reduce stigma, promote engagement and challenge perceptions the public may have regarding the police, mental health staff and those who experience mental health problems. Improved perceptions and reduced stigma could mean users who are struggling with their mental health might feel more comfortable to access services earlier. Much like demonstrated in Sam's narrative, whereby she had not been accepting of the suggestion from her GP to be referred to mental health services. This was possibly due to her perceptions of mental health services and her own stigma towards those with a mental health issue. If having a mental illness was more acceptable by the wider public and a person could seek help without fear of stigma or prejudice, it is possible less people would end up in a mental health crisis, warranting a team such as the Street Triage, to be involved. Normalising mental illness and accessing help, needs to be part of the overall implementation strategy of the team, promoting an awareness among the wider general public, not only of services that could help in a crisis, but that help is also available in helping prevent a person becoming distressed in the first place.

The final objective of this research was to enhance knowledge regarding initiatives for addressing mental health crisis situations, one such initiative being the Street Triage model itself experienced by all three participants in this study. There are, of course, other models of such crisis initiatives, some of which have been explored in this study in chapters 1 and 2. In the UK, these currently encompass a range of pilot sites and models that include; dedicated nurses based in the custody suites, or in the police communications centre, or in police cars; multi-professional teams working in one dedicated centre; or pathways and telephone access services (DoH, 2015), the latter being the model in this study.

The research, explored in chapter 2, examined best practice models and the evidence base for each different type of service model. As one would expect there are both advantages and disadvantages to each different model. Reuland et al. (2009) examined a model based in Vancouver, Canada, known as Car 87, in which

a nurse was deployed with a police officer to incidents suspected to involve a person in a mental health crisis. Whilst positive results were gained from this initiative in relation to the service users who were diverted from A and E, or treated at home, it did not explore the fact that the model is limited to one incident occurring at a time, this being rare in a city like Vancouver for that to be the case (Reuland et al., 2009). The use of such initiatives as the Street Triage team in this study, ensures that a nurse is always available on the phone to the police for advice and discussion rather than only one nurse being available in a car who is then only available to one incident at a time. This means any police officer, or multiple officers, attending incidents across the area, will be able to access such advice in a timely manner. Such a model is a cost effective way of delivering the required clinical expertise to a wider population, in this case across Bury and HMR (The Kings Fund, 2015).

Whilst this study is not able to compare different models of crisis care, as each participant was cared for using the same model, the fact that each participant self-reported their perspective of the seamless and effective pathways between both the police and the health services, and how this positively impacted on their experience, seems to highlight this model is likely to meet the required needs of an identified population. Crompton et al. (2008) reviewed 20 research papers with a view to identifying which model of a crisis intervention team, including police officers, has the best outcomes for all involved; service users and blue light professionals as well as health staff. Whilst overall it recommended more research, they did identify that the best models ensured there was an ability to take the person in mental distress to a safe place, where a trained mental health professional could offer timely, evidence based, help. This is reflected in the participants' narratives regarding Street Triage. Whilst Carmel did not want to take up this offer she was still able to feel less anxious knowing help would come to her in a place she felt safe. Both Tim and Sam were taken to a dedicated safe room at the hospital and were seen by a dedicated skilled mental health practitioner. In all of the narratives each participant described principles contained in the Crisis Care Concordat (2014) and appeared to demonstrate the Street Triage model that had been developed was achieving the aims of the Crisis Care Concordat (2014), offering timely and appropriate access to help when a person is in a mental health crisis.

In terms of the final objective of this study, namely '*to enhance the knowledge regarding initiatives for addressing mental health crisis situations*' Carmel's narrative indicated better IT systems that support timely access to notes and a person's history at the point of contact was essential to effective care (Freudenheim 2012; Kawamoro et al ., 2005). In light of this, ensuring such systems are built into the service is essential. The most obvious change, identified in all three narratives was the service as a whole would benefit from improving follow up arrangements. Whilst the Crisis Care Concordat (2014) outlines the principles that should be co-produced by a multi-agency approach, it falls short of identifying what services should be developed and implemented in order to achieve recovery from a crisis and keeps people well, thus preventing the need for such services in the future. The focus of this work is to develop a crisis response that is well designed, appropriately implemented and offers joined up models of care to address a mental health crisis, but of course the concern is this that this is at the expense of building services that also support recovery and keep people well.

In each of the three narratives, the participants were awaiting the next step in their recovery. For Carmel this was allocation of a community worker, for Tim it was onward specialist Cognitive Behavioural Therapy and for Sam it was allocation of a CPN. Only in Sam's case was she still actively engaged in support from the Street Triage service, neither Tim nor Carmel has such input, but had been given the telephone number of the team should they require it. This was to be used if they started to experience another mental health crisis. It felt that the experience of the participants was such that their needs were met by the service response when in a crisis, but that the service response to keeping them well and averting further crisis was not readily forthcoming.

In summary, this discussion chapter has explored the overall aim and objectives of this study and been able to discuss these in the context of the findings from data generated in this study, as well as the theories and research available in the existent literature. In doing so the study is able to now conclude and offer recommendations for practice and future research.

The final chapter in this study will elaborate on how data gathered, analysed and discussed, is able to offer a unique and new contribution to knowledge offer overall

conclusions to the study and make recommendations for further research. In doing so I hope to recommend how to continue to enhance and develop the service user experience for those service users who access care from the Street Triage Team in Bury and HMR through post-doctoral work.

CHAPTER 9: CONCLUSION AND RECOMMENDATIONS

Conclusion:

This final chapter of the study outlines the conclusions, the limitations of the study as well as recommendations for practice and future research. It will also articulate how this research offers a unique contribution and new knowledge in this area.

The study had one overall aim and four objectives.

The aim of this study is to explore and understand the experiences of service users, who have had a mental health crisis and were treated using the Street Triage Service. The objectives of the study are:

- To explore the perspectives of service users regarding their experiences of using the Street Triage service in Bury and Heywood, Middleton and Rochdale.
- To ascertain which, if any, aspects service users found to be beneficial
- To identify any aspects of the service that from a service user perspective could be changed
- To enhance knowledge regarding initiatives for addressing mental health crisis situations.

To achieve the overall aim, the study undertook a narrative research approach, contained within a qualitative paradigm, with three participants who had experiences of using the Street Triage service in Bury and HMR. With the objectives of the study wanting to explore their experience of using this service, looking at what was beneficial, what could be changed and ultimately enhancing the knowledge regarding initiatives for addressing the needs of service users when in a mental health crisis. It concludes with the objective of analysing the provided data which enabled the findings to be generated. These findings, therefore, are informative for both practice and future research.

The strength in this thesis lies within each narrative being presented individually, to preserve each participant's story as a whole, as well as presenting common themes

across all three narratives. Using Fraser's Seven Phase Framework (2004) enabled the objectives of the study to be clearly articulated in terms of the findings, whilst retaining the integrity, authenticity and uniqueness of each narrative. This framework also enabled the service user voice to be heard. This desire to hear the service user voice was a major driving force behind the study with the main aim to ensure that this was achieved. By ensuring each unique narrative was represented in its entirety, as well as the cross narrative commonalities, ensured that this service user voice was loud and clear and central to the study.

Bringing the findings together, the study has presented a discussion on the interpretation of the analysis of the data, linked this back to the aim and objectives of the study and set it within the context of the current literature. By taking the qualitative, narrative research approach, I believe the study did achieve the aim of exploring and understanding the experiences of service users, who have had a mental health crisis and were treated using the Street Triage service. Throughout the chapters one to eight, this exploration and understanding is evident, each one of these chapters being linked to the overall aim and objectives to ensure the study stayed aligned to its focus.

The main findings of the study were categorised into four main areas. These themes were (1) shared experiences, (2) learning from their experiences, (3) blue light interactions and (4) interaction with the Street Triage team.

By analysing each area under these themes the study is able to then make recommendations that have been informed by the personal experience and perspective of three service users who had real lived experience of the service under review.

9.1. Limitations to the study:

It is acknowledged that each participant in this study was white British by background in an area with a large black and minority ethnic (BAME) population. Understanding if the perceptions of members of this population group are different to other groups could help to inform future practice and is recommended as a topic for further research.

It also has to be acknowledged that I am a senior nurse manager in the organisation, and service area, that the research took place in and there is a possibility that the three participants may have known this and answered accordingly. Although I had no previous knowledge of any of the three participants and did not feel this was the case.

Finally there were only three participants in this study, yet even with such a small number the richness of the data produced still ensures the study is meaningful and insightful in its findings.

If the research was to be repeated I would address such limitations by targeting more service user forums and local groups with the aim of recruiting more participants of a mixture of BAME backgrounds. I would also recruit staff from the service to leave information in the waiting rooms and appointment areas to hopefully recruit more participants through this process.

I would also undertake this research in a different area of the Trust, that I have no previous knowledge of, to address any potential service user knowledge of me in a different role.

9.2. Recommendations:

Using the four objectives and exploring the findings generated through this study several recommendations are highlighted informing future practice and research. These recommendations have been developed from the interpretation of the data from all three narratives and all are designed to improve practice and future service delivery for service users who may need to access the Street Triage Service in Bury and HMR.

1. To discuss with Greater Manchester Police force what current training officers receive in relation to mental health and what they believe their training needs are in this area.
2. To collaboratively develop a bespoke package to meet these training needs of the Greater Manchester Police force, ensuring this is delivered, evaluated and has ongoing monitoring to address contemporary issues as

they arise.

3. To ensure all services in Pennine Care NHS Foundation Trust (PCFT) undertake the 15 step challenge and create a good first impression to improve the experience for service users.
4. To review IT systems in PCFT and ensure access to timely information is readily available at all points of need.
5. To review the current service offered to those in recovery after a crisis to enable access to ongoing support from the wider Health and Social Care economy, as well as third sector providers, whilst awaiting a specialist service.
6. To undertake further research in the wider PCFT services that also includes participants that reflect the local population to examine if such perceptions differ.

9.3. Unique Contribution and New Knowledge:

The overall research in this study has been able to offer a unique contribution to understanding the service user perception and experience when in a mental health crisis and being treated by the Street Triage service in Bury and HMR. This service has been running for two years and has undergone much evaluation, but from an organisational perspective. This has included how many calls they have received, the nature of such calls and what the outcomes were. This research has been able to offer the unique perspective from those that actually used the service and received care, and in doing so generate new knowledge on what is beneficial and what could be done to improve the service. By completing this study it is evident that this contribution and new knowledge can go on to further enhance practice in the service as well as promoting wider research potential.

References

Adebolawe, Lord (2013). *Independent Commission on Mental Health and Policing Report*. 2013.

Aliaga M & Gunderson B (2003). *Interactive Statistics* (2nd Edition). Prentice Hall, 2003

Anderson, James; Mangels, Nancie; Langsam, Adam (2004). "Child Sexual Abuse: A Public Health Issue". *The Justice Professional*. 17: 107–126

Association of Chief Police Officers (2012) *National Decision Making Model*. Home Office Publications, 2012.

Atkinson P (1992). *Understanding Ethnographic Text*. Sage: Newbury Park.

Baba, V. V. & Jamal, M. (1991) Routinisation of job context and job content as related to employees' quality of work. *Psychology*, **39**, 94–102.

Bamberg M (2004). Talk, small stories and adolescent identities. *Human development* 47: 366-9

Bamberger S, Vinding A, Larsen A, Neilson P, Fonager K, Nielson R, Ryom P, Omland O (2012). The impact of organisational change on mental health, a systematic review. *British Medical Journal* Vol 69 issue 8.

Ban, TA (2007). 50 years of chlorpromazine a historical perspective. *Neuropsychiatric disease and treatment* 3 (4) pg. 495-500

Bannister P, Burnam E, Parker I, Taylor M and Tindall C (1995). *Qualitative Methods in Psychology: A research guide*. Open University press: Buckingham

Barker P, (2009). *Psychiatric and mental health Nursing: The craft of caring*. Oxford University Press. 2009.

Bartova Z, (2014). '*Learning from the experts: A qualitative study of the lived experience of mental illness.*' Professional Doctorate (unpublished).

Barton J., Smith L., Totterdell P., Spelten E. & Folkard S. (1993). *Does individual choice determine shift system acceptability?* *Ergonomics* 36 (1–3), 93–99.

Barton R (1959) *Institutional neuroses* Bristol: John Wright and Sons

Baumeister, R. F.; Tice, D. M. (1990). Anxiety and social exclusion. *Journal of Social and Clinical Psychology*. **9**: 165–195. [doi:10.1521/jscp.1990.9.2.165](https://doi.org/10.1521/jscp.1990.9.2.165).

Beresford P (2002). User involvement in research and evaluation: liberation or regulation. *Social Policy society* 1 (2) 95-105

Berne, Eric (1964). *Games People Play – The Basic Hand Book of Transactional Analysis*. New York: Ballantine Books.

Bjorkdahl A, Perseius K, Samuelsson M, Lindberg M (2016). Sensory rooms and psychiatric in patient care. *International Journal of Mental Health Nursing*, Vol 62 Page 34-40.

Black D, Trickey D (2000). Long term psychiatric effects of trauma on children. *Trauma Vol 2* 261-268.

Bond J, Newnes, C, Mooniach F, (1990). User views of the inpatient psychiatric services at Shelton Hospital. *Clinical Psychology Forum* 49:21-26.

Borrill, C. S., Wall, T. D. & West, M. A. (1996) *Mental Health of the Workforce of the NHS Trusts, Phase 1: Final Report*. Sheffield/Leeds: Institute of Work Psychology, University of Sheffield, and Department of Psychology, University of Leeds.

Bowlby J (1973). *Separation: Anxiety & Anger. Attachment and Loss (vol. 2); (International psycho-analytical library no.95)*. London: Hogarth Press

Brett A (2003). Information skills training: a systematic review of literature. *Health information and libraries journal* 2003, 20 pp 3-9

Broadbent M (2002). Improving competence in emergency mental health triage. *Accident and emergency nursing*, 10,155-162.

Burgess, Ann Wolbert; Lynda Lytle Holmström (1974). Rape Trauma Syndrome. *AMJ Psychiatry*. 131 (9): 981–986.

Burnham E and Parker J (1993). Feminism and discourse in developmental psychology: identification, subjectivity and interpretation'. *Feminism and psychology*, 2 (1), 45-60

Campbell D (2015). A and E staff attitudes to mental health patients. *The Guardian*, 12th June.

Canada K E, Angell B, Watson A (2012). Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls. *Community Mental Health Journal* 48.6: 746-55. 2012

Carrigan T, Watson A (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry. Feb Vol 1* 16-20.

Charmaz, K. (2011). *Grounded Theory Methods in Social Justice Research*. In *Handbook of Qualitative Research 4th ed.*, edited by N.K. Denzin and Y.E. Lincoln. Sage.

Clancy J. & McVicar A. (1994) Circadian rhythms 2: shift work and health. *British Journal of Nursing* 3 (14), 712–717.

Clarke D, Duscome D and Hughes L (2007). Emergency department from the mental health client's perspective. *International Journal of Mental Health Nursing*, 16 126-131.

Clark D, Layard R and Smithies R (2008). Improving Access to Psychological Therapy: Initial Evaluation of the Two Demonstration Sites *LSE Centre for Economic Performance, 2008*

Coffey L., Skipper J. & Jung F. (1988) Nurses and shift work: effects on job performance and job related stress. *Journal of Advanced Nursing* 13, 245–254.

Colaizzi, P.F (1978). *Psychological research as the phenomenologist views it*. Oxford University Press, New York.

Compton M, Bahora M, Watson A and Olivia J (2008). A comprehensive review of extant research on crisis intervention team (CIT) programmes. *Journal of American Academy of Psychiatry and the law* 36:1:47-5

Cooper J, Steeg S, Bennewith O, Lowe M, Gunnell D, House A, Hawton K, Napur N, (2011). Are Hospital services for self-harm getting better? *British Medical Journal Open* 2011

Creswell J W (2011). *Qualitative Inquiry and research design: Choosing among five traditions*. (3rd edition). Thousand Oaks CA: Sage.

Crombie I K (1996). *The Pocket Guide to Critical Appraisal*. BMJ Publishing Group. London

Culler, J (1980). Fabula and Sjuzhet in the analysis of narrative: some American discussions. *Poetics today*, 1, 27-37.

Denzin N (1970). *The research Act in Sociology*. London: Butterworth

Duchan E, Patel DR (2012). Epidemiology of autism spectrum disorders. *Paediatric. Clin. North Am.* 59 (1): 27–43.

Duggan S (2013) Crisis Care in the NHS, *Health Service Journal* June 24th 2013 pp23-25

Dunham R. (1977) Shift work: a review and theoretical analysis. *Academy of Management Review*, 2, 624–634.

DePrince, A.P. & Freyd, J.J. (2002). *The Harm of Trauma: Pathological fear, shattered assumptions, or betrayal* In Kauffman J. *Loss of the Assumptive World: a theory of traumatic loss* (PDF). New York: Brunner-Routledge. pp. 71–82.

DoH publication (2015). The street triage models, update on pilot sites. Accessed online April 2018.

Eales S, Callaghan P and Johnson B (2006). Service users and stakeholder's evaluation of a liaison mental health service in an accident and emergency department and a general hospital setting. *Journal of Psychiatric and Mental Health Nursing*, pg. 70-77 2006.

Equity and excellence liberating the NHS. Houses of Parliament White Paper. 2010

Fitzgerald H, Bocknek E, Hossam Z, Roggman L (2015). Reflections on fathers and infant mental health. *International Journal of Mental Health*, Vol 36, issue 1 75-77.

Fossey E. (1990) Shift work can seriously damage your health. *Professional Nurse* June, 476–480.

Foster, J. H (2008). Relapse prevention in serious and enduring mental illness: A pilot study. *Journal of Psychiatry and Mental Health Nursing*. Oct 2008

Frank, A, W (1995). *The Wounded Storyteller*. The University of Chicago Press: Chicago

Frank, A.W (2007). Five dramas of illness. *Perspectives in biology and medicines*, volume 50, number 3, pp 319-394.

Franz S and Borum R (2010). Crisis intervention teams may prevent arrests of people with mental illnesses, *Police practice and research*, 1-8.

Fraser H, (2004). *Doing narrative research, analysing personal stories line by line*. Thousand Oaks. Sage.

Freeman, M (2006). Life on 'holiday' in defence of big stories. *Narrative inquiry* 16 131-8.

Fredli L, & Watson S (2004). Social prescribing for mental health. *Durham Northern Centre for Mental Health*.

Freudenheim M (2012). *The ups and downs of electronic medical records*. New York Press.

Georgakopolou, A (2006). Thinking big with small stories in narrative and identity analysis. *Narrative inquiry* 16. 122-30.

Glaser, B.G and Strauss, A.L (1967). *The Discovery of Grounded Theory. Strategies for Qualitative Research*. Chicago, Aldine Publishing Company

Goffman, E (1967) *Asylums: Essays on the social situation of mental patients and other inmates*. Penguin Books.

Goodwin I, Holmes G, Newnes C, Waltho D (1999). A qualitative analysis of the views of in-patient mental health service users. *Journal of Mental Health*. 1999 8:1 43-54.

Griffiths, R (1988). *The Griffiths Report: Community Care: Agenda for Action*: National Institute for Social Work, 1988

Grant M and Brett A (2009) A typology of reviews: an analysis of 14 review types and associated methodologies. *Health information and libraries journal* 26 pp91-108

Greene J C, Caracelli V UJ, Graham W F (1989) Toward a conceptual framework for mixed-methods evaluation designs *Educational evaluation and policy analysis*, 11 (3) 255-274

Greenhalgh (1997). *How to read a paper*. London: Sage

Grob, GN (1994). *The mad amongst us: A history of the care of Americas mentally ill*. New York: The free press.

Grohol, J (2016). Denial is a powerful impediment to treatment. *Psych central Journal Vol 4* 23-27.

Grounds A (2001) Reforming the MHA *British Medical Journal*. Nov 2001 179 pg. 387-389

Hails J and Borum R (2003). Police training and specialised approaches to respond to people with mental illnesses. *Mental illnesses Crime and delinquency*, Vol 49 No 1, 52-61.

Hall J.M and Powel. J (2011). Understanding the person through narrative. *Nursing research and practice*. Volume 2 2011.

Hammersley M (1992). *What's wrong with ethnography? Methodological Explorations*. London: Routledge

Hampson M (2011). Raising standards in relation to section 136 of the Mental Health Act 1983. *Mental Health Practice Journal*, 2011.

Health and Social Care Act 2008 www.legislation.gov.uk/ukpga/2008/ Accessed June 2017.

Holloway and Freshwater D (2007). *Narrative Research in Nursing*. Blackwell Publishing Ltd.

Holloway, I (1997). *Basic Concepts for qualitative research*. Blackwell Science.

Holmes TH, Rahe RH (1967). The Social Readjustment Rating Scale. *Journal Psycho som Res*. 11 (2): 213–8

HMIC (2015). The welfare of vulnerable people in police custody, www.justiceinspectorates.gov.uk/hmic accessed 11th May 2017

Hughes L and Clarke D (2002). Psychiatric nurses in hospital emergency departments. *The Canadian Nurse*, Vol 10, pg. 23-26 2002.

[Improving Access to Psychological Therapies payment: an introduction](#) Monitor and NHS England, 27 July 2015

Jeronimus, B.F., Ormel, J., Aleman, A., Penninx, B.W.J.H., Riese, H. (2013). Negative and positive life events are associated with small but lasting change in neuroticism. *Psychological Medicine*. 43 (11): 2403–15.

Johnson S (2013). Crisis Resolution and Home Treatment teams: An evolving model. *Advances in Psychiatric Treatment*. March 2013

Johnson S, Lloyd-Evans B, Morant N, (2010) Alternatives to standard acute in-patient care in England: roles and populations served. *British Journal of Psychiatry* 197 (suppl 53): s6–13.

Jones S L & Mason T (2002). Quality of treatment following police detention of mentally disordered offenders, *Journal of Psychiatric and Mental Health Nursing*, Vol 9, pp.73-80

Jones R (2011) *Mental Health Act Manual*. Sweet and Maxwell.

Juritzen T I, Grimen H and Heggen K (2011). Protecting vulnerable research participants: A Foucault inspired analysis of ethics committees. *Nursing ethics* 18 (5) 640-650 2011.

Kawamoro K, Halihan C, Balas E, Andrew E, Lobach A, David F. (2005). Improving clinical practice using decision support systems. *British Medical Journal* 330 pg. 765-744

Kellie E, Angell B, Watson A 2012. Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls. *Community Mental Health Journal* 48.6: 746-55.

Kvale, S (1989). *Issues of validity in Qualitative research*. Studentlitteratur, Lund.

Labov, W and Waletzky, J. 1967. *Narrative analysis*. In J. Helm (ed.), *Essays on the Verbal and Visual Arts*. Seattle: U. of Washington Press. Pp. 12-44

Lakeman, R, McAndrew, S, MacGabhann, L and Warne, T (2012). That was helpful...no one has talked to me about that before': Research participation as a therapeutic activity. *International Journal of Mental health Nursing*. 2012.

Lam KS, Aman MG (2007). The Repetitive Behaviour Scale-Revised: independent validation in individuals with autism spectrum disorders. *J Autism Dev Disorder*. 37 (5): 855–66

Lamb H R, Weinberger, L E, DeCuir, W J (2002). The Police and Mental Health. *Psychiatric Services* 46 (12): 1267-1271

Leiter, M. P. & Harvie, P. L. (1996) Burnout among mental health workers: a review and a research agenda. *International Journal of Social Psychiatry*, 42, 90–101.

Lewin, Kurt (June 1947). Frontiers in Group Dynamics: Concept, Method and Reality in Social Science; Social Equilibria and Social Change. *Human Relations*. 1: 5–41.

Lewis, A. (1934). The psychopathology of insight. *British Journal of medical psychology*, 14 332-348

Leslie, S. and Pritchard, J. (2009) *A review of relevant legislation in adult protection*. In Pritchard, J. (ed.) *Good practice in law and safeguarding adults (p15-36)*. London: Jessica Kingsley Publishers.

Lincoln, Y.S and Guba, E.G (1985). *Naturalistic inquiry*. Sage, Beverly Hills.

Marshall C and Rossman G B (1989) *Designing qualitative research* Newbury Park, CA: Sage

Maslow, A. H. (1954). *Motivation and personality*. New York, NY: Harper.

Mayes N and Pope C (1995) Qualitative Research: Rigor and qualitative research *British Medical Journal* July 8th 1995

Maxwell, J A (1992). Understanding and validity in qualitative research. *Harvard educational review*, 62, 279-300.

McAndrew S. (2008) Gay men and suicidality: an exploration of the significant biographical experiences fore-grounded during childhood, adolescence and early adulthood of some gay men who have engaged in suicidality. Unpublished PhD Thesis, School of Psychology, University of Leeds.

Mental Health Crisis Care Concordat accessed July 2015 www.gov.uk/dh2014

Miller E, Cook A, Alexander H, Cooper S and Hubbard G (2006) Research Policy and Planning. *Research journal* 24 (3) pg. 197-208

[*"Mind's Policy on User Involvement"*](#), *Mind.org.uk*, retrieved 6 July 2010

Moroz, Kathleen J. (2005). The Effects of Psychological Trauma on Children and Adolescents. *British Medical Journal*, June 2005, Vol 15, page 35-42

Myers D H, Leahy A, Shoeb H, Ryder J (1990). The patients view of life in a psychiatric hospital. *British Journal of Psychiatry* 156. 853-860

National Audit Office 2007. *Helping people through mental health crisis: The role of the Crisis Resolution and Home Treatment Services*. The Stationary Office.

National Service Framework 1999, <https://www.gov.uk/quality-standards-for-mental-health-services> Accessed June 2016

Nelson K (2004). *Construction of the cultural self in early narratives* in *Narrative Analysis Studying the development of individuals in society*: in Daiute C and Lighfoot C Eds pp87-107. Sage: Thousand Oaks, California, USA.

NHS Community Care Act 1990, www.legislation.gov.uk/ukpga/1990/ Accessed June 2016.

Noyes J (2008). *Chapter 20 Qualitative research and Cochrane reviews*. Cochrane handbook for systematic reviews of interventions version 5.0.1 September 2008.

Noens I, van Berckelaer-Onnes I, Verpoorten R, van Duijn G (2006). The Comfort: an instrument for the indication of augmentative communication in people with autism and intellectual disability. *Journal of Intellect Disability Res.* 50 (9): 621–32.

Nolan P and Smojkis M (2003). The mental health of nurses in the UK. *Advances in psychiatric treatment*. Volume 9 pg. 374-379.

Parry-Jones, William LI. (1972). *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries*. London: Routledge

Pecillo, Małgorzata (2016). The concept of resilience in OSH management: A review of approaches. *International Journal of Occupational Safety and Ergonomics*. 22 (2): 291–300.

Pellar G (1987). Reason and the mob. The politics of representation. *Tikkín* 2 (3), 28-95

Phoenix, A (2008) *Analysing Narrative Contexts in Doing Narrative research* (Squire et al, 2008) Sage: London.

Plummer, K (2001). *Documents of life 2. An invitation to a critical humanism*. 2nd edition. London: Sage

Polkinghorne, D. E. (1988). *Narrative knowing and the Human Sciences*. Albany: SUNY Press

Pope C., Mays N. (1995) Qualitative Research: Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal* 311: 42-45

Porter, Roy (2006). *Madmen: A Social History of Madhouses, Mad-Doctors & Lunatics*. Stroud: Temp

Rankine, D (2015). Planning Capacity and Demand in Mental Health Services using simulation modelling. *Efficiency and reform in Health and Social care*. Feb 2015.

Rapley M (1995). Black swans: Conversation analysis of interviews with people with learning disabilities. *Clinical Psychology Forum* 84, 17-23.

Reeves S and Hodges B (2008) Qualitative research methodologies: ethnography *British Medical Journal* pg. 337

Reissman, CK, (1993). *Narrative Analysis*. Sage Publications: 1993.

Repper J and Perkins, R (2003). *Social Inclusion and Recovery 1st Edition*. Health Sciences Publication.

Rethink (2010). Recovery Insights. Accessed online May 2018

Reuland M, Schwarzfeld M, Draper L (2009). *Law enforcement responses to people with mental illness: A guide to research informed policy and practice*. New York: Council of State Government's Justice Centre.

Richmond, H.J (2002). Learners Lives: A Narrative Analysis. The Qualitative Report. *Volume 7. Number 3, 2002*.

Riley G (2011). A frightening experience: detainees and carers experiences of being detained under section 136 of the Mental Health Act 1983. *Medicine, Science and the Law* 51 (3) pp164-169.

Roger J. Stancliffe, Renáta Tichá, Sheryl A. Larson, Amy S. Hewitt and Derek Nord. (2015) Responsiveness to Self-Report Interview Questions by Adults with Intellectual and Developmental Disability. *Intellectual and Developmental Disabilities* 53:3, 163-181.

Rothschild B (2000). *The body remembers: the psychophysiology of trauma and trauma treatment*. New York: Norton

Russell, David (1996). *Scenes from Bedlam: History of the Bethlem Royal and Maudsley Hospitals*. Baillie Tindall.

Sands N, Elsom S, Marangu E, Keppich-Arnold S and Henderson K (2013). Mental Health Telephone Triage: Managing Psychiatric Crisis and Emergency *Perspectives in Psychiatric Care* 49 (2013) 65-72

Sainsbury Centre for Mental Health (2009). *Briefing 39: Mental health care and the criminal justice system*.

Sarantakos S. (1994). *Social research*. Macmillan, London.

Sensky, Tom (2002). Knowledge Management. *Advances in Psychiatric Treatment*. **8** (5): 387–395

Spehar, M, Campbell, R, Carron C, Palacios, P, Scott, D, Baker, J, Bjornstad, B, B Wolfson, J (2005). Seamless Care: Safe Patient Transitions from Hospital to Home. *Advances in Patient Safety: Research to Implementation Volume 1: 2005*.

Shields PJ, Morrison P, Hart D (1988). Consumer satisfaction on a psychiatric ward. *Journal of advanced nursing* 13. 396-400.

Sibbald B and Martin R (1998). Understanding Controlled Trials: Why are randomised controlled trials important? *British Medical Journal* 1998 316doi:201

Silverman D (2000). *Doing qualitative research, a practical handbook*. Sage publications London: Thousand Oaks.

Smart D, Pollard, C and Walpole B (1999). Mental health Triage in emergency medicine. *Australian and new Zealand Journal of Psychiatry* 33 pg. 57-66

Smith G (2002) *Goffman and Social organisation: Studies of a sociological legacy* in Taylor and Francis page 5 Sage.

Squire, C, Andrews, M, and Tamboukou M (2008). *Doing Narrative Research*. Sage

Stake R E (1995). *The art of case study research*. Thousand Oaks, CA: Sage

Steinberg, David (2010). Altruism in medicine: its definition, nature, and dilemmas. *Cambridge Quarterly of Healthcare Ethics*. 19 (2): 249–57

Strauss, A and Corbin, J (1990). *Basis of qualitative research: grounded theory procedures and techniques*. Sage, Newbury Park.

Streubert, H.J and Carpenter, D.R (1995). *Qualitative research in Nursing: Advancing the human imperative*. J.B Lippincott Co, Philadelphia, P.A.

Stockwell F (1972). *The unpopular patient*. Blackwell Press.

Stone E (1988). *Black sheep and kissing cousins. How family stories shape us*. Time Books: New York, USA.

Tadros G, Rafik A. Salama, Paul Kingston, Nageen Mustafa, Eliza Johnson, Rachel Pannell, Mahnaz Hashmi (2013). Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model DOI: 10.1192/pb.bp.111.037366 Published 2 January 2013

Taylor R, Chae D, Lincoln K, Chatters L (2015). Extended family and friendship support networks are both protective and risk factors for major depressive disorders and depressive symptoms among African American and Black Caribbean. *HHS Public Access*. 203 (2) pg. 132-140

The Kings Fund (2015) *Mental Health under Pressure Published by the Kings Fund Press 2015*

The Sainsbury Centre for Mental Health (2008) *Briefing 36: The police and mental health brief*.

Thomas, B. (1997) Management strategies to tackle stress in mental health nursing. *Mental Health Care*, 1, 15–16.

Thomas J (1993). *Doing critical ethnography*. Sage: Newbury Park.

Thornicroft G, Brohan E, Kassam A (2008). Reducing stigma and discrimination. *International Journal of Mental Health*, Vol 2 2008.

Traynor M (2015). Focus group research. *Nursing Standard* May 13, 29 (37) 44-48.

Turner T, Salter M and Deahl M, (1999). Mental health Act Reform. *Psychiatric Bulletin* 1999 pg. 578-581

Turner T (2007) Chlorpromazine: unlocking psychosis. *British Medical Journal* 334 (4) (supp 1) 57.

Twenge JM, Catanese KR, Baumeister RF (2002). Social exclusion causes self-defeating behavior. *Journal Personal Sociology Psychol.* 83 (3): 606–15. PMID 12219857. Doi:10.1037/0022-3514.83.3.606.

Varcarolis. E (2010). *Manual of Psychiatric Nursing Care Planning: Assessment Guides, Diagnoses and Psychopharmacology*. 4th Ed. New York: Saunders Elsevier.

Warne T., & McAndrew S., (2007) Passive Patient or Engaged Expert? Using a Ptolemaic approach to enhance Mental Health Nurse Education and Practice. *International Journal of Mental Health Nursing* 16 (4) 224 -229

Watson, A.C, Morabito, M.S, Draine, J and Ottati, V. (2008). Improving police response to persons with mental illness: A multi-level conceptualisation of CIT. *International Journal of Law and Psychiatry*, 31, 359-368

Werner, E. E. (1971). *The children of Kauai: a longitudinal study from the prenatal period to age ten*. Honolulu: University of Hawaii Press

William N (2005). *Your research project*. 2nd edition. Sage

Wilson J (2002). The impact of shift patterns on healthcare professions. *Journal of nursing management*. 10. Page 211-219

Winston, Mark (1994). The Bethel at Norwich: An Eighteenth-Century Hospital for Lunatics. *Medical History*. 38 (1): 27–51

Wolcott H (2001) *Writing up qualitative research*. 2nd Edition thousand Oaks Sage

Wood, D; Pistrang, N; (2004) A safe place? Service users' experiences of an acute mental health ward. *Journal of Community and Applied Social Psychology*, 14 (1) pp. 16-28.

World Health Organisation (1991). *Community Involvement in Health Care Development. Report of a WHO study group*. Technical report series no. 809. Geneva: WHO.

Young, K.G (1987). *Tale worlds and story realms: the phenomenology of narrative*. Boston: Martinus Nijhoff.

Appendix 1: Literature Review Synthesis Table:

Synthesis Table Literature Review

<u>Author</u>	<u>Title and Reference of Paper</u>	<u>Area of Study</u>	<u>Method and approach of Research</u>	<u>Aims/Purpose</u>	<u>Key Findings</u>	<u>Summary of Points</u>
Sands N, Elsom S, Marangu E, Keppich-Arnold S, Henderson, K.	Mental Health Telephone Triage: Managing Psychiatric Crisis and Emergency. <i>Perspectives in Psychiatric Care 49 (2013) 65-72</i>	The use of telephone triage to manage psychiatric crisis and emergencies in urban Australia	Mixed methods, both quantative and qualitative Use of observation design with listening and analysis of the nature of the 197 total calls	To identify and articulate how the Mental Health Telephone Triage clinicians manage a mental health crisis and emergencies via the telephone system.	Based in a 350 bed tertiary hospital in a large urban setting in Australia. Use of the recognised MH Triage Government scale to identify scale of service required. Used a 58 item observation tool derived from the guidelines attached to the MH Triage scale. Used standard descriptive analysis for quantative data such	Main calls from the 197 were for advice. 70 calls classed as crisis or Psych emergency (PE). Suicidal 28.6% Psychosis 21.4% Co Morbid with drugs and or alcohol 60% Issues with risk assessment completeness due to lack of availability and also not being able to talk to carers or family. Identified MHTT looked for community support first rather than hospital. Most frequently used intervention was supportive counselling.

					<p>as frequency of calls, outcomes.</p> <p>Qualitative data analysed using content analysis.</p>	<p>In PE most frequently used intervention was de-escalation.</p> <p>Timely interventions and use of non-coercive techniques evident</p> <p>Study does recognise its limitations in terms of small scale, one hospital, urban setting and cannot extrapolate findings to the general population but does demonstrate brief crisis intervention via the telephone can be useful in rapidly stabilising a PE</p>
Jones S L, and Mason T.	<p>Quality of Treatment following police detention of mentally disordered offenders</p> <p><i>Journal of Psychiatric and Mental health</i></p>	Mental Health Service User perspective on their treatment from the police whilst being detained under the Mental Health Act.	<p>Qualitative</p> <p>Grounded theory using analysis by analysing audio taped interviews using a three level coding system.</p>	To understand, study and explore, through personal accounts, impact on subsequent mental health treatment of person with a mental disorder who	<p>Service users expected the police to be negative to them and were surprised when this did not always happen, they felt this attitude was better when in a care setting rather than a cell</p> <p>They did, however, expect health staff to</p>	<p>Small sample size</p> <p>Limited to one NHS Trust and one custody suite</p> <p>40 assessments in 1 year</p> <p>All male</p> <p>That said the one to one interviews did provide a richness of data, that whilst cannot be applied to the whole, do give rise to interesting insights into the link</p>

	<i>Nursing, 2002, 9 73-80</i>			interacts with the police.	be kind and caring and when this did not happen they felt very let down and hopeless. Key model on interface between attitudes of police and health staff and the resulting feelings then experienced by the patient is very telling in this study.	between police and health professionals attitudes and the resulting feelings experienced then by the service user.
Watson, A.C, Morabito, M.S, Draine, J and Ottati, V.	Improving police response to persons with mental illness: A multi-level conceptualisation of CIT. <i>International Journal of Law</i>	Police response to Mental Illness and Crime Diversion as well as factors likely to improve the effectiveness of a Crisis	Systematic Review of the Literature	To produce a conceptual model of police response to persons with a mental illness that takes into account the officer themselves, the	Implementation of the CITs (with specially trained police officers) does improve outcomes for people with Mental Illness but accepts there is limited research and thus evidence is on police feedback only.	400 CITs No core curriculum of the training of the officers in each CIT Variances in approaches exist and there is currently no rich evidence to suggest which is best.

	<i>and Psychiatry</i> , 31, 359-368 2008	Intervention Team. Based in the USA		organisations, the Mental Health System in place as well as the community.	Issues raised as police gate keep as mental health system is not set up to mobilise to help. CITs are now set up in over 400 places in the USA.	CIT is more than just training it links to organisational and links to treatment offers in the community as well as the interactions with police officers and the innate characteristics of a CIT officer. Implementation processes are key to a successful model of CIT
Riley G, Freeman E, Laidlaw J and Pugh D	A frightening experience: Detainees and carers experiences of being detained under section 136 of the Mental Health Act 1983.	The views of detainees and their carers of their experiences of being detained under section 136 of the MHA and to explore their satisfaction or otherwise of the quality and care of the treatment they received.	Qualitative Interviews using grounded theory	To ascertain the views of service users and carers on their experiences of being detained under section 136 of the Mental Health Act	Used a semi structured interview Data was analysed using a grounded theory approach, QSS NVivo codes and categories Detainees in cells reported feeling like criminals, frightened, handcuffed, agitated although a few did feel the police helped.	The study was in Gloucestershire only, limited to largely rural (with two urban centres with low BME populations). Only 18 detainees interviewed and 6 carers. All white British All but 2 detainees and all carers thought the police cell was not the right place to be, they should be in hospital and have access to someone who could talk to them and understood the issues.

	<i>Medicine, Science and the Law</i> 51 (3) pp164-169. 2011				<p>Patients felt in emotional distress and that removing their comforts in a cell, being cold, scared dark they felt worse and increased their stress. Felt they were being punished for being ill.</p> <p>Lack of medical attention reported</p> <p>No provision of information given to wither patient or carer</p> <p>Limited follow up given after the event.</p>	<p>Felt police don't have the skills to do this.</p> <p>Most also thought the ED was not suitable and that it should be a specialist place attached to a hospital with trained staff available.</p> <p>14 were not given follow up after their discharge.</p> <p>Felt their emotional needs were not met in the cells and felt disempowered throughout the whole process.</p> <p>Felt police needed better education as that could have helped and in the end they were just passive recipients of the whole process.</p>
Reuland M, Schwarzfeld M, Draper L	Law enforcement responses to people with mental illness: A guide to research informed policy and practice.	Police responses to people with mental illness. Research informed policy and practice and developed	Systematic reviewed literature with specialist panel input	To highlight current issues, some evidenced based solutions and give direction on future	Encounters between law enforcement and people with mental illness have key features:	Believes should use research based responses to local need to develop sustainable models fit for purpose for the community they serve

	<p><i>New York: Council of State Government's Justice Centre. 2009</i></p>	<p>policy and procedures.</p>		<p>policy development based on data and evidence not 'ground up' anecdotes</p>	<p>Take more time than other calls, requires special training and skills, successful outcomes based on community services, repeat contacts, nuisance offences and occasionally very risky.</p> <p>Missed opportunities when using discretion not to arrest.</p> <p>Specialised law enforcement strategies can create a positive change, increased officer safety, increased access to mental health services, decreases frequency of calls and associated costs.</p> <p>Acknowledged as a starting point but need</p>	
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					to build on CITs and co-responding CITs	
Canada K E, Angell B, Watson A	Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls. <i>Community Mental Health Journal</i> 48.6: 746-55. 2012	How does specialised training of police officers in CIT affect their responses compared to those who aren't trained?	Qualitative Use of surveys followed up with face to face interviews using grounded theory	To explore the differences in effectiveness of responses and the resulting implications for policy.	CIT has three core components: 1. Training 2. Partnerships with community providers 3. Take on the new role in the police department CIT officers report feeling more prepared with increased attitudes, increased knowledge and patience and increase in links to mental health services Could also reduce stigma	CIT training gives better outcomes. Can diffuse to other non CIT officers as can help with stigma and attitudes. People with mental illness don't respond well to control and command techniques. There is little research on effectiveness on CIT and non CIT this happens to address the gap. CIT is a voluntary programme so those who apply are already predisposed to more positive views on mental illness.

					<p>Advanced CITs being developed for military vets and juveniles</p> <p>Outcomes of research are currently limited; Chicago study reveals differences in inks to services between CIT and non CIT trained officers. 60% who had completed CIT training described their responses to scenarios very differently than non CIT trained officers in relations to:</p> <ul style="list-style-type: none"> • Assessment • Response tactics • Disposition 	
Franz S and Borum R	Crisis intervention teams may prevent arrests of people with	Study examined the arrest rates of persons with mental illness	Mixed methods, quantative in numbers of calls and	To study the encounters between CIT officers and people with a	After CIT implementation arrests rates for offenders with mental illness declined evidencing that CIT	<p>Arrest rate was number of calls to CIT divided by number of arrests.</p> <p>Prevented arrests were based on police opinion of those who would have</p>

	<p>mental illnesses, <i>Police practice and research</i>, 1-8 2010</p>	<p>and the number of arrests that might have been prevented after the implementation of a CIT programme in a large county in Florida, USA</p>	<p>arrests and qualitative in terms of officers opinions.</p>	<p>mental illness. To estimate the number of calls made to CIT and how many arrests were prevented as a result.</p>	<p>programs may indeed be useful in this area.</p> <p>7-10% of all police contacts in the USA have a mental health component and the arrest rate is disproportionate to this.</p> <p>Some anecdotal reports of the criminalisation of mental illness have emerged.</p> <p>2 key variables were examined in the study, the arrest and disposal of people and the arrests prevented</p> <p>Based on officers opinions of what would have happened if there wasn't a CIT team</p> <p>Data analysed using a descriptive method.</p>	<p>been arrested before a CIT team was present divided by the number of calls</p> <p>CIT calls over 5 years remained static; arrest rate reduced and estimated no CIT arrests rose.</p> <p>Results suggest people with a mental illness are rarely arrested when CIT officers are involved.</p> <p>Limited by pre-CIT data and lack of overall calls to the police not just CIT calls and of course subjective opinions of police officers on what might have happened before can be subjected to bias.</p>
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Clarke D, Duscome D and Hughes L	Emergency department from the mental health client's perspective. <i>International Journal of Mental Health Nursing,</i> 16 126-131 2007	General Hospital EDs and a service users, and their carers, experience of attending these settings when in a mental health crisis	Qualitative Use of focus groups and thematic analysis	To determine satisfaction from service users and their families on the care received in an ED and in particular the role of the Psychiatric Emergency Nurse (PEN)	Mental Health presentations to the ED are often vague, difficult to access a specialty practitioner and the ED staff are not equipped to manage such presentations. This can lead to tension with such service users. Previous studies evidence long waits and a lack of understanding and compassion for such service users and their carers. To address this Canadian government put PENs in the EDs. Evidence suggests tis role is overwhelming well received and very positive. But some	Themes: <ul style="list-style-type: none"> • <u>Waiting in the ED:</u> felt left to the last after triage. Long waits sometimes up to 10 hours, shorter when a PEN available of accompanies by a carer or professional, felt abandoned, basic need such as food and water not met and some gave up and left. • <u>Attitudes:</u> Made to feel bad or criminal for going to the ED but some positive experiences if seen by the PEN. • <u>Diagnostic overshadowing:</u> When mental health patients go to the ED for a physical reason they are not believed and judged as making their illness up. • <u>Nowhere else to go:</u> Despite concerns of the ED they continue to use it as they have no other choice out of hours • <u>Family's needs:</u> Would like written information or crisis numbers
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					<p>limitations to the studies. Hence the focus group approach in this study.</p> <p>8 focus groups, 5 service users, 1 carers, 1 mixed and 1 community and third section providers.</p> <p>27 service users</p> <p>7 carers</p> <p>5 Community providers</p> <p>Equal number men and women</p>	<ul style="list-style-type: none"> • Wish List: PENs 24/7. Mental health awareness in all ED staff and the police. <p>How people are treated in the ED shapes the perceptions on the health care system as a whole and their future interface with it. This is not just a Canadian issue. Interesting discussion on the success of the ED visit, patient is to be admitted, staff is for an alternative to be found, need a range of alternatives to satisfy both.</p> <p>Limitations to the study are low numbers of participants, frequent users of ED, no new users or first timers; sample was all urban and was not representative of the local population.</p>
Hails J and Borum R	<p>Police training and specialised approaches to respond to people with mental illnesses.</p> <p><i>Mental illnesses</i> <i>Crime and</i></p>	Impact of specialised training on responses to people with mental illness	Quantative survey	To explore the nature and extent of training that police agencies provide and the impact this has on police responses to	<p>Many communities have experienced high profile cases of police interactions with people with mental illness resulting in poor outcomes, this led to criticism and being</p>	<p>Innate personality of officers is essential to successful to CIT training</p> <p>Police are frequently called to incidents with people with mental illness, need adequate training and reasonable policies and procedures to aid the response. Training ranges from 1 hour to 6 hours but recommendation is a minimum of 16 hours with CIT</p>

	<p><i>delinquency</i>, Vol 49 No 1, 52-61 2003</p>			<p>people with mental illness</p>	<p>sued, this was one driver behind CITs.</p> <p>685,000 people with severe mental illness are in prison in the USA more than in psychiatric hospitals.</p> <p>First generation training is basic and good but limited and doesn't address attitudes and increase in knowledge of how to manage people with mental illness, 2nd generation training programmes do address this. In this study the questionnaire was aimed at two questions; The extent of calls about people with mental illness and the existence of specialised trained officers</p>	<p>programmes being 40hours, training needs to be specialised.</p>
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Compton M, Bahora M, Watson A and Olivia J	<p>A comprehensive review of extant research on crisis intervention team (CIT) programmes.</p> <p><i>Journal of American Academy of Psychiatry and the law</i> 36:1:47-5 2008</p>	Due to the rapid development of CIT models in the USA and limited research this paper would systematically review the research on CITs to date	Systematic review and a critical analysis on 'research on CIT' using narrative synthesis	To review current research and comment on future avenues of research	<p>CITs bring together police, health. Advocates and community there are 2 models CITs and Co responders which are CITs and health teams together</p> <p>This led to three categories:</p> <ul style="list-style-type: none"> • Officer level outcomes • Disposition • Memphis model being the exemplar of best practice <p>Backed by various studies, future research needs to look at the link between officer led outcomes and patient led outcomes, best model has a dedicated health place for taking mental health patients.</p>	<p>Research affirms CIT more ready than non CIT</p> <p>Pre and post surveys to training show differences in attitudes to aggression, understanding of mental illness and better outcomes to patients and families.</p> <p>Reduced levels of social distance</p> <p>CIT training reduces stigma, CIT officers refer to services more appropriately and sooner, need to develop tailored programmes for local needs, recommends best practice for CIT training and fidelity to CIT models.</p> <p>CIT is also associated with lower use of SWAT teams and reduction in officer injuries and increase in referrals to mental health services.</p>
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Appendix 2: Ethics Application University of Salford



College Research Ethical Approval FILTER Form

No research can be started without full, unconditional ethical approval. There are a number of routes for obtaining ethical approval depending on the potential participants and type of study involved – please complete the checklists below to determine which is the most appropriate route for your research study.

A. Teaching & Learning Research (ROUTE FOR STAFF ONLY)

1.	Is the proposed study being undertaken by a member of UoS staff?	Yes	No
2.	Is the purpose of the study to evaluate the effectiveness of UoS teaching and learning practices by identifying areas for improvement, piloting changes and improvements to current practices or helping students identify and work on areas for improvement in their own study practices?	Yes	No
3.	Will the study be explained to staff and students and their informed consent obtained?	Yes	No
4.	Will participants have the right to refuse to participate and to withdraw from the study?	Yes	No
5.	Will the findings from the study be used solely for internal purposes? <i>e.g. there is no intention to publish or disseminate the findings in journal articles or external presentations</i>	Yes	No
If you have answered Yes to all Qs1-5 your study does not require UoS ethical approval as the work sits under enhancing quality of teaching and learning.			
If you have answered No to any of Qs1-5 you should complete the checklists below to determine which route you should use to apply for ethical approval of your study.			

B. National Research Ethics Service (NRES)

To find out if your study requires ethical approval through NRES answer the questions below. Does you study:			
1.	Involve access to NHS patients or their data, or involve participants identified from, or because of, their past or present use of NHS services?	<u>Yes</u>	No
2.	Include adults who lack capacity to consent as research participants and/or those under 18 years of age.	Yes	<u>No</u>

3.	Involve the collection and/or use of human tissue as defined by the Human Tissue Act 2004? **	Yes	No
<p>If you have answered Yes to any of Qs1-3 you should complete this application form, for University of Salford ethics review, you should have a response within 4weeks of submission. Once you have UoS approval you can then complete and submit the relevant NHS National Research Ethics Service (NRES) form. (The information from the UoS forms can be transferred onto the NRES forms) For further information and details of how to apply to NRES can be found at http://www.nres.nhs.uk/</p>			
<p>If you have answered No to Qs1-3 complete the checklist below to determine whether your application is eligible for Fast Track (proportionate) review or full review.</p>			

C. Full versus 'Fast Track' (Proportionate Review)

Does the proposed study:			
1.	Expose participants to high levels of risk, or levels of risks beyond those which the participant is likely to encounter in their everyday activities? These risks may be psychological, physical, social, economic, cause legal harm or devalue a person's self-worth. <i>e.g. untrained volunteers exposed to high levels of physical exertion; participants purposefully exposed to stressful situations; research where participants are persuaded to reveal information which they would not otherwise disclose in the course of everyday life.</i>	Yes	No
2.	Involve the administration of drugs, medicines or nutritional supplements as part of the research design?	Yes	No
3.	Include adults who may be classed as vulnerable? <i>e.g. adults with learning disabilities or mental illness; drug/substance users; young offenders; prisoners/probationers; those in a dependent relationship with the researcher</i>	Yes	No
4.	Include children or young adults (below 18)?	Yes	No
5.	Involve the discussion or disclosure of topics which participants might find sensitive or distressing? <i>e.g. sexual activity; criminal activity; drug use; mental health; previous traumatic experiences; illness; bereavement</i>	Yes	No
6.	Use questionnaires which focus on highly sensitive areas? <i>e.g. illegal activity; criminal activity; disclosure and analysis of findings based on sensitive personal information as defined by Data Protection Act e.g. racial or ethnic origin; political opinions; religious beliefs; trade union membership; physical or mental health; sexual life</i>	Yes	No
7.	Incorporate interviews or focus groups which involve the discussion of highly sensitive areas?	Yes	No

	<i>e.g. illegal activity; criminal activity; disclosure and analysis of findings based on sensitive personal information as defined by Data Protection Act e.g. racial or ethnic origin; political opinions; religious beliefs; trade union membership; physical or mental health; sexual life</i>		
8.	For research accessing and analysing existing datasets. Will the dataset include information which would allow the identification of individual participants?	Yes	No <u>NA</u>
9.	Involve deliberately misleading participants in any way?	Yes	<u>No</u>
10.	Involve recruiting participants who have not been provided with a participant information sheet and asked to sign a consent form? <i>Please note that for questionnaire based studies where the questionnaire is completed by the participant, a consent form is generally not required as consent is implied by the completion of the questionnaire. Applicants conducting questionnaire-only studies should answer NO</i>	Yes	<u>No</u>
11.	Involve the collection and/or use of human tissue from healthy volunteers? <i>Under these circumstances human tissue is as defined by the Human Tissue Act 2004 - "Any, and all, constituent part/s of the human body formed by cells." Research studies involving the use of plasma or serum are not covered by the HTA.</i>	Yes	<u>No</u>
12.	Involve high levels of risks to the researcher? <i>e.g. lone working at night; interviewing in your own or participants homes, observation in potentially volatile or sensitive situations</i>	<u>Yes</u>	No
<p>If you have answered No to all Qs1-12 your study is eligible for 'fast track' review. You should complete the following application form and submit it electronically with any supporting documentation e.g. participant information sheets, recruitment material, consent forms to Health-ResearchEthics@salford.ac.uk . Please ensure that your electronic submission is anonymised (all names removed) and that versions and dates are completed on the checklist with the same included on corresponding documents.</p> <p>Staff – please submit from your email address including your name and email in the body of the email</p> <p>Students – please ensure your application is submitted by your supervisor</p> <p>Supervisors – please submit the fully anonymised version of your student's application from your email account as way of approving the application to be sent for review, please ensure in the body of the email you include the full name of your student (and cc them in)</p> <p>Your application will be reviewed by a sub-committee of the University REC and you will be informed of the outcome within 4 weeks. Please note that if the allocated reviewer finds that your application</p>			

has been wrongly submitted for 'fast track' review you will be notified and your application will be forwarded for full review which can take up to 6 weeks.

If you have answered **Yes to any of Qs1-12** your study is not eligible for 'fast track' review and will be considered for full review. You should complete the following application form and submit it electronically with any supporting documentation e.g. participant information sheets, recruitment letters, consent forms to Health-ResearchEthics@salford.ac.uk. Please ensure that your electronic submission is anonymised (all names removed) and that versions and dates are completed on the checklist with the same included on corresponding documents.

Staff – please submit from your email address including your name and email in the body of the email

Students – please ensure your application is submitted by your supervisor

Supervisors – please submit the fully anonymised version of your students application from your email account as way of approving the application to be sent for review, please ensure in the body of the email you include the full name of your student (and cc them in)

REF:

College Research Ethical Approval Application Form CHECKLIST

Name of applicant: Clair Louise Carson

Programme of study/school: Professional Doctorate

Title of Study: The experience of Mental Health Crisis intervention through a Street Telephone Triage System: The service user perspective.

Please tick which of the boxes below applies to your research:

NRES

☒

'Fast Track'

(Proportionate review)

☐

Full review

☐

The checklist **MUST BE COMPLETED**. It is designed to help you to ensure that you have all the supporting documents submitted with your ethics application form. This information is necessary for the committee to be able to review and approve your application. Please complete the relevant boxes indicating whether a document is enclosed and where appropriate identifying the **date and version** number allocated to the specific document (*in the header/footer*). Additional documents can be recorded in the boxes provided or extra boxes added to the list if necessary.

Document	Enclosed? (circle appropriate response)		Date	Version No	Office Use
	Yes	No			
Application Form	Mandatory		26/2/16	1.0	
Protocol	Optional		None used		
Risk Assessment Form	Mandatory		26/2/16	1.0	
DBS Check	Yes	No	2014		
Participant Invitation Letter	Yes	No	26/2/16	1.0	
Participant Information Sheet	Yes	No	11 th April 2016	2.0	
Participant Consent Form	Yes	No	26/2/16	1.0	
Participant Recruitment Material - e.g. copies of Posters, newspaper adverts, website, emails	Yes	No	None used		
Organisation Management Consent/Agreement Letter	Yes	No	Enclosed		
Research instrument, validated questionnaire	Yes	No	None used		
Research instrument, non-validated questionnaire	Yes	No	None used		
Draft Interview guide/ Topic guides for participants	Yes	No	Appendix 4		

NOTE: If the appropriate documents are not submitted with the application form then the application will be returned directly to the applicant and will need to be re-submitted at a later date thus delaying the approval process.

College Research Ethical Approval APPLICATION Form

1.1

1.2 ETHICAL APPROVAL FORM FOR STAFF AND POSTGRADUATES RESEARCH (PGR) STUDENTS

Ethical approval must be obtained by all applicants prior to starting research with human subjects, animals or human tissue.

Postgraduate students **must** discuss the content of this form with their PhD supervisor(s). A final copy of this application form should be agreed between the student and supervisor(s). Staff must submit a fully anonymised version to Research Centres Support Team (Health-ResearchEthics@salford.ac.uk), students must have their fully anonymised application submitted by their supervisor (from the supervisors email account) to Research Centres Support Team (Health-ResearchEthics@salford.ac.uk)

Is this application a resubmission? *(delete as appropriate)*

No

If Yes, please indicate Ref No. *(if known)*

Is this an amended version of the original application? (Please ensure that the changes are highlighted within the documents) *(delete as appropriate)*

☐

No

Name of staff/PGR student:	
Staff/PGR student experience/qualifications:	BSc (Hons) Psychology MSc Leadership in Health and Social Care
School:	

Course of study: <i>(PGR use only)</i>	Professional Doctorate
Supervisor(s):	

Start date of project:

Sept 2015

End date of project:

Sept 2018

Proposed start date for participant recruitment:

June 2016

Will this project take place on University premises?

(delete as appropriate)

☐
☐ **No**

If you answer 'yes' to any of the above question, a risk assessment of the project is required and **MUST** be submitted with the application.

Is a DBS check required? *(delete as appropriate)*

☐
☐ **Yes**
☐

Have you read the Lone Worker Policy?*(delete as appropriate)*

☐
☐ **Yes**
☐

The form must be completed electronically; the sections can be expanded to the size required but not exceeding the word count specified. To assist you with the completion of this form there are 'Guidance Notes for Completing the College Research Ethics Approval Form' on the website (<http://www.salford.ac.uk/chsc/research/staff-pgr-students-research-ethics>) which indicate what is required for each section.

1. Title of proposed research project *(refer to guidelines section 1)*

The experience of Mental Health Crisis intervention through a Street Telephone Triage System: The service user perspective.

2. Project summary *(refer to guidelines section 2)*

The focus of the study will be to explore and understand the experiences of service users, who have experienced a mental health crisis and were treated using the street telephone triage service. The exploration of such experiences, using a narrative approach, will enable the identification of current aspects of the service that are considered beneficial, as well as areas that could be improved to provide a better service.

3. Project objectives *(refer to guidelines section 3)*

- To explore the perceptions of service users regarding their experiences of using the street telephone triage service in Bury and Rochdale.
- To ascertain which, if any, aspects service users found to be beneficial
- To identify any aspects of the service that from a service user perspective could be improved
- To add to a very limited body of knowledge regarding initiatives for addressing mental health crisis situations.
- To use the findings of the study to make recommendations that will inform the development of the service in the future.

4. What is the rationale which led to this project? (refer to guidelines section 4)

In recent years the A and E department has become the default environment for service users seeking help during a mental health crisis (Hughs & Clarke 2002). Likewise, the Police are reporting major concerns about the amount of mental health issues they are expected to deal with in their everyday workload (Lamb et al., 2002). In February 2014 the Mental Health Crisis Care Concordat was published with over 20 organisations signing their declaration to work together to improve the care and treatment the vulnerable, mentally unwell service user will receive when they are in a crisis. This included a multi-agency approach to collaboratively developing more services to support the delivery of the concordat. One such service is commonly known as 'Street Triage'.

As a result of the Concordat and local partnership working between Pennine Care NHS Foundation Trust (PCFT) and Greater Manchester Police (GMP), in March 2014 the local Boroughs of Bury and Rochdale established a pilot to deliver a telephone based model of Street Triage in response to the need to meet the standards now expected. As part of the pilot process, Greater Manchester Police commissioned an independent evaluation of the model from researchers at Manchester Metropolitan and Salford Universities. The report, as yet unpublished, demonstrated the clear benefits to both the organisations involved in the pilot, but highlighting the need to undertake further research to establish the service user experience of the service, thus truly enabling the completeness of the evaluation.

As such services are relatively new, and having been developed and delivered in a variety of ways, there is limited research evidence available regarding their effectiveness. In particular, research on the service user experience is limited in a study by Jones and Mason (2002), although now over 10 years old, emphasis was placed on services who continue to utilise police cells as a place to 'look after' those who are mentally unwell. The study reported that from a service user perspective the experience was custodial and none therapeutic. Participants' differentiated between two settings; when being detained in a cell they believed police officers did not consider their mental illness first, but if the police took them to the A and E department and sat with them to wait, even though this could be a very long process, the police were more sympathetic to their illness. Clarke et al (2007) explored the self-reported experiences of service users who attended A and E in a mental health crisis. Findings from their study revealed an overwhelming disappointment with the service received, but in the absence of any alternative, the authors acknowledged that these service users would have to return again if the same situation should occur. More recently, Riley (2011), building on Jones and Mason's (2002) study interviewed 18 individuals who had been taken to the police cells following detention by the police under Section 136 of the Mental Health Act (1983). The study highlighted service users found the whole process 'extremely distressing', as they felt like 'criminals' and in some cases the process itself made the individuals' mental health condition worsen.

Recognising all of these issues, the Concordat sought to bring agencies together to collaboratively address the problems and design services that would meet the needs of service users whilst enabling organisations to maximise available resources within a town, rather than trying to provide care in isolation. An initial pilot project, run via the

existing A and E Mental Health Team in Bury and Heywood Middleton Rochdale, known as the Rapid Assessment Intervention and Discharge (RAID) service, was established. This is a recognised model of A and E delivering a service to those experiencing a mental health crisis. The team consists of highly experienced and specialist nurses and social workers all skilled in the care of the mentally unwell service user arriving at A and E in a crisis. The Street Telephone Triage service is operated through this team and enables the police/ambulance service to contact them and to access the skills of this team before they decide on a course of action. This discussion with the street telephone triage team enables a better decision making process for the police or ambulance service. This in turn enables a better outcome for the service user involved and, as a result, a more appropriate care pathway. Eales et al (2006) identified an improvement of the service user experience, alongside a more effective management of presentation, when a dedicated mental health team was available. The Street telephone triage service, as described, offers just that service and in fact extends that availability to reach outside of the A and E environment.

Capturing service user perspectives regarding how they feel the Police and Healthcare professionals have treated them when they experienced a mental health crisis could help to inform a future model for effectively meeting the needs of those who, at times, use these services. With this in mind, this research project will explore the experience of the service user who, in a mental health crisis, has used the Street telephone Triage pilot service.

- 5. Research Methodology.** Please provide an indication of the project duration or project schedule in your research strategy or as an appendix. Please detail the study design, explain and justify the recruitment approach, identify the study setting/location, describe how data will be collected and analysed. (*refer to guidelines section 6*)

Research Method and approach:

Qualitative research using a narrative approach will be used to meet the aim and objectives of this study. Qualitative research seeks to understand the experience of the service users through their discourse and, as such, is a 'form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live' (Holloway, 1997). The project intends to take a narrative approach, as this lends itself to elicit experiences as recounted by those that have lived them. Narratives or stories are 'the oral versions of personal experiences' which is exactly what this project seeks to ascertain (Labov & Waletzky, 1967).

Recruitment of Participants:

The sample group required in this study will be service users who have had a mental health crisis, and who have been cared for via the Street Telephone Triage pilot delivered by PCFT and GMP. By definition of this sample group these will be vulnerable people who may not want to be identified and who may not want to participate even if identified. This has to be acknowledged in the study design.

As a practitioner within PCFT I do have access to the Trust wide service user forum. This is a group of people who represent the views of those who use the services delivered by PCFT. I also have access to local forums attended by service users in the Boroughs of Bury and Rochdale, which might encompass people in the target population. Attending these forums will allow the researcher an opportunity to highlight the plans for the undertaking of the research with service users who meet the criteria for the study. I will also be able to leave a short letter inviting people to participate in the study (appendix 1) which will contain my contact details so service users can contact me directly should they wish to learn more about the study and help them to decide whether or not to participate. In taking this approach it is hoped that relevant service users who have experienced the Street Telephone Triage service will contact the researcher with a view to participating. When potential participants contact the researcher, I will arrange to give them a participant information sheet (appendix 2), either by meeting with them at a venue suitable to both parties or by posting the information to them. Once they have had chance to read the information I will contact them again to ensure they understand all of the information and to ascertain if they are still interested in participating. If they are interested a time and place for the interview to take place will be negotiated and prior to it starting I will ask them to sign a consent form (appendix3).

As this will be considered as a sensitive topic it might be difficult to recruit participants. The process outlined above may only generate a very small number of participants and as such validates the use of a narrative approach. (Creswell 2011). While such methods have been criticised as being 'intrinsic and limited' (Stake 1994), they can also produce a richness of data and information that, although may not be able to be generalised across a wider population, can be very useful in informing local developments, as well as promoting an understanding of local experiences to aid in future research and possible service development (Hamersley 1992).

Data Collection.

Data will be collected via face to face interviews at a venue agreed between the participant and the researcher. Interviews will last around 1 hour, with a short, off the record, debriefing opportunity at the end of each interview. This will give opportunity for the participant to say how they are feeling and to offer them advice as to where they might get help in the longer term if that is what they want.

With the participants permission the 1 hour interviews will be audio-taped. While narrative interviewing facilitates the telling of a person's story, the researcher will have identified areas to cover, as outlined (appendix 4). Participants will be given the topic: What impact did the street telephone triage have on your mental health, which could be used as the 'starter question' or they could simply talk about 'the story of experiencing street telephone triage. Interviews will be transcribed by the researcher in preparation for data analysis.

Data Analysis

Once transcribed, the narratives will be analysed by two possible methods; (1) Content Analysis (Holloway & Freshwater, 2007), this allows for the analysis of just one case study

or (2) Holistic Analysis (Reissman, 1993) as this can allow a full analysis of the experience and the interpretation placed on it by the story teller. The actual method employed to analyse the data will be decided upon when numbers of interviews are finalised and richness of data gathered and understood in order to ensure the approach used maximises the opportunity to elicit the information desired by the project.

6. How many participants will be recruited and/or involved in the research study, and what is the rationale behind this number? (refer to guidelines section 7)

Due to the sensitive nature of the project it is hoped that the recruitment process will generate a minimum of 1 participant and a maximum of 8. This is to allow a narrative analysis approach to take place whilst ensuring the project is manageable and elicits the desired data. (Reissman1993).

7. Please describe how you plan to obtain organisational agreement for your project (if required). (refer to guidelines section 8)

Local agreement at Pennine Care NHS Foundation Trust will be through the research and audit committee

NHS approval will be sought through the NRES process.

8. Please identify which Code of Conduct and/or Governance Framework you will be adhering to? (refer to guidelines section 9)

The NMC Code of Conduct as a registered nurse

Pennine Care Foundation Trusts Governance processes as these service users will be Pennine Care patients This will include their confidentiality policy, lone working policy, data protection policy and risk management, both corporate and clinical.

9. Please describe the data protection issues that you need to address?

(refer to guidelines section 10)

1. Each participant will be allocated a code and their names, or any other identifying details will not appear in my thesis or any other research outputs.
2. All participants' details and contact addresses will be password protected on an NHS computer system accessed only by the researcher.
3. The recording of the interviews will be by 'Big Hand' that is stored on a password protected computer only accessible to the researcher. The files for these recordings will be coded by the agreed code for each participant and not their initials, name or any other identifiable information.
4. There will be no need to transport any files as these are contained on an NHS password protected file that the researcher can access at any location with a mobile, password encrypted laptop.
5. Hard data (consent forms) will be kept in a locked draw in the researcher's locked office at the Trust. No one other than the researcher will have access to these
6. The publication of the thesis and other research outputs will not identify the participants involved.
7. The data collected and stored via the encrypted password protected process will be kept stored for a minimum of three years after the completion of the data collection
8. All data collected, both consent forms and recordings of interviews, will be destroyed via the confidential waste process within the host Trust after the three year agreed storage timescale.

10. Please describe how other ethical issues will be considered, e.g. reporting of incidental findings from assessments, reporting adverse event, addressing sensitive issues, dealing with vulnerable populations or working alone. *(refer to guidelines section 12)*

The study will involve a vulnerable group, namely the mentally unwell service user who has experienced a crisis.

Each participant will have already received a letter of invitation (appendix 1), a participant information sheet (appendix 2), a consent form (appendix 3) and had the opportunity to discuss the process before they agree to be involved in it. In addition, the researcher will ensure they are fully aware of the process and support they will receive if required. The vulnerability and risk of this group is recognised by the researcher, but as a registered mental health nurse with 29 years' experience it will be built into the interview process, through offering breaks as and when necessary during the interview, reminding them they can stop and withdraw their participation at any time and by offering a short debriefing time at the end of the interview. The researcher will be able to recognise if the participant is becoming distressed during the interview and will stop the process and deal with the distress in a clinically appropriate manner such as seeking alternative help, accessing existing support professionals involved or any other process required. If the interview is

completed the researcher will offer a 15-20 minute none recorded debrief to ensure the participant is able to leave safely and that there are no residual requirements to access a care package before they go. The offer of support and access to correct support will remain open to all participants after the interview should they wish and this will be made clear to them before they leave with the contact numbers they require, such as the crisis helpline, Healthy Minds Primary Care Mental Health and Home Treatment team numbers, being made available.

11. Please identify if reimbursements and/or incentives will be provided to participants. (refer to guidelines section 13)

There should be no need to offer reimbursements or identification of incentives. The researcher will ensure the interviews are held in a location convenient to the participant and their participation in the project will be on a voluntary basis.

12. Please describe the dissemination strategies for your project findings. (refer to guidelines section 13)

Publications – thesis, academic journal papers

Trust Website

Local Practice Development Forums

Conference Presentations

RCN Website for best practice and research

13. References – provide full list of all references used

Burnham E and Parker J (1993). Feminism and discourse in developmental psychology: identification, subjectivity and interpretation'. *Feminism and psychology*, 2 (1), 45-60

Clarke D, Duscome D and Hughes L (2007). Emergency department from the mental health client's perspective. *International Journal of Mental Health Nursing*, 16 126-131.

Creswell J W (2011). *Qualitative Inquiry and research design: Choosing among five traditions. (3rd edition)*. Thousand Oaks CA: Sage.

- Eales S, Callaghan P and Johnson B (2006). Service users and stakeholder's evaluation of a liaison mental health service in an accident and emergency department and a general hospital setting. *Journal of Psychiatric and Mental Health Nursing*, pg. 70-77 2006.
- Hammersley M (1992). *What's wrong with ethnography? Methodological Explorations*. London: Routledge
- Holloway I (1997). *Basic Concepts for Qualitative Research*. Blackwell Sciences Ltd.
- Holloway I and Freshwater D (2007). *Narrative Research in Nursing*. Blackwell Publishing Ltd.
- Hughes L and Clarke D (2002). Psychiatric nurses in hospital emergency departments. *The Canadian Nurse*, Vol 10, pg. 23-26 2002.
- Jones S L, Mason T (2002). Quality of treatment following police detention of mentally disordered offenders, *Journal of Psychiatric and Mental Health Nursing*, Vol 9, pp.73-80
- Lamb H R, Weinberger, L E, DeCuir, W J (2002). The Police and Mental Health. *Psychiatric Services* 46 (12): 1267-1271
- Marshall C (2003). *Designing qualitative research*. London: Sage
- Mental Health Crisis Care Concordat accessed July 2015 www.gov.uk/dh2014
- Reissman C K (1993). *Narrative Analysis*. London: Sage
- Riley G (2011). A frightening experience: detainees and carers experiences of being detained under section 136 of the Mental Health Act 1983. *Medicine, Science and the Law* 51 (3) pp164-169.
- Sands N, Elsom S, Marangu E, Keppich-Arnold S and Henderson K (2013). Mental Health Telephone Triage: Managing Psychiatric Crisis and Emergency *Perspectives in Psychiatric Care* 49 (2013) 65-72
- Stake R E (1995). *The art of case study research*. Thousand Oaks, CA: Sage

NB. Projects that involve NHS patients, patients' records or NHS staff, will require ethical approval by the appropriate NRES. The College Research Ethics Panel will require written confirmation that such approval has been granted. Where a project forms part of a larger, already approved, project, the approving REC should be informed about, and approve, the use of an additional co-researcher.

NB: The ethical and efficient conduct of research by PGR students is the direct responsibility of the supervisor.

I certify that the above information is, to the best of my knowledge, accurate and correct. I understand the need to ensure I undertake my research in a manner that reflects good principles of ethical research practice.

*By submitting your application via email you are confirming you will comply with the above

Please note that whilst the College indemnifies PGR student research projects, the supervisor is signing that they are satisfied that the student has considered the ethical implications of their work and to confirm for the PGR student's project to proceed subject to approval by the ethics panel

*By submitting your students' application you are confirming you will comply with the above

Prior to submitting the application form:

***Please refer to the 'Application Checklist' and ensure appropriate supporting documentation is submitted complete with version and date, with the application form**

Failure to complete the necessary documents will result in the application being returned to the applicant without being reviewed thus delaying the application process

Ethics Approval University



19 April 2016

Dear Clair,

RE: ETHICS APPLICATION HSCR 16-19 –The experience of Mental Health Crisis intervention through a Street Telephone Triage System: The service user perspective.

Based on the information you provided, I am pleased to inform you that application HSCR16-19 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Steve Pearson

Deputy Chair of the Research Ethics Panel

Research, Innovation and Academic Engagement Ethical Approval Panel

Research Centres Support Team

G0.3 Joule House

University of Salford

M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk

IRAS Application (abstract) and IRAS Approval Letter

Full Set of Project Data

IRAS Version 5.3.0

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Street Triage : The Service Users Perspective.

1. Is your project research?

☒ Yes ☐ No

2. Select one category from the list below:

- ☐ Clinical trial of an investigational medicinal product
- ☐ Clinical investigation or other study of a medical device
- ☐ Combined trial of an investigational medicinal product and an investigational medical device
- ☐ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- ☐ Basic science study involving procedures with human participants
- ☐ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- ☒ Study involving qualitative methods only
- ☐ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- ☐ Study limited to working with data (specific project only)
- ☐ Research tissue bank
- ☐ Research database

If your work does not fit any of these categories, select the option below:

☐ Other study

2a. Please answer the following question(s):

- a) Does the study involve the use of any ionising radiation? ☐ Yes ☒ No
- b) Will you be taking new human tissue samples (or other human biological samples)? ☐ Yes ☒ No
- c) Will you be using existing human tissue samples (or other human biological samples)? ☐ Yes ☒ No

3. In which countries of the UK will the research sites be located? (Tick all that apply)

- ☒ England
- ☐ Scotland



Health Research Authority

North West - Haydock Research Ethics Committee

3rd Floor - Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0207 104 8012

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

22 July 2016

Miss Clair Carson
Assistant Director of Operations Mental Health
Pennine Care NHS Foundation Trust
Trust Headquarters
225 Old Street
Ashton-Under-Lyne
OL6 7SR

Dear Miss Carson

Study title:	Street Triage : The Service Users Perspective.
REC reference:	16/NW/0487
Protocol number:	HSCR16-19
IRAS project ID:	203330

The Research Ethics Committee reviewed the above application at the meeting held on 12 July 2016. Thank you for attending with Dr Sue McAndrew to discuss the application.

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

Favourable opinion

Appendix 3: Participant letter



School of Nursing, Midwifery, Social Work &
Social Science
University of Salford
Salford, Greater Manchester
M6 6UP United Kingdom
Tel:
E-mail:

Date

Invitation to participate in a research study

My name is XXXXX and I am a student at the University of Salford, as well as a Registered Mental Health Nurse working within Pennine Care NHS Foundation Trust.

I am undertaking a research project to find out about the experience service users have of the Street Telephone Triage service in the Boroughs of Bury and Rochdale.

Enclosed with this letter is an information leaflet that gives you more details about the study and what you will be asked to do if you want to take part. Please read the leaflet and if you feel that you would like to participate in the research, please contact me on the phone number or e-mail addresses are at the bottom of this letter.

Once you make contact please ask as many questions as you want and I will attempt to answer them before you decide to participate.

If you decide to participate in the study, you will be asked to sign a consent form and any information you give to me will be kept confidential

So if you are interested, please contact me via phone or e-mail

Tel XXXXXXXX
Email XXXXXXXX

Your help would be greatly appreciated

Yours sincerely

Appendix 4: Participant Information Sheet



Participant Information Sheet

Title of Study: Service User Experience of the Street Telephone Triage Service

INVITING YOU TO HELP US

This study aims to find out about the experience of the service users who have utilised the street telephone triage service in Rochdale and Bury. If you feel able to help with this then I would like to invite you to participate in the study.

Before deciding if you would like to help or not, please take time to read the rest of this leaflet and if you wish to, please discuss taking part with others

WHAT IS THIS STUDY ABOUT?

It is about the overall experience of being treated using the street telephone triage service with a view to highlighting what works well and what could be improved from the view of those that use it.

If you feel that you would like to talk to me about your experiences of this service please read the rest of this leaflet.

WHAT IS THIS STUDY HOPING TO DO?

To capture your own experiences, if they were good or bad, by talking to you about this.

To explore how you felt and what you think might have made the experience useful or what could have been better

To then use the findings from the overall study to inform and improve the future service we deliver.

DO I HAVE TO TAKE PART

No you do not have to take part. If you decide that this is not for you it will not affect the care you or your family receive in any way.

BEFORE PARTICIPATING IN THE RESEARCH

Please read the covering letter and this leaflet and if you feel able to participate and that you might wish to do so please contact me on the details at the end. If you are happy to participate I will arrange for us to meet at a time that is convenient for you and at a location you feel happy to attend.

WHAT WILL HAPPEN DURING THE RESEARCH?

Before participating you will be asked to sign consent form that will be fully explained by me before the interview will commence.

Once you have given written consent I will proceed with the interview. With your permission the interview will be audiotaped.

During the interview I will be careful not to use your real name (an agreed name prior to the interview starting can be used if you prefer) or the names of people or places that might identify you.

The interview will last approximately one hour. At the end of the interview the audiotape will be turned off and there will be some time for you to talk about any aspects of the interview, especially if you found anything upsetting or difficult. This information will not be included in the research.

You will be free to terminate the interview at any time. If you do decide to no longer participate in the research the information you have given will be destroyed and not used in the research.

At the end of the interview you will be given contact numbers to ring should you wish to be updated on the progress of the research or numbers you may require as a result of the interview process.

WHAT HAPPENS AFTER THE INTERVIEW

I would like to interview a number of service users and this will of course take a period of time.

Once all the interviews are completed I will analyse them.

Once this work is complete I will write a full report and all information in the report will be anonymised.

The report may be published and will again to be anonymised if this is the case

CONFIDENTIALITY

What is said in the interview will remain confidential between us both, but I must

highlight that if you do tell me anything that is illegal, I am duty bound to report it to the appropriate authorities.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THE RESEARCH

By sharing your experiences you will be able to contribute to the development of the service for yourself and others who may use this in the future.

□

WHAT ARE THE DRAWBACKS TO PARTICIPATING IN THE RESEARCH

Talking about your experiences might be distressing. At the end of the interview I will turn off the tape recorder and provide an opportunity for you to talk about any aspects of the interview that you wish. This will not form part of the research. If you feel that you would like further help I will be able to direct you to appropriate services that you can choose to contact.

MAKING A COMPLAINT:

If you wish to make a complaint about the research you can contact:

Supervisor details XXXXXXXXXXXXX

If you remain dissatisfied you can contact:

Mr. Anish Kurien Research & Innovation Manager – email: a.kurien@salford.ac.uk
Telephone number 0161 295 5276

WHAT NEXT?

Please take the information leaflet and think about participation, contact details are written at the bottom of this sheet if you want more information.
If you are unsure please talk to someone you trust and feel will be able to help you make a decision as to whether or not you should participate.

Researcher's name: XXXXX XXXXX

Phone number: XXXXXXXXXX

E-mail XXXXXXXXXXXXXXXXXXXX

Thank you for taking time to read this leaflet.

Appendix 5: Consent Form

Consent Form

**Project Title: The experience of Mental Health Crisis intervention through a
Street Telephone Triage System: The service user perspective.**

Please tick and initial the appropriate boxes

Y N

Taking Part

I have read the information sheet (v1 26.2.16) and I have been verbally informed about the above research and I understand what I am being asked to do. ☐ ☐

I have been given the opportunity to ask questions about the project, and all questions have been satisfactory answered. ☐ ☐

I agree to participate in a one to one interview with the researcher identified and for the interview to be audio-recorded. ☐ ☐

I understand that my taking part is voluntary; I can withdraw from the study at any time and I do not have to give any reasons for why I no longer want to take part, and it will not affect any aspect of my or my family's care. ☐ ☐

If I do decide to withdraw I understand that the information I have given will not be used in the research. ☐ ☐

I understand that if I reveal any criminal activity or intended harm to self or others the researcher will be duty bound to report it. Wherever possible this will be done with my permission ☐ ☐

Use of the information I provide is for this project only

I understand that my personal details will be kept confidential ☐ ☐

I understand that my words may be anonymously quoted in the researcher's thesis, publications and other research outputs.

☐ ☐

Researcher

[printed]

Signature

Date

Name of participant [printed] Signature

Date

Appendix 6: Transcript from Carmel

Interview - February 2017

CC- Thank you for agreeing to undertake this interview with me today

X-I might waffle on a bit you'll have to sometimes ...

CC-No that's alright – I think let me just have a look, okay so we have discussed the information sheet about the project I am doing and you have agreed and signed the consent form, if you want me to stop at any time please just let me know

X-If I get upset don't worry

CC- Well that's the other thing that I was going to say that if you do want to stop at any time please just stop I'll turn it off

X- Yes if I need a breather – yes you'll be able to tell you'll see me breathing.

CC- Right so I've got an hour so there's no rush if you are alright with that

X-= 'only an hour' (laugh),

CC- is that alright with you?

X-Yep I better not repeat myself then. Right that's alright.

CC- OK so really like I say what I am interested in is your last episode when you were helped by the police so like I say –over to you.

X- Right I just don't know where to begin – mmm right right so I started in breakdown end of November, this breakdown, but I am very independent and I do value my privacy and because I have been left in despair so many times anyway with no support I am not able to leave the house to get the assessment done you see. Even then it takes 2 weeks if I do get to Casualty for the assessment. There's nobody mentally health trained up there which is ridiculous. There was years ago

but not anymore so we have to come from Bury to sit there for 6 to 8 hours in anxiety it's too much. So I tend to just cope myself but I can't anymore.

CC-Mmm

X-I had no medication whatsoever, I was being constantly harassed when I did leave the house by the ex-rapist who I tried to prosecute but couldn't.

CC- Mmmm mmmm

X-so I just collapsed

CC-mmmm

X-while the police were here I think it's that when I did break properly and they weren't prepared to leave me with no-one because they know I've no family anyway, they know I've nobody, only one friend and her family is in intensive care at the moment so I won't even attempt to bother her, you know, and to be honest she not right much help because she got an idealic life so she doesn't understand me suicidal.. So she gets in the way anyway so like I say I'm on own but I can't any longer cope on my own. So like I say no medication at all originally then I got some off my GP, the Epilim which is a mood stabiliser but unfortunately it takes 6 weeks to kick in so I'm only on that beginning of my third week now

CC-mmm

X- so I was on my knees really with literally no medication in me and erm so I reported this 30 year old crime, it's haunted me severely even when I'm not in breakdown I am carrying this burden for my ex psychopathic husband, which I left 20 years ago but he still hounds and haunts me. Lost my children to his sick control that I raised on my own so I were just on my knees by time police came, you know - to unburden my mind because I knew I was suicidal I don't doubt when I'm suicidal, I don't have any doubt at all, I have different stages of despair but when I'm suicidal I actually am, do you know what I mean, I don't just say it for sayings sake

CC-yes

X- I don't want any fuss or any attention at all. I'm not – I don't say it unless I mean it, do you know what I mean

CC- yes

X- and them that know me know that because I've OD'd twice and not told nobody. (cough cough) but mmm yes so I rang the police and mmm I thought I'd feel relief because I'd carried that burden 30 years on and off (sniff) that shame and everything you know

CC- mmm

X- and I thought zero tolerance I'm having no more, you know I'm going to expose this man and how psychopathic he is because he's got away with his psychopathy all his life. He drove me to suicide within 3 weeks of marriage, cheating on me, that was my first big OD and because he was a charge nurse he came into hospital and took my out before a psychiatrist, before I got to tell anybody that it was him that drove me to it

CC- mmm.

X- I'm not I don't think I'd have had all the trouble I've had but anyway that's another story isn't it. So I do get mixed up but that's how bad he is do you understand me. Anyway erm yes so I told the police and err about his murdering vulnerable patients and ... and that I was in fear and I couldn't report it at the time because I was in fear and trapped with the kids and I didn't know there were refuges, I didn't know there was any escape from him, I was in fear of him daily, hourly. Absolute mad man. You see there isn't any madness in me, mines trauma; my issues are through trauma, so I can't be around anybody mentally ill do you know what I mean

CC-yes

X- Terrifies me... coz I've never harmed anybody in my life, I'm a gentle person and highly sensitive and I don't wish to harm anyone. Any way so erm police said mmm have you got any help, I said well my GP knows I'm in breakdown I said but I thought I'd be alright you know and mmm but I didn't feel any relief so I did 30 year old story, I wished I hadn't because the ex-husband has been harassing me since, wanting to know why I'm going to the police do you what I mean. But it was the only way I could defend myself against him, I haven't told him why I've gone to police, I don't want to give him time to make anything up

CC-mmm

X- Any way so it's been very painful and that but I had to let it out but I also regret it because it hasn't really brought me much mmm, it's cleared my conscience but that's all it's done. Maybe because it's I'm so ill anyway in general I don't know. But that was the breaking point for me, having to tell the police this to unburden myself; because you know I'm an honest, decent person mmm can't even image doing anything wrong or wish to do you know what I mean

CC- yes

X- it's not in my character but unfortunately I've had abuse from mad men all my life so I'm terrified of mad people now. Hence another reason why I don't like going up to Psychiatric place, I have anxiety attack getting there and mmm and there's always someone hanging about that you know unsettles me. Anyway mmm so police rang Bury RAID team, I only had the number but said I'm not always aware, I am broken

CC-yes

X- I'm still independent and so strong willed, so adamant I can cope, well I can't really

CC-mmm

X- but this is the trouble I have part of my condition, I have difficulty knowing what's real and what isn't real now you know, I've had so many breakdowns, I have had so much trauma, I do have difficulty, I have a lot of flashbacks in breakdown constantly, in my sleep I'm tortured, tortured away, tortured in my sleep (small hesitation)

I see a lot of things

CC-mmm

X- a lot of horrific things (tearful) so I think am I losing my mind. Am I psychotic but apparently no, mmm its just trauma on trauma. I've have 54 years of constant sick psychopathy around me (tearful). Not even recognising it until Do you understand me?

CC- yes. Are you OK?

X-Yes but mmm that scares me so much. I always used to be able to tell what was real and unreal but I can't anymore. Because I'm in my 12th week of seeing horrendous things regular. I couldn't look at my GP because he had two heads the other day and he was awful with me and I walked out on him. Because I don't know whether (Still very tearful) but I won't be abused by anybody willingly and he was abusive, so I refuse to see him anymore. Got a nice lady now and she knows how to be with me, if somebody doesn't get me I can't relate to them, I don't care how professional they are, I've had so many abusive treatment over the years and treated like a piece of crap on the floor that I won't be treated willingly, abused by anybody. Because I got same rights as anyone else and respect is a two way thing just because he's a qualified doctor doesn't give him the right to treat me as bad as I have been treated over the years. So I have a fear really of going to the doctors unless I know they are mental health trained, I don't really open up but of course they have the big bible but they don't have time to read it obviously because they are so ignorant.

And even mental health torture me when I go up there, I have to go through the 54 years of abuse every single time I go up there and I think you got that big bible there why do I have to keep reiterating everything, and how's that supposed to help me when I'm suicidal you know, how's that supposed to help me. So thankfully last time I saw a Psychiatrist which is rare by the way these days, I don't know what situation you have to be in to get one but mmm, she was lovely and she got me in 2 minutes and mmm she mmm and that was last August, last breakdown before this one. She knew instantly what to prescribe me, she said I'm not going to go through your history Carol I have already been through it and I said thank god for that. I said because I haven't slept or anything having to do through all that

CC- mmm.

X- She's the only one I've never had to go through everything with. It was such a relief, but the medication she gave me, I wasn't suited to it, I've had a lot of medications that I've had allergic reactions with before (oh don't worry about it) or mmm I just couldn't tolerate the side effects or I have been suicidal on some.

CC-So when the police came

X-'I'm going to get lost'

CC- it's alright, that's fine, are you alright to carry on?

X- Yes

CC-Okay.

CC- When the police came that time and said they've contacted RAID what happened then?

X-So I was bit annoyed at the police in a way because they rang RAID and mmm first of all they said to me mmm we can get you help today – I said no there's no point there's never any help, no I'm going to Bury I said mmm I can't leave the house, I'm not going there. I've taken to Bury so many times and just dumped there

and you end up being sent home in the middle of the night on my own. £15 taxi home on benefits you know. They get you there by police car or ambulance but they don't think to let you get back safely, when you're vulnerable as well. So I try and avoid going to anywhere at all costs because I have difficulty leaving the house anyway and mmm so they just asked if I'd speak to RAID so I said I'll speak to them but I'm not going to Bury, I'm not moving, not going anywhere. Not when I was going to sleep anyway. Said I'm not going out nowhere but you see they're not allowed to leave you

CC- mmm

X- so I was drained and I wanted them to go, I hadn't slept for about 4 nights and erm yes so then I chatted to XXXXXX and she did calm me down, I think she must have known something on me I don't know, I didn't recognise her name but I must be on file mustn't I? yes, I will be won't I?

CC-yes

X- She was very nice but I can't remember what she said. She was very nice anyway and I think she asked if I could get there and I said no I'm not going there no, I'm staying at home, you know, I'll be alright, and I was weary and I was desperate just for some sleep, I didn't want to be going up there for 8 hours and mmm I forgot what she said, think she said she'd refer me to Birch Hill I said well I'm already waiting for a Birch Hill appointment mmm that's right I wasn't due to go to Birch Hill until about the 8th March and I rang up and said I can't wait to the 8th March, I have been in breakdown since the 28th November here alone, I said you need to see me sooner, I said my medication is not helping or anything because I hadn't been on it long enough, only a week then. So they did, I was screaming with anger at them, and he's such a nice man but I've just been offered promises of support all these years, we'll support you, we'll get you support, there's never anything. Do you know what I mean; it's really hard if you're in despair you're in despair

CC-mmm

X- you should get all the help there is

CC-mmm

X- There just isn't any, not for somebody like me who can't actually leave the house to access it. They should come to your home and assess you for god sake, shouldn't they. Mmm it hurts to..... at moment, I get so anxious

CC-Are you still okay to carry on?

X-No I'm alright I'll carry on yes, or I'll go blank if I stop, I'll lose it all.

CC-So did you bring that appointment forward?

X-They did to mmm Friday just gone but I was too ill, in 5 minutes you know I was too ill to speak. Right Couldn't breathe. So she is coming 8 days later at 9:30pm at night knowing that I won't be answering the door. Which isn't good is it

CC-Mmmm

X- but I'm ready for bed then

CC- yes

X- I'm weary then, even if I don't sleep I like to be in my room, I don't like being down here. It's only that one room that I haven't been raped in, that I've changed to that room. So I don't like going to the door at night, during the day as well as at night.

Its pitch black isn't it at 9:30pm

CC-mmm

X- So I must be last client. So what did? ---- So she doesn't know me so that's all. And is that someone from Access, that's coming? I think so. Right.

CC- So when XXXXXX spoke to you when the police were here over the phone, did she organise for her to come and see you, did you see Lesley at all?

X-Did we organise what love.

CC-Did you see XXXXXX at all, did you see her or did you just speak to her on the phone?

X-I only spoke to XXXXXX on the phone, no I weren't able to get there no. No.

CC-So what happened from that night to now? Are you seeing anybody?

X- Just XXXX XXXX. Friday and she's not coming for another 8 days

CC-right

X- so it's not good, I used to get twice a day Crisis Home Treatment Team, I knew them all by name, and they were like family

CC- yes

X- They always got me though, you know, I loved them like family. Sometimes I used to sack them; you know if they weren't very good

CC-hmmm

X- got to remember I used to do the job myself. So I know whether they are good or not, do you know what I mean

CC- mmm

X- I can't stand anybody who's not efficient, I'm not being funny erm but I haven't got patience when I'm having a breakdown for somebody asking me what should happen, do you know, what's best for me, you know. I had one lady come and she sat there and fell asleep

CC- oh dear

X- I said excuse me am I boring you. Disgusting -- that's not long ago.

CC- So what do you think would help? If you were on that night again and you were suicidal again

X- Yes, I still am.

CC- So what sort of things, have you phoned the police, because you phoned the police that time, did you? How did the police become involved that night? Did you ring them?

X-That was at breaking point

CC-yes

X- that was when I was really on my knees I had to get if off my conscience.

CC-So what do you think would have helped you that night? In an ideal world what would have been good for you

X-The people I know and that know me, the Home Treatment Team

CC-For someone to take you there and bring you back and support you

X-No just come to the house I can't go out at all anywhere. For somebody to come to the house. Them that know me and I don't have to go through 54 years of abuse.

CC- Right. So having the information on you as well.

X-Well they know me anyway and I know them. So is that quite It's a vital service for somebody like me. Yes that's why I don't even bother contacting them anymore. Because I don't know what you have to do to get them now. Whether it's because I can't any longer get up there I don't know maybe that's the reason. assessment (mmm) I shouldn't be left 2 weeks. So I've not been assessed because I'm not well enough.

CC- So when the lady came to see you on Friday, did she

X- No I had to go and see her. I had an asthma attack on the way, anxiety, couldn't breathe.

CC-Right

X- And then there was a man that the police brought in that was obviously on some drugs, terrified him. Up at the John Elliott Unit there's always someone iffy hanging around, I'm on my own remember vulnerable.

CC-So is that something else that would help as well being in a safe environment?

X- It was long way to come to here, why couldn't you realise that before you dragged me here, you know, in the dark. I don't even like going out in the light, on my own remember. Couldn't breathe when I got there, just collapsed.

CC-Where the police nice with you?

X-Police are lovely with me because they know that we've tried to prosecute a few times and they know I've ended up taking suicidal thoughts with the stress of not being able to prosecute, right, so they know, they can't do enough for me. I have no complaints about Rochdale police and again they are like family and you see. So he's really mmm he comes and bollocks me sometimes (laugh). Wait for a while left my house to get in the ambulance go to Bury then dropped off at 1am like I was minus my, no coat either, when I'm gone I'm gone. He said to put a coat on I didn't know where I was going; I thought it was Rochdale, of course it was bloody Bury. No coat or anything.

CC- So that's one of the things that would help then if you are ill enough have to be taken to hospital because obviously sometimes if you take an overdose you might have to go to hospital for treatment, but that after you've been discharged

X-yes that's happened twice, I've managed on my own, I've just woke up and haven't even told anybody, which is bad isn't it really?

CC- well yes, you shouldn't have to feel like that. Is part of not going for treatment the concern about how you're going to get back? Or does that not cross your mind at the time?

X-Well like I said, he brought me back last time; I didn't want to be here so I tried hanging myself in Bury in Casualty (right) Tried hanging myself on the bed

CC- mmm.

X-So I suppose part of what I am trying to sayI have agoraphobic tendencies and because I'm being harassed by a mad man who I can't prosecute for 3 rapes by the way. He took £10K of my money. For his drugs, now do you understand why my fear of drugs. He is still around. That's why I can't leave the house. That's the reason, that's why I'm desperate to be moved. I tried to move twice while I was in the relationship, never a relationship; I tried to move twice but he wouldn't leave me alone (mmm). I was too ill to move do you understand me

CC- yes

X- He's drove me to suicide twice now; you know he is a lot to do with this one. Because I can't get him. Any way the police are very supportive with that even though

CC- it sounds like their hands are tied a little bit for whatever reason but they are supportive with you – do you feel supported by the police?

X-Yes I'm

CC-What else would help you to mmm to move – what sort of support, practical support around moving or

X- Yes I've been a tenant here since I came out of the refuge 20 years. I'm attached to this house, I raised my children here, on our own its my refuge, ... I feel homeless because where ever I go he finds me, he just turns up. I can't shop for food, I can't do anything. Part of me wants to stay but it would be pointless I would be driven

out of my home again. But I know he'll never leave me alone, he's an addict. He won't leave me alone. I'm in fear of him. Because there's no deterrent – 3 rapes, I had a 2 year restraint order on him, he broke it several times. It's not right. So I get that I can give up because I can't find any peace. I've never had a day in my life of peace mmm yes I can give up.

CC- But you haven't, and what is it that keeps you going?

X- Well this is the thing, I don't have a reason anymore. It used to be my children but it's not anymore. Because they don't care anyway.

CC-Are they around, your children? Are they grown up now?

X-No – that's the thing that broke me. I lost contact with them – last time we were together I was 50 I'm now 56.

CC-These are you're girls are they? (Points to picture)

X- Yes I lost them to madness, the father. Their father's madness, that why I have to prosecute him just to prove to them if nothing else erm he is the mad one, I'm not I'm the good one, and I hurt so much. I don't regret having them; I just regret having them with him. But they don't care anyway because I've had no contact in 6 years, which hurts every day. So I have very little to live for I'm being honest. They were my whole world. We didn't go in a refuge because he was a nice man did we! No, I Had a posh house.

CC-So what sort of support do you think would help you? What do you think would help at this moment in time? You mentioned the Crisis Team before hand and they used to come couple of times a day.

X-Twice a day they used to come. Sometimes it used to annoy me twice you know, used to say oh don't come tonight, I need to get to bed early because it would disturb my sleep coming in the mornings. I sleep when my mind switches off which is very rare by the way. I mean I've had insomnia all my life.

CC- But that did help you though?

X-The Crisis Team. Oh definitely it always got me through, yes, it wasn't a struggle then. I only struggled since I've had no help.

CC-So that's been this episode, so you said yourself

X-No I've not had them for over a year, I've had 4 breakdowns in that time, but this has been the hardest one.

CC-And did those other breakdowns look like. Did they do the same thing, did you end up going into A&E, and did you seek, how did you cope with those, and what did you do?

X-Well I have highs and lows, don't know whether you know. I have severe highs right, but exceedingly low lows. I decorate the whole house on my highs even with vertigo at the time but anyway. It's my nerves, it's not my ears, I've been tested, it's my nerves. No balance sometimes. My whole body can lock. Just had a bath but my body still locked in the bath. Severe anxiety I have daily, all the time. I've forgotten what you asked me, I'm sorry.

CC-The question was what did you do, so you've had 4 breakdowns in the last year, so what happened in those times, did you go to Casualty, did you like you say when you were high you decorated the house, what did you do when you were low?

X-Can't get out of bed, can't move, can't wash or anything. Just in that deep bloody awful hole.

CC-What would have helped then? If you'd have had somebody at the end of the phone, maybe then?

X-Yes definitely, yes. Because I've no-one. One year I didn't have any conversation with my one friend, I had nobody. Seventh Christmas alone. It's hard.

CC- So it would be useful if you feel like that for you to have maybe a number to ring and somebody at the end of it,

X- I can hardly speak though it depends how I am. I can't always speak. I can't put two words together, if I'm really distraught. That's when I get the urge to self-harm

CC- But that's probably the time that you really need to be talking to somebody isn't it?

X- Yes but you don't know, they know I can't talk, they know I only ring when I have got over the initial urge, right.

CC- So it is people knowing you really?

X- I think that is helpful. I think what you have said is Oh I think I'm famous now love, (laughing), they've known me 17 years now.

CC- I suppose in some respects it just means that I think one of the things that distresses you when you're in crisis is you don't want to have to tell your tale again, you don't want to have to say 54 years of

X- that's so hard, you want people to know that already and just wish (if they've got the bloody bible they carry everywhere) So they should know that information. They should recap anyway, (that would be useful) then they would know me – they don't have to read them notes. That's what I love about it, the crisis team, I can sit in a chair and weep with them, you know, I let it out

CC- Yes. Well that makes sense, so that would be quite useful. So even if it was the police that came here first, if they could phone and then somebody knew you like you had with Lesley, she might not have known you but she had information in front of her, that helps because she is not already saying and 'what's is your name' and etc. and all that kind of stuff, that's not what you want to be talking about at that point in time, is it.

X- No it really isn't

CC- OK so that's useful to know. That is useful to know.

X- Well when I'm suicidal I'm not really compos mentis anyway do you know what I mean, I've had mmm had to work at being able to talk to you today. Even though I've known for a week you were coming I've had to prepare, right, I've had to talk to myself and practice talking.

CC- oh right

X- Because I don't see anyone one week to next. Do you know what I mean? and I had a bit of brain damage from the last overdose, I was unconscious so long I ended up dyslexic, I was so bright mentally, with English and reading and spelling I've always been brilliant at but – all got English degrees in the family, children, the goes through all the family. But I have had to learn to read and write, I am actually dyslexic now. So ...

CC- Because of the damage from the tablets?

X- Yes I was unconscious 4 days. They shouldn't have brought me round really.

CC- oh dear.

X- I had gone, near death experience, I've had 3 now.

CC- And who found you that time?

X-The Police

CC-Oh right – OK

X-Mmm well it were, I took the overdose on the Friday and the following Monday, about 3 o'clock mmm I should have been having a new front door on because it was very insecure my old one. We were all having new doors. And he couldn't get in, he must have known I knew he was coming but I didn't because I was so depressed. I didn't know he was coming, do you understand me, I didn't want finding, obviously so if I did I would have took it Monday morning you know what I mean

CC- yes.

X- So he panicked and raised the alarm and they rang the police right away. Because I must be on file as high risk suicide.

CC- So they came round then

X- Police know me you see, the police

CC-Do you remember them coming round? Do you have any recollection of them coming round?

X-Yes because he was well fit (laugh). So oh good. Fair enough then (laughing). So we have a bit of a banter going. He gets upset because he's seen me twice since. Come on – you know I've seen you dead and it was them words that shocked me into getting into that ambulance. He made me come to some people can, some people I don't even want to hear the voice, you know, I'm gone I do have different mmm how can I explain iterm I go on a different, hard to explain it, mmm, like a different sphere (right) mmm I'm gone . I've gone, not being unconscious

CC-I know what you mean – yes

X- I'm not functioning at all. The pain is so bad. It does hurt you know. I have deep pain. It's not surface pain mine, I've had so much counselling, nothing works. I end up OD'ing at the end of it. Do you understand me, so nothing actually eases my deep trauma and knowing that is why it is easy for me to go to sleep. Because I know, I know I will never heal, I know that. I have been trying all my life to heal but there is so much to heal, if I could just get away from here (yes) it's a start (yes) and sometimes I could just go to sleep it would be so much easier. You know (mmm) it might sound crazy to you.

CC- No not at all I just think like you said maybe.....

X- I honestly know I'll never ever be burden free. I'll never ever function how I used to be able to function and I just feel – I'm sick of existing. I've tried so hard to help

myself as much as I can do but I attract madness. I don't know why, well I do know why, because I had no guidance as a child (right) raped by daddy, and all his friends, and being until nearly 7 ummm and then any psychology I've read over the years, show me the child I will give you the adult. Show me the child at 5 and I will give you the adult. So it's not that I've never tried to be successful and whatever I do I do give 100% but what I lack in achievement and motivation, I think I make up for in my decency and kindness, it a cross roads and I was abused by an addict, and money £10K.

CC- But they are attributes to be proud of?

X- They are but when you've From being born I was brought up and went into the nuns they used to wake me up when they wanted to lay out the dead bodies. I was only 6/7 years of age. That was traumatic in itself I had to see a Psychiatrist at age 7 because I started rebelling by then. They said I was maladjusted at 7 so I had been mislabelled all my life. Hence why I cannot judge anyone because I know how it feels to be misjudged

CC- yes, yes

X- I was just rebelling because I had had a thousand rapes maybe by then. There was no-one near me then, it wasn't that I was feral, we weren't fed, we were beaten, we were tortured. We probably were feral but I don't honestly remember harming anyone (mmm) ever.

CC- Did your counselling cover the trauma informed stuff, because that's a very traumatic experience that you've just said.

X-Yes that's what I see regular, yes, that's what's in my sleep even.

CC- Did the counselling focus on that, or did it focus on the here and now.

X-No it didn't focus on my childhood

CC-Right – is it just something that's too much for you?

X-Yes, maybe it would cure me but I don't want to take that risk, a lot of people do say that,...and I had so much shit counsellors anyway, I have walked out many a times because they are crap.

CC- But they don't work.

X- You need a rapport with a counsellor, you need trust (yes yes) especially, I'm not being funny I've only had one decent one, and she bloody left half way through I could have told her mmm but she left half way through my treatment so I didn't go again.

CC- Well it's a very deep rooted personal thing to talk about isn't it and to get to that point

X- I have never had in my life and I am a private person that's the one thing that hurts. I don't want to be known as Miss Suicide do you know what I mean I don't want to die a victim if I'm really really honest (yes) because that means all that torture I've been through has been for nothing. In vain (yes) you know but it is hard when you're all alone (yes) like me and I don't deserve to be alone (no) If I harmed people; if I was nasty; I forgave the rapist because I couldn't bear to hate him, I didn't know how to hate him but that just made him not leave me alone (yes) so I got more torture and abuse, do you understand me, (yes) I can't not help somebody in need. I can't say no. I know it's 2 letters but because I loved him deeply (yes) and he was the first man I had ever loved and I was originally sexually at ease with, that is a big thing for me (yes) because I was never sexually at ease in my marriage, I knew he was weird, strange (yes) so is this one but because he had so many chemicals he seemed nice, but that's madness, it's hidden erm but I'm an open book, I can't hide anything, I know I'm not mad because I'm not comfortable around madness. I can't always recognise it, maybe I'm used to it I don't know.

CC- Well it comes in many different forms doesn't it,

X- Psychopathy really interests me actually funnily enough, they can be very charming psychopaths can't they? Oh god but it's all glib isn't it. It's all fake.

CC- Absolutely

X- It's all about them – he had every trait this last one. Every trait. I used to say do you know you're just like my ex-husband, and I left him, I left the posh house, the big car, the 2 bloody jobs, money in the bank, left him devastated on his knees. He was devastated. They are all inadequate (mmm) I'll never be that inadequate (mmm) I might get suicidal but with bloody good reason it's not through inadequacy.

CC- Well those are the things you need to hold on to aren't they.

X- I do, I use mindfulness everyday

CC- Yes

X- I am very spiritual, I am very psychic, I taught myself to play piano, as therapy as a child yes. I've never had a lesson in my life, I play classical piano. This is my old second hand one but it's knackered, I (turns piano on ...) I taught myself, no lessons of nobody. Used to have, because I grew up with nuns, I think that's where my decency is from the nuns I cover up, hate the boobs and cover up, my daughter's do thankfully. Well not as well as I'd like them to but one does and one doesn't (laugh) but can mould them but you can't make them something they're not. They are decent and they have got careers, Mental Health nurse – the one that doesn't speak to me, the other ones a school teacher.

But I had no bond with the first one, no bond with her at all because I had taken the overdose just before I got pregnant with her (right) I had no counselling, I hated him, he never once apologised, a psychopath I am thinking I am not allowed to mention it, he nearly killed me (yes) that was a bad OD as well. My grandma, I remember, I got grandma (mmm) and she said it's not your time Carol and she pushed me back, I'd passed over when she pushed me back and I begged her I said no let me be with you (tearful).

CC-It must have been for a good reason?

X- she got that wrong.

CC- But then I suppose you never had your 2 kids

X- No bloody memory left have I – no that was my last attempt at trying to reunite with them. That's what broke me. There was always a reason not to OD, but not anymore. That's hard to accept but I do accept I can go with a clear conscious now. They're not bothered anyway.

CC- What would you ideally like to do? What would your life look like?

X- I'd like to live on a farm with about 100 dogs, but they've all been injured. I can only be around dogs now.

CC- You like animals?

X- Only dogs (yes) – feed my birds everyday (yes) and my squirrel. Because it is unconditional love (yes) and they have all been injured . My ex-husband beat my dog and broke every bone in his body but I saved him. It's what I mean, psychopathic trait that. I can't harm an animal it's just unbearable, I can't think about that.

CC- Well decant human beings don't do that, don't harm any thing

X- Well they don't drive their wives to suicide either (no) rape them, but he never did anything sexual to me my husband he never did. That's the reason I stayed with him

CC- So when the lady last saw you on Friday, what was she intending on doing, did she say? Did she talk about referring you to see a Psychiatrist or getting some additional help?

X- No I told you I collapsed I couldn't go through it, she's coming here on I'm losing my hair, it's this drug.

CC- When is she coming?

X- Who

CC- The lady, when is she coming back?

X- Mmm Saturday night bloody 9:30pm, in the dark, to let her in, I'll be in bed by then.

CC-Is that something – I mean I can have a word and she is we can swap the appointment

X- No it's the only appointment she's got all day love.

CC-Right

X- She did say, it's the last appointment. It's on her way home, I think she's fitting me in actually at the end of the day and on her way home. You can image though, they are fully booked, I know they are busy, I was a bit disgusted because I thought you know I'm not fit to be interviewed and yet you're not coming for 8 days. Who is mentally ill here. You know what I mean. You wonder why I get angry.

CC- Did they give you some numbers to ring or anything if you got into difficulty at all? Did they give you any numbers?

X- Oh I've got RAID numbers – can't be bothered talking to people, I'm not being funny (right) I need to be on my own, with my deep thoughts, 70% are. We were 30 I do achieve, I do. You know make use of your time (yes)

CC-Talked about doing mindfulness – is that a good technique for you?

X- Ummm yes sometimes, depends what state I am in really. Can't always think my mind, you know what I mean. But if I could just get away from here nice dog to take me, I always end up with soft ones that I ruin anyway (laugh). Wake me up to get under the duvet

CC-yes that's mine.....

X-on the fluffy bed and they wake me still under the duvet. I've asthma, I shouldn't be near them really but I like me white cotton sheets. They have them little eyes don't they. That convince you this is the right thing to do. They have yes. They have yes. Bloody hell. Can't look at the pictures I won't stop crying.

CC- Do you think that might be something that might help then to get some practical advice around how you would move, where you could move to?

X-Well I've rung them on my knees.

CC-Is this council or private?

X-It's not council - got to be out of Rochdale you see I think that's what makes it hard for them. I can't remain in Rochdale any longer. Because he's hounded me for the last 6 years. Because it's a lovely house and I suppose I have cared for it, there's only me lived in it so it is mine in my eyes (yes) that's why I've had enough (yes) I know I can't recover in this house. I now accept that (yes). I used to be in denial (yes) used to stay just to prove a point but I know now if I go out and see him I'm on my knees again (yes) I can't allow it. Do you know what I mean; zero tolerance isn't it (yes)

CC- So that is a practical thing that Services could help you with in terms of

X- I need help. Those are the sorts of things that can be done aren't they, the practical advice around housing. There's things I can't physically lift you know, I have to strip the carpets and everything to move (yes). I think they will move me now because they do know me suicidal history. To be honest if they don't I will sue everybody, every one of them. And I do think that's a very clear thing to say. Because I hate saying this, that I will die in this house. The way I still feel.

CC- Well that is the biggest motive to move on isn't it.

X- If they ignore that, I'm sorry they deserve suing because I am a human being and I have got human rights (yes) I know living on the street but I'm not

an addict, you know what I mean, neighbour, you know what I mean (mmm). I have to put up with that, one of the guests sexually assaulted me in my kitchen (oh god) 2 years ago, I tried to prosecute. It sounds like maybe he comes every day, it's not that I sit dwelling, it's everywhere around me every room is a rape memory (yes) It's just a shell, it isn't a home (yes) I know I've looked after it, yes I know I've decorated, that's immaterial (yes). I can decorate somewhere else. I just need to feel I can relax, I can breathe, and I can open my door and go out. I mean I opened my window and I was shit scared of him coming in the window (yes) do you know what I mean (yes) It's no good putting me locks on, do you know what I mean, it's in here.

CC-Sounds a bit like ...

X-I've been here 20 years I've tolerated a lot of shit here in this 20 years (yes) it's time to move on. Do you know what they said to me 2 years ago, they promised me a move with the last suicide, 2 years ago since then, I took that overdose, right, he said to me over the phone my Housing Officer, I met him when I come out of the refuge, I housed you 20 years ago and he knew I had just been raped and couldn't prosecute and he knew I'd just OD'd. Is that ethical. 20 years ago.

CC- I think most people do move more than once in 20 years so....

X-That's what I mean, People move don't they. I've been stuck here because I haven't had the finances but when I had the addict took it anyway (yes) so I'm still stuck here.

CC-But I'm sure that's

X-But I can smell him do you understand me love. I can't even basic food shop anymore (right).

CC-So you are trapped in this home?

X-I am – trapped in here, yes I do get agoraphobic, not through choice. I used to be so social and out-going

CC-and that's where you need to get back to don't you, like you say

X- I'd like to walk a dog (yes) just somewhere quiet and not feel I am going to be jumped out on, startled, do you know I jumped because I heard a car horn, because my window was open, wide, I didn't realise I'd opened it, because I smoke in my bedroom so I don't like it to smell. So I had it wide open and I don't normally, but I knew it was a calm day and it wouldn't blow fully open but it was open wide. Because they do open wide these, you can fit through them. There is a lock on them but you don't get any air in then (mmm). So I opened it wide and something tooted and I absolutely jumped out of my skin, then I thought god it's horrendous (mmm) I'm just like this, when I first came out of refuge, do you know what I mean. My anxiety is the highest it's ever been. It's constant, day and night, I can't switch off. Do you understand me? (Yes)

CC-So you do have a Housing Officer then?

X-We all have officially on benefits yes It doesn't mean anything that, but apparently it's gone to the top boss but I don't believe it, I'm sorry I don't.

CC- But that may be something that the Mental Health Services could help with then?

X-Need a bomb up their arses. They won't do it on their own, no. Yes, but if there'sget me a move, and a doctors letter, I don't know what will. (mmm) Well that didn't make any difference.

CC-Maybe now, you've obviously come back into Crisis Services, you've used Street Triage you used RAID, you've got

X- What's Street Triage?

CC- It's when the police phoned Lesley, that process is the police having direct access to mental health services, that's the model that exists, What the police have said to us is it is very helpful for them when they come across situations where they think somebody is in distress to be able to phone a mental health specialist for advice and they said that that was helpful.

X-But I had the bloody number anyway, I've had it 10 years. So there was no need really.

CC-But they rang it didn't they so I think they wanted some advice.

X-I wouldn't have rung it if they'd gone. No I think they knew that.

CC-Right

X-I think they know me. Yes – so I suppose it was useful in terms of having the conversation with XXXXXX. Cried, and then cried myself to sleep, because I can cry 5 hours. No I'm glad they did because you know, but then again I haven't achieved much because I still don't know who is going to help me (right) you know (OK) I have a social worker, he was a nice man, couldn't tell a word he was saying he was African I think, but he was lovely and told me straight over the phone, blubbing like a whale and mmm quite distraught and you could tell it was in his voice, he just give me that little bit of hope you know (yes yes) and I can't remember what he said but words really overwhelmed me especially when I'm low. I do love words they are so powerful aren't they. ...words I get a bit fed up now but he said I can tell XXXXX you are genuine – you're not pulling the leg and at the time I didn't know what it meant because I'm not able to talk on the phone and do you get me (yes) I'm not able to suss things (mmm) that I used to be able to do and I didn't get it right away, but since I put the phone down I thought, I go over it, and I thought how sweet of him (mmm) at the time I didn't know what he meant, you're not pulling the leg or something the system and I thought what system there is no frigging system (laugh) (yes) Not in mental health there ain't (yes). Maybe if I was psychotic I might get help. I shouldn't say that, I wouldn't want to be psychotic (no).

CC- You still have every right to access help like everybody else though

X- Yes but I mean I have had years when I didn't feel believed (mmm) I had one GP, I'd never met her before and she ran out of the room so I looked at the monitor while she ran out and it said schizophrenia, well I now actually think I am schizophrenic. You know cause I've had so much trauma since then (mmm) it's one of the main causes, there are 8 types, you probably know this (mmm) you'll know more than me won't you.

CC- I do know about schizophrenia

X- I didn't know there were 8, I thought there was just paranoid schizophrenia, I thought that was it, because there's 2 in my family by the way. So there is mental illness in my family (yes yes). So ... both parents were (mmm) so I was born to the wrong people, you know what I mean

CC- Well you were born susceptible to it weren't you

X- Yes exactly, exactly mmm I see things and hear things (yes) but I'm mmm she ran out as if I was some threat to her and mmm she never came back (oh dear) and I'm sat there thinking, I'm harmless you know what I mean, need medication, need counselling, I'm traumatised. Never saw her again (laugh) (oh dear). So yes I will bloody sue one day because I've had some bad you know what I mean (mmm) just been misjudged, this is why even an addict, I won't judge them because I know it's an illness (yes) Do you understand me (yes) and I have had so much misjudging all my life, every Psychiatrist, are you a prostitute, are you promiscuous no, no decant. They look at you like you're lying, are you an alcoholic, T-total. Paul? Danny? was an alcoholic. My ex-husband was an alcoholic. Do you use drugs – no, don't even like prescribed drugs. Do you know what I mean it's all mmm for somebody like me I just felt like I was never treated as an individual, I was just classed as mentally ill, nothing else. Just one of millions (yes) Do you know what I mean, I've never harmed anybody, I never would, I couldn't bear the thought of harming anyone. Do you know what I mean. I give the bloody homeless money, when I'm

on benefits mmm I have given mothers up there who are addicts, but I've bought the tin of milk for the baby, they probably sold it for drugs later on, to get their drug money, but I did my bit, you know what I mean. I am sorting some stuff out at the moment for the homeless because I've been homeless myself. Do you know what I mean. I know better than anybody else. I'm more decant than a lot (yes) That's what hurts me (mmm) All my life my decency has never been recognised. I don't want a bloody medal you know what I mean. My friend calls me unique, I don't know what she means by that. It's just me (laugh) she's tight as arse holes, she can't give a penny, she rich, big posh house (mmm).

CC- That's how the rich stay rich isn't it

X- Took me about 3 years to even slightly bond with that – yes, she text me MINDs number last night, I thought god, I've known her about how many years, but she tries bless her, but she irritates me a lot (mmm) I didn't miss her that year but I not OD's - close (yes)

So I've done well not to crack till I can laugh at myself

CC- Well yes and I suppose we're coming up the end now but I suppose

X-good I'm drained – (laugh) only joking – but I am a bit

CC- I do really really thank you for your time I know it's been difficult

X- No I look forward to it, yes, I've been dying to get a lot off my chest for years.

CC-Good

X-For years, how bad it is.

CC- Well I have going to leave you some numbers but I'm sure that you've probably already go them but more importantly I think on here is just a little bit more of an explanation of the project that I am doing

X- Yes – is it your thesis

CC- It is my thesis I'm doing a doctorate so when I have completed it and I have written it up mmm I will be sending you a copy mmm which you can read if you want to read it

X-Oh I will yes I'll analysis it

CC-Well I will be sending you a copy and just again, just to reassure you that mmm you will recognise yourself in it, in the transcript because we've had this conversation

X- Don't forget I've short term memory – I've no short term only long term

CC Well what I might do when I send, it depends how long it takes me to write it. When I send it to you what I will say is your patient, because I'll name the patient's 1, 2, 3, 4, 5 – I'll tell you which one you are.

X-Oh right

CC-So when you're reading it you know which one it is.

X- Like you say, I probably forget it, but it depends how I am

CC-Yes – well absolutely but nobody else would.

X-And hopefully very well by that time. Well hopefully yes – we will see, if I get some

CC-Hopefully so – but there are some numbers on there if you do need them, I know you've probably already got them.

X- Are all the other patients complex

CC- They are all very different, they are people that have used the police line, so that's the only thing that you have to have in common

X- Oh right, Are they mentally ill though

CC- Yes – they have to be. So it's people that have got vulnerable presentations and I suppose what I am trying to get to a point of is when people feel like that, what sort of things will help. So someone coming to your house, I think was mentioned.

..... to leave it? Understanding you, having your notes, being able to

X- Been in system 17 years – there's no excuse is there

CC- So it's all those things that would help

X-There shouldn't be an excuse for that

CC- So what you've been able to contribute to is hopefully a better

X- Because I always used to ask for help but not anymore (no) no. You're on your own.

CC- Well hopefully you might use some of these numbers

X- Laughing.....

CC- I'll leave that with you mmm like I said thank you very very much for your time today and I know it's not been easy

X- No it's alright, it's just I'm not with it at the moment but it's not been any pressure, don't worry. I wouldn't have done it if I weren't up to it.

CC-Aw that's very kind of you – thank you

X-I've got a heavy day love, whether you're here or not, so

Interview ended

De-Brief as per agreed data collection process then took place unrecorded