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Double helix of research and practice—developing a practice model for crisis resolution and home treatment through participatory action research

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Abstract
Over the last five years Crisis Resolution/Home Treatment (CR/HT) teams have been established in Norway. These teams provide an alternative to in-patient acute care services offering assessment as well as direct care. This paper addresses a method of examining the nature of practice models that are being developed in a CR/HT team incorporating the philosophy of open dialogue and the open lifeworld approach. The overall design of this research is action research applying a cooperative inquiry perspective. Multistage focus group interviews are used as a method for generating data, followed by phenomenological–hermeneutic approach in analyzing the data. Three themes were identified: (a) "keeping the dialogue open" referring to the emphasis of openness in dialogues and opening up for a variety of perspectives on what's going on; (b) "tolerance of uncertainty" referring to the need to accept and deal with uncertainty and multiplicity; and (c) "nurturing everyday life issues" referring to the emphasis on illustrating clinical situations in detail through remaking of stories. The on-going co-processes of research and practice was a double helix that links the happenings in the practice with the findings in the research revealing the knowledge in practice and further developing that knowledge.

Key words: *Cooperative inquiry, open dialogue, knowledge dialogues, mental health care*

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Introduction

In Norway, models of community care are now being established that target to minimize hospitalization and maximize the acute care and rehabilitation within the context of the family and social environment of the individuals (European Commission, 2005). One significant recent development is Crisis Resolution/Home Treatment (CR/HT) teams that provide an alternative to acute in-patient care, offering assessment as well as direct care (Johnson, Lloyd-Evans, Gilburt, & Slade, 2007; Karlsson, Borg, & Kim, 2008).

Although community mental health care has a long history and it has evolved to encompass various service models in practice, it has often been associated with rehabilitation. The major focus of CR/HT teams is to provide appropriate services for acute crisis events, and this shift in focus from rehabilitation to crisis management calls for development of relevant practice models. The present paper addresses this need through an investigation of an evolving model of practice in a newly established CR/HT team. The research questions addressed in this paper are: (a) What are the processes used by a CR/HT team in developing its new practice model and (b) What are the characteristics of knowledge being developed in the team?

The research context was the practice of team members of a local CR/HT team, which started in this model of service in 2007. The team members as active participants in this participatory action research were involved in an on-going process of developing their practice in the new service model through practice and research. Research and practice were thus interlinked to produce an emerging model and knowledge for practice. The relationship between qualitative research and practice development in the mental heath services is not new and has

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been highlighted by Davidson, Tondora, O'Connell, Kirk, Rockholz & Evans (2007).

Background—the research perspective

The idea of CR/HT teams encompasses a shift in practice to service-user orientation, emphasizing active participation of service-users and family members in the service provision and the mental health care processes in the everyday life context (Ball, Links, Strike, & Boydell, 2005; Borg & Davidson, 2008). This orientation was the basis for the research approach incorporating the perspective of *open dialogue* as the base for practice and *the open lifeworld approach* as the principal posture for the research process.

The social network theory named *open dialogue* (OD) was developed in Finish Western Lapland in the early 1980s (Seikkula, Aaltonen, Rasinkangas, Alakare, Holma & Lethinen, 2003), and later inspired service development in many countries, particularly in Scandinavia (Seikkula, Aaltonen, Alakare, Haarankangas, Keränen & Lethinen 2006). The basic philosophy of OD is providing family-oriented services for all patients within their individual and social support systems. Three principles of communication practices are fundamental in OD, which we also found helpful in the research: *the tolerance of uncertainty, dialogism*, and *polyphony in social networks* (Seikkula et al., 2003, 2006). These principles are critical for generating knowledge for and in action (Hummelvoll, 2008; Schøn, 1987). *Tolerance of uncertainty* is developed through continuity in support and frequent meetings among service-users, families, and professionals and by the quality of the dialogue with emphasis on available help and support and trustworthy relationships. Hearing out and responding to every person's voice and point of view is the typical way of ensuring trust and safety. When this kind of tolerance for an often-chaotic situation is developed, it increases the dialogical possibilities within the family and social networks, and it is possible more easily to talk about and reflect on the experiences of crisis. The *practice of dialogism* is strongly inspired by the Russian language philosopher Bakthin (Seikkulla et al., 2006). In OD, language and communication are seen as primary constitutes of social reality where constructing words and establishing symbolic communication is voice-making, identity-making, and getting involved in activities jointly among persons. A crisis becomes an opportunity to make and remake the fabrication of stories, identities, and relationships that construct the self and a social world. The idea of listening is very important in OD, and far more important than interviewing. The term *polyphony* in OD refers to the inclusion of voices of all persons involved in a crisis situation. Every person in a situation can contribute to the conversation in his or her own way. An important rule is that everyone present has the right to comment (Seikkula et al., 2006). Questions or reflections within the meetings should not interrupt on-going dialogues except used to clarify and make sense of themes that are present in the situation. The shift between listening and talking in the reflective process generates new opportunities for participants to renegotiate their experiences (Haarakangas, 1997; Hultberg & Karlsson, 2007).

These three principles of communication in OD align well with the basic terms in *the open lifeworld approach* (Dahlberg, Dahlberg, & Nyström, 2007). The open lifeworld approach in research is based on two fundamental orientations: the phenomenological turn to "the things" being studied, i.e., the phenomena themselves, and secondly the demand of sensitivity to "the things." "Going to the things themselves" involves approaching the experienced reality with the objective of understanding the phenomena from the perspective of the experiencing persons (Dahlberg et al., 2007).

In the philosophy of OD and the open lifeworld research there is no conception of truth or reality that can be separated from or outside of human expression. The meaning of any phenomenon is generated and created through dialogues in social relations as words and stories are shared in a common and intersubjective discourse. The research into the process of establishing a CR/HT team and developing practice processes within the team, therefore, began with these perspectives as the foundational ideas.

This research thus addresses how mental health clinicians evolve in developing their practice in CR/HT to align with these perspectives. In this research, the focus is on the clinicians because it is assumed that OD and the open lifeworld approach require changes in both the commitment and behaviors of the practitioners, and these philosophies are generally counter to the traditional orientation of professional dominance and control.

Methods

Design

The overall design of this research is action research applying a cooperative inquiry perspective. Cooperative inquiry refers to a variety of approaches, and it is regarded as particularly appropriate in action research based on participatory philosophy (Kemmis & McTaggart, 2000). The research questions were

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addressed through this participatory action research involving a team of mental health clinicians. In order to address the research questions through this research design, we selected a CR/HT team that was being established in a local service sector in Norway. The research was implemented with an assumption of OD and open lifeworld approach as the foundation. The design was longitudinal, qualitative, and cooperative.

The approach—cooperative inquiry and focus group meetings

Cooperative inquiry involves not only integrating theory and research into the practice of participants (Karlsson, 2004), but also developing new knowledge through the inquiry process itself (Cornwall & Jewkes, 1995). Researchers and participants in the role as co-researchers work collaboratively in identifying problems, deciding on themes for inquiry, selecting a research design, and designing projects for clinical implementation (Reason, 1994). In a cooperative inquiry practice innovation runs parallel to the research process. It is essential that the researchers take an active part in the on-going, innovation process, and do not become isolated as outsiders who observe events as they occur (Cornwall & Jewkes, 1995).

In the present study multistage focus group meetings were adopted to engage the clinicians actively in the research. The open lifeworld approach incorporated into the focus group meetings provided the perspective that the development of practice processes for the CR/HT team would emerge from the experiences of the clinicians themselves. The multistage focus group is characterized by exploring a certain theme or phenomenon through several meetings, and is described by Hummelvoll (2008) as inquiring into knowledge dialogues emerging from experiential material. In this way it is possible both to articulate the participants' clinical knowledge and to elevate this experience-based knowledge to a higher level of abstraction. The focus group meetings, although open and free flowing, were facilitated by the researchers in order for the participants to become immersed in the philosophy of OD as the base of their practice.

Data collection

Focus group meetings were held monthly in order to follow, attend, and discuss the processes through which the clinical practice developed and innovations were implemented. The clinical team decided on the topics they wanted to attend to and discuss, although the participants were aware of the aim of this research, i.e., to develop their practice in a new model of practice. Often the discussions began as responses to what patients or families communicated to the members. Because the meetings started in the period of establishing the CR/HT team, topics discussed were clinical, ethical, theoretical, as well as organizational. This paper reports the results from the four focus group meetings, of which transcripts and logbooks kept by the researchers were the material for analysis. The first two authors participated in all meetings and a research fellow took part in the last two. Each author wrote down impressions and reflections in logbooks after the focus group meetings. The meetings were audio-taped and transcribed. Summarized notes of the transcriptions for each meeting were shared with the participants (the clinicians) at the beginning of the subsequent meeting for feedback and in order to provide a context for "dialogue-based" changes and implementing the elicited knowledge in daily practice. The duration of the meetings was usually 1.5–2 h. The team members were eager in raising topics of concern related to service development and implementation. In the four meetings the topics in focus were "clinical judgment," "mental health crisis," "safety," "team profile," and "team communication and collaboration," the first two topics being the most predominant ones that were elaborated at the meetings.

Informants—co-researchers

The participants in the study were all members of the CR/HT team, consisting of 12 professionals—one psychologist, two social workers, and nine mental health nurses (three men and nine women). In the four focus group meetings 10 of 12 team members participated. Absence was due to clinical responsibilities and personal illness. All the meetings were led by the researchers for beginning and concluding the sessions.

Data analysis

The transcripts and logbook material were analyzed by applying phenomenological reduction as outlined by Kvale & Brinkmann (2008), and Lindseth and Norberg (2004) as the cooperative inquiry research process is based on a hermeneutic–phenomenological approach (Kemmis & McTaggart, 2000). Cooperative inquiry is oriented to describing phenomena as detailed and precise as possible from the perspective of participants, and the open lifeworld research (Dahlberg, Dahlberg, & Nyström, 2007) requires the data to be analyzed from the perspective of and understanding for the experiences as revealed by

participants. A step-wise approach was used in the process of identifying themes. The transcriptions and individual logbooks were analyzed for units of meaning separately by each author. This was followed by comparing and modifying findings, and agreeing on major themes. Finally we returned to transcripts to verify and supplement findings and discussions.

Ethical issues

The project was approved by the Regional Committee for Medical Research Ethics South-East Norway and Norwegian Social Science Data Service in 2007 for both the protection of the research participants and the safeguarding and protection of data.

Results

Three themes were extracted as critical elements in the processes of developing the team and generating knowledge embedded in the clinical practice. These two processes were intertwined as the team in a new mode of service was developing as a team for crisis intervention at home and at the same time the members of the team were involved in clarifying and generating practice knowledge through their engagement in this new mode of practice and in this action research. These were "keeping the dialogue open," "tolerance of uncertainty," and "nurturing everyday life issues," which are relevant to both of these processes.

Keeping the dialogues open

This theme from Seikkula and others (2006) on OD was used both as the basis for the process for the team and for practice development as well as in the research context. The researchers from the beginning emphasized OD as the process for the team development and developing practice. This theme had three dimensions: OD in the research process, OD regarding clinical issues, and OD in practice.

First, OD in the research process meant that the participants, both the researchers and clinicians, in the focus groups were oriented to and engaged in keeping their dialogue open without feeling any constraints. The researchers especially acted on to stimulate the on-going dialogue open by engaging the participants with open-ended follow-up questions: What do you actually mean when you say "these ordinary things?," How do you deal with uncertainness and insecurity in critical situations like you just described?, or What do you usually do in these situations as when a person is just laying silently in bed? The principle of OD was practiced in the discussions as the focus group meetings typically started with a participant offering her or his perspective on a theme and the researcher following up by continuously asking for more details. After a while other members became involved in discussions bringing in new ideas and views or just elaborating on the theme. Humor, reflections, and introducing and repeating the slogan "we are among friends here" was very helpful in keeping the openness at work.

Second, OD for clinical issues meant delving into variations in ideas, approaches, and perspectives regarding clinical issues in order to gain a deeper understanding of practice for crisis resolution and developing knowledge for practice. For example, the team's discussion of clinical judgment involved remaining open with the concept.

> Researcher: But there was another concept here . . . was it you Sofie who talked about clinical judgment?
>
> Sofie: I'm a bit interested in that clinical judgment . . . in a way it is many things . . . it is what you see, it is what you have in depth experience of . . .

We continued this reflection on clinical judgment, how it can be developed in practice; how various clinical contexts can have an impact; the individual clinician's personal capacities and talents; and whether a team can develop a kind of common clinical judgment.

The discussion regarding what mental health crisis meant to the team members also reflected their openness.

> Researcher: . . . If we start with the concept of mental health crisis. What are your ideas on that?
>
> Monika: Our target group is acute mental crisis.
>
> Siri: Well, that's how it is sometimes. Like the evening shift today there was definitely a patient in a mental health crisis where we in a way decided to discharge him, as he wasn't kind of acute enough.

The researchers continued to probe by asking what differed acute from non-acute to which the nurse, Monika, continued by saying that the major difference here was whether the service-user was suicidal or not or critically psychotic or not. The team continuously came back to the issue of how crisis actually can be understood and how they as a team should define it—crisis being the target of their interventions. The discussions focused on crisis situations that sometimes seemed to be individual

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while others involved many people, like families and friends. In other situations the team saw crisis more or less permanent as they reoccurred frequently and the service-user's situation did not change. The team questioned whether a recurrent crisis situation should be defined as crisis at all. The researchers continuously reminded and encouraged the focus group members to keep their reflections going, not closing the discussions and avoiding closures with conclusive or fixed ideas.

Third, OD in practice meant that the clinicians were engaged in keeping their dialogues open with service-users and caregivers. They emphasized such openness by articulating an open perspective on human life, and focusing on peoples' preferences and ways of living. In contrast to polarizing right or wrong ideas, with the encouragement by the researchers they began to articulate solutions or daily practices through many-faceted realities. In investigating the practice experiences the group tried to keep the questions as open as possible and not relate to what is typically defined as clinical symptoms or classified as psychiatric diagnosis or to the practice guidelines and mandatory statements for the team. This openness gave the clinicians enriched practice knowledge. Keeping the dialogues open for practice process and practice knowledge meant openness to differences in concept formation, definition of situations, interpretation of meanings, and approaches to service.

Tolerance of uncertainty

In clinical practice, tolerance of uncertainty in crisis situations is developed through frequent meetings and by the quality of the dialogue in the social context (Seikkula et al., 2006). Tolerance of uncertainty is also essential in the process of clinical research and for eliciting tacit knowledge. This theme was apparent in dealing with clinical practice issues and in the participants' engagement in the research process. Tolerance of uncertainty implies being able to be flexible in thinking and expecting unusual and extraordinary in situations. It needs to be addressed by appreciating and listening to what people involved actually have to say. It encourages dwelling on issues, opening up for a variety of perspectives on what is going on and trying to find words for the experiences and activities. The clinical examples raised in the group represented an opening to make and remake stories, identities, and relationships that constructed new understanding. Tolerance of uncertainty also meant an acceptance of varied or opposite interpretations as viable ones. For example, it was apparent in a situation where the assessment of a crisis situation was framed in relation to the relevance of orderliness and chaos in people's homes.

> It can be chaos, it can be filthy and the patient can be poorly dressed and filthy. And one is absolutely sure (that here is a mental health crisis). But in this situation it was shiny, wasn't it. It was shiny . . . Things were in order. So it differs a lot what's hiding behind the front door.

They reflected on how difficult it sometimes was to know when there was a need to worry and take actions, and when the person just needed some limited support. For some people a bit of "chaos" in the home environment simply was cozy while the tidiness felt a bit sterile. For others the opposite ideas were upheld. This led to the discussion of the need to assess crisis situations in the context of home environment and in consultation with the individual and his/her network, rather than relying on definitive answers.

An issue rarely discussed in the methodology literature is the uncertainty and insecurity of researchers with a methodology and how this is dealt with. In our situation one of the researchers had previous experiences in using the focus group approach in research, while the other researcher was new with this method. This gave this researcher the challenge of dealing with the insecurity of a new research role but at the same time the opportunity to be an examiner of the method both by the process of establishing a new role and observing the group process. In-depth understanding of the fundamental principles of the OD philosophy guided both the emotional and tactical foundations for developing the sense of security with the method. The same also seemed to have applied to the team members who participated in the focus groups as co-researchers.

Nurturing everyday life issues

This theme was central to developing new approaches to practice and drawing out practice knowledge. During the entire process of this action research, the team members were engaged in fervent discussions with the researchers' input regarding the importance of uniqueness and singularity of practice context in relation to the service-users and families they met. This involved concerns and worries of the individual team member and the team as a whole about patients and caregivers they met regarding the everyday life issues.

> Margit: . . . you know, that's when you see that it is there (*the crisis*), when all these ordinary daily life

> things sort of collapses. They just cannot take care of themselves. So in a way she was dependant on others' help.
>
> Researcher: But these ordinary things ... what do you mean by that?
>
> Margit: I simply think about the general daily activities like washing yourself, going to the toilet, eating, cooking, water, drinking. That's in a way completely absent. So you think you have to remain there, she needs someone to take care of her.

In the focus group meetings the participants highlighted the difference of having peoples' homes as the helping context opposed to a psychiatric institution. They talked about the impact this had on understanding the situation, assessment, involving others such as family members in the planning, and on their own role and skills as professionals. One participant expressed:

> In the institution I had the firm walls around me that felt supportive. Suddenly the walls are gone and there are only light-walls to lean on. This is the change I have had in relation to working in people's homes.

In order to support in-depth discussions on the details of everyday life in relation to service-users' crisis experiences and the professionals' responses to them, the researchers encouraged the team members to illustrate clinical situations in detail through remaking of stories. This involved careful listening and open questioning not only by the tellers of the stories but also by all participants including the researchers. The service-users' own coping strategies became more visible and explicit when meeting them at home.

What became evident was the value of being in the service-users' home environment and assess the crisis situation there together with the individual and his/her network. Being in people's homes the team members could more easily capture the situation from the person and the family's points of view. This was especially due to the fact that the clinicians realized what the service-users and their family members talked about most often was how mental health problems and treatment affect their everyday life in a variety of ways and create practical problems. As the focus group meetings often raised issues associated with practicalities and concrete everyday life activities of the service-users for in-depth discussions, it became clearer to the members that the trivialities of everyday life are anything but trivial in community mental health care.

Discussion

The three themes that have been extracted to undergird the processes of developing the team and generating practice knowledge in the newly launched CR/HT team suggest the dynamics with which the team was moving with these two processes. The two themes, *keeping the dialogue open* and *tolerance of uncertainty*, were instrumental in helping the team to move ahead as a team, and at the same time gave the clinicians the methods to keep their practice in check and to uncover and seek out new knowledge both in and for practice. The third theme, *nurturing everyday life issues*, was a way for the clinicians to redirect their practice to fit into the mode of crisis resolution in home care setting. Thus, this became the base from which new knowledge for practice was being developed. The first two themes thus refer to how the clinicians were able to discuss and make a shift in their practice to align with the third theme, *nurturing everyday life issues*.

The first process for developing the team in a new service model progressed with a focus on creating an atmosphere of safety and acknowledgment, conveying curiosity and an open attitude to knowledge, as well as to mental health. This was the stage, a safe place, in which the research participants (co-researchers) were able to engage in on-going dialogues to discover hidden knowledge and develop new knowledge for practice. In working with the OD philosophy and the open lifeworld research approach to talk about the practice of a crisis resolution and home treatment team, the clinicians were invited to dwell on practicalities and everyday life issues typical for community care. The idea of loving the questions themselves and not searching for answers (Seikkula et al., 2006) was how the OD and the open lifeworld research inspired the participants in this research to address various questions of practice.

The findings associated with the themes of "keeping the dialogues open" and "tolerance of uncertainty" suggest the participating clinicians' willingness and acceptance of the open process in dealing with clinical situations with tentativeness and multiple interpretations. This does not mean that the clinicians became frozen with inability to move forth with assessments and service plans, but it means they were able to see multiple meanings and interpretations, and were open for shared decision-making and accepting alternatives and new ways of seeing clinical situations from the perspectives of other clinicians as well as of service-users and family members (Schauer, Everett, del Veccio, & Anderson,

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2007). First, the research perspective seemed to have supported the participants in order to shed the "psychiatric mind" and to view "crisis" not as a specific diagnostic category but in the context of service-users' everyday life. Through the emphasis on learning about the patients' and the networks' experiences and understandings and appreciating many voices and different ways of seeing a situation (Borg, 2007; Karlsson, 2004), an open approach seemed to be nourished. Listening carefully to what service-users have to say invites to see the person as an individual and a human being rather than as a patient category or "a crisis."

Second, knowing in practice became a process rather than a product gained through nurturing of many voices and perspectives. Such knowledge seemed to expand their understanding of problems in various clinical situations and to make contextualization more evident in dealing with problems of services users as well as their own as clinicians. Because the knowledge was a process, it expanded as the research progressed through the continued focus group meetings in which discussing differences in activities, in understanding, and in interpretations were encouraged. As the focus within action research is "knowledge for action" (Hummelvoll, 2008), the focus group was engaged in both questioning their own knowledge in practice and different ways of seeing same situations through OD and with their increasing tolerance for uncertainty. In this study tacit knowledge was in focus: tacit knowledge, the kind that is not easily visible and expressible but is embedded in actions in contrast to explicit knowledge, the kind that can be readily transmitted across individuals formally and systematically. According to Polanyi (1966), tacit knowledge is characterized by it being personal, context specific, and therefore hard to formalize and communicate. Polanyi contends that human beings acquire knowledge by actively creating and organizing their own experiences. Subjective insights, intuitions, and hunches fall into this category of knowledge. Furthermore, tacit knowledge is deeply rooted in individuals' actions and experiences, as well as in the ideals, values or emotions. Sharing such knowledge was an important aspect of this action research. Knowledge development as an integral process offered opportunities for "going to the things themselves" (Dahlberg et al., 2007) as well as allowing the inclusion of many voices (Seikkula et al., 2006).

The results in the theme of "nurturing everyday life issues" point to the subtle shift in the perspective of the clinicians in seeing, understanding, and interpreting clinical situations they encountered. This shift was into the perspective of everyday life as the focal point of contextualizing both for understanding the service-users' problems and also for designing approaches in dealing with crisis. The clinicians paid more attention to what may have been considered trivial and unimportant aspects of everyday life situations (Borg & Davidson, 2008). This also meant a movement toward de-medicalization of crisis by taking up crisis in relation to various aspects in everyday life as both affecting the experiences themselves and also as influencing approaches to deal with crisis (Ball et al., 2005). It is hoped the present study can contribute to a growing body of knowledge that attempts to explore, understand, and address mental health problems within the context of the person's everyday life. In a life world research approach the person and his/her social and material environment is emphasized as well as the variety of ways the problems and challenges that are associated with crisis and mental distress are experienced and addressed by the person and the network (Dahlberg et al., 2007; Karlsson et al., 2008; Seikkula et al., 2003).

Conclusion

Crisis resolution/home treatment as a form of community mental health care is being established as one viable approach to deal with mental health-related crises in home environment. The model of practice processes that emerged from the results suggests the importance of realigning clinicians' perspectives to engage with people's crisis through open process of dialogue and lifeworld orientation. The philosophy of CR/HT is reflected in the model by the interjection of home environment and everyday life issues into the processes of service provision. The focus group meetings were the sites at which values, meanings, and modes of application of these themes were discussed and developed to have significance in the practice of the team as well as of the participating clinicians. This means that CR/HT teams are in a strategic position to develop practice processes that address the needs of people in crisis at home focusing not only on resolving crisis but also on assisting them to manage their daily lives better. This also means that such teams need to expand their orientations beyond the psychiatric mind-set.

Participatory action research applied in this project was an approach through which the practitioners were given opportunities to discuss new thinking and innovative ways of practice and were able to examine how the team was evolving as a practice unit. The focus group meetings became the forums for reflection about their own practice and service development and for moving with various forms of transformation in practice (Davidson et al., 2007). There was a continuing feedback between what

happened in practice and what ensued in the research process. This feedback nature of research and practice feeding into each other resulted in an emergence of an understanding and development of practice processes in CR/HT. The on-going co-processes of research and practice was a double helix that links the happenings in the practice with the findings in the research revealing the knowledge in practice and further developing that knowledge. As the research project moves into the second phase, there will be more knowledge discovered in practice and further transformations in practice processes that can be applied to updating and revising the model of practice for CR/HT teams.

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