Check for updates

Received: 16 May 2020 | Revised: 4 January 2021 | Accepted: 28 January 2021

DOI: 10.1111/jpm.12738

ORIGINAL ARTICLE

WILEY

Nurses' Experiences of Care at Crisis Resolution Home Treatment Teams: A case study research

David Giménez-Díez[1,2] | Rubén Maldonado-Alía[3] | Lídia Torrent-Solà[4] | Nina Granel[2] | Maria Dolors Bernabeu-Tamayo[2]

[1]CPB Serveis de Salut Mental, Barcelona, Spain

[2]Nursing Department, Universitat Autònoma de Barcelona, Barcelona, Spain

[3]Associació per a un Major Empoderament Social i de la Salut, Barcelona, Spain

[4]Consorci Corporació Sanitària Parc Taulí, Centre de Salut Mental, Barcelona, Spain

Correspondence
Nina Granel, Nursing Department, Universitat Autònoma de Barcelona, Bellaterra, Barcelona, Spain.
Email: nina.granel@uab.cat

Accessible summary

What is known on the subject?

- There are many international studies on CRHTTs; however, there has been little research on nurses' experiences of working with CRHTTs.
- Earlier studies focused on the nurses' gatekeeping role but did not explore nurses' perception of care as a construct.

What does the paper add to existing knowledge?

- This study provides information based on mental health nurses' experiences. It explains the home environment, the therapeutic relationship and the process of mental health nursing care during a crisis. Also, the study explains nurses' satisfaction with care provided at patients' home.
- Unlike other studies, this study focused on nurses' experiences while providing care, rather than on nurses' general responsibilities and the services they provide. This study is the first of its kind in Spain with such a focus.

What are the implications for practice?

- Acknowledging nurses' experiences and their perspectives about the care they provide could help shift mental health nursing paradigms from those based on biomedical models to newer perspectives found in recovery models. Furthermore, this knowledge could improve the quality of care in mental health settings due to its potential to guide nursing practices.
- Raising mental health care providers' awareness of mental health nurses' personal and professional care constructs would help implement support systems to meet the professional's needs. Meeting the needs of nurses related to the care they provide is likely to impact patient care positively.

Abstract

Introduction: Crisis resolution home treatment teams (CRHTTs) provide short-term, intensive home treatment to people experiencing mental health crises. There is limited research on nurses' experiences with CRHTTs. While earlier studies mainly focussed on mental health nurses' gatekeeping responsibilities, more investigation is needed in this field.

Aim: To explore nurses' perceptions and constructions about care in CRHTT services.

 © 2021 John Wiley & Sons Ltd

Method: A qualitative case study was employed. Ten semi-structured interviews were performed to nursing staff working in CRHTT services.

Results: Three main categories emerged from the data analysis: nurses' perspectives of the care provided, nursing setting of care at home and nursing care plan at home.

Discussions: Findings revealed that nurses experienced greater satisfaction providing care in the home settings, and therefore, it positively impacted the quality of care and reduced patient's stigma. This study also relates the value of developing care plans centred on patients' environments increasing Mental Health Nursing (MHN) work satisfaction.

Implications for practice: Knowledge of the intrinsic experiences of care provided by nurses in CRHTTs may help facilitate the development of the nursing role in CRHTT by improving understanding of care in mental health settings.

KEYWORDS

CRHTT, home treatment, mental health, mental health nursing, therapeutic relationship

1 | INTRODUCTION

During the last four decades, advancements in mental health service system have been implemented to benefit patients and their families (Ness et al., 2012). The most important change in mental health care has been the psychiatric reform, and it conducted to adopt a more community-based approach. Crisis resolution home treatment teams (CRHTTs) is one of the services within this framework that endeavours to improve the comfort and privacy of patients experiencing a mental health crisis at home.

CRHTTs provide short-term and intensive home treatment to people experiencing mental health crises, humanizing services and enhancing efficacy (Klevan et al., 2018). The service is designed to reduce hospital admissions and help patients return home promptly after an acute admission to a psychiatric hospital (Lloyd-Evans et al., 2018). This modality has been considered less invasive and traumatic than hospital admissions (Giménez-Díez et al., 2019). It allows greater participation, improved quality of life and increased privacy for patients (Barker & Buchanan-Barker, 2011). The literature suggests that hospital admission can be harmful and stigmatizing to patients (Verhaeghe et al., 2007). Current research reveals that stigmatization still exists and has unfavourable outcomes for patients of psychiatric hospitals and clients of alternative settings (Liggins & Hatcher, 2005). However, when crises are managed within a patient's space, the relationships among patients, their relatives and healthcare professionals are more natural and less dominated by imbalances of power; thus, home care improves relationships at different levels and offers a new approach to patients, who reported that they prefer the availability of CRHTT devices and their additional services, such as professional support in person, on the phone, and in their homes (Burns-Lynch et al., 2014).

The nursing role within an acute mental health setting is multidimensional and complex. It encompasses facilitating and promoting health, dignity and self-determination. It also focuses on the importance of person-centred care. In such cases, control is placed in patients' rather than in mental health professionals' (Bolton, 2000; Glover, 2012; Meehan et al., 2008; Wyder et al., 2017).

It is essential to ensure that effective nursing practices are implemented and that staff working in CRHTTs is confident and competent in their abilities to practice while delivering services that meet patients' needs. Care activities involve socially directed participation (e.g. education related to living with chronic health conditions) and activities linked to successful discharge and reduced re-admission. However, some of these goals are often left behind in the hospital settings (Carthon et al., 2015; Harvey et al., 2018).

Evidence related to the nursing experiences working in CRHTTs is limited (Begum & Riordan, 2016; Winness et al., 2010). Mental health nursing (MHN) staff in CRHTT work with patients during mental health crises facing high levels of distress. Rudge (2013) found that to dismiss these inputs of distress, nurses attempt to control their work by reorganizing their responsibilities to fit within an organization's productivity drive (Hall et al. 2018) identified that prioritization is affected by many aspects; identifying how to manage such stress becomes difficult because of the unpredictable nature of patient responses to illness.

Previous research has indicated that understanding nursing perceptions about their healthcare practice could improve the care nurses provide to their patients (Xie et al., 2019). This understanding is important because it can guide nursing practice (Yous et al., 2019). Moreover, knowing mental health nurses' lived experiences could provide evidence distanced from the biomedical paradigm (Tanaka, 2019).

While earlier studies mainly focussed on mental health nurses' gatekeeping responsibilities (Begum & Riordan, 2016), more investigation of nurses' experiences within CRHTTs is needed. In this research, we focused on understanding nurses' perceptions and

constructions about care in CRHTT services. We also explored their ideas about satisfaction with care given, general health, mental health, patients, community and the differences between care given in CRHTTs and other services, including hospital admission.

2 | METHODOLOGY

A case study was adopted to understand mental health nurses' experiences of the care at crisis resolutions home treatment teams. The aim of a case study is to use the case to understand a phenomenon of interest. Case studies provide researchers with the opportunity to gain an intimate understanding of a person's conditions, thoughts, actions, interventions and environment (Stake, 2005; Yin, 2014).

2.1 | Population and sample

The Unit of Partial Hospitalization at Home of Centre Psicoteràpia Barcelona Serveis de Salut Mental (CPBSSM)—Hospital de la Santa Creu i Sant Pau (UHPAD), was the first Catalan medical facility to offer CRHTT care for adults in 2016. CRHTT is a 24-hr service that combines daily visiting hours with emergency phone service. All nurses who had worked or were working in this service since its founding were included. There were no exclusion criteria. Convenience sampling was used to recruit participants, and they were provided information about the study and its objective.

2.2 | Research Instrument and data collection

We designed semi-structured interviews based on a literature review (Winness et al., 2010), exploring aspects of home nursing care. A preliminary test was administered to two interviewers. As a result of the test, the research team decided to increase the interview script's flexibility, making it more open and fluid. The external expert of the research team reviewed the interview questions and elaborated the final interview version with the principal investigator. We conducted a total of ten in-depth semi-structured qualitative interviews. Each interview lasted one hour, was audio-recorded, and transcribed. We removed all identifying data from the transcript to ensure confidentiality, and the participants validated their transcripts to ensure accuracy. All changes were reflected in the data.

2.3 | Data analysis

The principal investigator and a qualitative research specialist, unaffiliated with the research team, independently conducted data analysis. Subsequently, the two independent analyses were compared to achieve consensus. A conceptual framework based on the current literature was used for the analysis under the Constructivism theory (Lauckner et al., 2012). The analysis focused on the participants' experiences, assumptions and preconceptions about the care they provide. It allowed the research team to get close to the participants' world and get an "insider's perspective" of the studied phenomena (Mjøsund et al., 2017). All relevant text was grouped into codes and categories using Atlas. Ti software. Emerging categories were identified after repeated readings of the data and named using content-characteristic words. Subcategories of similar events were grouped beneath the main categories.

This process was repeated until the main categories, and subcategories were identified.

2.4 | Ethical standards

The present study was approved by the Ethics and Clinical Research Committee of Centre Psicoterapia Barcelona (CPB) Serveis Salut Mental (service which the UHPAD depends on). This study also subscribed to the Declarations of Helsinki. Although the participants did not suffer any adverse effects from the study, they were informed of their rights as participants and the study's possible effects. Participation was voluntary, and every participant signed an informed consent form. They were also informed that they could leave the study at any point, with no repercussion. In this study, there was no conflict of interest.

2.5 | Validity and reliability/rigor

The study was evaluated using Lincoln and Guba's criteria of credibility, confirmability, meaning in context, saturations and transferability (Lincoln and Guba, 1985). The Critical Appraisal Skills Programme Español (CASPe) method was followed to give a critical analysis of the research (Santamaria-Olmo, 2017).

The research team was formed by nurses working at the university and by an external and unaffiliated researcher assuring validity through researcher triangulation. The interviews were conducted by a mental health nurse, who was previously acquainted with some of the interviewees, which could be a source of bias. However, to mitigate this, the interviews were conducted objectively and without personal implications, the purpose of the study was clearly defined to the participants, the interviewer critically examined his role and the participants validated their transcripts.

To assure credibility data were also analysed by two researchers simultaneously, one of them not belonging to the university or to the institution involved in the research. Data saturation was achieved after seven interviews; however, it was decided to interview all the nursing team.

To reduce the possibility of generic or socially desirable responses, the participants were informed that their answers were confidential and would only be used for this study.

3 | RESULTS

Participants' age ranged between 27 and 50 years old, and all were experienced in the field. Table 1 includes other sociodemographic data of the respondents. Three main categories emerged from the data analysis to understand nurses' perceptions and constructions about care in CRHTT services: nurses' perspectives of the care provided, nursing setting of care at home and nursing care plan at home. Table 2 illustrates the categories and subcategories of the research. Globally, no discrepancies were found among the participants perceptions regarding their nursing care experiences with the CRHTT. Participant qualitatively defined mental health nursing experiences of care working at CRHTT as "the lived relationship of helping through care to a patient or family in a domiciliary setting, allowing patients to have more time and presence to agree on goals and achieve them, always working day by day with the patient and families. It allows you to create a much stronger therapeutic relationship in less time, and in the end, as a professional, you are entering the patient's intimate world, space, and privacy."

3.1 | Nurses' perspectives of care provided

The nurses explained that a mental health nurse who provides care at home during a crisis is a professional with experience and technical knowledge who considers the patients' well-being. This category was divided into two subcategories: the act of caring and nurses' satisfaction with the care provided.

The participants understood the act of caring to be an act that reduces patient suffering or any action that provides, facilitates, helps or accompanies the patient, providing global, congruent and humanistic attention, considering the person's needs. Nurses provide care, empathy and compassion, based on empirical data, with a non-judgmental and equal approach. They use techniques, data and knowledge evidence based.

> It is a complicated concept to explain by words, but that could be summed up in caring with the patient's needs in mind and accompanying the patient in his decisions… it is an idea that is born from humanism or the soul of the human being, and that seeks to provide welfare to others voluntarily.
>
> (Nurse 6).

Nurses believed that providing home care facilitates an intimate perspective, which creates a special bond with patients and instils personal satisfaction with their work. Nurses felt more involved and responsible when they were close to patients and applied care adapted to real needs, often establishing a close relation with the patient, immersing into the lifestyle of the patient.

> It is a complicated concept to explain by words, but that could be summed up in caring with the patient's needs in mind and accompanying the patient in his decisions… it is an idea that is born from humanism or the soul of the human being, and that seeks to provide welfare to others voluntarily
>
> (Nurse 8).

> Perhaps, if we did not enter the home, we would never see certain situations or problems, which allows you to have a better approach and a feeling of fullness… getting into the life of a patient, in his day to day, at

TABLE 1 Respondents' Sociodemographic Data

Participant	Age	Gender	Civil Status	Education	Years of experience in mental health	Years of experience in CRHHT's[a]
N1	28	Male	Living as a couple	MSc, RN[b]	3 years	<1 year
N2	28	Female	Single	MSc, RN	4 years	<1 year
N3	34	Female	Single	MSc, RN	6 years	<1year
N4	39	Male	Married	MSc, RN	8 years	3 years
N5	28	Female	Living as a couple	MSc, RN	6 years	2 years
N6	48	Female	Divorced	MSc, RN	25 years	3 years
N7	50	Female	Married	MSc, RN	28 years	3 years
N8	33	Female	Living as a couple	MSc, RN	10 years	<1 year
N9	27	Female	Single	MSc, RN	4 years	<1 year
N10	29	Male	Living as a couple	MSc, RN	3 years	<1 year

[a]Crisis resolution home treatment teams.

[b]Registered Nurse.

TABLE 2 Categories and Subcategories of Nurses' Experiences with Crisis Resolution Home Treatment Teams

Categories	Subcategories
Nurses' perspectives of the care provided	- The act of caring - Nurses' satisfaction with care
Nursing setting of care at home	- The environment of the patient - The therapeutic relationship
Nursing care plan at home	- Nursing diagnoses - Nursing interventions - Nursing outcomes

> home, makes you feel very special… makes you feel connected and comfortable, at ease and safe
>
> (Nurse 10).

3.2 | Setting of home nursing care

Nurses provided home care as the main point in crisis resolution treatment for mental health patients. This category was divided into two subcategories: the environment of the patient and the therapeutic relationship.

The patient's environment from the nurses' perspective and experience refer to the patient's home. "Their places" are those spaces frequented during their daily routines, such as walking routes, coffee shops, supermarkets and libraries. Nurses must be cognizant of the environment, rhythms, times, tendencies and idiosyncrasies of each patient's life. When patients are free to engage in their typical lifestyle patterns, they are less reticent and more cooperative. This allows nurses to be more genuine, accessible, relational and focused on the therapeutic objectives. Patients perceive nurses as less invasive and less adversary, and encounters with patient relatives are easier to manage within a secure setting.

In this way, the service is unique, offering an alternative space and understanding of mental health. Providing person-centred care allows nurses to observe things that would not be apparent if a patient was hospitalized. Nurses in the interviews addressed the advantages of adapting care to the needs of the patient.

> The service is profoundly unique in offering a new space and a new understanding of mental health and patients…we are at their home because they let us be there, which allows us to enter their privacy and their moments of vulnerability, accompanying from the presence and emotional bond and esteem, creating a great bond… Our service aims to be the basis of a truly community-based and patient-centred mental health care system.
>
> (Nurse 1).

> …to be able to access the patient's reality, to its most intimate environment, is what differentiates us as a service, and that is, at the same time, our basis of treatment and our way of understanding mental health… allows you to see things that you do not see when they are hospitalized and assess whether their activities and needs are really covered since you are in their usual environment and not in a specific environment, such as the hospital, which is a very structured environment and rigid that makes it difficult to know the real abilities of the patient…Relationships are more intense and the patient sees you at home as an equal.
>
> (Nurse 5).

The nurses defined the therapeutic relationship as the components that permit establishing an honest relationship of care. Those components included establishing communication adapted to the patient's environment, applying active listening, being empathic and non-judgmental, preserving a respectful approach, dedicated time to the patient in each daily visit, and accessibility. To adapt communication also implies offering horizontal proposals, avoiding imposition and allowing patients to make choices and decisions. This commitment to personalized communication enables the therapeutic relationship to become effective, fostering a climate of change and significant improvement.

> Embracing the patient's story and encouraging their communication without protocols allows to create a spontaneous and unique care experience that creates a relationship of trust and security…this has to be done from the patient's home, and from a truly community vision, is by addressing the patient's problems and offering coping strategies to the affected person and his family what at the end creates a very powerful link that facilitates change.
>
> (Nurse 7).

> The link, the therapeutic relation, is born by the presence, by being unjudged, showing a sincere interest, by truly showing the patient that we are concerned about what he is concerned about, by helping him to take the reins, to feel us… and evolve, Over time, towards a very natural, intuitive and nutritious relationship of accompaniment and listening… that is how we create a strong relationship fleeing from situations of power and rigidity, a clear and sincere relationship where the priority is mutual understanding and consensual decision making.
>
> (Nurse 2).

3.3 | Nursing care planning at home

CRHTT nurses' actions are based on care plans designed and agreed upon by the patients and their families. Nurses considered that the

current North American Nursing Diagnosis Association (NANDA), Nursing Outcomes Classification (NOC) and Nursing interventions classification (NIC) did not complete the scope of their work with the patients and their relatives. This category's results were grouped into three subcategories: nursing diagnoses, nursing interventions and nursing outcomes.

Nurses agreed that diagnoses should be altered based on the patient's subjectivity, characterized by spiritual suffering associated with an important historical and cultural stigma, which is translated into symptomatology that causes the patient to lose functionality and requires CRHTT nurse intervention.

> I identify and treat by observing symptomatology that makes the patient lose functionality…a vital experience that consists of deep and acute suffering, which implies fragility and needs…situation that causes the person to be having a hard time and suffering because otherwise, we would not be working together…a phase in which a person presents alterations in their patterns and in which parts of them cease to be functional, where challenges and very great suffering appear and also discomfort that requires learning new personal and relational skills, as well as handling adverse situations and feelings.
>
> (Nurse 6).

Nursing interventions are planned to include the patient and family within the therapeutic relationship framework, providing health education and designing global interventions that extend beyond concrete techniques practiced reducing patient suffering.

> Nursing intervention is to always be available to the patient, and in fact this availability alone is key in the improvement of all cases where you have to give support and accompaniment to the other person and their family…nursing care in mental health greatly transcends concrete techniques, and requires a phenomenological approach to the other, where we offer ourselves as professionals to the patient, who is the one who decides to what extent they will be allowed to be helped and accompanied.
>
> (Nurse 9).

Nursing outcomes must be based on an equal power relationship. Empowering patients to face the disease, accept their state of health, integrate into the mental health network and in society, work on the hope and desire to live, find a new purpose in life, reordering or rereading the past and creating health-seeking behaviours. Those outcomes are always accompanied by and emotionally reinforced by the patient's usual environment, considering their personal needs, based on trust.

> You must establish a relationship of trust with the patient and family that facilitates the work of professionals and ensures greater well-being for the affected person and their relatives by achieving certain things such as organizing the basic activities of the patient, establishing daily behaviours, routines, seeking a stabilization of symptoms and reducing anxiety, redirecting crises or serious situations…at the end is to help the patient at home, whatever it is, but by making specific therapeutic outcomes.
>
> (Nurse 3).

4 | DISCUSSION

This section includes a discussion of the three main categories emerged and a description of a model created by the authors from the constructs that nurses have around their patients' care, along with the implications for practice, a limitations section and recommendations for further research.

According to the evidence, the work environment for nurses is significantly related to patients' experiences and their quality of care (Kieft et al., 2014). This study findings revealed the importance of working within the patient environment to achieve outcomes that significantly impact the quality of care. According to our results, CRHTT nurses work in favourable conditions for the patients and their perception of high-quality care provided was manifested. Harris and Panozzo, (2019) showed that patients increasingly embrace recovery approaches to mental health that prioritize therapeutic activities within the context of collaborative relationships.

The perception of satisfaction nurses received by providing care is commensurate with the freedom and responsibility granted within cases that maintain morale and motivation among nursing staff. Having close therapeutic relationships with patients culminates in feeling less stress, avoiding burnout and having enough time to make effective interventions. In other studies, nursing satisfaction related to caregiving has been primarily associated with inferring satisfactory signs from clients (Yamamoto-Mitani et al., 2018). As also indicated in the study of Giménez-Díez et al., 2019) the health agent plays an important role in the patient's recovery in CRHTTs and care becomes personalized, which is why the therapeutic relationship becomes significant and satisfactory for the persons implicated. This satisfaction was also found in our findings. Harris and Panozzo, (2019) also indicated the importance of working with patient-centred care plans, contributing to increased MHN satisfaction.

Seeking patients' empowerment and involving them in decision-making is a tactic widely supported in the literature (Jørgensen & Rendtorff, 2018). Cleary et al., (2018) highlighted nurses' perception of the importance of applying care plans based on patients' environment and integrating them into the mental health network and society. MHN perceptions and construction studies have been important to understand their actions, motivations and satisfaction. Although the reasons are unclear, there is considerable variance in

using Systematic Nursing Language throughout diverse contexts (Olatubi et al., 2019). The CRHTT nurses studied also considered that applying NANDA, NOC and NIC taxonomy did not complete the scope of their work with the patients and their relatives. This finding showed the need of developing care plans centred on patients' environments increasing MHN work satisfaction.

Research suggests that educational interventions and treatments at home, like those provided by CRHTTs, decrease patient stigma (Henderson et al., 2014; Hibbard et al., 2010). Henderson et al. (2014) reported that the direct contact mental healthcare professionals have with people with mental illness corresponds with positive attitudes regarding civil rights and promotes better conceptions and expectations of patient recovery. These expectations would promote improved care and positive improvements (Hibbard et al., 2010).

The Constructivism theory (Winter & Feixas, 2019) increased understanding of mental health nursing care of individuals and relatives treated at this CRHTT and offered a framework to understand mental health and its implications. The results of our study allowed the authors to create a model (Figure 1) based on a constructivist point of view including the constructs that nurses have around their patients' care in the context of CRHTTs and constructs of the hospital settings based on the literature review (Keogh et al., 2015). The constructs differ significantly in both settings having clearly implications for nursing practice. This relation between the constructs and the implications for practice was also evidenced in the study of Jussim (2017).

4.1 | Study limitations

One limitation of the present study is that the study explored MHN experiences in a specific setting. The CRHTT sample was based in urban, inner-city areas, and, therefore, the results cannot be generalized. To improve the research findings' validity, the study may have benefitted from using other forms of data collection to triangulate the data. It may have been appropriate to conduct a focus group to gain feedback on the participants' initial analysis. This focus group could have provided additional data, and a means to validate the analysis.

Qualitative studies have limited data extrapolation, although it allows for new hypotheses and explaining of phenomena. The sample size can also be considered insufficient or biased. Moreover, this study is difficult to replicate in other contexts. It focuses on a new, specialized unit, although used in other parts of the world. In future research, these limitations should be considered, but this study presents a strong foundation on a topic of which there is a shortage of studies.

4.2 | Implications for practice

Acknowledging nurses' experiences and their perspectives about the care they provide could help shift mental health nursing paradigms from those based on biomedical models to newer perspectives found in recovery models. Furthermore, this knowledge could

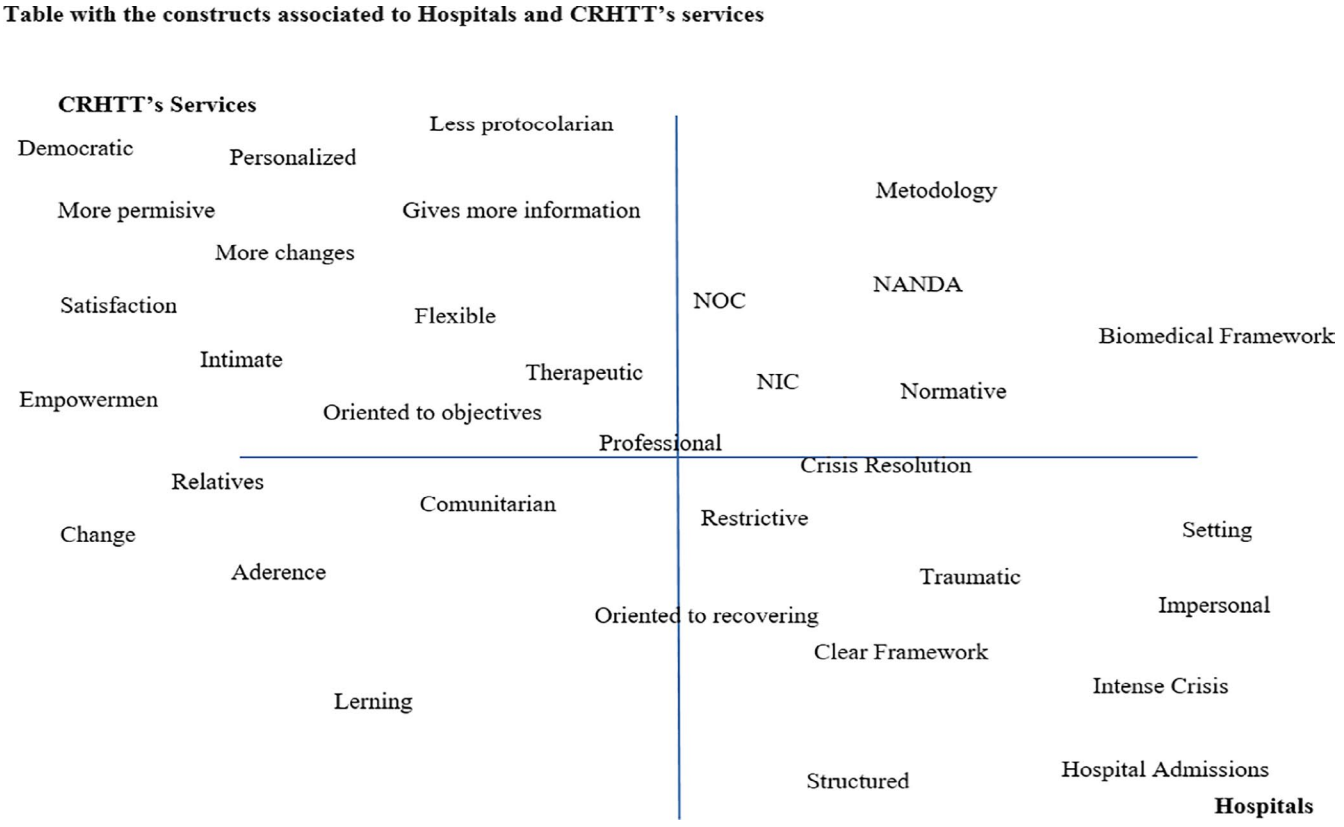


FIGURE 1 Findings from a Constructivism Perspective

improve the quality of care in mental health settings due to its potential to guide nursing practices.

Raising mental healthcare providers' awareness of mental health nurses' personal and professional care constructs would help implement support systems to meet the professional's needs. Meeting the needs of nurses related to the care they provide is likely to impact patient care positively.

4.3 | Future research

The results showed many factors relevant to the experience of care in CRHTTs. It would be useful to explore the nurses' experiences further using a larger sample size and including mental health nurses working in different CRHTTs worldwide. It would also be useful to compare the findings with other professionals' experiences involved in CRHTTs. There are aspects of the study that could be explored in more detail, for example, issues relevant to nurse therapeutic relationships in CRHTTs and care plans based on patients' environment.

5 | RELEVANCE STATEMENT

This study is important for the nursing profession's development, as it highlights what mental health nurses' value regarding home care for mental health patients. This study is also the first to evaluate the experiences of mental health nurses' who provide care with CRHTTs in Spain. More research is needed to replicate this study's findings, validate the findings using a different methodology and compare the findings with mental health nurses' experiences in CRHTTs in other countries. Research on nurses' experiences providing care on CRHTT units and mental health devices is required to guide nursing practices better.

ACKNOWLEDGMENTS

We acknowledge the support and assistance provided by Eva Gausachs, Rosa Sánchez, Cristina Torres, Irving Clarke, Alba González, Silvia Rodríguez, Iago Castro, Lidia Juan, Juan Cremades and Elisabeth, staff members of the CRHT team at CPB Serveis de Salut Mental—Hospital de la Santa Creu i Sant Pau, during the conducting of this research project.

CONFLICT OF INTEREST

Authors have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS

D. G. D, R. M. A, L. T. S and MD. B. T contributed to the design and implementation of the research, D. G. D performed data collection and the analysis of the results were made by D. G. D and N. G. Lastly, D. G. D, MD. B. T and N. G contributed to the writing of the manuscript.

ETHICAL STATEMENTS

Institutional ethical approval was obtained for this study, which was conducted in accordance with the code of ethics of the World Medical Association (Declaration of Helsinki).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

David Giménez-Díez https://orcid.org/0000-0002-6677-3300
Nina Granel https://orcid.org/0000-0001-7404-0564
Maria Dolors Bernabeu-Tamayo https://orcid.org/0000-0001-5914-3776

REFERENCES

Barker, P., & Buchanan-Barker, P. (2011). Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing*, *20*(5),337–344. https://doi.org/10.1111/j.1447-0349.2010.00734.x

Begum, R., & Riordan, S. (2016). Nurses experiences of working in Crisis Resolution Home Treatment Teams with its additional gatekeeping responsibilities. *Journal of Psychiatric and Mental Health Nursing*, *23*(1), 45–53. https://doi.org/10.1111/jpm.12276

Bolton, S. (2000). Who cares? Offering emotion work as a 'gift' in the nursing labour process. *Journal of Advanced Nursing*, *32*(3), 580–586. https://doi.org/10.1046/j.1365-2648.2000.01516.x

Burns-Lynch, B., Murphy, A. A., Gill, K. J., & Brice, G. Jr (2014). Persons in recovery, family members, and staff perspectives of psychiatric crisis needs. *American Journal of Psychiatric Rehabilitation*, *17*(2), 114–127. https://doi.org/10.1080/15487768.2014.903874

Carthon, J. M. B., Lasater, K. B., Sloane, D. M., & Kutney-Lee, A. (2015). The quality of hospital work environments and missed nursing care is linked to heart failure readmissions: A cross-sectional study of US hospitals. *BMJ Quality & Safety*, *24*(4), 255–263. https://doi.org/10.1136/bmjqs-2014-003346

Cleary, M., Raeburn, T., West, S., Escott, P., & Lopez, V. (2018). Two approaches, one goal: How mental health registered nurses perceive their role and the role of peer support workers in facilitating consumer decision-making. *International Journal of Mental Health Nursing*, *27*(4), 1212–1218. https://doi.org/10.1111/inm.12473

Giménez-Díez, D., Maldonado Alía, R., Rodríguez Jiménez, S., Granel, N., Torrent Solà, L., & Bernabeu-Tamayo, M. D. (2019). Treating mental health crises at home: Patient satisfaction with home nursing care. *Journal of Psychiatric and Mental Health Nursing*, *27*(3), 246–257. https://doi.org/10.1111/jpm.12573

Glover, H. (2012). Recovery, lifelong learning, social inclusion and empowerment: Is a new paradigm emerging? In P. Ryan, S. Ramon, & T. Greacen (Eds.), *Empowerment, Lifelong Learning and Recovery in Mental Health: Towards a New Paradigm* (pp. 15–35). Palgrave Publishers.

Hall, W., Williams, L., Smith, N., Gold, M., Coast, J., Kapiriri, L., Danis, M., & Mitton, C. (2018). Past, present and future challenges in health care priority setting: Findings from an international expert survey. *Journal of Health Organization and Management*, *32*(3), 444–462. https://doi.org/10.1108/JHOM-01-2018-0005

Harris, B., & Panozzo, G. (2019). Barriers to recovery-focused care within therapeutic relationships in nursing: Attitudes and perceptions. *International Journal of Mental Health Nursing*, *28*(5), 1220–1227. https://doi.org/10.1111/inm.12611

Harvey, C. L., Baret, C., Rochefort, C. M., Meyer, A., Ausserhofer, D., Ciutene, R., & Schubert, M. (2018). Discursive practice – lean thinking, nurses' responsibilities and the cost to care. *Journal of Health Organization and Management*, *10*, 762–778.

Henderson, C., Noblett, J. O., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B., & Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *The Lancet Psychiatry*, *1*(6), 467–482. https://doi.org/10.1016/S2215-0366(14)00023-6

Hibbard, J. H., Collins, P. A., Mahoney, E., & Baker, L. H. (2010). The development and testing of a measure assessing clinician beliefs about patient self-management. *Health Expectations*, *13*(1), 65–72. https://doi.org/10.1111/j.1369-7625.2009.00571.x

Jørgensen, K., & Rendtorff, J. D. (2018). Patient participation in mental health care - perspectives of healthcare professionals: An integrative review. *Scandinavian Journal of Caring Sciences*, *32*(2), 490–501. https://doi.org/10.1111/scs.12531

Jussim, L. (2017). Précis of Social Perception and Social Reality: Why accuracy dominates bias and self-fulfilling prophecy. *The Behavioral and Brain Sciencies*, *40*, e1. https://doi.org/10.1017/S0140525X1500062X

Keogh, B., Callaghan, P., & Higgins, A. (2015). Managing preconceived expectations: Mental health service users experiences of going home from hospital: A grounded theory study. *Journal of Psychiatric and Mental Health Nursing*, *22*(9), 715–723. https://doi.org/10.1111/jpm.12265

Kieft, R. A., de Brouwer, B. B., Francke, A. L., & Delnoij, D. M. (2014). How nurses and their work environment affect patient experiences of the quality of care: A qualitative study. *BMC Health Services Research*, *14*(1), 249. https://doi.org/10.1186/1472-6963-14-249

Klevan, T., Karlsson, B., Ness, O., Grant, A., & Ruud, T. (2018). Between a rock and a softer place—A discourse analysis of helping cultures in crisis resolution teams. *Qualitative Social Work*, *17*(2), 252–267. https://doi.org/10.1177/1473325016668896

Lauckner, H., Paterson, M., & Krupa, T. (2012). Using constructivist case study methodology to understand community development processes: Proposed methodological questions to guide the research process. *Qualitative Report*, *17*, 25.

Liggins, J., & Hatcher, S. (2005). Stigma toward the mentally ill in the general hospital: A qualitative study. *General Hospital Psychiatry*, *27*(5), 359–364. https://doi.org/10.1016/j.genhosppsych.2005.05.006

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Sage Publications.

Lloyd-Evans, B., Paterson, B., Onyett, S., Brown, E., Istead, H., Gray, R., Henderson, C., & Johnson, S. (2018). National implementation of a mental health service model: A survey of crisis resolution teams in England. *International Journal of Mental Health Nursing*, *27*(1), 214–226. https://doi.org/10.1111/inm.12311

Meehan, T., King,R., Beavis, P., & Robinson, J. (2008). Recovery-based practice: Do we know what we mean or mean what we know? *Australian and New Zealand Journal of Psychiatry*, *42*,177–182. https://doi.org/10.1080/00048670701827234

Mjøsund, N. H., Eriksson, M., Espnes, G. A., Haaland-Øverby, M., Jensen, S. L., Norheim, I., & Vinje, H. F. (2017). Service user involvement enhanced the research quality in a study using interpretative phenomenological analysis–the power of multiple perspectives. *Journal of Advanced Nursing*, *73*(1), 265–278. https://doi.org/10.1080/00048670701827234

Ness, O., Karlsson,B., Borg, M., Biong, S., & Hesook, S. K. (2012). A crisis resolution and home treatment team in Norway: A longitudinal survey study Part 1. Patient characteristics at admission and referral. *International Journal of Mental Health Systems*, *6*(1), 18. https://doi.org/10.1186/1752-4458-6-18

Olatubi, M. I., Oyediran, O. O., Faremi, F. A., & Salau, O. R. (2019). Knowledge, Perception, and Utilization of Standardized Nursing Language (SNL) (NNN) among Nurses in Three Selected Hospitals in Ondo State, Nigeria. *International Journal of Nursing Knowledge*, *30*(1), 43–48. https://doi.org/10.1111/2047-3095.12197

Rudge, T. (2013). Desiring productivity: Nary a wasted moment, never a missed step. *Nursing Philosophy*, *14*(3), 201–211. https://doi.org/10.1111/nup.12019

Santamaria-Olmo, R. (2017). Programa de Habilidades en Lectura Crítica Español (CASPe). *Nefroplus*, *9*(1), 100-101.

Stake, R. E. (2005). Qualitative cas estudies. In N. Denzin, & Y. Lincoln (Eds) *The Sage handbook of qualitative research* (3rd ed., pp. 443–446). Sage.

Tanaka, K. (2019). Experiences of community mental health nurses in Japan as the basis of their nursing philosophies. *Perspectives in Psychiatric Care*, *55*(4), 636–643. https://doi.org/10.1111/ppc.12386

Verhaeghe, M., Bracke, P., & Bruynooghe, K. (2007). Stigmatization in different mental health services: A comparison of psychiatric and general hospitals. *The Journal of Behavioral Health Services & Research*, *34*(2), 186–197. https://doi.org/10.1007/s11414-007-9056-4

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

Winter, D. A., & Feixas, G. (2019). Toward a constructivist model of radicalization and deradicalization: A conceptual and methodological proposal. *Frontiers in Psychology*, *10*, 412. https://doi.org/10.3389/fpsyg.2019.00412

Wyder, M., Ehrlich, C., Crompton, D., McArthur, L., Delaforce, C., Dziopa, F., Ramon, S., & Powell, E. (2017). Nurses experiences of delivering care in acute inpatient mental health settings: A narrative synthesis of the literature. *International Journal of Mental Health Nursing*, *26*(6), 527–540. https://doi.org/10.1111/inm.12315

Xie, N., Kalia, K., Strudwick, G., & Lau, F. (2019). Understanding mental health nurses' perceptions of barcode medication administration: a qualitative descriptive study. *Issues in Mental Health Nursing*, *40*(4), 326–334. https://doi.org/10.1080/01612840.2018.1528321

Yamamoto-Mitani, N., Saito, Y., Takaoka, M., Takai, Y., & Igarashi, A. (2018). Nurses' and care workers' perception of care quality in Japanese long-term care wards: A qualitative descriptive study. *Global Qualitative Nursing Research*, *5*, 2333393618812189. https://doi.org/10.1177/2333393618812189

Yin, R. (2014). *Case study research : Design and methods* (5th ed.). Sage.

Yous, M. L., Ploeg, J., Kaasalainen, S., & Martin, L. S. (2019). Nurses' Experiences in Caring for Older Adults with Responsive Behaviors of Dementia in Acute Care. *SAGE Open Nursing*, *5*, 2377960819834127. https://doi.org/10.1177/2377960819834127

How to cite this article: Giménez Díez D, Maldonado Alía R, Torrent Solà L, Granel N, Bernabeu-Tamayo MD. Nurses' experiences of care at crisis resolution home treatment teams: A case study research. *J Psychiatr Ment Health Nurs*. 2021;00:1–9. https://doi.org/10.1111/jpm.12738