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ARTICLE

'No service is an island': experiences of collaboration with crisis resolution teams in Norway

Trude Klevan [a,b], Bengt Karlsson[a], Nina Hasselberg[b], and Torleif Ruud[b,c]

[a]Center for Mental Health and Substance Abuse, Faculty of Health and Social Sciences, Department of Health, Social and Welfare Studies, University of South-Eastern Norway, Drammen, Norway; [b]Mental Health Services, Akershus University Hospital, Lillestrøm, Lørenskog, Norway.; [c]Institute of Clinical Medicine, University of Oslo, Oslo, Norway

ABSTRACT

Crisis resolution teams (CRTs) are a community-based service targeting adults experiencing acute mental health crises. The rationale for the development of CRTs is both value and efficacy based, suggesting that CRTs should contribute to the humanizing of mental health services and replace some acute hospital-based services with services in the community. Despite the collaborative nature of CRT work, how professionals from health and social services experience collaboration with CRTs is scantly explored. In the current study, semi-structured focus group interviews with eight different groups of 44 clinicians collaborating with CRTs in Norway were conducted. Data were analyzed using thematic analysis and categorized into four themes: (1) 'The accessible experts', (2) 'A broad and deep expertise', (3) 'Doing it together' and (4) 'Toward a new culture?'. The themes elaborate on issues related to the content and organization of CRT services, emphasizing the need for CRTs to be able to contribute their professional expertise in accessible, flexible and collaborative ways. A diversity in the knowledge base and in how services are organized may pose a challenge in interprofessional mental health crisis collaboration and mutual expectations. The study suggests that a shift toward a value-based and coherent mental health and social system could be a purposeful direction.

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Introduction

Services for adults with mental health problems have undergone major changes the past three to four decades. A transition from institutional- to community-based care has led to the development of different models of community care aimed at reducing the use of hospital admissions (Klevan et al., 2017; Morant et al., 2017; Topor et al., 2016). The shift in service delivery has brought the need for a different approach to mental health-related problems in general and to mental health crises in particular. Because mental health crises are commonly recognized as complex and multifaceted, several studies support the need for collaborative and interprofessional approaches to crises response (Bindman, 2009; Johnson, 2013; Winters et al., 2015).

Background

Crisis resolution teams (CRTs) deliver acute, short-term mental health care to the community, targeting people experiencing an acute mental health crisis. The principal objectives of CRTs are to offer comprehensive treatment and support in people's home environments in a mental health crisis, thereby trying to prevent unnecessary hospital admissions and to contribute to the development of more humane and collaborative mental health services (Borg & Karlsson, 2010). In the Western world, CRTs have been implemented as part of national mental health services to a varying degree, with the UK having implemented the service to the largest extent. In Norway, where this study was conducted, CRTs also form part of national mental health policy and have been implemented regionally (Lloyd-Evans et al., 2016; Morant et al., 2017).

Key characteristics of CRTs recommended in government and expert guidance are (1) rapid response and 24/7 availability, (2) multidisciplinary and holistic approach to crises, (3) gatekeeping function assessing all patients before admission to acute wards and considering home treatment as an alternative and (4) facilitation of prompt discharge from acute wards (Lloyd-Evans et al., 2019). However, the CRT model has not been highly specified in the literature, leading to diverse approaches to implementing these services (Lloyd-Evans et al., 2019; Wheeler et al., 2015). Thus, Norwegian CRTs show a diversity of key characteristics related to opening hours, treatment philosophy, practices and organization (Ruud et al., 2015).

Despite a diversity of practices and organization, a main and outspoken aim is to reduce the number and length of hospital admissions through providing home-based treatment for people experiencing mental health crises (Lloyd-Evans et al., 2019; Wheeler et al., 2015). This implies the necessity of CRTs having to collaborate with other professionals in community-based mental health and social services. Moreover, because CRTs provide short-term treatment in a mental health crisis, service users supported by CRTs will normally be in contact with other community-based services before, during and after the contact

CONTACT Trude Klevan tkl@usn.no Center for Mental Health and Substance Abuse, Faculty of Health and Social Sciences, Department of Health, Social and Welfare Studies, University of South-Eastern Norway, P.O. Box 7053, 3007 Drammen, Norway.

with their local CRT. Thus, CRTs are part of the overall interprofessional services dealing with mental health crises.

Reeves et al. (2017) describe interprofessional collaboration as " the process by which different health and social care professional groups work together to positively impact care." Through interprofessional collaboration, CRTs may contribute to more seamless help and facilitate better continuity of care for people experiencing mental health crises (Rhodes & Giles, 2014; Ruud et al., 2015). Furthermore, CRTs may support community-based mental health services and cease their workload and burden of responsibility. However, with their clearly stated mandate of assessing people in a mental health crisis and determining whether they are in need of hospitalization, CRTs may also cause disagreements with other services and contribute to fragmentation (Rhodes & Giles, 2014). Assessments and decisions made by CRTs may be contradictive to how professionals in other services understand the situation with the possibility that these professionals can experience being overruled. Thus, according to McGlynn (2006), the relationship between CRTs and other services may be confrontational: 'this issue has probably resulted in more friction than anything else between teams and between professional groups'.

Despite the collaborative nature of CRT work, how professionals from other services experience collaboration with CRTs in their respective roles is scantly explored. The current study elaborates on the experiences of professionals collaborating with CRTs. It was part of a larger project describing and exploring practices and experiences with CRTs in Norway, using both quantitative and qualitative research methods (Ruud et al., 2015). This article aims to describe and explore how professionals in community primary and secondary health and social services experience collaboration with CRTs and the help and support offered by these teams. Furthermore, the article aims to explore what kind of changes in CRT practices collaborative professionals call for.

Method

The study had a descriptive, explorative and interpretive design. We chose a qualitative methodology as a means by which to acquire a deeper understanding of the experiences of interprofessional collaboration with CRTs.

Local context, participants and procedures

Norway has approximately 5 million inhabitants. The geography is varied with diverse settlements, ranging from rural areas consisting of small municipalities of 1,000 inhabitants or less to the main capital with 600,000 inhabitants. Some CRTs cover expansive and rural catchment areas that are sparsely populated, while others cover urban and densely populated areas. The geographical placement of the respective CRT and the size of the population in the catchment area means the number and characteristics of available collaborators within the health and social services vary greatly (Ruud et al., 2015).

The participants in the study were recruited from all four Regional Health Trusts in Norway. A rural-based CRT and an urban-based CRT were included from each health trust region to elaborate on a diversity of experiences and practices. Through a process of strategic sampling, these eight CRTs recruited professionals from services that the respective team would normally collaborate with, including the primary and secondary level of the mental health system. To ensure diverse views and experiences, the recruiting teams were encouraged to recruit participants from a variety of services and with various professional background. The recruiting teams' knowledge about the local context and services was considered an important prerequisite. In Norway, the national mental health system for adults consists of three service levels. At the first level, there are general practitioners (GPs) and mental health teams in primary care settings provided at the local municipality level. At the second level, there are regional, specialized services provided through community mental health centers. The community mental health centers comprise different types of care units and teams and are often referred to as specialized mental health services. CRTs are located at this level. At the third level, there are psychiatric hospital wards, including acute wards (Hasselberg et al., 2011).

Altogether, 44 professionals participated in this study. They were interviewed through eight focus group interviews, one in each area of the recruiting teams. Interviews were conducted in 2013. The number of participants in the focus groups varied from two to seven participants, with an average of six participants per group. Participants ranged in age from 25 to 64 years, and there were 35 women and nine men. The participants consisted of 22 nurses, eight social workers, nine physicians and five with another educational background. The participants worked as GPs, community mental health nurses, physicians and nurses at general emergency wards, professionals from the specialized mental health services and in the substance abuse services.

The semi-structured interviews lasted 90–120 minutes. A thematic interview guide was used, covering topics such as experiences and understandings of referrals, target groups, organization, best practices and treatment, services user involvement and collaboration in a CRT context. The interviews were kept as open-ended as possible to enable the discussion of subjects that arose in the conversation. Interviews were audio recorded in Norwegian and transcribed verbatim. The direct quotes from the participants were translated by the first author for this article. To ensure accuracy of the translations, translations were discussed with the other authors.

Data analysis

Data were analyzed using a thematic analysis, inspired by Braun and Clarke (2006). Braun and Clarke describe thematic analysis as an appropriate method for identifying, analyzing and reporting patterns and themes within data grounded in rich descriptions and interpreting various aspects of the research topics. The analysis of the current study places itself within an understanding of truth and knowledge as being multifaceted and interpreted (Crotty, 1998). Although the following description of the procedures of the analysis follows a step-by-step outline, steps in the qualitative analysis are overlapping and difficult to separate. Thus, the procedures may more aptly be described as a back-and-forth process between descriptive and interpretive dimensions of analysis.

The authors, T.K. and B.K., conducted the analysis. Both authors read the transcribed text separately, searching for possible meaning units and interpretations. Each author labeled the meaning units with coding words. The two authors then discussed and arranged the coded meaning units into sub-themes, aiming to stay as close to the text as possible. The authors clustered and organized the sub-themes into preliminary main themes through an iterative back-and-forth process between the text and the evolving themes. The interpretations of the text and development of themes underwent thorough discussion between the two authors before the final four themes were agreed upon.

Ethical considerations

The study was carried out in accordance with regulations of The Norwegian National Research Ethics Committee. Because of the nature of the study, the ethics committee assessed that the study did not require formal ethics approval (2012/1458a). The Norwegian Center for Research Data and the Data Protection Official at the respective health trusts gave their approval. Written informed consent was required before participation in the study, and data were made anonymous through the transcribing process. Participation in the study was optional.

Findings

Experiences of collaborating with CRTs were multifaceted and appeared to reflect the diversity of participants' professional affiliation and contextual factors, such as geography and local organization of services. The themes reflected a diversity regarding practices and organization of CRTs in Norway. The four themes generated through the analysis were: (1) 'The accessible experts', (2) 'A broad and deep expertise', (3) 'Doing it together' and (4) 'Toward a new culture?'.

The accessible experts

This theme explores how the participants experienced organizational issues related to CRT work as important. An important issue emphasized in all the focus groups was how CRTs provided improved access to the specialized mental health services, often referred to as 'the experts'. Many participants described this as an improvement compared with the previous organizing of services. They experienced that CRTs increased the possibility to receive 'expert' support to conduct complicated assessments in a crisis. This was, in particular, related to the possibility of contacting the CRT directly without a referral from the GP, and that the team was operative beyond regular office hours.

One focus group discussed the following with regard to accessibility:

> *P1: Accessibility. That's what comes to my mind. P2: Yes, that they are easy to reach. P3: That is what made it so welcome when the service was first introduced. P2: and that service users could actually contact them. P1: and the GPs, they also thought it was a good service. Because there was a gap, on the low-threshold level. P2: Yes, it was a good offer for both the service users and us.*

The participants had diverse experiences of the accessibility of their local CRT. Some worked in an area where the CRT required a referral from a GP before they would work with a service user. Others described that their local CRT did not require a referral and that professionals, service users or family carers could contact the CRT directly. Open access to the CRT was described as the preferable organization of the service:

> *P1: I think that is the whole clue. It's almost as though I don't understand what you are asking because I think that's the whole thing. That you can call directly, someone who is interested, right there and then. That there is no gate, but a meeting between human beings: 'What's the matter of concern, what do you need and what can we do now?' It's crucial that there is a low threshold. P2: I have also experienced that family carers have called and that's gratifying because that means it's working. That they have that support.*

Knowing that service users and family carers could access the CRTs without a referral was described as easing the burden on other professionals. It was easier to go home from work knowing that the service users and carers had someone they could call during a crisis. Accessibility was closely connected to opening hours, and many participants strongly advocated the importance of extended opening hours. To be experienced as a helpful service and useful collaborative partner, it was important that the CRTs operated at hours when other municipality mental health services did not.

> *P1: Well, the first thing that comes to my mind is that they are accessible. I mean, that's in the name, isn't it. Acute ambulatory team [note: Norwegian name for CRTs]. That they are . . . on the spot quickly. Easy to get ahold of. That they are accessible. P2: I think they should be accessible day and night, that they are open at the weekend, evenings and nighttime. P3: I agree. P2: That's often when we need them the most. Outside regular opening hours.*

None of the CRTs in this study were open 24/7, but some were open during evenings and partly on weekends. Although many participants would have preferred 24/7 opening hours, they also described how that might be a costly service. Some kind of accessibility, like a 24/7 open phone line, was described as a possible helpful way of organizing the CRT service. For several participants, this kind of accessibility could in many cases safeguard the needs of professionals and service users and serve as a good substitute for the team physically operating 24/7. Experiences like the following were frequently shared in the focus groups:

> *P1: Just knowing that you have the possibility to call . . . P2: That's often enough so that you don't actually have to call. P3: For our service users, we are only there during the daytime, mostly. And when we go home, they have no one. And they are not always capable of contacting the ER. And being able to contact the CRT if things get tough can prevent that they get worse and need to be hospitalized.*

The organizational issue of accessibility appeared to be closely connected to feelings of safety of support.

A broad and deep expertise

This theme describes and elaborates how the participants perceived 'the experts' mentioned in the theme above and which qualities and qualifications they found valuable and helpful. Thus, the benefits of collaboration with CRTs were closely connected to the team members possessing certain

qualifications. This included a deep expert knowledge on issues related to a mental health crisis and a more general and broad knowledge of mental health and the system as a whole.

In the case of a mental health crisis, the participants shared how they needed support from someone with specific expertise. The expectation that the CRT should possess skills that went beyond other professionals was clear. The expert competence of the CRT was also described as an important prerequisite for collaborative professionals to carry out their job.

> *P1: If I meet a physician in a temporary position, straight from intern, then that does not satisfy my needs. Or, if I feel that the social worker or nurse is insecure, then that's an unsatisfactory service for me. I expect their competence to be higher than mine. P2: That is absolutely necessary! Because what we are talking about is that they assess what I should do next, in a way …*

Many participants described how they experienced that the CRTs had a specific expert competence in assessing suicide risk. Having the CRT assess one of their service users felt reassuring.

> *P1: I think that the CRT has a better competence than general physicians, maybe, who have to deal with all kind of things. […] I'm thinking that [the] CRT has a unique competence, that there is no way that all the different physicians at the ER can possibly have.*

Despite participants expressing faith in the competence of the CRTs, some participants expressed doubt about whether the team members actually had the necessary competence. They described that, in some cases, the GP who often knew the patient well was the one who could provide the best assessment and help when a crisis occurred. This understanding was also connected to questioning whether CRTs were capable of making psychiatric assessments and that they should perhaps stick to what they were good at, having therapeutic conversations. As such, in some of the focus groups, the participants appeared to discuss the necessity of making a distinction between mental health work and psychiatry.

> *P1: I'm thinking that those assessments need to be done quite early. So that one doesn't spend a lot of time giving therapeutic conversations, and then it turns out that this was actually so severe that someone with a psychiatric background, and who can medicate, should have been involved early.*

Besides being experts on assessing mental health crises, participants also described as useful that the team had a broad competence that could capture the many sides of mental health crises. A commonly described topic was the need for CRTs to be multidisciplinary. As such, when describing the desired competence of the CRTs, participants often talked about the necessary competence in the team as a whole and not just of the individual team member.

> *P1: I'm thinking about the level of knowledge in these CRTs. If they are to be useful, then they need to be something broader, embracing something more than the rest of us do, so I would think, that they are multidisciplinary. P2: For assessments, it safeguards a broader and more multidisciplinary understanding … yes … so there should be both psychiatrists and psychologists. P3: There doesn't always need to be a psychiatrist. P2: No, but that the team has access to one. P4: I think that they make assessments together. Always. P1: I think it is wise that they do it together.*

The need for CRTs to have broad expertise also included competence at a more system-oriented level. This involved having an overview of available services, possibilities for collaboration and legal dos and don'ts.

> *P1: It promotes good practice that the team is stable. And that the people there know their job. And that they know their municipality well … P2: Yes … or their collaborative partners, that they have a good overview.*

To serve as a useful collaborative partner, the competence of CRTs needed to complement and expand the competency already present in other parts of the system

Doing it together

This theme explores how the participants, though wanting the expertise from the CRT, also wanted to be included and acknowledged for their own competence. Although the CRTs were a separate service, many participants shared how they experienced collaboration with CRTs as a feeling of sharing responsibility. Collaborating with the CRT meant not having to deal with demanding assessments and decisions alone. Many participants worked in small and sparsely populated municipalities and had few colleagues to collaborate with in their daily work. To them, having someone to collaborate with could be crucial.

> *P1: Many of us are quite alone in our everyday life, and to have that access, as a colleague support, to think aloud together, that is very valuable. It is in itself a best practice. P2: I agree that it can be a kind of consultation unit, for other health workers in the community, for GPs, that they can call and get advice. Without the CRT taking over.*

An essential part of this support was to build on each other's competence, meaning that the team members had their areas of expertise and so did the professionals in other services. In the experience of the participants, this could enable a better totality of the support provided for the service users.

> *P1: To have a close dialogue, in a way. P2: Yes, that we complement each other … One day you are there. And the other they, they are there … So that we talk with each other and make a joint safety plan.*

Acknowledging the competence of the local professionals also involved taking seriously their concerns, their assessments of their service users' condition and their asking for support. The local professionals were the ones who knew the service users best, and thus, when they assessed the situation to be serious, the CRT should act.

Many participants shared positive experiences of working closely with the CRT to provide safe and helpful support for service users. However, some had also experienced that the CRTs could 'take over', leaving the local professionals and their competence out. The participants described this as something that could hinder the promotion of broad understandings of the help that the service users needed in a crisis.

> *P1: I think that mental health workers in the community, we have a lot of competence, we have competency about the municipality. And often, we have the biggest competence in the service user as well. And I think, well this thing about the specialist mental health service, the community mental health service, I am not saying it is so, but I'm posing the question, if there is an imbalance in this relationship … P2: I haven't felt it that much, but I have discussed this with many*

people and . . . This issue about who has the answer. And if we know the service user, that we can say something about what we think, and that we are heard. Because collaboration with the local municipality is very important.

A balanced and even collaboration recognizing diverse and complementary competencies and roles appeared to be fundamental prerequisites to give 'helpful help'. Thus, helpful help in mental health crises was described as a collaborative project.

Toward a new culture?

This theme comprises how the participants described their understandings of whether and how CRTs contributed to changing the culture within mental health services. This concerned several issues relating to what the participants understood as helpful help, who could provide the best help and how they understood collaboration. How participants understood the tasks of the CRT varied to some extent. Despite the participants in the different focus groups sharing an understanding of CRTs having a specific responsibility of assessing and helping people in a mental health crisis, many participants also described an understanding of the responsibility of the CRTs reaching further than that. They expressed a hope for the CRTs to serve as a change agent in the field of mental health.

P1: So, if someone comes to this unit . . . they are not automatically hospitalized. Then some of the service users in our user population will not try for that anymore. [. . .] There are other options, and it is a culture that needs to be changed over time. P2: Many of those who are now hospitalized should not really be hospitalized, but it has become the solution. It is the easiest solution sometimes, just to hospitalize. It is. Because then you have solved the problem, you have secured yourself. It's fine there and then, but over time, it is wrong. [. . .] So, I'm thinking that the CRT could be part of stopping this easy-peasy solution. P3: You can't blame a certain group of patients for being hospitalized when it suits them. It's we, the professionals, who have taught them this culture. Or solution. We need to change first.

The possibility and need to change cultures were described as complicated. Though many participants saw the need for a change of culture and understanding of help in the field of mental health, they experienced it as challenging to try to work differently. Many described how CRTs often worked in network-oriented ways. Despite seeing this as useful, it was also time-consuming and not necessarily compatible with the way local services were organized.

P1: So, if they come and want to include the GP in the conversation, which may take two hours. That can be challenging when the waiting room is filling up. So, how much do they actually need to have the GP there, for the GP needs to work after all. Sometimes, you trap the GP for two hours while everyone else is waiting. P2: And at the same time, it is good that they have the time. And that they are part of the picture at an early stage before the GP has started planning what needs to be done. Because, to be included further up the road, where the plans have been made . . . that is more difficult.

Other participants described how the network-oriented approach used by some CRTs could expand the understanding of mental health crisis. Involving the network in trying to resolve the crisis signaled that crises are multifaceted and subjective experiences:

P1: It is an important signal that the CRT, in my experience, often gives. It is to ask who should be involved, who are important persons for the service user? I think it is an important signal, in a way, that you are not alone. That different kinds of help can contribute to the situation. That it is possible to involve others, which is good. Then it may vary what the service user wants, and that is the most important.

Discussion

The findings of the study elaborate how experiences of collaboration with CRTs relate to the content of what CRTs provide and do, how the CRTs are organized and the role of the CRTs within the mental health-care system. The study shows how collaborative professionals experience CRT staff possessing certain skills and expertise as helpful. This is connected to CRTs having an expertise that the collaborative professionals do not necessarily have, such as expertise in assessing suicide risk or, more broadly, assessing the severity of a mental health crisis.

However, our findings also show how collaborative professionals can wish for CRTs to simultaneously have an expertise *and* serve as change agents, adding to and altering current practices and knowledge body in mental health crisis services. CRTs operate in a diverse field, where they are intended to provide 'something more' or 'something new' than other services. This includes not only having expert skills in assessing acute mental distress and suicide risk but also having skills and capacity to inform a more collaborative and interprofessional approach to crises. As such, the expectations for collaboration with CRTs are diverse, reflecting the diverse rationale for CRTs, comprising components related to effectiveness and cost reduction and more value-based components related to contributing to humanizing mental health services (Klevan et al., 2018; Wheeler et al., 2015).

Furthermore, the broad range of professionals that CRTs collaborate with work in a variety of professional cultures. According to Craven and Bland (2006), interprofessional care involves collaboration between different specialties and sectors to offer complementary care and support. However, different knowledge bases and cultures within organizations can make collaboration challenging. Because mental health crises are complex and multifaceted, this often calls for the need to involve people with diverse types of knowledge and traditions. Thus, the biomedical model that is likely to guide the understanding and care of GPs can appear as contradictive to the more socially oriented knowledge that informs social services (Kingdon, 2009). This could imply that interprofessional expectations and desires related to what expertise and skills to expect from CRTs could be varied and at times contradictive.

The study also elaborates how experiences of collaboration with CRTs relate to organizational issues. Important organizational features that can enhance collaboration were related in particular to accessibility, opening hours and flexibility. These features have also been emphasized in previous studies (Morant et al., 2017). Having access to an expert service during a mental health crisis is emphasized as important because mental health crises are demanding and difficult to assess. Furthermore, many

professionals in rural services have few colleagues, and the CRT can serve as an important collaborative partner, providing collegial support. The findings of the study align with those of Rhodes and Giles (2014), indicating that a successful and supportive collaboration is related to mutual trust and fellowship – the sense of doing the job together. However, for this to work, it seems pivotal that CRTs are organized with extended opening hours and are accessible and flexible when professionals in community services need their support. These findings parallel those of other studies that have explored important ingredients of CRT care (Morant et al., 2017).

The study shows how issues related to content and organization of CRTs are difficult to separate and often appear to be entwined. For instance, what in this study was described as desired professional expertise from CRT clinicians also related to these experts being accessible and flexible. Furthermore, the current study shows how helpful collaboration with CRTs is contextually related.

A considerate amount of CRT research has focused on describing and identifying key factors of a helpful and effective CRT model (Lloyd-Evans et al., 2016, 2019). Specifying these key factors could certainly be important in providing good crisis help that could serve as an alternative to hospital admission. However, what could be argued to lack in some of this research is the recognition of how CRTs are part of a vast and complex network of services within mental health and social work that target people in a mental health crisis. These mental health and social work networks are also situated in a local context. Rather than defining and emphasizing how to develop a decontextualized, specialized and standardized service for people in a mental health crisis, it could be argued that an emphasis on how to develop a consistent organization could be valuable. Mental health crises are diverse and difficult to define, and developing a model for crisis care can be difficult. Taking local contexts and resources into account, the current study implies the possibility that more loosely and flexibly organized teams, placing the person experiencing a crisis in the middle and shaping the help and interprofessional collaboration accordingly, could be purposeful. In line with a more person- and context-centered shift within the field of mental health, this can also be understood as a movement away from an individualistic, biomedical perspective on mental health crisis and treatment (McCabe et al., 2018). shift toward a value-based and coherent mental health and social system could be a purposeful direction, or, in the words of Mezzina (2014) 'a whole-system, recovery-oriented approach to community mental health care'.

Strengths and limitations

The study was conducted within a Norwegian context, thus providing findings from a specific context. The purpose of an explorative study like this one is not to generalize but to explore and interpret lived experiences related to certain phenomena. The experiences shared and discussed in this study contribute to the knowledge base of how professionals in primary and secondary health services and social services experience collaboration with CRTs. The participants were recruited from eight different geographic areas within the four Health Trust Regions, and the CRTs were encouraged to recruit professionals who represented services that the CRT would normally collaborate with. It is uncertain whether our participants are representative of typical collaborative professionals of Norwegian CRTs. However, the experiences shared in this study show how collaboration and support in mental health crises are multifaceted and contextual. Thus, the idea of a typical CRT or collaborative professional may be of limited value because the CRT is part of a diverse and complex local network of services meeting the needs of people with a mental crisis.

In a qualitative study like the current one, the experiences shared in interview situations can be argued to be products of the interaction between the researcher and the participants. Experiences from the interview setting and the researcher's background will also have an effect on the process of the analysis and on how data is interpreted. To strengthen the validity, the analysis process was performed as a collaboration between the first and second author. We have also attempted to make our procedures as transparent as possible.

Conclusion

This study explores how professionals in collaborating services experience how the content of CRT practices is entangled with how CRTs are organized. CRTs appear to provide a useful supplement to existing services dealing with mental health crises, offering a specialized competency on mental health crises. However, to be useful, this competence needs to be easily accessible for service users, carers and professionals. A possible challenge in promoting interprofessional care in mental health crises appears to be that diverse services work using different knowledge bases, implying that understandings of mental health crises and crisis support vary. Furthermore, services are organized differently, entailing that the possibilities for collaboration and working flexibly vary. This may lead to diverse and sometimes incompatible expectations of how CRTs can contribute.

The authors would argue that a possible clinical implication of the study is the call for a more whole-system understanding and approach to mental health crises, where a variety of professions, services and knowledge bases should inform the help given. This again calls for a radical shift in the understanding of mental health work and mental health services. This involves a shift from an idea of putting diverse parts together and anticipating that this will lead to change and not only to reorganizing each isolated part but also emphasizing the values and practices that guide the mental health system as a whole.

Notes on contributors

Trude Klevan is associate professor in mental health at the University of South-Eastern Norway. She teaches and conducts research in the field of mental health and social work.

Bengt Karlsson is professor in mental health and leader of Center of mental health and substance abuse, University of South-Eastern Norway.

Nina Hasselberg is is a clinical psychologist and PhD. She is currently part of a research group working on fidelity and treatment outcome in Crisis Resolution Teams in Norway.

Torleif Ruud is professor emeritus at the University of Oslo and senior researcher at Akershus University Hospital. He is a psychiatrist, and he has been principal investigator for several studies in mental health services research.

ORCID

Trude Klevan http://orcid.org/0000-0002-6849-7848

References

Bindman, J. (2008). The crisis resolution team within the community service system. In S. Johnson, J. Needle, J. Bindman, & G. Thornicroft (Eds.), *Crisis resolution and home treatment in mental health* (pp. 85–96). Cambridge University Press.

Borg, M., & Karlsson, B. (2010). Working in people's homes—Dilemmas in humanistic practices in mental health care. *Tidsskrift for Sygepleieforskning*, *26*(2–3), 47–53.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Craven, M., & Bland, R. (2006). Better practices in collaborative mental health care: An analysis of the evidence base.. *Canadian Journal of Psychiatry*, *51*(Suppl 1), 7S–72S.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Hasselberg, N., Gråwe, R. W., Johnson, S., & Ruud, T. (2011). An implementation study of the crisis resolution team model in Norway: Are the crisis resolution teams fulfilling their role? *BMC Health Services Research*, *11*(1), 96. https://doi.org/10.1186/1472-6963-11-96

Johnson, S. (2013). Crisis resolution and home treatment teams: An evolving model. *Advances in Psychiatric Treatment*, *19*(2), 115–123. https://doi.org/10.1192/apt.bp.107.004192

Kingdon, D. G. (2009). Interprofessional collaboration in mental health. *Journal of Interprofessional Care*, *6*(2), 141–147. https://doi.org/10.3109/13561829209014928

Klevan, T., Karlsson, B., Ness, O., Grant, A., & Ruud, T. (2018). Between a rock and a softer place—a discourse analysis of helping cultures in crisis resolution teams. *Qualitative Social Work*, *17*(2), 252–267. https://doi.org/10.1177/1473325016668962

Klevan, T., Karlsson, B., & Ruud, T. (2017). 'At the extremities of life'–Service user experiences of helpful help in mental health crises. *American Journal of Psychiatric Rehabilitation*, *20*(2), 87–105. https://doi.org/10.1080/15487768.2017.1302370

Lloyd-Evans, B., Bond, G. R., Ruud, T., Ivanecka, A., Gray, R., Osborn, D., & Kelly, K. (2016). Development of a measure of model fidelity for mental health crisis resolution teams. *BMC Psychiatry*, *16*(1), 427. https://doi.org/10.1186/s12888-016-1139-4

Lloyd-Evans, B., Christoforou, M., Osborn, D., Ambler, G., Marston, L., Lamb, D., & Hunter, ,. R. (2019). Crisis resolution teams for people experiencing mental health crises: The CORE mixed-methods research programme including two RCTs. *Programme Grants for Applied Research*, *7*(1), 1–102. https://doi.org/10.3310/pgfar07010

McCabe, R., Whittington, R., Cramond, L., & Perkins, E. (2018). Contestedunderstandings of recovery in mental health. *Journal of Mental Health*, *27*(5), 475–481. https://doi.org/10.1080/09638237.2018.1466037

McGlynn, P. (2006). *Crisis resolution and home treatment: A practical guide*. Sainsbury Centre for Mental Health.

Mezzina, R. (2014). Community mental health care in Trieste and beyond: An "open door–no restraint" system of care for recovery and citizenship. *The Journal of Nervous and Mental Disease*, *202*(6), 440–445. https://doi.org/10.1097/NMD.0000000000000142

Morant, N., Lloyd-Evans, B., Lamb, D., Fullarton, K., Brown, E., Paterson, B., & Henderson, C. (2017). Crisis resolution and home treatment: Stakeholders' views on critical ingredients and implementation in England. *BMC Psychiatry*, *17*(1), 254. https://doi.org/10.1186/s12888-017-1421-0

Reeves, S., Pelone, F., Harrison, R., Goldman, J., & Zwarenstein, M. (2017). Interprofessional collaboration to improve professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews*, 6. DOI:10.1002/14651858.CD000072.pub3

Rhodes, P., & Giles, S. J. (2014). 'Risky business': A critical analysis of the role of crisis resolution and home treatment teams. *Journal of Mental Health*, *23*(3), 130–134. https://doi.org/10.3109/09638237.2014.889284

Ruud, T., Karlsson, B., Klevan, T., & Hasselberg, N. (2015). *Ambulante akutteam i Norge: Praksis og erfaringer*. [Crisis resolution teams in Norway: Practice and experiences]. Akershus University Hospital.

Topor, A., Andersson, G., Bülow, P., Stefansson, C. G., & Denhov, A. (2016). After the asylum? The new institutional landscape. *Community Mental Health Journal*, *52*(6), 731–737. https://doi.org/10.1007/s10597-015-9928-7

Wheeler, C., Lloyd-Evans, B., Churchard, A., Fitzgerald, C., Fullarton, K., Mosse, L., … Johnson, S. (2015). Implementation of the crisis resolution team model in adult mental health settings: A systematic review. *BMC Psychiatry*, *15*(1), 74. https://doi.org/10.1186/s12888-015-0441-x

Winters, S., Magalhaes, L., & Kinsella, E. A. (2015). Interprofessional collaboration in mental health crisis response systems: A scoping review. *Disability and Rehabilitation*, *37*(23), 2212–2224. https://doi.org/10.3109/09638288.2014.1002576