


Background and intention

- NHS England funds allocated across regions for crisis workforce and planning
- PPN-SE identified the potential project to utilise some of this funding
- We used this to appoint 2 Crisis Fellows
- Remit: map workforce, identify evidence-based practice / good practice examples, highlight gaps, identify training needs, make recommendations and develop connections between crisis services in the South-East
- Output: paper and establishment of South-East Crisis Community of Practice

Whilst this was a crisis focused project, we believe that the resulting model and paper has clear applicability to other acute teams (and even beyond)

Session plan

 Background and intention – *Dr Bill Tiplady*

 Service user voice – *Helen Leigh-Phippard*

 Project process

 Theme and model summary

 **Q&A** regarding model

 Practical applications of the toolkit

 Looking ahead

 **Q&A** regarding practical applications

 Closing remarks – *Dr Adrian Whittington*

Service user and carer voice



Helen Leigh-Phippard
 (EBE, PPN-SE)

Previous research, guidance and opinion papers

-  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

Crisis community of practice members

Lived experience survey
 (EBE, PPN-SE)

My EbE role

Task

- Bring the service user perspective, voice, themes, research into the writing.
- Hold the aim of the paper as “having the service user voice central” to account.

Approach

- Personal concern about not being adequately representative
- Time limited so had to be realistic about what we could achieve
- Developed a service user survey shared regionally within PPN SE and by all 3 PPN SE EBEs with a range of service user/carer networks across the region

What did service users/carers say about crisis care?



Treat us with care & compassion



Give us enough time to talk and listen to what we say



Give us choices & involve us in our care



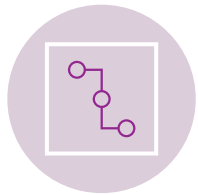
Understand us, especially our experience of trauma



Be honest & transparent about service limitations



Give us proper therapeutic input, not just monitoring



Provide continuity of care



Provide consistent care

What did service users/carers say about psychological input in crisis care?

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”

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”

Accessible

“For every individual under crisis services to be able to access some psychological input”

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”

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”

Thoughts on my experience

- Very positive experience - felt valued and listened to by the rest of the team and think that shows in the final report
- Top tips that are realistic but will lead to real improvement in service user experience if implemented

Bree and Laura's reflections

Experience

It adds a richer perspective and an alternative lens.

You don't know what you don't know!

Helen kept bringing us back to the core of the service user work, which helped to focus us when there were options.

Impact

The language changed and became more accessible

The penny dropped! Service user feedback and psychologically informed teams.

The process and direction were often altered by Helen's perspective.

Thank you also to the steering group who guided and influenced the paper: Helen, Kaye Adamson (Programme Manager PPN-SE), Melissa Rae (Assistant Psychologist PPN-SE), Dr Bill Tiplady (Director of Psychological Professions, Oxford Health NHS Foundation Trust & PPN-SE co chair), Dr Adrian Whittington (National Clinical Lead for Psychological Professions NHS England & PPN-SE co chair)

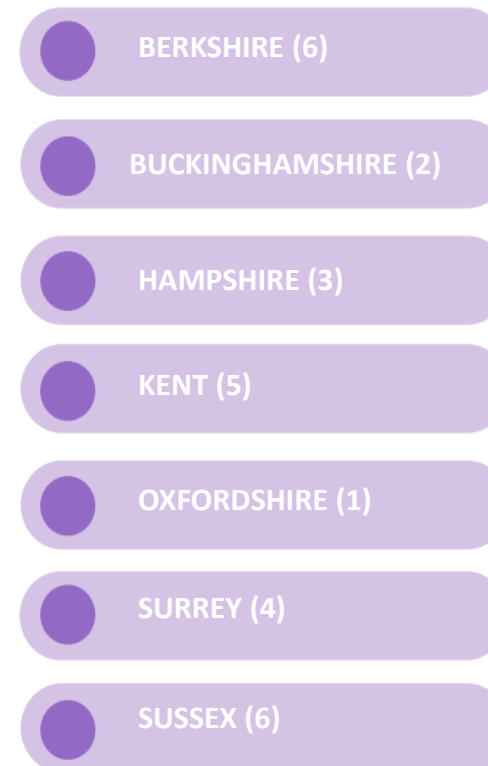
Our gratitude to the South East CCoP members who have been so generous with their time, energy and ideas

Project process

Gap analysis approach: what do we know about the optimal service, where are we currently in the South-East, and how can we bridge the gap

- 1) Engagement and understanding
- 2) Bringing together themes, ideas and people
- 3) Developing a useable model
- 4) Dissemination
- 5) Action: future steps via CCoP and further work

Challenges... keeping it focused enough on **psychologically informed care** rather than 'good' crisis care, choice to specify adult CRHTT settings, surface acknowledgement of factors we couldn't do justice to (e.g. EDI, broader transformation work)



Psychologically informed care vs. Psychological workforce

Psychologically informed care is an approach to delivering services that considers individuals' emotional and psychological needs and responds to these compassionately.

There is particular emphasis on the impact of trauma, collaborative person-centred decision making and involvement of loved ones.

Psychologically informed care can increase empathy, hope, and focus on recovery.

Multi-disciplinary teams (MDTs) trained in psychologically informed ways of are key to progressive mental health care. This approach is emphasised in policy and best practice guidance within acute care (NHS England, 2023a).



... links clearly back to what service users are asking for in the crisis literature and our own scoping work

Workforce mapping themes

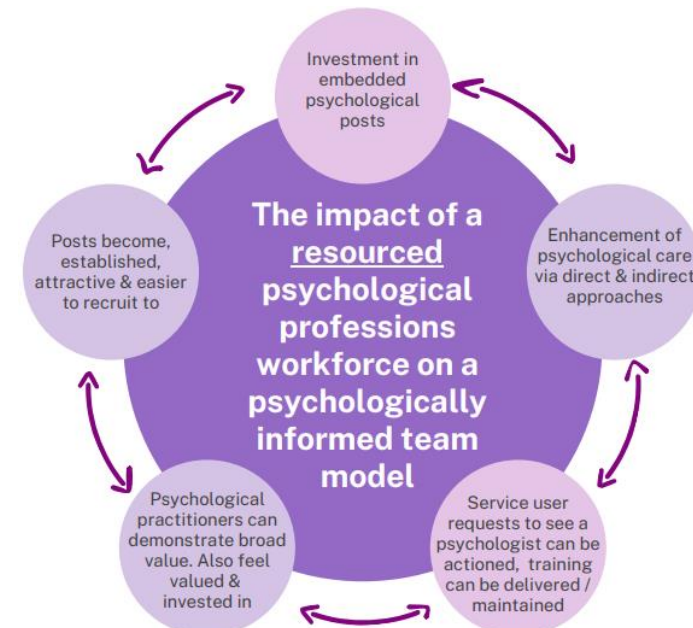
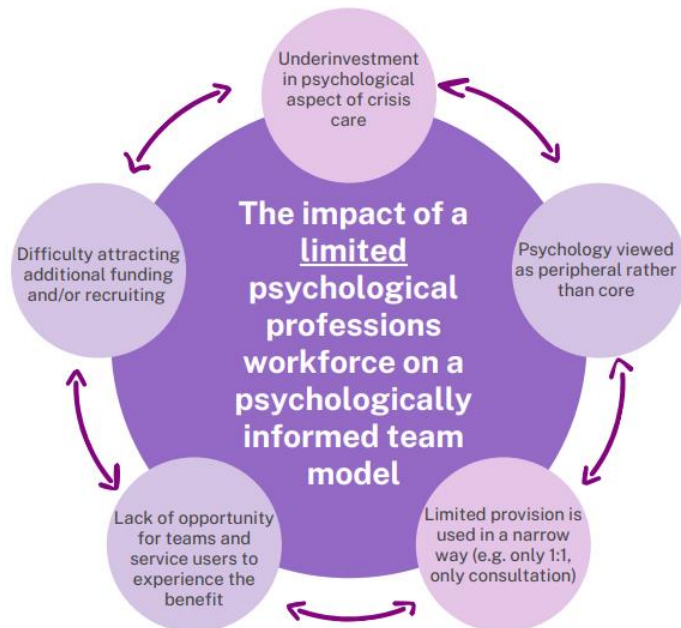
Generally:

- **Significant variability** in provision, models (e.g. HTT vs CRHTT), referral criteria, remit of work and resource allocation / resource distribution. Noted within as well as between trusts

Psychology in CRHTT's:

- Majority of SE CRHTT's **below 'core' level recommended psychological workforce** when compared with ACP/BPS acute workforce guidance ([Association of Clinical Psychology and British Psychological Society briefing paper, 2021](#))
- **Clinical Psychologists are the predominant profession**. There was noted to be growing awareness and presence of more junior or alternative roles e.g. AP's, MHWP's, CAPS
- **Limited trainee representation** across the region was cited as both an offer & take up issue
- **Significant variation in psychology offer** including direct vs. indirect balance. Direct psychological intervention offer was related to workforce size; teams with less provision prioritising consultation and formulation
- Some trusts reported issues gaining **funding for recruitment**, whilst others with funding experiencing **longstanding vacancies** due to challenges recruiting
- Encouragingly, **good retention rates** were reported, with psychological professionals in post conveying their passion and positive experience of working in CRHTTs
- Many **regional examples of innovative psychological models** in the crisis context, showing good feedback and outcomes (some included as best practice examples in the paper)

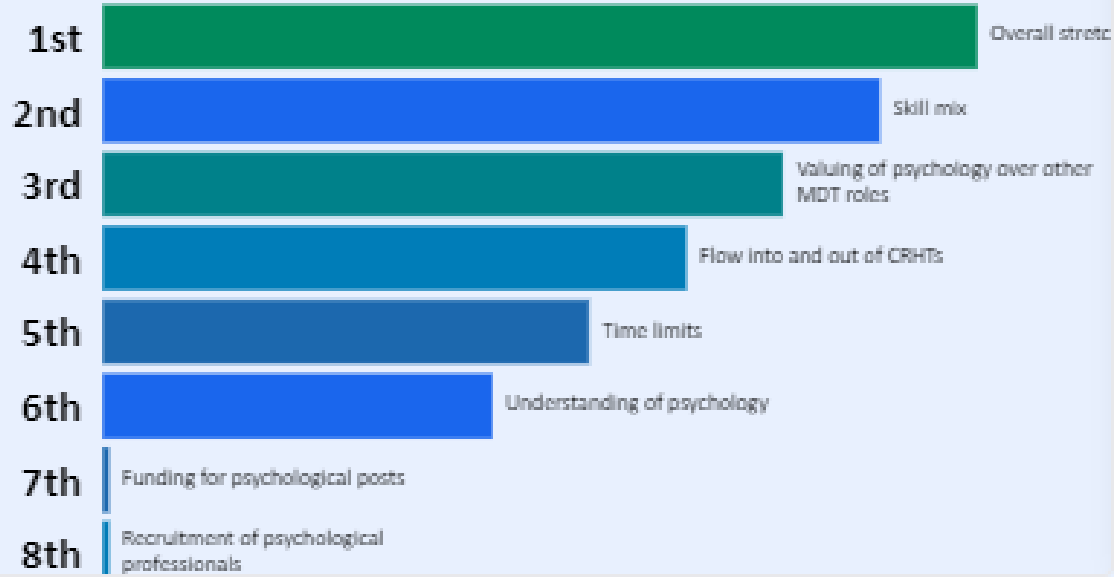
Conceptualisations of limited vs. resourced psychological workforce in CRHTT's



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What do you perceive as the biggest obstacles to you / your local crisis team in delivering psychologically



If you had a magic wand and could make one change to get your / your local crisis service closer to that it be?

2 responses

Increased training for adapted therapies

Specialist psychological supervision

Opportunity to complete the Menti (and take a quick comfort break as needed!)



Model and toolkit: Macdonald & Goody (2024)

- *What do we mean?*
- *Why is it important?*
- *How do we achieve it?*



Adequate skill mix



What?

There is a recognised recommended skill mix for CRHTTs. This includes a Team Lead RMN's, Support Worker(s), Pharmacist, Consultant Psychiatrist, Occupational Therapists, Psychological Professionals, access to administrative support and AMHP(s).

Why?

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.

How?

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. Attention not just to representation but to WTE numbers, levels of seniority and presence over the full crisis care period. 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.

Kent crisis services have developed clear guidance across shift patterns as to presence of a diverse multi-disciplinary team (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)

Embedded psychological workforce



What?

The ACP/BPS (2021) paper recommends a robust CRHTT psychological professions workforce to build / sustain a psychologically informed culture, deliver evidence-based interventions and support delivery of team psychosocial interventions.

Why?

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 should allow most service users to receive psychological input unless there is a rationale as to why this would not be appropriate.

How?

Ensure that psychological professionals are included in the CRHTT workforce, at a level that allows them to be used to their full potential (ACP/BPS workforce as a guide). Consider using the psychological professions in a stepped care way:

- 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.

Oxford CRHTT have an embedded team of psychological professionals considered 'comprehensive' against ACP/BPS guidance; including senior presence, preceptorship, trainee and assistant posts. This workforce has grown significantly, demonstrating value of psychological care in CRHTTs can = increased funding. Creativity of posts, investment in trainees, developmental pathways and thoughtful job planning have been crucial and allows a 'pyramid of care' stepped model

Shared by Laura Goody (Oxford Health NHS Foundation Trust)

Team and skills training



What?

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.

Why?

To promote a psychologically informed culture in a team, it should be ensured that there is availability for **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.

How?

Appropriate team training e.g. TiC, with specific consideration to the crisis context

Potential areas for skills-based training are highlighted related to clinical presentation

EBE input into training is highly recommended

Training must be maintained via supervision & refresher sessions

- (PP workforce can support)

Solent crisis team in Hampshire model is for psychological understanding to be held across the MDT. All CRHT clinicians have been trained in the Cope, Comprehend, Connect (CCC) model (Harris, Clarke & Riches, 2023), and is used within the emotion dysregulation pathway and to inform all clinical discussions. Psychologist 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)

Example MDT 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

Direct psychological interventions



What?

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

Why?

The nature and duration of crisis team input can appear prohibitive to offering psychological intervention. However, therapies can be adapted to be impactful over a short time-period, particularly with the ability to offer more intensive support. There is promising and emerging evidence from various models: CBT/3rd wave informed interventions, EMDR, CAT & family intervention

How?

Ensure that the service model includes access to higher level psychological interventions from an appropriately qualified psychological professionals. These interventions should be applied in an adapted, brief way suited to the crisis context e.g. bi-weekly sessions, skills-based work between sessions facilitated by MDT colleagues and handover of ongoing need. Group based CRHTT interventions may increase access and be cost effective for some presentations.

Brighton CRHT provide a range of direct psychological interventions, to supplement the MDT psychosocial interventions, including 3 weekly groups based on ACT, DBT and Trauma Stabilisation. Also, in depth assessments and formulation using a narrative trauma informed perspective, brief CBT / third wave interventions and brief intensive family sessions

- Shared by Isobel O'Reilly (Sussex Partnership NHS trust)

Example direct 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
<u>Self harm</u> and suicidality	CBT, Dialectical Behaviour Therapy (DBT), Mentalisation Based Therapy (MBT)
Substance misuse	CBT, MI

Keeping people safe



What?

A core part of CRHTT business is responding to risk; this should be psychologically informed and acknowledge competing demands that influence safety decisions. Teams should be explicitly considering how safety is promoted rather than risk being managed

Why?

Updated guidance is to avoid stratification of risk ([NICE, 2022](#)) due to the ineffectiveness of risk prediction. Instead to focus on formulating and mitigating risk via person-centred assessment. Collaborative safety planning is supported by the evidence base (safety planning and enhanced safety planning) and there is emerging evidence re. suicide specific interventions/protocols (CAMS, ASSIP, CBT for suicidality).

How?

Organisations should ensure regular risk management training 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. Forums where risk issues can be explored in more depth than possible at MDT handovers should be available.

In Buckinghamshire CRHTTs, the Consultant Psychologist chairs collaborative meetings for complex or high risk cases. The service user will be part of the discussion to formulate and understand the risk and develop shared goals or intervention plans. This is followed up one month later. This highlights commitment to collaborative risk formulation and directed intervention.

- *Shared by Shazma Thabusom (Buckinghamshire [Oxford Health NHS Foundation Trust])*

Reflective spaces



What?

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

Why?

TiC considers staff experience as well as service users, with staff potentially impacted personally as well as possibly vicariously in their roles. Reflective spaces provide a safe space to share, learn and support colleagues. Potential benefits include developing greater insight, increasing compassion, improving team morale or cohesion, and working more efficiently.



How?

Embedded psychological professionals can lead on this work if indirect role is defined in their role. Most commonly these protected spaces will include the four regular activities (pictured), along with post incident team reflection when indicated (ACP, 2024).

CRHTs in Kent & Medway offer reflective practice and bitesize training sessions shown to be accessible even in the busy crisis environment. They adopt a champion model to maintain skills and enthusiasm. Reflective practice spaces offer guidance and opportunity to reflect on their work, hopefully in turn positively impacting team wellbeing.

- Shared by Dan Brown (Kent and Medway NHS and Social Care Partnership Trust)

Service user feedback loops



What?

The lived experience voice of those accessing crisis services should be heard, understood, and used as a basis for service improvement. It is important that all services have explicit ways for both gathering this feedback on an ongoing basis, and for implementing change in response.

Why?

Quantitative and qualitative feedback allows teams to prioritise change, developments and further audits in a way that is truly service user centered. Feedback & serious incident reviews have repeatedly highlighted the need for SU's and carers to be more involved with care and decision making. RCPsych (2024) recent guidance emphasizes the use of PROMS across services.

How?

CRHTT senior leadership should support the regular use of patient-reported outcome and experience measures, thinking beyond trust measures such as FFT. A mixed methodology of quantitative and qualitative methods should be used e.g. focus groups, carers groups or drop ins alongside surveys. Co-production is essential to ensure accountability and realise broader feedback opportunities.

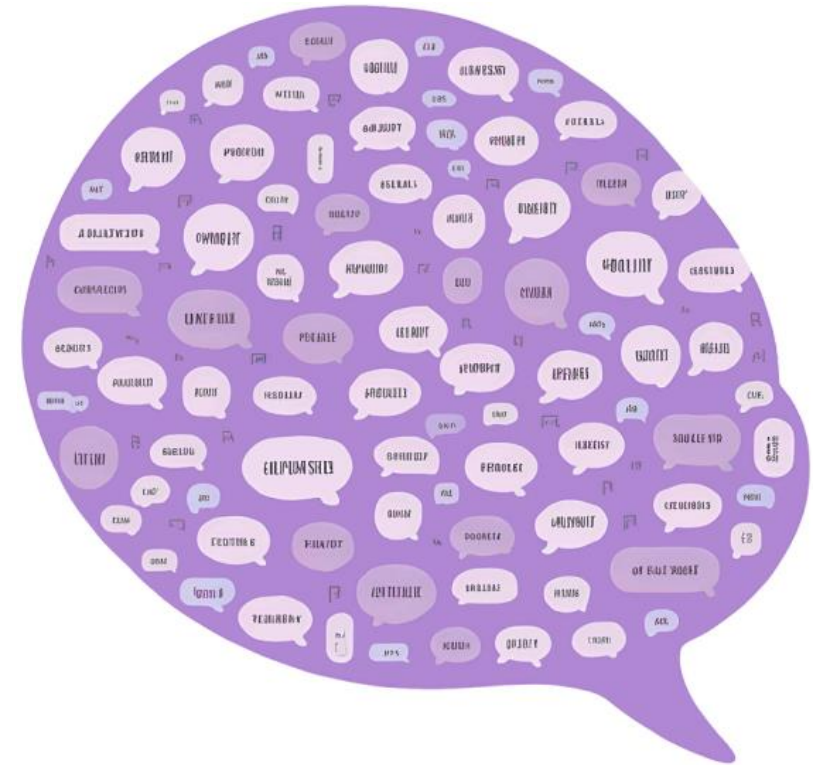
- Berkshire West CRHT have a monthly learning event focusing on areas of team development using a Quality Improvement (QI) approach. Patient feedback is a main area of focus which ensures regular, active discussions within the team, and ongoing implementation of improvement ideas. In addition, the QI tools highlight common themes from patient feedback to address concerns

- Shared by Saniya Rizvi (Berkshire Healthcare NHS Foundation Trust)

Q&A

An invitation...

To ask more about the project and the model, or share your reflections so far



Practical application of the model



Example top tips

	COMMISSIONERS	TEAM / SERVICE MANAGERS	PSYCHOLOGICAL PROFESSIONS LEADS	PSYCHOLOGICAL PROFESSIONALS
WORKFORCE	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Look beyond Clinical psychologists to other psychological professions roles e.g. CBT therapists, arts therapists, MHWP or EMDR therapists 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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

South-East best practice example

Psychological professionals in the Brighton Sussex CRHTT 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 and onward care planning. - Shared by Isobel O'Reilly (Sussex Partners)

Example best practice

Seven ideas for using the paper as a practical tool kit...

1. Using the top tips table
2. Using the model as an audit tool
3. Using the best practice examples
4. Using the one-page summary visual to share the content
5. Forming local trust “task and finish groups”
6. Attending the South East Community of Practice to share implementation ideas
7. Joining the NHS Futures page to communicate with others

1. The top tips table

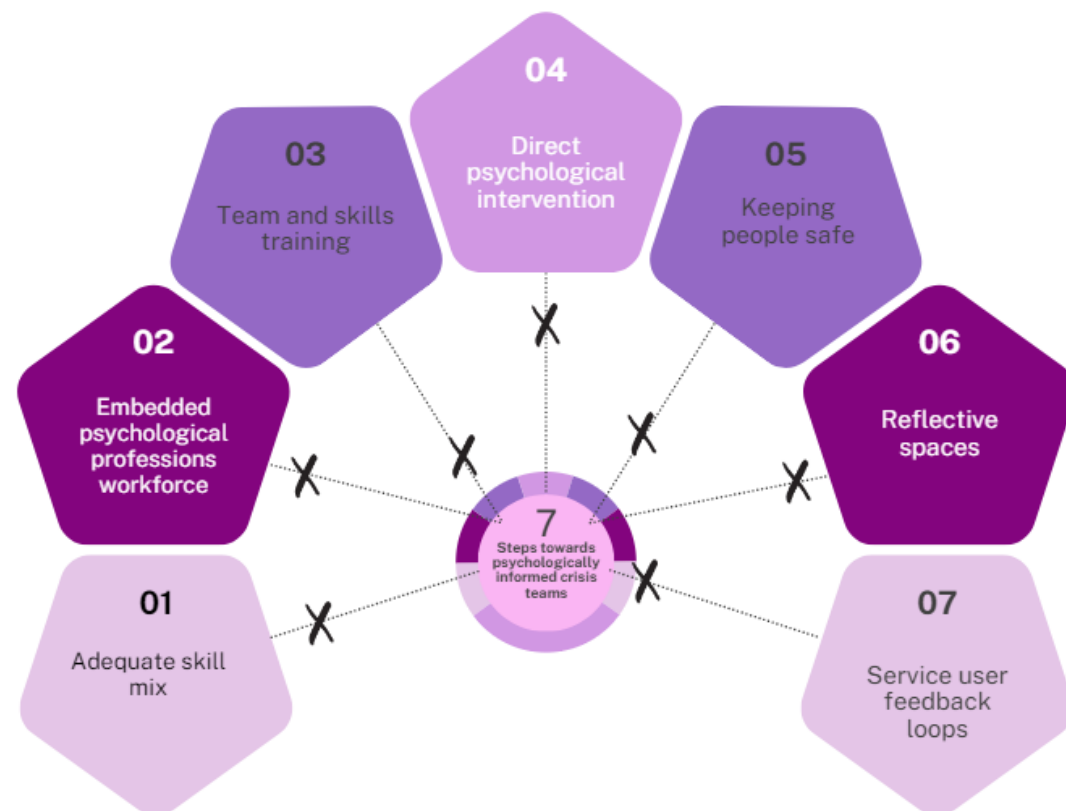
- **Four Roles:** *commissioners, service managers, psychological professionals leads, psychological professionals*
- **Four Sections:**
 - **Workforce:** *e.g. service managers might want to support a wider mix of psychological professions.*
 - **Training:** *e.g. psychological professional leads might want to prioritise and recommend key packages of training across all CRHT's on suicide, crisis care and self-harm.*
 - **Interventions:** *e.g. commissioners identify what evidence base they would like delivered in their CRHT's and consider what role / skill mix can do this.*
 - **Service user experience:** *e.g. psychological professional to engage in service user development based on consistent feedback.*

Example section of top tips table

	COMMISSIONERS	TEAM / SERVICE MANAGERS	PSYCHOLOGICAL PROFESSIONS LEADS	PSYCHOLOGICAL PROFESSIONALS
WORKFORCE	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Look beyond Clinical psychologists to other psychological professions roles e.g. CBT therapists, arts therapists, MHWP's 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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

2. Audit tool ideas

- Map your teams against the model, strengths and gaps in each area.
- Use the visual as a recovery star or archery board. Include values-based discussion.
- Use this to prioritise areas of work or QI projects.
- Use the model to celebrate what is already going well.



Audit cont.

(strengths and challenges example)

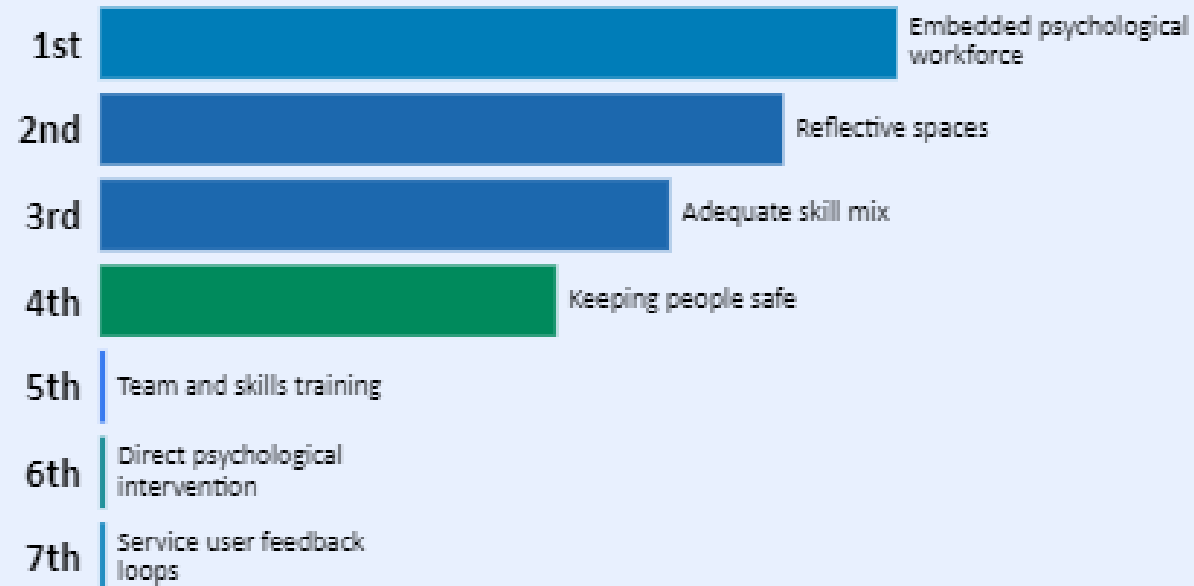
FACTOR	STRENGTHS	CHALLENGES	IDEAS
Skill mix	<i>do have a range of registered and non registered staff of different background</i>	<i>no recent audit of skill mix, predominance of nursing, only single AHP's</i>	<ul style="list-style-type: none"> - do an audit of skill mix - consider new roles e.g. Peer support workers
Embedded psychology workforce	<i>fully recruited to funded psychology posts, would meet 'core' if had an AP</i>	<i>existing provision means limited indirect work, mostly direct</i>	<ul style="list-style-type: none"> - look into recruiting an AP - broaden remit, potential business case for more psychology
Team and skills training	<i>some staff have existing training from previous teams</i>	<i>not consistent, no TI training, staff report feeling deskilled</i>	- ask team what they would value regularly and pull together a training proposal *
Direct psychological intervention	<i>a strength in the team as is a main focus of the psychological therapy role</i>	<i>psychologists needing appropriate supervision</i>	- consider with psychological professions lead re. supervision (internal or ?external)
Keeping people safe	<i>strong focus of the team in 1:1's and MDT discussions</i>	<i>team can struggle with least restrictive approach, impact on staff of dealing with suicide risk ++</i>	<ul style="list-style-type: none"> - consider one of the advanced training around suicide prevention in the paper - risk formulation meetings?
Reflective spaces	<i>present and working well</i>	<i>gap in post incident support</i>	- liaise with other urgent care teams for reciprocal arrangement for post incident support
Service user feedback loop	<i>team know to give out trust feedback form at discharge and do fairly consistently</i>	<i>low uptake on trust system, no real forum for taking feedback forward, would benefit from a regular robust system</i>	could ask local experts by experience to advise on how and what to set up

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Mentimeter

Rank your perceived order of the seven factors in relation to your local crisis team (1st being most well formed, 7th being least well formed)



3. Best practice examples

- Each of the 7 factors in the model has a local example of where this has gone well.

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)

- Use these for local development in your chosen area, or alongside the top tips table.

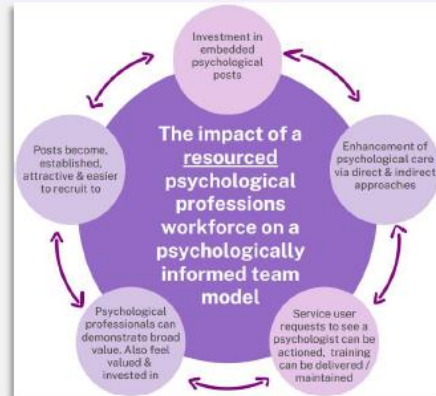
Developing Psychologically Informed Care in Crisis Resolution and Home Treatment Teams (CRHTTs)

CRHTTs sit in a pivotal place in the urgent care pathway. They act as gatekeepers for acute inpatient beds, facilitate early hospital discharge and provide person centred interventions in a home environment. Many people accessing these services have experienced trauma and are dealing with current distress. It is crucial that CRHTTs are set up to offer compassionate evidence-based care and avoid retraumatisation. This project outlines a model and toolkit to develop and maintain psychologically informed CRHTTs.

Psychologically Informed Care...

... is an approach to delivering services that takes into account individuals' emotional and psychological needs. There is an emphasis on recognising and responding to the impact of trauma on the individual and the system.

What do people using CRHTTs ask for?



Moving intention into action via...

- Regional best practice examples
- A model of care
- Top tips for commissioners, service managers & psychological professionals

A New Model of Psychologically Informed Crisis Care (Macdonald & Goody, 2024)



"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)

Research and guidance...
... endorses a psychological workforce supporting CRHTT care as outlined by Royal College of Psychiatry (QNCRHTT, 2022), Association of Clinical Psychology Acute Workforce Guidance (2021) & NICE guidance regarding access to psychological interventions.

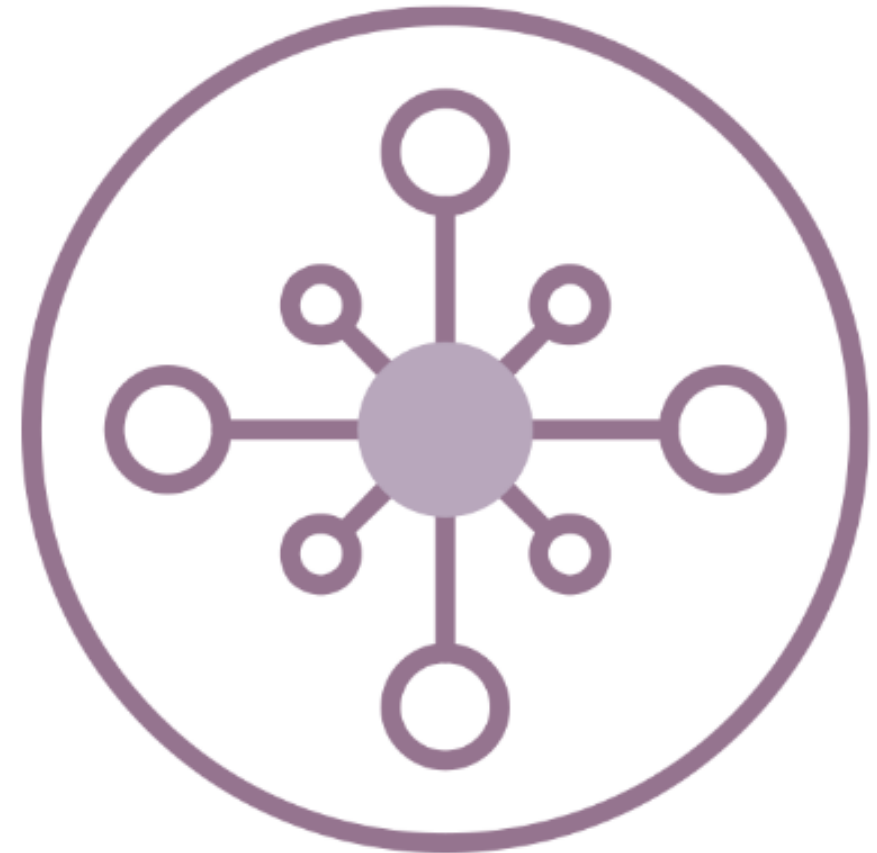
4. One-page visual summary

How and why to use the one-page summary visual

- Helps to share the paper within your trust and teams easily
- Can springboard an initial discussion with key decision makers
- Could use alongside other papers linked to psychologically informed work, e.g:
 - [*NHSE \(2023\) Acute mental health care guidance*](#)
 - [*BPS/ACP \(2021\) Acute psychological workforce guidance*](#)
 - [*Berry & Raphael \(2019\) Tulips inpatient study*](#)
 - [*Dekka et al \(2023\) Psychologically informed healthcare paper;*](#)

5. Forming local trust “task and finish groups”

- Vision of a hub and spoke model from the Crisis Community of Practice across the South East into each NHS trust (which could also be applied to other areas)
- Important to engage key decision makers and avoid echo chamber



6. SE Crisis Community of Practice



- Now well established with over 60 members
- Membership includes psychological professionals, EBE's, service managers and MDT colleagues
- Intended to be a forum for sharing best practice and supporting the implementation of the model across trusts

Use the QR code above or join the Crisis CoP here: [PPN - Crisis Community of Practice](#)

We meet quarterly. Our next meeting is on **22nd January 2025 @ 11 – 12.30pm** via teams

7. Join the CCoP NHS futures page


The screenshot shows the FutureNHS interface for the PPN-SE Crisis Community of Practice. The top navigation bar includes 'Home', 'My Dashboard', and 'My Workspaces'. A search bar is located in the top right. The main content area displays the PPN South East logo and the text 'Psychological Professions Network PROMOTING EXCELLENCE IN PSYCHOLOGICAL HEALTH & WELLBEING'. Below this, there is an 'About Us' section with text explaining the purpose of the CCoP. On the right side, there are four prominent buttons: 'PPN-SE Registration', 'Crisis Community of Practice Membership Form', 'Join the conversation', and 'PPN-SE News'. A sidebar on the left shows a 'Forum' section with 'Workspace Members section' and 'Workspace Managers Only (Private)'.

[PPN-SE Crisis Community of Practice - FutureNHS Collaboration Platform](#)

Final Q&A

Opportunity to share questions or ideas about practical application of the model

Join at [menti.com](https://www.menti.com) | use code 71721386



Mentimeter

What is one thing that has most impacted you- or that you will take forward- as a result of being part of this session today?

3 responses

All super interesting Recruit APs Coproduction

