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Care giving and receiving for people with complex emotional needs within a crisis resolution/home treatment setting: A qualitative evidence synthesis

Michael Haslam, Gary Lamph, Emma Jones & Karen Wright

ABSTRACT

Background: A growing body of qualitative evidence focusing upon the experiences of care within Crisis Resolution/Home Treatment (CRHT) is emerging, however, a firm evidence-base regarding both the giving and receiving of care for those with complex emotional needs (CEN) in this context is yet to be established.

Objective: A qualitative evidence synthesis was used to develop a comprehensive understanding of how crisis care for people with CEN is experienced by both those giving and receiving care, within the context of CRHT.

Method: Findings from 19 research papers considering both clinician and service users' experiential accounts of CRHT were synthesised using meta-ethnography.

Findings: Both the giving and receiving of care within a CRHT context was experienced across four related meta-themes: 'contextual', 'functional', 'relational' and 'decisional'.

Discussion: Service user accounts focused upon relational aspects, highlighting a significance to their experience of care. Meanwhile, clinicians focused more upon contextual issues linked to the management of organisational anxieties and resources. For those with CEN, a clinician's focus upon risk alone highlighted power differentials in the caring relationship.

Conclusions: There is a need for nurses to connect with the experience of the person in crisis, ensuring a better balance between contextual issues and relational working.

ACCESSIBLE SUMMARY

What is known on the subject?

- The term 'complex emotional needs' (CEN) is used here to describe people with difficulties and needs that are often associated with the diagnostic label of "personality disorder".
- People with CEN might use out of hours services such as emergency departments and Crisis Resolution/Home Treatment (CRHT) teams more often when experiencing a mental health crisis.
- Very little is understood about the experiences of both those receiving, and those delivering care, for people with CEN within CRHT settings.

What this paper adds to existing knowledge?

- There are differences between priorities for those delivering and those receiving care within CRHT settings. CRHT staff members are likely to focus more upon those aspects of their role relating to risk issues, managing resources, anxieties, and the expectations of others. Service users, meanwhile, focused upon the caring relationship, wanting staff to listen to them, and to feel supported and reassured.
- In the papers reviewed, service users experiencing CEN did not always feel 'listened to' or 'taken seriously' especially in relation to risk issues and decision-making.

What are the implications for practice?

- Relating the findings to mental health nursing and CEN within the context of CRHT, to better understand the person experiencing a mental health crisis, mental health nurses need to focus more upon the person and when making decisions around their care and must be aware of the potential for power imbalances.
- Collaborative 'sense-making' in relation to a person's risk behaviours may help.

KEYWORDS

complex emotional needs; crisis resolution home treatment; experience; mental health nurse; qualitative evidence synthesis; meta-ethnography; personality disorder; relationship

INTRODUCTION

'Complex emotional needs' (CEN) is the term used here to describe those difficulties and needs that are commonly (although not exclusively) associated with the more contentious and stigmatising (Bolton, *et al.* 2014) diagnostic label of 'personality disorder' (World Health Organisation, 2019; American Psychiatric Association, 2015). Despite the literature used within this review largely relating to the label of 'personality disorder', the alternative term CEN is adopted instead, in a response to the ongoing debate around terminology (Sheridan Rains, *et al.* 2021) and as one which may be more acceptable to users of mental health services. This is due to the considerable harms associated with the diagnostic label (Trevillion, *et al.* 2022), given its links with therapeutic pessimism and moral judgementalism (Wright, *et al.* 2007).

Caring for people with CEN who are experiencing a mental health crisis, can be more complex than supporting people facing other mental health challenges, considering the increased potential when unwell for interpersonal issues, heightened emotional arousal, self-injury, and complex social problems (Bolton, *et al.* 2014; NICE, 2009). Such challenges may potentially impede assessment and the ability of the mental health nurse to work with the service user effectively in crisis settings. Additionally, the associated diagnostic label of personality disorder, is one that is particularly linked with increased levels of health service utilisation (Hong, 2016) including frequent and unscheduled crisis presentations at Emergency Departments (ED) (Shaikh, *et al.* 2017) and to out of hours mental health services such as Crisis Resolution & Home Treatment (CRHT) teams.

A significant amount of literature already exists relating to the care of people with CEN who are seeking help when experiencing crisis (Hunter, *et al.* 2013; Saunders, *et al.* 2011; Murphy & McVey, 2003; Lewis & Appleby, 1998), although studies have focused more upon ED settings (Byrne, *et al.* 2021; O'Keefe, *et al.* 2021; Quinlivan, *et al.* 2021; Haslam & Jones, 2020; MacDonald, *et al.* 2020; Collom, *et al.* 2019; Haslam, 2019; Rayner, *et al.* 2017; Shaikh, *et al.* 2017). Existing literature for CRHT, meanwhile, has focused more upon team structure, outcomes, and function (Sjølie, *et al.* 2010). Studies examining experiential accounts of care giving and receiving within CRHT settings are emerging (Nelson, *et al.* 2016; Carpenter & Tracy, 2015; Carpenter, *et al.* 2013; Freeman, *et al.* 2011; Winness, *et al.* 2010), although a solid evidence base regarding the impact of CRHT on service user experience is still lacking (Dalton-Locke, *et al.* 2021) and too few of these studies focus upon the experiences of those with CEN within CRHT settings.

Considering experiential accounts of those with CEN within CRHT settings, is important, given that the experience of those in crisis remains poorly understood (Warrender, *et al.* 2020) and bearing in mind the potential impact of systemic challenges posed within a CRHT context, upon the nurse-patient relationship. The wider literature emphasises the importance of a positive therapeutic relationship and its crucial role in collaborative and person-centred care (Johnstone, *et al.* 2018; Wright, *et al.* 2007); Challenges stemming from broader systemic issues, may impact upon its development and such challenges, if not adequately addressed, might increase the potential for stigmatizing responses, and feelings of invalidation and dismissal for the service user (Ware, *et al.* 2022); a problem for those who might already be experiencing interpersonal struggles or have a history of significant adversity and trauma (Johnstone, *et al.* 2018).

Broader systemic challenges impacting, include those tensions relating to limitations in funding, a reduction in staffing levels, and ever-increasing caseloads (Beale, 2022), all of which contribute to unhelpful time constraints that are contrary to guidance (NICE, 2022; 2009). Furthermore, resource management through the gatekeeping role (Department of Health, 2001), coupled with the pursuit of externally monitored and defined targets (Haslam & Jones, 2020) may also lead to a distortion in clinical priorities (Haslam, 2019). The consequences of such challenges are that task-orientated care is given precedence above those interpersonal relationships needed (McKeown, 2023; Simpson, *et al.* 2016).

Moreover, those challenges unique to CRHT settings also include access to numerous professionals across multiple shift patterns, posing a problem for consistency and engagement, while endings and transitions of care need to be managed carefully due to the short-term nature of team involvement (NICE, 2009). Here, a continuity of care, fundamental to working with people with CEN, is needed (Trevillion, *et al.* 2022).

In light of the challenges, therefore, a further exploration of the giving and receiving of care within CRHT settings is warranted to support understanding around effective care for people with CEN. Recent reviews of crisis care for people with CEN have emerged (DeLeo, *et al.* 2022; Warrender, *et al.* 2020), although the need for a further review in this area is driven by a lack of qualitative evidence syntheses specifically within CRHT settings.

OBJECTIVE

A meta-ethnography (Noblit & Hare, 1988) was selected as a formal and systematic method of synthesising and reinterpreting (Sattar, *et al.* 2021) existing qualitative literature in relation to experiential accounts of care giving and receiving within a CRHT context. This was with the purpose of generating new understandings (Noble & Smith, 2018; Atkins, *et al.* 2008) into home-based mental health crisis care for people with CEN, and to how this is experienced by both those delivering and receiving care. It was also expected that this qualitative evidence synthesis would highlight the gaps in knowledge to guide further inquiry. This qualitative evidence synthesis follows eMERGe guidance for the reporting of meta-ethnography (France, *et al.* 2019a).

METHOD

Literature search strategy

To identify and define appropriate search terms for this qualitative evidence synthesis, the **PICo** model for qualitative reviews (Aromataris, *et al.* 2015; Stern, *et al.* 2014) was applied. Given the need to explore human experience over an outcome or comparator, search terms relating to the **P**opulation studied (people with complex emotional needs), the **P**henomenon of **I**nterest (experiences of care and the caring relationship) and the **R**esearch **C**ontext (mental health crisis services) were initially identified. These were further expanded to define additional related search terms (see table 1) to maximise the success of the literature search.

Table 1: Search terms used to identify appropriate literature.

P opulation	“Complex emotional needs” OR “Personality Disorder” OR “personality difficulties”
Phenomenon Of I nterest	Response* OR relation* OR care OR experience*
Research C ontext	Crisis OR “crisis resolution” OR “crisis team” OR “crisis service” OR “crisis support” OR “home treatment”

These search terms were then applied to the Web of Science, Scopus, PsycINFO, CINAHL and Medline databases between June 2022 and January 2023.

Selection of evidence

The initial search, total of 2,239 articles were identified (see fig.1). 664 duplicate records were removed before screening. The remaining sources (n=1575) were filtered according to the eligibility criteria in table 2.

Table 2: Eligibility criteria

Stage screened/assessed	Sources included	Sources excluded
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<p>Initial screening</p>	<ul style="list-style-type: none"> • Papers written in the English Language • Papers published after 2003 	<ul style="list-style-type: none"> • Papers written in any other language than English with no English translation • Papers published prior to 2003
<p>Reports assessed based upon title and abstract</p>	<ul style="list-style-type: none"> • Empirical papers that include qualitative primary research data (these can be reporting on studies that employ mixed methods approaches) 	<ul style="list-style-type: none"> • Empirical papers employing purely quantitative data research methods • Review papers • Expert Opinion papers
<p>Reports assessed and included/excluded depending upon their ability to contribute to the understanding of experiences of care giving or receiving within home-based CRHT setting</p>	<ul style="list-style-type: none"> • Papers must focus upon experiential accounts of care giving and/or receiving of home-based mental health crisis care for adults over the age of 18 	<ul style="list-style-type: none"> • Papers that primarily focus upon CRHT team structure, function, and outcomes/economic value rather than experiential accounts of care giving/receiving • Papers reporting studies that primarily focus upon participants under the age of 18. • Papers that report experiential accounts of general community, inpatient or ED settings • Papers where studies do not focus directly upon those who have directly delivered or received mental health crisis care (such as those primarily considering carers/families)

Papers published prior to 2003 were excluded based upon this being the year that the “No Longer a Diagnosis of Exclusion” (NIMHE, 2003a) and the ‘Personality Disorder Capabilities framework’ (NIMHE, 2003b) documents were published, both representing a significant change in the United Kingdom (UK) policy towards treatment for people with CEN. This is also reflective of CRHT team implementation in the UK; many having only been in existence since the early 2000s (Department of Health, 2001; McCulloch, *et al.* 2000; Minghella, *et al.* 1998). Beyond this, sources were screened for eligibility for inclusion in this synthesis and discarded if they were not qualitative primary research, not relevant to the topic under investigation, or did not explore experiential accounts of care giving and receiving within this context.

As very few papers specifically considered the lived experiences of care giving and receiving, specifically for people with CEN within the context of a CRHT setting (reflecting the lack of literature in in this area), the decision was therefore made not to exclude qualitative research papers that contributed to a more general understanding around how care is experienced across all diagnoses within this setting, especially as a number of papers identified, still included participants carrying a diagnosis of personality disorder within their sample. Full texts were obtained for the remaining 86 papers, and further papers (n=69) were excluded at the full text stage if they did not contribute to the understanding of the lived experience of care as received or delivered in a CRHT setting. Forward and backward reference search was also conducted to identify additional papers that were of relevance (n=2).

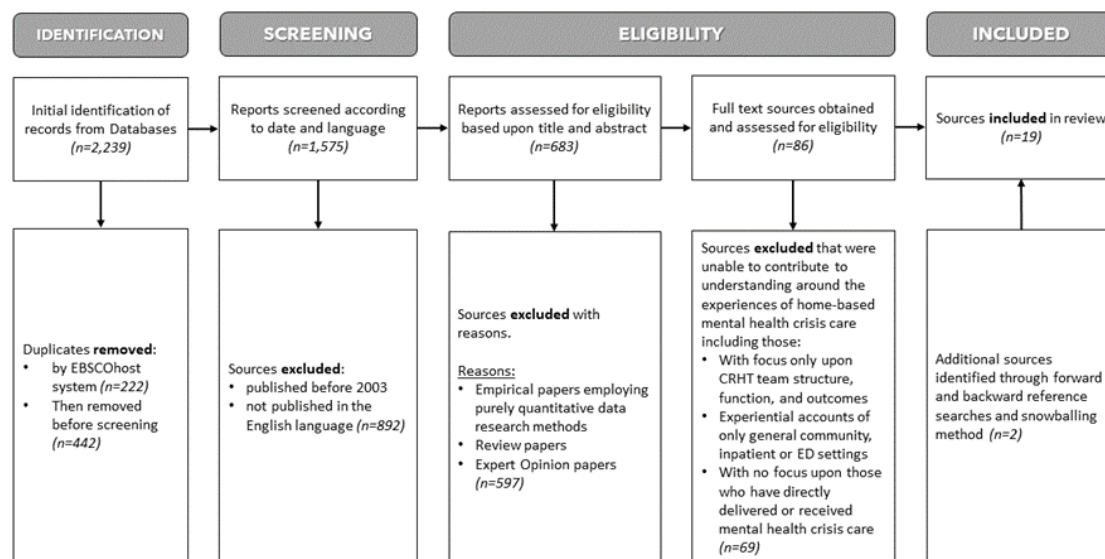


Fig.1: PRISMA diagram (Page, et al. 2021)

Characteristics of papers included in this review

Included in this review were 19 qualitative primary research papers (see table 3), all considered able to provide insight into the lived experience of care giving and receiving within the context of CRHT, and so able to contribute to the objectives of this qualitative evidence synthesis. Papers from across 4 countries were eligible for inclusion in this qualitative evidence synthesis, the majority (n=15) being published in the UK. Where studies were conducted outside of the UK, it was considered that the experience of CRHT was comparable to that of the UK given that home-based mental health crisis care was provided via a specialist team, (Karlsson, et al. 2008).

Of the 19 papers reviewed, 4 (Chilman, et al. 2021; Morant, et al. 2017 and Klevan, et al. 2018; 2017) were derived from, and reporting on different aspects of, the same 2 primary studies. In terms of participant characteristics, 8 papers considered the experiences of CRHT clinicians, 8 considered the experience of those receiving care and 3 considered the experiences of both clinicians and service user participants. Sample sizes ranged from 1 to 188 participants (Nelson, et al. 2016, and Morant, et al., 2017, respectively). Of the 19 papers, just 7 contained direct references to the diagnostic label of personality disorder (Taylor, et al. 2023; Chilman, et al. 2021; Rubio, et al. 2021; Morant, et al. 2017; Sacks & Iliopoulou, 2017; Nelson, et al. 2016; Carpenter & Tracy, 2015), either identified through the demographics of participants, or participants explicitly discussing their experiences in relation to the label. Only 1 of the included papers focused solely upon clinician experiences of working with this population (Taylor, et al. 2023), reflecting the paucity of qualitative research considering care giving and receiving for people with CEN within this setting.

Quality appraisal of papers reviewed

Although study appraisal is considered controversial within meta-ethnography due to the wide variety of qualitative research methodologies used in the papers reviewed (Noblit, 2019), all articles included in this synthesis were critically appraised using the Walsh & Downe's (2006) criteria, chosen specifically for its purpose in appraising qualitative research papers and its ability to be used for interpretive and constructivist reviews such as meta-ethnography (Majid & Vanstone, 2018). When measured against Walsh & Downe's (2006) tool, primary research papers reviewed were given a rating status based upon the quality (see Table 3), however as the authors suggest that criteria are used "imaginatively" rather than prescriptively, the over-rigorous application of criteria would potentially have led to the exclusion of papers that were intuitively felt to be important, though may not have fared quite as well in the quality assessment (Jones, et al. 2021). Furthermore, the lack of contextualisation and reporting of sampling

strategies in those papers rated as lower quality, did not necessarily equate with poorly conducted research (Atkins, *et al.* 2008). Papers were therefore not excluded based upon lower quality ratings.

Table 3: *Study characteristics and quality appraisal.*

Authors	Data collection methods	Participant numbers / characteristic	Intern'al context	Quality appraisal rating
Taylor, <i>et al.</i> (2023)	Semi-structured interviews	Clinicians = 7 all of whom worked within CRHT	UK	HIGH
Chilman, <i>et al.</i> (2021)	Analysis of 500 'Tweets' and compared with findings from Semi-structured interviews and focus groups (see Morant, <i>et al.</i> 2017).	Clinicians = unknown Service Users = unknown (381 tweets) -Personality Disorder diagnosis = unknown	UK	HIGH
Rubio, <i>et al.</i> (2021)	Semi-structured interviews & focus groups	Clinicians = 25 -Of whom worked within CRHT = 13 Service users = 15 -Personality disorder diagnosis = 2	UK	HIGH
Giménez-Díez <i>et al.</i> (2019)	Survey & interviews	Service users = 20 -Personality disorder diagnosis = unknown	Spain	HIGH
Lombardo, <i>et al.</i> (2019)	Semi-structured interviews	Clinicians = 12 all of whom worked within CRHT	UK	HIGH
Klevan, <i>et al.</i> (2018)	Semi-structured interviews	Clinicians = Unknown though all worked within CRHT	Norway	HIGH
Daggenvoorde & Goossens (2017)	Open interviews	Service users = 10 -Personality disorder diagnosis = 0	Netherlands	HIGH
Klevan, <i>et al.</i> (2017)	Semi-structured interviews	Service users = 14 -Personality disorder diagnosis = unknown	Norway	HIGH
Morant, <i>et al.</i> (2017)	Semi-structured interviews & focus groups	Clinicians = 147 -Worked within CRHT=61 Service users = 42 -Personality disorder diagnosis = 3 (further n=7 unknown)	UK	HIGH
Sacks & Iliopoulou (2017)	Focus Groups	Clinicians = 24 all of whom worked within CRHT	UK	LOW
Begum & Riordan (2016)	Semi-structured interviews	Clinicians = 6 all of whom worked within CRHT	UK	HIGH
Nelson, <i>et al.</i> (2016)	Reflections on a Semi-structured interview	Service users = 1 -Personality disorder = 1	UK	HIGH
Carpenter & Tracy (2015)	Semi-structured interviews	Service users = 10 -Personality disorder diagnosis = 3	UK	HIGH
Rhodes & Giles (2014)	Semi-structured interviews	Clinicians = 25 -Worked within CRHT = 24	UK	MEDIUM
Taylor, <i>et al.</i> (2012)	Questionnaire & face-to-face interviews	Service users = 49 -Personality disorder diagnosis = unknown	UK	HIGH
Freeman, <i>et al.</i> (2011)	Semi-structured interviews	Clinicians = 5 all of whom worked within CRHT	UK	HIGH
Middleton, <i>et al.</i> (2011)	Semi-structured interviews	Service users = 33 -Personality disorder diagnosis = Unknown	UK	HIGH
Tobitt & Kamboj (2010)	Semi-structured interviews	Clinicians = 39 all of whom worked within CRHT	UK	HIGH
Hopkins & Niemiec (2007)	2-stage Delphi study Semi-structured interviews	Service users = 70 Of whom carry a Personality disorder diagnosis = unknown	UK	HIGH

Quality appraisal ratings were conducted by the lead author before being discussed with, and corroborated by, the wider research team. Overall, the quality of most of the papers reviewed was determined as high (n=17); most papers containing a clear statement and rationale for conducting the studies, having first contextualised them within the existing literature and therefore providing congruence between method, study design and data collection/analysis and using data to support interpretation. However, many papers did not adequately describe the researchers' philosophical and cultural position or influence on the research (n=7), so it was unclear as to the differences between

differing assumptions underpinning studies. Some papers, including those rated as lower quality, also missed opportunities to demonstrate reflexivity and/or discuss how they addressed ethical concerns.

Method of data extraction and synthesis

Following the initial identification of the 19 primary research papers, repeat readings of these papers supported a familiarity with initial concepts and their themes. To illuminate those shared experiences of care considered important in a CRHT context, papers considering clinician and service user experiential accounts were then synthesised. First, a reciprocal translation was employed, given that papers reviewed were sufficiently similar in their focus (Sattar, *et al.* 2021), establishing how existing concepts from the papers reviewed, related to each other. Here, linked codes, such as “Managing expectations”, “Managing anxieties” and “Inappropriate referrals” were assigned to individual papers, allowing them to be clustered, thus facilitating the development of key ideas and concepts that resonated across multiple papers (in this case, these codes formed the sub-theme “Managing Tensions” - see fig.2).

Alongside this, an inductive approach was also utilized to corroborate findings and ensure that the context/meaning of original papers were preserved. This also ensured rigour and a systematic approach to the re-interpretation and synthesis of key concepts. For this, participant experiential accounts (forming the primary data in the papers reviewed) were also extracted and, using a line-by-line analysis within Microsoft Excel and Word programmes, all papers were coded using descriptive labels to identify common concepts. These were compared with those key concepts already identified from the reciprocal translation, and through a process of iterative revision, supported the development of new sub-themes.

Second, going beyond the initial translations, a final level of synthesis; the line of argument synthesis was employed (fig.3). Here, the thematic findings identified from the reciprocal translation, were combined with the primary data from the papers reviewed, to support the development of an overarching narrative discussing how care giving and receiving is experienced within the context of CRHT. Taking this approach placed findings into a new interpretive context (France, *et al.* 2019b), supporting a fuller ‘higher order’ interpretation of themes (Noblit, 2019), which allowed the emergence of new understandings. Highlighted, for instance, were those competing priorities, especially in respect of decision-making between those who give and those who receive care within a CRHT context.

Reflexivity

Given the lead author’s positionality as a mental health nurse formerly working within a CRHT setting and having conducted primary research in similar settings, reflexivity was needed to mitigate for the effects of potential bias (Ramani & Mann, 2016). Despite the potential to provide additional understanding and context to findings, existing presuppositions, such as those specifically relating to the delivery and quality of CRHT care, and barriers to effective care (as discussed in the introduction section) also had the potential to influence the interpretation of the data. As well as the use of a reflective log, to mitigate for potential biases, findings and themes were discussed with, and corroborated by, the wider research team to ensure that the interpretations and reinterpretations of the data were supported. Furthermore, the additional task of extracting and coding the primary data from the studies reviewed ensured that the overall synthesis and re-interpretation of initial author themes were also grounded within the data from the primary studies.

FINDINGS

Although the purpose of this qualitative evidence synthesis was to generate new understandings around how home-based mental health crisis care for people with CEN is experienced by both those delivering and receiving care, the paucity of qualitative evidence in this area indicates the need for further research exploring experiential accounts of care giving and receiving for those with CEN within this context. The themes discussed below, therefore, relate more broadly to the experiences of CRHT rather than what is known specifically for the care of people with CEN within CRHT although where possible:

1. Those papers which do explicitly discuss experiences relating to the diagnostic label of personality disorder are used to provide CEN context
2. Findings are further contextualised in the discussion section by relating back to wider literature around the experiences of those with CEN.

Reciprocal translation

A reciprocal translation was used first to establish how themes and concepts across the original papers reviewed related to each other (fig. 2). From this it appeared that both the giving and receiving of care within CRHT is experienced across four related meta-themes:

- a. 'Contextual' (concerning the role of CRHT in the wider systems within which teams operate)
- b. 'Functional' (concerning the organisation of everyday CRHT)
- c. 'Relational' (concerning the importance of interpersonal connections and relational working)
- d. And 'Decisional' (concerning decision-making within CRHT, with a particular emphasis upon risk).

Each meta-theme was developed from two or more co-occurring and related 'sub-themes' relating to how care is experienced within the context of CRHT (see fig. 2). These are discussed below and illustrated by representative quotations from the primary papers reviewed.

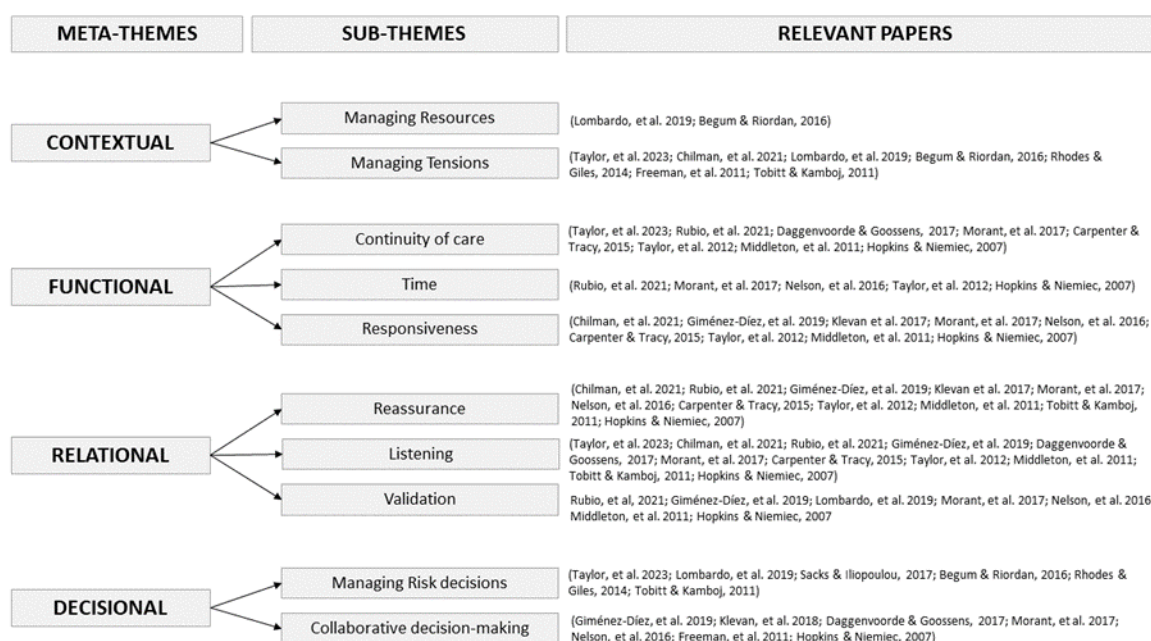


Fig.2: Reciprocal translation (list of meta-themes and related sub-themes)

Meta-theme 1: Contextual (Managing Resources & Managing Tensions)

This meta-theme, primarily discussed by clinician participants, was concerned with the existence and the role of CRHT within the wider space within which teams operate. Under the 'contextual' theme, there was an emphasis upon managing the throughput of service users and the management of organisational resources such as inpatient beds through the gatekeeping role:

“As gatekeepers we have a difficult job in making sure that we reduce admission rates and try and nurse service users at home.” (Clinician, Begum & Riordan, 2016, pg.48)

Also discussed under this meta-theme, was the team's role in the management of the anxieties and expectations of both service users (Taylor, et al. 2023; Begum & Riordan, 2016) and referrers (Chilman, et al. 2021; Lombardo, et al. 2019; Begum & Riordan, 2016; Rhodes & Giles, 2014; Freeman, et al. 2011; Tobitt & Kamboj, 2011). Clinician participants here, described tensions balancing the expectations of service users with what could realistically be offered.

“Our challenges are the expectations of the patient... if they perceive to want something else it can be very difficult to sell or discuss an idea if they've got something totally different in their mind that they want” (Clinician, Taylor, et al. 2023, pg.562)

The focus here, also, upon tensions raised by 'inappropriate' referrals, was put down to a perceived lack of understanding around the CRHT role (Klevan, *et al.* 2018; Morant, *et al.* 2017), or where anxieties are raised (Freeman, *et al.* 2011); teams being seen as an 'out of hours' extension of other community services (Rhodes & Giles, 2014) and considered as a 'dustbin' service for people experiencing distress (Tobitt & Kamboj, 2011). Under these circumstances, referrals were seen as being in the interests of the referrer rather than the individuals referred:

"There is a tendency. to see us as an out-of-hours extension of their service. We get referrals purely because it's the weekend; we get referrals from care co-ordinators if they're going on a fortnight's holiday." (Clinician, Rhodes & Giles, 2014, pg.133)

Meta-theme 2: Functional (Continuity of care, Time & Responsiveness)

The meta-theme, 'functional' related to the organisation of everyday CRHT as both delivered and received, and so discussed by both clinician and service user participants. The coordination of care fell within this meta-theme, concerned both with the continuity of clinicians within the team and the management of endings and transitions of care. *Familiarity with* (Morant, *et al.* 2017; Middleton, *et al.* 2011), and *consistency of*, CRHT clinicians were of importance here and discussed by both clinician (Taylor, *et al.* 2023) and service user participants (Rubio, *et al.* 2021; Morant, *et al.* 2017; Carpenter & Tracy, 2015; Taylor, *et al.* 2012; Middleton, *et al.* 2011; Hopkins & Niemiec, 2007). Continuity of CRHT workers supported a consistency in terms of advice (Taylor, *et al.* 2023; Carpenter & Tracy, 2015), ensured that individuals were not having to repeatedly answer the same questions (Rubio, *et al.* 2021; Taylor, *et al.* 2012) and facilitated the development of the therapeutic relationship (Rubio, *et al.* 2021; Morant, *et al.* 2017):

"It's very difficult when you've got a different person coming to your house every day. "How are you today?" "Well, I don't know you from Adam so-"" (Service User, Rubio, *et al.* 2021, pg.211)

Where it was necessary to have several people involved, good communication and a proper handover were deemed essential (Hopkins & Niemiec, 2007) as was the same for transition of care to other teams (Daggenvoorde & Goossens, 2017; Taylor, *et al.* 2012; Hopkins & Niemiec, 2007):

"A conversation between the crisis team, my therapist, and me: that would have been helpful. The most important people would have been together then and could have shared all the information." (Service User, Daggenvoorde & Goossens, 2017, pg.466)

Also falling under this meta-theme was the coordination of personal care received, identifying issues concerning time (in relation to home visits), the responsiveness of the team, and the continuity of care. Time, in relation to home visits, related both to the timing of visits (Rubio, *et al.* 2021; Nelson, *et al.* 2016; Taylor, *et al.* 2012; Hopkins & Niemiec, 2007), and to the duration of visits (Morant, *et al.* 2017; Hopkins & Niemiec, 2007). Participants in the papers reviewed, considered the need for clinicians to arrive at a time that was convenient, fitting around commitments (Nelson, *et al.* 2016) and family responsibilities (Rubio, *et al.* 2021). Where clinicians were late to planned appointments, this was considered disrespectful and was likely to increase anxieties (Taylor, *et al.* 2012; Hopkins & Niemiec, 2007):

"It doesn't mean that just because you are suffering from a depressive illness you are not also quite busy and I think that's part of respect, you can't arrive half an hour late for somebody" (Service User, Hopkins & Niemiec, 2007, pg.313)

Spending time was also considered important, linking into the 'relational' meta-theme around connection, reassurance and feeling 'listened to'. Where time was offered to listen to individuals, service users responded positively feeling that their experiences had been validated (Morant, *et al.* 2017; Hopkins & Niemiec, 2007). Equally, some service user participants reported feeling dismissed by those clinicians who did not offer the time to listen to their concerns (Rubio, *et al.* 2021) and sometimes this led to a potential increase in risk:

“Not having time to talk to me they made me feel I shouldn't be calling and that I was a pain. At times I'd come off the phone and self-harm as they'd upset me more” (Service User, Taylor, *et al.* 2012, pgs.451-452)

The responsiveness of the team was of significance to service user participants in the papers reviewed; further broken down into the availability and accessibility of the team via a 24 hour crisis telephone line (Chilman, *et al.* 2021; Giménez-Díez, *et al.* 2019; Klevan *et al.* 2017; Nelson, *et al.* 2016; Middleton, *et al.* 2011; Hopkins & Niemiec, 2007), and the immediacy of involvement from referral (Morant, *et al.* 2017; Carpenter & Tracy, 2015; Hopkins & Niemiec, 2007). Here, a timely referral and response were deemed essential, and where the team responded immediately to an individual's crisis, experiences were positive:

“One of the things that first strikes me is the availability and the immediacy of it...So the fact that the crisis team are so accessible at the point when you're actually in crisis is just almost... it feels like a miracle at the time” (Service User, Morant, *et al.* 2017, pg.5)

Negative experiences of CRHT, were attributed to a lack of clinician response (Taylor, *et al.* 2012; Middleton, *et al.* 2011) and availability (Chilman, *et al.* 2021):

“No one will answer the phone during handover for an hour, what if it's an emergency?” (Service User, Chilman, *et al.* 2021, pg.6)

Meta-theme 3: Relational (Reassurance, Listening & Validation)

A clear theme discussed across all papers that considered the experiences of service user participants, there was a strong convergence here relating to those qualities most valued in the caring relationship. Where there was an absence of these qualities, care was experienced as less satisfactory. A key sub-theme here was a need for reassurance. Reassurances were discussed both within the context of recovery and the promotion of hope (Chilman, *et al.* 2021; Carpenter & Tracy, 2015; Middleton, *et al.* 2011; Hopkins & Niemiec, 2007), and reassurances also around individuals' safety (Taylor, *et al.* 2012):

“They were a constant reassurance. The fact that they understood or seemed to understand what I was going through was really reassuring” (Service User, Middleton, *et al.* 2011, pg.152)

For some service user participants, reassurances by CRHT clinicians enhanced the perception that they were 'cared for' (Klevan *et al.* 2017) and where clinicians visited daily, service user participants reported feeling 'supported' by the team (Rubio, *et al.* 2021; Morant, *et al.* 2017; Middleton, *et al.* 2011; Hopkins & Niemiec, 2007) and where needed, contact was increased via telephone or text message (Giménez-Díez, *et al.* 2019). This was not the case for all service user participants, however, some reporting that they were not contacted as often as needed:

“I didn't contact anyone around me. I was all alone, and I felt very attached to the CRT... I wish they had called me, just to ask me how I was doing”. (Service User, Klevan *et al.* 2017, pg.99)

Effective communication was regarded as essential to the reassurance of service users. Information-giving relating to pathology and prognosis (Giménez-Díez, *et al.* 2019; Carpenter & Tracy, 2015), and how the team could help from the outset of treatment (Taylor, *et al.* 2012), was deemed helpful, as well as the identification of an individual's strengths and reminder of previous recovery (Nelson, *et al.* 2016; Tobitt & Kamboj, 2011).

Linked to communication, listening was considered fundamental to positive experiences of CRHT, discussed both in the respect of 'listening to' service user wishes and concerns and taking these on board (Chilman, *et al.* 2021; Giménez-Díez, *et al.* 2019; Morant, *et al.* 2017; Hopkins & Niemiec, 2007), and in the respect of CRHT clinicians taking time to listen and understand:

"It wasn't a case of 'we've got to go now'. They were there for me until I finished what I had to say and when they felt that I had had enough talking and I had got to the point where I didn't want to go any further, that is when they called it a day. It was 'we'll hold it there' not 'we've got to go now' which I thought was beautiful." (Service User, Hopkins & Niemiec, 2007, pg.312)

Negative experiences were reported by service user participants in papers where there was a dissonance between clinician and service user's perception of risk and need (Rubio, *et al.* 2021; Daggenvoorde & Goossens, 2017; Carpenter & Tracy, 2015; Taylor, *et al.* 2012), highlighting the importance of 'being listened to' around perceived needs, such as inpatient admission:

"I said I really want to go into [an MBU]. And [the community team] said "no, I don't think you need to go into one of those"... What I felt like was I can't cope with my normal life... I need to get away from it". (Service User, Rubio, *et al.* 2021, pg.214)

The perception of not being listened to, was experienced as invalidating and responses felt to be unhelpful, thus potentially increasing the individual's risk of self-injury (Chilman *et al.*, 2021; Taylor, *et al.* 2012):

"I was told mostly to go and "have a cup of tea." I don't even like tea. In desperation of phoning, I probably would have burned myself". (Service User, Taylor, *et al.* 2012, pg.451)

Where the diagnostic label of personality disorder intersected with risk issues, for some, this, led to perception of dismissal due to the diagnosis (Taylor, *et al.* 2023; Chilman *et al.*, 2021; Taylor, *et al.* 2012; Tobitt & Kamboj, 2011):

"The CRT find out you have a diagnosis of BPD, they just ignore you" (Service User, Chilman, *et al.* 2021, pg.5)

It was essential therefore to validate an individual's distress, especially where there were risk issues (Lombardo, *et al.* 2019):

"If he feels that the situation is not validated then he will increase his risk behaviours... I felt that we needed to validate his level of distress over that and try and keep it compact" (Clinician, Lombardo, *et al.* 2019, pg.64).

Where concerns were validated, CRHT input was experienced more positively by service user participants (Middleton, *et al.* 2011). Helpful responses here included those where experiences were normalised (Morant, *et al.* 2017; Middleton, *et al.* 2011; Hopkins & Niemiec, 2007):

"He made me feel like I was a human being who he was trying to relate to and assist at a critical time" (Service User, Hopkins & Niemiec, 2007, pg.313)

Meta-theme 4: Decisional (Managing risk decisions & Collaborative decision-making)

The 'Decisional' meta-theme, as concerned with decision-making processes within CRHT, was discussed by participants in over half of the papers reviewed. Here there was a particular emphasis upon risk decisions and the role of collaboration/individual agency in these. Closely linked to the other three meta-themes, risk decisions were often discussed within the context of resource availability (Chilman, *et al.* 2021; Begum & Riordan, 2016; Nelson, *et al.* 2016), and by clinicians in relation to anxieties of referrers in respect of service user risk (Begum & Riordan, 2016; Freeman, *et al.* 2011). Where the clinician's focus was upon risk (Rubio, *et al.* 2021; Sacks & Iliopoulou, 2017) this was considered a barrier to relational working.

This meta-theme was concerned with risk management and collaborative decision-making, the first being concerned with the responsibility associated with risk decisions (Sacks & Iliopoulou, 2017; Begum & Riordan, 2016), and the justification of those decisions:

“For her own safety, she was unpredictable, it would have been difficult to manage that in the community at that time. Admission was the right decision” (Clinician, Lombardo, et al. 2019, pg.62)

Clinician responses falling under this sub-category discussed risk behaviours as something that required ‘management’ (Taylor, et al. 2023; Rubio, et al. 2021; Lombardo, et al. 2019; Sacks & Iliopoulou, 2017; Begum & Riordan, 2016), while some reduced service users and their crises down to their ‘level’ of risk:

“Whether somebody is in crisis is often heavily defined by their level of risk, in relation to suicide, harming them self, or others...so from being in the team I’ve probably moved... to seeing [crisis] being much more about somebody’s level of risk” (Clinician, Tobitt & Kamboj, 2011, pg.675)

This was especially the case where the diagnostic label of personality disorder intersected with risk issues and service users’ actions were therefore interpreted through a risk ‘lens’; the label was felt to instigate fear in clinicians leading to either avoidance or an increase defensive practice (Taylor, et al. 2023):

“A lot of practitioners don’t feel happy with supporting people with that diagnosis ... because they are risky, and it scares them” (Clinician, Taylor, et al, 2023, pg.563)

The sub-category ‘Collaborative decision-making’ on the other hand, concerned itself with service user choice, the involvement of service users in their own treatment and risk decisions and so ‘working with’ the individual (Middleton, et al. 2011). References were made to pre-existing power imbalances within mental health services (Daggenvoorde & Goossens, 2017; Nelson, et al. 2016), and the positive experiences highlighted the importance of ‘empowering’ the individual receiving care, by considering individual agency and including service users in decision-making (Giménez-Díez, et al. 2019; Klevan, et al. 2018; Morant, et al. 2017; Nelson, et al. 2016; Freeman, et al. 2011; Hopkins & Niemiec, 2007):

“Crucially though, their strategy was to take responsibility yet at the same time to immediately begin to hand it back to me... I had to make a decision. I was given both the power and the responsibility to do that.” (Service User, Nelson, et al. 2016, pg.445)

DISCUSSION

Findings within this qualitative evidence synthesis are consistent with those previous reviews considering more generally the experiences of CRHT (Winness, et al. 2010; Carpenter, et al. 2013), highlighting the importance of accessibility, and of service users being understood as ‘normal’. Like earlier reviews, this synthesis also highlights the importance of the therapeutic relationship and reassurances (Winness, et al. 2010) while negative aspects of care relate to inconsistencies of staff, sudden endings and transitions and a lack of service user involvement in the decisional aspects of their care (Carpenter, et al. 2013).

While not all papers considered within this qualitative evidence synthesis focused solely upon the experiences of those with CEN, findings here are still consistent with those reviews considering the experiences of mental health crisis care as experienced by those with CEN (Warrender, et al. 2020; DeLeo, et al. 2022), influenced by relational, functional, and decisional aspects. Furthermore, specifically where experiential accounts of those with CEN were considered, pejorative judgements perpetuated by the diagnostic label of personality disorder had the potential to lead to exclusionary practice as observed in these earlier reviews (Warrender, et al. 2020; DeLeo, et al. 2022).

Line of argument synthesis

While the experiences of mental health crisis for those with CEN are often complex and subjective (Warrender, et al. 2020), the commonalities between service user experiential accounts in this review have identified those aspects of crisis care, deemed significant to service users. Aspects perceived to be most important such as availability and accessibility of the team, feeling listened to, validation of personal experience, and collaborative decision-making were observed, both by their presence within service user experiences (representing a positive care experience) and by their absence (representing

care that was lacking). The latter was often the case when experiences of crisis care were discussed in conjunction with the diagnostic label of personality disorder, thus highlighting how CRHT care can fall short of meeting the needs of service users with CEN.

Meanwhile, the synthesis of both service user and clinician experiential accounts have also highlighted the tensions between both groups relating to competing priorities, and issues around decision-making within a CRHT context. Service users and clinicians across all papers reviewed, discussed their experiences across all four of meta-themes identified, although service users focused more upon the relational (such as validating responses and being ‘listened to’) and functional aspects (such as consistency, constancy, and availability), indicating the importance of these features of care to their experience (see fig. 3). This finding reflects wider literature around the significance of individualised care and positive relationships in the community for those with CEN (Sheridan-Rains, *et al.* 2021; Bolton, *et al.* 2014).

In contrast, the focus of clinicians appeared to be more upon contextual issues, relating to the role of CRHT within the wider mental health system; such a position being natural for a team that shares multiple interfaces with other components of the mental health system (Hannigan, 2014). Identified areas of focus for clinicians related more to the decisional and procedural aspects of providing care and treatment, linked to the management of organisational anxieties and expectations of others, and to the management of resources. Where this was the focus of clinicians, they were experienced by service users as ‘cold’, ‘too professional’ (Rubio, *et al.* 2021) and not giving enough of themselves in the interaction.

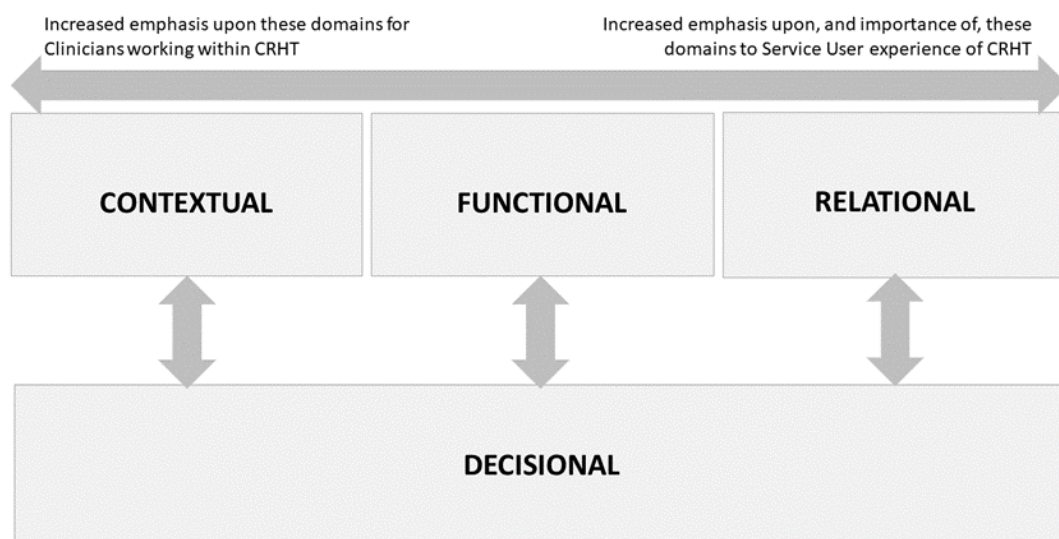


Fig.3: Thematic map illustrating a line of argument synthesis

The literature existing in relation to working with people with CEN within the context of CRHT is limited, although parallels may still be drawn between findings in this synthesis and research carried out in other areas of mental health care for people with CEN. Lamph, *et al.* (2021; 2019), for instance, described how service users carrying a label of personality disorder under the *Improving Access to Psychological Therapies* (IAPT) service in the UK, identified the lack of time to develop relationships and to ‘offload’, which was viewed as a barrier to progress (Lamph, *et al.* 2021). Clinicians however (Lamph, *et al.* 2019), identified rigid and restrictive treatment and organisational constraints as barriers to delivering the care required by service users. Findings from this review therefore support the idea that a clinician focus upon managerialism (Trevillion, *et al.* 2022) leads to a reduction in personalised care.

Where experiential accounts specifically of those with CEN were considered within the papers reviewed, the diagnostic label of personality disorder highlighted the potential for power imbalances within the caring relationship. Specifically, where risk issues relating to the decisional aspects of CRHT, intersected with the diagnostic label of personality disorder, feelings of dismissal both of service users' need and personal perception of risk, reflect the wider literature considering access issues (Clibbens, *et al.* 2023) and the denial of a person's subjectivity when experiencing crisis, unless a person's crisis contributed to an increase in risk (Ware, *et al.* 2022). This links to both epistemic injustice within wider mental health services (Fisher, 2023) and structural stigma for those with CEN (Klein, *et al.* 2022; Sheridan Rains, *et al.* 2021); both likely to lead to feelings of invalidation and increasing the risk of iatrogenic harm (Beale, 2022).

Furthermore, in the papers reviewed, clinicians working with those carrying the diagnostic label were sometimes described as 'fearful' and their practice, more 'defensive' than when working with people with other diagnoses (Taylor, *et al.* 2023; Chilman, *et al.* 2021), therefore not always practising in the best interests of service users. Relating these findings to the wider literature, where risk dominates the clinician's view, and especially in clinical areas where clinicians fear being criticised, they are likely to feel driven to take responsibility for the service user, thus denying them personal agency. There is a chance that this will undermine the person's need for individualised care (Felton, *et al.* 2018), whilst adding to service user's sense of emotional turmoil and lack of safety (Veale *et al.* 2023).

Implications for mental health nursing practice

Relating the findings to mental health nursing within the context of CRHT, the importance of focusing upon the 'embodied state' of the person experiencing a mental health crisis (Harrison, *et al.* 2018), would shift the mental health nurse's focus from the contextual aspects of care towards relational working, clearly valued by service user participants within the papers reviewed here. Where the mental health nurse's focus within CRHT is upon the contextual and procedural aspects of care, linked to the management of organisational resources and anxieties (Trevillion, *et al.* 2022), a connection with the person in crisis may renew the nurses focus upon relational working and the therapeutic relationship (Felton, *et al.* 2018), considered to be healing and restorative in its own right (Wright, 2021; Jones, *et al.* 2021) whilst being crucial to understanding the meaning behind the person's distress and responses within the context of their interpersonal relationships, community and culture (Johnstone, *et al.* 2018; Wright, *et al.* 2007).

Furthermore, where there are potential power differentials in relation to decision-making within CRHT contexts, as highlighted in papers where risk issues intersected with the personality disorder label, there is a need for these to be recognised and fully understood by mental health nurses. Intersubjectivity or shared 'sense-making' through a reciprocal dialogue around risk (Harrison, *et al.* 2018; Crossley 1996) and the use of collaborative safety/crisis plans (Clibbens, *et al.* 2023), would support the service user experience of being empathically supported (Veale *et al.* 2023) while reducing the experiences of power imbalances in the caring relationship (Haw, *et al.* 2023).

Limitations of this review

A limitation of meta-ethnography lies in the original focus of those papers chosen for synthesis and their subsequent impact upon the emergence of themes. Three of the papers reviewed here, for instance (Lombardo, *et al.* 2019; Sacks & Iliopoulou, 2017; Rhodes & Giles, 2014), specifically focused upon decision-making within the context of risk, increasing the danger of there being a greater emphasis here upon risk issues when developing higher order themes based upon those of the original authors. That said, the management of risk decisions and collaborative decision-making within the context of risk emerged here from most of the papers reviewed, justifying the inclusion of these as sub-themes.

Another limitation of this review relates to the extraction of true participant experience. First, the experiential accounts included in this synthesis are already restricted to what has been selected from a full dataset by the primary authors and so may not accurately reflect the totality of participant experience. Second, where a reciprocal translation and line of argument syntheses are used here to synthesise results, this further synthesis means that there is the potential that primary data may have already lost their explanatory context (Atkins, *et al.* 2008). Third, whilst useful for the expression of

these results, the presentation of themes identified in diagrammatical form in this review, takes a reductionist approach to, and therefore oversimplifies the complex interactions between service users and clinicians within the context of a CRHT setting. Nevertheless, what this qualitative evidence synthesis adds to existing literature is the fusion of both service user and clinician experiences of CRHT, and in highlighting the tensions between the two participant groups, offers a unique insight into the complexities of care giving and receiving within CRHT settings.

CONCLUSION

A qualitative evidence synthesis using meta-ethnography has supported new insights into how mental health care was experienced by both those delivering and receiving care within the context of CRHT. Service user accounts focused more upon the relational aspects of care received, highlighting the importance of this to their experience of care, whilst clinicians focused more upon the contextual issues linked to the management of organisational anxieties, expectations of others and organisational resources potentially leading to a reduction in personalised care. Specifically, in relation to the care of people with CEN, a focus upon risk alone or dismissing the person's perception of their own risk status, undermined the person's need for individualised care and highlighted potential power differentials within the caring relationship. Not only does this qualitative evidence synthesis highlight the need for more qualitative evidence specifically relating to individual experience of CRHT for people with CEN, but recommendations for mental health nursing practice within this context include the need for nurses to connect with the experience of the person in crisis, shifting their focus from contextual and risk issues to relational working. For those with CEN, a collaborative approach to care and shared 'sense-making' around risk, would reduce the experience of power imbalances in the caring relationship.

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