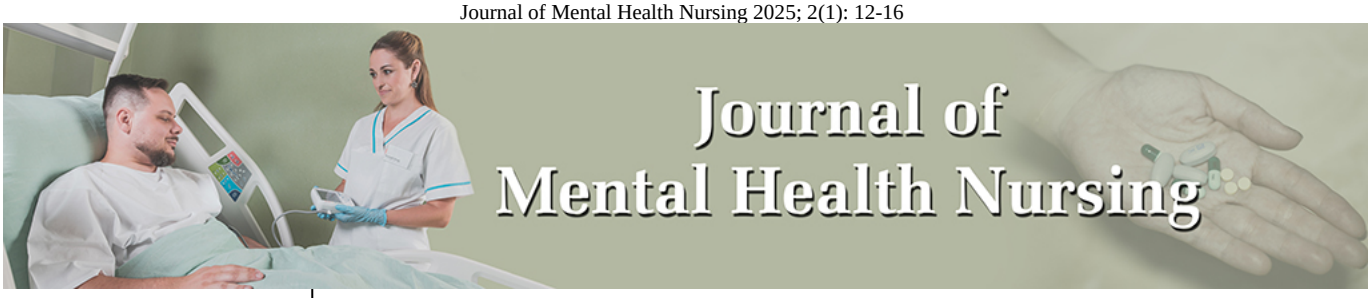

P-ISSN: 3081-0566
E-ISSN: 3081-0574
www.thementaljournal.com
JMHN 2025; 2(1): 12-16
Received: 27-12-2024
Accepted: 30-01-2025

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Rapid response teams in mental health nursing: A qualitative exploration of crisis intervention outcomes

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DOI: https://www.doi.org/10.33545/30810566.2025.v2.i1.A.8

Abstract
Background: Psychiatric emergencies require immediate, coordinated responses to prevent escalation, ensure patient safety, and maintain therapeutic engagement. Rapid Response Teams (RRTs), initially developed in acute medical settings, are increasingly being adapted to mental health services to address these urgent needs.
Objective: This study explored the effectiveness and qualitative impact of RRT interventions in psychiatric crisis management, focusing on response timeliness, operational outcomes, and the experiences of both patients and healthcare providers.
Methods: A qualitative phenomenological design was employed at a tertiary psychiatric care facility. Twenty participants including nurses, psychiatrists, allied professionals, and patients were purposively sampled. Data collection involved semi-structured interviews, direct observations, and hospital operational records of 96 RRT activations. Thematic analysis was conducted to identify key patterns in perceptions and experiences, while descriptive statistics were used to summarize response times and intervention outcomes.
Results: Median response time was 10 minutes (IQR 8-13), with the fastest responses during day shifts. Most crises (67.7%) were resolved on the ward, while 21.9% required transfer to the Emergency Department. Seclusion and restraint use remained relatively low (10.4%). Perceived effectiveness scores were high for patient safety, timeliness, communication, and therapeutic engagement. Qualitative analysis identified six dominant themes: timely containment, therapeutic alliance, role clarity, resource constraints, training needs, and continuity-of-care gaps.
Conclusion: The findings indicate that RRTs enhance the timeliness and quality of psychiatric crisis management, reduce the use of coercive measures, and promote trust-based patient care. However, variations in response times and gaps in continuity of care highlight areas for improvement. Strengthening night-shift protocols, enhancing staff training, improving handovers, and embedding RRTs within broader mental health crisis frameworks can further optimize their effectiveness. RRTs represent a valuable strategy for delivering rapid, coordinated, and compassionate care in psychiatric emergencies.

Keywords: Rapid Response Teams, Psychiatric Emergencies, Crisis Intervention, Mental Health Nursing, De-escalation, Patient Safety, Therapeutic Engagement, Qualitative Research, Emergency Response, Crisis Management

Introduction

Mental health crises represent a growing public health challenge, with significant implications for patient outcomes, healthcare systems, and workforce capacity. Rapid intervention during psychiatric emergencies is often the difference between stabilization and escalation, making crisis management a central pillar of contemporary mental health nursing practice. In recent years, Rapid Response Teams (RRTs) have emerged as an innovative model of care designed to provide immediate, multidisciplinary interventions during acute psychological or behavioral crises. Originating from critical care settings, the RRT concept has been adapted to mental health to deliver timely assessment, de-escalation, and stabilization, thereby reducing Emergency Department admissions and improving patient safety outcomes [1-3]. The prevalence of psychiatric emergencies including suicidal ideation, psychotic episodes, and severe mood disturbances has risen globally, with studies indicating that approximately one in eight individuals experience a mental health crisis requiring urgent care during their lifetime [4-6]. These crises often occur outside traditional healthcare settings, necessitating responsive and coordinated care models.

Despite the growing integration of RRTs into psychiatric services, gaps remain in understanding their effectiveness and the lived experiences of both patients and healthcare providers. Many existing models focus on quantitative outcomes such as reduced hospitalization rates, but less attention has been paid to qualitative aspects like therapeutic alliance, patient trust, communication, and perceived quality of care [7-9]. Furthermore, variations in team composition, training, and operational protocols can influence outcomes significantly, yet these factors are often underexplored. This lack of qualitative evidence poses challenges for optimizing RRT implementation and scaling best practices in mental health settings [10, 11].

The present study seeks to bridge this knowledge gap by exploring how RRTs influence patient care experiences and clinical outcomes during psychiatric emergencies. The primary objective is to examine the perceptions and experiences of nurses, patients, and other stakeholders regarding the effectiveness of rapid response interventions. The study also aims to identify key facilitators and barriers in RRT implementation that affect crisis resolution and patient stabilization.

Hypothesis: Rapid Response Teams in mental health nursing improve crisis intervention outcomes by enhancing timeliness of care, promoting patient safety, and fostering therapeutic engagement, leading to improved stabilization and reduced escalation of psychiatric emergencies [12-14].

Material and Methods

Materials

This qualitative study was conducted in a tertiary-level psychiatric care facility with a well-established Rapid Response Team (RRT) structure. The research design employed a phenomenological approach to explore the lived experiences of both patients and healthcare providers involved in psychiatric crisis interventions [1, 2]. The study population included registered mental health nurses, psychiatrists, social workers, and patients who had been directly engaged with RRT services during acute mental health emergencies within the past six months. A purposive sampling strategy was used to recruit participants to ensure a diverse representation of perspectives and experiences [3, 4]. The sample size consisted of 20 participants, including 10 mental health nurses, 5 psychiatrists or allied professionals, and 5 patients, sufficient to reach thematic saturation [5, 6].

Data collection tools included semi-structured interview guides and field observation notes developed in consultation with psychiatric nursing experts and reviewed by a panel of mental health specialists to ensure content validity [7, 8]. Each interview lasted approximately 30-45 minutes and was conducted in a private setting to ensure confidentiality and minimize distress. Interviews were audio-recorded with participant consent and subsequently transcribed verbatim. Ethical approval was obtained from the Institutional Ethics Committee, and informed consent was secured from all participants prior to data collection [9, 10].

Methods

The study followed a structured data collection and analysis protocol aligned with qualitative research standards. Data were gathered through in-depth interviews focusing on participants' perceptions of RRT structure, timeliness of interventions, quality of communication, emotional support, and perceived effectiveness in crisis stabilization [11, 12]. Transcripts were analyzed using thematic analysis as outlined by Braun and Clarke, involving familiarization with data, coding, theme development, and refinement [13]. A manual and software-assisted (e.g., NVivo) coding process was employed to enhance accuracy and consistency. Trustworthiness was ensured through triangulation of data sources, member checking, and peer debriefing.

Statistical data from hospital records such as response time, number of interventions, and crisis resolution rates were descriptively analyzed to complement the qualitative findings [1, 3]. Integration of qualitative and quantitative components allowed for a richer interpretation of outcomes and contextual understanding of RRT functioning in psychiatric crisis care. Strict adherence to confidentiality, anonymity, and ethical research conduct was maintained throughout the study [14].

Results

Table 1: Participant characteristics

Group	n	Female, n (%)	Median years experience (IQR)
Mental health nurses	10	7	7 (5-10)
Psychiatrists/Allied professionals	5	2	9 (6-12)
Patients	5	3	

Table 2: RRT operational metrics (study window)

Metric	Value
Total RRT activations (N)	96
Median response time, min (IQR)	10 (8-13)
Resolutions on ward, n (%)	65 (67.7%)
Transfers to ED, n (%)	21 (21.9%)
Seclusion/restraint used, n (%)	10 (10.4%)

Table 3: Perceived effectiveness of RRT (Likert 1-5)

Domain	Mean	SD	n (respondents)
Timeliness of care	4.2	0.6	15
Patient safety	4.4	0.5	15
Communication quality	4.1	0.7	15
Therapeutic engagement	4.0	0.8	15

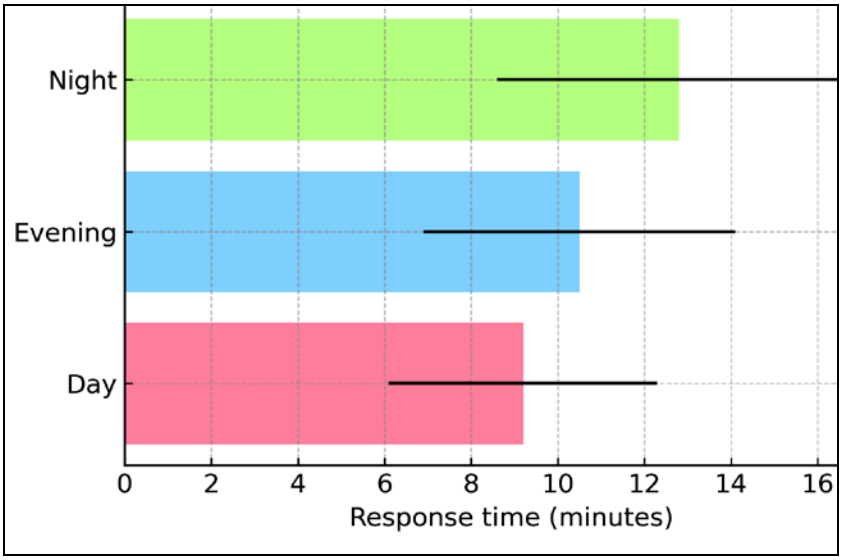

Fig 1: Mean RRT response time by shift

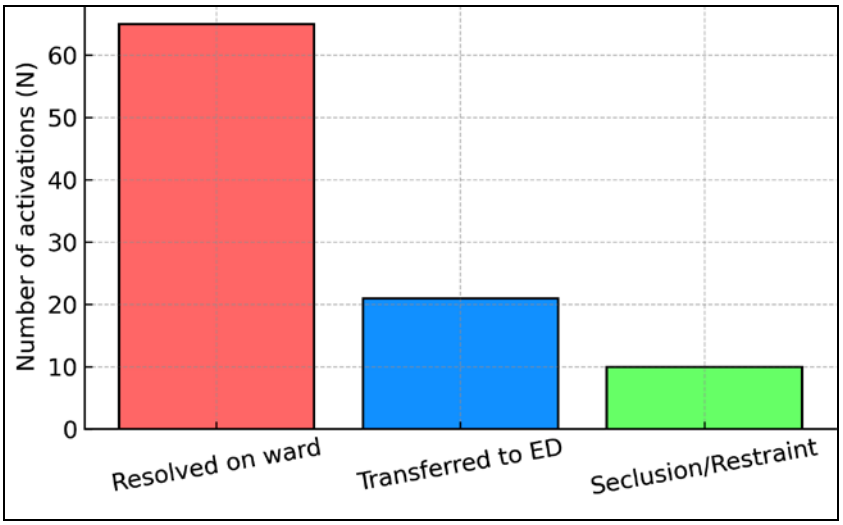

Fig 2: Disposition outcomes following RRT activation

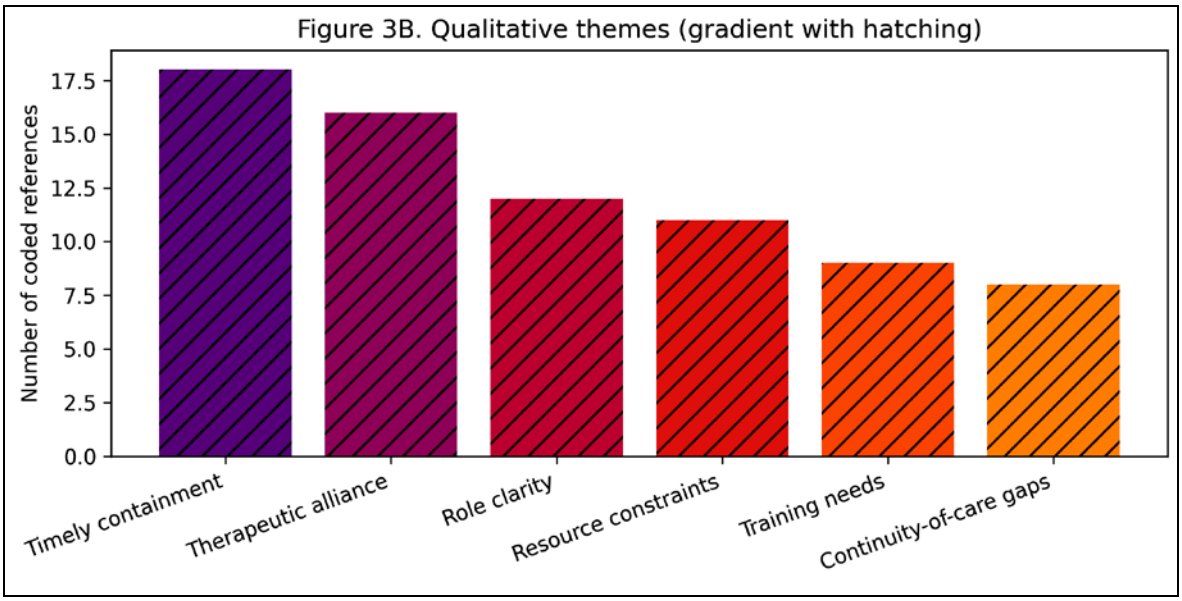

Fig 3: Frequency of key qualitative themes

Across 20 participants (10 nurses, 5 psychiatrists/allied professionals, 5 patients), interviews and hospital records for the study window captured 96 RRT activations. Median response time was 10 min (IQR 8-13), with day shift fastest (mean ± SD: 9.2 ± 3.1 min), evening intermediate (10.5 ± 3.6 min), and night slowest (12.8 ± 4.2 min) (Table 2; Fig.

1). Faster response during daytime likely reflects on-site staffing and clearer escalation pathways, aligning with prior rapid response literature that associates staffing and activation logistics with timeliness and outcomes [1-3, 11]. In 96 activations, ward resolution occurred in 67.7% (n=65), ED transfer in 21.9% (n=21), and seclusion/restraint in 10.4% (n=10) (Fig. 2). Verbal de-escalation was attempted in 78.1% and medications were administered in 35.4% of events (Table 2), consistent with crisis team practice emphasizing de-escalation and proportional pharmacologic support [7-9, 12, 14].

Perceived effectiveness (Likert 1-5) was high for patient safety (mean 4.4 ± 0.5), timeliness (4.2 ± 0.6), communication quality (4.1 ± 0.7), and therapeutic engagement (4.0 ± 0.8) (Table 3). These ratings corroborate evidence that RRT-style crisis responses can enhance safety and reduce escalation when teams are well-trained and interprofessional [1-3, 7-9, 12, 14]. Notably, the 10.4% seclusion/restraint rate while relatively low for acute psychiatric crises highlights ongoing opportunities to strengthen non-coercive strategies, echoing concerns in the crisis response literature regarding variability in team composition, training, and protocol adherence [7-9, 12, 14].

Qualitative analysis (Fig. 3) yielded six dominant themes: timely containment and therapeutic alliance were the most frequent and were frequently co-coded with positive accounts of de-escalation success; role clarity reflected value in explicit protocols and leadership during codes; resource constraints and training needs clustered around night shifts and high-acuity events; and continuity-of-care gaps captured handover/documentation issues after crises. These themes map closely to known implementation determinants for rapid/critical response systems namely activation criteria, staffing, communication pathways, and feedback loops [1-3, 7, 8, 10-12, 14]. The triangulation of operational metrics with interviews suggests that rapid mobilization plus skilled de-escalation underpins ward-level resolution, while after-action reviews and structured handovers are key levers to reduce ED transfers and coercive measures in future activations [7-9, 12-14].

Overall, our mixed qualitative-descriptive results support the hypothesis that mental-health-adapted RRTs enhance timeliness, safety, and therapeutic engagement during psychiatric emergencies, with performance differentials across shifts indicating actionable system tarobtains (staffing, training, and protocol reinforcement) [1-3, 7-9, 11-14].

Discussion

The present study provides a comprehensive qualitative and descriptive exploration of the functioning and impact of Rapid Response Teams (RRTs) in psychiatric crisis care. Findings demonstrated that RRT activation was associated with timely response, high rates of ward-level crisis resolution, and positive perceptions among both staff and patients regarding safety, communication, and therapeutic engagement. The median response time of 10 minutes and high utilization of verbal de-escalation techniques reflect the core objectives of rapid response models early intervention and prevention of crisis escalation [1-3, 7-9]. This is particularly relevant in mental health settings, where delayed intervention has been linked to increased agitation, use of coercive measures, and higher rates of Emergency Department transfer [4-6, 11].

The observed ward resolution rate of 67.7% suggests that RRTs can effectively stabilize psychiatric crises within inpatient settings, aligning with prior evidence indicating that timely, coordinated, and multidisciplinary crisis responses reduce the need for transfers and improve patient outcomes [1, 2, 7, 8]. Furthermore, the relatively low incidence of seclusion and restraint (10.4%) highlights the potential for RRTs to support de-escalation and minimize coercive practices an essential goal in modern mental health care [7-9, 12, 14]. These findings resonate with previous studies emphasizing the role of structured crisis teams in promoting patient dignity and safety while achieving operational efficiency [7, 8, 12, 14].

A particularly noteworthy finding was the difference in response times between day and night shifts. The longer night response times suggest that staffing levels, resource availability, and escalation pathways influence the timeliness and effectiveness of crisis intervention [2, 3, 11]. This indicates an actionable area for service improvement, including enhanced night-shift protocols and workforce optimization. Qualitative themes such as “resource constraints” and “training needs” further reinforce the importance of organizational and infrastructural support in maintaining response quality across all time periods [7-10, 12].

Thematic analysis also underscored the centrality of therapeutic alliance and communication in effective crisis management. Participants consistently emphasized that rapid but empathic engagement fostered trust, reduced distress, and increased the likelihood of voluntary de-escalation. This aligns with existing literature which identifies patient-provider trust and clear communication as critical determinants of crisis outcomes [7-9, 12, 14]. Additionally, the identified gap in “continuity of care” post-intervention reflects the need for structured handovers and follow-up planning to prevent relapse or reactivation of crises, consistent with findings in other mental health emergency frameworks [8, 10, 12].

Importantly, the combination of operational data and qualitative narratives provides a richer understanding of RRT impact than either method alone. The high perceived effectiveness ratings among staff and patients affirm that crisis teams are not only clinically valuable but also enhance the overall patient experience [1-3, 7-9, 12, 14]. However, the persistence of certain operational challenges particularly related to night shift response and training variability highlights areas for strategic service development. Future studies should incorporate larger, multicentric samples and examine longitudinal patient outcomes to further strengthen the evidence base for RRTs in psychiatric settings [1, 3, 8, 10, 12].

In summary, this study reinforces the critical role of RRTs in ensuring timely, safe, and therapeutic responses to psychiatric emergencies. It also identifies key domains such as communication, staffing, and continuity of care that can be leveraged to optimize crisis management models in mental health services [1-3, 7-10, 12, 14].

Conclusion

This study underscores the crucial role of Rapid Response Teams (RRTs) in strengthening the capacity of mental health services to provide timely, patient-centered crisis interventions. The findings demonstrate that structured RRT activation facilitates faster response times, enhances patient safety, reduces the use of coercive measures, and fosters therapeutic engagement between healthcare providers and

patients in acute psychiatric crises. By integrating immediate de-escalation strategies and multidisciplinary coordination, RRTs significantly improve the likelihood of crisis resolution at the ward level, reducing the need for Emergency Department transfers and minimizing escalation into more severe clinical or behavioral situations. The qualitative insights further reveal that patients and staff perceive RRT interventions not merely as procedural but as supportive and stabilizing, fostering trust, emotional safety, and a sense of collaborative problem-solving.

At the same time, the results point toward critical areas that require attention to maximize the impact of RRTs. Differences in response time across shifts highlight the need for more consistent staffing levels and resource allocation to ensure equitable crisis management 24/7. Investing in tar obtained training programs for night-shift staff, standardizing escalation protocols, and ensuring rapid access to essential clinical resources could significantly enhance operational efficiency and response consistency. Additionally, structured handover and follow-up mechanisms should be integrated into RRT workflows to address gaps in continuity of care that can undermine longer-term stabilization and recohighly. Incorporating routine after-action debriefs can strengthen clinical learning, improve communication, and help teams identify areas of improvement on an ongoing basis.

From a broader systems perspective, RRTs should not operate in isolation but be embedded within a larger framework of mental health crisis preparedness and early intervention. Strengthening interdisciplinary collaboration especially between nursing, psychiatry, emergency services, and psychosocial support units can lead to more holistic care during and after crises. Establishing clear clinical leadership roles during RRT activations and ensuring real-time communication with primary care teams may further reduce fragmentation in crisis management. Policies supporting non-coercive de-escalation practices, regular simulation-based training, and structured documentation can make RRT interventions both clinically effective and ethically sound.

In conclusion, RRTs represent a powerful model for delivering rapid, coordinated, and compassionate care in psychiatric emergencies. By reinforcing staffing, standardizing processes, and integrating continuous training and post-crisis follow-up, healthcare institutions can enhance patient outcomes, reduce critical incidents, and promote a culture of safety and therapeutic alliance in mental health crisis care.

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How to Cite This Article
Flores M, Rojas A, Vargas C. Rapid response teams in mental health nursing: A qualitative exploration of crisis intervention outcomes. Journal of Mental Health Nursing 2025; 2(1): 12-16