Between a rock and a softer place—A discourse analysis of helping cultures in crisis resolution teams

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Abstract
Crisis resolution teams are a community-based service, targeting adults experiencing acute mental health crises. The rationale for the development of crisis resolution teams is both value and efficacy-based: crisis resolution teams should contribute to the humanizing of mental health services and to enhanced efficacy. This diversity in purpose appears to affect the practices of help that are offered by crisis resolution teams, which research has shown to vary greatly. A discursive approach recognizes that practices are shaped by external paradigms and structures, and clinicians’ construction of professional identities and practices through their talk and meaning making. Thus, this study used a discursive psychological approach to identify discourses through which crisis resolution team clinicians talk about and understand helpful help in mental health crises. Focus group interviews with clinicians from eight crisis resolution teams revealed two broad and contradictory discourses: helpful help as something “made” with crisis resolution team workers as creators of collaborative and innovative practices, and

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helpful help as something “given” with the crisis resolution team workers as representatives of a predefined specialist mental health service culture. The contradictions between these discourses reflect the diverse rationale for the development of crisis resolution teams and the possible tensions and pressures under which crisis resolution team work is conducted. In this overall context, the study further critically examined the tensions between the discourse of constructing new practices, and existing practices constituted by the specialist mental health services’ traditional discourse. Failing to constantly reflect upon and question these tensions in collaboration with service users, carers, and other services can impair creativity and the development of humanizing helpful help.

**Keywords**
Discourse analysis, discursive psychology, crisis resolution team, mental health crisis, focus groups

**Introduction**

As a community-based service, crisis resolution teams (CRTs) target adults experiencing an acute mental health crisis. Over the past two decades, CRTs have been established in many Western countries as an alternative to hospitalization, offering rapid assessments and home-based treatment (Karlsson et al., 2011; Wheeler et al., 2015). Although these aims are commonly viewed and measured in terms of whether CRTs contribute to enhanced efficiency within mental health services, the original rationale for the development of CRTs is multifaceted, comprising theory and value components (Johnson et al., 2008; Wheeler et al., 2015). The theory-related aspects are based on research indicating that hospitalization often does no good and can even be harmful, and that managing crises in the community enables a superior contextual understanding of and solution to the crises (Johnson et al., 2008). The value-based aspects relate to humanistic values implying that hospitalization can violate human autonomy and dignity. Thus, in most cases, people experiencing mental distress are believed to be best helped within the community in an everyday context (Johnson et al., 2008; Mezzina and Vidoni, 1995).

This study was conducted in Norway, where in 2005 the Norwegian Parliament, inspired by the international focus on home-based services, mandated that by the end of 2009, all of the country’s community mental health centers (CMHC) should have established a CRT as part of their services (Karlsson et al., 2011). Norwegian CMHCs are part of the country’s mental health care system and offer specialized assessments and treatment locally, on an outpatient, ambulatory, or inpatient basis; as well as providing consultation, supervision, and support to primary mental health care services at the municipality level (Norwegian Directorate of Health, 2014). Although most CMHCs had established CRTs by 2015, they are diverse as regards organization, treatment philosophy, and practice (Ruud et al., 2015).
Research on service user experiences has shown that the humanizing values shaping the rationale for CRT development seem to be only partly reflected in practice (Mind, 2011). Although many service users report satisfaction with CRTs, emphasizing how receiving support in a home-based context increases opportunities to remain attached to their daily life and to be seen and treated as a person, they also mention difficulties with being taken seriously regarding their own subjective notion of a crisis, and with receiving sufficient support for several aspects of life (Mind, 2011; Winness et al., 2010).

Although several studies have examined service user experiences, most prior research on CRTs has focused on efficiency and the impact on hospital admission rates (Karlsson et al., 2011; Wheeler et al., 2015). While the efficiency and humanizing purposes of CRTs are closely related and difficult to separate, these could reflect different cultures that CRTs are expected to incorporate in their services. According to Grant (2015), who writes from an explicitly critical mental health standpoint, two different, mutually contradictory paradigms implicitly define how mental distress and help can be understood, and affect how mental health services and institutions are organized. Grant (2015) describes these two paradigms as, respectively, the technological and the human paradigm.

Mental distress is understood in the technological paradigm as a disease, with internal, biomedical causes, making it equivalent to physical diseases. Both cause and treatment are viewed as largely context independent, enabling diagnostic categorization and related standardized and empirically supported interventions (Grant, 2015; Johnstone, 2014). In contrast, Grant (2015) argues that in the human paradigm, which often implicitly and explicitly appears in mental health guidelines, a community-based, recovery-oriented approach to mental distress is advocated. Within this paradigm, mental health work, recovery, and human distress are all understood to be grounded in material and cultural circumstances, and in personal histories and relationships within these. The human paradigm, therefore, values context, meaning, and location as crucial in making sense of mental health crises, paying the utmost respect to how those suffering story their experiences of the central aspects of these crises (Grant, 2015). In this paradigm, exploring and understanding contextual issues and how people make meaning of their distress in specific and shifting circumstances is perceived as crucial and fundamental to obtaining adequate definitions and ensuring appropriate delivery of help (Grant, 2015; Klevan et al., 2016; Smith and Grant, 2016).

Mental health services are variously influenced by both these paradigms and this also appears to be the case with CRTs (Tickle et al., 2014). The intention of CRTs to be simultaneously humanizing in terms of adherence to humanistic and collaborative values, and effective in terms of adherence to current evidence-based and measurable standards and treatment guidelines, can result in contradictory demands and pressures being experienced by these services. This is because delivering accessible and quick assessments combined with intense, contextual, and individually oriented support is intrinsically contradictory (Mind, 2011).

However, a sole focus on these external paradigm-centric explanations fails to fully capture how CRT clinicians understand and talk about their mission, and
how this shapes current practices. Within a discursive approach, it is common to acknowledge that people and their actions are shaped by not only external structures and power relations, but also how people talk about and understand their world (Winther Jørgensen and Phillips, 1999). Clinicians tend to define a crisis based on specific symptoms and level of functioning, whereas service users and carers perceive an overall, subjective experience that may not easily be measured and described in specific terms (Burns-Lynch et al., 2014; Klevan et al., 2016; Lyons et al., 2009). This arguably reflects the extent to which clinicians are committed to working within the technical paradigm, whereas service users frame their experiences and need for help within human paradigm values.

Despite mental health guidelines advocating a holistic, normalizing, and contextually oriented approach to mental distress and service users reporting that such an approach is consistent with their needs in crisis, mental health services often continue to be characterized by practices belonging to the technological paradigm (Barker and Buchanan-Barker, 2011; Grant, 2010; Grant, 2015; Tickle et al., 2014). To further develop mental health services in line with what service users experience as helpful help, it is crucial to obtain better understanding of the discourses through which clinicians position their work and how these are negotiated and given meaning. The aim of this study was, therefore, to identify and explore how clinicians in CRTs construct discourses of helpful help.

**Methodology**

**Discourse analysis**

The study drew on a discursive psychological approach (Winther Jørgensen and Phillips, 1999). How people communicate and interact in a team is a matter of interest within discursive psychology, including how language is used in specific contexts to constitute and construct meaning and actions, and how different versions of elements like society, community, institutions, and experiences emerge through discourses (Onwuegbuzie et al., 2009; Winther Jørgensen and Phillips, 1999). Attitudes, values, and identities at both individual and group levels are regarded as socially constructed. Thus, discourses are regarded not as being merely “out there,” ready to be harvested by the researcher, but as actively and progressively constructed in a specific situation and context by the participants when interacting with other group members and the researcher. Simultaneously, discourses can be viewed as part of the power relations and social structures that promote or limit people’s ability to contribute to and shape the discourses they live and work within. Thus, discourses are both constitutive and constituted (Winther Jørgensen and Phillips, 1999).

**Context**

Context is considered important in discourse analysis because “the truth” is constructed through language and interaction between participants, and also in the
context of local, as well as broader cultural and historical, issues (Carbó et al., 2016). Thus, we used focus group interviews to generate data in this study because this method enabled discussion and meaning making between clinicians who normally work together as a team. We assumed that how the team talked about and constructed their understanding of helpful help would be influenced by both the current public and professional discussions regarding CRTs, and the historical roots shaping their rationale. In addition, personal motives and relationships among the participants were expected to play important roles in the negotiation and construction of discourses of helpful help because meaning making is a contextual and interpersonal practice, in both the situation of focus group interviews and everyday clinical practice.

The focus group interviews were conducted from October 2012 to May 2013, at which time the Norwegian Directorate of Health was preparing new recommendations for CRT best practice. The discussion preceding these recommendations was lively and varied, mirroring the diversity in organization and treatment philosophy in Norwegian CRTs. The teams’ participation could have been motivated by the opportunity to bring their views and experiences concerning “best practice” to the fore. As such, how they describe and construct their reality within a certain context is not merely a description of the world, but also has specific functions (Carbó et al., 2016).

Participants and procedure

All 58 Norwegian CRTs were invited to participate. Of the 24 teams that were interested, a strategic sample of eight teams was recruited, including two teams from each of the four national health regions, covering both rural and urban areas, and experienced and more newly established teams. We interviewed eight focus groups of CRT workers who were involved in clinical practice, with an average of six participants per group. Nurses, psychologists, and social workers were the most prominent professions, and three focus groups had a medical doctor or psychiatrist present in the interviews. Participants’ ages ranged from 25 to 64 years, two-thirds were women, and the average length of work experience in various mental health services was 11.5 years.

Semi-structured focus group interviews lasting 90–120 min were used to generate data. The interviews were kept as open-ended as possible to enable the discussion of subjects that arose in the conversation, and were audio recorded before being transcribed verbatim.

To enrich the analysis, a competence group of five people with experience as clinicians, carers, and/or service users was established. The group was informed about the project’s aims and given access to parts of the anonymous, transcribed data material. The group met four times during this study, for 2 h each time, to discuss the conversations among the focus group participants and how these could be interpreted in relation to possible discourses of helpful help in CRTs.
Ethics
The Regional Committee for Medical Research Ethics of Norway, southeast region, approved the study (2012/1458a). Written informed consent was required before participation and data were made anonymous through the transcribing process.

Analysis
Analysis within a discursive psychological framework does not follow a specific “recipe” (Potter and Wetherell, 1987). Therefore, the steps described below represent our understanding of how data can be analyzed using this approach, inspired by Potter and Wetherell (1987) and Winther Jørgensen and Philips (1999). Although presented as a step-by-step description, we did not follow a strict sequentiality. The identification of possible discourses in the text and how they are featured are better understood as constructs resulting from the back-and-forth movements between the steps, which were as follows: (a) repeatedly reading the text to become familiar with data; (b) rereading and interrogation of the text, including consultation with the competence group; (c) coding of sections in the material, focusing on content of possible discourses and how these were expressed; (d) organizing the coded material into clusters according to the content and how it was expressed; (e) organizing content clusters into possible discourses; and (f) interrogation of the possible discourses in relation to each interview and the data set as a whole, looking for possible patterns in terms of variations and consistency.

Two main discourses of helpful help in CRTs were identified: (a) “the creators of something new and different”—help as made and (b) “the representatives of the expert system”—help as given.

Identified discourses
The two discourses are explored through extracts of participants’ talk. Participants are referred to as “P1,” “P2,” and so on; the interviewer is referred to as “I.” The extracts are reflected upon in terms of content—what is said—and performance—how is the content expressed.

“The creators of something new and different”—Help as made
A dominant discourse of helpful help constructed in the focus groups concerned promoting and creating “new” values and practices within mental health services, as opposed to the “old” and more traditional medical culture. The participants understood help as being co-constructed in dialogue with the service user and his or her network, rather than as a predetermined practice. Thus, helpful help was talked about as something “in the making.”

Within this discourse, an important mission for the CRTs was challenging existing mental health practices. Participants talked positively about being proponents of a new
culture, constructing a sense of “we” within the team opposed to a sense of “they,” (i.e. other parts of the mental health services). In drawing this distinction, participants also enabled the construction of a different professional identity to emerge.

The following extract exemplifies how the participants talked about their understanding of how the CRT culture differs from other cultures in mental health services:

*Extract 1.* 

P1: I don’t trust the professional thinking among the leaders on the level above us. P2: I agree. P3: I’m thinking that, concerning culture. I feel that our team and CRTs and other ambulatory services . . . they have emerged from something slightly different than traditional psychiatry, which has a rather large institution-like character, with formalized things . . . So this . . . at its best, a CRT can be something more, something more fruitful, so that one can ascribe another dimension to it, where you can ensure that more formalized requirements regarding treatment are safeguarded, but you also have more flexibility and scope for creativity. Causing it to . . . I would say, be a more impactful treatment.

The participants seemed united in their construction of CRT culture as differing from more formal and institutional cultures, thus allowing other practices and values to emerge. Descriptions of the emerging culture as being “fruitful” and “flexible” is compared to the existing culture that is “traditional” and more “formalized.” Through their talk, the participants also indicated that in creating and promoting practices that differ from the organization’s dominant strategies, they ran the risk of these practices being counteracted. As such, participants’ understanding of a helpful culture appeared to diverge from that of the dominant organizational culture.

An opposing culture was also manifested in how the participants talked about helpful interventions in their daily practice. The extract below shows how a particular team constructed their understanding of helpful help in a crisis as being about keeping calm and representing a tranquil place in the midst of chaos. The participants constructed their understanding of helpful help within a discourse of non-expertise, where traditional roles and relationships come into play:

*Extract 2.* 

P1: I think there’s really a culture here for not being an expert on the other. That people themselves know something about what they need . . . When they are in crisis, we ask them “What do you need now?” We have a strong focus on that.

P2: I’m sitting here, thinking it would be difficult to say something about, if there should be a model, if you should do this and that. I’m sitting here, thinking that the most important thing we do is give people time. And that there is some peace and quiet here. Moreover, those things can be acted out just as the person needs them. In a crisis . . . we’re kind of “the eye of the storm.” It is peaceful, and we have the time. Just like that.

P3: We trust people’s ability to make their own judgments.

In this extract, the participants reflected upon their treatment philosophy and what comprised taking a non-expert stance. They used words with possible positive
connotations when talking about helpful help as being about non-action. To describe and justify their reasoning, words like “peaceful,” “give people time,” and the metaphor of being “the eye of the storm” were used, challenging the common assumption of help being about intervention. By emphasizing how this non-invasive approach brings the needs of the person in crisis to the fore, the participants also constructed a professional identity that distanced them from the expert role. Thus, the construction of helpful help was about what the team does or does not do, and constructing a new, professional identity. Participants’ understanding of help also appeared to entail the possibility of constructing a more competent service user role.

Challenging the status quo and constructing new practices and identities was also talked about as going beyond daily CRT practice. In the extract below, the participants spoke about contributing to a larger “movement”:

Extract 3. P1: A kind of additional prize is that you get to be part of a change of attitude when you succeed in stabilizing someone at home and the carers have been involved, and it compensates for the idea people have about hospitalization being the solution for everything. P2: Mmm. Yes. P3: Right. Because there, we need to make a huge change… We are part of changing mental health practices, overall. You know, that treatment should mainly take place out there. Where people live and have their lives… P4: Mmm. P3: To give people the belief that they can manage.

These changes were talked about as being positive and rewarding for both clinician and service user. The participants justified these changes through a construction of their necessity, and gave the changes credibility by referring to clinical experiences. Creating new practices was spoken about as a bottom-up development, as shown in the following extract:

Extract 4. P1: Our experience is that we have created something ourselves. We have created it together. P2: Yes, right, as something more or something different, or it’s created based on a need. The experience. So, we can absolutely say that we can’t get any closer to an experience-based practice.

The discourse of being “the creators of something new and different” was constructed as something creative and innovative, such that it was spoken about as something that belonged to the participants, and was rooted in their clinical experiences. Within this discourse, participants talked about constructing a new culture within mental health services, entailing new roles for professionals and service users, along with new practices of helpful help.

“The representatives of the expert system”—Help as given

Participants also talked about help as defined by an existing framework comprising predefined understandings of help in a CRT context and of rules and structures within the CMHC organization. Within this discourse, helpful help was
constructed as something more or less “given,” with an understanding of the CRT being the holders and suppliers of expertise competence and help, acting on the behalf of the CMHC organization.

The seemingly nonnegotiable definitions and structures of help within the organization were, in many cases, talked about as constituting quality and predictability for both the clinicians and service users, as shown in the following extract:

Extract 5. P1: I think we shall be able to make assessments quickly... People are [in] need for mental health support. P2: Yes. P3: So, I think we should be a service that assesses the mental state and then passes on to the right address in the system. If we can make the correct assessment at once, we can save the patient and the Hospital Trust from a lot of unnecessary back-and-forth. Quick access and then on to the right place... P1: Yes. P3: And I think one of the most important tasks is to avoid unnecessary hospital admissions. But also the opposite! To ensure swift and smooth admissions, when required.

In this extract, the participants’ construction of helpful help was connected to completing efficient and professional assessments, and then “passing patients on” to the correct service or department. The job of the CRT appeared to be clearly placed and defined within the existing mental health services. Rather than talking about change, participants drew on a discourse of professional efficacy; it is about filling a gap and contributing to improved quality and efficacy for both the patient and the Health Trust. Having a clearly defined understanding of one’s mission and place in the system can be experienced as a support in terms of not having to construct the daily practice and purpose. However, the limitations of acting as representatives of a predefined culture of help were also discussed. The following extract referenced a transition in practice from having open access to requiring a referral from health personnel in order to obtain assistance from the CRT:

Extract 6. P1: To require a referral... There are advantages, but we are losing a lot along the way. We lose the carers; we lose those who are affected by the state of the patient. We lose that. In a way... it has become easier for us, because we use fewer resources. It saves resources because the overview falls right into our laps. But earlier, we had to spend time asking, discussing, and thinking. Now, we don’t have to anymore, because they have done the thinking for us... P2: It’s an order from the GP. We used to spend a lot of time talking to the patient or the family, whereas now, we get these rather short facts from the GP.

From previously constructing the need for help in dialogue with service users and carers, the participants described a new practice where the need for help was defined and constructed by the general practitioner (GP) before being referred to the team. Participants spoke about not having to define and co-create crisis and help in each individual case as being time effective. However, when drawing on a discourse where help was already constituted and externally imposed, participants also agreed that “something” was lost when they were deprived of the possibility of responding to individual contexts.
Having a clearly defined place and mission within the mental health care system was also described as giving clear guidance for what not to do, and, thus, what others should do:

**Extract 7.** P1: *We are among those who want a referral, because we believe that you can’t just admit yourself to the orthopedist if you think that you have broken a leg. You know? So, there should be a referral from a physician who has made an assessment that it has actually happened.* P2: *So, that’s why we want a referral. Because, after all, we are a part of the specialist health care services. Yes...* I: *You have worked like this since the team was established?* P2: *Ye-ees, we have, and I think we have agreed on that.* P3: *Yes.* P1: *It has never been a big issue.* P3: *It’s something in which you can find support, so that, according to the purpose of CRTs, we don’t go and fulfill functions that others are supposed to cover.*

In this extract, the participants construct their professional identity as concurring with the dominant culture of the institution—the specialist care system. As they are specialists, they ought to do specialist work. Being placed within the specialist care system also resulted in the understanding of crisis and helpful help being constituted within an overly medical paradigm. In addition to such issues as requiring a GP’s assessment to confirm that a mental health crisis “has actually happened,” the language commonly used by the participants in their construction of helpful help mirrored the dominance of this paradigm:

**Extract 8.** P1: *If people are ill, they need to be hospitalized.* P2: *Yes.* P3: *Yes, we can’t manage without wards.* P2: *Yes.* P3: *For some, it’s not enough to have home visits four times a day.* P2: *Some need firm structures and we can never provide that...* P4: *And we are very conscious about when patients need hospitalization.* P3: *Yes.* P2: *Yes. And we are also conscious of discussing whether it is psychiatric [in nature] or public offense.* P4: *Or a social problem.*

Participants talked about mental health crises as psychiatric problems, drawing on a de-contextualized understanding. Coinciding with this understanding of crises, they constructed an understanding of help from CRTs as being about psychiatric assessments, and leaving others to work with the contextual parts of the crisis. This specific competence regarding crisis assessments and being recognized as the experts also appeared to engender professional pride and self-confidence, as talked about in the next extract:

**Extract 9.** P1: *We have more expertise. Not just maybe, but we do! Even though many GPs are skilled. That’s not what it is about. There’s a great disparity...* So, yes. You know, we do this all the time. There’s something about that!

The construction of an identity associated with being experts in the field of crisis resolution functioned to discursively distinguish CRT workers from other health
workers. Having a clearly defined identity and place in the mental health care system was viewed positively by the participants; however, a constitutive practice also appeared to limit and inhibit helpful practices:

Extract 10. P1: *It seems to me that what’s happening is a bit on the side of what CRTs were originally about, the way I see it. I mentioned flexibility earlier, and that is because now we have very clear and narrowly defined assignments. In addition, it seems to me like there is an attempt to run the business top-down, with short, separate sequences. Termination—one, two, three. “Done with him,” or something like that. Other Ps: Uh huh!*  

Participants described feeling limited by a constitutive, top-down practice that they believed was inconsistent with CRTs’ original purpose. The reference to the original rationale for having CRT placed in perspective the changed and de-contextualized practice. This evolving culture was talked about as limiting the clinicians’ flexibility and leeway in their day-to-day practice, and changing the construction of what the participants believed help and the role of the helper should be.

**Discussion**

This study identified two different discourses through which CRT clinicians talk about and understand helpful help. Although seemingly contradictory and incompatible, these discourses nonetheless appear to co-exist, shaping the discursive framework through which CRTs define and conduct practices of helpful help in their daily clinical practice. It could be argued that helpful practices of CRTs are performed and shaped in the squeeze between the struggle to construct new cultures and practices of helpful help, and to act on the behalf of a mental health organization with clearly defined understandings and practices.

**Helpful help in a cultural squeeze—Language, identities, and practices**

The rationale for having CRTs can be argued to be partly guided by market liberalistic principles, focusing on standardization of practices and improved efficacy, and partly by value, implying the need for the development of more humanistic and context-oriented practices. Thus, clinicians may be caught between expectations of co-constructing person- and context-oriented understandings of help together with the service user, and following procedures and standards to promote efficient and standardized help (Karlsson, 2015).

The two discourses in this study can be considered to share similarities with, and correspond to, the tensions between the human and technological paradigms discussed by Grant (2015). However, how clinicians talk about and understand helpful help is characterized by a mixture of commentary and values from both paradigms. For instance, although participants claimed to want to change the mental health field, words like “patient,” “ill,” “treatment,” and “experts” were used.
These results might reflect that clinicians are not sufficiently aware of these competing and often contradictory paradigms, their inscription within them, and the connection between language, professional identities, and practices. However, there might be several reasons for using the language of the technological paradigm despite claiming to be engaged in creating a new mental health culture. First, it is the common language within the specialist health care system. Even if CRTs partly draw on a humanizing discourse in defining mental health crises and help, the practicality of having a shared language can lead to the contextual experiences of service users and carers being translated into the technological language; thus, they may become de-contextualized.

The technological paradigm’s language can also be related to power and influence, indicating that its use can be expedient to ensure that one’s reflections and assessments are taken seriously when communicating with the people commonly associated with power and status in mental health systems. Thus, mastering this language is a way to appear competent and to construct an identity that adheres with the institution’s dominant professional culture (Hitzler, 2011). On the other hand, use of the language associated with the human paradigm might not necessarily be advantageous career-wise within the specialist health care system. Although a clearer separation from psychiatric languages, identities, and practices might be necessary in order to move mental health care toward a more recovery- and person-oriented approach, such a separation might have negative consequences on mental health practitioners’ careers (Barker and Buchanan-Barker, 2011).

The technological paradigm’s language is commonly associated with what is often considered “best practice” in health services, being assumed to describe more accurate, measureable, and standardized practices. However, the idea of juxtaposing mental distress with physical disease concerning determining both cause and treatment is heavily debated (Grant, 2015; Johnstone, 2014). The debate not only concerns actual practices, but also the politics of language use in mental health practice (Happell, 2007). The technological language risks cementing how mental distress and helpful help is viewed by professionals and how service users may come to view themselves and the appropriate help they require or contest such dominant meanings. Service users are frequently pulled into dominant narratives of mental health services (Grant, 2015). However, it can also be argued that professionals are pulled into dominant institutional narratives influencing their construction of professional identities and practices (Hitzler, 2011). To the extent that this undermines the fundamental principles of human paradigm work, it can impede the progressive development of these services in the direction of practice-based collaborative and humanistic values. Frank (2016) describes this problem as “failure of dialogical recognition,” whereby mental health workers construct knowledge of service users in ways that are almost exclusively informed by institutional practice assumptions. This can result in service users regarding mental health workers as lacking empathy and having insufficient contextual understanding of their lives (Grant, 2015; Smith and Grant, 2016). This form of narrative imposition is likely to affect how service users think professionals view them and
how professionals view themselves. As such, CRT clinicians may adopt a professional identity that follows the dominant institutional narrative, but which belies personal values and convictions.

The clinicians in this study appeared to be more engaged in discussing the frameworks and values of help, rather than its content, on a daily basis. This limited focus might mirror the understandings emerging from this study that the rationale for the development of CRTs is vague and diverse, leading to contradictory discourses for framing practice and professional identities. Thus, the teams appear to struggle to balance these perspectives, and the actual practices of helpful help run the risk of remaining unclear.

**Discursive availabilities and limitations**

Our results showed that constructing new practices of help while remaining true to values and practices within the specialist care system is challenging. To what extent CRTs are actually able to create a new culture, with corresponding language, identities, and practices, remains in question. Furthermore, it is not yet clear how much freedom there is for “new” cultures to develop within the team and what possible motivations and aspirations underlie the construction of cultures in a more close-range perspective. Are some words and constructions more legitimate than others between not only the specialist organization’s various levels but also among members of the same team? Within a team, there can be unspoken rules about which discourse the team professes and, thus, which professional understandings and identities are allowed to shape the team’s dominant narrative (Hitzler, 2011).

We also argue that to construct a “new” culture of help, certain larger discourses need to be available to the CRT members. If these two contradictory clinical discourses must be navigated by CRTs in daily practice, addressing how larger discourses influence and shape them is of interest. Moving beyond the discourses of CRTs’ daily practice, we argue that a market liberalistic-oriented discourse heavily influences the development of practices in specialist mental health services, implying that health services are run like a production business. The primacy of efficiency is more or less unquestionable (Frank, 2013), which means that when good clinical practice is equal to effective practice, practices that challenge the ideal of efficacy and standardization might not be praised. Thus, a way of dealing with opposing CRT discourses that may represent a breach with the organization’s dominant discourse could be to reorganize the CRT to make it adhere more with the dominant discourse. As such, it is unclear if the actual placement of CRTs within the specialist service system is compatible with the aim of constructing new understandings and practices.

Alvesson and Karreman (2000) distinguished between micro discourses, as constructed in interaction and talk in a local situational context, and Grand Discourses, which are part of a system-oriented context that people may not normally be aware of, but nonetheless influence ways of talking and constructing meaning. Without denying the impact of Grand Discourses, the authors argue
for the necessity of grounding and showing discourses rather than postulating them as structures (Alvesson and Karreman, 2000). Close-range discourses of everyday CRT practices can be regarded as both existing as structures and shaping practices through the goals, aspirations, and identities clinicians impose on themselves. However, as above, we question to what extent clinicians are free to construct practices and professional roles. Freedom is a complicated issue. According to Frank (2013: 21), who reflected on the works of Foucault, a problem in our time is that people “lack a reflective sense of how engagements in their own practices weave the nets that impair their freedom”. Frank further argued that it may be difficult to distinguish between acts of freedom representing a breach of structures, and those led by internalized self-discipline. We would argue that standardizing practices and emphasizing the importance of efficiency involves weaving a tighter net where the space for reflection on practice and oneself is limited. Thus, CRT practices that are dominated by constitutive discourses, whether imposed by structures shaping the Grand Discourses or by mutual self-discipline, may be incompatible with the aim of renewing mental health work.

Although not equally obvious, a constructive discourse of help as “made” may also restrain creativity and renewal. If this discourse becomes a united and unquestioned truth within the team, will there still be space for creativity and self-reflection? Furthermore, will clinicians necessarily want it? Despite the risk of practice reproducing itself, it is perhaps more comfortable to be on the inside, with likeminded colleagues, rather than standing on the outside and challenging the existing system (Foucault, 1971).

**Conclusion**

The study findings imply that CRT work is conducted in a context of tension between two contradictory discourses: the discourse of helpful help as something that is “made,” and the discourse of understanding help as something “given.” This contradiction reflects the diverse rationale for the development of CRTs.

Although the new practices that CRTs seem to be, at least partially, proponents of are based on humanistic and collaborative values, any practice risks being limiting and repressive without the space and will for self-reflection. As such, both strong outer structures of being a specialist health service and inner structures of being “something different” from the traditional mental health model can have constitutive effects. A reflective and transparent practice that involves collaboration with service users, carers, and other services in the further planning and performance of CRT services can contribute to helpful help in crises being understood as issues that must be kept alive and in progress.

**Strengths and limitations**

By identifying two broad discourses, nuances in the material might be lost. However, we argue that these somehow simplified discourses capture important
tensions that characterize CRT work on a daily basis. As discourse analysis is an interpretive practice, it can be argued that this study’s findings are heavily affected by the researchers involved and the context in which the study was conducted. However, we contend that this is more or less the case with all research. Our aim is not to plead any kind of objectivity or generalizability. We have attempted to make our procedures as transparent as possible so that readers can follow our situated reasoning and argumentation. Our discursive reasoning and understanding does not represent the truth, but it is one kind of truth that can contribute to further development of understanding and reflections.

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