EXPERIENCES OF SERVICE USERS WITH PSYCHOSIS AND CRISIS TEAMS: A SCOPING REVIEW

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Abstract

Deinstitutionalization in North America led to increased community mental health crises, prompting the development of Crisis Teams (CTs). Nursing plays a vital role for these teams, which specialize in crisis intervention. Service users with psychosis are frequent users of CT services, yet their experiences remain underexplored. The aim of this scoping review study was to explore the experiences of individuals with psychosis during interactions with CTs. A scoping review was the methodological approach for this study. Crisis theory was the theoretical framework and twenty-six articles met inclusion criteria. Findings from these articles were divided into three main themes: 1) service user, 2) carer, 3) healthcare professional. Service users and carers were mostly satisfied, though some found their experiences were stigmatizing and traumatizing. Both highlighted the need for better communication and compassion from CTs. Professionals reported high stress and educational gaps. Understanding these experiences could identify gaps and make care improvements.

Keywords: Crisis team, crisis intervention, psychosis, lived experience, mental health

Dedication

I would like to dedicate this
to my husband Georgio
and our son Yianni.
Thank you to my husband
for being an endless source of
support and guidance, without you
none of this would have been possible.
And to our son, Yianni,
who arrived in the last year of my degree,
thank you for reminding me of
the most important things in life.

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List of Abbreviations

ACT: Assertive Community Treatment

CAT: Crisis Assessment Team

CATS: Crisis Assessment and Treatment Service

CAU: Care As Usual

CBTp: Cognitive Behavioural Therapy for Psychosis

CIT: Crisis Intervention Team

CMHT: Community Mental Health Team

CRHT: Crisis Resolution Home Treatment

CRHTT: Crisis Resolution Home Treatment Team

CRT: Crisis Resolution Team

CT: Crisis Team

GP: General Practitioner

HBT: Home Based Treatment

HTT: Home Treatment Team

FACT: Flexible Assertive Community Treatment

FEP: First Episode Psychosis

IHT: Intensive Home Treatment

MCT: Mobile Crisis Team

MCIT: Mobile Crisis Intervention Team

MMHU: Mobile Mental Health Unit

NHS: National Health Service (of the UK)

NNTR: Number Needed to Retrieve

ODA: Open Dialogue Approach

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PRISMA-ScR: PRISMA for Scoping Reviews

RCT: Randomized Controlled Trial

RN: Registered Nurse

UK: United Kingdom

U.S.A: United States of America

QOL: Quality of Life

Glossary of Terms

Term	**Definition**
ACT	An ACT team is a multidisciplinary CMHT that offers services to individuals that are considered to have severe and persistent mental health challenges. The goals of these services include reduced repeat hospital admissions, improved quality of life, and normalizing activities of daily living. These services are not time-limited and are offered as long as needed (Dixon, 2000).
Biomedical model	Traditional psychiatry approach viewing mental health challenges as a "disease process" primarily caused by genetic and/or biochemical abnormalities (Escher & Romme, 2012).
Carer	A term that more broadly defines individuals who provide care to service users than just the term family, as it includes anyone in a caregiving or supportive role, which could include family, friends, or other social contacts (Marshall, 2023).
Circle of care	The circle of care refers to those who may receive information regarding the service for whose consent may be implied, such as for the provision of healthcare (Information and Privacy Commissioner of Ontario, 2015).
Crisis	A crisis can be defined as an imbalance in a person's perceived ability to deal with a certain situation of importance, and not having the resources or availability to do so (Caplan, 1964).
Crisis team	This term, abbreviated CT, was used in this scoping review to refer to all types of community teams mentioned in the literature (CAT, CATS, CIT, CRHT, CRT, HBT, IHT, MCIT, MCT) that generally follow the same criteria of providing crisis intervention to individuals within the community, using a multidisciplinary team that offers extended hours and rapid responses; although the professional team make-up, specific hours, and response times vary (Murphy et al., 2015; Wheeler et al., 2015; Winness et al., 2010).
Crisis theory	Origins first came from Lindeman's theory of classic grief reactions, and then was further developed by Caplan and Hobbs, which proposes viewing a period of crisis as a difficult period that an individual goes through in their lives, in which the current stressors outweigh the individual's capacity to cope (Black & Flynn, 2021; Caplan, 1964; Hobbs, 1984).

Crisis intervention	Swift, time-limited, intensive intervention which is provided in the community and involves the assessment and identification of the concern and then offering services, which may include combinations of medication, counselling, practical help, and support to the individual and their supports (Murphy et al., 2015).
Deinstitutionalization	The widespread shifting of mental health care from in-hospital institutions to community care (Scull, 2021).
Determinants of health	Non-medical factors that influence overall health and wellbeing, including conditions in which people are born, grow, live, work, age, and the complexities of the sociopolitical systems in their environment (WHO, n.d.).
Digital exclusion	Individual exclusion from needed care due to not having access to phone or the internet (Johnson et al., 2022).
Implicit bias	Involves making unconscious negative connections regarding a person due to certain characteristics, such as race, gender, or in this study mental health (FitzGerald & Hurst, 2017).
MMHU	In Greece, the mobile component of community mental health services has been delivered through the development of MMHUs in the early eighties, and there has been a tendency towards the introduction of these services in rural and remote areas of the mainland and several of the many Greek islands. These services were introduced to facilitate access to mental health services in underserved areas within Greece (Peritogiannis et al., 2017).
ODA	An approach to crisis intervention that was first developed in Finland, which is used primarily for service users with psychosis. CTs are responsible for forming the first meeting, preferably within 24 hours of the first crisis. There are seven key components to this approach: 1) family at the centre of all interventions, 2) the persons closest to the service user are invited to the meeting, 3) the approach should be needs-based using the most appropriate therapeutic process, 4) the crisis worker who first meets with the service user and family are responsible for the therapy process, 5) psychological continuity is important, 6) the CT should focus on building rapport, unconditional acceptance, and sense of safety with the service user and family, 7) communication should be encouraged, where the service user's self-empowerment is the key, not "psychiatric symptoms" (Kłapciński & Rymaszewska, 2015).

Pre-hospital care	Medical or psychiatric care that is provided prior to a person arriving at the hospital (Ford-Jones & Chaufan, 2017).
Psychosis	A mental state which is understood medically as detachment from known reality as defined by others living within the same environment and is often characterized in medical terminology by positive and negative symptoms (Faber et al., 2023).
Psychotic disorder	Has been medically defined as a disorder, such as schizophrenia, schizoaffective, schizophreniform, or delusional disorder, that is often first diagnosed by the presence of psychotic symptoms (American Psychiatric Association, 2013).
Psychological continuity	A term used in ODA by CTs in Finland, which refers to having consistency among healthcare professionals providing care during different stages of therapy (Kłapciński & Rymaszewska, 2015).
Recovery model	A view of mental health challenges that is radically different from the traditional medical approach to psychiatry. Although this model does not fully explain how individuals develop psychological problems, this model emphasizes resilience and promotes individual autonomy over problems and life situations (Baumgardt & Weinmann, 2022).
Self-efficacy	This concept refers to an individual's belief in their own ability to perform a task or achieve a goal, which is a building block in self-empowerment (Bandura, 1997).
Service user	A term which has replaced the word "client" and "patient" in recent health literature (Winness et al., 2010).
Severe mental illness	This term is often classified in medical terminology as psychotic or bipolar-type illnesses (Marshall, 2023; Moreno-Alonso et al., 2023).
Stigma	A term used by early sociologist Erving Goffman to refer to a personal attribute that may "ruin" the identity of a person, which causes others to react with discrimination to the person (Goffman, 1963).
Vulnerability-stress model	A more recent reframing of the biomedical model of traditional psychiatry, which introduces the idea that stressful life events, such as abuse, can trigger an underlying disease that a person is genetically predisposed to (Escher & Romme, 2012).

Chapter One: Introduction

Chapter one provides background information on psychosis, Crisis Teams (CTs), and other potential insights that may be gained from exploring experiences of crisis, such as identifying barriers and improving care for individuals. In the introduction, I also discuss my personal experiences caring for a loved one with psychosis, my professional background working for a CT, as well as outlining the study purpose and a brief outline of the entire thesis.

Background

In this scoping review study, I aimed to explore what is currently known regarding experiences of service users with psychosis and CT workers during a crisis interaction. The experience of psychosis can be considered a mental health crisis and is the "client group" most often seen by CTs (Kim & Kim, 2017; Murphy et al., 2015). The preliminary search of the literature did not demonstrate a significant number of articles simultaneously looking at experiences of service users with psychosis and CTs. Therefore, the crisis experiences of service users with psychosis and CT workers appeared to be underexplored in current literature.

As CTs commonly provide intervention to those with psychosis in the community, understanding these crisis experiences could be a key component to pre-hospital care that may illuminate potential barriers to care and areas for improvement in the overall system (Hogan & Goldman, 2021; Kim & Kim, 2017). Therefore, a scoping review was determined to be an appropriate approach to explore what is known about the experiences of service users with psychosis and CTs, and whether this information could reveal gaps in the literature as well as guide further research efforts. In the following section, I will provide background information on the key concepts of psychosis and CTs, which was found during the preliminary review of the literature, and further delineate the aims of this scoping review.

Psychosis

The Canadian Mental Health Association reports that 3 in every 100 people will have an episode of psychosis at some point in their lives, and recent studies indicate that the COVID-19 pandemic may have further increased these numbers (CMHA Ontario, n.d.; Segev et al., 2021). Psychosis can also have profound consequences for individuals, such as negative effects on their ability to maintain employment, find suitable housing, reach financial independence, obtain an education, and form meaningful relationships (Hasan & Musleh, 2017). Despite extensive research conducted on first episode psychosis, there continues to be high rates of disengagement by service users to recommended medicalized treatment by healthcare professionals, which was estimated between 19-40% in some studies (Tindall et al., 2015). Yet efforts aimed to improve "medication compliance" using "adherence therapy" among participants in six randomized controlled trials within the literature have not shown any consistent results (Brown et al., 2013).

In medical terms, an experience of psychosis is often understood as the detachment from a state of reality as defined by others living within the same environment (Faber et al., 2023). As also defined in medical terminology "symptoms" of psychosis are typically categorized by the presence of positive symptoms (delusions, hallucinations, disorganized thinking/behaviour), negative symptoms (difficulty with facial expression, thoughts, speech), and potential cognitive deficits (American Psychiatric Association, 2013). The biomedical and vulnerability-stress model of traditional psychiatry views psychosis and other "mental illnesses" as a type of disease process that can be triggered by stressful life events, such as abuse (Escher & Romme, 2012). However, this could be considered an oversimplification as it does not fully account for the significance of social determinants of health, which have been correlated with a higher predisposition for experiences of psychosis (Jester et al., 2023).

Non-medical theories of psychosis have focused on the social, environmental, psychological, cultural, and relational factors that move beyond traditional medical understandings and reach a more holistic view of psychosis being a multi-faceted experience rather than simply a medical condition (Brown & Harris, 1978; LeFrançois et al., 2013; Luhrmann, 2017). The social-causation theory highlights that there are many contributing social and environmental factors that may lead to mental health challenges, such as a traumatic life experience or social isolation (Brown & Harris, 1978). As for cultural interpretations of psychosis, Luhrmann (2017) states that psychosis is understood differently among certain cultures that may view experiences of hearing voices or seeing images as a spiritual or religious phenomenon. Another view of psychosis has been through the *mad studies* movement which views psychosis not always as a medical condition but as a response to differing forms of systemic oppression, such as gender, sexuality, disability, race, and class (LeFrançois et al., 2013). Escher and Romme (2012) discuss the voice hearers' movement, which acknowledges that voice hearing is a common variation in the human experience, and that voice hearers are not "patients with illnesses" but people with problems.

Psychosis has been described by some individuals as one of the most painful existential human experiences (Fusar-poli et al., 2022), whereas others have found comfort from their experiences (Escher & Romme, 2012). In an interpretive phenomenological study by Connell et al. (2015), the researchers explore how the effects of psychosis can have similarities to exposure to trauma. In this study, participants described their lived experience of psychosis as "losing themselves" and felt that hospital care often exacerbated their vulnerability (Connell et al., 2015).

In another study by Hagen and Nixon (2011), women with experiences of psychosis in the mental health system - particularly in-patient psychiatric units - described feeling invalidated, unheard, and emotionally violated by their experiences. Others described their experience of being hospitalized as traumatic when recounting use of restraints and injections of medication against their will (Hagen & Nixon, 2011). Participants in this study described the mental health system as a "label factory", which compared being diagnosed by a psychiatrist to a random process of pulling a "diagnostic slot machine" to generate a different label (Hagen & Nixon, 2011). The perceived "phoniness" of the healthcare experience led participants to reject these labels and learn the right words to say or "learning the script" in order be discharged (Hagen & Nixon, 2011).

As per Nolte (2018), those struggling with psychosis are often reluctant to seek care within the community, especially when police are involved. In a qualitative review by Fusar-Poli et al. (2022), the study indicated that early negative experiences impacted whether someone would seek care from the mental healthcare system in the future. Fear of being stigmatized and reluctance to engage in care are highly understandable when the experience begins by being taken in a police car - especially in handcuffs (Daggenvoorde et al., 2018). These concerns have pointed to a need for mental health service partnership with police, such as with CTs, to improve collaboration and facilitate a better response to mental health crisis in the community that reduce the criminalization and stigmatization of mental health challenges (Kisely et al., 2010).

Crisis Teams

The development of CTs can be traced back to the Post World War II deinstitutionalization movement which first began in Western industrialized countries and led to widespread shifting of individuals receiving care in psychiatric institutions into the community

(Kritsotaki et al., 2016; Scull, 2021). This led to significant challenges due a lack of community resources to meet the growing mental health needs of the population (Hahn, 2001). As in-patient beds have continued to decline through the years, there has been a simultaneous rise in the number of community mental health crises, as evidenced by increased use of emergency services, such as 911 calls and visits to the emergency department (Kim & Kim, 2017; Scull, 2021). Over the past 60 years, community resources are still not sufficient to meet the current needs of mental health care, and therefore emergency systems (emergency departments, police force, paramedic services) are often first to respond to mental health crises in the community (Hogan & Goldman, 2021). These emergency systems are often ill-prepared, have limited resources, and are being overstretched (Hogan & Goldman, 2021).

Movement from in-patient hospitalization to community care led to the development of interdisciplinary Community Mental Health Teams (CMHTs), one of those teams being CTs (Burns, 2004). CTs arose due to growing concerns that police were not equipped to deal with the increasing number of mental health crises occurring in the community (Borum et al., 2000). The earliest model of Crisis Intervention Teams (CITs) was developed in Memphis, Tennessee in the 1980s, where the Memphis Police Department worked with local mental health professionals to develop a specialized program for police officers that taught de-escalation and crisis intervention techniques (Teller & Ritter, 2008). This model was created in response to a variety of concerns, including the policing of mental health crises, criminalization of mental health challenges, and stigma (Teller & Ritter, 2008). Although initially pioneered in the U.S.A, CTs are now being used nationally in many areas of North America, Europe, and Australasia (Johnson et al., 2022).

According to Burns (2004), crisis services were "introduced into a 'failing' system as part of a new broom" to promote the reduction of in-patient hospital beds, particularly long-term psychiatric bed usage. The overall goal to the introduction of CTs is to provide crisis care within the community and decrease the need for presentation to the hospital by offering supportive intervention within the service users' living environment (Hogan & Goldman, 2021). A common problem is whether there is sufficient support in the community to provide appropriate care to individuals outside the hospital (Semple et al., 2021). As per Ford-Jones and Chaufan (2017), in their critical analysis of pre-hospital calls for emergency medical services, the researchers highlight the importance of social and political determinants of health on mental health challenges, and how policy must reach beyond the healthcare system to prevent mental health crises as opposed to just reacting to them.

The worldview of a CT is unique in that they are often composed of individuals from different professions (social work, nursing, police, paramedics), which are connected to various community and hospital programs across the healthcare system and are commonly informed by community and family-centered approaches (Winters et al., 2015). CTs are sometimes the first contact for service users and carers during a first episode of psychosis and can have a large role in setting the tone for future engagement (Ghelani, 2022). Given their ability to travel to the individual's environment during the point of crisis, exploring the experiences of service users with CTs can likely offer a unique perspective on the barriers and challenges individuals and their families may face in accessing appropriate care within the community. Additionally, there is an opportunity to explore the firsthand accounts of service users and their informal carers in experiences with CTs in existing literature. This perspective could help inform how best to improve the pre-hospital care system, promote mental health in the community, and avoid unnecessary and potentially traumatic experiences of being brought to hospital by police and/or hospitalized against one's wishes. Therefore, the primary aim of this scoping review is to explore the experiences of service users with psychosis and CT workers during a crisis interaction and how this could inform our perspectives of the challenges and barriers this population may face in accessing appropriate care.

Positionality

Before proceeding to the methods and search strategy used for this scoping review, I would like to state my positionality as a researcher for the study topic. It is important for researchers to reflect on their own experiences and maintain an awareness of how this may impact their research approach and interpretation of their findings. Professionally, I work as a mental health nurse for a CT, and I have cared for many individuals experiencing psychosis and observed the impacts that can arise after a diagnosis, such as psychological distress, relationship strain, increased suicide risk, and increased risk of homelessness and poverty. My personal and professional world collided when a close family member was diagnosed with psychosis, and I was plunged from the nurse's role to that of an intimate family member. The experience led to the development of another perspective of psychosis, and a deeper understanding of the impact this condition can have for individuals and their families.

Through this lens, I had begun a journey of exploring psychosis through a more holistic view, one that is person-centered, and more closely related to an individual's worldview and life circumstances. This viewpoint will influence the way that I conduct research, but I also consider my dual roles to be an asset. A dual role means that I can view the experience of psychosis through two lenses, which led me to rephrase my research question and analysis process to look at multiple perspectives (service user, carer, and professional). The research question began with asking what is known about the experiences of service users with psychosis, but then adapted to include the experiences of (informal) carers and healthcare professionals. My perspective is limited given that I do not have firsthand experience of being a service user with psychosis, which should be the primary lens, and therefore opportunities to triangulate with my family member who had this experience were invaluable to this study.

Study Purpose

The purpose of this scoping review was to explore what is currently known about the experiences of service users with psychosis and CT workers during a crisis interaction, which could provide further guidance on how to improve the care experience and illuminate potential gaps in the healthcare system. No scoping review or systematic review emerged from the preliminary search of the JBI database with key search terms (see Appendix A) which leads to the conclusion that one does not exist presently. To better guide further research efforts into understanding pre-hospital care for service users with psychosis, a scoping review was selected for this study to better understand what is known on the topic and how to best guide future research efforts.

Significance to Nursing

Nursing plays a vital role in the composition of CTs, and some teams consist primarily of mental health nursing staff (Carpenter et al., 2013; Hoult et al., 1984; Moreno-Alonso et al., 2023; Reynolds et al., 1990). The significance of this research for nursing is to give further insight into the point of crisis for individuals experiencing psychosis. The experiences of service users with psychosis and CT workers could have many valuable insights regarding the potential challenges and barriers that this population are currently facing. This deeper understanding may have the benefit of encouraging nurses and other care providers to adapt their approaches with service users, improving the care experience for individuals with psychosis, and leading to better outcomes.

Thesis Outline

The format of this thesis is designed in four chapters, including the introduction, methodology, results, and discussion sections, and then followed by the references and appendices. Chapter one introduces the thesis, provides background information on psychosis and CTs, addresses my positionality as a researcher, discusses the study's significance to nursing, and offers an outline for the thesis. Chapter two discusses the methodological approach, theoretical framework, search strategy, as well as the data generation and treatment, study rigour, and the study's strengths and limitations. Chapter three presents the results of the scoping review, which are organized into themes and subthemes, and highlights gaps and future considerations for the research. Chapter four presents the interpretation of the findings from the study, reflects on the results, provides some implications for nursing practice, and discusses any limitations.

Summary

In summary, the purpose of this review is to explore the experiences of service users with psychosis and CT workers during a crisis interaction, which could highlight current gaps in community research and guide future research efforts aimed to improve the current mental health system for service users with psychosis who receive support from these teams. Considering the low rates of service engagement among this population, understanding the care experience of the service user and their carers could be an important first step to improving care and health outcomes (Daggenvoorde et al., 2018; Tindall et al., 2015). The next chapter of this thesis will review the methodology used in conducting this scoping study.

Chapter Two: Methodology

Chapter two outlines the theoretical framework and methodological strategy used for this scoping review. This includes the search strategy employed to retrieve relevant literature for the review, an outline of how Arksey and O'Malley's (2005) five steps were followed, and how the data were charted, collated, and analyzed. In addition, I have discussed how this study has maintained rigour, disclosed any ethical concerns, and addressed potential limitations.

Theoretical Framework

As per Godfrey et al. (2010) employing a theoretical framework is useful for the process of synthesis within a scoping review as it can guide the search strategy, help with the detection and association of different concepts, and lead to identification of gaps and areas for further inquiry. For this scoping review, crisis theory was used as an overall framework for the area of substantive focus, which was the experience of service users with psychosis and Crisis Team (CT) workers in the literature.

Crisis theory

Origins of crisis theory first came from Lindeman's theory of classic grief reactions and was then further developed by Caplan and Hobbs (Black & Flynn, 2021; Caplan, 1964; Hobbs, 1984). Caplan (1964) considered a crisis to be an imbalance between the perceived difficulty and importance of dealing with a certain situation but not having the immediate availability to do so. In considering this definition, it is important to note that the individual experiencing psychosis often does not feel they have a "perceived difficulty", but rather others around them indicate an imbalance, especially in terms of their ability to fit in with social norms and societal expectations (Corrigan & Watson, 2002). Hobbs (1984) viewed a psychological crisis as a critical incident in someone's life that forms a response to significant life stressors or traumatic experiences, and that this does not necessarily lead to permanent disability but personal growth. In contrast to views of psychiatric illness as purely biological and chronic, crisis theory allows for a different view of so-called "mental illness", proposing that a crisis can be a point in time for an individual and an opportunity for change (Baumgardt & Weinmann, 2022). Crisis theory encourages shifting from biological explanations of mental health challenges and focuses instead on an opportunity for change or "recovery", which is where crisis theory overlaps with the recovery model (Baumgardt & Weinmann, 2022).

Crisis theory is in close relation with the more commonly known recovery model, which emphasizes that hope and recovery for individuals with mental health challenges are possible (Baumgardt & Weinmann, 2022). Whereby, the goal of treatment should be for individuals to regain a meaningful life as they define it, as opposed to simply "treating symptoms" often defined and focused on by clinicians (Baumgardt & Weinmann, 2022). A systemic perspective of crisis theory challenges the dominant biomedical model of "mental illness" and considers psychosocial factors that contribute to psychological distress that may occur during an experience of psychosis (Baumgardt & Weinmann, 2022). This perspective provides an opportunity to identify factors and triggers that may contribute to a psychiatric crisis, which are more easily identifiable by community teams like CTs, as opposed to emergency rooms or in-patient hospital care (Johnson et al., 2022).

Through a crisis theory lens, we can view psychosis as an experience that an individual goes through in their lives that may lead to a point of crisis, not simply as a psychiatric disease with symptoms (Black & Flynn, 2021). In discussing psychosis as a personal crisis Escher and Romme (2012) stated "hearing voices or auditory hallucinations and having unusual beliefs or delusions are in themselves not signs of psychopathology" (p. 17). These are more common in the general population without a diagnosed "mental illness" and there are more people who live content with these experiences than most realize (Escher & Romme, 2012). Many members of modern industrialized societies dismiss the idea that healthy people may hear voices, whereas in earlier times this view may have been more accepted (Escher & Romme, 2012). For example, historic figures - like Joan of Arc - were believed to hear divine voices, and influential figures such as Gandhi and Winston Churchill also reported hearing voices without being interpreted as "mental illness" (Escher & Romme, 2012). Shamans and traditional healers in some agricultural societies believe that those who hear voices require training to discern whether their voices originate from deities or evil spirits, with a nuanced understanding that is often lost in more modern societies (Escher & Romme, 2012).

Psychologist Monika Hoffmann discusses the process of helping service users understand the meaning behind hearing voices, such as helping some people to survive and others to harm themselves (Escher & Romme, 2012). When viewing psychosis as a personal crisis, we can better appreciate that challenges experienced by an individual are often not directly related to experiences of psychosis but from not fitting into societal expectations; these may lead to difficulties in functioning and potentially result in housing instability, inability to maintain employment, medical co-morbidities, financial dependence, social isolation, and substance use (Hasan & Musleh, 2017; Escher & Romme, 2012).

Crisis theory will be applied as a theoretical framework for this scoping review as it provides a holistic and recovery-centered approach to mental health (Baumgardt & Weinmann, 2022). The goal of this scoping review is to explore the experiences of service users with psychosis in their interactions with CTs. This framework has been used as a lens for which to guide the research questions during the collection and analysis of the findings. Additionally, the framework will help examine gaps in current mental health care, away from traditionally bio-medical perspectives of "mental illness" and towards a holistic, person-centered perspective that views a mental health crisis as a point in time for an individual that can lead to a meaningful life for that person.

Research Question

The research question for the completed study was: What is currently known about the experiences of service users with psychosis and Crisis Team workers during a crisis interaction? As my review of the literature progressed, I adapted the strategy to include the perspectives of carers and healthcare professionals to gain a more holistic view and a deeper understanding of the complexities of the interaction. The term "carer" has been used for informal caregiver in the scoping review, as this term was commonly used to refer to anyone that is part of the service users support system in the community, within the articles for this study. The research objectives were:

1. To examine the interactions between service users with psychosis, carers, and healthcare professionals working for CTs.
2. To identify any recommendations for how to improve the care experiences for service users with psychosis in their interactions with CTs.
3. To look for any existing gaps in the literature on crisis care for service users with psychosis.

Research Methodology

The research approach for this study was a scoping review based on the work of Arksey and O'Malley (2005). This original approach has been further developed by Levac et al. (2010), and then the framework was further advanced and extended by the Joanna Briggs Institute (JBI) and JBI corporation (Peters, Godfrey, et al., 2020). The JBI corporation is an organization that creates rigorous guidelines for the systematic review. JBI created an adapted checklist in the JBI guidelines recently updated in 2020, which builds on the original methodology of Arksey and O'Malley (Peters, Marnie, et al., 2021). These adapted guidelines extended the use of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist for use in scoping reviews, known as PRISMA-ScR (Peters, Marnie, et al., 2021). These guidelines and checklist were used in the conducting of this scoping review to keep with current best practice guidelines as per experts in the field (Peters, Marnie, et al., 2021).

A scoping review was chosen for this study due to its ability to provide a thorough and clear method for mapping areas of research and to identify potential gaps within existing literature (Arksey & O'Malley, 2005; Levac et al., 2010). To my knowledge there has not been a scoping review conducted on this subject, despite indication that service users with psychosis are among the highest users of CT services (Murphy et al., 2015). Arksey and O'Malley's (2005) original methodology was deemed to be the most appropriate as these researchers were integral to the inception of the scoping review approach. They were also first to outline this methodology, which has since been adapted by many researchers conducting scoping reviews (Levac et al., 2010).

There has been rapid growth in undertaking reviews of current literature, with many approaches that share a common goal of examining literature and determining what is currently known on a topic (Arksey & O'Malley, 2005). A scoping review allows for a broader approach to a literature search than other types of reviews, such as systematic reviews, that are often more focused on a specific question (Arksey & O'Malley, 2005). Whereby a systematic review typically includes a narrower range of quality studies, a scoping review tends to include a wider variety of studies and articles with differing methodologies (Arksey & O'Malley, 2005). Given the aim of the research question was to examine what is known about the experiences of service users with psychosis and CT workers during a crisis interaction, a scoping review emerged as the most appropriate for this study. This approach attempts to examine the nature and extent of what is known on the topic and can help identify gaps in current literature that could be pertinent for further study (Grant & Booth, 2009; Levac et al., 2010).

Ethical Considerations

There are no known ethical considerations as this scoping review study did not involve research with any participants and has only used publicly available literature. Therefore, ethics review was not required, and has been confirmed with the Office of Research Ethics at York University (see Appendix B).

Search Strategy

Literature from six databases available through York University Library were searched for this scoping review. These include Medline, PubMed, Web of Science, Embase, CINAHL, and Psych Info. A scoping review search strategy was developed in consultation with a Health Sciences librarian at York University. The original search strategy was created on Medline with the assistance of the librarian, and PubMed was used to assess if all relevant MeSH terms were identified for the three main concepts: Crisis Teams, service users with psychosis, and experiences (see Appendix A). For one of the main concepts "experiences", the search strategy was borrowed from the "patient issues" filter taken from the Nederlands Huisartsen Genootschap (The Dutch Society of General Practitioners), accessed on February 21, 2024. The term "experience" was chosen to view the interaction between service users with psychosis and CT workers as this is congruent with crisis theory, which views a mental health crisis as an experience an individual goes through rather than a disease with symptoms (Black & Flynn, 2021; Caplan, 1964). Different combinations of search terms were combined to find relevant results, however the search terms yielding the most relevant and pertinent results were selected. These terms were selected in collaboration with the Health Sciences librarian through a process of identifying relevant MeSH terms in Medline by expanding two of the main concepts, CTs and service users with psychosis, as the third concept strategy for experiences was borrowed. In addition to this, I examined common MeSH terms and keywords used in studies that were related to the study topic through Pubmed. After the initial strategy was developed, this was transferred into the four other databases: Web of Science, Embase, CINAHL, and Psych Info with librarian assistance. The complete search strategy for Medline has been included for reference (see Appendix C). Final search of all databases was conducted on April 13, 2024.

Methods

As per Arksey and O'Malley's (2005) approach, the following five steps were followed in the review: determining a research question, identifying relevant studies, study selection, charting the data, and collating, summarizing, and reporting the results. These steps are outlined in the following sections.

Step one: Research question

The aim of this study was to explore what is currently known in the literature about the experiences of service users with psychosis and their informal caregivers (carers) with healthcare professionals working for CTs. This focus could have insights into where current gaps exist in our community care, and how these could further guide research efforts aimed to improve the care experience for service users and hopefully increase engagement in potentially beneficial services. The research question for the completed study is: What is currently known about the experiences of service users with psychosis and Crisis Team workers during a crisis interaction? As my review of the literature progressed, I adapted the strategy to include the perspectives of carers and healthcare professionals to gain a more holistic view and a deeper understanding of the complexities of the interaction.

Step two: Identifying relevant studies

Relevant studies were identified within a wide variety of sources, including journal articles and scanning of reference lists. A total of 6134 articles were retrieved during the search, which will be further elaborated in the third chapter. The Health Sciences librarian from York University was consulted in developing a search strategy for the scoping review. The search strategy was developed to retrieve articles pertaining to the experiences of service users with psychosis and CT workers. Retrieved articles were first scanned for duplicates, then with duplicates removed, the titles and abstracts were reviewed to confirm their relevance to the study topic on the experiences of service users with psychosis and CTs. Once selected from the abstract and title screening, the article was retrieved in full text to review for inclusion and exclusion criteria. In cases where an article was not available for retrieval, a request was made through York University's library. If the library was unable to gain access to an article, then researchers from the study were contacted if their information was available, and a grace period of two weeks was provided before moving to the next stage.

Step three: Study selection

Inclusion and exclusion criteria were pre-determined, and selected articles from title and abstract screenings were then fully read to make sure they met all inclusion criteria and were not part of the exclusion criteria. Inclusion criteria were as follows:

1. Articles of all methodologies.

2. Peer-reviewed literature, and any grey literature that met criteria.

3. Articles that involved CT interactions with adult service users with psychosis (aged 16 and above) and/or their families/carers (Canadian Paediatric Society, 2022). This included service users with any diagnosed psychiatric condition if medically defined "symptoms" of psychosis are present at the time of encounter. Studies that included a mixed population of service users were included if majority of the participants were considered to have psychosis.

4. Published in English.

Given that the experiences of service users with psychosis and CT workers had been relatively understudied, as evidenced in preliminary data searches, there were no time limits set for the search. The exclusion criteria included:

1. Interdisciplinary teams that were not specific to time-limited crisis intervention in the community.
2. Articles which did not pertain to service users experiencing psychosis.
3. Articles that only involved service users assessed in hospital or admitted to an in-patient unit.
4. Articles that were not about CT interactions with service users or carers.

Step four: Charting the data

All articles that met the inclusion criteria were entered into the reference managing software program Mendeley. Relevant data were extracted from the articles and charted in Excel for data management. The following information was extracted from the articles: author(s), year of publication, study location, intervention type, study populations, aims of the study, methodology, outcome measures, and main results/findings.

Step five: Collating, summarizing, and reporting the results

A table was used to collate the extracted results organized under the corresponding headings and was included in the scoping review (see Appendix D). This allowed for comparison of the articles and to look for dominant areas and gaps within population demographics, study interventions, geographic location, methodology, and other demographics (workplace). Additionally, the data were analyzed for emerging themes and subthemes. These results were then reported in this thesis for submission to York University. See below for more details of these methods.

Data Generation and Treatment

Data extraction

All articles chosen for review were entered into the data managing system called Mendeley. Key information was extracted from the data, which included: author(s), year of publication, study location, intervention type, study populations, aims of the study, methodology, outcome measures, and main results/findings.

Data management

The data extracted from the articles were compiled into a table using Microsoft Word to organize relevant information. Once the data were organized into a table, this further enhanced clarity while keeping a consistent approach, as the articles were systematically examined for emerging themes and subthemes.

Data analysis

After all the data had been extracted, a thematic analysis was conducted (Levac et al., 2010). The thematic analysis involved examining the articles and exploring how they relate to the research questions (Levac et al., 2010). The thematic analysis allowed for the identification of themes and additional subthemes, which were then coded with terms that best reflected the findings (Braun & Clarke, 2006). Once the codes had been developed, this allowed for comparison among the sources to be examined for commonalities and patterns (Braun & Clarke, 2006). The data were reviewed multiple times until a period of saturation, whereby further coding of the data revealed no new themes or patterns (Polit & Beck, 2021). The process of data analysis was also iterative, as during the process of analysis and writing the results, I continually returned to the themes and tested them against any new data to check for accuracy (Polit & Beck, 2021).

Training

Theoretical knowledge of the research process had been gained through the Master of Science in Nursing program at York University, under the supervision of my thesis advisor Dr. Nazilla Khanlou and committee members Dr. Simon Adam and Dr. June Lam. During my Advanced Nursing Practicum conducted in the 2023 fall/winter semester, I had the opportunity to work alongside the Senior Interprofessional Research and Knowledge Mobilization Specialist at The Royal Ottawa Hospital, Shruti Patel, who is a master's prepared nurse, and this also helped solidify my theoretical knowledge in this area.

Study Rigour

As per the recently updated 2020 JBI guidelines, the scoping review approach to knowledge synthesis needed to be rigorously conducted, transparent, and trustworthy (Peters, Godfrey, et al., 2020). A significant way for this scoping review to exhibit study rigour was to document its review process within a protocol and to demonstrate how the study adhered to the JBI 2020 guidelines and PRISMA-ScR checklist (Pollock et al., 2021). The JBI guidelines and PRISMA checklist are the most advanced approach for maintaining study rigour and were developed by experts in the field of scoping reviews (Peters, Marnie, et al. 2021; Pollock et al., 2021). Therefore, the PRISMA-ScR checklist and JBI 2020 guidelines were used in combination with the original five steps outlined by Arksey and O'Malley (2005) to maintain study rigour in this scoping review (Peters, Marnie, et al. 2021; Pollock et al., 2021). Outlining the specific steps taken to conduct the scoping review search in the research protocol allows for the results to be replicated by another researcher and promotes transparency of the review (Peters, Marnie, et al., 2021). Trustworthiness has also been enhanced through consultation with my thesis advisor Dr. Nazilla Khanlou who is an established researcher in scoping reviews, as well as working with a Health Sciences librarian at York University to formulate the review's search strategy and identify appropriate databases for the review.

Strengths and Limitations

Some advantages of the scoping review design are that this type of review can allow for a quicker analysis and synthesis of data than a systematic review, which can be advantageous if information is needed quickly (Arksey & O'Malley, 2005). There are some limitations to the methodology of a scoping review, however, as they do not appraise the quality of evidence within the primary research in a formal context (Arksey & O'Malley, 2005; Peters, Marnie, et al., 2021). Since the scoping review does not appraise the quality of evidence, this allows for more flexibility to include different study designs as opposed to a systematic review, which is often primarily focused on measuring the effectiveness or appropriateness of a specific intervention (Arksey & O'Malley, 2005; Levac et al., 2010). Additionally, the volume of data can be substantial, which leads to questions about how to balance the breadth of material examined with the depth of the analysis (Arksey & O'Malley, 2005; Levac et al., 2010).

In this scoping review study, the preliminary literature review revealed a limited amount of research on the study topic, and although the volume of data retrieved within the scoping review contained a large quantity of articles (n=6134), the number of articles which met the full inclusion criteria (n=234) and those eventually included in the review after applying the full exclusion criteria (n=26) were manageable for the purposes of this study. As per Ross-White and Godfrey (2017) concepts that are not specifically defined with concrete limits will draw more articles. In this study, the concept "Crisis Team" has been poorly defined in the literature and has no specific MeSH term, and therefore would expect to have a higher number of articles retrieved overall. Rather than an arbitrary number, a review should aim to calculate the Number Needed to Retrieve (NNTR), which determines how many articles the search needs to retrieve to find one additional reference that meets inclusion criteria (Booth, 2006; Ross-White & Godfrey, 2017). The NNTR is calculated by dividing the total number of articles for screening by those meeting the inclusion criteria for the review (Booth, 2006; Ross-White & Godfrey, 2017). In this scoping review the NNTR has been calculated as 26, as 234 articles met the inclusion criteria from the initial 6134 total for abstract and title screening. Chilcott et al. (2003) suggested that an NNTR should be no greater than 100, as more than this number would constitute a general stopping rule. The NNTR of this study predicts that to find one more relevant article I would need to review 26, which demonstrates that my search strategy has been effective. However, a more specific approach to the search strategy could have helped to reduce the overall number of articles for title and abstract screening and focused the scoping review.

To enhance the scoping review framework, Levac et al. (2010) suggested there should be two reviewers conducting the screening of abstracts/full articles, and the optional step of consultation with key stakeholders should be considered mandatory. This study was a thesis project undertaken by a third year Master of Nursing student, and although there was opportunity for consultation with the thesis supervisor and thesis committee, the review of abstracts was undertaken solely by me. In terms of consultation with key stakeholders, this step was not incorporated due to time constraints of the program and was another potential limitation.

Summary

In summary, this chapter discussed the theoretical framework, methodology, ethical considerations, search strategy, data generation/treatment, rigour, as well as strengths and limitations of this scoping study. Arksey and O'Malley's (2005) five-step framework was followed in the process of completing this study and the search strategy was developed in consultation with the Health Sciences librarian at York University. The final search of all databases was conducted on April 13, 2024. Data were analyzed using thematic analysis to identify relevant themes and subthemes (Braun & Clarke, 2006). The next section of this thesis will discuss the results of the scoping study in detail.

Chapter Three: Results

Overview

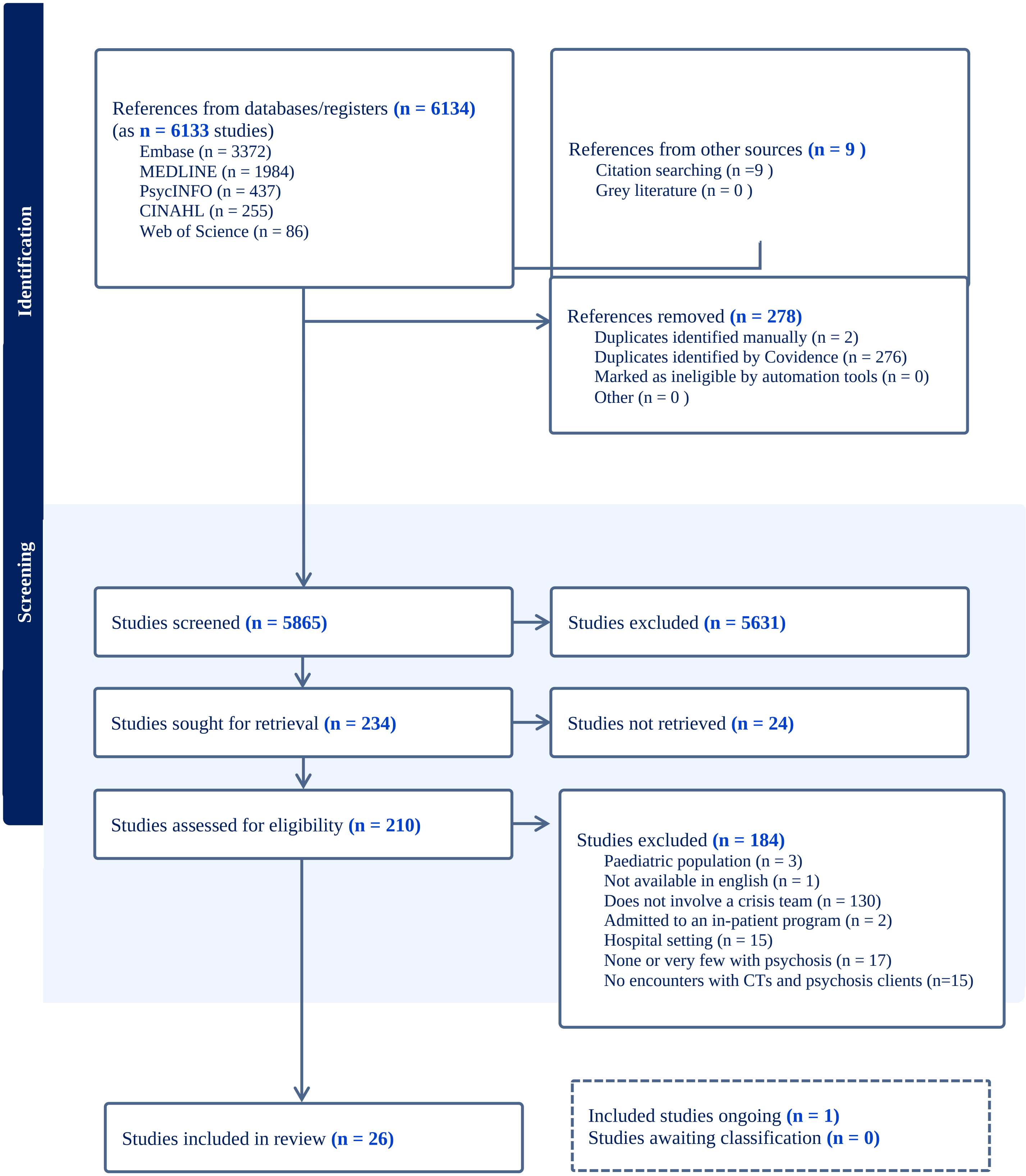
This chapter outlines the themes and subthemes that were identified from the scoping review and presents the summarized findings. I will describe the themes and then provide support from the findings of the articles included in the review. The results from the study were organized into three major themes which represented: 1) experiences of service users with psychosis, 2) experiences of carers, and 3) experiences of healthcare professionals. Each theme contains additional subthemes under each category and will be discussed further in the next section.

Study Information

Following Arksey and O'Malley's (2005) five steps, I retrieved a wide variety of articles, and dates spanned from 1976 to 2023 for those included in the review. In total, 6134 articles were retrieved from all databases and inputted to Covidence, an online screening and data collection tool for literature reviews, where 278 duplicates were removed. The titles and abstracts of the remaining articles were scanned for inclusion and exclusion criteria, which ended with 234 articles selected for full text review. Of the 234 articles sought in full text, 24 articles were not available through York University. Library requests were made through the university, but the articles were either unable to be located or only available as a conference abstract. In addition to library requests, researchers of unretrievable articles were contacted when their information was available (n=5), and a waiting period of two weeks was provided for response prior to moving to the next stage. In total, 26 articles met full inclusion criteria, 17 from the initial screening, and an additional 9 were added after references were reviewed from relevant articles (see Figure 1 - PRISMA diagram).

Figure 1

PRISMA Diagram



The 26 selected articles were entered into Mendeley reference management software, which is a tool used to collect, organize, and cite research sources. The relevant data were then recorded in a table (see Appendix D), as well as each article analyzed for themes and subthemes. The Crisis Teams (CTs) from these studies had participants from varying backgrounds, such as healthcare professional based teams like Crisis Resolution Home Treatment (CRHT) teams popular in areas within Europe, police-only Crisis Intervention Treatment (CIT) teams developed in the U.S.A, and co-response models like Mobile Crisis Intervention Teams (MCIT) common in Canada and Crisis Assessment Teams (CAT) used in Australia (see Appendix D).

From what information was available regarding the make-up of these teams: thirteen were comprised only of healthcare professionals (Barakat et al., 2021; Freeman et al., 2011; Fulford & Farhall, 2001; Goldsack et al, 2005; Hopkins & Niemiec, 2007; Hoult et al., 1984; Johnston, 2010; Kłapciński & Rymaszewska, 2015; Moreno-Alonso et al., 2023; Polak & Kirby, 1976; Ruggeri et al., 2006; Reynolds et al., 1990; Xanidis & Gumley, 2020), three compared separate responses to crisis with joint response from police and healthcare professionals (Boscarato et al., 2014; Brennan et al., 2016; Daggenvoorde et al., 2018), two studies discussed separate responses to crisis only (police-only or healthcare professional only) (Gregory & Thompson, 2013; Marshall, 2023), one compared data from both police-only and co-response teams (Lamanna et al., 2018), and seven discussed and compared multiple models (Carpenter et al., 2013; Holgersen et al., 2022; Johnson et al., 2022; Murphy et al., 2015; Sjølie et al., 2010; Wheeler et al., 2015; Winness et al., 2010). The healthcare professionals in these teams were of varying clinical backgrounds including mental health nurses, peer support workers, volunteers, psychiatrists, psychologists, psychiatric registrars, social workers, and occupational health (see Appendix D).

Most articles contained data from the UK (n=11), followed by Australia (n=7), with others from countries like Canada, Chile, Denmark, Ethiopia, France, Germany, Italy, Netherlands, New Zealand, Norway, Spain, South Korea, Poland, Switzerland, and the U.S.A. The review included various study designs (see Table 1), a mix of qualitative (n=8), quantitative (n=7), mixed study design (n=1), academic papers (n=4), and previous literature reviews (n=6). For qualitative studies, there were two phenomenology, two exploratory, an autoethnography, one focus group, one narrative, and a participatory action study. In terms of quantitative designs, there were three quasi-experimental, two correlational, a Randomized Controlled Trial (RCT), and a comparative study. There was one mixed method study, and four papers outside specific categories. For reviews there were five systematic and one scoping review.

Table 1

Source Breakdown of Study Design

Study type	Methodology	Source
Qualitative (n=8)	Phenomenology	Daggenvoorde et al., 2018; Freeman et al., 2011.
	Exploratory	Boscarato et al., 2014; Brennan et al., 2016.
	Autoethnography	Gregory & Thompson, 2013.
	Focus group	Xanidis & Gumley, 2020.
	Narrative	Goldsack et al., 2005.
	Participatory action	Hopkins & Niemiec, 2007.
Quantitative (n=7)	Quasi-experimental	Hoult et al., 1984; Moreno-Alonso et al., 2023; Polak & Kirby, 1976.
	Correlational	Fulford & Farhall, 2001; Reynolds et al., 1990.
	RCT	Barakat et al., 2021.
	Comparative	Ruggeri et al., 2006.
Mixed (n=1)	Mixed method study	Lamanna et al., 2018.
Paper (n=4)	Academic paper	Johnson et al., 2022; Johnston et al., 2010; Kłapciński & Rymaszewska, 2015; Marshall, 2023.
Literature review (n=6)	Systematic review	Carpenter et al., 2013; Murphy et al., 2015; Sjølie et al., 2010; Wheeler al., 2015; Winness et al., 2010.
	Scoping review	Holgersen et al., 2022.

Most articles were from English and Scandinavian origins. The findings from the review were organized into three major themes - service user, carer, and healthcare professional experiences - which contained additional subthemes under each category and will be discussed further in the next section.

Previous Literature Reviews

There were six previous literature reviews identified from the search that were pertinent to this study, including five systematic reviews, and one scoping review study (Carpenter et al., 2013; Holgersen et al., 2022; Murphy et al., 2015; Sjølie et al., 2010; Wheeler et al., 2015; Winness et al., 2010). The systematic review by Sjølie et al. (2010) discusses what is currently known regarding CRHT teams in English and Norwegian literature but does not include articles that pertain to individual perspectives of service users. Although the results from the review were illuminating in terms of structural benefits of these teams, such as reduction in hospital admissions and enhanced cost effectiveness, there is limited information available on specific crisis interventions, and indicates more research is needed on the service user, carer, and healthcare professional perspective (Sjølie et al., 2010).

Another systematic review by Winness et al. (2010) explored which aspects of care formed a positive experience for service users with CRHT teams. This study was of a small scale, analyzing 16 papers, and did not include carer or professionals' views, nor how experiences may differ per diagnosis. In a systematic review by Carpenter et al., (2013), researchers discussed only the effectiveness of Crisis Resolution Teams (CRTs) and not the firsthand experiences of service users, carers, or healthcare professionals. In a more recent systematic review by Wheeler et al. (2015), the researchers indicate that previous systematic reviews have focused solely on effectiveness of CRTs, rather than influencing factors, and therefore the aim of the review was to explore specific characteristics of CRTs that influence effectiveness. The study did consider that service user and carer satisfaction was an outcome to be measured for effectiveness, but their perspectives should be examined in more detail than what is expected in a systematic review (Wheeler et al., 2015).

In a newer scoping review study, Holgersen at al. (2022) discussed what is currently known in the research regarding CRT models in English and Scandinavian literature, but there is limited information on interventions or therapy aside from medications. In a systematic review by Murphy et al. (2015), the study indicates that intervention in the community by crisis intervention models could be a superior form of support as opposed to hospitalization for service users with mental health challenges but agrees that limited information is available on crisis intervention for those with severe psychological distress (Holgersen et al., 2022; Murphy et al., 2015). Perspectives from service users, carers, or healthcare professionals was not a prominent feature of either review (Holgersen et al., 2022; Murphy et al., 2015).

Although, there are six previous literature reviews on the topic of CTs, only one of the reviews discusses firsthand experiences of the service user but did not specify any clinical diagnosis (Winness et al, 2010). In this scoping study, the aim of the review is to explore what is currently known about the experiences of service users with psychosis and CT workers during a crisis interaction, which has not been previously explored in any known review.

Main Themes

The results of the study were organized into three main perspectives with additional sub-themes under each category (see Table 2). These main perspectives were: service user experiences, carer experiences, and healthcare professional experiences. Division of the findings into three main experiences allows for comparison of how these experiences relate and differ, as well as how positive and negative aspects of crisis care can contribute to the overall care experience. These perspectives were further divided into subthemes which are not completely independent of each other, as there is a degree of overlap among experiences, most significantly of service users and carers.

Table 2

Themes and Subthemes

Service User Experiences	Self-empowerment Accessibility & availability Level of satisfaction Care approach Stigma & traumatizing experiences Communication Care transitions
Carer Experiences	Confidentiality Caregiver stress Differences in care preferences Mixed feelings Part of the team
Professional Experiences	Workplace stress Labelling care Fast-moving trains Service integration Managing risks Education

Majority of the articles included in this review contained findings of the service user experience. In total, 10 articles contained information solely of the service user experience, and 10 more articles contained information about the service user and other groups (n=20) (see Table 3). Only three articles were specifically about experiences of carers with CTs in this scoping review, and another nine articles discussed carers' perspectives in combination with other perspective(s) (n=12) (see Table 3). In this review, only three articles spoke exclusively about healthcare professionals' experiences working for a CT, but six other articles spoke about professional perspectives along with other groups (n=9) (see Table 3).

Table 3

Source Breakdown of Themes

Service user (n=10)	Barakat et al., 2021; Boscarato et al., 2014; Carpenter et al., 2013; Hopkins & Niemiec, 2007; Johnson et al., 2022; Lamanna et al., 2018; Murphy et al., 2015; Polak & Kirby, 1976; Ruggeri et al., 2006; Winness et al., 2010.
Carer (n=3)	Brennan et al., 2016; Fulford & Farhall, 2001; Marshall, 2023.
Professional (n=3)	Freeman et al., 2011; Johnston, 2010; Xanidis & Gumley, 2020.
Servicer user/carer (n=4)	Daggenvoorde et al., 2018; Hoult et al., 1984; Moreno-Alonso et al., 2023; Reynolds et al., 1990.
Service user/ professional (n=1)	Gregory & Thompson, 2013.
All three (n=5)	Goldsack et al., 2005; Holgersen et al., 2022; Kłapciński & Rymaszewska, 2015; Sjølie et al., 2010; Wheeler at al., 2015.

Service user experiences

The term service user was used most frequently throughout the literature, and as per Winness et al. (2010) has replaced the word "client" or "patient" in recent health literature. Majority of the articles included in this review contained data pertaining to the service user experience (n=20), and these were broken down into 7 additional subthemes: self-empowerment, accessibility and availability, level of satisfaction, care approach, communication, stigma and traumatizing experiences, and care transitions (see Table 4).

Table 4

Source Breakdown of Service User Experiences' Subthemes

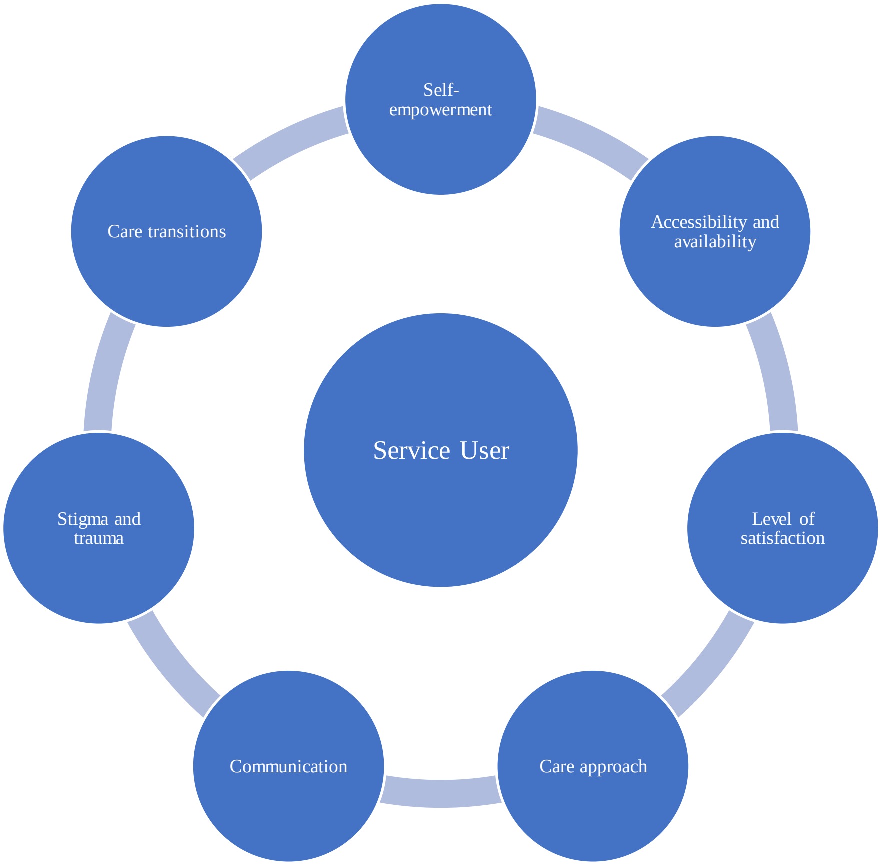
Subtheme - Service User Experiences	Source
Self-empowerment	Barakat et al., 2021; Goldsack et al., 2005; Hopkins & Niemiec, 2007; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Winness et al., 2010.
Accessibility & availability	Boscarato et al., 2014; Daggenvoorde et al., 2018; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec 2007; Hoult et al., 1984; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Moreno-Alonso et al., 2023; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Ruggeri et al., 2006; Wheeler et al., 2015; Winness et al., 2010.
Level of satisfaction	Boscarato et al., 2014; Carpenter et al., 2013; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec 2007; Hoult et al., 1984; Johnson et al., 2022; Lamanna et al., 2018; Morenso-Alonso et al., 2023; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Ruggeri et al., 2006; Wheeler et al., 2015; Winness et al., 2010.
Care approach	Boscarato et al., 2014; Daggenvoorde et al., 2018; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec, 2007; Hoult et al., 1984; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Marshall, 2023; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Wheeler et al., 2015; Winness et al., 2010.
Communication	Boscarato et al., 2014; Daggenvoorde et al., 2018; Carpenter et al., 2013; Gregory & Thompson, 2013; Goldsack et al., 2005; Hopkins & Niemiec, 2007; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Winness et al., 2010.
Stigma & traumatizing experiences	Boscarato et al., 2014; Daggenvoorde et al., 2018; Gregory & Thompson, 2013; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec, 2007; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Reynolds et al., 1990; Sjølie et al., 2010.
Care transitions	Daggenvoorde et al., 2018; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec, 2007; Hoult et al., 1984; Murphy et al., 2015; Reynolds et al., 1990.

Despite this, multiple articles examined in this review indicated that the service user perspective was only superficially explored, mostly through questionnaires, and that further in-depth exploration into service users’ experiences with CTs was warranted (Johnson et al., 2022;

Winness et al., 2010). More specifically, research is needed on the in-depth experiences of service users with psychosis in contact with a CT, as there has been little research conducted on CT intervention with those diagnosed with "severe mental illness", such as psychosis (Daggenvoorde et al., 2018; Murphy et al., 2015). There was not much information available on whether service users' experiences may differ depending on their diagnosis, and therefore, whether current crisis interventions should be adapted to specific service users. Figure 2 represents the seven subthemes under the over-arching theme of service user experiences, which will be discussed more in detail under each corresponding heading below.

Figure 2

Service User Experiences



Self-empowerment

Self-empowerment was a theme discussed in many studies as an important aspect of crisis care in the community (Barakat et al., 2021; Goldsack et al., 2005; Hopkins & Niemiec 2007; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Winness et al., 2010). In the systematic review by Winness et al. (2010), service users reported that staying in the community allowed them to deal with the crisis in their daily life. This promoted service users being seen as ordinary people and able to carry on with their lives despite being in crisis, as removing the person from their living environment would rob them of the opportunity to continue with their ordinary activities and social networks (Winness et al., 2010). Other studies in the literature agreed that receiving care within the service user's living environment promoted autonomy, as healthcare professionals can see the service user as an individual in their own environment (Johnson et al., 2022; Goldsack et al., 2005). Many of the articles also agreed that promoting a service user's self-empowerment was an important aspect of a CT service (Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018).

As per Barakat et al. (2021) improving service user's self-efficacy was an important part of resolving a crisis and helping service users achieve wellness, but CT support was not associated with improvement in self-efficacy in this study. According to Bandura (1997) self-efficacy is an individual’s belief in their ability to perform a task or achieve a goal. Self-efficacy is a building block towards self-empowerment, as once an individual believes in their capacity to reach a goal, they are more likely to take the necessary action (Bandura, 1997).

Conversely, service users from study by Lamanna et al. (2018) reported that the care they received from co-response teams with police and mental health professionals was empowering, as they felt the team had collaborated with them and acted with respect and understanding. In a study by Hopkins and Niemiec (2007), the researchers suggested that CTs should assist service users to create a joint crisis plan to prepare for a future crisis, which could improve service user's self-empowerment.

Accessibility and Availability

Many articles discussed the importance of accessibility and availability to service users and carers in times of crisis (Boscarato et al., 2014; Daggenvoorde et al., 2018; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec, 2007; Hoult et al., 1984; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Moreno-Alonso et al., 2023; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Ruggeri et al., 2006; Wheeler et al., 2015; Winness et al., 2010). Although CTs differed in their practices, most articles agreed that 24/7 operations would be preferred with rapid response times to the initial crisis (Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec, 2007; Hoult et al., 1984; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Moreno-Alonso et al., 2023; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Sjølie et al, 2010; Wheeler et al., 2015; Winness et al., 2010). This coincides with the National Institute for Health and Care Excellence (NICE) guidelines for those with psychosis in crisis to be offered 24-hour access to crisis services (NICE, 2014).

In a participatory action study by Hopkins and Niemiec (2007), service users identified that having quick access to crisis services was especially important at the beginning of the crisis, as well as having access to these services at any time of day or night. Both service users and carers in a phenomenological study by Daggenvoorde et al. (2018) felt that the CT service was delayed in responding to the crisis. As per Boscarato et al. (2014) in co-response models between healthcare professionals and police, preference would be for both services to arrive together; however, one service is often waiting for the other which delayed the response time. In a mixed methods study of a co-response model between healthcare professionals and police, Lamanna et al. (2018) reported that the average response time for the co-response team was 13 minutes longer than police-only. However, this was dependent on many details such as the location, jurisdiction, and individual staff members (Lamanna et al., 2018). Given that service users prefer joint response as opposed to police-only models (Boscarato et al., 2014; Lamanna et al., 2018) this leads to the question of how to improve these response times. The Ride Along model was suggested by Boscarato et al. (2014), in which both healthcare professionals and police respond together simultaneously to crisis in the community.

In addition to the type of response model, there were concerns about team availability for prompt response (Daggenvoorde et al., 2018; Johnston et al., 2022; Lamanna et al., 2018). Despite the preference of 24-hour availability to many service users and carers, most CTs are not resourced enough to provide care 24 hours a day (Johnson et al., 2022). A few studies indicated that a 24-hour crisis line was thought to be a potential solution for improving access to service users and carers (Hopkins & Niemiec, 2007; Johnson et al., 2022; Winness et al., 2010). On the other hand, this could lead to "digital exclusion" for those who do not have access to phone or internet (Johnson et al., 2022).

Level of Satisfaction

Most of the research agreed service users and carers are generally satisfied with care from CTs above that received in hospital (Boscarato et al., 2014; Carpenter et al., 2013; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec 2007; Hoult et al., 1984; Johnson et al., 2022; Lamanna et al., 2018; Morenso-Alonso et al., 2023; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Ruggeri et al., 2006; Wheeler et al., 2015; Winness et al., 2010). However, much of the data that measured general satisfaction was taken by questionnaire, which would limit the kind of information that could be obtained (Goldsack et al., 2005; Hopkins & Niemiec, 2007; Moreno-Alonso et al., 2023; Polak & Kirby, 1976; Reynolds et al., 1990; Ruggeri et al., 2006; Wheeler et al., 2015).

Although satisfaction questionnaires are commonly used in health research, they often fail to capture the nuances of an individual's experience and usually do not provide an ability for participants to freely express themselves (Stallard, 1996). In addition to this, service user satisfaction scores based solely on questionnaire data have been shown to overestimate levels of satisfaction, and interview-based data have been shown to demonstrate more reliable and specific information (Williams & Wilkinson, 1995). As per Ruggeri et al. (2006), service user satisfaction is a key component of service planning, especially for mental health, as satisfaction leads to greater service engagement. Therefore, improving service user satisfaction should be a main objective of mental health services (Ruggeri et al., 2006).

In a phenomenological study by Daggenvoorde et al. (2018), multiple participants reported being dissatisfied with the care received from a CT. Interestingly, the healthcare professionals working for the CT were often described as empathetic and understanding, and most of the dissatisfaction reported was due to joint police involvement (Daggenvoorde et al., 2018). The encounter with a CT was described as a "bumpy road" and many felt that they had received poor communication from the team and that they played a minimal role in their own care (Daggenvoorde et al., 2018). Several participants reported feeling "humiliated" due to being "treated like a criminal" by police and felt stigmatized when neighbours observed them being taken in a police car - sometimes in handcuffs (Daggenvoorde et al., 2018).

In an autoethnography by Gregory and Thompson (2013), one of the researchers in the study had experienced an episode of psychosis (operating under a nom de plume Alex) and reported that the communication she had received in the hospital was better than in the community. Although Alex felt that the CT included her in the care decisions to stay home initially, she did not feel that she was provided enough explanation to fully appreciate the situation at the time (Gregory & Thompson, 2013). Alex reported that she did not feel safe and included in her care plan until she met with a friendly social worker at the hospital after being brought in by police under the Mental Health Act (Gregory & Thompson, 2013). Later in her admission, Alex's key worker explained to her about ideas of reference, and she found this to be very helpful in further understanding her experience (Gregory & Thompson, 2013).

In a study by Boscarato et al. (2014) the unsatisfactory and inconsistent experiences of separate response between CTs and police led to co-response models in Australia. Although many participants would ideally desire co-response, they felt that these co-responding teams were not meeting their full potential due to lack of partnership onsite and ineffective use of each personnel's skills (Boscarato et al., 2014). Experiences of co-response teams varied among participants from human and compassionate to overreactive and violent; most felt that the teams were delayed in responding and disjointed in their communication (Boscarato et al., 2014).

In a systematic review by Winness et al. (2010), service user perspectives with CTs were examined and found that a great deal of criticism has been raised by service users, carers, and professionals. Despite CTs being created to adapt themselves to service users' needs, there remains no specific rubric for which to evaluate them, and no evidence that service user perspectives and/or preferences are being used to develop these services. Although much of the research indicated that service users and carers are generally satisfied with their care, a few pertinent studies also found many criticisms (i.e., poor communication, stigmatization, criminalization, disjointed and/or delayed response) where more open-ended responses were permitted, and this should be further explored (Boscarato et al., 2014; Daggenvoorde et al., 2018; Winness et al., 2010).

Care approach

Care approaches in crisis care were discussed throughout the articles, which included what service users found both positive and negative (Boscarato et al., 2014; Daggenvoorde et al., 2018; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec, 2007; Hoult et al., 1984; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Wheeler et al., 2015; Winness et al., 2010). An approach to care that is humanizing for service users was discussed in many articles as a preferred approach to crisis care (Boscarato et al., 2014; Daggenvoorde et al., 2018; Hopkins & Niemiec, 2007; Hoult et al., 1984; Kłapciński & Rymaszewska, 2015; Winness et al., 2010).

Some service users reported that the care they received from a CT was positive, humanizing, and were treated as "normal" (Hoult et al., 1984; Winness et al., 2010). Whereas other studies described a negative or dehumanizing interaction, where service users and carers received a lack of communication and care was sometimes experienced as threatening or even traumatizing (Daggenvoorde et al., 2018; Gregory & Thompson, 2013). In another study exploring co-response models with healthcare professionals and police, service users described a variation in responses from humane and compassionate to violent and overreactive on the part of police responding to the crisis (Boscarato et al., 2014). This was reflected in another study where carers also found that crisis intervention by joint response and police-only models was inconsistent (Brennan et al., 2016).

Conversely, in the first controlled trial study comparing hospital care and CTs in Australia, service users in the experimental group indicated a lot of positive experiences with CTs and stated that the caring supportive approach was appreciated (Hoult et al., 1984). Lamanna et al. (2018) also reported that a compassionate approach was associated with a positive crisis experience and felt that co-responding teams, as opposed to police-only, were more compassionate in their approach. In a participatory action study by Hopkins and Niemiec (2007), service users reported that the quality of interaction contributed to the care experience and highlighted being listened to and treated like a human being as important. The therapeutic relationship with CT staff was described as "almost like a friend" (Hopkins & Niemiec, 2007).

In Poland, there is a humanistic approach used during care with those who have experienced mental health challenges, and interventions with healthcare professionals are seen as an opportunity to communicate with the service user openly - rather than merely providing a prescription (Kłapciński & Rymaszewska, 2015). The humanistic attitude to mental health care evolved from the works of Antoni Kępiński, who was a Polish psychiatrist and researcher (Kępiński, 1972; Kłapciński & Rymaszewska, 2015). Kępiński described a process of "getting attuned" with the service user through empathetic listening, attention to non-verbal communication, and willingness to pay attention to how the conversation is impacting others (Kępiński, 1972; Kłapciński & Rymaszewska, 2015). This humanistic attitude is the basis of the Open Dialogue Approach (ODA) implemented in many Scandinavian countries, which was adapted by MCITs in Finland, and emphasizes a trialogue of communication between service user, carer, and healthcare professional (Kłapciński & Rymaszewska, 2015).

There are seven key components to the ODA model: 1) family at the centre of all interventions, 2) the persons closest to the service user are invited to the meeting, 3) the approach should be needs-based using the most appropriate therapeutic process, 4) the crisis worker who first meets with the service user and family are responsible for the therapy process, 5) psychological continuity is important, 6) the CT should focus on building rapport, unconditional acceptance, and sense of safety with the service user and family, 7) communication should be encouraged, where the service user's self-empowerment is the key, not "psychiatric symptoms" (Kłapciński & Rymaszewska, 2015).

In addition to having a care experience that is humanistic, compassionate, caring, and supportive, a continuity-of-care experience was discussed as an important factor in crisis care by many service users (Hopkins & Niemiec, 2007; Kłapciński & Rymaszewska, 2015; Wheeler et al., 2015). Generally, service users and carers had more inconsistent care with police-only response to crisis, than a co-response model with a CT (Boscarato et al., 2014). In a study by Hopkins and Niemiec (2007) participants reported that having their living environment visited by many staff was unsettling, and that consistency among crisis staff was helpful.

According to a systematic review by Wheeler et al. (2015), managers of CTs should prioritize limiting staff changes per service user by assigning a key worker, to further promote continuity in the service user experience. As per Hoult et al. (1984), receiving consistent care from CTs should be a key factor of the care model. In ODA, psychological continuity is also reported to be a key concept in the model (Kłapciński & Rymaszewska, 2015). Psychological continuity in this approach refers to consistency among healthcare professionals providing care during different stages of therapy (Kłapciński & Rymaszewska, 2015).

Communication

Many articles highlighted the importance of communication from CT professionals, and there was a divide between service users who felt that the communication was either delivered well or found to be lacking (Boscarato et al., 2014; Carpenter et al., 2013; Daggenvoorde et al., 2018; Goldsack et al., 2005; Gregory & Thompson, 2013; Hopkins & Niemiec, 2007; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Marshall, 2023; Winness et al., 2010). In a study by Marshall (2023), some carers reported that members of the CT took time to explain things, acted with empathy, and this made all the difference; but others felt dismissed. Emphasis was placed on the communicative style of the CT members, such as the tone of voice (Marshall, 2023).

One autoethnographic study described a first-hand account of an episode of psychosis written in part by one of the researchers who is also a social worker (Gregory & Thompson, 2013). The service user's experience began during a first contact with a CT after believing her husband was planning to kill her; once the CT assessed the service user, the shared decision was for her to be supported in the community (Gregory & Thompson, 2013). Although the service user was included in the decision to stay at home initially, she felt she had not been in the right frame of mind to make the decision (Gregory & Thompson, 2013). The article did not clearly indicate whether communication from the CT was inadequate or if the lack of understanding was influenced by the service user's feeling "hazy" at the time. However, Alex did describe lack of communication from police who had taken her to hospital after they felt the CT would not respond promptly enough to the second crisis (Gregory & Thompson, 2013). In fact, the service user felt she had not fully understood the situation until speaking with a social worker, once she was eventually admitted to the hospital (Gregory & Thompson, 2013).

In a participatory action study by Hopkins and Niemiec (2007), service users identified multiple communication points that were important during crisis intervention with a CT in Newcastle. These were between the CT, service users, families, and other services. Communication between any of these groups could either assist to open lines of communication or to close them (Hopkins & Niemiec, 2007).

The ODA was discussed in the literature as an emerging new therapy used in Scandinavian countries, which advocates for the use of an open trialogue between service users, carers, and CT healthcare professionals, and is a possible solution that could be explored (Kłapciński & Rymaszewska, 2015; Johnson et al., 2022). Cognitive Behavioural Therapy for psychosis (CBTp) was another potential therapy that was explored in the literature as a tool for crisis intervention that improved communication with service users (Xanidis & Gumley, 2020).

Stigma and traumatizing experiences

Many service users shared experiences of stigma and trauma during past crisis experiences; however, the literature was divided on whether CTs reduced these experiences, or contributed to them (Boscarato et al., 2014; Daggenvoorde et al., 2018; Goldsack et al., 2005; Gregory & Thompson, 2013; Holgersen et al., 2022; Hopkins & Niemiec, 2007; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Lamanna et al., 2018; Reynolds et al., 1990; Sjølie et al., 2010; Winness et al., 2010). In a few studies service users and carers reported that receiving care in their community by a CT resulted in less experiences of stigma and/or trauma that can sometimes be associated with hospital care (Johnson et al., 2022; Goldsack et al., 2005; Sjølie et al., 2010).

Others reported that they felt stigma during the interaction with a CT and that experiences were sometimes traumatizing, especially when police and use of handcuffs were involved (Boscarato et al., 2014; Daggenvoorde et al., 2018). Perceived stigma and/or previous traumatic experiences lead service users to feel reluctant in seeking out crisis services in the future (Gregory & Thompson, 2013; Johnson et al., 2022). In a study by Boscarato et al. (2014), police use of excessive force or non-lethal weapons led to service users feeling threatened and exacerbated the crisis. Whereas participants in other studies reported that CTs were supportive and compassionate, which helped to reduce potential stigma and improve care experiences (Goldsack et al., 2005; Hopkins & Niemiec, 2007).

Service users who were asked about their experiences receiving care from a co-responding CT and a police-only team describe their police-only experience as being treated like a criminal, often ending up in handcuffs and escorted either to jail or to the hospital (Lamanna et al., 2018). In an autoethnographic study, a service user with a dual experience as a researcher described a dissatisfactory outcome after initial contact by a CT (Gregory & Thompson, 2013). In this experience, the service user described that they had been included in the decision to stay in the community with care from family but later felt that they were not able to appreciate the situation fully (Gregory & Thompson, 2013). This led to the latter involvement of police, in which the service user was handcuffed and taken to the hospital in a police car, and the experience was described as traumatizing (Gregory & Thompson, 2013).

Conversely, other studies found that service users who received care in the community from a CT felt it was a normalizing experience of the crisis and contributed to less stigma (Boscarato et al., 2014; Hopkins & Niemiec, 2007; Sjølie et al., 2010; Winness et al., 2010). Some service users described that the caring, supportive approach used by CTs made them feel truly listened to and included in care decisions, which contributed to lessening the degree of stigma experienced (Goldsack et al., 2005; Hopkins & Niemiec, 2007; Johnson et al., 2022). As per Kłapciński and Rymaszewska (2015), using a trialogue of open communication between service users, carers, and healthcare professionals helps to cushion care experiences from stigma.

According to Johnson et al. (2022), when police are used as frontline mental health care workers during a crisis, there are potentially worse outcomes in terms of escalation of the crisis, unnecessary arrests, increased transports to hospital, and increased trauma and coercion experienced. In agreement with this, Daggenvoorde et al. (2018) indicates that service users sometimes experience their care as threatening and even traumatizing. Additionally, there is a lack of information on the systematic practices of CTs in terms of the activities, attitudes and interventions provided by these teams, as well as the experiences of the service users and their carers (Daggenvoorde et al., 2018).

Care Transitions

Another prominent theme in the research was how CTs handled their discharge and transfer of care processes from hospital or other services (Daggenvoorde et al., 2018; Goldsack et al., 2005; Holgersen et al., 2022; Hopkins & Niemiec, 2007; Hoult et al., 1984; Murphy et al., 2015; Reynolds et al., 1990). Despite the benefits of using CTs for crisis situations, such as preventing unnecessary admissions, providing effective care in the community, and reducing costs, the research supports that long term follow-up is often needed (Reynolds et al., 1990). CTs were made to be short-term intensive services, not a replacement for hospital care and longer-term follow-up, which is needed in many cases (Reynolds et al., 1990).

Although much of the literature in a systematic review by Murphy et al. (2015) agreed that CTs were to provide intensive time-limited care, an earlier study by Hoult et al. (1984) indicated that a key component of effective crisis care was ongoing extensive care rather than a one-time service. Furthermore, some studies reported apprehension and dissatisfaction with how service users were discharged from CT services and the follow-up provided to them (Hopkins & Niemiec, 2007; Goldsack et al., 2005).

In a study by Hopkins and Niemiec (2007), service users expressed many thoughts on being discharged from CT services to other follow-up and was the area they were least satisfied with. Participants would have preferred sufficient warning prior to discharge, be given an explanation about the next steps, have a specific plan of follow-up, and know what to do if another crisis occurs (Hopkins & Niemiec, 2007). According to Goldsack et al. (2005), some service users felt the timing of discharge was appropriate, but others felt they needed more support or a slower transition.

Another important care transition mentioned in the literature was being discharged from hospital back into the community, which was an area that CTs could potentially assist with (Murphy et al., 2015). When service users are discharged from a hospital and transition back to the community without proper supports, they may fall more easily into another crisis and be re-admitted to hospital quicker (Murphy et al., 2015). CTs could potentially assist with transitions from hospital, offering better support and education to service users and carers (Marshall, 2023). Joint crisis plans were mentioned in the literature as a practical solution to help service users and carers in future planning and prepare in advance for future crisis situations that may arise (Daggenvoorde et al., 2018; Hopkins & Niemiec, 2007).

Carer experiences

Despite the importance of informal support, experiences of carers in mental health crisis were found to be lacking in the research (Brennan et al., 2016; Fulford & Farhall, 2001; Sjølie et al., 2010; Wheeler et al., 2015). The perspective of carers for service users with psychosis was discussed in 12 articles, which was the second most discussed in the literature, and these findings were organized into five additional subthemes: confidentiality, caregiver stress, differences in care preferences, mixed feelings, and part of the team (see Table 5).

Table 5

Source Breakdown of Carer Experiences' Subthemes

Subtheme - Carer Experiences	**Source**
Confidentiality	Brennan et al., 2016; Hopkins & Niemiec, 2007; Marshall, 2023; Reynolds et al., 1990.
Caregiver stress	Brennan et al., 2016; Goldsack et al., 2005; Marshall, 2023; Moreno-Alonso et al., 2023; Reynolds et al., 1990; Sjølie et al., 2010.
Differences in care preferences	Brennan et al., 2016; Daggenvoorde et al., 2018; Fulford & Farhall, 2001; Goldsack et al., 2005; Holgersen et al., 2022; Hoult et al., 1984; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Moreno-Alonso et al., 2023; Reynolds et al., 1990; Sjølie et al., 2010; Wheeler et al., 2015.
Mixed feelings	Brennan et al., 2016; Marshall, 2023; Reynolds et al., 1990.
Part of the team	Brennan et al., 2016; Goldsack et al., 2005; Holgersen et al., 2022; Hoult et al., 1984; Kłapciński & Rymaszewska, 2015; Marshall, 2023; Sjølie et al., 2010.

The word carer was used in this review to encompass different informal supports of service users with psychosis, as this term is more inclusive than just family. Carers can include family, friends, neighbours, as well as other social contacts, and can play an integral role in service users' health and well-being, which should not be overlooked in the literature (Marshall, 2023). Figure 3 represents the five subthemes for the main theme of carer experiences, which will be discussed more in detail under each of the corresponding headings below.

Figure 3

Carer Experiences

Confidentiality

Confidentiality was considered a significant barrier for carers when attempting to get help for their loved ones and during discharge from care (Brennan et al., 2016; Hopkins & Niemiec, 2007; Marshall, 2023; Reynolds et al., 1990). According to Marshall (2023), carers often felt left out of decisions with service users, attributing this to strong adherence of confidentiality guidelines or lack of consent. Furthermore, strict adherence to confidentiality by healthcare professionals can sometimes hinder the ability of families or other carers to act in partnership with different services and provide help to the service user (Reynolds et al., 1990). As per

Brennan et al. (2016), privacy legislations were seen as a barrier to getting appropriate services, as being included in information sharing and making care decisions was seen as an important aspect to resolving the crisis and providing ongoing care.

In interviews conducted with carers in a study by Marshall (2023), participants described experiences where they had contacted a CT with safety concerns but were informed that intervention could only occur once the service user consented. These types of interactions created feelings of frustration and uncertainty among carers, especially in situations where the service user was perceived to be too unwell to actively participate in their care (Marshall, 2023). Many carers of service users with psychosis are marked by fear of risk for harm, but also express not knowing where to turn, and crisis services being inaccessible or unwilling to involve carers in decisions (Marshall, 2023). However, little research has been focused on the experiences of carers in providing support to service users with psychosis and mitigating risks (Marshall, 2023). In a study by Hopkins and Niemiec (2007), confidentiality was noted to be important to some service users, but others wished the team would communicate more openly with their informal carers to provide support and alleviate stress for them. This is an interesting finding, given that most confidentiality rules are presumably in place to protect the privacy of service users.

Caregiver stress

A prominent subtheme in the literature was the impact of caregiver stress on the carers of service users with psychosis (Brennan et al., 2016; Goldsack et al., 2005; Marshall, 2023; Moreno-Alonso et al., 2023; Reynolds et al., 1990; Sjølie et al., 2010). In a study by Moreno-Alonso et al. (2023), a recently established CT in Spain found service users reported high levels of satisfaction and improved quality of life in the questionnaire but with no reduction in caregiver stress. This was deemed to be a result of continued responsibility of supporting the service user in the community, rather than the respite that is sometimes provided with a hospital admission (Hoult et al., 1984; Moreno-Alonso et al., 2023).

According to Reynolds et al. (1990), crisis care provided by a CT could potentially increase caregiver stress, due to the service user remaining in their living environment instead of providing respite in a hospital setting. In addition to this, some carers have discussed inconsistent experiences with CTs and described this as a stressful and dissatisfactory aspect of receiving care (Boscarato et al., 2014; Brennan et al., 2016). This high stress can sometimes result in carers distancing themselves from the service user due to finding the situation too difficult to cope with (Reynolds et al., 1990). Conversely, in a systematic review by Sjølie et al. (2010) the findings from the review seemed to indicate that CTs decreased caregiver stress overall, but these findings were inconclusive.

Carers often reported experiencing significant stress after witnessing their loved one go through a crisis episode and were rarely provided any education or follow-up afterwards (Brennan et al., 2016; Marshall, 2023). Many carers reported that the experience of receiving crisis intervention for their loved ones was traumatizing, especially when the incident was handled with excessive force by police (Brennan et al., 2016; Marshall, 2023). This leaves many carers feeling reluctant to seek help from emergency services in the future and try to cope with the crisis on their own (Brennan et al., 2016). Supporting a loved one through a crisis often takes its toll on carers emotionally, physically, and can bleed into other aspects of their life, such as financial strain and other responsibilities (Brennan et al., 2016; Marshall, 2023). This highlights a need to better understand how this caregiving affects the supporters of those with mental health challenges, such as carers for service users with psychosis.

Differences in care preferences

Care preferences differed between carers and service users throughout the literature (Brennan et al., 2016; Daggenvoorde et al., 2018; Fulford & Farhall, 2001; Goldsack et al., 2005; Holgersen et al., 2022; Hoult et al., 1984; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Moreno-Alonso et al., 2023; Reynolds et al., 1990; Sjølie et al., 2010; Wheeler et al., 2015). Many articles indicated that service users, and in some cases carers, preferred support to be received in the community (Goldsack et al., 2005; Holgersen et al., 2022; Hoult et al., 1984; Johnson et al., 2022; Reynolds et al. 1990; Sjølie et al., 2010; Wheeler et al., 2015). Other carers indicated a preference for service users to receive hospital support, which was related to a need for carer respite in some cases (Daggenvoorde et al., 2018; Fulford & Farhall, 2001; Goldsack et al., 2005; Hoult et al., 1984; Reynolds et al. 1990).

As per Johnson et al. (2022), community support was reported to be less distressing for many, and therefore preferable to in-person hospital care. Community-based assessment also carries the benefit of involving informal carers to a more in-depth level than what is often possible in-hospital, as the community setting offers more opportunity for ongoing collaboration without some limiting aspects of hospitals (Johnson et al., 2022). Despite the intended rapid response nature of CTs, the research indicates that recent response times were found to be quite delayed in some cases, and communication was often less than optimal (Daggenvoorde et al., 2018; Johnson et al. 2022).

In terms of the type of crisis intervention, in a qualitative exploratory study done by Boscarato et al. (2014), service users reported a preference for an informal crisis intervention (ie. applying mental health first aid techniques, or family psychosocial interventions) by family and/or friends, second to that was family physician or case manager. None of the 11 participants in this study preferred police intervention and only one preferred CT intervention (Boscarato et al., 2014). Although much of the research indicated that intensive community support was generally preferred, hospital care was still felt to be needed in some cases (Hoult et al., 1984; Reynolds et al., 1990). In a study by Reynolds et al. (1990), both service users and carers were greatly satisfied with care from CTs in their living environment, though carers more than service users indicated a need for easier access to hospital, especially when providing care for service users in the community was considered too challenging for carers.

Mixed feelings

A few articles in the literature discussed carers having mixed feelings when involving crisis services with their loved ones (Brennan et al., 2016; Marshall, 2023; Reynolds et al., 1990). In a study by Brennan et al., (2016), many participants felt their experiences with CTs and police were variable and inconsistent, leaving carers unsure whether to contact crisis services or manage things themselves. Both negative and positive experiences were described by carers in the literature. Negative experiences were often pertaining to police responding in a way that was criminalizing to the person with mental health challenges due to lack of knowledge or training (Brennan et al., 2016). Positive experiences were related to a rapid response to the crisis, as well as staff being knowledgeable, having good communication, and an empathetic attitude (Brennan et al., 2016).

Given that many service users with mental health challenges, such as psychosis, either do not feel they need help or want the type of help that is offered from existing models of care, this can leave carers feeling they are in a precarious position (Reynolds et al., 1990). In a study by Marshall (2023), carers described feeling like they are "juggling knives", as trying to mitigate any safety risks for their loved ones with psychosis - despite physical exhaustion - led to them juggling multiple responsibilities while trying to maintain alertness. This underscores the importance of providing more consistent responses to crisis and offering more support to carers, ultimately improving the care experience for service users and carers while reducing apprehension in contacting services. Thereby, minimizing situations where crisis services are activated but then later regretted, which can then leave carers with mixed feelings.

Part of the team

Many articles discussed whether carers felt they were part of the team and were included in decision making with their loved ones and crisis services (Brennan et al., 2016; Goldsack et al., 2005; Holgersen et al., 2022; Hoult et al., 1984; Kłapciński & Rymaszewska, 2015; Marshall, 2023; Sjølie et al., 2010). Collaboration with carers and crisis services allows for a combining of skillsets between the mental health knowledge of CT staff and the intimate knowledge and expertise of the carer who know the service user well (Brennan et al., 2016). Another common finding was the need for CTs to better understand carers' perspectives and find ways to involve them whenever possible and deemed appropriate (Brennan et al., 2016; Goldsack et al., 2005; Kłapciński & Rymaszewska, 2015; Reynolds et al., 1990; Sjølie et al., 2010). As per a systematic review carried out by Sjølie et al. (2010), CTs make the social environment of the service user an important part of caring for them in the community, and this may include family, friends, and other social networks.

In a study by Marshall (2023), carers reported feeling like mediators between the service user and the healthcare professionals but were left out of actual decision-making. Other carers reported that being left out of important conversations led to lack of knowledge on how to support their loved ones in the community and was also considered a missed opportunity to offer support to them (Marshall, 2023). Conversely, in another study by Goldsack et al. (2005), carers reported feeling included in decision-making and were supported by the CT. Carers expressed that they "embraced us as part of the team, I think they really respected our judgement", and another stated "they did feel like members of the family, because we spent such a lot of time with them" (Goldsack et al., 2005, p. 20). Other carers have expressed being left out of discharge planning entirely, having their loved ones discharged to the community after a crisis (sometimes to the carer's home) without much notice and wished they had been given more instruction on how to provide care in the community (Marshall, 2023).

In the ODA adapted by CTs in Finland, the family or those closest to the service user are at the centre of all therapeutic activities (Kłapciński & Rymaszewska, 2015). Maintaining open, trusting communication between the service user, carers, and healthcare professionals is foundational to the approach (Kłapciński & Rymaszewska, 2015; Sjølie et al., 2010). The ODA is based on therapeutic meetings with the service user and their entire network, which may involve family, friends, or other important relationships to that person (Kłapciński & Rymaszewska, 2015). The CT worker in this interaction acts a moderator for the service user with psychosis to reflect on their experience while being listened to by the others (Kłapciński & Rymaszewska, 2015). As per Kłapciński and Rymaszewska (2015), this meaning making process enables the transformation of the "stigmatising and impoverishing language of diagnosis or psychopathology to a more restorative one of hope and empowerment" (p. 1185).

Professional experiences

There is a paucity of research in firsthand staff perspectives working for CTs, and specifically of qualitative, in-depth accounts - as most research focusses on outcomes, admission rates, and bed occupancy (Freeman et al., 2011). Throughout the literature, many names were used to describe community teams that focus on crisis intervention, such as Crisis Resolution

Teams, Crisis Resolution Home Treatment, Crisis Assessment Team, Crisis Assessment Treatment Service, Home-Based Treatment, Intensive Home Treatment, Mobile Crisis Intervention Team, and Mobile Crisis Team (Murphy et al., 2015; Sjølie et al., 2010). For this review, the most prevalent term (CT) was used to describe all types of interdisciplinary teams that specialize in time-limited crisis intervention in the community that provide extended hours and prioritize quick response. Seven articles discussed the perspectives of healthcare providers within this study, and the findings were organized into six subthemes: workplace stress, labelling care, fast-moving trains, managing risks, service integration, and education (Table 6).

Table 6

Source Breakdown of Professional Experiences' Subthemes

Subtheme - Professional Experiences	Source
Workplace stress	Freeman et al., 2011; Goldsack et al., 2005; Johnston, 2010; Xanidis & Gumley, 2020.
Labelling care	Brennan et al., 2016; Goldsack et al., 2005; Holgersen et al., 2022; Johnston, 2010.
Fast-moving trains	Freeman et al., 2011; Johnston, 2010; Wheeler et al., 2015; Xanidis & Gumley, 2020.
Managing risks	Freeman et al., 2011; Goldsack et al., 2005; Johnson et al., 2022; Johnston, 2010; Marshall, 2023; Sjølie et al., 2010; Xanidis & Gumley, 2020.
Service integration	Freeman et al., 2011; Goldsack et al., 2005; Holgersen et al., 2022; Johnson et al., 2022; Sjølie et al., 2010; Wheeler et al., 2015.
Education	Boscarato et al., 2014; Freeman et al., 2011; Goldsack et al., 2005; Gregory & Thompson, 2013; Holgersen et al., 2022; Kłapciński & Rymaszewska, 2015; Sjølie et al., 2010; Wheeler et al., 2015.

Understanding the healthcare professionals' experiences working for a CT could help to illuminate some of the negative experiences and perceived barriers expressed by service users and carers in the previous two major themes. Figure 4 represents the six subthemes for the overarching theme of healthcare professional experiences, which will be discussed more in detail under each corresponding heading below.

Figure 4

Professional Experiences

Workplace stress

In general, healthcare workers have been shown to have higher levels of stress than other sectors (Nigam et al., 2023), which may lead to negative outcomes in mental and physical health. Little research has been done to evaluate stress for CT staff in the literature (Freeman et al., 2011). Workplace stress was a theme discussed in four articles in this review (Freeman et al., 2011; Goldsack et al., 2005; Johnston, 2010; Xanidis & Gumley, 2020).

In an interpretive phenomenological study, Freeman et al. (2011) interviewed four mental health nurses and one peer-support worker employed by a CRHT team in South Wales to understand factors related to work-related stress and coping. Reported stressors in working for CTs have been in relation to the complexity of the working environment, expectations from referrers and service users, inappropriate referrals, unpredictability of the role, lack of control with high responsibility, and demands exceeding available resources (Freeman et al., 2011). Healthcare professionals also discussed inappropriate referrals as being one of the most frustrating parts of their job, such as receiving a referral that does not meet requirements for CT services, likely due to anxiety from the referrer (Freeman et al., 2011). Other less satisfactory aspects were workplace politics and needing to continually explain their role to other services (Freeman et al., 2011; Goldsack et al., 2005).

In his paper, Johnston (2010) discusses his experience as a psychiatrist and psychotherapist in establishing two reflective practice groups in two acute psychiatric settings: one on an in-patient ward and the other with a CT. The main aim of the study was to provide a safe space for professionals to discuss how they feel about service users, their work, and other coworkers (Johnston, 2010). In addition to the complex work environment, CT staff reported that their greatest fear related to their job was risk of death for service users and the associated shame and blame placed on healthcare professionals when this occurs, albeit infrequently (Johnston, 2010).

However, there were parts of the job that were motivating, such as increased service user choice, creating an environment where service users are involved in decisions, and empowering the service user (Freeman et al., 2011). In a study by Goldsack et al. (2005), CT nurses discussed high levels of satisfaction in being part of a team, working in an advanced capacity, and building strong relationships with service users and carers. According to Freeman et al. (2011), staff expressed three main team resources for coping with workplace stress, which were more informational, emotional, and management support.

Labelling care

The labelling of care for service users was discussed in four articles throughout this review (Brennan et al., 2016; Goldsack et al., 2005; Johnston, 2010; Moreno-Alonso et al., 2023). In a paper by Johnston (2010), the researcher was a psychiatrist and psychotherapist who conducted weekly reflective practice meetings with CT staff. In these practice meetings, CT staff discussed the labelling of service users in acute care settings into two different groups. One group was labelled "ill legitimate", those truly "ill" and deserving of treatment, and the other labelled "illegitimate", such as those with personality disorders (Johnston, 2010). Johnston (2010) also describes how a separation can develop between professionals and service users, creating a divide. This divide is reinforced when professionals assign a specific "diagnostic label", which acts to further distance them from the service user (Johnston, 2010).

The experience of individuals with psychosis was perceived to be more distinct from those of the professional, therefore becoming easier to distance further emotionally and is more comfortable for the clinician (Johnston, 2010). This was further evidenced by the firsthand experiences of a carer who was told that the CAT team would not come to assess their family member due to the diagnosis being borderline personality disorder, rather than a psychotic disorder like schizophrenia (Brennan et al., 2016). This carer was reportedly told that the CAT team would not respond to the crisis where their relative was experiencing possible psychosis due to the diagnosis (Brennan et al., 2016).

According to Goldsack et al., (2005) some service users felt shocked when their experience was given a label, whereas others felt that the diagnosis of their condition was helpful. Many sources in the literature consider a "severe mental illness" to be someone with a diagnosis of psychotic disorder or bipolar disorder (Moreno-Alonso et al., 2023; Reynolds et al., 1990; Ruggeri et al., 2006). Those with other disorders, such as depressive, anxiety, or personality disorders are considered by some to be "mild mental disorders" (Moreno-Alonso et al., 2023), which could be a barrier to seeking help.

Fast-moving trains

The fast-paced nature of how CTs typically work in the community was discussed in multiple articles (Freeman et al., 2011; Goldsack et al., 2005; Johnston, 2010; Wheeler et al., 2015; Xanidis & Gumley, 2020). In one study, the CT was described as a "fast moving train", rarely stopping to reflect on their practice (Johnston, 2010). This study also described the CT interactions with service users as a "hit and run", quick by necessity but barely scratching the surface of service users' lives before moving onto the next crisis (Johnston, 2010).

According to Xanidis and Gumley (2020), having high caseloads and lack of protected time for quality interactions with service users resulted in CT staff having less time with each service user to implement new psychological therapy, such as CBT for psychosis (CBTp) in this study. In prioritizing their time, the psychological needs of service users were sometimes seen as secondary to achieving outcome measures, and staff may revert to the medical model with emphasis on medication instead of therapy (Xanidis & Gumley, 2020). As per Wheeler et al. (2015), managers of CTs should support their staff having sufficient time to be less task-oriented and prioritize listening to service users and carers. In a study by Goldsack et al. (2005), CT staff acknowledged that rapidly beginning and ending an intense relationship such as the one required for proper crisis intervention can be challenging and requires a specific skillset.

As indicated by Freeman et al. (2011), staff working for a CT reported that caseloads were high and sometimes the demands of the job were higher than the resources available, which could help explain why CTs move fast through service user' lives, like a "hit and run". This is also understandable, given that most participants in other studies reported that a quick response time was important to them (Brennan et al., 2016; Winness et al., 2010). However, prioritizing a quick response time above quality interaction could lead to staff having less time to spend time with service users and carers on other therapies, such as CBTp.

Managing risks

The importance of risk assessment and managing various service user risks was discussed throughout many articles (Freeman et al., 2011; Goldsack et al., 2005; Johnson et al., 2022, Johnston, 2010; Marshall, 2023; Sjølie et al., 2010; Xanidis & Gumley, 2020). During a period of crisis, individuals with psychosis can sometimes experience increases in psychological distress, which may involve what is known medically as "hallucinations" and "delusional thinking" and could potentially escalate to a point of risk for the person or others (Murphy et al., 2015). As per Marshall (2023), individuals experiencing psychosis are at a higher risk of suicidal behaviour than the general population. As such, an important aspect of risk assessment can be the inclusion of carers, where deemed appropriate and therapeutic for the service user (Marshall, 2023). The inclusion of therapeutic carers can provide an opportunity for education on risk assessment, providing a safe environment, and monitoring for triggers.

Risk assessment is an important aspect of a CT's role, and important risks to be assessed are risk of harm to self or others, such as suicide or homicide risks (Johnson et al., 2022; Sjølie et al., 2010). Healthcare professionals may sometimes experience scrutiny after an adverse event with a service user, which can create anxiety in the professional who fears the finger of blame being pointed at them (Johnson et al., 2022). Risk of death can be highly anxiety-provoking for healthcare professionals, as after a death there is often shame and blame placed on the staff members involved, as well as a negative light shone onto the team (Johnston, 2010).

Additionally, there is a need to train CT staff on how to properly assess risk and intervene effectively, and this was found to be lacking in some studies (Freeman et al., 2011; Johnston, 2010). Healthcare professionals from one study felt unprepared to answer crisis calls, describing them as assessing risk blindly over the phone, and instead, preferred in-person assessment (Johnston, 2010). In a study by Goldsack et al. (2005), nurses reported that working for a CT required them to perform at an advanced level, as they made decisions everyday which carried high levels of risk, such as performing risk assessments and risk-benefit analysis.

In addition to safety risks for those with psychosis, the assessment of risk for psychosis in individuals who have previously experienced or are at risk to experience psychosis is also an aspect of the role (Xanidis & Gumley, 2020). CBTp is a recent therapy that has shown effectiveness in preventing psychological distress and supporting those experiencing psychosis (Hutton & Taylor, 2014). NICE guidelines for the professional care of psychosis recommend that all individuals experiencing or at risk for psychosis should be offered CBTp (NICE, 2014). In a study by Xanidis and Gumley (2020), the researchers explored the implementation of CBTp with staff who work for a CT. Another potential resource is developing a formal risk management plan with CT staff, as this was cited by some families to be helpful in preparing for future crises and knowing what steps to take (Goldsack et al., 2005).

Service integration

The literature discussed CTs as complex services and how these teams are integrated into the wider healthcare system was discussed in several articles (Boscarato et al., 2014; Freeman et al., 2011; Goldsack et al., 2005; Johnson et al., 2022; Wheeler et al., 2015; Xanidis & Gumley, 2020). CTs were created after the deinstitutionalization movement of the 1960s, which led to widespread closure of mental health hospitals (Scull, 2021). Closure of most psychiatric hospitals without the creation of well-integrated community systems could lead to negative outcomes for mental health service users (Polak & Kirby, 1976). As per Johnson et al. (2022), a well-integrated team is optimal but a system which is too complex will lead to fragmentation and service users falling through the cracks. According to Freeman et al. (2011), many CT staff stressors also arise from the complexity of the system, and negative views from other healthcare professionals who do not understand the role of CTs.

In addition to CT complexity, service users and carers throughout the literature indicated that communication from CT teams was found to be lacking (Daggenvoorde et al., 2018; Johnson et al. 2022). When CT communication is poor, this may cause gaps for service users when information is not properly relayed to them or others in the circle of care (Freeman et al., 2011; Goldsack et al., 2005; Hopkins & Niemiec, 2007; Wheeler et al., 2015). Some service users found that when emergency services and mental health professionals responded to crises separately there were issues with communication and delayed response time (Boscarato et al., 2014). When CTs were disjointed in their responses to crisis, there is the potential of miscommunication which may increase the potential for service users to fall through the cracks (Boscarato et al., 2014; Johnson et al., 2022). Setting clear priorities and definitions for teams in how they are structured and organized within the larger acute care system could help better integrate these services (Johnson et al., 2022; Polak & Kirby, 1976).

As per Wheeler et al. (2015) professional stakeholders, such as CT staff and management, often have different priorities then the care preferences of service users and carers. Professional stakeholders often prioritize organization and team resources, whereas service users and carers place emphasis on the quality of the care experience (Wheeler et al., 2015). Differing priorities could lead to service users feeling their voices are not heard by healthcare professionals, which could further contribute to the lack of engagement from service users. When service users do not engage with services due to contextual barriers from a complex care system, this may worsen care gaps and fragmentation of services, which should be a priority for clinical leadership (Xanidis & Gumley, 2020).

In a study by Goldsack et al. (2005), a major takeaway was for community-based services from CTs to be part of the whole care system and be supported within the larger care system. Further implementation of digital services has been suggested to further integrate crisis care (Johnson et al., 2022). Moving to digital services, such as phone-based crisis care, has improved access for many but leads to "digital exclusion" for others that do not have access to internet or phone (Johnson et al., 2022).

Educational Needs

The need to properly train staff working for interdisciplinary CTs was highlighted in many articles as a key component (Boscarato et al., 2014; Freeman et al., 2011; Goldsack et al., 2005; Gregory & Thompson, 2013; Holgersen et al., 2022; Kłapciński & Rymaszewska, 2015; Sjølie et al., 2010; Wheeler et al., 2015). In one phenomenological study, staff identified the need for added supervision and training for staff and that proper guidance and training programs for crisis intervention were lacking (Freeman et al., 2011).

The need for education, particularly regarding police officers and primary care, was a theme highlighted in some articles (Boscarato et al., 2014; Gregory & Thompson, 2013). In an autoethnography by Gregory and Thompson (2013), Alex's experience with psychosis began with stopping and re-starting one of her anti-depressants, which had been on a repeat prescription for five years after having a very brief check-in with her family doctor every 6 months. When her experiences of psychosis began, Alex was unable to reach her family doctor directly due to automated phone lines, which began a snowball effect eventually leading to admission (Gregory & Thompson, 2013). Automated phone lines have become common practice in response to pressure on family physicians to see their clients quickly, but there is an issue of using automated lines when there is an emergency (Gregory & Thompson, 2013). As per Gregory and Thompson (2013) mental health training for family doctors appears in need of improvement.

Concerns have also been raised with police acting as frontline mental health workers for service users in crisis, without adequate support or education (Johnson et al., 2022). A potential solution indicated in the literature has been police-led CITs, which involve a 40-hour mental health training program for police officers (Boscarato et al., 2014). Although the question remains whether 40 hours is sufficient or if police are the most appropriate resource to be leading these types of interventions (Boscarato et al., 2014). There are also co-response models to crisis intervention where mental health workers and police respond to crisis together, however there is limited research from the service user perspective on their reception (Boscarato et al., 2014). In one study by Boscarato et al. (2014), service users felt that a Ride Along model, where police and medical professionals responded together, was the best approach.

There is also a need for more streamlined education for members working for CTs, most notably crisis de-escalation techniques and discharge processes, as studies indicate that there is currently a wide variability in how teams currently operate (Freeman et al., 2011; Goldsack et al., 2015; Wheeler et al., 2015). As per Holgersen et al. (2022), there is also an expressed need for more knowledge on therapeutic interventions used by CTs as relatively few articles address these interventions and how staff are trained to implement these techniques. Educating CT staff on risk assessment and management, as well as how to support service users and carers during crisis intervention has been indicated in other studies (Brennan et al., 2016; Freeman et al., 2011). Further education for CT staff and other acute mental health services should be designed with service users and carers in mind, including their feedback (Boscarato et al., 2014).

The ODA approach used in many Scandinavian countries has been regarded in multiple studies as a training opportunity for CT staff and other healthcare professionals to improve their communication skills and overall approach with service users and carers (Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Marshall, 2023).

Summary

In summary, this section presented the results of the scoping study, which came from the findings of the 26 articles selected for the review that met study criteria. The next chapter will discuss in more depth how this study answered the research questions, was guided by crisis theory as a theoretical framework, how the findings have been interpreted, potential gaps in the literature, and implications for practice.

Chapter Four: Discussion

This chapter will offer further discussion of the study results and help to contextualize themes and subthemes using the research questions, objectives, and theoretical framework. I will discuss how findings from the results have been interpreted within the scoping review methodology and how each theme and subtheme impact the overall care experience for service users with psychosis and Crisis Team (CT) workers.

The research question for this review was: What is currently known about the experiences of service users with psychosis and Crisis Team workers during a crisis interaction? In accordance with the review's primary research question, the findings from this scoping review have helped to outline what is currently known regarding experiences of service users with psychosis and CTs, and the findings have been organized to encompass the viewpoints of the service users, their (informal) carers, and healthcare professionals working for these teams. Lastly, I will discuss potential implications for practice, research, and plans for dissemination of the results.

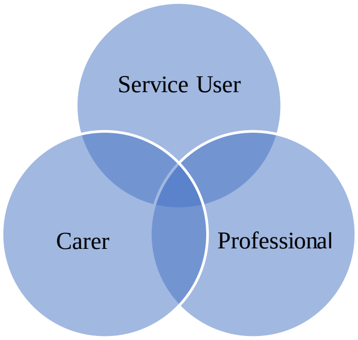
The previous chapter organized the findings from the scoping review into themes and subthemes, which helped to view the crisis experience from the viewpoint of the service user with psychosis, the carer, and the CT healthcare professional. This section will aim to interpret these findings using the theoretical framework of crisis and provide reflection both personally and professionally. An interpretation and reflection of these findings could offer valuable insights into the care experience, which will inform practice for nurses working in mental health, as well as make implications for future research in this area.

Summary of Key Findings

The primary objective of this scoping review was to explore what is known about experiences of service users with psychosis and CT workers during a crisis interaction. Through the process of reviewing the relevant literature, three unique perspectives were identified regarding these experiences, which were: service users, carers, and healthcare professionals. However, these perspectives were not completely individualized as there was a degree of overlap in the experiences (see Figure 5). There were both positive aspects and criticisms of CTs within the literature, as well as suggestions for improvement.

Figure 5

Overlap of Care Experiences



Much of the research described a variation of CT experiences, although most studies reported that service users and carers were generally satisfied with their care from CTs, some participants reported feeling stigmatized and/or traumatized by their interactions - mostly related to physical police intervention (Boscarato et al., 2014; Daggenvoorde et al., 2018; Gregory & Thompson, 2013; Murphy et al., 2015; Winness et al., 2010). Despite mixed experiences, most service users and carers indicated that support in the community was preferred above the hospital (Daggenvoorde et al., 2018; Fulford & Farhall, 2001; Goldsack et al., 2005; Hoult et al., 1984; Reynolds et al. 1990). However, hospital care was still reported to be needed in cases where mostly carers - but also sometimes service users - felt that they needed increased support above what was available in the community (Fulford & Farhall, 2001; Goldsack et al., 2005). More carers than service users indicated that easier access to hospital was needed, and this was likely due to the need for some type of respite from those living at home with carers, whether in hospital or elsewhere (Hoult et al., 1984; Moreno-Alonso et al., 2023). In a study by Fulford and Farhall (2001), about half of carers in the study expressed that hospital care was preferred over intervention from a CT. This was found in cases where the carer perceived that their loved one's mental health challenges were severe and the situation was too stressful for them to cope with (Fulford & Farhall, 2001). Conversely, in a different study by Goldsack et al. (2005) both carers and service users expressed preference for care in the community, as hospitals were seen as "scary" and "just the worst experience ever" by service users, and carers wished to be supportive. The healthcare professionals' experience working for a CT was marked by various workplace stressors, and they also expressed need for more education, which will be discussed further in the next sections below (Freeman et al., 2011; Xanidis & Gumley, 2020).

Interpretation of Results

This section will aim to interpret and discuss the findings from the scoping review using an interpretative lens grounded in crisis theory. Nursing is the disciplinary focus of this review with caring as a major construct. In addition to this, my analysis was also informed by a relational lens which considers the inter-connected nature of the relationship between the individual receiving care, nursing or other healthcare professionals, and carers. The results from exploring the experiences of service users with psychosis and CTs have been interpreted through a crisis theory and relational lens. This view of psychosis can be understood via crisis theory as a personal crisis someone encounters in their life, rather than simply a disease with symptoms (Black & Flynn, 2021). A relational lens underscores the importance of supportive relationships and networks, such as with crisis staff and/or informal carers, in navigating a crisis. An important aspect of exploring this perspective on mental health is to identify other psychosocial factors that could contribute to the crisis, even in cases of severe psychological distress (Baumgardt & Weinmann, 2022). This interpretative lens was influenced by the facilitators and barriers to care experienced by individuals with psychosis and aimed to inform nursing practice. This scoping review provided findings which offer information on the types of factors that both positively and negatively influence an individual's care experience by a CT and how this may impact their recovery from crisis. Findings from the review have been divided into three main themes: 1) service user experiences, 2) carer experiences, and 3) healthcare professional experiences, which have been presented in figures below. This will address the primary aim of this study, which was to examine the interactions between service users with psychosis, carers, and healthcare professionals working for CTs. Latter discussion will focus on the remaining two objectives.

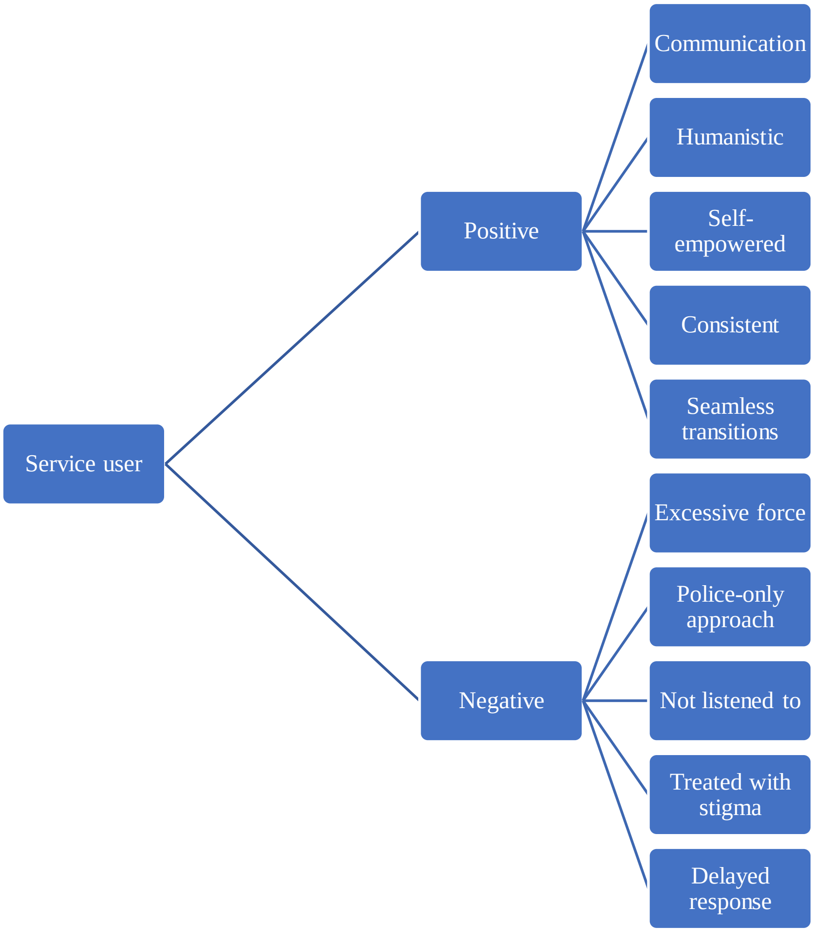
Service user experiences

Generally, service users described that an ideal positive care experience with CTs would be self-empowering, use a humanistic approach, have good communication, consistent care, and a more seamless discharge and transfer process (Daggenvoorde et al., 2018; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Reynolds et al., 1990; Winness et al., 2010). However, some felt that their experience led to being stigmatized and/or traumatized, especially when excessive force or handcuffs were used by police (Daggenvoorde et al., 2018; Boscarato et al., 2014;

Gregory & Thompson, 2013). The care experience for the service user has been contextualized to help draw links between aspects that make for a positive or negative experience, as informed by the scoping review (see Figure 6).

Figure 6

Aspects of Service User Experience

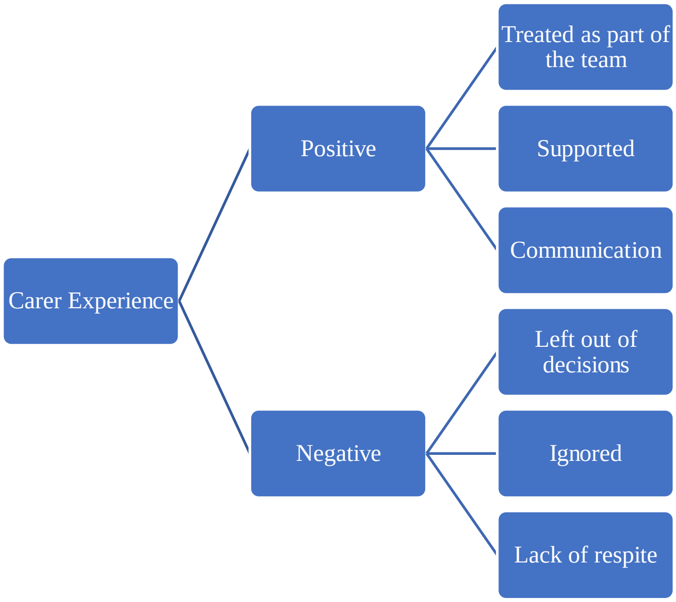


Carer experiences

Carers discussed wanting to feel part of the team and having information shared with them, even if this was general information on the situation and how to manage care in the community (Brennan et al., 2016; Goldsack et al., 2015; Marshall, 2023). Some carers discussed having mixed feelings in contacting crisis services due to inconsistent interactions, and others described high levels of caregiver stress with caring for loved ones in the community (Brennan et al., 2016; Marshall, 2023; Reynolds et al., 1990). There should be a balance between supporting service users in the community where feasible and safe, and when individuals should be seen in hospital for a higher level of care. Many sources indicated that hospital care is still needed in some cases, as the controlled environment is uniquely qualified to manage and mitigate high safety risks (Polak & Kirby, 1976). The care experience for carers has also been contextualized to help draw links between positive and negative aspects of the carer experience during CT intervention (see Figure 7).

Figure 7

Aspects of Carer Experience



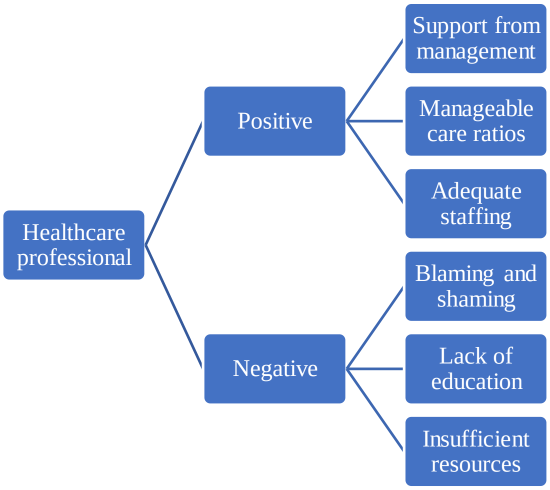
Most service users and carers did not prefer response from police and indicated that a joint response with healthcare professionals and police would be preferred (Boscarato et al., 2014; Lamanna et al., 2018). Many expressed concerns with excessive force, misunderstanding of the mental health condition, and exacerbation of the crisis when police responded alone (Lamanna et al., 2018). However, in cases where a joint response occurred, a delay in response was often observed when police and healthcare professionals did not arrive together and had to wait for the other (Boscarato et al., 2014). In this case, a more cohesive joint response is indicated, and a Ride Along model where both parties respond together was indicated in some studies (Boscarato et al., 2014; Lamanna et al., 2018).

Professional Experiences

From a healthcare professional perspective, working for a CT team is fast-paced and rewarding work, but comes with many stressors, including a high workload and staffing issues (Freeman et al., 2011; Xanidis & Gumley, 2020). The pressures that are placed on staff to work fast, provide short-term intensive care, and quickly move onto the next crisis make it difficult to have the kind of quality interactions and good communication that service users and carers desire and that leads to better care (Winness et al., 2010). There is a need to balance the accessibility and availability of these teams, while also maintaining the quality of crisis care that is provided. In conjunction with quality interactions, making sure that discharges and transitions to other services are completed smoothly should also be a priority to avoid individuals experiencing a subsequent crisis once care with the service has ended (Goldsack et al., 2005; Hopkins & Niemiec, 2007). As with the previous two experiences, the healthcare professional perspective has also been contextualized below to represent aspects of both positive and negative experiences in providing crisis care (see Figure 8).

Figure 8

Aspects of Professional Experience

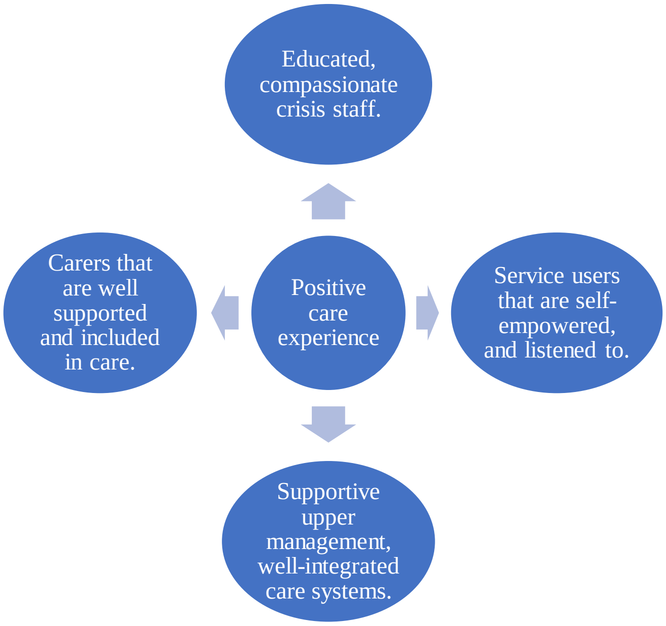


In addition to improving CT availability and quality of care, there is a need to further explore how specific diagnostic labels impact a services user's experiences with CTs. In a study by Johnston (2010), the researcher indicated that service users were divided into categories of being legitimately "ill" or illegitimate. This was reinforced by statements from a caregiver of a service user with borderline personality disorder, who expressed concerns about psychosis-like experiences and reported that care was denied due to the diagnosis (Brennan et al., 2016). Further research is needed to explore this concept further and understand how to address the issue, so that service users are not being denied care due to diagnostic labelling.

This scoping review has identified both positive and negative aspects of the care experience for service users, carers, and healthcare professionals. The second objective of this study was to identify any recommendations for how to improve the care experience, which has been represented in Figure 9 to illustrate the factors which make for a positive care experience.

Figure 9

Positive Care Experience Factors



The literature placed emphasis on improving communication and education for CTs (Daggenvoorde et al., 2018; Freeman et al., 2011; Goldsack et al., 2015), as well as improving accessibility and availability of services (Brennan et al., 2016; Johnson et al., 2022). There is also a need for strong leadership within these teams to ensure workloads are balanced, staff have sufficient quality time with service users, and receive the education and training necessary to effectively assess risks and deliver the intensive short-term interactions that are crucial to the role. Further research could explore what is known about CT staff education and preparation for the role, as well as the types of interventions that are provided during a crisis interaction.

A crisis theory lens was used to interpret these findings and is in close relation with the Recovery Model, which promotes hope and recovery for those with mental health challenges and the goal is for individuals to return to a life that is meaningful for them (Baumgardt &

Weinmann, 2022). Understanding factors that make the crisis care experience positive may help improve services and promote recovery for these individuals. Conversely, identifying factors which add to individual experience of stigma and/or traumatization is also crucial, as this may pose detrimental effects to recovery. Through a crisis theory lens, a crisis can be viewed as a vulnerable period in an individual's life for which a healthcare experience, such as an encounter with a CT, can have a major impact. From a relational lens, a CT can make a positive impact by offering support that aligns with a person's goals, or it can further perpetuate the situation and create negative associations that influence whether they seek similar help in the future. I have created these prior figures to connect findings regarding the facilitators and barriers together so that they can be used to inform practice, specifically on how these teams can improve the care experience for individuals with psychosis in the community.

The primary objective of the scoping review aimed to examine the interactions between service users with psychosis, carers, and healthcare professionals. In the second objective, I sought to identify areas of improvement for the care experience. According to the third and final objective, gaps in the literature will be discussed in latter sections below.

Reflections

Throughout this scoping study, there was an opportunity to reflect on my own experiences and perspectives as both an informal carer of someone with psychosis, and a healthcare professional on a CT who has worked extensively with service users who have psychosis and their supporters. I have a passion for the work that I do and feel that both my personal and professional experiences have given me a unique perspective in looking at these findings. This perspective is unique given the duality of my role as both a professional care provider to service users with psychosis and an informal carer to a family member with psychosis. I intend to use this perspective to inform how I conduct myself in both my professional life as a CT worker and in my academic pursuits as a new researcher.

The experience of caring for a family member with psychosis has changed the way that I do my work as a crisis worker, shifting away from the role of a nurse "assessing and treating patients" and towards "listening to and helping other people". After my experience, the way I viewed my work had changed and I listened differently. Every day, I saw my family member in the people that I encountered and realized that anyone could be susceptible to this phenomenon labelled "psychosis". During conversations with individuals who have experienced psychosis, I listened to their concerns of being unsatisfied with their care and feeling reluctant to seek services offered to help them, and I wanted to have a deeper understanding. I also wanted to use my research to encourage healthcare professionals to gain a deeper understanding of how their encounters may be perceived and understood by those they care for professionally. Given my dual perspective, I also wanted to view the encounter with individuals who have psychosis from a multi-perspective, which is why I chose to look at the interaction from the experiences of service users, carers, and healthcare professionals. I would like to highlight that my perspective is limited as I do not have experience as a service user with psychosis, which is why discussions with my family member during the process of this thesis have been invaluable to my analysis and interpretation of the results.

In speaking to my personal experiences as an informal carer, many of the findings resonated with me in terms of caregiver stress and mixed feelings that come with providing care to a loved one who is experiencing psychosis. During those moments, being treated as part of the team, feeling validated and listened to were integral to a positive experience. Conversely, being excluded and left out of important conversations led to feelings of confusion, frustration, and added stress. As a healthcare professional working for a CT, I have experienced many workplace stressors and felt the anxiety around assessing risk and caring for service users in their own living environment. The clinical work is fast-paced, often with staffing issues and high workloads, which make the job even more demanding. However, this work is also highly rewarding and provides a lot of opportunity for growth. I agree with the findings from this study on a personal and professional level that some key insights are a need for improved communication techniques (such as Open Dialogue Approach used by CTs in Finland) and education for crisis professionals. As a mental health nurse working in this field, I have often operated in an advanced capacity and further guidance on risk assessment and crisis intervention would be beneficial. Adapting crisis care to contain more therapeutic and counselling aspects, such as Cognitive Behavioural Therapy for psychosis or the Open Dialogue Approach could help improve communication with service users and carers.

Gaps in the Literature

The third and last objective of this scoping review was to identify pertinent gaps in the literature regarding service users with psychosis and CT workers. One major gap was the inconsistency and diversity of CT models and composition of CT staff (e.g., co-response vs. police-only vs. healthcare staff only vs. community based vs. clinicians from different backgrounds); these teams have been found to have many names, and there has been a lack of concrete definition for CT or crisis care found among studies (Murphy et al., 2015; Sjølie et al., 2010). According to a systematic review by Murphy et al. (2015), there is also a lack of empirical evidence and staff perspectives on how crisis care is currently being delivered. However, this review only contained Randomized Controlled Trials (RCTs), and therefore, may be missing other types of articles more likely to include these types of data, such as qualitative studies (Murphy et al., 2015). This is further evidence to support the need for this scoping review, which did not limit the study type when searching for relevant articles.

In addition to missing the staff perspective, the literature highlighted the need to better understand the perspectives from service users and carers. Although the service user perspective was most prominent in the review, there was only one systematic review that explored in-depth service user perspectives in crisis care, which did not include diagnostic information or whether this impacted an individual's experience (Winness et al., 2010). Multiple articles discussed that service users are being categorized into mild or severe diagnostic categories, and some were even denied care due to their diagnosis; therefore, this is an area that could be further explored (Brennan et al., 2016; Goldsack et al., 2005; Holgersen et al., 2022; Johnston, 2010). The literature also supports that the carers experience is not well understood, especially in terms of caregiver stress and how best to support carers while respecting confidentiality (Brennan et al., 2016; Marshall, 2023).

In their phenomenological study, Daggenvoorde et al. (2018) suggested that understanding the experience from the perspectives of service users and their families is the first step to understanding the diverse experience of crisis care provided by CT teams, and second to that would be staff themselves. Yet many relevant studies examined in this scoping review measured efficiency of teams in preventing hospitalizations, reducing costs, or distributed simple questionnaires to service users and carers to assess their "satisfaction" (Hopkins & Niemiec, 2007; Moreno-Alonso et al., 2023; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Ruggeri et al., 2006; Wheeler et al., 2015). These quantitative statistics may not be sufficient to understand the care experience of service users with psychosis and/or carers (Goldsack et al., 2005).

Many of the articles examined primarily used bio-medical language, focussing on clinical terms rather than considering the perspective of the individual with psychosis (Barakat et al., 2021; Carpenter et al., 2013; Fulford & Farhall, 2001; Holgersen et al., 2022; Hoult et al., 1984; Johnston, 2010; Lamanna et al., 2018; Moreno-Alonso et al., 2023; Murphy et al., 2015; Polak & Kirby, 1976; Reynolds et al., 1990; Ruggeri et al., 2006). This approach can depersonalize the voices of service users, framing individuals with mental health challenges as "abnormal" rather than seeing this as a spectrum of the human experience (Baumgardt & Weinmann, 2022). A central part of crisis theory is the "normalization of mental illness" and viewing a crisis as a normal part of the human experience, which does not form the person's identity (Baumgardt & Weinmann, 2022). Changing this narrative can begin with shifting language, moving beyond a medicalized understanding of so-called "mental illness" to a more holistic perspective that normalizes mental health challenges as part of being human (Baumgardt & Weinmann, 2022).

Limitations

The aim of this review was to examine the experiences of service users with psychosis and CT workers during a crisis interaction, and therefore, studies that did not contain a majority of service users with psychosis were excluded. This was waived in a few circumstances where the information was not available, and the study contained rich qualitative data from service users and carers. In addition to this, there were many articles primarily containing data regarding other community teams such as Assertive Community Treatment (ACT), Flexible Assertive Community Treatment (FACT), and First Episode Psychosis (FEP) programs, which were not included. Despite some similarities in interdisciplinary community teams that support those with psychosis, this study was primarily focused on teams who specialize in rapid, time-limited crisis intervention within the community.

The search strategy for this review was designed with the assistance of the Health Sciences librarian at York University. Preliminary searches of the literature did not reveal a large quantity of articles, and therefore the strategy was intentionally broad to ensure that potentially relevant articles were not missed. Upon reflection, using a more specific approach would have been helpful in reducing the large number of articles (n=6134) retrieved in the search and focussing the scoping review. However, the Number Needed to Retrieve (NNTR) was 26, which indicates that the search strategy was effective in retrieving enough relevant articles to justify the overall size (Booth, 2006; Chilcott et al., 2003; Ross-White & Godfrey, 2017).

As this scoping review was designed to examine the existing body of evidence on the study topic, a variety of articles were selected but not formally appraised for quality. Nevertheless, this scoping study may serve as a base for what is currently known regarding experiences of service users with psychosis and CT workers during a crisis interaction, which can inform further research on the topic.

Given the varying degree of overlap among similar crisis services in differing countries, as well as inconsistent terms used to describe these teams, it is possible that relevant studies may have been omitted. To mitigate this risk, a broad search strategy was employed with the assistance of the Health Sciences librarian for the purposes of this scoping review. Due to the feasibility of this being a thesis project, a further limitation is that this scoping review was undertaken by one reviewer (myself) and would ordinarily have at least two reviewers. This may have also potentially led to relevant articles being wrongfully excluded, although this limitation was mitigated through triangulation with my thesis supervisor and by using my clinical and personal experiences.

Implications for Practice, Research, and Dissemination

CTs are interdisciplinary and are made up of different compositions, however, nursing staff make a significant contribution (see Appendix D). Across the studies, predominantly nurses were found working for CTs, with some teams being comprised primarily of nursing staff (Carpenter et al., 2013; Hoult et al., 1984; Moreno-Alonso et al., 2023; Reynolds et al., 1990; Ruggeri et al., 2006). Nursing plays an important role in CTs, and the aim of this scoping review study was to inform frontline nursing staff working in crisis care.

The initial implications from the findings would be for nursing and other professionals working in crisis care to examine their own practice, in terms of their communication with service users who have psychosis and informal carers (Daggenvoorde et al., 2018; Carpenter et al., 2013; Gregory & Thompson, 2013). Upon further exploration, it became clear that the issue was more complex than individual staff improvements and related to time constraints and high workloads, which impacted the protected time that staff have for each crisis intervention (Freeman et al., 2011; Xanidis & Gumley, 2020). High work-related stress has been reported by many staff and incorporation of reflective practice working groups, such as in the paper by Johnston (2010), could be a needed source of support and potential outlet to express this.

Staff should aim to find ways to include informal carers in crisis intervention where appropriate, which could be as simple as providing generalized education and instruction when confidential information cannot be shared. There should also be efforts to examine personal implicit biases that could contribute to the experience of stigmatization of service users with mental health challenges (Daggenvoorde et al., 2018; Boscarato et al., 2014). Implicit bias involves making unconscious negative connections regarding a person due to certain characteristics, such as race, gender, or in this case mental health (FitzGerald & Hurst, 2017). Current evidence has indicated that healthcare professionals display the same level of bias as the general population and that this has been correlated with lower quality of care (FitzGerald & Hurst, 2017). Reflective peer-to-peer practice groups for staff could be a potential way to discuss personal feelings in encounters with service users and examine these biases (Johnston, 2010).

In addition to an individual level, there were implications for management of these teams to prioritize consistency of staff with service users and ensure staff have enough time for quality interactions. A part of this was the nature of the working environment, another aspect having sufficient staffing and budgetary resources to support these teams and the important work they do. There were also implications to strengthen existing partnerships CT teams engage in with police, paramedics, and other community partners so that inappropriate referrals are minimized, co-responses are more synchronized, and service users have a more seamless transition to less intensive services (Boscarato et al., 2014; Lamanna et al., 2018).

Service users discussed wanting crisis care to be available and accessible, promote self-empowerment, demonstrate good communication, employ a humanistic approach, and facilitate smooth transitions to less intensive services in the community (Daggenvoorde et al., 2018; Johnson et al., 2022; Kłapciński & Rymaszewska, 2015; Reynolds et al., 1990; Winness et al., 2010). Carers wanted to be a part of the team and have general information shared with them, such as basic instructions on how to care for their loved ones in the community (Brennan et al., 2016; Goldsack et al., 2015; Marshall, 2023). Service users and carers differed in that carers wanted easier access to hospital when considered necessary, but service users mostly preferred care in their own living environment (Wheeler et al., 2015). The findings indicated that care from a CT was generally satisfactory, cost-effective, and helped reduce unnecessary hospital admission (Murphy et al., 2015).

However, some service users described their experience with a CT as stigmatizing and even traumatizing - often related to physical intervention by police (Boscarato et al., 2014; Daggenvoorde et al., 2018). Carers expressed mixed feelings with activating crisis services, and some felt that keeping their loved ones in the community further perpetuated caregiver stress as in-hospital care offered more respite (Fulford & Farhall, 2001).

Service users and carers appreciated when CTs offered open communication and used a compassionate approach that made them feel listened to (Boscarato et al., 2014; Daggenvoorde et al., 2018; Hopkins & Niemiec, 2007; Hoult et al., 1984; Kłapciński & Rymaszewska, 2015; Winness et al., 2010). Education for CT staff should include crisis intervention, risk assessment and mitigation, counselling, and alternate therapy approaches (Boscarato et al., 2014; Freeman et al., 2011; Goldsack et al., 2005; Gregory & Thompson, 2013; Holgersen et al., 2022; Kłapciński & Rymaszewska, 2015; Sjølie et al., 2010; Wheeler et al., 2015). The literature suggested that co-response teams between CTs and police need to improve their joint responses and communication, as well as police requiring increased knowledge on mental health and crisis intervention (Boscarato et al., 2014; Lamanna et al., 2018). For other community partners, there has been an expressed need for further education on CT services, to promote collaboration and decrease inappropriate referrals, which may also aid the transition to other services when discharged from CTs (Freeman et al., 2011; Goldsack et al., 2005).

From an organizational standpoint, a concerted effort is needed to have more consistent definitions, interventions, and evaluations of CTs, which take service user and carer feedback into consideration. Assertive Community Treatment (ACT) teams, in contrast, created a model of care that has been well-defined and implemented globally with higher fidelity to the model linked with better outcomes (Dixon, 2000).

Future research could focus on the development and testing of fidelity within different CT models of care and specific crisis interventions to improve service delivery. Feedback from service users with psychosis and informal carers should be used towards developing a model of care that is consistent with their goals. Healthcare professional feedback should also be used in making improvements to staff-client ratios and education. The first step should be using in-depth experiences of service users, carers, and healthcare professionals to make improvements to the overall system.

Management of CTs should prioritize consistency of staff to improve care experiences for service users and should further develop the education and training process. Given that CTs have been widely viewed as effective as in-patient hospital care, and have demonstrated cost-effectiveness, overall satisfaction, and lowered bed occupancy rates (Murphy et al., 2015; Wheeler et al., 2015); these teams should be properly funded so that staffing, workload, and education are sufficient to provide proper intervention and follow-up.

Although not formally explored, the experiences of staff working for services that partner with CTs, such as police and paramedics, would also be helpful in further understanding the crisis care system and some of the barriers and facilitators for individuals with psychosis. As this scoping review focused primarily on the experiences of service users with psychosis, future research could explore experiences of individuals meeting other diagnostic criteria. In addition to better understanding these perspectives, there is a need for more research on how crisis care is provided globally and how to improve availability and accessibility to those most in need (Johnson et al., 2022).

Crisis care provided by phone or video has been indicated as a method of improving access and availability but can lead to digital exclusion for some, which requires rigorous research to inform future developments of remote crisis care (Johnson et al., 2022). In rural and remote areas of Greece, Mobile Mental Health Units (MMHU) have emerged as a solution for those with mental health challenges requiring care that are underserved in the population (Peritogiannis et al., 2017). In a study by Peritogiannis et al. (2017), a total of 12 employees were employed within an MMHU in Northwest Greece, consisting of one psychiatrist, two psychologists, two nurses, two health visitors, and two social workers.

This multidisciplinary team had the capacity to provide services to those living in rural and remote areas that otherwise would have no access to care (Peritogiannis et al., 2017). These teams were not highly specialized, such as CT or ACT, but rather offered basic mental health services to remote, rural, and deprived areas (Peritogiannis et al., 2017). They were described as a cost-effective means for providing rural mental healthcare that had been well-accepted by service users and carers in the community (Peritogiannis et al., 2017), which could play an important role in mitigating future crisis.

Dissemination of these findings will initially be completed by submission as a Master of Nursing thesis through York University. In the future, I have plans to disseminate findings through publication and presentations in nursing and mental health-related journals and conferences. In addition to this, I will aim to present these findings within my organization's CT and their communication channels with other CTs in the region.

Conclusion

In conclusion, this review explored in-depth what is currently known regarding the experiences of individuals with psychosis and CT workers in crisis interactions. Since the deinstitutionalization movement of the 1960's that began in North America, CTs have become prevalent in many parts of the world. While prominent in many English and Scandinavian countries, many other regions have also developed similar models of crisis intervention.

Service users with psychosis are among the most frequent users of CT services and may face unique challenges in accessing and engaging in community services. This scoping review sought to explore what is known regarding service users with psychosis and CT workers during a crisis interaction, to examine aspects of care that could potentially illuminate gaps and barriers in service. In this scoping review, the findings were categorized into three main themes that encompassed the service user, carer, and healthcare professional experience of a crisis interaction. These experiences were further divided into subthemes, which helped to characterize the findings and provide insights into the commonalities and differences between service users and carers, as well as how healthcare professional experiences may influence aspects of care.

Two key findings from this review were the need for CTs to improve staff education and enhance communication with service users, carers, other services, and within their own teams. Service users and carers have expressed that quality interactions with CTs are most important, whereas CT healthcare professionals and management often prioritized numerical and statistical data, such as cost-effectiveness and bed occupancy rates. Improving the care experience could reduce costs and lower hospital admissions, as service users and carers would be less likely to face a subsequent crisis if community care provided adequate support and smooth transitions to other services.

However, CT workers reported already feeling like "fast-moving trains", with high workloads, insufficient staff, and over-whelming responsibility. Therefore, added pressure on teams to move faster does not seem a plausible solution, but rather ensuring there are sufficient staff, supportive management, and proper training and education. CTs play a critical role as a frontline service, offering essential support during moments of psychological distress for individuals and their loved ones, and efforts to strengthen and sustain the work they do should be prioritized to promote person-centered care and improved well-being.

References

References marked with an asterisk indicate articles included in the scoping review.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8(1), 19-32.

Bandura, A. (1997). *Self-efficacy: The exercise of control.* W. H. Freeman.

*Barakat, A., Blankers, M., Cornelis, J. E., Lommerse, N. M., Beekman, A. T., & Dekker, J. J. (2021). The effects of intensive home treatment on self-efficacy in patients recovering from a psychiatric crisis. *International Journal of Mental Health Systems*, 15(1). https://doi.org/10.1186/s13033-020-00426-y.

Baumgardt, J., & Weinmann, S. (2022). Using crisis theory in dealing with severe mental illness - a step toward normalization? *Frontiers in Sociology*, 7, 805604. https://doi.org/10.3389/fsoc.2022.805604.

Black, L. L., & Flynn, S. V. (2021). *Crisis, trauma, and disaster: A clinician's guide.* Sage Publications Ltd.

Booth, A. (2006). The number needed to retrieve: a practically useful measure of information retrieval? *Health Information and Libraries Journal*, 23(3), 229–232. https://doi.org/10.1111/j.1471-1842.2006.00663.x.

Borum, R., Williams, M., & Lattimore, P. K. (2000). Police training and specialized services: A critical review of community-based models. *Law and Human Behavior*, 24(6), 633-654.

*Boscarato, K., Lee, S., Kroschel, J., Hollander, Y., Brennan, A., & Warren, N. (2014). Consumer experience of formal crisis-response services and preferred methods of crisis intervention. *International Journal of Mental Health Nursing*, 23(4), 287–295. https://doi.org/10.1111/inm.12059.

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

*Brennan, A., Warren, N., Peterson, V., Hollander, Y., Boscarato, K., & Lee, S. (2016). Collaboration in crisis: Carer perspectives on police and mental health professional's responses to mental health crises. *International Journal of Mental Health Nursing*, 25(5), 452–461. https://doi.org/10.1111/inm.12233.

Brown, E., Gray, R., Jones, M., & Whitfield, S. (2013). Effectiveness of adherence therapy in patients with early psychosis: A mirror image study. *International Journal of Mental Health Nursing*, 22(1), 24–34. https://doi.org/10.1111/j.1447-0349.2012.00829.x.

Brown, G. W., Harris., T. (1978). Social origins of depression. *Psychological Medicine*, 8(4), 577-588. https://doi.org/10.1017/S0033291700018791.

Burns, T. (2004). Crisis resolution and home treatment teams. Crisis intervention theory and the history of crisis teams. *In Community Mental Health Teams: A Guide to Current Practices.* Oxford University Press. https://doi.org/10.1093/oso/9780198529996.003.0006.

Caplan, C. (1964). *Principles of preventive psychiatry.* Basic Books, Inc., New York.

Canadian Paediatric Society. (2022). *A call for action: Recommendations to improve transition to adult care for youth with complex health care needs.* Canadian Paediatric Society. https://cps.ca/en/documents/position/transition-to-adult-care-for-youth.

*Carpenter, R. A., Falkenburg, J., White, T. P., & Tracy, D. K. (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.

Chilcott, J., Brennan, A., Booth, A., Karnon, J., & Tappenden, P. (2003). The role of modelling in prioritising and planning clinical trials. *Health Technology Assessment (Winchester, England)*, 7(23), iii–iii. https://doi.org/10.3310/hta7230.

CMHA Ontario. (n.d.). *Mental health.* Canadian Mental Health Association Ontario. https://ontario.cmha.ca/documents/understanding-psychosis-and-finding-help-early/.

Connell, M., Schweitzer, R., & King, R. (2015). Recovery from first-episode psychosis and recovering self: A qualitative study. *Psychiatric Rehabilitation Journal,* 38(4), 359-364. https://doi.org/10.1037/prj0000077.

Corrigan, P. W., & Watson, A. C. (2002). The stigma of mental illness: Pathways to recovery. *Psychiatric Rehabilitation Journal,* 25(4), 405-409. https://doi.org/10.2975/25.2002.405.409.

*Daggenvoorde, T. H., Gijsman, H. J., & Goossens, P. J. J. (2018). 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. *Perspectives in Psychiatric Care*, 54(4), 462–468. https://doi.org/10.1111/ppc.12247.

Dixon, L. (2000). Assertive Community Treatment: Twenty-five years of gold. *Psychiatric Services (Washington, D.C.)*, 51(6), 759–765. https://doi.org/10.1176/appi.ps.51.6.759.

Escher, S., & Romme, M. A. J. (2012). *Psychosis as a personal crisis: An experience-based approach*. Routledge.

Faber, S. C., Khanna Roy, A., Michaels, T. I., & Williams, M. T. (2023). The weaponization of medicine: Early psychosis in the Black community and the need for racially informed mental healthcare. *Frontiers in Psychiatry*, 14, 1098292. https://doi.org/10.3389/fpsyt.2023.1098292.

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics*, *18*(1), 19–19. https://doi.org/10.1186/s12910-017-0179-8.

Ford-Jones, P. C., & Chaufan, C. (2017). A critical analysis of debates around mental health calls in the prehospital setting. *Inquiry: A Journal of Medical Care Organization, Provision, and Financing*, 54, 46958017704608. https://doi.org/10.1177/0046958017704608.

*Freeman, J., Vidgen, A., & Davies-Edwards, E. (2011). Staff experiences of working in crisis resolution and home treatment. *Mental Health Review Journal*, 16(2), 76–87. https://doi.org/10.1108/13619321111158016.

*Fulford, M., & Farhall, J. (2001). Hospital versus home care for the acutely mentally ill? Preferences of caregivers who have experienced both forms of service. *Australian and New Zealand Journal of Psychiatry*, 35(5), 619–625. https://doi.org/10.1046/j.1440-1614.2001.00915.x.

Fusar-Poli, P., Estradé, A., Stanghellini, G., Venables, J., Onwumere, J., Messas, G., Gilardi, L., Nelson, B., Patel, V., Bonoldi, I., Aragona, M., Cabrera, A., Rico, J., Hoque, A., Otaiku, J., Hunter, N., Tamelini, M. G., Maschião, L. F., Puchivailo, M. C., Piedade, V. L., Kéri, P., Kpodo, L., Sunkel, C., Bao, J., Shiers, D., Kuipers, E., Arango, C., Maj, M. (2022). The lived experience of psychosis: A bottom-up review co-written by experts by experience and academics. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *21*(2), 168–188. https://doi.org/10.1002/wps.20959.

Ghelani A. (2022). Knowledge and skills for social workers on Crisis Teams. *Clinical Social Work Journal*, 50(4), 414–425. https://doi.org/10.1007/s10615-021-00823-x.

Godfrey, C. M., Harrison, M. B., Graham, I. D., & Ross-White, A. (2010). Utilisation of theoretical models and frameworks in the process of evidence synthesis. *JBI Library of Systematic Reviews*, 8(18), 730–751. https://doi.org/10.11124/01938924-201008180-00001.

Goffman, E. (1963). *Stigma. Notes on the management of spoiled identity.* London: Penguin Books.

*Goldsack, S., Reet, M., Lapsley, H., & Gingell, M. (2005). *Experiencing a recovery-oriented acute mental health service: Home-based treatment from the perspectives of service users, their families and mental health professionals*. Mental Health Commission.

Grant, M. J., & Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information and Libraries Journal,* 26(2), 91–108. https://doi.org/10.1111/j.1471-1842.2009.00848.x.

*Gregory, M. J., & Thompson, A. (2013). From here to recovery: One service user’s journey through a mental health crisis: Some reflections on experience, policy and practice. *Journal of Social Work Practice*, 27(4), 455–470. https://doi.org/10.1080/02650533.2013.802678.

Hagen, B., & Nixon, G. (2011). Spider in a jar: Women who have recovered from psychosis and their experience of the mental health care system. *Ethical Human Psychology and Psychiatry: An International Journal of Critical Inquiry,* 13(1), 47-63. https://doi.org/10.1891/1559-4343.13.1.47.

Hahn, H. (2001). A history of crisis intervention in the U.S. *Journal of Mental Health,* 10(4), 369-377.

Hasan, A. A., & Musleh, M. (2017). Barriers to seeking early psychiatric treatment amongst first-episode psychosis patients: A qualitative study. *Issues in Mental Health Nursing,* 38(8), 669677. https://doi.org/10.1080/01612840.2017.1317307.

Hobbs M. (1984). Crisis intervention in theory and practice: A selective review. *British Journal of Medical Psychology*, 57(1), 23-34. https://doi.org/10.1111/j.2044-8341.1984.tb01577.x.

Hogan, M. F., & Goldman, M. L. (2021). New opportunities to improve mental health crisis systems. *Psychiatric Services (Washington, D.C.)*, 72(2), 169–173. https://doi.org/10.1176/appi.ps.202000114.

*Holgersen, K. H., Pedersen, S. A., Brattland, H., & Hynnekleiv, T. (2022). A scoping review of studies into crisis resolution teams in community mental health services. *Nordic Journal of Psychiatry*, 76(8), 565–574. https://doi.org/10.1080/08039488.2022.2029941.

*Hopkins, C., & Niemiec, S. (2007). Mental health crisis at home: Service user perspectives on what helps and what hinders. *Journal of Psychiatric and Mental Health Nursing*, 14(3), 310–318. https://doi.org/10.1111/j.1365-2850.2007.01083.x.

*Hoult, J., Rosen, A., & Reynolds, I. (1984). Community orientated treatment compared to psychiatric hospital orientated treatment. *Social Science and Medicine,* 18(11), 1005–1010. https://doi.org/10.1016/0277-9536(84)90272-7.

Hutton, P., & Taylor, P. J. (2014). Cognitive behavioural therapy for psychosis prevention: A systematic review and meta-analysis. *Psychological Medicine*, 44(3), 449–468. https://doi.org/10.1017/S0033291713000354.

Information and Privacy Commissioner of Ontario (2015). *Circle of care: Sharing personal health information for health-care purposes*. https://www.ipc.on.ca/en/resources-and-decisions/circle-care-sharing-personal-health-information-health-care-purposes.

Jester, D. J., Thomas, M. L., Sturm, E. T., Harvey, P. D., Keshavan, M., Davis, B. J., Saxena, S., Tampi, R., Leutwyler, H., Compton, M. T., Palmer, B. W., & Jeste, D. V. (2023). Review of major social determinants of health in schizophrenia-spectrum psychotic disorders: I.

Clinical outcomes. *Schizophrenia Bulletin*, 49(4), 837–850. https://doi.org/10.1093/schbul/sbad023.

*Johnson, S., Dalton-Locke, C., Baker, J., Hanlon, C., Salisbury, T. T., Fossey, M., Newbigging, K., Carr, S. E., Hensel, J., Carrà, G., Hepp, U., Caneo, C., Needle, J. J., & Lloyd-Evans, B. (2022). Acute psychiatric care: Approaches to increasing the range of services and improving access and quality of care. *World Psychiatry,* 21(2), 220–236. https://doi.org/10.1002/wps.20962.

*Johnston, J. (2010). Being disturbed: Integration and disintegration in the patient and professional relationship. *Psychoanalytic Psychotherapy*, 24(3), 231–251. https://doi.org/10.1080/02668734.2010.502306.

Kępiński, A. (1972). *Psychopatologia nerwic.* Warsaw: Państwowy Zakład Wydawnictw Lekarskich.

Kim, S., Kim, H. (2017) Determinants of the use of community-based mental health services after mobile crisis services: an empirical approach using the Cox proportional hazard model. *Journal of Community Psychology,* 45(7), 877–887.

Kisely, S., Campbell, L. A., Peddle, S., Hare, S., Pyche, M., Spicer, D., & Moore, B. (2010). A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. *Canadian Journal of Psychiatry,* 55(10), 662–668. https://doi.org/10.1177/070674371005501005.

*Kłapciński, M., & Rymaszewska, J. (2015). Open dialogue approach – about the phenomenon of Scandinavian psychiatry. *Psychiatria Polska*, 49(6), 1179–1190. https://doi.org/10.12740/pp/36677.

Kritsotaki, D., Long, V., & Smith, M. (2016). *Deinstitutionalization and after: Post-war psychiatry in the western world.* Springer.

*Lamanna, D., Shapiro, G. K., Kirst, M., Matheson, F. I., Nakhost, A., & Stergiopoulos, V. (2018). Co-responding police–mental health programmes: Service user experiences and outcomes in a large urban centre. *International Journal of Mental Health Nursing*, 27(2), 891–900. https://doi.org/10.1111/inm.12384.

LeFrançois, B. A., Menzies, R., & Reaume, G. (2013). *Mad matters: A critical reader in Canadian mad studies.* Canadian Scholars' Press Inc.

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation Science*, 5(69). doi:10.1186/1748-5908-5-69.

Luhrmann, T. M. (2017). Diversity within the psychotic continuum. *Schizophrenia Bulletin*, 43(1), 27-31. https://doi.org/10.1093/schbul/sbw137.

*Marshall, P. (2023). *Caring for a friend or family member who has experienced psychosis and suicidal behaviour: A qualitative investigation.* [Doctoral Thesis, Lancaster University]. Lancaster University. https://doi.org/10.17635/lancaster/thesis/1968.

*Moreno-Alonso et al., I., Nieves-Carnicer, M., Noguero-Alegre, A., Alvarez-Mon, M. A., Rodriguez-Quiroga, A., Dorado, J. F., Mora, F., & Quintero, J. (2023). Patient satisfaction and outcomes of crisis resolution home treatment for the management of acute psychiatric crises: A study during the COVID-19 pandemic in Madrid. *Frontiers in Psychiatry*, 14. https://doi.org/10.3389/fpsyt.2023.1197833.

*Murphy, S. M., Irving, C. B., Adams, C. E., & Waqar, M. (2015). Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews*, 2015(12). https://doi.org/10.1002/14651858.cd001087.pub5.

National Collaborating Centre for Mental Health (UK). (2014). *Psychosis and schizophrenia in adults: Treatment and management.* National Institute for Health and Care Excellence (UK).

Nederlands Huisartsen Genootschap. (n.d.). *Search filters - Patient Issues*. Sign. https://www.sign.ac.uk/what-we-do/methodology/search-filters/.

Nigam, J., A., Barker, R., M., Cunningham, T. R., Swanson, N. G., & Chosewood, L. C. (2023). Vital signs: Health worker–perceived working conditions and symptoms of poor mental health - quality of worklife survey, United States, 2018–2022. *Morbidity and Mortality Weekly Report*, 72, 1197–1205. DOI: http://dx.doi.org/10.15585/mmwr.mm7244e1.

Nolte, L. (2018). Weathering a violent storm together - Witnessing and co-constructing meaning in collaborative engagement with those experiencing psychosis-related challenges. *Arts and Humanities in Higher Education*, 17(1), 48-57. https://doi.org/10.1177/1474022217732869.

Peters, M. D. J., Godfrey, C., McInerney, P., Munn, Z., Tricco, A. C., & Khalil, H. (2020). *JBI manual for evidence synthesis.* Joanna Briggs Institute. https://doi.org/10.46658/JBIMES-20-12.

Peters, M. D. J., Marnie, C., Colquhoun, H., Garritty, C. M., Hempel, S., Horsley, T., Langlois, E. V., Lillie, E., O'Brien, K. K., Tunçalp, Ö., Wilson, M. G., Zarin, W., & Tricco, A. C. (2021). Scoping reviews: Reinforcing and advancing the methodology and application. *Systematic Reviews*, 10(1), 263. https://doi.org/10.1186/s13643-021-01821-3.

Peritogiannis, V., Manthopoulou, T., Gogou, A., & Mavreas, V. (2017). Mental healthcare delivery in rural Greece: A 10-year account of a Mobile Mental Health Unit. *Journal of Neurosciences in Rural Practice*, 8(4), 556–561. https://doi.org/10.4103/jnrp.jnrp_142_17.

*Polak, P. R., & Kirby, M. W. (1976). A model to replace psychiatric hospitals. *The Journal of Nervous and Mental Disease*, 162(1), 13–22. https://doi.org/10.1097/00005053-197601000-00003.

Polit, D. F., & Beck, C. T. (2021). *Nursing research: generating and assessing evidence for nursing practice.* (11th ed.). Wolters Kluwer.

Pollock, D., Davies, E. L., Peters, M. D. J., Tricco, A. C., Alexander, L., McInerney, P., Godfrey, C. M., Khalil, H., & Munn, Z. (2021). Undertaking a scoping review: A practical guide for nursing and midwifery students, clinicians, researchers, and academics. *Journal of Advanced Nursing*, 77(4), 2102–2113. https://doi.org/10.1111/jan.14743.

*Reynolds, I., Jones, J. E., Berry, D. W., & Hoult, J. E. (1990). A crisis team for the mentally ill: The effect on patients, relatives and admissions. *Medical Journal of Australia*, 152(12), 646–652. https://doi.org/10.5694/j.1326-5377.1990.tb125421.x.

Ross-White, A., & Godfrey, C. (2017). Is there an optimum number needed to retrieve to justify inclusion of a database in a systematic review search? *Health Information and Libraries Journal*, 34(3), 217–224. https://doi.org/10.1111/hir.12185.

*Ruggeri, M., Salvi, G., Perwanger, V., Phelan, M., Pellegrini, N., & Parabiaghi, A. (2006). Satisfaction with community and hospital-based emergency services amongst severely mentally ill service users. *Social Psychiatry and Psychiatric Epidemiology*, 41(4), 302–309. https://doi.org/10.1007/s00127-006-0030-x.

Scull, A. (2021). "Community Care": Historical perspective on deinstitutionalization. *Perspectives in Biology and Medicine*, 64(1), 70-81. https://dx.doi.org/10.1353/pbm.2021.0006.

Segev, A., Hirsch-Klein, E., Kotz, G., Kamhi-Nesher, S., Halimi, S., Qashu, K., Schreiber, E., & Krivoy, A. (2021). Trends of new-onset psychosis or mania in psychiatric emergency departments during the COVID19 pandemic: A longitudinal comparative study. *Scientific Reports*, 11(1). https://doi.org/10.1038/s41598-021-00310-w.

Semple, T., Tomlin, M., Bennell, C., & Jenkins, B. (2021). An evaluation of a community based Mobile Crisis Intervention Team in a small Canadian police service. *Community Mental Health Journal*, *57*(3), 567–578. https://doi.org/10.1007/s10597-020-00683-8.

*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.

Stallard P. (1996) The role and use of consumer satisfaction surveys in mental health services. *Journal of Mental Health*, 5, 333–348.

Teller, J. L., & Ritter, C. (2008). The Memphis model of crisis intervention: A review of the evidence. *Journal of Mental Health*, 17(6), 531-538.

Tindall, R., Francey, S., & Hamilton, B. (2015). Factors influencing engagement with case managers: Perspectives of young people with a diagnosis of first episode psychosis. *International Journal of Mental Health Nursing*, 24(4), 295–303. https://doi.org/10.1111/inm.12133.

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

Williams, B., & Wilkinson, G. (1995). Patient satisfaction in mental health care: Evaluating an evaluative method. *The British Journal of Psychiatry: The Journal of Mental Science,* 166(5), 559-562. https://doi.org/10.1192/bjp.166.5.559.

*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.

Winters, S., Magalhaes, L., & Kinsella, E. A. (2015). Interprofessional collaboration in mental health crisis response systems: A scoping review. *Disability and Rehabilitation*, 37(23), 2212–2224. https://doi.org/10.3109/09638288.2014.100257.

World Health Organization (n.d.). *Social Determinants of Health*. World Health Organization. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

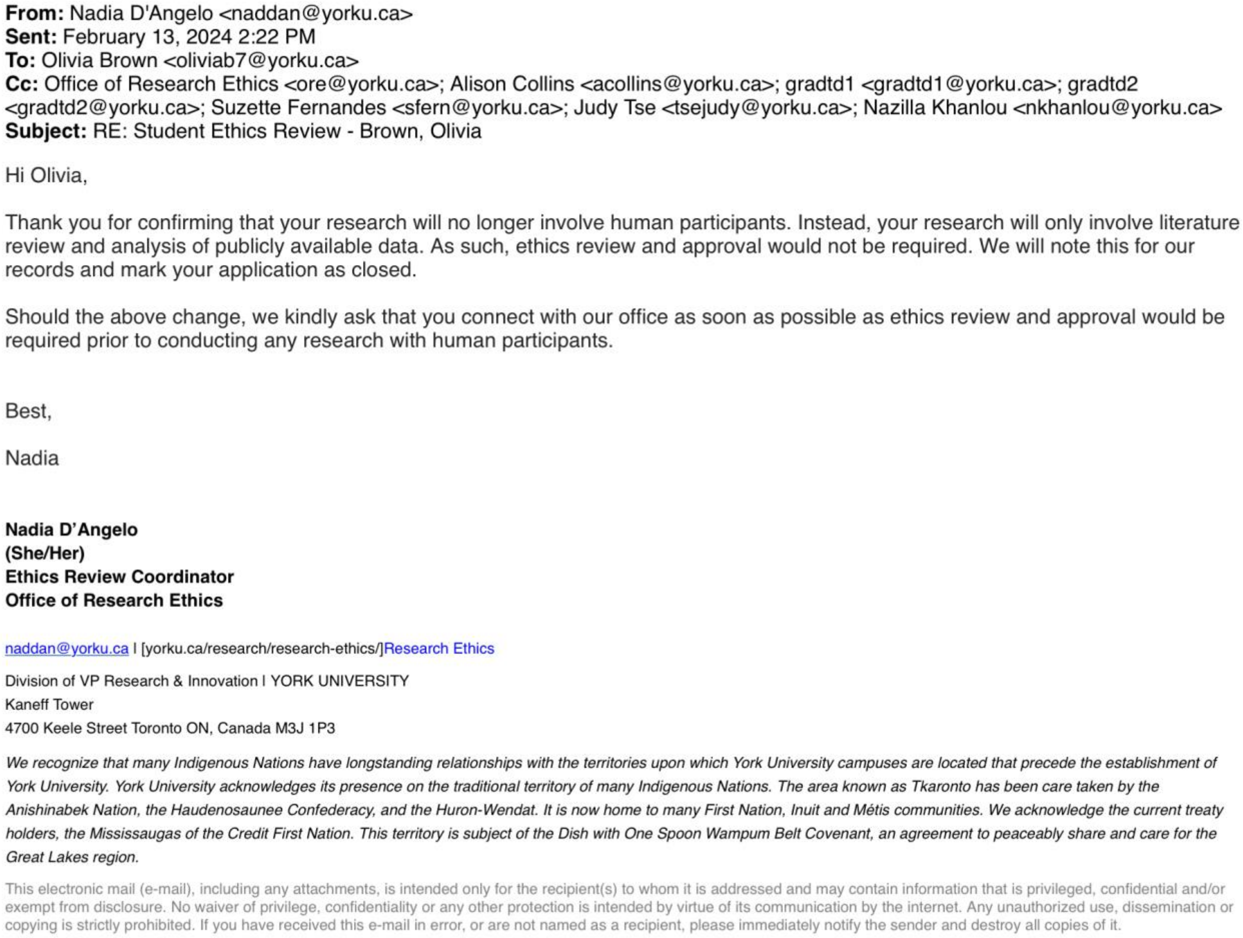
*Xanidis, N., & Gumley, A. (2020). Exploring the implementation of cognitive behaviour therapy for psychosis using the normalization process theory framework. *Psychology and Psychotherapy: Theory, Research and Practice,* 93(2), 241–257. https://doi.org/10.1111/papt.12217.

Appendices

Appendix A: Terms searched

Population	**Intervention**	**Outcome**
Individuals with psychosis	**Crisis team**	**Experience**
Bipolar Psychosis Psychoses Psychotic Schizophreni* Delusion* Hallucination*	**(((Crisis or crises or emergenc* or mental or psychologic* or psychiatr* or communit*) adj4 (manag* or resolution or team* or mobile or intervention* or service*)) or hotline* or house call* or police or EMS or emergency medical service*).mp.** Crisis management Crisis resolution teams Emergency Mental health crises Mental health crisis Mental health services Mental health therapies Mobile crisis team Psychiatry Psychological interventions	((patient$ or consumer$ or client$) adj3 (participat$ or decisi$ or decid$)).ti,ab. Patient-focused patient-centered patient-centred (patient adj3 (attitude$ or preference$)).ti,ab. patient satisfaction self-efficacy.ti,ab. coping.ti,ab. "informed choice".ti,ab. "shared decision making".ti,ab. empowerment.tw. "focus group" adj3 (patient$ or parent$ or famil$ or spouse$)).ti,ab. *"Quality of Life"/ "Quality of Life"/px [Psychology] (QoL or "quality of life").ti. self-management.ti. ((patient$ or consumer$ or client$ or parent$ or famil$ or spouse$) adj (attitude$ or involvement or desir$ or perspective$ or activation or view$ or preference$)).ti,ab. "expert patient".ti,ab. vignette*.ti,ab. exp Patients/px [Psychology] (patient$ or consumer$ or client$).ti. "focus group$".ti,ab. qualitative.ti.

Appendix B: Ethics exemption



From: Nadia D'Angelo <naddan@yorku.ca>
Sent: February 13, 2024 2:22 PM
To: Olivia Brown <oliviab7@yorku.ca>
Cc: Office of Research Ethics <ore@yorku.ca>; Alison Collins <acollins@yorku.ca>; gradtd1 <gradtd1@yorku.ca>; gradtd2 <gradtd2@yorku.ca>; Suzette Fernandes <sfern@yorku.ca>; Judy Tse <tsejudy@yorku.ca>; Nazilla Khanlou <nkhanlou@yorku.ca>
Subject: RE: Student Ethics Review - Brown, Olivia

Hi Olivia,

Thank you for confirming that your research will no longer involve human participants. Instead, your research will only involve literature review and analysis of publicly available data. As such, ethics review and approval would not be required. We will note this for our records and mark your application as closed.

Should the above change, we kindly ask that you connect with our office as soon as possible as ethics review and approval would be required prior to conducting any research with human participants.

Best,

Nadia

Nadia D'Angelo
(She/Her)
Ethics Review Coordinator
Office of Research Ethics

naddan@yorku.ca I [yorku.ca/research/research-ethics/]Research Ethics

Division of VP Research & Innovation I YORK UNIVERSITY
Kaneff Tower
4700 Keele Street Toronto ON, Canada M3J 1P3

We recognize that many Indigenous Nations have longstanding relationships with the territories upon which York University campuses are located that precede the establishment of York University. York University acknowledges its presence on the traditional territory of many Indigenous Nations. The area known as Tkaronto has been care taken by the Anishinabek Nation, the Haudenosaunee Confederacy, and the Huron-Wendat. It is now home to many First Nation, Inuit and Métis communities. We acknowledge the current treaty holders, the Mississaugas of the Credit First Nation. This territory is subject of the Dish with One Spoon Wampum Belt Covenant, an agreement to peaceably share and care for the Great Lakes region.

Appendix C: Search strategy from one database

Database(s): **Ovid MEDLINE(R) and In-Process, In-Data-Review & Other Non-Indexed Citations** 1946 to March 12, 2024

Search Strategy: Thesis Medline 2024-04-13

#	Searches	Results
1	Affective disorders, psychotic/	2320
2	Bipolar disorder/	45853
3	Delusions/	8211
4	Hallucinations/	12065
5	Psychotic disorders/	53384
6	Schizophrenia/	112578
7	Schizophrenia, disorganized/	544
8	Schizophrenic psychology/	34426
9	Schizophrenia, treatment-resistant/	154
10	or/1-9	203490
11	Bipolar.ti,ab.	74521
12	Psychosis.ti,ab.	44083
13	Psychoses.ti,ab.	9734
14	Psychotic.ti,ab.	39325
15	Schizophreni*.ti,ab.	139812
16	Delusion*.ti,ab.	12411
17	Hallucination*.ti,ab.	15472
18	or/11-17	262453
19	10 or 18	309498
20	Community Mental Health Services/	19079
21	Crisis Intervention/	6301
22	Emergency Service, Psychiatric/	2557
23	Home care services/	36699
24	Hotlines/	2969
25	House calls/	4217
26	Law enforcement/	4594
27	Mobile health units/	3935

28	Psychological first aid/	42
29	Police/	6960
30	or/20-29	83552
31	(((Crisis or crises or emergenc* or mental or psychologic* or psychiatr* or communit*) adj4 (manag* or resolution or team* or mobile or intervention* or service*)) or hotline* or house call* or police or EMS or emergency medical service*).mp.	157640
32	30 or 31	218135
33	exp Consumer Participation/	48472
34	((patient$ or consumer$ or client$) adj3 (participat$ or decisi$ or decid$)).ti,ab.	66564
35	"Patient Acceptance of Health Care"/	55562
36	exp attitude to health/	475063
37	consumer satisfaction/	24163
38	exp *Consumer Satisfaction/	11702
39	Patient Preference/	10867
40	"patient-focused".ti,ab.	2029
41	"patient-centered".ti,ab.	23024
42	"patient-centred".ti,ab.	7983
43	(patient adj3 (attitude$ or preference$)).ti,ab.	17327
44	"patient satisfaction".ti.	7677
45	Cooperative Behavior/	46226
46	exp self-efficacy/	24775
47	self-efficacy.ti,ab.	41067
48	exp adaptation, psychological/	141185
49	coping.ti,ab.	72352
50	("self-perception" or "self-concept").ti,ab.	11177
51	exp health education/	264847
52	patient education as topic/	88431
53	exp attitude to health/	475063
54	health knowledge, attitudes, practice/	127911
55	"informed choice".ti,ab.	1806

56	"shared decision making".ti,ab.	13681
57	empowerment.tw.	17055
58	("focus group" adj3 (patient$ or parent$ or famil$ or spouse$)).ti,ab.	1041
59	*"Quality of Life"/	115739
60	"Quality of Life"/px [Psychology]	34839
61	(QoL or "quality of life").ti.	92170
62	personal autonomy/	18412
63	self concept/	61217
64	Consumer Advocacy/	3481
65	freedom/	6314
66	needs assessment/	32550
67	patient advocacy/	24247
68	self-help groups/	9659
69	life change events/	23818
70	attitude to death/	16781
71	patient-centered care/	23362
72	exp professional-patient relations/	148905
73	self care/	36375
74	self-management.ti.	9255
75	((patient$ or consumer$ or client$ or parent$ or famil$ or spouse$) adj (attitude$ or involvement or desir$ or perspective$ or activation or view$ or preference$)).ti,ab.	59549
76	"expert patient".ti,ab.	187
77	or/33-76	1437056
78	exp decision making/	236429
79	exp communication/	372861
80	stress, psychological/	134770
81	emotions/	88913
82	vignette*.ti,ab.	14245
83	or/78-82	792018
84	exp Patients/px [Psychology]	18580
85	(patient$ or consumer$ or client$).ti.	2337249

86	or/84-85	2347969
87	83 and 86	70827
88	"focus group$".ti,ab.	66227
89	focus groups/	36704
90	narration/	10431
91	qualitative.ti.	75014
92	or/88-91	144551
93	77 or 87 or 92	1550596
94	19 and 32 and 93	1984

Appendix D: Data extraction table

Some columns have been left blank to indicate that there were no data available or applicable.

Authors & Title	Study location & Year	Intervention type	Study population	Aims of study	Methodology	Outcome measures	Results
Barakat, Blankers, Cornelis, Lommerse, Beekman, & Dekker. The effects of intensive home treatment on self-efficacy in patients recovering from a psychiatric crisis.	2021. Amsterdam, The Netherlands.	Randomized controlled trial, pre-randomized. One group were IHT teams that provide care at least twice a week and continue until crisis is resolved (~6 weeks) made up of interdisciplinary healthcare professionals. The CAU (Care As Usual) group are patients allocated to a specialised mental health care hospital or other less intensive outpatient care.	Participants were recruited from IHT and in-patient wards, 18-65 years old, experiencing a psychiatric crisis. The data were analyzed from 142 participants in total. 49 to CAU and 92 to IHT. 38 participants had schizophrenia or psychosis-related disorder (27.1%), which was the most common diagnosis in the sample.	To determine if IHT (also known as CRHTT) is effective in improving client's self-efficacy, and if self-efficacy plays a considerable role in client's recovery and quality of life.	Zelen double consent RCT design. RCT comparing IHT to CAU. Pre-randomized to each study group, and had follow-up at 6, 26, and 52 weeks.	Self-efficacy is measured using the Mental Health Confidence Scale. The 5-dimensional Euro-Quality of Life instrument and the Brief Psychiatric Rating Scale were used to measure quality of life and symptomatic recovery.	This study did not support the hypothesis that self-efficacy scores would be improved. However, the results showed that self-efficacy is strongly associated with symptomatic recovery and quality of life. Additional research is needed to understand the complexity of self-efficacy and its role in psychiatric conditions.
Boscarato, Lee, Kroschel, Hollander, Brennan, & Warren. Consumer experience of formal crisis-response	2014. Melbourne, Australia	Experiences with a formal crisis service (i.e. police, formal crisis assessment, and treatment by CAT teams).	Eleven mental health consumers who have experienced at least one crisis intervention that involved staff from	The aim of the study was to explore mental health consumers' experiences with formal crisis services, preferred	Exploratory qualitative study.	Findings were grouped into three categories: experiences with formal crisis-response mechanisms, consumers' preferred	The quality of crisis interventions varied greatly. Most participants would prefer friends

services and preferred methods of crisis intervention.			both policing and mental health systems. Most of the participants had experience from a separate response model to crisis, and only one participant had experience of a joint response or "Ride Along" model.	crisis supports, and opinions of four collaborative interagency response models.		crisis responses, and consumers' opinions of the four crisis-resolution approaches.	and family intervention but when a formal response was required, GPs and case managers were preferred. No one preferred police, and one person preferred the CAT team. Of the four responses, participants preferred the Ride Along model.
Brennan, Warren, Peterson, Hollander, Boscarato, & Lee. Collaboration in crisis: Carer perspectives on police and mental health professional’s responses to mental health crises.	2016. Melbourne, Australia	Crisis intervention with CAT team and police during a mental health crisis with a family member.	9 caregivers of clients with mental health challenges in crisis who were responded to by a CAT and police team during mental health crises. Diagnostic data was not collected regarding the clients with mental health challenges.	The study's aim was to examine carers experiences of mental health crises and responses provided by mental health professionals and police services, and how this may impact caregiver stress.	Qualitative exploratory study.	Outcomes measured were defined as the perceived impact of mental health crises for carers, how carers experience the crisis response, and how the professional’s response impacted carers.	Results of the study showed that carers suffer during a crisis, they have inconsistent experience with crisis systems, desire collaboration with services, and feel burden due to lack of trust. Priorities were accessibility, rapid response times, involve-

							ment, communic-ation, and recognit-ion throughout the crisis.
Carpenter, Falkenburg, White, & Tracy. Crisis teams: Systematic review of their effectiveness in practice.	2013. London, England.	Interventions: only studies containing a CRT as defined in The NHS Plan, and therefore only those published after 2000. CRT was a term referring to teams known variously as CRHTTs, CRTs, and HTTs. By 2006 in the NHS, 343 teams had been introduced as per the NHS plan and were teams of approx. 14 multidiscip-linary staff (mostly nursing).	The review looked at articles specifically with working age adults.	This systematic review explored whether CRTs: (a) affected voluntary and compulsory admissions; (b) treat particular patient groups; (c) are cost-effective; and (d) provide care patients value.	Systematic review, both RCTs and non-RCTs were reviewed.	Outcomes: studies that addressed one or more of the research questions, that is: (a) voluntary and/or compulsory admission rates and duration of admission either between an area with a CRT compared with an area without, or pre- and post-CRT introduction in a certain catchment area; (2) the characterist-ics of patients admitted to hospital since CRT introduction; (c) the cost-effectiveness of CRTs; and (d) quantitative and qualitative measures of patient satisfaction with CRT care.	The review overall indicated trending down of admission rates, although there was limited evidence to support it was related to CRTs. The most consistent findings were that clients are generally satisfied with care and that CRTs are an effective cost-saving measure. CRTs are under-researched and there is a wide variability in the make-up of teams and clients served.

Daggenvoorde, Gijsman, & Goossens. 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.	2018. Deventer, The Netherlands.	The data was collected using open-ended individual interviews, starting with: How *did you experience the (last) crisis in which you or your family member had acute psychotic and/or manic symptoms and a mobile crisis team (MCT) intervened?*	10 clients with diagnosis of psychosis or mania that experienced a crisis within the past 2 years that led to involvement with an MCT, 10 family members who were present at the time of crisis during a visit with the MCT. Crisis responses varied from MCTs responding alone, to responding with police or calling for assistance, to police responding alone. Remains unclear on the background of the MCT staff.	The aim of the study is to explore the lived experiences of clients with psychosis or manic disorder and/or their families in first interactions with an MCT.	A qualitative, phenomenological study design.	16 crises were analyzed and coded, to which 6 main themes emerged from the data: the experience of the crisis, experiences with emergency care with a crisis team, experiences with crisis professionals, role of out-patient treatment team, stigma, and family members as caregivers	Most clients felt trapped within the psychosis thoughts and inner confusion they experienced during the crisis. Family members felt at a loss to help. Family members felt heard by the crisis team members. However, participants felt the team took a long time to arrive on scene. Calmness, empathy, and understanding were thought to be essential elements by clients. Patients felt stigma and in some cases traumatized by their experiences. Family felt relieved. There was

							mixed experience of the team lacking communication and others feeling heard. There was emphasis on needing good communication and explanation in the first interaction but little guidance.
Freeman, Vidgen, & Davies-Edwards. Staff experiences of working in crisis resolution and home treatment.	2011. South Wales, UK.	The intervention was working for a CRHT.	Five participants took part in the study and were recruited from one CRHT team in South Wales. Four were qualified mental health nurses, one was a community support worker.	The purpose of the study was to explore the subjective experiences of the participants working for a CRHT, mainly in terms of the stressful experiences and how participants coped.	Interpretive phenomenology.	There were two main outcomes measured: work stressors and coping.	Three main themes emerged, these were "motivating factors", "stressors", and "coping". The findings from the study emphasized opportunities to build relationships with service users and illuminate perceived stressors, such as service complexity, operational issues, responsib-

							ilities, and training needs.
Fulford & Farhall. Hospital versus home care for the acutely mentally ill? Preferences of caregivers who have experienced both forms of service.	2001. State of Victoria, Australia.	Drawing upon burden and coping literature, a Carer Questionnaire with four sections was developed: section a) demographics, b) the Attitudes to Psychiatric Hospitals Questionnaire, c) five scales devised to measure psychological variables: perceived severity of illness, d) preference for hospital versus CAT team care.	77 carers of clients with severe mental health challenges (did not specify type) who had contact with a CAT team within 5 years were interviewed within the state of Victoria.	The first aim of the study was to assess the proportion of family carers who preferred CAT team care to hospitalization when their relative experiences a mental health relapse. The second aim of the study was to identify predictors of preference for hospital or CAT treatment.	Quantitative, correlational design.	Outcomes measured: preference for hospital care or CAT team care, and predictors of preference for hospital.	Overall, slightly more carers preferred hospitalization to CAT team care, but not statistically significant. Carer preference was associated with which had higher expectations of either service and how severe they felt their relatives condition to be.
Goldsack, Reet, Lapsley, & Gingell. Experiencing a recovery-oriented acute mental health service: Home based treatment from the perspectives of service users, their families and mental health professionals.	2005. Wellington, New Zealand.	Service experiences of service users, family, and professionals who have encountered or are working for an HBT (nursing staff, psychiatrist, social work). Some service users had diagnosis of psychosis or psychotic disorder but	30 interviews were conducted in total: 12 with service users, six with family, five with HBT nursing staff; and four with allied health (social worker, in-patient nurse, psychiatric registrar, community mental	The aim was to use narratives of service experience obtained from service users, families, and service providers, in order to develop understandings of how practices might promote recovery. Also, to act as a guide	Qualitative study, narrative approach.	How practices of an HBT promote recovery.	Service users and families were positive in discussing their experiences of HBT service; reports from HBT team members were overwhelmingly positive. Allied professionals were

		unclear the percentages. Clients met criteria if episode was severe enough to warrant an admission.	health nurse).	to settling local debates regarding recovery-oriented services.			also impressed by HBT. The client transition process was seen as something that needed to be adapted as well as the issue of training needs for team members.
Gregory & Thompson. From here to recovery: One service user's journey through a mental health crisis: Some reflections on experience, policy and practice.	2013. Sheffield, UK.	Service user and researcher told first-hand account of experience, and read medical records from the event, as well as spoke to healthcare professionals after the fact. The crisis team that attended her home during the first crisis consisted of a consultant psychiatrist, a mental health nurse, and a social worker (her GP also visited her home that day). Police attended her home the next day after the CT to another	The service user is in the social work profession, is a co-researcher, and writing under a "nom de plume" Alex to describe her experience in crisis with psychosis. The service user also interviewed a senior police officer and nurse manager.	The aim of this ethnography is to describe the service user's experience through a mental health crisis, although critical of some care received, the user partnered with the local police force to provide education to officers.	Auto-ethnography, first-hand account from one of the researchers on experience of psychosis.		Alex did not feel she was aware of the situation when included in decisions to stay home with CT and family support. Being removed from her home by police increased trauma. Training for family doctors and police officers is in need. Good relationships with mental health staff and a collaborative approach are

		crisis episode.					imperative.
Holgersen, Pedersen, Brattland, & Hynnekleiv. A scoping review of studies into crisis resolution teams in community mental health services.	2022. Trondheim, Norway.	Crisis Resolution Team (CRT) in English and Scandinavian literature.	129 studies were included in the review. Mostly UK, followed by Norway, and then Netherlands, Ireland, Switzerland, Australia, Spain, Denmark, USA, Germany, France, and South Korea.	The aim of the study was to provide an overview of available research on Crisis Resolution Teams (CRTs) in English and Scandinavian literature. To aid the further development of crisis team service and guide future research.	Scoping review.	Majority of studies were grouped into three major categories with some additional subcategories: Characteristic (principle, intervention), Implementation (descriptive, normative), and Effects.	Results indicate that the CRT may be a promising alternative to hospital admission, but elements such as specialist competence, extended hours, close follow-up, continuity of care, and solid collaboration with other services are prerequisites to the effective functioning of these teams.
Hopkins & Niemiec. Mental health crisis at home: service user perspectives on what helps and what hinders.	2007. Newcastle, UK.	Home visit with the CATs team within 16 months of their existence. Service users mention nurse and psychiatrist on the team, but exact makeup of the team is unknown.	70 participants who had been treated at home during the initial 16 months of the team's existence took part in the study. There was no demographic data collected on the participants.	The aim of the study was to find out from service users what aspects of their contact with the service had been most important, this was then used to formulate a questionnaire for further	Participatory action research.	The results of the study were organized into 7 overarching themes: accessibility, availability, consistency, quality, choice, negotiation, communication, and changes or endings.	The results of the study demonstrated the following aspects as important to service users: being able to access the service easily and quickly; the service being available and timely;

				service evaluation.			having clinicians visit who are aware of all the information; being listened to respectfully; being offered opportunity to take part in all aspects of care; good communication; and a slow fully informed ending of the service.
Hoult, Rosen, & Reynolds. Community orientated treatment compared to psychiatric hospital orientated treatment.	1984. Sydney, Australia	The experimental group received community care including 24-hour crisis care and the control group received standard hospital care and aftercare. The staff from the Community Treatment Team and 24-hour crisis service were made up of 3 psychiatric nurses, 2 social workers, one occupational	120 patients presenting to the state hospital for admission were randomized to experimental or control groups. More than half of participants had a psychotic disorder, such as schizophrenia.	The main aims of the study were: (1) to demonstrate that it is feasible to treat psychiatric patients in the community as an alternative to mental hospital (2) to show that this can be done without detriment to the patients, their families, or the community and (3) to demonstrate	Quasi-experimental, quantitative (non-RCT).	The effectiveness of standard hospital care vs community orientated treatment was compared from the viewpoint of clients, their relatives, & results of clinical instruments. Assessments were carried out at presentation and 1, 4, 8 and 12 months later.	96% of the control group were admitted, 50% more than once; compared to 40% of the experimental group, and only 8% more than once. Clients and the controls spent 53.5 days in hospital, whereas the experimental group spend 8.4 days. The crisis care in the community was

		therapist, one psychologist, and one psychiatrist.		that treatment costs no more than standard after-care.			felt to be more satisfactory to clients and caregivers and cost effective.
Johnson, Dalton-Locke, Baker, Hanlon, Salisbury, Fossey, Newbigging, Carr, Hense, Carrà, Hepp, Caneo, Needle, & Lloyd-Evans. Acute psychiatric care: Approaches to increasing the range of services and improving access and quality of care.	2022. Majority of the authors from this paper published in World Psychiatry are from the UK, however there are also authors from Australia, Ethiopia, Canada, Italy, Switzerland, and Chile.	The authors conducted a literature review on available evidence regarding a wide range of services in acute psychiatric care (including crisis teams) available in high, middle, and low-income countries.	Focus was on working-age adults with mental illness accessing various care services for a mental health crisis.	The main aim of the study was to examine current management for acute mental health crisis through exploring specific acute care models and the potential they hold for improving care and widening the range of options available in a crisis.	Not expressly stated, described as a paper, but does seem to be a literature review.	The main outcomes measured were: initial response to the acute crisis, including assessment, triage and initial care planning; settings in which intensive intervention to resolve the crisis is delivered; perspectives on crisis care delivery, focusing on contributions from the voluntary sector; the role of service users and peer workers in designing, leading, and delivering crisis services; remote delivery of crisis care; and crisis prevention.	When service users seek help, they are affected more by accessibility and availability of crisis service than quality of individual services. Very little research has focused on the patient's journey in crisis care. An accessible and flexible crisis service that meets service user needs and integrates sectors is optimal. However, a complex system will lead to care fragmentation and further gaps. Crisis care

							should be an integrated system, and co-produced by service users, their communities, and staff in relevant sectors. This should be a research and policy-maker priority.
Johnston. Being disturbed: Integration and disintegration in the patient and professional relationship.	2010. Leeds, UK.	The researcher (psychiatrist and psychotherapist) conducted reflective practice groups with staff in an in-patient psychiatric ward and a crisis team as a psychoanalytic application of the client and professional relationship. The article discusses perspectives of mental health nurses and psychiatrists on the in-patient ward and mental health nurses on the crisis team.	Two groups of working professionals, an in-patient psychiatric ward and crisis team, engaged with the researcher in weekly reflective practice groups (running for 4 & 2 years respectively). There were no specific demographics or quantifiable statistics available for either group.	The main aims of the study were to allow a safe space for staff to speak honestly about how they feel about their clients, work, and themselves, which would ideally foster empathy and shared humanity of the problems clients are dealing with.	Not expressly stated, described as a "paper" rather than a study.	Disintegration and integration of the client and healthcare professional relationship.	There are two types of clients described by care providers in both groups, the ones with psychotic disorders who are "truly ill", are met with "pity" and deserving of help; and those with personality disorders and not "truly ill". Crisis teams are like a "fast-moving" train, and not stopping to reflect on

							practice. They do not have many opportunities to reflect and express themselves.
Kłapciński & Rymaszewska. Open dialogue approach – about the phenomenon of Scandinavian Psychiatry.	2015. Wroclaw Poland.	The authors conducted a literature review, which outlined the history of development of ODA in Scandinavian countries, which includes the mobilization of crisis teams.	Review contained data from clients (mostly aged 16-45) and families of diagnosis of schizophrenia, and mental health professionals who attended an ODA 2-day training event in Poland. The healthcare professionals that attended this training were doctors, psychologists, nurses, therapists, and social workers.	The aim of the paper is to acquaint readers with the development of ODA in Scandinavian countries.	Not expressly stated, described as a paper, but does seem to be a literature review		ODA has shown evidence in various Scandinavian countries to be effective in treating schizophrenia and reducing numbers of schizophrenia diagnosis. Key ingredients are including the client, family, and entire therapeutic team in all important decisions regarding the client.
Lamanna, Shapiro, Kirst, Matheson, Nakhost, & Stergiopoulos. Co-responding police–mental health programmes:	2018. Toronto, Canada.	Crisis intervention with a co-responding MCIT or police-only team.	18 years or older, experienced an MCIT and/or police only crisis intervention over a period of 6 months. 42.9% had a psychotic disorder,	The aim of the study was to gain information on the rates of injury and arrest in co-responding teams, to understand how co-responding teams	Mixed-methods study.	Outcomes measured were response times, rate of services user injuries, arrests, and ED escorts, as well as ED handover times.	Findings from the current study indicate prompt response times, reduced ED handover times, low rates of arrest and

Service user experiences and outcomes in a large urban centre.			which was the majority client group.	compared to police-only teams in response times, escorts to ED, and ED handover times. Lastly to understand how service users experience co-responding and police-only team interactions.			injury, and positive service user experience in co-response teams. This seems to add value to existing crisis response systems.
Marshall. Caring for a friend or family member who has experienced psychosis and suicidal behaviour: A qualitative investigation.	2023. UK.	The intervention varied from literature review in chapter one, to online peer conversations in chapter two, and in-depth semi-structured interviews with a researcher for chapters three and four. Multiple carers in this study described their experiences during crisis with a loved one and CT or police.	The thesis contained data from carers of clients with psychosis or bipolar disorder and suicidal behaviour. Carers were to be over 16 years of age for the online peer group (n=19), and over 18 years old for the interviews (n=17), and a close friend or family member to someone with psychosis or bipolar disorder.	The aim of this thesis was to examine carers' experiences of supporting friends or family members with psychosis and suicidal behaviour.	Doctoral thesis. Three research methods were used to create four chapters. First, qualitative thematic synthesis used to investigate carers' experiences of supporting a friend or family member with suicidal behaviour. Secondly, reflexive thematic analysis was used to analyse online peer conver-	Outcomes measured were carer's experience of supporting friend/family with psychosis or bipolar disorder and suicidal behaviour.	Many carers' experience was marked by fear of suicide, leaving them stuck in a cycle of hypervigilance, exasperation, and fatigue. Many were left not knowing how to respond. Understanding how psychosis symptoms can lead to suicidal behaviour was helpful, as well as effective

					sations related to caring for someone with psychosis or bipolar disorder and suicidal behaviour. Third, reflexive thematic analysis was used to analyse interviews with friends and family members of people with psychosis and suicidal behaviour. Two articles based on this interview data are reported.		health-services. Negative experiences with services, inaccessible or unwilling to work with carers was common and disheartening.
Moreno-Alonso, Nieves-Carnicer, Noguero-Alegre, Angel, Alvarez-Mon, Rodriguez-Quiroga, Dorado, Mora, & Quintero. Patient satisfaction and outcomes of crisis resolution	2023. Madrid, Spain.	The intervention was treatment by the Vallecas CRHT unit. This team consists of 3 psychiatrists and 3 mental health nurses, with the workload divided into pairings of 1 nurse and 1 psychiatrist for home visits.	The participants were 90 clients between ages of 18-90, with the majority diagnosis being psychotic disorders (47.78%), as well as 54 caregivers.	The aims of the study were (1) to describe the demographic characteristics, referral criteria, and pathology of the patients treated at the Mental Health CRHT; (2)	The article does not expressly state the type, but is a quantitative study, likely quasi-experimental.	The outcomes measured were effectiveness of the CRHT intervention, patient satisfaction, which patients benefit the most, and impact on caregiver stress.	The intervention did not significantly reduce caregiver stress, clients were found to have high levels of satisfaction with the CRHT, and CRHT intervention was

home treatment for the management of acute psychiatric crises: A study during the COVID-19 pandemic in Madrid.				to analyze the effectiveness of the program in terms of overall patient improvement; (3) to assess patient satisfaction with the Mental Health CRHT through a satisfaction survey; (4) to identify which patients benefit the most from CRHT and which patients are most satisfied; and (5) to evaluate the potential benefits in terms of caregiver stress.			associated with better quality of life.
Murphy, Irving, Adams, & Waqar. Crisis intervention for people with severe mental illnesses.	2015. Trials were based in Australia, Canada, USA, and UK.	Crisis intervention versus standard care was measured.	All randomised controlled trials of crisis-intervention models versus standard care for people with severe mental illnesses that met inclusion criteria. 8	The aim of the study is to review the effects of crisis-intervention models for clients with serious mental illness experiencing an acute episode	Systematic review, examining only RCTs.	Main outcomes are hospital use, global state, mental state, quality of life, participant satisfaction and family burden. Outcomes were divided into 3, 6, 7-12 month, and +1 year intervals.	Crisis intervention may reduce repeat admissions and does appear to decrease caregiver stress and improve mental state. Participants were

			studies included with a total of 1144 participants, whom were adults with schizophrenia or other psychotic disorder in crisis.	compared to the standard care. And to compare the effects of crisis teams visiting patients' homes with crisis units based in residential houses.			more satisfied with crisis care, but quality of life scores were similar. No differences in death rates. Some suggest crisis care to be more cost effective, but results were skewed or unusable. There was no data found on staff or carer input, complications with medication or numbers of relapses.
Polak & Kirby. A model to replace psychiatric hospitals.	1976. Denver, Colorado, U.S.A.	Clients slotted for admission were randomly assigned to either intervention by a crisis team or regular hospital care. The crisis team is comprised of clinical staff and volunteers (peer support workers).	85 clients requiring in-patient hospitalization over an 18-month period were randomized to experimental (crisis team) or control (hospital care). Majority of the group treated at home by the crisis team were under the	To evaluate the effectiveness of care for those about to be hospitalized who were randomly allocated to treatment at home by a crisis team or to in-patient hospitalization.	Quasi-experimental quantitative study. The groups were randomly allocated but study does not state it is an RCT.	The primary outcomes measured were: treatment effectiveness, goal attainment, self-disclosure, and community adjustment.	Clients treated in their homes reported overall greater satisfaction levels, goal attainment, and had greater levels of self-disclosure than the hospital group. These

			psychotic disorder category (46%).				results seem to support the hypothesis that home treatment is "at least as effective as treatment in the psychiatric hospital".
Reynolds, Jones, Hoult, & Berry. A crisis team for the mentally ill: The effect on patients, relatives and admissions.	1990. Sydney, Australia	24-hour crisis team service provided by 8 mental health nurses was the intervention.	The sample consisted of 69 participants, aged 16-65, seen during a 3-month period by a crisis team, and suffering from either functional or borderline psychoses, had a previous admission to the hospital, and were presenting to MacQuarie hospital for admission.	The aim of the study was to evaluate a crisis team functioning in a routine setting rather than an experimental one.	Quantitative, correlational design.	The primary outcomes measured were effects on patients, relatives, and hospital admission.	Hospital records confirmed the crisis team had halved admissions, and most patients and relatives in a follow-up interview with a psychologist reported feeling "very satisfied" and that the team had helped "greatly".
Ruggeri, Salvi, Perwanger, Phelan, Pellegrini, & Parabiaghi. Satisfaction with community and hospital-based emergency services amongst severely	2006. South-Verona, Italy and Nunhead, South-London, UK.	Comparison of emergency services in South-Verona (psychiatric emergency room service, and community mental health service that includes a	The sample consisted of 48 users in Nunhead and 40 users in South Verona. All clients had a diagnosis of psychosis.	The aim of the study was to compare service users' satisfaction with crisis intervention in two different services: a well-developed and staffed	Quantitative-comparative design.	Seven dimensions are measured: overall satisfaction, professional skills and behaviour, information, access, efficacy, types of intervention, and	The study shows greater satisfaction with emergency interventions provided in the community to primarily hospital-based

mentally ill service users.		crisis team that provides home visits) and Nunhead (hospital-based care in a general emergency room and very limited home-based services by medical staff when requested by a GP). The CT staff were nurses or psychiatrists.		community-based service and a mental health service relying intensively on emergency clinics and minimal community intervention.		relatives' involvement.	care. Future work is needed to confirm the relationship between different approaches to emergency interventions and user satisfaction by a CT.
Sjølie, Karlsson, & Kim. Crisis resolution and home treatment: Structure, process, and outcome – A literature review.	2010. Drammen, Norway.	The intervention was treatment by a CRHT team. Multiple teams from 35 different studies published in English and Norwegian were examined.	Research pertaining to adult mental health service users who have accessed care through a CRHT, however, research that only takes service user perspective into account were omitted.	The purpose of the review is to explore what is currently known regarding the structure, process, and outcome of CRHT as a community mental health service.	Systematic review.	Three main outcomes were measured: the structure of the teams, process in terms of clinical interventions, and the outcomes of service.	The literature is illuminating regarding structural aspects of CRHT, and research suggests these teams reduce hospitalization and are more cost-effective. However, there is a paucity of studies that discuss specific clinical interventions and more information on how CRHT

							teams affect service users, carers, and professionals are needed.
Wheeler, Lloyd-Evans, Churchard, Fitzgerald, Fullarton, Mosse, Paterson, Zugaro, & Johnson. Implementation of the crisis resolution team model in adult mental health settings: A systematic review.	2015. England, UK.	Studies were selected that compared CRTs to Treatment as Usual; comparing two or more CRT models, national or regional surveys of CRT service qualitative studies of stakeholder views; guidelines from government and expert organizations.	69 studies were included. The participants of these studies were adults with acute mental health problems who would otherwise be admitted to hospital and were served by a CRT. CRTs were multidisciplinary of varying professional backgrounds including 16 teams that offered access to medical coverage, such as a psychiatrist. Older age adults were included if they had a functional mental illness, not of organic origin.	The aim of this review is to establish what evidence exists regarding the characteristics of effective and acceptable CRTs.	Systematic review, both quantitative and qualitative studies.	Outcomes measured are: Firstly, what characteristics of CRTs are associated with positive outcomes? Secondly, what do service users, carers, and staff identify in qualitative studies and quantitative questionnaires as important elements? Lastly, what recommendations do government agencies and non-statutory organizations and experts make regarding CRT services?	Quantitative studies suggested that longer opening hours and a team psychiatrist would help CRTs ability to prevent admission. Stakeholders emphasize communication and integration with other services, limiting staff variability in home visits. Existing guidelines suggested 24/7 service and high-quality staff training.
Winness, Borg, & Kim. Service users' experiences with help	2010. Kongsberg, Norway.	Studies selected involved data from service users on their experiences with an	Only 16 studies were included in the review and included both qualitative	The aim of this study was to identify positive and satisfying aspects of	Systematic review, both quantitative and qualitative studies.	Positive aspects of treatment from an acute mobile/ambulatory	The study found three key themes of positive experience according to the

and support from crisis resolution teams. A literature review.		acute mobile/ambulatory healthcare service. Specific diagnostic information on the service users was not provided.	and quantitative research that addressed service user experiences with an acute mobile/ambulatory health care service.	CRHT service users that is revealed in the literature.		health care service.	service users: (a) accessibility and availability, (b) being understood as a "normal" human being, (c) dealing with crises in everyday life.
Xanidis & Gumley. Exploring the implementation of cognitive behaviour therapy for psychosis using the normalization process theory framework.	2020. Glascow, UK.	The intervention was implementation of CBT for psychosis in staff working for a community or mental health crisis team, all staff were grouped together, and responses analyzed within a focus group.	14 staff members in community and mental health crisis teams were recruited who had on average 17 years' experience with psychosis clients. Participants consisted of mental health nurses (n=5), consultant psychiatrists (n=2), clinical/counselling psychologists (n=2), CBT therapists (n=2), an occupational therapist (n=1), a team leader (n=1), and a senior adult mental health manager	The aim of the study was to explore the views and experiences of staff regarding implementation of CBT for psychosis.	Qualitative study, using semi-structured focus groups.	Thematic analysis was used to generate initial themes. Inductive coding generated five overarching themes: perceived barriers to engagement; contextual barriers to implementation; optimization of implementation; positive attitudes towards implementation; and expectations of implementing CBTp.	The results of this study showed a mixture of barriers and facilitators to implementing CBTp and highlight the importance of strong leadership to combat these.

			(n=1) but unclear which staff were from CT or CMHT.				