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Foreword

The response that local mental health services offer people when they are at their most vulnerable can be fateful. CRHTs intervene at a point where it is judged that someone's distress may merit their admission to hospital. This is where effective joint working along the acute care pathway can have a dramatic effect on outcomes and user's satisfaction with services.

Working to avoid unnecessary admission is intensive work requiring confident and skilled responses from the team. It is wonderful, therefore, that clinical psychologists are focussing such energy to this key area of work, and expanding their numbers, despite the challenges to psychological practice that this context provides.

Local mental health services can be fraught with schisms. The divides between disciplines, local teams, health and social care, community and inpatient care, and primary and specialist care are just some of the boundaries that provide a major headache for users and their supports. The authors of this document have sought to promote greater integration of care by carefully considering the role of psychologists through the process of assessment, planning, intervention and resolution, taking a broader systemic view that incorporates, for example, the role of carers and the importance of the wider community and people's social inclusion within it. They have explored the added value that the psychologist can bring to the team as a whole, for example as a 'boundary spanner' working to promote better relations between the CRHT and other parts of the local service. Our national survey of teams highlighted that poor understanding of the role of the CRHTs is a considerable obstacle to their effective operation.

The intensity and short duration of CRHT work means that it may too often focus on medical interventions and risk to the exclusion of approaches that build resilience to future crises. Providing intensive psychological input in one well-defined role can help to counter this by providing a broader view and affording the right status to a more contextualised approach. Perhaps the most important aspect of integration that skilled psychological intervention at this point can provide is an opportunity to help users and their supports achieve greater personal integration by helping them to develop their understanding of the cycles of distress and service involvement that has brought them to the doorstep of inpatient care.

Beyond the role of practitioner this document also shows where psychologists can improve the whole acute care pathway through supporting promoting effective user involvement, leadership, training, evaluation, audit and service development. I hope this excellent document is widely used to support the even greater involvement of psychologists at this critical point in the user's journey. If we can get it right here, it is much more likely that the wider local service system for people in severe distress will be able to operate more effectively in future.

Professor Steve Onyett
Senior Development Consultant
Care Service Improvement Partnership SW (incorporating NIMHE)

Executive Summary

This briefing paper is intended for use by psychology managers, service managers, commissioners and psychologists working with Crisis Resolution Home Treatment (CRHT) services. The authors form part of the CRHT Psychologist Network within the Psychosis and Complex Mental Health Faculty of the Division of Clinical Psychology.

www.bps.org.uk/dcp-sigpr/faculty_networks/crht/crht_home.cfm

This document reflects the issues that psychologists often face working in CRHT teams. It is not intended as a definitive, evidence-based guide to practice. We hope that it will offer support to psychologists who already work in these settings, as well as offering guidance to those who are preparing to set-up such services.

Following the Department of Health National Service Framework (1999) and subsequent NHS plan (DoH, 2000), CRHT teams have been created in England and Wales. The Mental Health Policy Implementation Guide (MHPIG) (DoH, 2001) sets out guidelines for the setting up and implementation of CRHT teams. The MHPIG recommends that CRHT teams deliver a service to people between 16 and 65 years with a diagnosis of severe and enduring mental health problems who are experiencing acute mental health crises, which, without intervention, would necessitate hospitalisation. The MHPIG recommends that psychologists are part of the staffing of a CRHT team.

The psychologist working in a CRHT team can play many different roles, from direct work with service users through to indirect work. The MHPIG recommends four phases of CRHT work: Assessment, Planning, Intervention and Resolution. At each of these phases, psychologists can draw on their skills and knowledge in applying psychological principles to the service user's care. At assessment, psychologists can highlight relevant features of a client's thoughts, behaviours, emotions and the impact of wider social systems on a person's mental health. The planning stage can be supported by psychological formulations, particularly for complex presentations involving a history of abuse, adjustment issues and wider systemic issues. During the intervention stage, psychologists can bring a wide range of evidence-based approaches to bear on a variety of presenting problems. The resolution of a period of work can be enhanced by service users gaining an understanding of recurring cycles. This may help those people who may be at risk of presenting to services repeatedly over time.

There are many forms of indirect work that psychologists are trained to undertake, e.g. service evaluation and development, audit and research, team development, interfacing with other teams and services, contributing to training within the team and providing a supervisory and consultancy role to CRHT staff.

Psychologists are well positioned to support service user and carer involvement initiatives, such as organising forums for feedback, service development groups and involving service users in the day-to-day running of a CRHT team.

Finally, the current briefing paper considers issues around the employment and management of psychologists working in CRHT teams, and the potential challenges that can be encountered in this field of work. Amongst other things, consideration should be given to the extent of integration or separation from the team, the degree of core or specialist input and line management structures.

Key recommendations described in the current paper are as follows:

- Addressing the shortfall of psychologists working in CRHT teams with the further development of posts nationally.
- As a result of the diverse range of specialist skills brought to the team, an Agenda for Change (AFC) banding of at least 8a is recommended.
- The developmental stage of the team and its receptiveness to psychological principles should be considered when deciding which psychological approaches to utilise within the team.
- The psychologist should, at times, be able to separate from the core work of the team to enable the full range of psychology input to be implemented. Time for activities such as therapy, audit, research and service development needs to be ring-fenced.
- The role of the psychologist should be negotiated with both the manager and the team.
- The psychologist should have access to experienced supervisors and psychology support networks that have a focus on CRHT working.

Section 1: Background

1.1 The Policy Context

In 1999, the Department of Health published the *National Service Framework (NSF) for Mental Health* in an attempt to define standards of service delivery. Of the seven standards outlined in the NSF, three covered issues relating to care delivery for people in mental health crisis. Standard 3 focused on 'access to services', setting the goal that 'any individual with a mental health problem should be able to make contact round the clock with the local services necessary to meet their needs….' Standard 4 focused on specialist care, stating that 'all mental health service users on CPA [Care Programme Approach] should receive care which optimises engagement, anticipates or prevents a crisis and reduces risk'. CRHT teams were 'born' directly from this standard with the publication of the NHS Plan (DoH, 2000) promising 335 such teams by the end of 2004. Finally, Standard 5 of the NSF set targets for hospital and crisis accommodation, specifying that service users who need a period of time away from home should have access to care in the least restrictive environment (taking risks into account) situated as close to their home as possible.

If the NSF laid the standards for mental health provision then the NHS Plan (DoH, 2000) and the Mental Health Policy Implementation Guide (MHPIG) (DoH, 2001) for CRHT teams aimed to support the delivery of these standards in clinical practice. The MHPIG offered an operational definition of CRHT teams that has since underpinned service developments in this area. As part of this operational definition, the MHPIG describes, in detail, a four-phase process of CRHT work comprising:

- assessment;
- planning;
- intervention;
- resolution.

Each of these phases will be described later in this document with recommendations about how psychologists can contribute to each phase.

Although the NSF, the NHS Plan and resulting MHPIG have been the main policy drivers for the development of CRHT teams, other documents have also supported their development including the National Suicide Prevention Strategy (DOH, 2006a). Launched in 2002, this strategy aims to reduce suicide rates by at least 20 per cent by the year 2010. People with acute mental health problems, particularly those who have recently been discharged from hospital, are identified as a high-risk group for suicide. The introduction of CRHT teams,

providing intensive support for people in a mental health crisis, has been an important part of the National Suicide Prevention Strategy. The importance of the integration of acute inpatient units and CRHT teams and the need for close working between the two, particularly around early discharge planning, has been highlighted as vital for achieving the goal of suicide reduction (Smyth, 2003).

In 2004, the DOH published *The National Service Framework for Mental Health – Five Years On*. In this document, the progress of the NSF targets was described. Of note, £17 million had reportedly been made available to Trusts by 2004 to improve access to services for people in mental health crisis. Of the 335 CRHT teams proposed in the NSF, 168 had been developed by 2004, employing over 2000 staff. Of these 168 teams, 'most' met the MHPIG criteria, thus providing evidence that the development of CRHT services was well underway by this point in time. A recent National Survey of Crisis Resolution teams in England (Onyett et al, accepted for publication) estimated the number of CRHT teams to have risen to 243, with only 40 per cent, however, describing themselves as 'fully set up' to meet local needs. Finally, a 2006 document published by The Sainsbury Centre for Mental Health noted the operation of 343 CRHT teams, concluding that the NHS Plan target of 335 teams had therefore been achieved. Whatever the precise figure, it is clear that the delivery of home-based care for people in crisis is becoming more prevalent in mental health services.

Finally, further support for the importance of home-based treatment comes from the recent *10 High Impact Changes in Mental Health Services* document produced jointly by the National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership (CSIP) and published by the Department of Health (DOH, 2006b). This document aims to guide service improvements in mental health and strongly supports the concept of home-based care as the 'norm' for mental health services.

Having described the policy developments leading to the setting up of CRHT teams throughout the 1990s and early 2000s, this document will now provide a more detailed description of CRHT teams, as described in the MHPIG.

1.2 What are Crisis Resolution Home Treatment Teams?

CRHT teams aim to deliver a service to people aged between 16 and 65 years with diagnoses of severe and enduring mental health problems, who are experiencing an acute mental health crisis which, without intervention, would necessitate hospitalisation. CRHT teams attempt to treat people 'in the least restrictive environment with the minimum of disruption to their lives' (DoH, 2001, p.11). They can be provided in a range of formats and offer an alternative to hospital care through the provision of immediate multidisciplinary,

community based treatment 24 hours a day, seven days a week. The MHPIG outlines a number of the necessary characteristics that CRHT teams require to effectively carry out their remit. These include the ability to:

- Gate-keep access to mental health services, in particular, acute inpatient beds.
- Provide immediate, community-based treatment, 24 hours a day, seven days a week.
- Respond flexibly and intensively to people who are in the acute stage of a crisis.
- Actively involve family members and supporters in assessment and intervention.
- Assertively engage people in the service.
- Remain involved with a person until the crisis has passed and to effectively link service users into follow-up care packages.
- Be actively involved in discharge planning from acute inpatient units to facilitate earlier discharge and return home for service users and to support earlier discharge through the provision of intense and structured home based supports and interventions.
- Help people to reduce their vulnerability to future episodes and relapse, through maximising resilience and awareness of early signs of deterioration.
- Be involved in helping people learn from their mental health crisis and take something positive into their future.
- Provide a flexible but time-limited intervention.

It is evident that time periods for use of the service varies between teams. A survey conducted with a sample of psychologists working in CRHT teams (N=30) found that contact ranged from a single appointment to six months, with the average being four to five weeks. The length of time available is largely dependent on what has been agreed with the team and the relevant service managers and commissioners.

Teams that possess the above necessary characteristics are considered more able to effectively carry out the two broad aims of CRHT teams, i.e. to prevent hospital admission and to facilitate earlier discharge from hospital where admission has occurred. Furthermore, CRHT teams have a role to play in the prevention of emergency re-admission to acute inpatient mental health units (i.e. re-admission within 28 days of discharge). This is a performance indicator as outlined in Standard 4 of the MHPIG (also discussed by the Health Commission, 2005). Whilst the MHPIG describes the 'ideal' CRHT team, the recent National survey (Onyett et al., accepted for publication) shows that there is yet some way to go in meeting these recommendations, particularly in regards to gate keeping and relapse prevention roles.

1.3 The MHPIG Recommended Service Delivery Model

1.3.1 Team Context

The MHPIG recommends that CRHT be provided by a discrete, specialist team comprising staff members whose main responsibility is the support of people with severe mental health problems in crisis. The team requires an adequate skill mix to provide all the appropriate interventions, and to form strong links with other mental health services and local community resources.

The team configuration should be based on a needs assessment of the geographical area, demography, epidemiology and Health and Social Services boundaries.

Estimates suggest a team will have a caseload of 20 to 30 service users at any one time, based on a population of 150,000. Team sensitivity to age, culture, disability and gender is highlighted. Teams are encouraged to liaise closely and actively with service users, supporters/families and other agencies at all stages of service delivery.

1.3.2 Team Composition

Based on a typical caseload of 20 to 30 service users, the MHPIG recommends a total staff group of 14. This should include a Team Leader, Community Psychiatric Nurses, Approved Social Workers, Occupational Therapists, Psychologists, Support, Time and Recovery Workers (including service users) and an administrative assistant.

The level of psychiatric input should be determined by local need and service configuration, although active involvement from both middle grade and Consultant Psychiatrists is recommended, as is 24-hour access to 'senior psychiatrists able to do home visits'.

Specialist skills are detailed as being Occupational Therapy, Psychology and Social Work. Where components of these skills are provided by generic members of the team, supervision and training from a specialist worker is required.

1.3.3 MHPIG Phases of CRHT Work

1.3.3.1 Assessment
Assessment may occur at the point of crisis in the community, or during an inpatient stay when the CRHT team is facilitating early discharge. In either situation, assessment includes: initial screening for suitability of the service to the service user's needs, physical health assessment and multidisciplinary assessment including risk assessment. Assessments should actively involve the service user, supporters, family and all other relevant agencies. They should be rapidly conducted following referral (within one hour), take place in the service user's home where possible, and adopt a 'problem-solving' approach.

1.3.3.2 Planning
Ongoing assessment, liaison with relevant agencies and care planning should occur at all stages of care. Assessments should produce a focused, flexible care plan with input from the multi-disciplinary team, service user, and carers.
It should consider discharge planning at an early stage. This should form an integral part of the CPA.

1.3.3.3 Intervention
MHPIG recommendations are for:

- Designated named workers to co-ordinate care and communication.
- Intensive support with ongoing assessment.
- Medication (administration, concordance work and side effect monitoring).
- Practical help with daily living (e.g. childcare, housing).
- Family/carer support including psycho-education and practical help.
- Interventions to increase resilience, including problem-solving, stress management, brief supportive counselling, promotion of social inclusion.
- Relapse prevention, to include early warning signs monitoring, identification of triggers and risk situations and formation of relapse prevention plans.
- Crisis plan development including when and how to access help.
- Respite – preferably in non-hospital surroundings.
- Access to day services.
- Links with inpatient services and other agencies to aid seamless transfer and discharge planning.

Underpinning these interventions is the broad aim of helping people to remain connected to their usual social, occupational, educational and relational lives throughout their period of crisis.

1.3.3.4 Resolution
At resolution of the mental health crisis, information should be exchanged with relevant others. Referral onwards should consider primary care, assertive

outreach, early intervention, continuing care and other mental health services, as well as Third Sector providers. Prior to discharge, the team should ensure there is a shared understanding of why the crisis occurred and how it could be avoided in the future. In addition coping strategies will have been explored, a relapse prevention plan will be in place, and the service user and their carers will have had an opportunity to feed back on the service received and contribute to service improvement. Robust care plans must be in place for future care and support of the service user. These should be clearly communicated and shared between the relevant agencies, the service user and their supporters.

1.4 Are CRHT teams an effective intervention?

CRHT teams providing 'emergency psychiatric treatment' in the community first emerged in the 1980s in Australia, the US and the UK. Evaluation studies have generally demonstrated positive outcomes in terms of reduced admissions, reduced lengths of hospital stays, and improvements in care in terms of service user's satisfaction (Hoult et al., 1983, Stein & Test, 1980). These findings are supported by more recent UK studies that have compared home versus hospital-based care for people with acute mental heath problems (Marks et al., 1994). This includes the results of at least one randomised controlled trial comparing CRHT team intervention with standard inpatient and community mental health team based care (Johnson et al., 2005).

The effectiveness of CRHT teams is, according to one recent report (CSIP, 2006b) likely to be influenced by a number of factors including:

- Staffing and resources.
- Having the gate-keeping role.
- Effective referral pathways.
- Whole system working.
- Audit, training and practice development.

A recent Sainsbury report (2006), notes the criticism that 'some CRHT teams offer little more than medication monitoring' (p.18). In order to improve the effectiveness of team outcomes, the report suggests that 'CRHT staff must engage properly with people on their caseload' (p.19) and 'should spend time talking to service users and their social networks' (p.19). Both strong leadership and training are deemed vital if CRHT teams are to fulfil their therapeutic potential and maximise their effectiveness. Each of these areas is described below as potential aspects of psychologist involvement.

Section 2: The role of the Psychologist

The recent document *New Ways Of Working for Applied Psychologists in Health and Social Care* (DOH, 2007) outlines key factors to consider when working in team contexts. CRHT psychologists need to adopt the key tenets of this document. In particular, when working in such diverse and complex systems, CRHT psychologists need to be clear about their specific role and ensure that this clarity is communicated and understood by colleagues and managers alike. The following section outlines some specific roles that psychologists can play within CRHT teams, ranging from direct clinical interventions to those aimed at improving team functioning.

Mental health services in the UK are moving towards a recovery-based model of care (NIMHE, 2005). Psychologists can have a role in influencing the development of recovery-based approaches in acute mental health care settings such as CRHT teams. Psychological approaches are based on a bio-psychosocial framework and are formulation-driven, rather than based on more traditional diagnostic models. Psychologists use a formulation-based approach to support CRHT teams in each of the four phases identified in the MHPIG. This may involve working directly with service users or relatives/supporters, as well as offering indirect work to CRHT teams, for example, through staff training and supervision, facilitating reflective practice, and contributing to audit and service evaluation.

An important consideration for psychologists working in CRHT teams is the level of separation or integration with the rest of the team. This differs between services across the country and leads to variations of task, team process and location.

- Task refers to whether the psychologist undertakes the core work of the team, e.g. conducting initial screening and assessment, or whether they have a greater focus on more specific psychological assessment.
- Team processes refers to the psychologist's participation in handover, client review meetings, CPA process and team meetings.
- Location refers to the psychologist's proximal distance from the team, including where and with whom the psychologist has their accommodation, and the accessibility of the psychologist.

The issue of the psychologist's separation or integration within the team (DOH 2007, pp.14–15) needs to be negotiated locally and will be influenced by team and organisational requirements, psychologist level of experience and funding issues.

A recently published survey of CRHT teams in England (Onyett et al., accepted for publication) suggested that psychologists comprise just 0.4 per cent of the CRHT workforce nationally, this being provided by just 13 Clinical Psychologists. However, at the time of writing this briefing paper, the CRHT psychologist network has 70 members, of whom 44 are clinical and counselling psychologists known to be working in CRHT teams. Whilst this suggests a welcome increase in the number of psychologists working in CRHT teams, it is important to recognise that there are 343 CRHT teams in the UK (Sainsbury Centre for Mental Health, 2006), and psychologists continue to be under-resourced.

2.1 Direct Work

A wide variety of psychological approaches can be used in direct work with a client. The psychologist will consider various factors in deciding which interventions to utilise. These include the client's capacity and willingness to undertake a particular approach, the amount of time available to undertake the work, the venue for direct work (i.e. in the client's home or clinic setting) and the client's own view of whether their difficulties have a psychological component.

After assessing these factors the psychologist may follow up with advice and recommendations, or undertake interventions ranging from generic approaches to more structured evidence-based input. The percentage of the psychologist's time devoted to direct work will depend on the demands of the service, the amount of additional psychological resources available in the wider service and the amount of psychological work that can be facilitated through other team members (as a result of training, supervision and consultation).

The four main stages of direct client work are explored in more detail below.

2.1.1 Assessment

During initial assessment staff commonly encounter difficulties engaging potential service users. Psychologists have an awareness of working with obstacles to engagement such as readiness to change, attachment style, shame and lack of trust. To help the CRHT team work with engagement difficulties and risk, psychologists can draw on their understanding of therapeutic relationships and related principles such as transference, counter-transference and the need to create safe therapeutic environments, (e.g. Seager, 2007) . During assessment it can also be important to establish good boundaries, which may be particularly relevant for service users who have experienced abuse, or rejection and who may have been labelled as having a 'personality disorder'.

Psychologists can conduct a range of assessments within a CRHT team, including initial screening assessments (which usually include an aspect of risk assessment), through to more specialised psychological assessments (e.g. of specific cognitive, behavioural and interpersonal factors). Most assessments will aim to gather information about crisis triggers (internal or external) and the client's interpretations of and reactions to these triggers. Social factors are assessed, including relationships, finances and housing (amongst others). Such information helps to inform an understanding of the systemic context in which the client lives. Assessments can take the form of interviews with the client, supporters and family members as well as the use of standardised psychometric assessment tools and, where appropriate, neuropsychological assessment. All assessment information is gathered with the purpose of aiding the development of a formulation, or shared understanding, of the client's recent history and current needs. This formulation is usually discussed with the client and with the team to inform care planning.

2.1.2 Planning

Formulations help guide appropriate interventions and help provide an understanding of a service user's difficulties for them and their families. Psychologists have a broad range of knowledge about different theoretical perspectives on human development and psychological therapies. This makes them particularly well placed to contribute to care planning for service users with complex presentations (e.g. related to childhood abuse, adjustment issues, trauma and dual diagnosis). An understanding of systemic issues in relation to families, social networks, wider social inclusion, and universal services can also be brought to care planning. Bringing together this information can help make decisions about the most appropriate type of intervention to be used, and the timing and frequency of visits. In our experience, workers in CRHT teams do not act as care co-ordinators. However, psychologists and other workers in CRHT teams may become named workers whilst the client is supported by the team.

2.1.3 Intervention

Psychologists are trained to apply evidence-based approaches in their practice, and a wide variety of interventions can be used in a CRHT team with a plethora of service user scenarios. National Institute of Clinical Excellence (NICE) guidelines for conditions such as anxiety, depression, bipolar disorder, eating disorders, obsessive compulsive disorder, post-traumatic stress disorder and schizophrenia all recommend that psychological therapies are provided, or at least considered. Such evidence-based approaches recommended by NICE include Cognitive Behavioural Therapy (CBT), Cognitive Analytic Therapy (CAT), Problem-Solving Therapy, Family Intervention, Interpersonal Psychotherapy (IPT), Focal Psychodynamic Therapy, Eye Movement Desensitisation and Reprocessing (EMDR) and Counselling.

Working in the context of CRHT teams where the focus is on people with severe and enduring mental health problems who are in crisis, experience has shown that the types of interventions or techniques from which it might be useful to draw on are:

- Cognitive Behavioural Therapy (CBT) including aspects of Dialectical Behaviour Therapy (DBT).
- Psychodynamic approaches (including IPT, CAT and Focal Psychodynamic Therapy).
- Psycho-educational approaches (including early warning signs, relapse prevention and provision of self-help material).
- Brief Solution-Focused Therapy.
- Problem-Solving approaches.
- Family Work for Psychosis.
- Motivational Interviewing.
- Person-Centred approaches.
- Systemic approaches.

In our experience, the therapeutic approach taken is largely influenced by the client's length of involvement with the team. As mentioned above (Section 1.2), the amount of time service users are involved with CRHT teams varies considerably across different services, with the average being four to five weeks. This timeframe restricts psychological interventions to mainly short-term, and some medium-term approaches. However, the range of client issues that are found within CRHT teams are not all appropriate for short-term interventions, and many clients need referring on to services able to provide medium to long-term work. Similarly, some service users may not be able to tolerate certain interventions due to the distress they are experiencing and they often need a period of stability before undertaking more in-depth or exploratory psychological interventions.

2.1.4 Resolution

For ongoing difficulties, referral to other appropriate services usually takes place. A typical ending to a piece of work with a client involves relapse prevention planning. Psychologists often present formulations that inform clients about negative or self-destructive cycles, and likely triggers, which can be particularly helpful for people who present to services repeatedly over time. As a way to consolidate understanding, insight and change, therapeutic work is sometimes summarised in a letter at the end of the intervention, which can be used by the client in their ongoing work with other mental health teams.

2.2 Indirect Work

Indirect work within CRHT teams aims to improve team working and effectiveness and requires the CRHT Psychologist to undertake tasks often associated with 'leadership'. Such tasks can be defined as: creating the conditions that enable the team to do its job, building and maintaining the team as a performing unit and coaching and supporting the team to success (DOH, 2007, p.40). Sections 2.2.1. to 2.2.4 describe a number of processes through which these leadership tasks can be achieved.

2.2.1 Evaluation/Audit work

Audit is an essential component of any CRHT service (CSIP, 2006b). For example, in Newcastle, service users were invited to offer their views on important aspects of CRHT service provision and a service evaluation questionnaire was developed from this process. Thus, the voice of service users was included in the evaluation process from the start (Hopkins & Niemiec, 2006).

Because of their training in research methodologies, psychologists within CRHT teams have a valuable role to play in facilitating or leading evaluation and audit work. Within the CRHT psychologist's network, several such pieces of work are being conducted, often focussing on service user satisfaction and uptake of services. For example, Parnham and Greer (personal communication) report on the first year of a clinical psychology service in Swindon's CRHT team, documenting the uptake of this service. They make recommendations for future applications of psychology provision within the team, including:

- The initiation of team supervision to enable reflection on work and to move towards a more holistic, formulation-based approach.
- An increase in teaching and training on psychological concepts as informed by a survey of the perceived training needs of the team.
- To enhance skills around working with service users who present with challenging behaviours, such as people with a diagnosis of personality disorder.
- Increased day-to-day involvement of the psychologist with the team, such as attendance at handover meetings and informal time with the team, to increase psychological thinking.
- Improved links between the CRHT team's generic work and the work of the psychologist, such that the psychologist's input is part of the team's shared approach to treatment.

By participating in such evaluation and audit projects, psychologists can support teams in reflecting on their strengths and in helping them to improve areas of continuing need.

Positive Practice Box 1

Example (i)

In Bristol, the first year of operation (1997–1998) of the Central Sector Crisis Team was audited. This covered the audit standards of service users satisfaction, referrer satisfaction, reduction in admission rates and providing a service to people experiencing severe mental illness. Three of these standards were fully met (service user satisfaction, referrer satisfaction and admission rates). The other standard, providing a service to people experiencing severe mental illness, was partially met, with at least 70 per cent of referrals having a diagnosis that met severe mental illness criteria. Recommendations were made in this audit about extending the hours of operation, which were implemented, and the need for crisis residential alternatives to hospital, which has not happened despite a number of plans. Two of the four authors of this audit were Clinical Psychologists, one of whom worked in the Crisis Team. This also enabled the involvement of psychology assistants to deal with data analysis. The audit provided a foundation for future developments of the then fledgling Crisis Service (Taylor et al., 1998).

Nick Horn, Bristol Citywide Home Intervention Service.

Example (ii)

Newcastle Crisis Assessment and Home Treatment Service was established in 2000. In mid-2001, previous users of the home treatment part of the service were invited to give their views about what was most important to them about this experience. A participatory research approach combined a two-stage modified Delphi study and semi-structured interview. This was conducted by service user interviewers and used to obtain rich data to inform the development of a service evaluation questionnaire. The questionnaire is now in routine use for every person who is in receipt of treatment at home. The feedback used from the questionnaire will be used to shape and refine the service provided by the team in the future.

(Hopkins & Niemiec – Personal communication.)

2.2.2 Research and Outcomes

Outcomes within CRHT settings can be considered at many levels, both micro and macro. Micro level outcomes may include the following:

- Clinical outcomes for the individual service user in relation to symptom profiles, quality of life, social inclusion, recovery and well-being (to name but a few).
- Outcomes for the team itself (e.g. the improved psychological mindedness of the team, the well-being and job satisfaction of team staff, sickness levels and retention rates).

Psychologists working within CRHT teams can play a part in evaluating outcomes on this micro level. This may include, for example, using psychometric assessments with service users pre- and post-team intervention, developing and conducting service user satisfaction surveys and establishing methods for staff to routinely feedback information on their satisfaction with their roles. The evaluation of these outcomes may occur as a routine part of clinical care or as part of a more specific project or research plan, perhaps conducted in conjunction with other team members. The results of these evaluations should be fed back into clinical practice and, where necessary, improvements in service delivery should be implemented.

At the macro level, psychologists can work with colleagues and, where necessary, external networks (e.g. the DCP CRHT Network, Mental Health Research Networks and their hubs) (http://www.mhrn.info/dnn/). These links can be used to develop pertinent research questions and to design appropriate studies to test these questions.

Studies to date suggest that most CRHT research and evaluation has been directed towards establishing:

(a) Whether CRHT teams are concordant with the criteria laid down by the MHPIG (Catty et al., 2002, CSIP, 2006); or
(b) The ability of CRHT teams to reduce hospital admissions (e.g. Johnson et al., 2005).

Less evidence is currently available to define what the effective elements of such teams are. A recent National Audit Office report (NAO 2007) highlighted this point, concluding that 'The current CRHT target regime has been an effective driver to implementation, but is limited by its focus on outputs (e.g. CRHT episodes) rather than outcomes (e.g. benefit to service users)'. Furthermore, 'the Department plans to place less emphasis on existing targets for the number of teams and episodes and to encourage the introduction of more locally managed and outcomes-based metrics of performance' (p.7) Thus, there is much scope for psychologists to shape the development of clinically relevant outcome measures and research questions which explore the effectiveness of such teams.

Positive Practice Box 2

Example (i)

The Clinical Psychologist in the Sheffield Crisis Assessment and Home Treatment team conducted a clinical outcome study involving 123 service users during a six-month period in 2005. Outcome measures included the Crisis Triage Rating Scale (CTRS), Health of the Nation Outcome Scale (HoNOS) and the Brief Psychiatric Rating Scale – Expanded (BPRS-E).
The results demonstrated that the appropriate population was being treated in the home, and that significant symptomatic improvements, as well as social and behavioural improvements, were seen. The study also gave information on the types of service users who needed inpatient care, and demographic information on which service users most benefited from home treatment.
Jo Nicholson, Sheffield CAHT team. Jo.Nicholson@SCT.NHS.UK

2.2.3 Team Development

2.2.3.1 Within the Team

Psychologists can contribute to the development of the general functioning of the team. This is largely because psychologists are often trained and knowledgeable in systems theory and systemic practice, sometimes through generic training or through specialist post-qualification training.

The Capable Practitioner report (Sainsbury Centre, 2001) discusses the core capabilities required to implement the NSF Standards for Mental Health and focuses on the skills required of all mental health practitioners. The most important skills in this report include being effective and reflective in mental health work. Within these two broad areas of skill, practitioners are expected to be capable in the following areas:

- Performance (i.e. the clinical tasks of the role).
- Ethical (knowledge, values and social awareness).
- Reflective (in-action and on-action).
- Effective (implementation of evidence-based interventions).
- Commitment and responsibility to lifelong learning.

CRHT teams can often be reactive due to the acute clinical nature of the work. Busy and reactive teams may be high on 'performance' capabilities whilst finding that they struggle to maintain their 'reflective' and 'effective' capabilities. CRHT team psychologists have a role to play in helping their teams to create and maintain opportunities for reflection and training. Within the 'Capable Practitioner Framework' this type of role is referred to as 'Clinical and Practice Leadership' and includes tasks such as:

- Developing and promoting evidence based practice within the team so that the treatments on offer are in line with NSF standards and NICE guidance.
- Facilitating the development of staff appraisals within the team.
- Initiating clinical supervision and staff support as a means to enhance job satisfaction and prevent burnout.
- Initiating and implementing clinical and practice research, and service evaluation.

Whilst many of these tasks would be expected to fall to the Team Leader or Manager, CRHT team psychologists possess the skills to contribute to such team developments, providing that the local context is welcoming of, and ready for, such contributions.

2.2.3.2 Beyond the Team

Psychologists who work in CRHT teams in a professional managerial role (Agenda For Change Band 8c and above) are also likely to hold responsibility for service developments that extend beyond the CRHT team itself. Some examples of these service developments are described below:

Interface Processes and Procedures

CRHT teams inevitably interface with many other teams within a mental health service and, as the number of interfaces increases so too does the potential for ruptures and breaks to emerge in these interfaces (for both service users and workers). Consultant Psychologists may have a role to play in facilitating clear, well-defined processes to guide such interfaces, thus reducing the potential for problematic processes to develop. This can be achieved, for example, by the development of clear operational policies (at a Directorate level) guiding communication and liaison between teams.

Care Pathway Development

Consultant Psychologists may also become involved in the development of care pathway processes which enable service users to move as seamlessly as possible through the various levels of their service involvement. Such care pathways can be developed for particular clinical presentations (e.g. guidance on how service users diagnosed with co-morbid personality disorders can be assessed and treated within the context of a CRHT contact). Alternatively, they may be developed for particular areas of the system (e.g. the development of protocols to guide clinical care between CRHT and inpatient services).

National Service Developments

Consultant Psychologists working in CRHT teams and who may hold responsibility for psychology provision within acute care as a whole need also to be aware of the various external drivers that potentially impact on their areas of

service delivery. That is, psychologists should be aware of the various governance and service improvement agendas that are in force at any given point in time so that they are able to work, in partnership with others, to promote organisational change. Current examples of such external drivers in adult acute care include: The AIMS project (AIMS@cru.rcpsych.ac.uk), the STAR WARDS project (www.starwards.org.uk), and Acute Care Forum developments (DoH, 2002; SCMH, 2004; 2006). In this way, psychologists engage fully in the Clinical Governance (e.g. DoH, 2004) and New Ways of Working agendas (Lavender & Hope, 2007). This promotes increased access to psychological therapies and models, helping services to become more psychologically minded and capable and, where possible, setting standards for the quality of psychological approaches offered by other professional groups within the organisation.

The core training of psychologists, along with experience of organisational systems, provides them with a range of appropriate skills with which to contribute to service development. The core skills that are of particular benefit to this type of work are:

(1) Using psychological theory of process issues and motivating relevant stakeholders for change.
(2) Utilising audit and research findings to enable change.
(3) Using analytic and complex problem-solving skills to generate solutions.
(4) Utilising effective project management skills.

Clearly no one person alone could contribute to all the service developments noted above. Therefore, Consultant Psychologists wishing to undertake such work should do so in the context of existing Trust mechanisms and processes. Alternatively, they may wish to make the argument for the development of fora in which such discussions and service improvement initiatives could occur.

2.2.4 Training

The psychologist has a role in teaching and training, for both psychologists and non-psychologists. A benefit of the CRHT team psychologist undertaking training within the team is their ongoing availability to troubleshoot, refine and hone the skills taught, so that their contribution is used most appropriately and to maximum benefit.

As well as providing training in specific psychological techniques, it may also be appropriate for the psychologist to provide training in psychological models or theories of behaviour and functioning as a way to promote the team's broader understanding and formulation of service users' difficulties.

Positive Practice Box 3

Example (i)

The Clinical Psychologist in the CRHT team undertook a survey of the team's training needs by circulating a list of potential training topics that were considered relevant to the team. The team was asked to tick which topics they felt would be most beneficial as well as to add other suggestions to the list. The psychologist then developed a programme of psychological teaching sessions. This included work on fundamental counselling skills, distraction techniques, use of validation, cognitive-behavioural techniques for anxiety and depression, dialectical behaviour therapy techniques for managing distress and relapse prevention work. The team have also received Family Work for Psychosis skills training as an extended programme. This includes monthly follow-up supervision to refine the skills taught.

Lynda Parnham, Clinical Psychologist, formerly at Swindon CRHT team.

2.2.5 Supervision and Consultancy

Psychologists have an important role in supervision and consultancy. Supervision may extend beyond that of graduate psychology staff (such as Assistant Psychologists and Trainee Clinical Psychologists) and junior colleagues to other members of the team. It may also include facilitating reflective practice groups, peer consultation and group supervision. Group supervision may be considered to have three foci (Hawkins & Shohet, 2004):

- The task in hand, i.e. the day-to-day clinical work.
- Well-being of the individual practitioner.
- Well-being of the team.

The type of supervision that the psychologist offers to the CRHT team will be heavily influenced by their position in relation to the rest of the team. In the CRHT Psychologist Network, it is our experience that it is more complex to offer supervision to the team when the psychologist is embedded in the team.

Psychologists can also play a role in offering psychological consultation to staff, which can aid in developing a tiered model of care, dependent upon service user need. By offering consultation to help determine the service user's level of psychological need, psychologists are able to facilitate the psychological mindedness of colleagues and to direct their attention to those interventions that are most suitable for that person at that particular point in time. Successful consultation approaches can ensure that:

- The team's understanding of psychological need is increased.
- A stepped approach to assessment and care within the CRHT team is developed.

Such approaches have been successfully piloted within community contexts (Day, 2005 – personal communication) and would appear to have an application to CRHT team settings, although the vehicle by which consultation is offered may differ in CRHT team contexts. For example, consultation may be offered via daily handover and clinical review meetings rather than necessarily through one-to-one meetings with individual workers.

2.3 Service User/Carer Involvement and the Psychologist

Service user and carer involvement covers a wide range of issues – from the macro level of service design and policy to micro levels of individual clinical work, teamwork and consultation. The CRHT Psychologist Network has discovered a variety of forms of carer and user involvement in CRHT teams. This includes involvement in audits, service user satisfaction surveys, facilitation of carer's groups, service development groups, employing service users and linking with advocacy groups (see Positive Practice Box 4 below). The training of psychologists in research and group work (both therapeutic and educational) enables them to make a specific contribution to the development of these facets of user and carer involvement.

Collaborative working, using the CPA process and through carer assessments, is an important part of involving service users in the planning of care. At a more macro-level is the involvement of service users in the planning and development of services. One aspect of this level of involvement is the employment of service user development workers. Relton and Thomas (2002) describe the role of service user development workers in a home intervention team in Bradford. They describe some of the aspects of their role as participating in review meetings and providing training and information to the team. They may also visit service users from time to time, if, for example, someone wants to talk about the politics of mental health, or if they simply want to talk to another person with service user experience.

Involving service users in this way can help in 'supporting the team to develop and maintain a non-medical philosophy' (Relton & Thomas, 2002). Although there is no single unitary service user 'perspective', a common theme of service user involvement is the provision of alternative perspectives on the understanding of mental health, therapy, social inclusion, power, etc. (Tait & Lester, 2005). Whilst psychology cannot claim a monopoly upon alternative professional understandings of mental health problems, psychologists' emphasis on more holistic, biopsychosocial formulations is perhaps more consistent with alternative, open dialogues about mental health issues from a service user perspective. Therefore, psychologists can fruitfully contribute to service user led work.

Positive Practice Box 4

Example (i)

'In our team there are two dedicated service user development workers employed. Both are users of mental health services. Their role is to be constantly evaluating the service, the interventions used and information provided as a service from a user perspective. They are involved in clinical discussions and in working directly with some clients, often discussing issues about being a user of mental health services. These visits offer a chance to explore different perspectives of mental health and provides the experience of being able to meet someone who has had their own mental health crises but who have been able to move forward. Service user development workers in our team are also exceptionally well informed about many of the practical and systemic issues in mental health services, including legal, administrative and social factors.' *Nick Horn, Bristol Citywide Home Intervention Service.*

Example (ii)

South West Kent CRHT team has run a Service Development Group. This involved an informal monthly meeting where CRHT team past and current service users were invited to give feedback on the service. This led to the development of patient leaflets, help in the design of a client satisfaction survey, and involvement on interview panels. City and Hackney Crisis Service have similarly involved service users in providing feedback on the service they received from the team during staff training sessions.
Elaine Johnston, South West Kent CRHT team.

Example (iii)

The Isle of Wight Mental Health Assessment and Treatment Service (MATS) incorporates Crisis Intervention and Home Treatment within its service. They have actively involved service users in providing feedback in the planning of groups. There is potential for some of these groups to be run by service users. Furthermore, service users have also undertaken client satisfaction surveys.
Isle of Wight MATS.

Section 3: Employing and retaining psychologists in CRHT teams

3.1 Recommended Experience and Characteristics of the CRHT Psychologist

In order to work effectively in a CRHT team, we have found the following helpful:

- Previous experience of acute mental health work.
- Flexibility, creativity, robustness, open-mindedness, clarity of thinking.
- Ability to adapt standard interventions to the particular demands of CRHT working.
- Ability to promote psychological understanding in a context that may be unfamiliar to this way of working.
- The ability to stay calm in a crisis.
- The ability to work closely as part of a 24-hour multidisciplinary team.
- A good sense of humour!

3.2 Banding of the Psychologist

In order to carry out the range of direct and indirect work described in this paper, a banding of Principal Clinical Psychologist (formerly Highly Specialist Clinical Psychologist), at band 8a or above is necessary. Whilst a proportion of psychologists within the Network have entered CRHT teams at band 7, the number of challenges in these teams related to practice and negotiation of role, along with the necessity of having worked previously with people with severe mental health problems, cautions against the use of posts at this grade. Psychologists at band 8a or 8b, however, will have additional experience allowing them to better meet the range of needs of the team whilst employment of psychologists at managerial grades (i.e. 8c and above) allows the full range of micro and macro involvements as described in this paper. Assistant Psychologists (band 5) can be employed to support the work of qualified Psychology staff within CRHT teams. Whatever the banding, psychologists within CRHT teams require supervision from a more experienced colleague (see Section 3.5 below).

3.3 Full- or Part-Time?

The MHPIG (DoH, 2001) offers 'suggested staffing levels' for CRHT teams including psychologists as part of the team cohort. No specific recommendations are made as to whether psychology input should be provided on a full or part-time basis, or indeed, how many psychologists should be employed per team. The CRHT Network has identified that most psychologists (approximately two thirds) work full time within their teams. However the relatively small number of psychologists within the Network lags behind estimates of the number of CRHT teams currently operating across the country (243 – Onyett et al., 343 – SCMH – 2006). This suggests that only a small proportion of CRHT teams currently include a psychologist within the staff team. Whilst full-time practitioners should be able to undertake both direct and indirect work within the team as described in this briefing paper, it should be fully understood that achieving this range of input will be difficult for the part-timer. In these circumstances, there is a need for negotiation with the team as to the nature of work in which the practitioner engages. This negotiation may take into account a number of factors, e.g. the teams own 'developmental level' (i.e. its age, outlook and position within the organisation), the team's 'psychological mindedness' and the relative experience of the psychological practitioner. It is the experience of Network members, for example, that early on in the introduction of psychology into a CRHT team, there is a need for the practitioner to engage the team in psychological ways of working through direct work that aims to model psychological assessment and intervention. As the team's familiarity and comfort with psychological approaches grows, it will be helpful to include more indirect approaches such as teaching/training, supervision and consultation. In this way, the psychologist approaches the team itself in a psychological manner, offering the interventions that best fit the team's readiness to engage with psychological work.

3.4 Working Hours

Many CRHT teams use a shift system with a rota to cover the extended hours of operation. Many teams operate 24 hours a day, seven days a week. Feedback from the CRHT Psychologist Network shows that while psychologists recognised the need to be flexible, the vast majority were not on the staff rota. It is widely felt that being on a rota restricts the ability to provide regular therapy sessions, supervision sessions and to be accessible during busy times for consultation. Psychologists tend to work traditional hours from Monday to Friday, but with negotiated flexibility for evening or weekend work.

3.5 Supervision of the Psychologist

Psychologists of all grades must have access to appropriate supervision (DCP, 2003). From our experience of working in CRHT teams, some helpful supervisor characteristics are:

- An understanding of CRHT team work.
- An understanding of brief psychology interventions.
- An ability to work effectively with high levels of risk.

Peer supervision (whether from the CRHT Network or local psychology colleagues) is also important to share experience and learning and helps the psychologist to maintain their specific professional identity in the multi-disciplinary team.

3.6 Management of the Psychologist

Management of the psychologist in the CRHT team is often shared between the CRHT team and the psychology department. In our experience, the locality lead psychologist professionally manages the majority of psychologists. The CRHT team manager offers line management. When this arrangement works this is acceptable. However, there are certain considerations worth taking into account. Being line managed by the CRHT team manager can create a difficult dynamic as the psychologist may be on an equivalent or possibly higher pay banding than the team manager. It is certainly recommended that there is a good relationship between the psychologist and the CRHT manager, such that the CRHT manager is fully aware of the remit and role of the psychologist. Decisions on how management is organised may also be influenced by where the budget for the psychology post is held. Being professionally managed by the psychology department ensures the maintenance of professional identity as a psychologist, and can be very helpful in planning continuing professional development activities and appraisal processes in terms of career development.

Section 4: Conclusion and Key Recommendations

Psychologists play an important role in providing CRHT teams with a psychological understanding of service users difficulties, supporting staff in a very demanding environment, and implementing service evaluation and team development activities. However, although the number of CRHT teams employing a psychologist is increasing, there are still a large proportion of teams without this vital input. This shortfall needs to be addressed by the further development of psychology posts in CRHT teams nationally.

Our key recommendations are highlighted below. This is not a definitive guide; however, these recommendations have emerged from the direct experiences of psychologists who have worked in CRHT teams across the UK. Important areas to consider are:

- Many of the capabilities and roles described in this briefing paper are not exclusively the domains of psychologists, and some can be carried out by other professions. However, an experienced psychologist will bring all of these assets to a CRHT team. We recommend that the range of specialist skills brought to the team requires an AFC banding of at least 8a. The banding of 8a or above, as opposed to band 7, ensures an added emphasis on the development of others in the team, a greater role and responsibility in quality issues and service development, and being an active contributor in the planning and supervision of the team's work.
- We recommend that when applying a range of psychological approaches within a CRHT setting, psychologists consider the developmental stage of the team and its receptiveness to psychological principles. For example, in the early stages of providing psychological input into a team, it may be necessary to provide one-to-one work with individual clients to prove the value of psychological intervention before increasing this to incorporate psychological thinking in case discussions, during meetings, within supervision, etc. The amount of experience the psychologist has may also dictate the range of roles undertaken.
- We recommend that psychologists in CRHT teams be somewhat separate from the core work of the team, and that psychologists should not do shift work as this will inhibit them in enabling the full range of psychology services to be made available.
- The psychologist should be able to ring fence some of their time for equally important activities such as audit, research, service development, etc., which would be difficult to undertake if the psychologist were also contributing to the core tasks of the team.

- We recommend that specific attention be paid to the importance of negotiating the role of the psychologist with both the team manager and the team. This should be supported directly by the supervising psychologist
- We recommend that due to the demanding nature of the work, the psychologist has access to psychology support networks that have a focus on CRHT working, as well as access to individual supervision from a senior, experienced colleague.

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