The dodo bird verdict and the elephant in the room: A service user-led investigation of crisis resolution and home treatment

HUGH MIDDLETON

School of Sociology and Social Policy, University of Nottingham and Nottinghamshire Healthcare NHS Trust, Nottingham, UK

REBECCA SHAW

Independent Service User, Mental Health Research Practitioner, Nottinghamshire, UK

RON COLLIER

Independent Mental Health Research Consultant, Nottinghamshire, UK

AIMIE PURSER

School of Sociology and Social Policy, University of Nottingham and Nottinghamshire Healthcare NHS Trust, Nottingham, UK

BRIAN FERGUSON

Lincolnshire Partnership NHS Foundation Trust, Lincolnshire, UK

ABSTRACT

Recent years have seen an international move towards home treatment of acute mental health difficulties. This has been based upon trial data which do little to develop understanding of how or why this approach is as effective as it seems to be. In order to explore this question the study interviewed patients who had recently used the services of a crisis resolution home treatment (CRHT) team in the English East Midlands. Triangulated parallel qualitative analyses of 33 semi-structured interviews conducted by service users trained in research techniques demonstrated that successful CRHT reflected practitioners' ability to provide clients with a sense of feeling safe, accepted and understood. Unhelpful outcomes followed when participants did not experience such unconditionally supportive relationships. These findings further endorse the primacy of relational factors in mental health practice. They are discussed in relation to the Dodo Bird verdict upon psychological therapies and systemic difficulties acknowledging an inconvenient truth.

KEYWORDS: mental health; community treatment; erklären; verstehen; epistemology; common factors; sociology

INTRODUCTION

One of the threads uniting the study of mental health difficulties and those who administer to them with social science is that both are continually challenged by similar epistemological, conceptual and methodological issues. Karl Jaspers is credited with first applying the terms *erklären* (translated as 'to explain') and *verstehen*

(translated as 'to understand') to different ways of making sense of mental disorder or difficulties almost 100 years ago (Jaspers 1913 [1963]). This distinction has been familiar amongst social scientists for as long, if not longer. Wilhelm Dilthey (1833–1911) is credited with introducing the terms into philosophy and human sciences. The conceptual and methodological implications of distinctions between explanatory and interpretive approaches to social knowledge are explicit in the works of Emile Durkheim, George Simmel, Max Weber and Talcott Parsons. They include distinctions between positivist and anti-positivist epistemologies, approximately parallel distinctions between quantitative and qualitative research methodologies, and the different implications of nomothetic, dimensional and idiographic approaches to classification.

In terms of Jasper's application to mental health issues, *erklären* is the development of knowledge that might inform a more mechanistic, medical approach, such as when and how to apply a formal diagnosis, prescribe a medicine or offer a psychological 'treatment'. This form of knowing is generally derived from an external, 'expert' perspective using an experimental and positivist approach generated by quantitative methods. By contrast, *verstehen* places emphasis on capturing patients' unique lived experiences of their psychological/emotional distress and assisting them through a dialogue that acknowledges it. This form of knowing is generally derived from accounts of experiences or being administered to during an episode of psychological difficulty using an interpretive approach generated by qualitative methods. Broadly, following decline in the popularity and influence of psychoanalysis and rising interest in psychopharmacology during the 1960s and 1970s, mainstream mental health practice and policy making have followed an ideology based upon the former: mental health difficulties are viewed as 'illnesses to be treated' rather than the result of individuals' sufferings as they negotiate life's challenges.

This ideological position faces a growing number of criticisms. They include several coherent accounts which suggest that claims for efficacy amongst psycho-pharmaceuticals may be at least as much a marketing ploy as they are dispassionately obtained scientific findings (Kirsch et al. 2008); the voices of dissatisfied service users empowered by more consumerist approaches to healthcare (May 2010; Hearing Voices Network 2011); and more individualised approaches fuelled by needs to respect the diverse expectations and experiences of a racially and culturally heterogeneous population.

One area of practice where challenges to the dominant 'illness' ideology are prominently visible is in the activities of home treatment or crisis resolution teams. In recent years crisis resolution home treatment (CRHT) teams have become an integral part of mental health services in many parts of the world. Broadly, they were introduced to provide an alternative to the commonly stigmatising and intimidating experience of being admitted to an acute mental health inpatient facility when in crisis. Circumstances which might benefit from CRHT team support and which previously may have resulted in admission include intensified derogatory auditory hallucinations (hearing voices) causing distress and desperate behaviour; depression and despair leading to acts of self-harm or suicide, where emotional support, practical help and perhaps attention to medication can be helpful; and intense anxiety impeding the ability to get out and about and tend to essential needs and responsibilities such as shopping or childcare. Of necessity CRHT teams address problems well beyond the administration of medicines and provision of specific psychological therapies. CRHT practitioners are inevitably called upon to engage with the individualised details of their clients' lives and circumstances.

The earliest Australian research into the effectiveness of psychiatric home treatment was conducted by John Hoult and his colleagues. This study involved 120 people who would otherwise have been admitted to North Sydney's Macquarie Hospital, and it demonstrated quite clearly that home treatment was a viable alternative,

provided better outcomes and was considered more satisfactory and helpful by patients and relatives (Hoult and Reynolds 1984). It followed a similar investigation in the US (Stein and Test 1980), and subsequently a similarly influential trial was undertaken in the UK (Dean and Gadd 1990). These trials have played a central part in encouraging moves to home treatment of 'mental illness' wherever possible. In the UK these moves were driven by explicit Department of Health target-focused policy implementation. National Health Service (NHS) commissioning and provider organisations were obliged to ensure that mental health CRHT was available to the entire working age population of England by the end of 2004. The population to be covered by any one team was specified (150,000), as was the size (14 full-time equivalent members of staff) and composition of each team (Department of Health 2001). When surveyed in 2005–2006, 243 teams were identified that followed a variety of practices and service arrangements, and many acknowledged that their teams were not yet fully constituted (Onyett et al. 2008). Nevertheless, where a CRHT team had been established there was an impact on bed usage (Glover et al. 2006). In addition, there has been continuing evidence of service user and carer satisfaction (Johnson et al. 2005). Thus, the recent English introduction of CRHT was based upon seemingly robust evidence, amounted to a major change in mental health policy involving significant investment, and was achieved by robust management. On the whole it has resulted in popular outcomes (National Audit Office 2008).

Despite this success, closer scrutiny suggests that the evidence used to support these changes and investment is not what it seems. Although the development of CRHT in Australia, Europe and the USA was encouraged by clinical trials, there are limits to how well this research actually informs clinical practice. Based as it is upon a positivist epistemology, it cannot illuminate the qualitative (inter)subjective details of relationship which inevitably occur under such circumstances and which may be significant in determining

outcomes. Convention demands that psychiatric research teams emulate the gold standard of randomised controlled clinical trials (RCCT). However there are few circumstances where this is wholly possible. Generating knowledge which can advance explanation of the effects of different treatments in a way that truly and empirically supports statements, such as 'this intervention has that outcome and that intervention has this outcome', assumes an experimental design rarely available in mental health circles. The RCCT is regarded as 'gold standard' in the hierarchy of clinical trials evidence because it is assumed to achieve the conditions of a properly conducted scientific experiment wherein all contributing variables are held constant, apart from the object of the hypothesis under examination. In a routine and credible RCCT this means that the only distinction between subjects receiving the experimental treatment and those receiving the control treatment is the intervention under test. In particular, subjects must be unaware of whether they are receiving the test treatment or control and administering practitioners must be equally blind to the subject's treatment status, as must any third party engaged to assess outcome. If any of these very strict conditions are breached then very real possibilities of expectation, bias and placebo confound the interpretation of differences between experimental and control treatment outcomes. It is likely that discernible drug side effects have distorted evaluation of psycho-pharmaceutical treatments in this way (Middleton and Moncrieff 2011). How much more likely is it that similar confounds may have occurred in the evaluation of home treatment, where treatment status cannot be obscured at all?

This argument does not deny the relevance of trials which report improved outcome with home treatment or indeed a great number of clinical trials from other areas of mental health research. It simply draws attention to the fact that their findings cannot be regarded as anything other than merely pragmatic. When *these* patients were provided with *this* package of care in *this* community setting (Madison, Wisconsin; Sydney, NSW or

North Birmingham, England), they fared better than peers who did not receive such a package. There is no epistemological justification for considering these findings evidence of a generalised scientific 'truth'. They do not explain mechanisms underpinning successful recovery at home, or otherwise; they do not contribute to *erklären,* and it is reasonable to argue that the same is true for the majority of so-called evidence based statements about treatment for mental health difficulties. Although seemingly conclusive, they are based upon evidence from trials purporting to fulfil RCCT criteria in circumstances where that is rarely if ever possible to achieve: medication without discernible side effects, patients unable to judge which of the various treatment options they are receiving, and practitioners and assessors truly blind to their clients' treatment status. Particularly in the case of CRHT interventions, it is an epistemological fallacy to argue that clear and positive clinical trial findings from a setting that cannot fulfil strict RCCT criteria may be generalised and somehow add to knowledge concerning underlying mechanisms. There is good evidence that certain packages of care provided in certain settings result in better outcomes than other approaches but research to date provides no explanation or understanding of why this is so.

Crisis resolution home treatment is a complex intervention with a great deal of scope for contextual variability. Theoretical approaches to crisis intervention consider a series of phases, steps or stages exemplified by Roberts' seven-stage model. This specifies a process that begins with assessment and moves through, in turn, establishing rapport and relationship, identifying major problems, dealing with feelings and emotions, generating and exploring alternatives, developing and formulating an action plan, and establishing a follow-up plan and agreement (Roberts and Ottens 2005). Prescriptive expectations set by the Mental Health Policy Implementation Guide include problem solving, brief supportive counselling, and social interventions. Some potentially useful procedures are also identified, such

as assistance with benefits and housing, education about crisis and the illness, and frequent contact (Department of Health 2001). While these details provide a framework for intervention, they do not specify the actions CRHT team members might take, and therefore fail to identify what it is that results in the observed favourable outcomes.

Considering a complex treatment package such as CRHT as a whole and subjecting it to clinical trial is clearly an oversimplification. More detailed investigation of what a package could contain, in terms of facilitating recovery from crisis, is needed if the activities of CRHT teams are to be improved and refined. This could be approached as a series of empirical investigations testing specific hypotheses about individual elements of the service. However, the available theory and empirical findings (Dean and Gadd 1990; Department of Health 2001; Hoult and Reynolds 1984; Johnson et al. 2005; Roberts and Ottens 2005; Stein and Test 1980) all point to more individual and subjective phenomena. In other words, this is an important illustration of the need to approach such a question from a different point of view and with a different set of research tools; to seek understanding or to acquire *verstehen*. If the aim is to further knowledge with a view to refining the activities of CRHT teams and other mental health practitioners, then it would seem obligatory to adopt a different epistemological position from which to conduct research explicitly focused on developing understandings of the (inter)subjective or relational dimensions of therapeutic activity.

This is commonly approached by obtaining accounts from participants and subjecting them to formal qualitative analysis. Such accounts are usually obtained by a clinician or a professional researcher which introduces a particular perspective. Under these circumstances the participant is inescapably the subject of investigation and therefore restricted in his or her ability to communicate subjectivity (Godin et al. 2007) or fully recount experiences as a human narrative (Charon 2004). Full understanding would require

co-participation but this is an unrealistic goal in most structured research settings. However, it can be approached when those obtaining accounts are truly able to empathise with the participant; when the investigation is conducted by individuals who have equivalent experiences of such clinical environments and contexts, and can truly provide such empathy (Clark et al. 1999; Lester et al. 2006; Mishler 1986; Rose et al. 2006). In order to outline these methodological goals and illuminate processes underpinning successful and unsuccessful CRHT, we report on a piece of service user led research investigating the experiences of receiving care from a CRHT team.

METHODS

This research received formal Research Ethics Approval from North Nottinghamshire NHS Research Ethics Committee, Application Reference 07/Q2402/3.

Interviews were conducted with 36 service users of the nine CRHT teams that cover a mixed urban/rural population of 1.2 million in Eastern England. The sample comprised 13 males with a mean age of 42.9 years and 23 females with a mean age of 44.3 years. A series of focus groups attended by service users and carer representatives identified domains to be covered. All patients newly referred to the teams during a two-week census period were invited to take part in the research. They were given written information by their treating teams, along with a response paid envelope addressed to the research group. There was no further involvement by the crisis teams and participants were advised that their individual responses would not be shared with the treating team.

The preliminary focus groups resulted in a semi-structured interview schedule that explored the experience of negotiating a period of crisis with help from a CRHT team. Orientation was supported by inviting a short reconstruction of events leading up to the crisis, after which respondents were invited to outline how family, friends and other sources of informal support

had contributed, and whether it was helpful or unhelpful. They were asked to outline how they had made contact with or had been referred to the CRHT team; their experiences of this first contact with the team; what the team had done for, to and with them; what had proved helpful and what had proved unhelpful. Additional questions were asked about ease of access, advanced directives, and involvement in relapse planning and decisions about discharge.

Interviewers were trained at the outset and workshops were held during the project at which they had an opportunity to review one another's experiences and techniques and resolve differences. All were people who identified themselves as having significant experiences of receiving care from mental health services or of providing informal care for someone with mental health difficulties. They interviewed in pairs to provide mutual support and ensure safety.

Thirty-six interviews were conducted in interviewees' homes or third party venues, such as general practice premises. All interviews took place within 2–6 months after the index referral. All were tape recorded. In two instances the recording was technically unsatisfactory and in one instance an interviewee's carer made so substantial a contribution that the interviewee's own contribution was negligible. A decision was made not to include these three interviews in the analysis. Thus, findings are drawn from 33 transcripts.

Transcripts were analysed by two processes conducted in parallel. One was carried out by a group of interviewers supported by a research consultant, and the other by a post-doctoral career social scientist with formal qualitative research training who had had no prior contact with the primary data. There was no interaction between the two analytic processes until both were declared complete. This approach has allowed 'triangulation' of findings between the two approaches, confirming the validity of each insofar as they agree. A broadly defined grounded theory (avoiding a priori assumptions) approach to identifying the phenomenology (subjective

experiences) of interviewees' interactions with the team and others that were either helpful or delayed recovery was adopted by both. The service user researchers chose to consider the transcripts stage by stage, as the interview proceeded through the respondent's recollections of their 'journey', and then aggregated these into an overall view of 'What helps recovery?' and 'What hinders recovery?'. The academic sought answers to 'What was helpful?' and 'What was unhelpful?' from the transcripts as a whole. She found little consistency amongst them when considered at the level of specific concrete actions or inactions on the part of the team or others, and sought common themes at a higher or more abstract level.

RESULTS

The service user researchers' findings summarised the content of transcripts that referred to influences aiding recovery as follows:

- *Reassurance:* Knowing that there was someone who understood what was happening and was available either in person or by phone.
- *Positive relationships:* The experience of non-judgemental consistency, acceptance and understanding.
- *Involvement in the process:* An experience of control, making their own decisions and having choice in what was done to or for them.
- *Practical support:* Assistance with household tasks, shopping, cleaning, gardening and childcare, which relieved pressure.
- *Access and flexibility:* Feeling that support was available from professional services, family or friends when it was needed and in an appropriate form.

Their summary of influences that hindered recovery was:
- *Unhelpful attitudes and behaviour:* Anything, particularly relational factors that interfered with any of the above, helpful relational issues.
- *Un-met expectations:* Disappointed, unrealistically high expectations as a result of misleading information.

- *Lack of continuity:* Where this was experienced it hindered development of an effective supporting relationship with the team.
- *Lack of appropriate or sufficiently well organised follow-up:* A common experience was poor availability of follow-up provision such as psychological therapy or other services. Where involvement with CRHT had to come to an end before another indicated provision could become available, the experience was an unhelpful one.

The post-doctoral social scientist was less drawn to the mechanics of service provision and more to the subjective experiences different activities and contacts evoked. Her analysis distilled the transcripts to central roles for whether or not contact with the team, or informal carers had resulted in a sense of feeling safe, accepted and understood:

> Just knowing somebody was there for you was nice. And that's what the CRHT team did when they got involved. They were a constant reassurance … the fact that they understood or seemed to understand what I was going through was really reassuring, and the fact that I could contact them at any time was also helpful. Although I didn't do it, I knew I could if I needed to … and also to know that other people were like that as well. Because they would say, 'This is what other people have told me', and you think … 'You're not just on your own with it'. (Female, number 10, 53 years old)

In more detail, these resonate very closely with the service user researchers' conclusions.

Safe

The experience of feeling safe was a reflection of knowing that the team was there or available, a sense of consistency in what they were providing and an experience of being in safe hands. 'Knowing that they are there' was facilitated by consistency and stability in the team's availability. This included both a routine of visits and phone

calls and the experience of sensing that the team was always available to them. Critically, availability reflected the trust and confidence the service user had in the team's ability to catch them should they fall:

> Knowing that they were always at the end of the phone, knowing that it was 24 hours available to me. If I was going through a difficult time I could ring them up and talk to them over the phone … I didn't really use that service but I knew it was available to me, and it was there if I wanted it. That was obviously beneficial for me, knowing they were there 24/7. (Male, number 3, 24 years old)

When the experience felt unsafe, the outcome was less satisfactory:

> I found they weren't there when I needed them. I'd got nobody else, I've told you that, and I'd been promised they'd be there, day, night, any time I needed to speak, to talk to them, they would be there for me, to express I suppose what I was going through. My grief, I suppose, weren't it? And they weren't. And because they weren't, I just went back on the booze. (Female, number 15, 53 years old)

Accepted

Experiences were considered helpful when the interviewee felt unconditionally accepted; not judged or considered personally responsible for events leading up to the crisis. When this was violated the experience was unsatisfactory and unhelpful:

> Her answer to me feeling suicidal was, 'Would you like to go swimming'? [Laughter] … 'I can see you if you'd like to go swimming'. [Laughter] So she could see me more often than three weeks if I went swimming. And there's no way I could face going swimming, not how I was feeling, no way. (Female, number 7, 37 years old)

Many expected to feel judged and responsible for their own difficulties, and found the development of a relationship that did not carry those demands was therapeutic in its own right:

> It was very difficult to start off with. I can remember I couldn't even look at them, and I had this terrible paranoia that they were going to section me, and they went to great lengths to explain that they look at risk from a positive point of view and they do everything they can to keep me in my home. The more I realised how non-judgmental they were and how they really wanted to work with me and not to me, sort of thing, not directive, the more I think I started to relax. (Female, number 4, 44 years old)

Understood

Feeling understood referred to experiences enabling the interviewee to feel that the team could empathise with experiences of crisis. This extended beyond experiences of the CRHT, but was exemplified by them, and included appreciation of the service user's need for practical support and appreciation of how the service user understood and experienced his or her particular difficulties. The experience of being listened to by others who seemed to understand their difficulties was often reported as particularly helpful, and the frequent use of first person expressions emphasised the importance of a professionally appropriate empathic understanding:

> Yes. I did [feel understood] because two of them had gone through similar problems and although they didn't go into their problems, they said they'd experienced similar types of feelings. (Female, number 18, 45 years old)

Feeling understood was related to the team's sensitivity to the interviewee's social context, including the potential stigma of being identified as a mental health patient:

> One experience with them that actually set me back quite a bit: it was quite near the beginning and two came that didn't really know me. They came to the door, one of them was

carrying their diary, you know I'm paranoid about people thinking, you know because if you're not used to having people coming to your door and the neighbours, you know, curtains do twitch, and you've got this diary, and looking all sort of official, and they came in and they quite clearly knew nothing about me. (Female, number 4, 44 years old)

DISCUSSION

Although the two independent analyses of the transcripts were conducted in different ways, and from different perspectives, their conclusions were consistent and 'triangulated' upon an important (though not necessarily surprising) conclusion. Contact with the CRHT team was considered helpful if it resulted in the experience of a supportive, understanding and unconditionally accepting relationship. It was considered unhelpful if this experience was undermined in any way.

Experiences of care and whether they are perceived as helpful or otherwise offer an important perspective for researchers and policy makers. This is probably just as important in the context of the experiences of care provided to individuals suffering acute emotional distress as it might be anywhere. In this study, interviewers were struck by the intensity of the experiences their respondents recalled and their sensitivities to relational influences that were or were not helpful. It is often difficult to get an unbiased account of something as intimate as emotional distress or psychological breakdown, but these respondents appeared to be giving a full account as they shared their experiences with someone who could genuinely empathise. Thus, these accounts are both evidence of the experiences of encountering health care practitioners in times of exceptional need, and validated by the way in which they were obtained. The possibility that conclusions might be limited to the context in which they were generated has been mitigated by the use of two, triangulating analyses.

The 'professional' analysis resulted in an abstraction that identified senses of being 'safe', 'accepted' and 'understood' as the core features of a helping relationship conducted in this situation. From a more structured point of view, the unhelpful effects of misunderstanding practitioners, the need to negotiate organisational structures, the perceived availability of practitioners' time and their flexibility were all regarded as important determinants of how successfully or otherwise that was achieved. Marking clear resonance with the 'professional' analysis, the service user researchers placed central importance on similar determinants of a quality relationship: availability, consistency and unconditional respect. They also drew attention to some of the organisational determinants of these outcomes, good and bad. Their findings resonate strongly with similar research conducted amongst individuals recently admitted to a psychiatric inpatient unit (Mishler 1986) and with quantitative analysis of routine psychotherapy outcome data (Stiles et al. 2008), both of which also assert the importance of relationship in achieving a successful therapeutic alliance.

The importance of the therapeutic relationship in mental health care and other medical endeavours has long been recognised (Frank 1961; Lester et al. 2006). In the context of formal psychological therapies, the pre-eminence of relationship, the so-called Dodo verdict or equivalence paradox, has been recognised for three quarters of a century (Rosenzweig 1936) and has recently been reviewed by Budd and Hughes (2009). The Dodo Bird verdict or equivalence paradox refers to the fact that non-specific features of the relationship between client and professional play an important, if not overwhelming, part in determining outcome. This is a central and often acknowledged feature of informal practice wisdom but it goes largely un-researched by academics and unaddressed by managers and commissioners.

Our findings amongst users of CRHT teams provide yet another illustration of this

important, but commonly overlooked, dimension. They draw together earlier theories concerning the potential for personal growth and development triggered by a 'mental health' crisis (Brandon 1970), recent research and conceptual development concerning growth following adversity (Joseph and Linley 2006), and reflections on the non-specific features of the therapeutic relationship. Unlike formal psychotherapies, such as cognitive behaviour therapy, but common to many 'psychiatric' encounters, CRHT is essentially a-theoretical. As accounts of CRHT emphasise, under these circumstances elements of the relationship *are* the therapy. They point to a need for approaches based upon epistemology which can address inter-subjective phenomena, such as a helping relationship. Relationship is a key human attribute and it is barely surprising to find that it plays a central part in determining how well an individual weathers a period of emotional/psychological distress. Theory and guidance of practitioners charged with providing for the distressed (Roberts and Ottens 2005; Department of Health 2001) encourages processes that might achieve this, but does not explicitly articulate them. This reflects a gap in the knowledge needed to better inform practitioners and managers of mental health services and points to a need for research to address it.

Relationship cannot be measured and identified as a variable contributing to part of an empirical experiment. As an inter-subjective phenomenon, it is idiographic, anti-positivist and accessible only through qualitative, phenomenological and interpretive methods. It is notable that a phenomenon so central to psychological well being and the outcomes of mental health service interventions is so inaccessible to research based upon a positivist epistemology. A research agenda that does justice to the self-evident importance of common or non-specific features must respect the importance of subjectivity and employ appropriate methods to study it.

This is problematic in a world dominated by the ideology of *erklären*. At present a high quality, collaborative therapeutic relationship is generally considered a desirable, but not central, feature of 'treatment' or the commissioned care pathway. As a result, when other more 'evidence based' or organisationally pressing priorities intervene, attention to the therapeutic relationship is often neglected. To a large extent this is because the evidence base which legitimises these activities is drawn from a narrowly positivist epistemology. The Dodo Bird verdict and research such as that reported here point to the likelihood that mental health outcomes are strongly determined by inter-subjective phenomena that cannot be investigated in this way.

Perhaps, for many, this is an inconvenient truth or an elephant in the room; that research seeking *erklären* and based upon positivist approaches to knowledge is only of limited application to the understanding of mental health difficulties and how they might be addressed. Elephant in the room or not, this is an issue social scientists and mental health practitioners have held in common for many years. Though it may have been studiously ignored in mental health circles during recent decades, perhaps this is beginning to change.

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