Developing psychologically informed care in Crisis Resolution and Home Treatment Teams: a model and toolkit

The Psychological Professions Network

A collaboration of regional networks sponsored by NHS England to give voice to all psychological professions in workforce planning and to promote excellence in practice

About the Psychological Professions Network South East (PPN-SE)

The PPN-SE is a regional membership network for all qualified, trainee and aspiring psychological professionals, experts by experience and other interested parties contributing to NHS commissioned psychological healthcare across the South East of England.

We are commissioned by NHS England in the South East of England to provide a joined-up voice for the psychological professions in workforce planning and development, and to support excellence in practice. We are one of seven regional PPNs who come together to form the national Psychological Professions Network.

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Acknowledgements

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Executive Summary

Mental health services are rapidly changing and adapting to growing need and service user feedback. Crisis care holds a particularly pivotal position within this challenged system, by supporting the interface between community and inpatient care. Most people accessing crisis services are in acute distress and have often experienced previous trauma. Feedback from service users in research and routine evaluation gives a consistent message that person centred care based on humanity and compassion is a high priority.

Psychologically informed care is an approach to delivering services that considers individuals' emotional and psychological needs, with particular emphasis on the impact of trauma. Psychologically informed care is of relevance to all parts of our system and has encouraging outcomes across a range of health care settings (Dekka et al 2023). There is a clear link between relational ways of working which champion collaboration and shared decision making with positive outcomes for service users, staff and organisations. Multi-disciplinary staff teams (MDTs) trained in psychologically informed ways of working along with embedded psychological professionals are key to progressive mental health care.

This paper proposes a model of psychologically informed care that is particularly applicable to crisis resolution home treatment teams (CRHTTs) and includes tips and best practice examples to demonstrate the application of evidence-based recommendations. Whilst this model and toolkit is generalisable to other mental and physical health care teams, it is important to note that this paper is focused on Adult CRHTTs. Further exploration would be beneficial in specialist crisis teams such as those in children's or intellectual disability services. We envisage that the paper can be utilised as a tool kit for teams to develop this way of working through bringing together national recommendations for acute mental health care, sharing of best practice examples from the South East, and outlining a model to strategically develop services.

Recommendations

In this report we have recommended a model of seven key factors to enhance psychologically informed work in crisis teams. These can be considered individually or in relation to each other. It is recommended that each of the seven mental health trusts in the South East of England identify a small multidisciplinary task and finish group to consider the implementation of this psychologically informed model into local CRHTTs. The newly formed South East crisis community of practice will continue to support development around these proposals. The below points summarise the key recommendations as outlined by the model:

Adequate skill mix
- Organisations should audit their workforce to ensure their multidisciplinary skill mix allows them to deliver good quality biopsychosocial care as set out in this document and in other guidance.

Embedded psychological workforce

- CRHTTs are expected to offer brief evidence-based psychological interventions and require the appropriate workforce to do so. A 'core' workforce of psychological professionals within crisis services is key to building capacity and expertise to deliver direct and indirect psychological interventions.

Team and skills training

- CRHTT staff should be supported to access psychologically informed team and individual training; with particular focus on the areas of care culture, risk management and skills-based interventions.

Direct psychological intervention

- CRHTTs should be able to deliver a three stepped model of psychological input, which involves 1) all staff receiving broad psychologically informed training, 2) direct delivery of psychosocial interventions by trained MDT clinicians and 3) direct evidence-based intervention by psychological professionals.

Keeping people safe

- Organisations should ensure that there is regular risk management training available for staff that supports a safety promotion culture and is underpinned by trauma informed care (TiC). In addition to mandatory training, trusts should consider in depth or bespoke training for CRHTTs on working intensively with risk of suicidality and self-harm.

Reflective spaces

- CRHTT staff should be able to access regular supervisory and reflective spaces to consider the impact of the work on them and their wider team. This in turn supports quality of care for service users experiencing mental health crises.

Service user feedback loops

- CRHTT senior leadership teams should support the regular use of patient-reported outcome and experience measures. The lived experience voice of those accessing crisis services should be heard, understood, and used as a basis for service improvement.

1. What we know about CRHTTs

1.1 The national context of mental health crisis teams

> "Crisis resolution and home treatment teams (CRHTTs) are the interface between acute and community mental health services. Focused on patients' recovery and empowerment, they are an alternative to hospital admission, providing treatment in a less restrictive environment"
> (Lombardo et al., 2019)

CRHTTs were established in 2000 to provide a least restrictive alternative to hospital admission, offering a biopsychosocial model of care delivered at home by multi-disciplinary teams. Central tasks of CRHTTs include rapid assessment; care and crisis planning; monitoring of medication; practical help; carer support; and relapse prevention (Appleby et al., 2000). This occurs most commonly over a period of 2-8 weeks and often includes daily visits, therefore allowing more intensive delivery of care than that of a community mental health team. There is particular emphasis on the management of risk and on the delivery of brief interventions. Teams nationally have been established differently based on regional commissioning and service models. Service user feedback and research has identified that crisis care nationally is extremely varied in practice, both in terms of delivery and multi-disciplinary skill mix (QN-CRHTT, 2022). The CORE study (Lloyd-Evans 2019) aimed to improve the consistency of care and standards offered by CRHTTs nationally via development of a fidelity tool that describes and measured best practice. This was augmented in 2022 by best practice guidance for CRHTTs (QN-CRHTT, 2022).

1.2 What defines psychologically informed care?

Historically, the medical model has been the predominant framework to understand mental ill-health, with a subsequent reliance on medical management of symptoms. Growth in understanding the role of life experiences and trauma in the development of mental health problems has led to a significant shift in approach. This biopsychosocial approach is reflected across clinical guidance such as the National Institute for Clinical Excellence (NICE) guidelines, which recommend psychological interventions as core treatments alongside medication.

A psychologically informed approach designs services in a way that considers individuals' history and holds in mind their emotional experience. This in turn can increase empathy, hope, and focus on recovery. Psychologically informed care in teams uses this understanding to communicate in a compassionate way and ensure collaborative person-

centred decision making. Integral to this is the opportunity for inclusion of family, friends and/or carers (when agreeable to the service user). This approach is emphasised in policy and best practice guidance within acute care (NHS England, 2023a).

One of the most well-known examples of a psychologically informed approach is the concept of trauma informed care (TiC). TiC is an approach which recognises that many people accessing secondary mental health services will have experienced multiple traumas in their lives. Trauma is experienced more frequently by people from vulnerable populations or those affected by inequality, including people using acute mental health services (Messina et al., 2014). Therefore, trauma informed care principles are of particular relevance for staff working in acute mental health teams such as CRHTTs. TiC is grounded in a body of evidence on how trauma exposure affects peoples neurological, biological, psychological and social development. The aim is that awareness of the impact of trauma can lead services to improve care for individuals and avoid inadvertently retraumatising people or contributing to iatrogenic harm. The approach has six guiding principles: safety; trustworthiness; choice; collaboration, empowerment and cultural consideration (Office for Health Improvement and Disparities, 2022).

1.3 What do service users tell us they want from CRHTTs?

> **"Much of what we learnt was about how people were being treated - with respect and kindness, or without - and the difference this made"**
> (MIND, 2012)

1.3.1 Key themes of previous research

There is a strong overall theme from service users of a preference for crisis teams when compared to inpatient care (MIND, 2012). This reflects evidence that a greater emphasis on recovery and hope is more easily achieved at home, with the added support of family and friends and the maintenance of existing routines. In contrast, inpatient admissions can include being moved a long way from home, involve the added complexities of being surrounded by others in significant distress, and potentially invites a dynamic which places the expertise of recovery in professional hands. Service user feedback has highlighted the role of professional power structures in exacerbating this dynamic in inpatient settings. In 2023 NHS England produced a "vision" of inpatient care (NHS England, 2023a), and the principles that should underpin this, as well as further guidance in 2024 on the culture of

inpatient mental health care ([NHS England, 2024](#)). There is continued emphasis on the benefits of out of hospital care and facilitating purposeful discharges to crisis or community teams to support collaborative recovery.

The request to be treated with "humanity" is repeated in multiple service user feedback documents pertaining to mental health crisis work. This relates to being listened to, heard, respected, understood and treated as an individual (MIND, 2012). Conversely, people have fed back that when they have not been treated with compassion and humanity this has further exacerbated their mental health crisis. Indeed, the Care Quality Commission (CQC) "right here right now" (2015) report outlined that whilst studies have highlighted compassion as a key feature of what CRHTT service users' value in their crisis care (Farrelly et al., 2014), only 46% of people receiving care from CRHTTs felt that staff had treated them with compassion.

Service user preference is for a biopsychosocial approach including access to psychological therapies, with a three-fold preference for psychological therapies over other forms of help and treatment (McHugh et al., 2013). Perkins et al., (2023) gives a helpful summary of what service users receiving acute care value most; kindness, holding hope, valuing difference, including important others, being non-judgemental, remaining person centred and being strengths focussed.

Feedback also includes requests for family and friends to be included in a meaningful way. The triangle of care sets out six key elements to this which include having dedicated posts focused on carer inclusion and clear guidelines around confidentiality (Hannan, 2013). People who use crisis teams ask for fewer assessments and find seeing different people on visits understandably challenging. Collaborative care and shared decision making is key, with people wanting to feel at the centre of their care, and to have control over decisions being made about them.

An overall culture that takes account of service user feedback includes paying attention to the way we use language, and the impact of this. Liberati et al (2023) describes how focusing heavily on "disorders" encourages an idea that there is something different, wrong, or even dangerous about the person. The result may be a distancing, fear, or othering. In contrast, a compassionate formulation of a person's difficulties enables staff and service users to make sense of certain behaviours and choices. Placing someone's distress in context can help staff to be compassionate about the roots of these behaviours, and thereby move closer to understanding the individual.

The centrality of the relationship between service user and staff member for recovery is echoed in many acute descriptions of 'failed systems or care'. Investigations into care which has become neglectful or abusive often highlight the breakdown of compassionate collaborative relationships. Where service users are not known and understood, and are instead objectified or distanced from, abuse of power can follow. Care described as good often features staff who are available physically and emotionally with power imbalances minimised or addressed thoughtfully.

In recent guidance papers this relational approach is often described as 'personalised care', with 'shared decision making', as in the 2023 NHS guidance for acute mental health (NHS 2023a). This was described as "the terms of engagement" in the seminal MIND paper 'Listening to experience. An independent enquiry into acute and crisis mental healthcare' (2012). From medication choices to choices around how family members might be involved in care, clinicians and service users should be "equal partners" in decision making.

Figure 1: Service user feedback themes from previous research

- Humanity, compassion, and kindness
- Safe care
- Biopsychosocial approach
- Being close to home
- Option to involve loved ones
- Respecting and valuing difference
- Collaborative care
- Seeing fewer people
- Not repeating assessments
- Choice and control
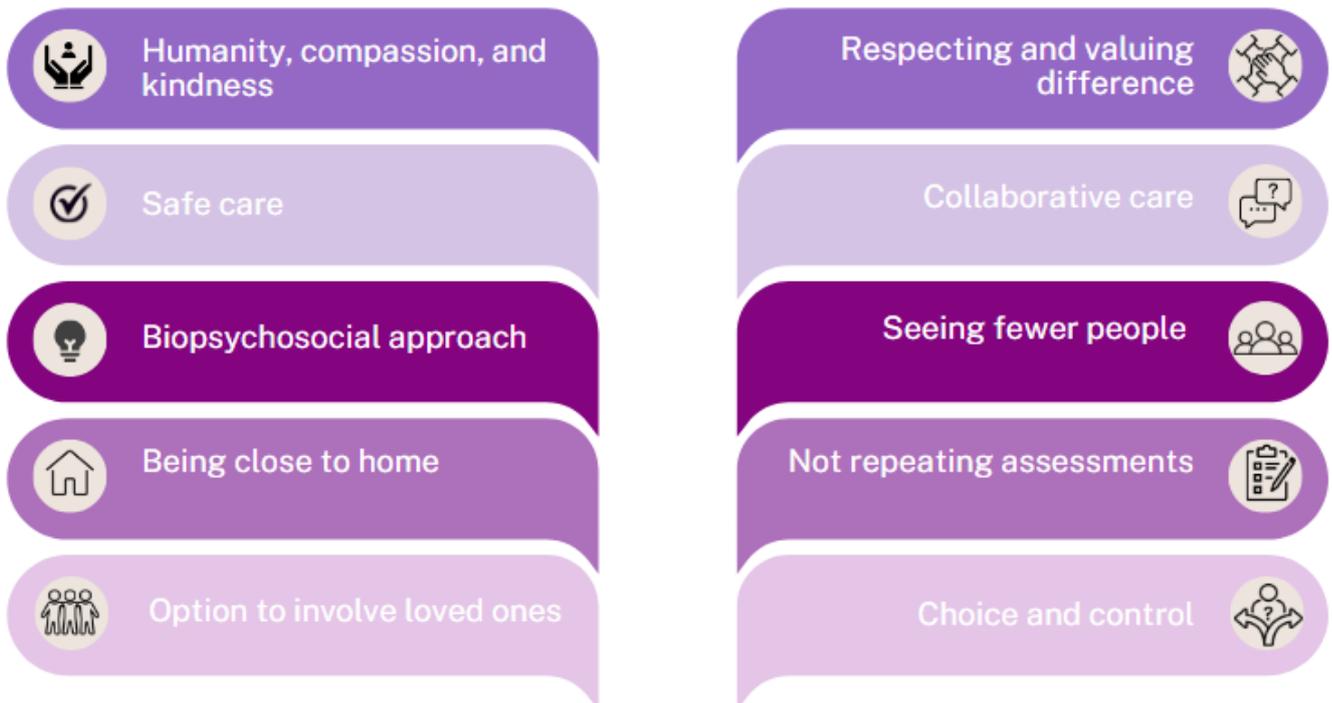
It is important to recognise that there are some challenges inherent to the CRHTT context which need to be acknowledged when considering how such needs are addressed. The logistical challenge of running a 24/7 intensive community service requires a large staff group and a rota system. The responsive nature of the service can lead to either a lack of flexibility or tendency for change within the schedule of shifts. There is a necessary tension between providing care within these constraints and providing continuity and consistency to individual service users. Some service users report benefit from receiving input from different professionals and value the ability of teams to be responsive and flexible. However, there is a risk that - without careful attention - this could lead to poor continuity of care, a lack of psychological safety and a sense of limited choice or control over appointments. It is important that practical challenges are not seen as natural or inevitable, but instead that services have mechanisms for balancing individual service user need and feedback with the practical challenges of operating a team of this type.

1.3.2 South East England CRHTT Service User Feedback

> *"More than anything - a culture of kindness and compassion - to have a sense that people care and have hope for you"*
> *(PPN-SE Crisis Lived Experience Survey, 2024)*

As part of this project, a survey was sent to people with lived experience of using crisis teams to ask if these themes in previous research were still as relevant to them. Respondents were asked to rate the importance of the themes identified in the previous research, then to add examples or feedback from their own experience of crisis care. We received a total of 54 responses; with 77% of respondents identifying as a 'service user', 19% identifying as a 'carer', 5% identifying as 'other'. There was representation of views from six of the seven South East trust regions.

What was clear from this survey is that the themes outlined from previous research hold true in the South East, particularly in terms of the expectation of receiving compassionate and accessible care from knowledgeable staff. It was also evident that experiences of crisis care in the South East can vary significantly and can be hugely dependent on the relational experience between the service user and the team. Key responses from our survey are summarised below. In the context of crisis care, the ask was to be:

- Treated with care and compassion
- Given enough time to talk and to be truly listened to
- Given choice and be involved in decision making
- To be understood, particularly in relation to past trauma
- To be provided with information and some predictability
- To be approached with honesty and transparency about service limitations
- To be offered therapeutic input that is evidence based, responsive and active (not just monitoring)
- To be provided with continuity of care (not have to keep repeating the same story)
- To be provided with consistent care (not dependent on which clinician visits)
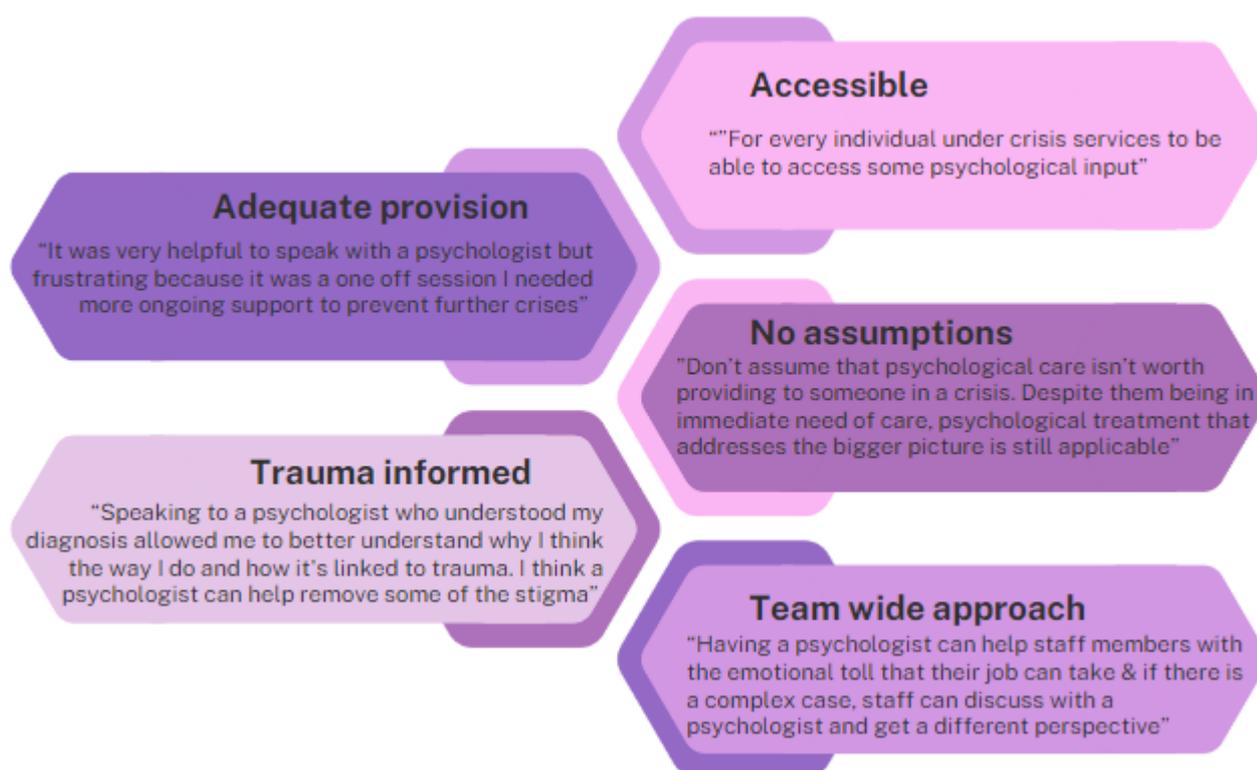
> *"My experiences have been varied, based on individual practitioners. Some have been understanding and treated me as an individual enabling me to feel safe and heard. Others have seen me as my "labels" and not listened, just acted on assumptions"*
> *(PPN-SE Crisis Lived Experience Survey, 2024)*

1.3.3 Psychology in crisis teams in the South East.

The PPN-SE Crisis Lived Experience Survey asked specifically about experience of psychology in crisis care. Feedback showed that 54% of respondents had met with a psychological professional during periods of crisis care. There was a clear ask for more access to psychological care and support. There was perceived value in a psychological presence in crisis teams both in relation to direct therapeutic contacts and to influence the overall care journey. The quotes in the infographic below highlight what service user respondents felt to be important for effective psychological care in a crisis service. The strong response to the survey identifies that this is an important issue that experts by experience are motivated to engage with. It is important that this pool of knowledge is used and supported to influence teams to become more psychologically informed in the future.

Figure 2: Quotes from the service user feedback survey

Accessible
""For every individual under crisis services to be able to access some psychological input"

Adequate provision
"It was very helpful to speak with a psychologist but frustrating because it was a one off session I needed more ongoing support to prevent further crises"

No assumptions
"Don't assume that psychological care isn't worth providing to someone in a crisis. Despite them being in immediate need of care, psychological treatment that addresses the bigger picture is still applicable"

Trauma informed
"Speaking to a psychologist who understood my diagnosis allowed me to better understand why I think the way I do and how it's linked to trauma. I think a psychologist can help remove some of the stigma"

Team wide approach
"Having a psychologist can help staff members with the emotional toll that their job can take & if there is a complex case, staff can discuss with a psychologist and get a different perspective"

1.4 Equality diversity and Inclusion in CRHTTs

The CRHTTs in the South East serve different populations with varying health needs, reflecting a range of factors including age range, ethnic distribution, and socio-economic deprivation of the local population. These factors help us to understand local trends in the mental health of the people the team serves, and the way in which the population may choose to access services or face challenges in doing so. Nationally, it is known that there

are key groups of people who are overly represented in acute mental health services, and groups who have less positive outcomes from the care and treatment they receive. For example, there is increased awareness that a greater proportion of people from some minority ethnic backgrounds are detained under the Mental Health Act when compared with those from 'White' backgrounds (McManus et al., 2016; NHS Digital, 2018, Race Equality Foundation, 2019). Acknowledgement of these patterns has led to the development of the NHS Patient and Carer Race Equality Framework (NHS, 2023b)

It is also well understood that the experience of mental distress is influenced by a number of intersecting factors which can be subject to discrimination including race, gender, sexuality, disability, and social class. It is important that teams have opportunities to reflect on their response to difference and diversity in their caseload and how they implement reasonable adjustments. Teams are more likely to be able to do this if they reflect their local community, and, are able to value and discuss diversity within their staff team. In 2023 the Psychological Professions Network South East (2023) developed an Equality Diversity and Inclusion (EDI) toolkit to support services to engage in this work.

2   Mapping CRHTTs in South East England

2.1 Current South East CRHTT provision

The South East of England is made up of 7 mental health trusts.

Figure 3: The number of CRHTTs in each trust at the point of publication

- BERKSHIRE (6)
- BUCKINGHAMSHIRE (2)
- HAMPSHIRE (3)
- KENT (5)
- OXFORDSHIRE (1)
- SURREY (4)
- SUSSEX (6)
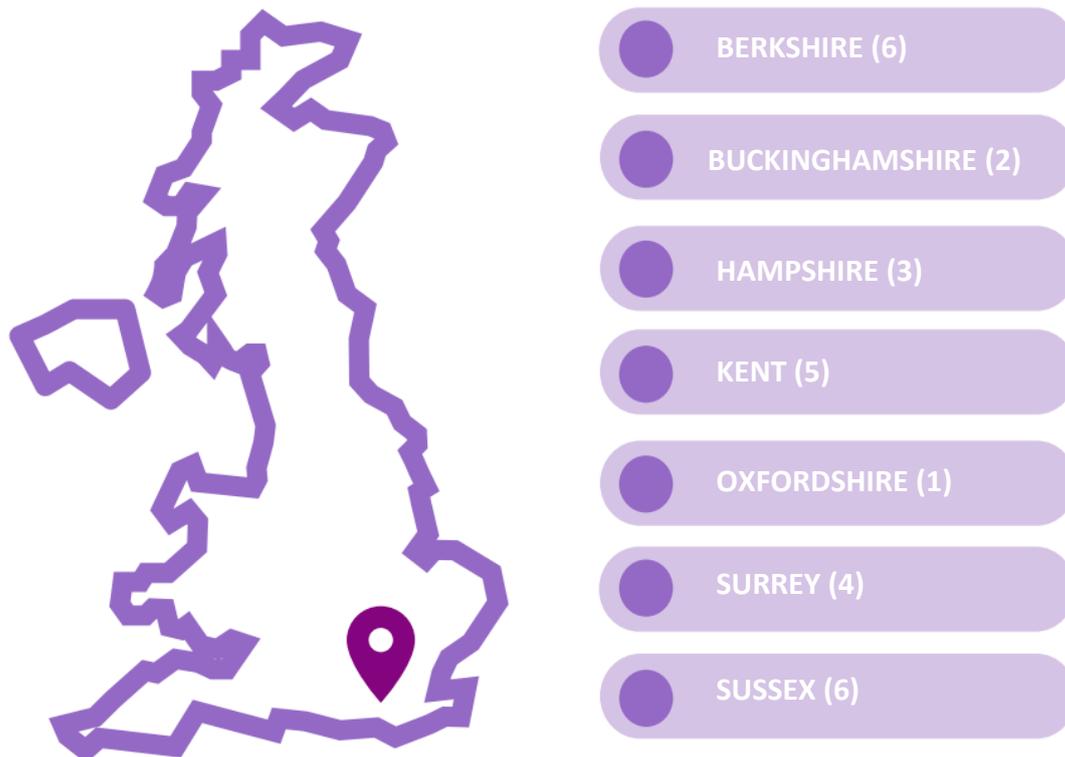
2.2 South East CRHTT Psychological workforce

Since the introduction of CRHTTs, psychological roles have been a core part of the multidisciplinary workforce. However, until the [Association of Clinical Psychology and British Psychological Society briefing paper (2021)](), there was no consistent guidance on the amount of recommended psychological workforce per team. The ACP/BPS recommendations are outlined in Table 1.

The ACP/BPS (2021) guidance outlines two levels of workforce, core and comprehensive. These pertain to the level and quality of service delivery which can be delivered with the associated workforce, as defined in the table.

Table 1. ACP/BPS (2021) Acute Workforce Guidance summary

	Crisis Response Home Treatment Teams [per team, 40–50 caseload size)
Core - To provide a range of direct [1]and indirect interventions, enabling access to psychological interventions to 70 – 75% of service users	• 0.5 wte Band 8b Principal Psychologist • 1.0 wte Band 8a Senior Psychologist/Psychological Therapist • 0.5 wte Band 6 CAP[2] • 0.5 wte Band 5 Assistant Psychologist
Comprehensive - To provide a full range of indirect interventions and increase access to psychological interventions to most service users	• 1.0 wte Band 8c Consultant Psychologist • 1.0 wte Band 8b Principal Psychologist • 1.0 wte Band 8a Senior Psychologist/Psychological Therapist • 1.0 wte Band 6 CAP • 0.5 wte Band 5 Assistant Psychologist

As part of the current project, data was collected on the psychological workforce in CRHTTs across the South East trusts and teams. This highlighted significant variability in psychological workforce establishments across the region, as well as in vacancy rates. Some services are fully recruited to with funded psychological professions posts. Other teams have struggled to recruit despite having secured funding. Objectively, 94% of crisis teams in the South East are operating below the core level of psychological professions staffing as outlined in the ACP and BPS (2021) workforce briefing paper seen in table one, with only 6% of individual teams approaching a 'comprehensive' level of psychological professions provision. Whilst some of this is related to unfilled vacancies, more commonly this is linked to limited psychological professions posts currently established within CRHTTs.

Of note, considering the MDT more broadly, there was variability in the general approach of the teams both regarding model of care and multidisciplinary workforce. Currently in the South East, the recommended skill mix of professions is broadly present in terms of representation of each professional group. However, there is significant variability in how these numbers are made up from team to team with, for example, some teams having a larger proportion of doctors and nurses and others which have a wider mix of MDT roles.

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[1] *Direct interventions are those which happen between a psychological practitioner and a service user (e.g a CBT session); indirect is where the psychological therapist offers supervision, training or reflective spaces to other staff members to assist their delivery of interventions.*

[2] *The Clinical Associate Practitioner (CAP) is a new role, and may not as yet be present in local services. This role could be interchanged with a band 7 psychological practitioner or a Mental Health Wellbeing Practitioner (MHWP). The latter is also a new role, but one that is specifically related to providing low intensity psychological interventions in secondary mental health. As the role and the training has developed we are now seeing our first trainees in crisis teams in the SE region in SPFT.*

2.3 Crisis Community of Practice feedback regarding CRHTT psychology within the South East

A community of practice (CoP)[3] for crisis teams was formed in South East England as part of the current project. Psychological professionals in these teams were invited, along with experts by experience, associated team colleagues, and those in leadership or commissioning roles. The following themes regarding the psychological professions workforce in crisis teams were collected from discussions from the group and in one-to-one meetings with CoP members:

- Overall, the majority of crisis and home treatment teams across the South East fed back that the psychological workforce is below the levels outlined in the ACP/BPS (2021) briefing paper.
- Most psychological professionals in crisis teams in the South East are Clinical Psychologists or Assistant Psychologists, with smaller numbers of psychological therapists, CBT therapists and arts psychotherapists in post. Few teams reported CAPS, in line with relatively low uptake of these roles in the South East more broadly.
- There appears to be a growing awareness of the psychological professions workforce beyond practitioner psychologists - as described in the PPN (2020) career map - and a valuing of junior staff such as Assistant Psychologists in teams; the latter requiring a supervising practitioner psychologist within the team.
- Crisis teams in the South East host very few trainee clinical/counselling psychologists or trainee psychological therapists. This is likely to impact on future available workforce and recruitment.
- In Sussex, trainee Mental Health and Wellbeing Practitioners (MHWPs) are being hosted in CRHTTs for the first time nationally.
- Different workforce configurations and approaches means that there is significant variation in models of psychological care across the region. Some teams prioritise 1:1 input, others offering group work, and others using an indirect consultation model.
- Feedback suggests that the psychological therapy provision offered is directly related to workforce size with teams with less provision being unable to offer direct clinical work and instead prioritising consultation and formulation.
- Teams have been commissioned differently over the years, with service manager discretion about how roles are combined into a team establishment. Budgets can also complicate recruitment and role clarity, particularly when there may be varying expectations due to the budget from which a post is drawn.
- Some trusts note significant challenges gaining funding for additional psychology posts within acute services, due to stretched budgets combined with a lack of understanding about the purpose and benefit of such posts.
- In contrast, some trusts which have funded psychological posts have carried very longstanding vacancies despite significant recruitment drives. This has impacted on

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[3] Communities of practice (CoPs) are networks of professionals that share common goals or interests. CoPs can be sources of knowledge, learning and support" https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2015/08/learning-handbook-communities-of-practice.pdf

the credibility of arguments to build the psychological workforce or to allocate additional funding in line with guidance.

- Encouragingly, there does not seem to be a significant issue noted around retention once psychological professionals are recruited, with those in post conveying their passion and positive experience of working in CRHTTs. This reflects a theme encountered more widely of psychological professionals feeling passionate about the acute and crisis work they do and reporting job satisfaction in this setting.
- There are many regional examples of innovative psychological models in the crisis context, showing good feedback and outcomes. Some are captured in this paper.

2.4 Limited vs. resourced psychological workforce in CRHTTs

While the understanding of psychological needs for those accessing acute care has improved, psychological posts have not increased proportionally to enable full access to psychological interventions (Ebrahim, 2021; Raphael et al., 2021). The variance in provision is interesting and poses the question of what is maintaining the problem. This seems to be multifactorial including issues related to team culture, funding approaches, variability in models of care, career pathway and job planning. It has also been proposed that a lack of a clear model of psychological work in crisis care adds to this. There are currently no clear processes to ensure transparency and accountability for providers in relation to the provision of psychological components of crisis care.

A relevant study which does offer a clear evidenced based model in acute care is the TULIPS inpatient study (Berry & Raphael, 2019). The TULIPS RCT study 'Talk, Understand, Listen for Inpatient Settings' is a trial of a stepped model of psychologically informed care. The project aimed to evaluate the impact of embedding psychological skills training for staff and team supervision and the potential economic benefits of psychological provision via evaluation of staff wellbeing, psychological mindedness, quality of team formulation, service users' mental health and subsequent use of services. One theme identified was the perceived conflict between a view of acute care as brief input to stabilise risk, and a perception of psychological therapy needing to be longer in nature and therefore not particularly compatible with acute services. Resolving this conflict requires flexibility both in how acute mental health care is conceptualised as well as how models of psychological intervention can fit into this setting.

There is evidence of a similar self-fulfilling vicious cycle regarding psychological provision in CRHTTs. For example, a psychological professional in a team for only two days a week can offer a limited service, with the team unlikely to feel the full value of the role. This can limit the perceived rationale for increasing it. Similarly, a predominance of a model based on diagnosis, risk, and rapid discharge in a team could act as a barrier to more psychologically informed work, which may in turn impact both the funding of psychological posts and the attractiveness of a post to potential applicants. The conceptualisation below proposes how some of these factors interact to maintain a limited psychological workforce and, in turn, impact on whether crisis care is psychologically informed.
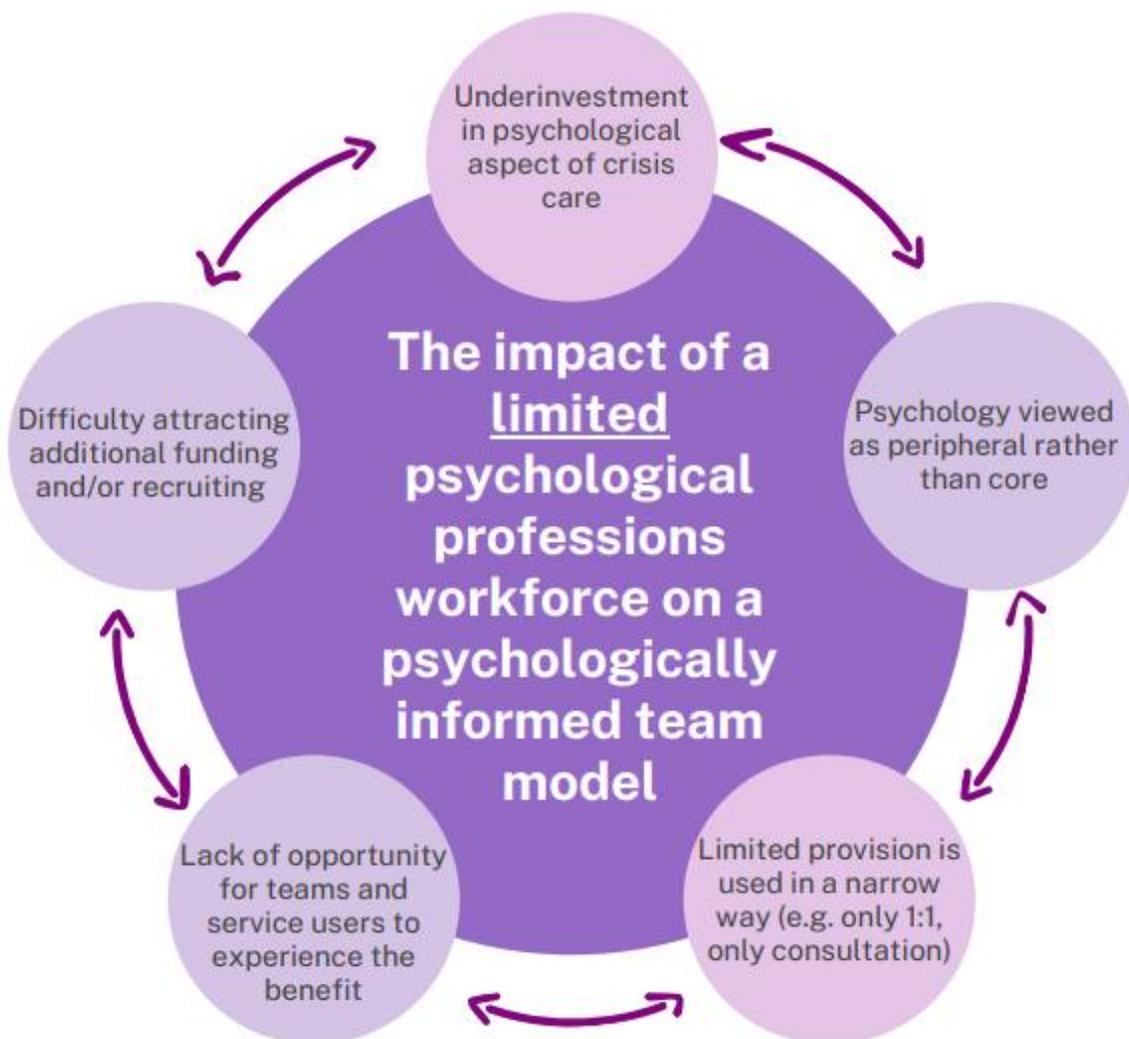
Conversely, there are teams with more psychological provision and capacity to deliver psychologically informed care. Staff in these teams highlight that full time roles, an embedded approach, and a mix of psychological professions in teams enables them to inform the care of more service users. They have capacity to offer important team spaces and facilitate training to increase the overall psychological offer. The increased input helps a team to understand and value the role. The ACP/BPS (2021) guidance, NHS (2024) inpatient guidance and QNCRHTT (2022) standards, has helped psychological professions leads in these services to make this case and think with service managers about what could be expected from these roles. This might include the knowledge that they can fulfil NICE guidance by offering all service users a level of psychological intervention and promote trauma informed care. This positively impacts on service user experience, team and clinician satisfaction.

The impact of a **resourced** psychological professions workforce on a psychologically informed team model

- Investment in embedded psychological posts
- Enhancement of psychological care via direct & indirect approaches
- Service user requests to see a psychologist can be actioned, training can be delivered / maintained
- Psychological professionals can demonstrate broad value. Also feel valued & invested in
- Posts become, established, attractive & easier to recruit to
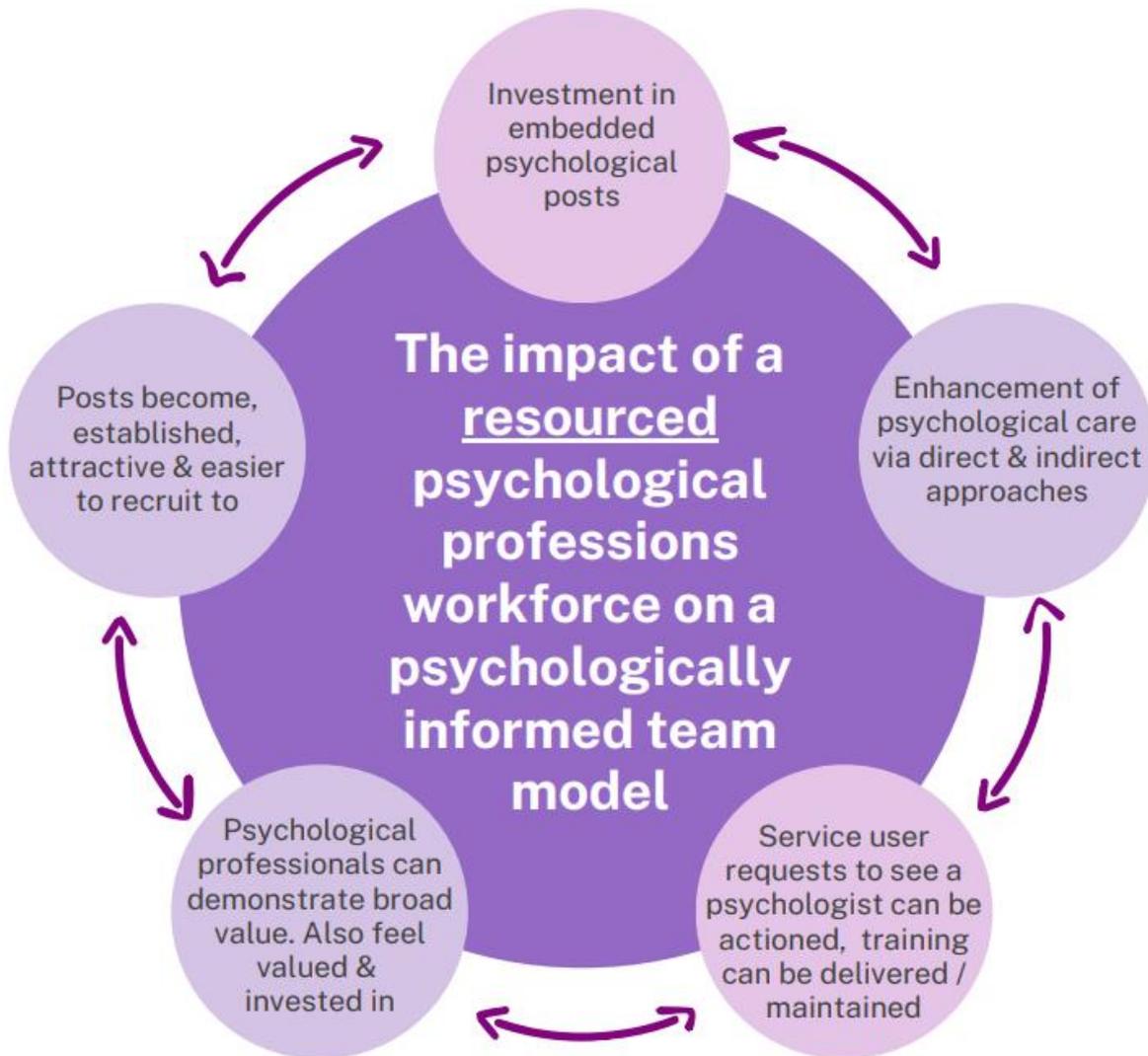
3. A model and toolkit for developing psychologically informed CRHTTs

> **"It also involves recognising that even when in crisis or acutely unwell, people are experts in their own lives and have valuable contributions to make about the support that they need both before, during and after their hospital stay"**
> (NHS England, 2023)

3.1: A new model of psychologically informed crisis care (Macdonald & Goody, 2024)

We are proposing that in order to support CRHTTs to hold psychologically informed care at their centre, a number of elements need to be in place. The direct and indirect work of psychological professionals forms a key part of this, with other factors also required to support this way of working. These seven factors are shown in the model below (figure 4) Each part of the model is then further defined, its importance outlined, and examples of representative best practice in the South East presented.

Figure 6: A model of psychologically informed crisis care (Macdonald & Goody, 2024)

3.1.1. Adequate skill mix

What do we mean?

There is a recognised recommended skill mix for CRHTTs. This includes a Team Lead, Registered Mental Health Nurses, Support Worker(s), Pharmacist, Consultant Psychiatrist, Occupational Therapists, Psychological professionals, access to administrative support and AMHP(s). It is recommended that there should be thoughtful consideration to the skill mix of professionals on shift.

Why is it important?

A CRHTT should be multi-disciplinary in nature to ensure holistic assessment and planning of care. Each profession has its own training, specialism, and knowledge to bring to crisis care. If there is a predominance of one profession, there is likely to be a predominance of one model, which is unlikely to fit the diverse and complex needs of people in a mental health crisis. The principles of working in a multi-disciplinary team are reflective of how different approaches can complement and enhance someone's recovery. It is therefore important not just to have all professions represented, but to have the recommended levels of representation to provide the interventions needed.

How do we deliver it?

It is important to hold in mind literature and service user feedback regarding the importance of holistic MDT care in a crisis when recruiting into teams or reviewing team make-up. Clarity from each professional group as to the recommended national numbers per team helps with commissioning and service manager decision making. It is helpful to fully understand what interventions or approaches each profession should, and could, be delivering for different presenting issues and/or for different points of a service user's journey with a crisis team. Psychological safety within a team is also likely to support on-going conversations as to the different needs of service users, and the required variation in skill mix needed to provide this.

South East best practice example: adequate skill mix

Kent crisis services have developed clear guidance across shift patterns as to presence of a diverse multi-disciplinary team. This ensures that there is representation of different roles and attends to adequate whole time equivalent guidance to ensure a meaningful offer. The model in Kent includes nurses, occupational therapists, peer support workers, medics, pharmacists, social workers, psychologists, physical health practitioners, administrators, and managers. Within each professional group there are different levels of seniority included in funded posts from assistants and trainee practitioners to consultant level posts. Consideration is given to the overall working week; for example what skills mix is needed in the daytime versus out of hours .
-   *Shared by Dan Brown (Kent and Medway NHS and Social Care Partnership Trust)*

3.1.2. Embedded psychological professions workforce

EMBEDDED PSYCHOLOGICAL PROFESSIONS WORKFORCE

What do we mean?
The ACP/BPS (2021) paper recommends a robust psychological professions workforce for crisis teams nationally, as previously outlined in Table 1. The role of this workforce is to build and sustain a psychologically informed culture, deliver direct evidence-based interventions and support delivery of psycho-social interventions in the team.

Why is it important?
The value of a psychological perspective in MDT working has been noted across the acute care pathway (Murphy et al., 2013; Wood et al., 2018). Psychologists within acute teams influence the culture, increase understanding of service user's difficulties and foster collaborative working within teams (ACP/BPS, 2021). Furthermore, NICE guidance highlights that everyone using mental health services should be offered a psychological intervention. Provision needs to be at a level that allows most service users to receive psychological input unless there is a rationale as to why this would not be appropriate.

How do we deliver it?
One way of effectively utilising an embedded psychological workforce is via a **stepped care model.** There are examples of stepped care models in some services, in research, and in several CRHTTs in the South East of England. In general, this consists of:
1. Training staff in psychologically informed ways of working as a team.
2. Training and supervising MDT clinicians providing direct psycho-social interventions.
3. Direct delivery of brief evidence based psychological interventions.

If there is sufficient embedded psychological professions workforce, then all three levels can be delivered and can complement each other. To ensure the effective provision of a three-step model, it is important to have a senior strategic presence (8b/8c) specific to the CRHTT or acute pathway. This aligns to the ACP workforce recommendations, supporting recruitment, retention, supervision, outcome reporting and the ongoing delivery of a stepped care model.

> **South East best practice example: embedded psychological workforce**
> Oxford CRHTT have an embedded team of psychological professionals at a level considered 'comprehensive' against ACP/BPS guidance. This includes a senior psychologist providing strategic oversight, preceptorship psychologist and assistant substantive resource. The psychological professions workforce has grown significantly, demonstrating how showing value of psychological care in CRHTTs can lead to increased funding. Creativity of posts, investment in trainees, developmental pathways and thoughtful job planning have been important factors in building the psychological workforce. This allows the team to implement a 'pyramid of care' model, akin to stepped care. *- Shared by Laura Goody (Oxford Health NHS Foundation Trust)*

3.1.3: Team and skills training

What do we mean?

To promote a psychologically informed culture in a team, two types of training are predominantly recommended. **MDT team training** focusing on the overall psychologically informed working of the team, and **individual clinical skills training** to enhance the delivery of evidence based psychologically informed interventions. Both impact the overall culture of a team and are reflective of a stepped care model.

Why is it important?

The culture within a team drives the behaviour and decision making of staff. Service user feedback tells us that when service users experience trauma informed care, they recover more quickly due to feeling safe and cared for (Perkins et al., 2023)

Team training

Trauma informed care (TIC) is a well developed and highly recommended example of an MDT training which can significantly impact team approach. Trauma informed care and a recovery-based approach have a lot in common; both are an approach not an intervention, and focus on "the journey not the destination". NHS England recognises TIC as one of four key elements for high-quality therapeutic acute mental health care (NHS England, 2023a). TIC has also been identified as best practice in the NHS Long Term Plan, the NHS Mental Health Implementation Plan, and the UK government's "All our Health" guidance. This outlines the benefits to the people who use services, their caregivers and whole organisations (NHS, 2019a; NHS, 2019b; UK Government, 2015; Scottish Government, 2023).

Individual clinical skills training

One to one skills training for the MDT further complements a psychologically informed approach. Morant et al. (2017) highlighted excessive emphasis on medication provision over other person centred and compassion-focused forms of support. This is despite consistent feedback from service users that they value the opportunity to engage in direct focused psychological interventions within a CRHTT context. QNCRHTT (2022) guidance states that CRHTTs should be able to provide a range of therapies to patients and their family/carers based on need. Most contacts for patients in crises will be with nurses, support workers or allied health professionals. It is therefore important that psychological interventions are not only delivered by psychological professionals. This emphasises the need to have regular refresher and upskilling training for teams and individuals.

How do we deliver it?

Team training

There is now a multitude of training packages for teams and individuals such as TIC. Whilst much of this is delivered at a Trust level, we would recommend that there is training

particularly focused on the challenges of providing recovery focused, compassionate and trauma informed care in a crisis team. There is strength in having this training as a team, and face to face. It is likely that local trusts will have clinicians or organisations who can provide this regionally. Having expert by experience input within training is highly recommended. Training sessions on team culture and psychological skills can be delivered by psychological professionals within the team and may be supplemented by trust training or external training. Due to a limited evidence base, there are no robustly recommended packages of training specific to crisis teams. However, we have peppered this report with national and local examples of training that have enhanced psychologically informed care. It is important that any training is maintained through appropriate supervision and refresher opportunities; most efficiently this would be done 'in house' by embedded psychological professionals.

Individual skills training
Skills based psycho-social interventions often have an evidence base related to particular presenting problems. Table 2 gives an overview of interventions that may be possible for an MDT with appropriate training to deliver, supplementing formal psychological interventions.

Table 2: Example psychosocial interventions

PRESENTING ISSUE	PSYCHOSOCIAL INTERVENTIONS (MDT)
Psychosis / unusual experiences	Modular work e.g. sleep, carer support, Cognitive Behaviour Therapy (CBT) informed interventions
Mood instability	Relapse prevention, mood monitoring and management
Complex emotional needs	Structured clinical management (SCM), Dialectical behaviour therapy (DBT) skills
Trauma symptoms	Trauma stabilisation e.g. grounding, psychoeducation
Low mood	Behavioural activation (BA), CBT informed interventions
Anxiety	Graded exposure, CBT informed interventions, relaxation training
Self harm and suicidality	Safety planning, DBT skills
Substance misuse	Motivational interviewing (MI), harm minimisation

South East best practice example
Solent crisis team in Hampshire have implemented a model whereby psychological understanding is held and utilised across the MDT. All CRHT clinicians have been trained in the Cope, Comprehend, Connect (CCC) model (Harris, Clarke & Riches, 2023), and the team use this within their emotion dysregulation pathway and to inform all clinical discussions. The psychologist within the team holds a 'train the trainer' qualification in the CCC model, allowing efficient ongoing dissemination of skills training and supervision of existing and newly recruited staff members.
Shared by Candy Conner-Wong (Southern Health NHS Foundation Trust)

3.1.4. Direct psychological interventions

What do we mean?

An embedded psychological professions workforce has the opportunity to inform the culture of the team and upskill MDT colleagues. They should also be able to deliver higher level psychological interventions in an adapted, brief way suited to the crisis context.

Why is it important?

Quality Network for Crisis Resolution and Home Treatment Teams (2022) good practice guidance states that all service users should receive a comprehensive evidence-based assessment, which includes their psychosocial and psychological needs. Furthermore, NICE guidelines outline that there should be brief models of level one interventions which are suitable for MHLTs, crisis teams and inpatient wards. Experts by experience have called for increased access to psychological therapies in acute settings, in order to address their psychological needs whilst in crisis and help direct their longer-term care needs. The nature and duration of crisis team input can appear prohibitive to offering psychological intervention. However, there is evidence that some therapies can be adapted to be impactful over a short time-period, particularly with the ability to offer more intensive support. Additionally, the therapeutic offer of psychological formulation and brief intervention - even if not specifically offering therapy - should not be underestimated. The experience of developing a shared understanding of distress has been cited as extremely powerful for service users.

How do we deliver it?

Models with the most empirical support for individual direct work with psychological therapists in crisis teams are DBT and CBT based interventions. For example, Gøtzsche & Gøtzsche (2017) determined that Brief Cognitive Behavioural Therapy (BCBT) reduced the risk of a new suicide attempt by 50% compared to the usual treatment. Simon Proudlock has also provided strong evidence regarding delivering Eye Movement Desensitisation Reprocessing (EMDR) in crisis teams for those with complex PTSD (Proudlock, 2016), including an impact on admissions (Proudlock and Peris 2020). There is also some emerging evidence for other general psychological models in acute settings, such as Cognitive Analytic Therapy (CAT), Acceptance and Commitment Therapy (ACT) and Compassion Focused Therapy (CFT). Further work is needed to develop a robust evidence base for these therapies in CRHTTs.

What is clear is that there is scope to do meaningful therapeutic work in a crisis team, with the need to adapt the approach to meet the needs of the service user and the demands of the service context e.g. bi-weekly sessions, skills-based work between sessions facilitated by MDT colleagues and the handover of ongoing needs to other services. Group based CRHTT interventions may also increase access to psychological resources for service users, promoting the cost effectiveness of treatment (Proudlock & Wellman, 2011). However, as

yet, there is little empirical evidence specific to group interventions in this setting. There are some case studies and examples of innovative group work within acute care that show the potential promise of group interventions in a crisis setting.

Table 3 is shown below with a focus on NICE recommended interventions that can be adapted by a psychological therapist to CRHTT context. As shown here, there is a multitude of therapeutic modalities that are likely to be relevant to a crisis setting given the diversity of presentations seen. It is therefore important that psychological professionals hold and maintain therapeutic skills, in order to deliver interventions and offer expert supervision to MDT colleagues delivering psychosocial skills work.

Table 3. Example psychological interventions based on NICE guidance.

	Evidence based psychological interventions (psychological therapists / practitioner psychologists)
Psychosis / unusual experiences	Cognitive Behavioural Therapy (CBT) for psychosis/ Family Intervention (FI)
Mood instability	CBT, FI
Complex emotional needs	Schema therapy; Dialectical Behaviour Therapy (DBT); Mentalisation Based Therapy (MBT); Transference Focused Psychotherapy (TFP); Interpersonal Group Therapy (IGP); Cognitive Analytic Therapy (CAT) Structured Clinical Management (SCM)
Trauma symptoms	Trauma focused CBT; EMDR, Narrative Exposure Therapy (NET)
Low mood	CBT, BA, Interpersonal Psychotherapy (ITP), Short Term Psychotherapy (STPP)
Anxiety	CBT, exposure work
Self harm and suicidality	CBT, Dialectical Behaviour Therapy (DBT), Mentalisation Based Therapy (MBT)
Substance misuse	CBT, MI

South East best practice example

Psychological professionals in the Brighton Sussex CRHT provide a range of direct psychological interventions, to supplement the psychosocial interventions that they support the MDT to deliver. This includes 3 weekly groups based on ACT, DBT and Trauma Stabilisation. They also offer in depth assessments and formulation using a narrative trauma informed perspective, which informs the overall care and potentially indicates brief CBT and third wave interventions with the embedded psychological professionals. Additionally, a successful QI project led to an ongoing offer within the service of brief intensive family sessions to provide a systemic perspective on crises and onward care planning. - *Shared by Isobel O'Reilly (Sussex Partnership NHS trust)*

3.1.5. Keeping people safe

What do we mean?

People being supported by a CRHTT have been assessed as "at risk". These risks include that they may take their own life; they may hurt themselves; they may not be able to attend to their own care; there is risk of deterioration of their mental health. Guidance is to avoid stratification of risk because risk prediction is ineffective (NICE, 2022), instead focusing on formulating and mitigating risk, based on person-centred assessment. Team and organisational culture are shown to impact greatly on risk appraisal and, in turn, how service users are supported to hold hope and take steps towards recovery. Language in this area is evolving, and whilst the predominantly used term withing the NHS remains 'risk management', there is movement towards terms such as 'safety promotion' to reflect the goal of supporting service users to feel and be safe.

Why is it important?

Due to how vulnerable people are to harm and distress when under a crisis team, a major part of the work that a team does is around promoting safety and understanding risk. Promoting a shared understanding around suicidality and self-harm or neglect is crucial. In response to anxiety about risk, there is the potential for an over emphasis on physical safety and a lack of attention to "emotional safety". It is therefore particularly important that all CRHTT clinicians feel skilled and equipped to support service users who are at risk of harm. Haslam's (2024) work highlights how, when service users are viewed through a risk dominant lens, clinician's practice was seen by peers to be more defensive, and experienced by service users as being more dismissive. Haslam warns that if we socially construct service users as risk objects, everyone's experience is more "fearful". Ironically this may reduce emotional and physical safety.

Research demonstrates that suicidal thoughts and behaviour are transdiagnostic symptoms warranting attention beyond or regardless of an underlying diagnosis. There are emerging models focused on targeting suicidality directly. We do not yet know which interventions work best for which individuals, or the application of the limited existing research to diverse populations. Challenges to suicide prevention efficacy research have included the low base rate of suicidal behaviours and safety concerns regarding inclusion of individuals at risk leading to historical exclusion (Brodsky, Spruch-Feiner & Stanley, 2018). Whilst a stronger evidence base is awaited and hoped for, individuals continue to experience crises in real time. Repeated feedback has been given by service users of feeling misunderstood, unsupported or disempowered when accessing crisis services due to suicidality or self-harm.

How do we deliver it?

Sufrate-Sorzano et al. (2023) note the need for active upskilling of people experiencing suicidal ideation through coping tools, behavioural interventions and therapeutic

engagement. A number of suicide-specific interventions have been developed and evaluated for their effectiveness and efficacy in reducing suicidal ideation and behaviour (Daglas et al 2024). Team and individual training around such models is highly recommended, along with a commitment within team Standard Operating Procedures as to how <u>safety is promoted</u> rather than <u>risk being managed</u>.

A key evidence-based approach that could be incorporated into CRHTT training and practice is collaborative safety planning, based on person-centred assessment and formulation of risk. Crisis Response Planning (CRP) and Enhanced CRP (E-CRP) have been associated with a decreased likelihood of psychiatric hospitalization, greater increases in positive emotional states (calmness and hope) and reductions in negative emotional states when compared with 'contracts for safety' (Bryan et al. 2018). Flood et al. (2006) also identified that joint crisis plans and collaborative working reduced compulsions by half as compared to those with no plan. Team frameworks such as the Collaborative Assessment and Management of Suicidality (CAMS) have also shown in a meta-analysis to be "well supported", with statistically significant reductions in suicidal ideation and overall symptom distress, while positively impacting hope/hopelessness and increasing treatment acceptability (Swift, 2021). There is very early emerging support for crisis specific therapeutic risk interventions that can be delivered by psychological professionals. These include the Attempted Suicide Short Intervention Program (ASSIP); a risk focused brief, client-centred intervention designed to reduce suicide risk in 3–4 sessions, supplemented by ongoing contact. ASSIP participants tended to endorse higher ratings of the therapeutic alliance, treatment satisfaction and satisfaction with therapeutic outcomes which has been related to reduced suicidal ideation (Connor et al. 2021). Cognitive Therapy for Suicide Prevention (CT-SP) and Brief Cognitive Behaviour Therapy (BCBT) have also shown promise in reducing suicidal behaviour (Stanley, Brodski & Monahan, 2024).

Whilst direct psychological interventions focused on risk and safety are relevant, it is most important that risk is considered and approached with the individuals' experience and needs at the forefront. Taking the time to develop a shared understanding, and working collaboratively to formulate and maintain safety is a crucial part of psychologically informed crisis care.

South East best practice example:

In Buckinghamshire CRHTs, the Consultant Psychologist chairs collaborative care planning meetings when delivery of crisis care is complex or there are concerns about risk and safety. The service user will be part of the discussion alongside relevant professionals in order to formulate and understand the risk or complexity and develop shared goals or intervention plans. This is followed up one month later to consider progress. This approach displays the importance of speaking explicitly about risk, truly understanding what underlies risk and committing to identify direct interventions that help mitigate risk and promote safety.
Shared by Shazma Thabusom (Buckinghamshire [Oxford Health NHS FT])

3.1.6. Reflective spaces

What do we mean?

Along with direct therapeutic interventions, research highlights the need for reflective spaces in crisis settings. Most commonly these include reflective practice; team formulation and debriefs following serious incidents. Increased psychological safety is associated with better outcomes and higher staff satisfaction. It particularly refers to team's feeling safe enough to raise problems, disagree, and speak up.

Why is it important?

The Trauma informed Care approach considers the needs of the workforce (Substance Abuse and Mental Health Services Administration, 2014; Treisman, 2018; NHS Education for Scotland, 2019); recognising that staff are likely to be impacted by trauma personally, as well as possibly vicariously in their roles (Berger, et al., 2012; Hartley, et al., 2013; Martin, et al., 2009). Clinicians have shared their views on the importance of forums such as reflective practice, supervision and learning spaces to manage the emotional intensity and clinical demands of crisis work. Spandler & Stickley (2011) identified the importance of psychologically safe work contexts within which staff feel able to share strong emotional reactions and consider the impact vicarious trauma may be having on them. By improving the wellbeing and function of the staff team, service user experience should also be improved. Effectively facilitated reflective spaces allow the team to:

• Develop greater personal insight and self-awareness
• Enhance understanding of complexity
• Improve team morale & cohesion
• Increase compassion for service users
• Become more professionally and personally effective

Reflective spaces also serve as a way to maintain other factors outlined in this model, through identifying actions for individual and team development, or improvement of practice.

How do we deliver it?

Having embedded psychological professionals within the team with a clear remit for indirect work allows the facilitation of reflective spaces.

O'Reilly (in press) notes that psychologists can take a lead on facilitating reflective forums within crisis teams, with explicit attention to the importance of fostering constructive team processes within CRHTT settings. Most commonly this would include a combination of weekly, bi-weekly and monthly protected meeting slots. It is important that the organisational element of this is supported by the team leader or service manager, particularly due to the shift working nature of CRHTTs which makes this more challenging. Most commonly these protected spaces will include the four regular activities (below), along with post incident team reflection when indicated (ACP, 2024).

Reflective Practice | Team Formulation | Teaching & Learning | Clinical Supervision

South East practice example:

CRHTs in Kent & Medway are utilising various team forums to optimise psychologically informed care. They run weekly reflective practice and bitesize training sessions which have been found to be accessible even in the busy environment of a crisis team. They also adopt a champion model of training (all clinicians have foundation training in psychosocial skills e.g. DBT skills) which the psychological professionals deliver and then maintain via monthly supervision groups. This demonstrates the adaptation of forums to the context of a crisis team. The reflective spaces directly impact on the delivery of key interventions as well as offering space to staff to reflect on their work, hopefully in turn positively impacting their wellbeing.
Shared by Dan Brown (Kent and Medway NHS and Social Care Partnership Trust)

3.1.7. Service user feedback loops

What do we mean?

In order to progress and develop CRHTTs in a psychologically informed way, we need meaningful reliable ways of collecting feedback from service users and carers. The predominant model of feedback in most trusts is via a complaints process, or the "family and friends test". The latter is brief, quantitative and uses a scaling methodology. There are few teams who then receive this feedback, in order to make changes based upon it. There is also a need for a more consistent collection of clinical outcomes either from specific interventions, or from time of assessment to time of moving on.

Why is it important?

Collecting quantitative and qualitative feedback on clinical interventions allows a team to prioritise changes, developments and further audits in a way that is truly centred on lived experience. Nationally there is now clear NHS England guidance on the requirement to use patient reported outcome measures (PROMS) in adult community services to support this (RCPsych. 2024). The service user voice provides a reflection of how we are progressing, and highlights aspects of the service that practitioners are unable to comment on. It should be the key barometer by which we make decisions. Feedback about CRHTTs constantly highlights the need for loved ones to be more involved in care - when this is important to the service user – to aid care planning and safety. Evidence from serious incidents have regular recommendations that family and friends should be more closely aligned to the care; with some incidents deemed avoidable had this occurred.

How do we deliver it?

Patient Rated Outcome Measures (PROMs) are tools which measure changes in mental health. Teams need to establish systems to implement these, and most importantly, use the data to make service developments and/or introduce clinical initiatives. In relation to gathering service user and carer feedback, it is nationally recommended that a mixed methodology of quantitative and qualitative methods are used. Focus groups, carers groups or drop ins bring the relational dynamic to the fore when considering next steps in services. Co-production is essential at every level of the service. Experts by experience in a variety of roles in trusts also supports wider networks for feedback loops to be developed and realised.

> **South East practice example:**
> Berkshire West CRHT have a monthly learning event which is useful for focusing on areas of team development, and reflects a Quality Improvement (QI) approach. Patient feedback is a main area of focus within QI which ensures regular, active discussions within the team, and the ongoing implementation of improvement ideas. In addition, the QI tools highlight common themes from patient feedback to address concerns.
>
> *Shared by Saniya Rizvi (Berkshire Healthcare NHS Foundation Trust)*

3.2. South East England Crisis community of practice (CCOP)

The South East England Crisis Community Of Practice fed into the content of this report and can now act as a group to take forward these recommendations and approaches for working in a more psychologically informed way in crisis teams. In terms of interested parties, and supporting development, the table below also sets out some quick wins and longer term aims for all key interested parties to further reflect, develop and/or implement this work.

3.3. Top tips for Commissioners, Managers, Professional Leads and Psychological Professionals with CRHTTs

The model above outlines the aspiration for CRHTTs who wish to be more psychologically informed, and the best practice examples outline some team-based examples of this in action. Key parties involved in the set up and delivery of crisis care face specific challenges and hold different responsibilities. As such we have compiled a 'top tips' table to aid individuals to focus on what they can bring to developing psychologically informed teams.

	COMMISSIONERS	TEAM / SERVICE MANAGERS	PSYCHOLOGICAL PROFESSIONS LEADS	PSYCHOLOGICAL PROFESSIONALS
WORKFORCE	• Review ACP/BPS guidance for an understanding of core and comprehensive workforce • Invest into the roles described at each level including developmental pathways (Assistant > Consultant grades) • Promote ways of collecting data and measuring the impact of a psychological workforce e.g. PROMS, staff experience • Review data, audits or evidence of posts on clinical outcomes. Consider these when making decisions regarding prioritization of funding • Consider how the wider forums for crisis care are linked together, and communication between different agencies can be promoted and facilitated	• Look beyond Clinical psychologists to other psychological professions roles e.g. CBT therapists, arts therapists, MHWPs or therapists trained in other psychological therapies e.g. EMDR • Work with HR recruitment teams to make adverts most impactful. Explore there are any additional incentives available for hard to recruit posts mandated by the CQC. • Support psychological professionals to be fully embedded in teams and focus on psychological work • Support the process of bringing trainees in teams • Support training opportunities for all roles • Ensure reflective spaces are easy to access, even on a shift rota	• Link in with local training courses across psychological therapies and organise trainees in teams. • Consider an Assistant Psychologist, MHWP or CAP workforce to supplement / support qualified psychological professionals • Ensure clear development opportunities (therapy CPD, senior posts) • Consider split posts & flexible working; CRHTT's often work on a rota system and may be better placed than other teams for bespoke patterns • Set up a system of shadowing or secondments which give psychological professionals an opportunity to return or experience the CRHTT context	• Support ongoing feedback loop regarding the experience of SUs receiving psychological input • Identify what is working for who and ensure the balance of direct and indirect work • Disseminate psychological skills appropriately across the MDT • Offer supervision for assistant psychologists and placements for trainees • Invest in trainees: 'grow your own' approach to workforce • Develop appropriate supervision and job planning for role clarity. • Link with other psychological professionals in acute care on away day and to give/receive CPD

	COMMISSIONERS	TEAM / SERVICE MANAGERS	PSYCHOLOGICAL PROFESSIONS LEADS	PSYCHOLOGICAL PROFESSIONALS
TRAINING	• Allocate funding for psychologically informed training for both MDT and individual practitioners • Support a TIC culture • Ensure EBEs are part of any commissioned training	• Champion model using PP specialist skills to support MDT: maintain not just train • Ensure adequate CRHT specific training in 3 key areas: TIC, skills, risk management.	• Organise and prioritise team and individual training consistent across trust CRHTT's • Job plan psychological therapists to be able to facilitate training • Ensure psychological professionals training is invested in in order to adequately deliver therapeutic interventions and supervise team interventions at a specialist level • Recommend key training packages on suicide, crisis care and self harm	• Include EBE voice in any training • Continue to develop therapeutic competencies relevant to an acute setting • Ensure that psychological training is included and prioritised in the team, offering to deliver and maintain via supervision/refresher training as appropriate • Facilitate training on working with suicidality and self harm
INTERVENTIONS	• Identify the different evidence based psychological therapies which can currently be offered in your local crisis teams. Consider what roles might be needed to ensure the NICE recommended interventions can be delivered	• Support the offer and delivery of psychological therapies early in someone's CRHTT experience • Work with professional leads to agree clinical measures for each pathway, in order to collect feedback on recovery rates • Work with the team on a rota which supports all members of the team to access reflective spaces regularly • Ensure created psychology posts factor in opportunity for indirect and direct work	• Communicate NICE guidelines to service managers and psychological professionals • Have leaflets or weblinks available for staff and service users as to expected psychological interventions within CRHTT care • Job plan time for PP staff to facilitate reflective spaces such as supervision, RP and debriefs • Support acute PP staff attending their own reflective spaces	• Set up an expectation that psychologically informed interventions are part of CRHTT core business • Create consultation opportunities for the team to discuss cases • Create clear process models to offer direct and indirect interventions; who, what, why and when (optimise available workforce) • Facilitate regular consistent reflective spaces • Engage in own therapeutic development via reflective spaces and training
SERVICE USER EXPERIENCE	• Link with service managers as to their outcomes, and what they understand about these	• Devise systems which support outcome measures including Patient Reported Outcome Measures (PROMS). • Devise systems which collect data together, present and use this with the team • Promote all team members to attend trauma informed training • Encourage team members to discuss therapeutic responses to risk in RP	• Help define PROMS for each evidence based psychological therapy for crisis care • Provide opportunity for service related projects & quality improvement focusing on service user experience • Include EBE's across workforce and training initiatives	• Regularly use PROMs • Engage in service development and QI activity in response to SU feedback • Promote TiC throughout all aspects of role • Enable and model service user involvement

4. Conclusions and next steps

> "We have come to understand that for some people who have experienced trauma, accessing, engaging with, and feeling safe when using services can be difficult. We know that services and systems (i.e., services and organisations that work together) set up to try and help people can use practices and processes that can be traumatising or re-traumatising, albeit unintentionally (SAMHSA, 2014). Without proactively recognising this and deconstructing barriers to engagement, people at risk of mental health crisis who have experienced trauma may struggle to find the right help or continuity of care until their needs become acute
> (The King's Fund, 2019).

We have come a long way from mental health services which are predominantly driven by a medical and expert model which can potentially create a top-down dynamic. However, acute care teams remain vulnerable to this given their setting and remit.

The benefits of psychologically informed teams which reflect a biopsychosocial model are clear in the literature (Dekka, 2023). Their very definition aligns with what service users have been asking for since the inception of CRHTTs in 2000. Delivering this should increase service user satisfaction, which in turn would improve recovery rates and time spent in CRHTT and on the urgent care pathway. As the most expensive part of the mental health system this brings significant financial savings with it (ACP/BPS, 2021).

We know that psychologically informed crisis care is hugely important to service users and should include opportunity to meet with a psychological professional during periods of crisis. An embedded psychological professions workforce not only responds to this need but also allows the dissemination of psychological skills and thinking via training, reflective spaces and direct intervention. We believe that the Macdonald and Goody (2024) model of psychologically informed crisis care proposed in this paper provides a structure in which to scaffold services in order to achieve this goal. The model can be used to assess current status and then identify ways to build a more psychologically informed team. The recommendations, top tips and best practice examples suggest ways to do this in practice alongside the theory.

Guidance exists as to the psychological professions workforce needed to drive forward this model in teams. This guidance has been taken up in variable amounts across the South East of England. The differing impact on the team of the psychological professions workforce can be seen in the vicious cycle diagrams in section 2.4. This paper has sought to bring together many of the recommendations that exist in literature and guidance, and give helpful ideas of approaches which have helped teams to work together more safely and effectively.

CRHTTs in the South East of England are undertaking a number of innovative and exciting ways of working. The often isolated nature of crisis teams from each other - and from other parts of the system - makes sharing good practice challenging. The newly formed South East England PPN Crisis Community of Practice (CCOP) has sought to bring staff together, so that innovations, developments and solutions can be shared more easily.

Next steps

- The model of psychologically informed teams in this paper was developed with a focus on crisis teams. However, it is also applicable to other mental health care teams.

- The table of top tips outlines how the model can be operationalised in short and long-term actions for different parts of the system - at all levels of decision making and implementation - in order to support working towards a psychologically informed model of care.

- The PPN South East England Crisis Community of Practice will continue to link teams in the region, share best practice, and consider how to move closer to the model.

- In order to support implementation, it will be essential for a short piece of work (possibly via the CCOP) to collect and report data on the impact of working in this way. The aim would be to establish a way of measuring each petal. To then use the top tips table to make changes to one of more of the petals. And look at pre and post outcomes of this work, using the agreed measure.

- Service user involvement is key in all future pieces of work. This is particularly pertinent hearing the current feedback echoing previous themes, emphasising a need for renewed commitment to improving care for those experiencing mental health crisis

> "if we are going to truly change things for the better, we need to think about people as a whole – what makes up their lives, and their needs, wants and ambitions...These varied and personal needs must be reflected in the support and treatment we receive from public services too. Here we should be striving for needs based, not diagnosis-based care and treatment...we also need to empower and enable clinicians to work with us to understand our needs as a whole person before agreeing a course of actions to keep us well. We need choice and to practice shared decision-making."
>
> Department of Health and Social Care (2023)

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