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REVIEW ARTICLE

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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

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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, focus 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.

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.

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

1 | 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' (American Psychiatric Association, 2013; World Health Organisation, 2019). 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; Lewis & Appleby, 1988; Murphy & McVey, 2003; Saunders et al., 2011), although studies have focused more upon ED settings (Byrne et al., 2021; Collom et al., 2019; Haslam, 2019; Haslam & Jones, 2020; MacDonald et al., 2020; O'Keefe et al., 2021; Quinlivan et al., 2021; Rayner et al., 2018; 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 (Carpenter et al., 2013; Carpenter & Tracy, 2015; Freeman et al., 2011; Nelson et al., 2016; 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 stigmatising 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, 2009, 2022). 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.

1.1 | 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 (Atkins et al., 2008; Noble & Smith, 2018) 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, Cunningham, et al., 2019).

2 | METHOD

2.1 | 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 Phenomenon of **I**nterest (experiences of care and the caring relationship) and the Research **Co**ntext (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.

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

2.2 | Selection of evidence

The initial search, total of 2239 articles were identified (see Figure 1). In total, 664 duplicate records were removed before screening. The remaining sources ($n=1575$) were filtered according to the eligibility criteria in Table 2.

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 ($n=2$).

TABLE 1 Search terms used to identify appropriate literature.

Population	"Complex emotional needs" OR "personality disorder" OR "personality difficulties"
Phenomenon of **I**nterest	Response* OR relation* OR care OR experience*
Research **Co**ntext	Crisis OR "crisis resolution" OR "crisis team" OR "crisis service" OR "crisis support" OR "home treatment"

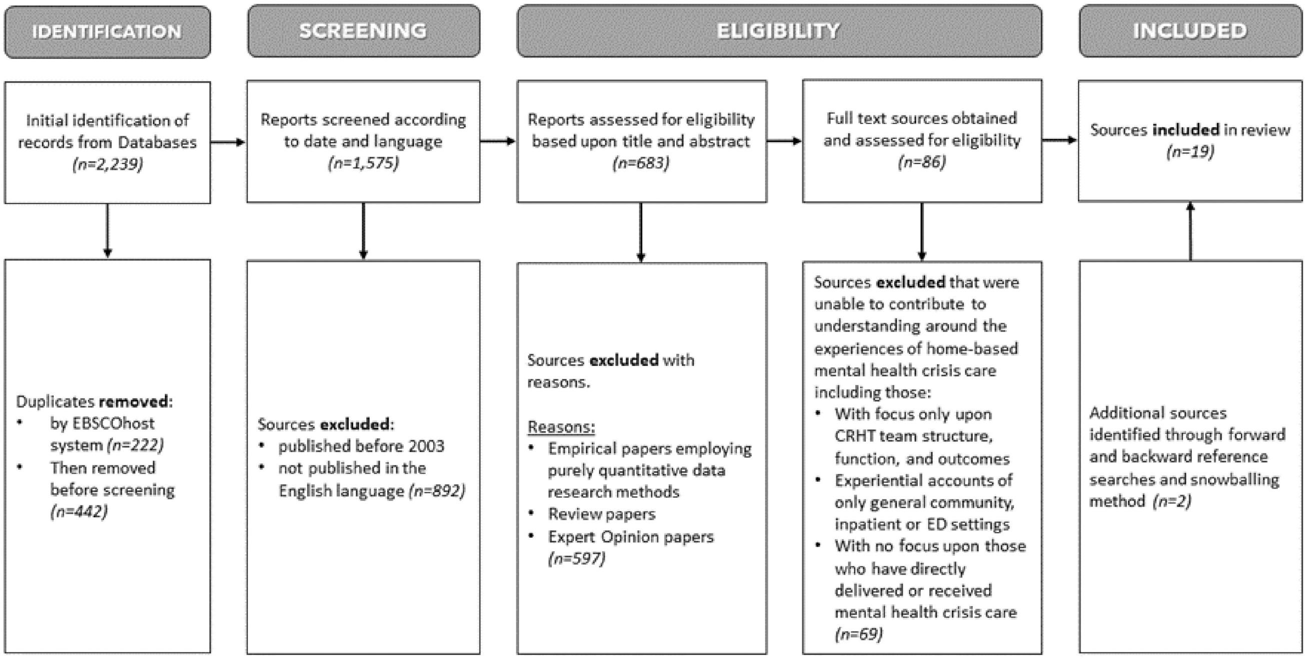


FIGURE 1 PRISMA diagram (Page et al., 2021).

2.3 | 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 four 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; Klevan et al., 2017, 2018; Morant et al., 2017) were derived from, and reporting on different aspects of, the same 2 primary studies. In terms of participant characteristics, eight papers considered the experiences of CRHT clinicians, eight considered the experience of those receiving care and three considered the experiences of both clinicians and service user participants. Sample sizes ranged from 1 to 188 participants (Morant et al., 2017, and Nelson et al., 2016, respectively). Of the 19 papers, just 7 contained direct references to the diagnostic label of personality disorder (Carpenter & Tracy, 2015; Chilman et al., 2021; Morant et al., 2017; Nelson et al., 2016; Rubio et al., 2021; Sacks & Iliopoulou, 2017; Taylor et al., 2023), 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.

2.4 | 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 and 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 and 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.

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

TABLE 2 Eligibility criteria.

Stage screened/assessed	Sources included	Sources excluded
Initial screening	• Papers written in the English Language • Papers published after 2003	• Papers written in any other language than English with no English translation • Papers published prior to 2003
Reports assessed based upon title and abstract	• Empirical papers that include qualitative primary research data (these can be reporting on studies that employ mixed methods approaches)	• Empirical papers employing purely quantitative data research methods • Review papers • Expert Opinion papers
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	• 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	• 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)

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.

2.5 | 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 Figure 2).

Alongside this, an inductive approach was also utilised 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 (Figure 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, Uny, et al. 2019), 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.

2.6 | 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.

TABLE 3 Study characteristics and quality appraisal.

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

3 | 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.

3.1 | Reciprocal translation

A reciprocal translation was used first to establish how themes and concepts across the original papers reviewed related to each other (Figure 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).

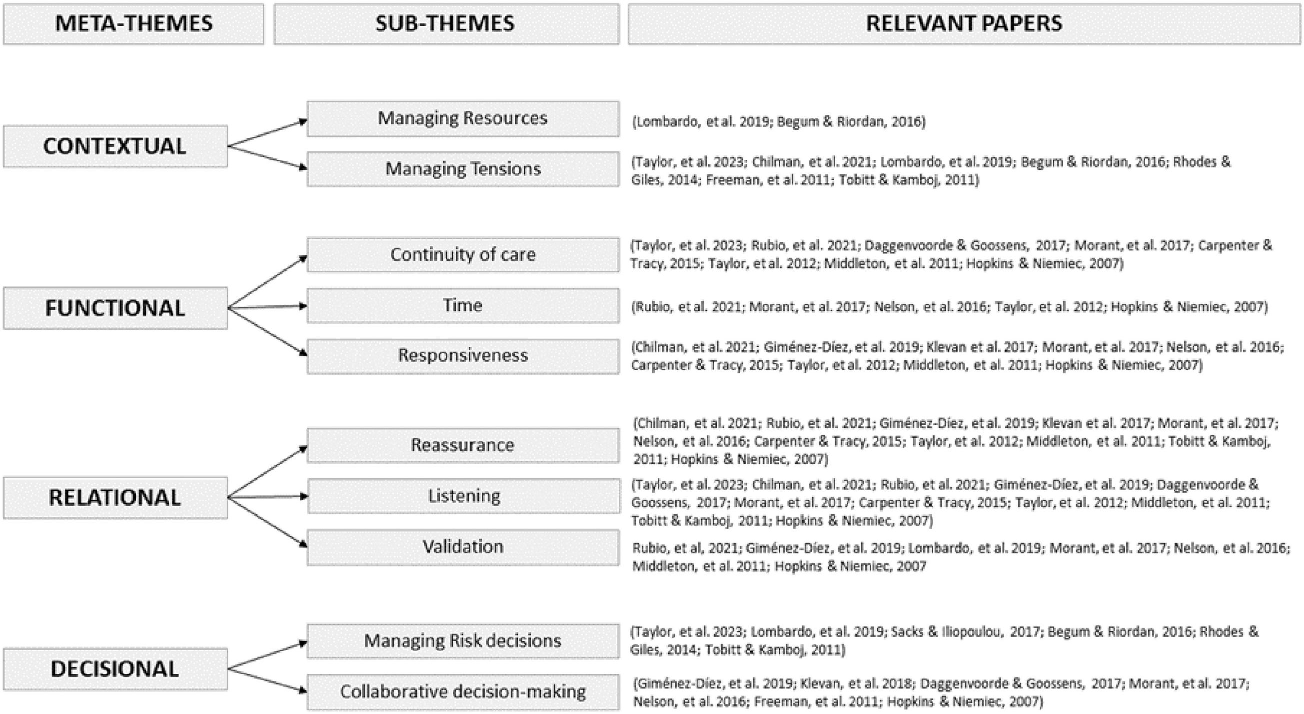
Each meta-theme was developed from two or more co-occurring and related ‘sub-themes’ relating to how care is experienced within the context of CRHT (see Figure 2). These are discussed below and illustrated by representative quotations from the primary papers reviewed.

Meta-theme 1: Contextual (Managing Resources and 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, p. 48)

Also discussed under this meta-theme, was the team's role in the management of the anxieties and expectations of both service users (Begum & Riordan, 2016; Taylor et al., 2023) and referrers (Begum & Riordan, 2016; Chilman et al., 2021; Freeman et al., 2011;



META-THEMES	SUB-THEMES	RELEVANT PAPERS
CONTEXTUAL	Managing Resources	(Lombardo, et al. 2019; Begum & Riordan, 2016)
	Managing Tensions	(Taylor, et al. 2023; Chilman, et al. 2021; Lombardo, et al. 2019; Begum & Riordan, 2016; Rhodes & Giles, 2014; Freeman, et al. 2011; Tobitt & Kamboj, 2011)
FUNCTIONAL	Continuity of care	(Taylor, et al. 2023; Rubio, et al. 2021; Daggenvoorde & Goossens, 2017; Morant, et al. 2017; Carpenter & Tracy, 2015; Taylor, et al. 2012; Middleton, et al. 2011; Hopkins & Niemiec, 2007)
	Time	(Rubio, et al. 2021; Morant, et al. 2017; Nelson, et al. 2016; Taylor, et al. 2012; Hopkins & Niemiec, 2007)
	Responsiveness	(Chilman, et al. 2021; Giménez-Díez, et al. 2019; Klevan et al. 2017; Morant, et al. 2017; Nelson, et al. 2016; Carpenter & Tracy, 2015; Taylor, et al. 2012; Middleton, et al. 2011; Hopkins & Niemiec, 2007)
RELATIONAL	Reassurance	(Chilman, et al. 2021; Rubio, et al. 2021; Giménez-Díez, et al. 2019; Klevan et al. 2017; Morant, et al. 2017; Nelson, et al. 2016; Carpenter & Tracy, 2015; Taylor, et al. 2012; Middleton, et al. 2011; Tobitt & Kamboj, 2011; Hopkins & Niemiec, 2007)
	Listening	(Taylor, et al. 2023; Chilman, et al. 2021; Rubio, et al. 2021; Giménez-Díez, et al. 2019; Daggenvoorde & Goossens, 2017; Morant, et al. 2017; Carpenter & Tracy, 2015; Taylor, et al. 2012; Middleton, et al. 2011; Tobitt & Kamboj, 2011; Hopkins & Niemiec, 2007)
	Validation	Rubio, et al, 2021; Giménez-Díez, et al. 2019; Lombardo, et al. 2019; Morant, et al. 2017; Nelson, et al. 2016; Middleton, et al. 2011; Hopkins & Niemiec, 2007
DECISIONAL	Managing Risk decisions	(Taylor, et al. 2023; Lombardo, et al. 2019; Sacks & Iliopoulou, 2017; Begum & Riordan, 2016; Rhodes & Giles, 2014; Tobitt & Kamboj, 2011)
	Collaborative decision-making	(Giménez-Díez, et al. 2019; Klevan, et al. 2018; Daggenvoorde & Goossens, 2017; Morant, et al. 2017; Nelson, et al. 2016; Freeman, et al. 2011; Hopkins & Niemiec, 2007)

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

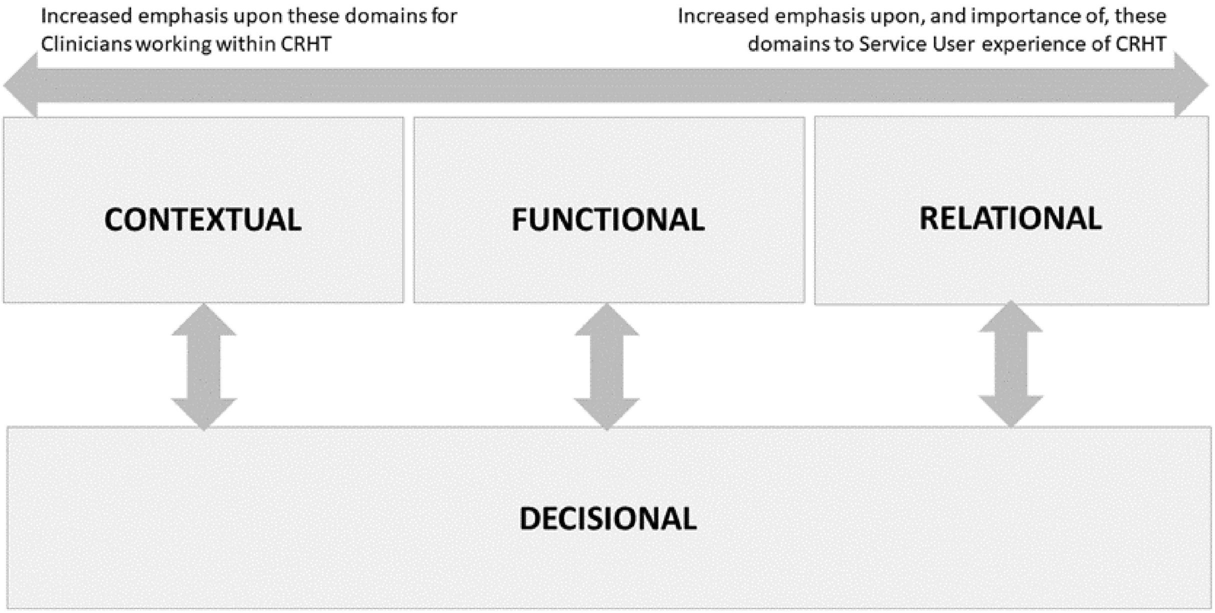


FIGURE 3 Thematic map illustrating a line of argument synthesis.

Lombardo et al., 2019; Rhodes & Giles, 2014; 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, p. 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, p. 133)

Meta-theme 2: Functional (Continuity of care, Time and 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* (Middleton et al., 2011; Morant et al., 2017), and *consistency of*, CRHT clinicians were of importance here and discussed by both clinician (Taylor et al., 2023) and service user participants (Carpenter & Tracy, 2015; Hopkins & Niemiec, 2007; Middleton et al., 2011; Morant et al., 2017; Rubio et al., 2021; Taylor et al., 2012). Continuity of CRHT workers supported a consistency in terms of advice (Carpenter & Tracy, 2015; Taylor et al., 2023), 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 (Morant et al., 2017; Rubio et al., 2021):

> 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, p. 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 et al., 2017; Hopkins & Niemiec, 2007; Taylor et al., 2012):

> 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 et al., 2017, p. 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 (Hopkins & Niemiec, 2007; Nelson et al., 2016; Rubio et al., 2021; Taylor et al., 2012), and to the duration of visits (Hopkins & Niemiec, 2007; Morant et al., 2017). 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 (Hopkins & Niemiec, 2007; Taylor et al., 2012):

> 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, p. 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 (Hopkins & Niemiec, 2007; Morant et al., 2017). 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, pp. 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 h crisis telephone line (Chilman et al., 2021; Giménez-Díez et al., 2019; Hopkins & Niemiec, 2007; Klevan et al., 2017; Middleton et al., 2011; Nelson et al., 2016), and the immediacy of involvement from referral (Carpenter & Tracy, 2015; Hopkins & Niemiec, 2007; Morant et al., 2017). 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, p. 5)

Negative experiences of CRHT were attributed to a lack of clinician response (Middleton et al., 2011; Taylor et al., 2012) 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, p. 6)

Meta-theme 3: Relational (Reassurance, Listening and 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 (Carpenter & Tracy, 2015; Chilman et al., 2021; Hopkins & Niemiec, 2007; Middleton et al., 2011), 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, p. 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 (Hopkins & Niemiec, 2007; Middleton et al., 2011; Morant et al., 2017; Rubio et al., 2021) 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, p. 99)

Effective communication was regarded as essential to the reassurance of service users. Information-giving relating to pathology and prognosis (Carpenter & Tracy, 2015; Giménez-Díez et al., 2019), 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; Hopkins & Niemiec, 2007; Morant et al., 2017), 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, p. 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 (Carpenter & Tracy, 2015; Daggenvoorde et al., 2017; Rubio et al., 2021; 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, p. 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, p. 451)

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

> The CRT find out you have a diagnosis of BPD, they just ignore you.
>
> (Service User, Chilman et al., 2021, p. 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, p. 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 (Hopkins & Niemiec, 2007; Middleton et al., 2011; Morant et al., 2017):

> 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, p. 313)

Meta-theme 4: Decisional (Managing risk decisions and 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 (Begum & Riordan, 2016; Chilman et al., 2021; 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 (Begum & Riordan, 2016; Sacks & Iliopoulou, 2017), 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, p. 62)

Clinician responses falling under this sub-category discussed risk behaviours as something that required 'management' (Begum & Riordan, 2016; Lombardo et al., 2019; Rubio et al., 2021; Sacks & Iliopoulou, 2017; Taylor et al., 2023), 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, p. 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, p. 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 et al., 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 (Freeman et al., 2011; Giménez-Díez et al., 2019; Hopkins & Niemiec, 2007; Klevan et al., 2018; Morant et al., 2017; Nelson et al., 2016):

> 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, p. 445)

4 | DISCUSSION

Findings within this qualitative evidence synthesis are consistent with those previous reviews considering more generally the experiences of CRHT (Carpenter et al., 2013; Winness et al., 2010), 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 (DeLeo et al., 2022; Warrender et al., 2020), 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 (DeLeo et al., 2022; Warrender et al., 2020).

4.1 | 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 has 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 Figure 3). This finding reflects wider literature around the significance of individualised care and positive relationships in the community for those with CEN (Bolton et al., 2014; Sheridan Rains et al., 2021).

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.

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. (2019, 2021), 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., 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, Trevillion et al., 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 (Chilman et al., 2021; Taylor et al., 2023), 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), while adding to service user's sense of emotional turmoil and lack of safety (Veale et al., 2023).

4.2 | 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 (Jones et al., 2021; Wright, 2021) while 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 (Crossley, 1996; Harrison et al., 2018) 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).

4.3 | 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; Rhodes & Giles, 2014; Sacks & Iliopoulou, 2017), 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, while 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.

5 | 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, while 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.

AUTHOR CONTRIBUTIONS

All the authors have: Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data. Been involved in drafting the manuscript or revising it critically for important intellectual content. Given final approval of the version to be published and Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

CONFLICT OF INTEREST STATEMENT

Mr Haslam has nothing to disclose.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

Aromataris, E., Fernandez, R., Godfrey, C. M., Holly, C., Khalil, H., & Tungpunkom, P. (2015). Summarizing systematic reviews: Methodological development, conduct and reporting of an umbrella review approach. *International Journal of Evidence-Based Healthcare*, *13*(3), 132–140. https://doi.org/10.1097/xeb.0000000000000055

Atkins, S., Lewin, S., Smith, H. Engel,M., Fretheim, A. & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology* Vol.*8*(21). https://doi.org/10.1186/1471-2288-8-21

Beale, C. (2022). Magical thinking and moral injury: Exclusion culture in psychiatry. *BJPysch Bulletin.*, *46*, 16–19. https://doi.org/10.1192/bjb.2021.86

Begum, R., & Riordan, S. (2016). *Nurses experiences of working in crisis resolution home treatment teams with its additional gatekeeping responsibilities*. Blackwell Science. https://doi.org/10.1111/jpm.12276

Bolton, W., Lovell, K., Morgan, L., & Wood, H. (2014). *Meeting the challenge, making a difference: Working effectively to support people with personality disorder in the community*. Project Report. Department of Health.

Byrne, S. J., Bellairs-Walsh, I., Rice, S. M., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M., & Robinson, J. A. (2021). A qualitative account of young people's experiences seeking care from emergency departments for self-harm. *International Journal of Environment Research Public Health*, *18*(6), 2892. https://doi.org/10.3390/ijerph18062892

Carpenter, R., Falkenburg, J., White, T., & Tracy, D. (2013). Crisis teams: Systematic review of their effectiveness in practice. *The Psychiatrist*, *37*(7), 232–237. https://doi.org/10.1192/pb.bp.112.039933

Carpenter, R. A., & Tracy, D. K. (2015). Home treatment teams: What should they do? A qualitative study of patient opinions. *Journal of Mental Health*, *24*(2), 98–102. https://doi.org/10.3109/09638237.2015.1019046

Chilman, N., Morant, N., Lloyd-Evans, B., Wackett, J., & Johnson, S. (2021). Twitter users' views on mental health crisis resolution team care compared with stakeholder interviews and focus groups: Qualitative analysis. *JMIR Mental Health*, *8*(6), e25742. https://doi.org/10.2196/25742

Clibbens, N., Baker, J., Booth, A., Berzins, K., Ashman, M. C., Sharda, L., Thompson, J., Kendal, S., & Weich, S. (2023). Explanation of context, mechanisms and outcomes in adult community mental health crisis care: The MH-CREST realist evidence synthesis. Health and Social Care Delivery. *Research*, *11*(15), 161. https://eprints.whiterose.ac.uk/203492/1/3042863.pdf

Collom, J., Patterson, E., Lawrence-Smith, G., & Tracy, D. (2019). The unheard voice: A qualitative exploration of companions' experiences of liaison psychiatry and mental health crises in the emergency department. *BJPsych Bulletin*, *43*(5), 204–209. https://doi.org/10.1192/bjb.2019.2

Crossley, N. (1996). *Intersubjectivity: The fabric of social becoming*. Sage.

Daggenvoorde, T. H., Gijsman, H. J., & Goossens, P. J. J. (2017). *Emergency care in case of acute psychotic and/or manic symptoms: Lived experiences of patients and their families with the first interventions of a mobile crisis team. A phenomenological study*. Blackwell Pub. https://doi.org/10.1111/ppc.12247

Dalton-Locke, C., Johnson, S., Harju-Seppänen, J., Lyons, N., Sheridan Rains, L., Stuart, R., Campbell, A., Clark, J., Clifford, A., Courtney, L., Dare, C., Kelly, K., Lynch, C., McCrone, P., Nairi, S., Newbigging, K., Nyikavaranda, P., Osborn, D., Persaud, K., … Lloyd-Evans, B. (2021). Emerging models and trends in mental health crisis care in England: A national investigation of crisis care systems. *BMC Health Service Research*, *21*, 1174. https://doi.org/10.1186/s12913-021-07181-x

DeLeo, K., Maconick, L., McCabe, R., Broeckelmann, E. S., Rains, L., Rowe, S., & Johnson, S. (2022). Experiences of crisis care among service users with complex emotional needs or a diagnosis of 'personality disorder', and other stakeholders: Systematic review and meta-synthesis of the qualitative literature. *BJPsych Open*, *8*(2), e53. https://doi.org/10.1192/bjo.2022.1

Department of Health. (2001). *Mental health policy implementation guide: Crisis resolution/home treatment teams*. Department of Health.

Felton, A., Repper, J., & Avis, M. (2018). The construction of people with mental health problems as risk objects: Findings of a case study inquiry. *Journal of Psychiatric and Mental Health Nursing*, *25*, 558–568. https://doi.org/10.1111/jpm.12501

Fisher, J. (2023). Epistemic injustice: The silenced voices. *International Journal of Mental Health Nursing*, *32*, 1186–1189. https://doi.org/10.1111/inm.13163

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A. S., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., Booth, A., Britten, N., Flemming, K., Gallagher, I., Garside, R., Hannes, K., Lewin, S., Noblit, G. W., Pope, C., Thomas, J., … Noyes, J. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *BMC Medical Research Methodology*, *19*, 25. https://doi.org/10.1186/s12874-018-0600-0

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A. S., Jepson, R. G., Roberts, R. J., & Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC Medical Research Methodology.*, *19*(1), 35. https://doi.org/10.1186/s12874-019-0670-7

Freeman, J., Vidgen, A., & Davies-Edwards, E. (2011). *Staff experiences of working in crisis resolution and home treatment*. Pavilion Pub in Association with the Centre for Mental Health Services Development, King's College. https://doi.org/10.1108/13619321111158016

Giménez-Díez, D., Maldonado Alía, R., Rodríguez Jiménez, S., Granel, N., Torrent Solà, L., & Bernabeu-Tamayo, M. D. (2019). *Treating mental health crises at home: Patient satisfaction with home nursing care*. Blackwell Science. https://doi.org/10.1111/jpm.12573

Hannigan, B. (2014). There's a lot of tasks that can be done by any: Findings from an ethnographic study into work and organisation in UK community crisis resolution and home treatment services.

Health, *18*(4), 406–421. https://doi.org/10.1177/1363459313501359

Harrison, H. F., Kinsella, E. A., & DeLuca, S. (2018). Locating the lived body in client-nurse interactions: Embodiment, intersubjectivity and intercorporeality. *Nursing Philosophy*, *20*, e12241. https://doi.org/10.1111/nup.12241

Haslam, M. (2019). How the emergency department four-hour target affects clinical outcomes for patients diagnosed with a personality disorder. *Emergency Nurse*, *27*(4), 20–24. https://doi.org/10.7748/en.2019.e1930

Haslam, M., & Jones, E. S. (2020). The impact of the Emergency Department target upon the discharge decision for people who self-harm. *Journal of Public Mental Health*, *19*(2), 89–97. https://doi.org/10.1108/JPMH-01-2019-0003

Haw, R., Hartley, S., Trelfa, S., & Taylor, P. J. (2023). A systematic review and meta-ethnography to explore people's experiences of psychotherapy for self-harm. *British Journal of Clinical Psychology*, *62*, 392–410. https://doi.org/10.1111/bjc.12414

Hong, V. (2016). Borderline personality disorder in the emergency department: Good psychiatric management. *Harvard Review of Psychiatry*, *24*(5), 357–366.

Hopkins, C., & Niemiec, S. (2007). *Mental health crisis at home: Service user perspectives on what helps and what hinders*. Blackwell Science. https://doi.org/10.1111/j.1365-2850.2007.01083.x

Hunter, C., Chantler, K., Kapur, N., & Cooper, J. (2013). Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking: A qualitative study. *Journal of Affective Disorders*, *145*(3), 315–323. https://doi.org/10.1016/j.jad.2012.08.009

Johnstone, L., & Boyle, M., with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behavior, as an alternative to functional psychiatric diagnosis*. British Psychological Society.

Jones, E., Wright, K. M., & McKeown, M. (2021). An integrative review exploring the experiences of service users carrying a diagnosis of personality disorder and student mental health nurses and the time they share together. *Nurse Education Today*, *98*, 104659. https://doi.org/10.1016/j.nedt.2020.104659

Karlsson, B., Borg, M., & Kim, H. S. (2008). From good intentions to real life: Introducing crisis resolution teams in Norway. *Nursing Inquiry*, *15*, 206–215. https://doi.org/10.1111/j.1440-1800.2008.00416.x

Klein, P., Fairweather, K. A., & Lawn, S. (2022). Structural stigma and its impact on healthcare for borderline personality disorder: A scoping review. *International Journal of Mental Health Systems*, *16*, 48. https://doi.org/10.1186/s13033-022-00558-3

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*. Sage Publications. https://doi.org/10.1177/1473325016668962

Klevan, T., Karlsson, B., Ruud, T., Klevan, T., Karlsson, B., & Ruud, T. (2017). *"At the extremities of life"—Service user experiences of helpful help in mental health crises*. Taylor and Francis, Inc. https://doi.org/10.1080/15487768.2017.1302370

Lamph, G., Baker, J., Dickinson, T., & Lovell, K. (2019). Personality disorder co-morbidity in primary care 'Improving Access to Psychological Therapy' services: A qualitative study exploring professionals' perspectives of working with this patient group. *Personality and Mental Health*, *13*, 168–179. https://doi.org/10.1002/pmh.1454

Lamph, G., Baker, J., Dickinson, T., & Lovell, K. (2021). Personality disorder co-morbidity in primary care 'Improving Access to Psychological Therapy' (IAPT) services: A qualitative study exploring patient perspectives on treatment experience. *Behavioural and Cognitive Psychotherapy*, *49*(2), 144–158. https://doi.org/10.1017/S1352465820000594

Lewis, G., & Appleby, L. (1988). Personality disorder: The patients psychiatrist's dislike. *British Journal of Psychiatry*, *153*, 44–49. https://doi.org/10.1192/bjp.153.1.44

Lombardo, C., Santos, M., Van Bortel, T., Croos, R., Arensman, E., & Kar Ray, M. (2019). Decision-making in crisis resolution and home treatment teams: The AWARE framework. *BJPsych Bulletin*, *43*, 61–66. https://doi.org/10.1192/bjb.2018.94

MacDonald, S., Sampson, C., Turley, R., Biddle, L., Ring, N., Begley, R., & Evans, R. (2020). Patients' experiences of emergency hospital care following self-harm: Systematic review and thematic synthesis of qualitative research. *Qualitative Health Research*, *30*(3), 471–485. https://doi.org/10.1177/1049732319886566

Majid, U., & Vanstone, M. (2018). Appraising qualitative research for evidence syntheses: A compendium of quality appraisal tools. *Qualitative Health Research*, *28*(13), 2115–2131. https://doi.org/10.1177/1049732318785358

McCulloch, A., Muijen, M., & Harper, H. (2000). New developments in mental health policy in the United Kingdom. *International Journal of Law and Psychiatry*, *23*(3–4), 261–276. https://doi.org/10.1016/s0160-2527(00)00038-8

McKeown, M. (2023). On the bullshitisation of mental health nursing: A reluctant work rant. *Nursing Inquiry*, *31*, e12595. https://doi.org/10.1111/nin.12595

Middleton, H., Shaw, R., Collier, R., Purser, A., & Ferguson, B. (2011). *The dodo bird verdict and the elephant in the room: A service user-led investigation of crisis resolution and home treatment*. Flinders University. https://doi.org/10.5172/hesr.2011.20.2.147

Minghella, E., Ford, R., Freeman, T., Hoult, J., McGlynn, P., & O'Halloran, P. (1998). *Open all hours*. Sainsbury Centre for Mental Health https://www.i-ht.nl/wp-content/uploads/2014/03/Open-all-hours.pdf

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

Murphy, N., & McVey, D. (2003). The challenge of nursing personality disordered patients. *British Journal of Forensic Practice*, *5*(1), 3–19. https://doi.org/10.1108/14636646200300002

National Institute for Health and Care Excellence. (2009). *Borderline personality disorder: Treatment and management*. NICE.

National Institute for Health and Care Excellence. (2022). *Self-harm: Assessment, management and preventing recurrence*. NICE.

National Institute for Mental Health in England (NIMHE). (2003a). *Personality disorder: No longer a diagnosis of exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder*. Department of Health.

National Institute for Mental Health in England (NIMHE) (2003b). *Breaking the cycle of rejection: The personality disorders capabilities framework*. Department of Health. https://www.personalitydisorder.org.uk/wp-content/uploads/2023/12/personalitydisorders-capabilities-framework.pdf

Nelson, L. J., Miller, P. K., & Ashman, D. (2016). *'Dale': An interpretative phenomenological analysis of a service user's experience with a crisis resolution/home treatment team in the United Kingdom*. Blackwell Science. https://doi.org/10.1111/jpm.12328

Noble, H., & Smith, J. (2018). Reviewing the literature: Choosing a review design. *Evidence Based Nursing*, *21*(2), 39–41. https://doi.org/10.1136/eb-2018-102895

Noblit, G. (2019). Meta-ethnography in education. *Oxford Research Encyclopaedia of Education*. https://doi.org/10.1093/acrefore/9780190264093.013.348

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Sage Publications. https://doi.org/10.4135/9781412985000

O'Keefe, S., Suzuki, M., Ryan, M., Hunter, J., & McCabe, R. (2021). Experiences of care for self-harm in the emergency department: Comparison of the perspectives of patients, carers and practitioners. *BJPsych Open*, *7*(5), E175. https://doi.org/10.1192/bjo.2021.1006

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *Systematic Reviews*, *10*, 89. https://doi.org/10.1136/bmj.n71

Quinlivan, L. M., Gorman, L., Littlewood, D. L., Monaghan, E., Barlow, S. J., Campbell, S. M., Webb, R. T., & Kapur, N. (2021). "Relieved to be seen"-patient and carer experiences of psychosocial assessment in the emergency department following self-harm: Qualitative analysis of 102 free-text survey responses. *BMJ Open*, *11*, e044434. https://doi.org/10.1136/bmjopen-2020-044434

Ramani, S., & Mann, K. (2016). Introducing medical educators to qualitative study design: Twelve tips from inception to completion. *Medical Teacher*, *38*(5), 456–463. https://doi.org/10.3109/0142159x.2015.1035244

Rayner, G., Blackburn, J., Edward, K.-L., Stephenson, J., & Ousey, K. (2018). Emergency department nurses attitudes towards patients who self-harm: A meta-analysis. *International Journal of Mental Health Nursing*, *28*(1), 40–53. https://doi.org/10.1111/inm.12550

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

Rubio, L., Taylor, B. L., Johnson, S., Rubio, L., Lever Taylor, B., Morant, N., & Johnson, S. (2021). *Experiences of intensive home treatment for a mental health crisis during the perinatal period: A UK qualitative study*. Blackwell Pub. https://doi.org/10.1111/inm.12774

Sacks, M. & Iliopoulou, M. (2017). The impact of professional role on working with risk in a home treatment team. Routledge. https://doi.org/10.1080/13642537.2017.1289968

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: A guide to using a meta-ethnographic approach for literature synthesis. *BMC Health Service Research*, *21*(50). https://doi.org/10.1186/s12913-020-06049-w

Saunders, K., Hawton, K., & Fortune, S. (2011). Attitudes and knowledge of clinical staff regarding people who self-harm; systematic review. *Journal of Affective Disorders*, *139*(3), 205–216. https://doi.org/10.1016/j.jad.2011.08.024

Shaikh, U., Qamar, I., Jafry, F., Hassan, M., Shagufta, S., Odhejo, Y. I., & Ahmed, S. (2017). Patients with borderline personality disorder in emergency departments. *Frontiers in Psychiatry*, *8*(136), 1–12. https://doi.org/10.3389/fpsyt.2017.00136

Sheridan Rains, L., Echave, A., Rees, J., Scott, H. R., Lever Taylor, B., Broeckelmann, E., Steare, T., Barnett, P., Cooper, C., Jeynes, T., Russell, J., Oram, S., Rowe, S., & Johnson, S. (2021). Service user experiences of community services for complex emotional needs: A qualitative thematic synthesis. *PLoS ONE*, *16*(4), e0248316. https://doi.org/10.1371/journal.pone.0248316

Simpson, A., Hannigan, B., Coffey, M., Jones, A., Barlow, S., Cohen, R., Vseteckkova, J., & Faulkner, A. (2016). Cross-national comparative mixed-methods case study of recovery focused mental health care planning and co-ordination: Collaborative care planning project (COCAAP). *Health Services and Delivery Research.*, *4*(5), 1–189.

Sjølie, H., Karlsson, B., & Kim, H. S. (2010). Crisis resolution and home treatment: Structure, process, and outcome—A literature review. *Journal of Psychiatric and Mental Health Nursing*, *17*(10), 881–892. https://doi.org/10.1111/j.1365-2850.2010.01621.x

Stern, C., Jordan, Z., & McArthur, A. (2014). Developing the review question and inclusion criteria. *American Journal of Nursing*, *114*(4), 53–56. https://doi.org/10.1097/01.naj.0000445689.67800.86

Taylor, S., Abbott, S., Hardy, S., Taylor, S., Abbott, S., & Hardy, S. (2012). *The INFORM project: A service user-led research endeavor*. WB Saunders. https://doi.org/10.1016/j.apnu.2012.02.005

Taylor, T., Stockton, S., & Bowen, M. (2023). Crisis resolution home treatment team Clinicians' perceptions of using a recovery approach with people with a diagnosis of borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, *30*(3), 558–567. https://doi.org/10.1111/jpm.12891

Tobitt, S., & Kamboj, S. (2011). Crisis resolution/home treatment team workers' understandings of the concept of crisis. *Social Psychiatry and Psychiatric Epidemiology*, *46*, 671–683. https://doi.org/10.1007/s00127-010-0234-y

Trevillion, K., Stuart, R., Ocloo, J., Broeckelmann, E., Jeffreys, S., Jeynes, T., Allen, D., Russell, J., Billings, J., Crawford, M. J., & Dale, O. (2022). Service user perspectives of community mental health services for people with complex emotional needs: A co-produced qualitative interview study. *BMC Psychiatry*, *22*, 55. https://doi.org/10.1186/s12888-021-03605-4

Veale, D., Robins, E., Thomson, A., & Gilbert, P. (2023). No safety without emotional safety. *The Lancet Psychiatry*, *10*(1), 65–70. https://doi.org/10.1016/S2215-0366(22)00373-X

Walsh, D., & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery*, *22*(2), 108–119. https://doi.org/10.1016/j.midw.2005.05.004

Ware, A., Preston, A., & Draycott, S. (2022). "It doesn't get taken seriously until it gets bad": Experiences of risk management from people diagnosed with a borderline personality disorder. *Mental Health Review Journal*, *27*(3), 333–347. https://doi.org/10.1108/MHRJ-02-2021-0016

Warrender, D., Bain, H., Murray, I., & Kennedy, C. (2020). Perspectives of crisis intervention for people diagnosed with "borderline personality disorder": An integrative review. *Journal of Psychiatric and Mental Health Nursing*, *28*, 208–236. https://doi.org/10.1111/jpm.12637

Winness, M. G., Borg, M., & Kim, H. S. (2010). Service users' experiences with help and support from crisis resolution teams. A literature review. *Journal of Mental Health*, *19*(1), 75–87. https://doi.org/10.3109/09638230903469178

World Health Organization. (2019). *International Statistical Classification of Diseases and Related Health Problems [ICD]* (11th ed.). World Health Organization. https://icd.who.int/

Wright, K., Haigh, K., & McKeown, M. (2007). Reclaiming the humanity in personality disorder. *International Journal of Mental Health Nursing*, *16*(4), 236–246. https://doi.org/10.1111/j.1447-0349.2007.00480.x

Wright, K. M. (2021). Exploring the therapeutic relationship in nursing theory and practice. *Mental Health Practice*, *24*(5), 34–41. https://doi.org/10.7748/mhp.2021.e1561

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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