A GROUNDED THEORY STUDY OF THE EXPERIENCES OF CLINICAL PSYCHOLOGISTS WORKING IN CRISIS RESOLUTION AND HOME TREATMENT TEAMS

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ABSTRACT

There has been a rapid development and implementation of Crisis Resolution Home Treatment Teams (CRHT) in the United Kingdom over the past decade. The available research studies of this service provision to date have largely focussed on issues related to the *'outputs'* of CRHT, for example cost efficacy and the impact on admission rates. There is no available research on the experiences of clinical psychologists within CRHT. This is despite the fact that it would seem that research exploring the experiences of clinical psychologists in CRHT is important, as working in a new area of service provision may present specific challenges. An understanding of the nature of these challenges is considered important in order to support clinical psychologists in these settings, and to sustain and improve service delivery.

This study presents a qualitative exploration of clinical psychologists' experiences of working in a CRHT. Eleven clinical psychologists were interviewed about their perceptions of working within CRHT, their relationships with other professionals and their experiences of working with service users in *'crisis'*. The Grounded Theory approach was employed to analyse participants' accounts.

Three broad themes relating to *'Psychological and Clinical Work'*, *'Teamwork'* and '*Positive and Negative Aspects of CRHT Working'* were identified in the study. The emergent themes are compared to the wider literature on clinical psychologists' experiences of working in teams, and working with service users in crisis. The findings have a range of implications for clinical practice in CRHT, service development and future research.

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1.1 OVERVIEW

This chapter gives an overview of the relevant literature on Crisis Resolution and Home Treatment Teams (CRHT) as a method of service provision. A definition of the term *'crisis'* will be provided, in relation to mental health service users. In addition, literature on the experiences of clinicians working with service users in crisis will be considered. The available evidence regarding the experiences of clinical psychologists within teams more generally, and in CRHT will then be outlined. Finally, the rationale for investigating clinical psychologists' perceptions and experiences of working within CRHT will be provided in the context of the present study.

1.2 INTRODUCTION TO CRISIS RESOLUTION HOME TREATMENT TEAMS

1.2.1 Historical and Policy Development

The development of CRHT service provision for people with mental health problems can be traced to historical developments and reorganisation of mental health care policy in the United Kingdom. These included: 1) the Community Care Movement (Department of Health; DoH, 1989; NHS and Community Care Act, 1990), 2) service user views regarding the unacceptability of inpatient services (e.g. Rose, 2001; Glasby & Lester, 2005) and 3) evidence for the cost effectiveness of community care compared with inpatient care (e.g. National Audit Office; NAO, 2007a, National

Institute for Mental Health in England; NIMHE, 2006). Each of these factors contributed to the development of CRHT policy and service provision, and will be outlined in the following section.

1.2.1.1 Changes in Mental Health Care Policy towards Community Care

The development of community services can be linked to the move towards deinstitutionalisation, prevention of hospital admission and increased community care during the 1950s (NHS and Community Care Act, 1990). Home treatment for mental health crises was introduced shortly after the Second World War, with mental health services in Amsterdam establishing a 24-hour *'first aid'* emergency home service (Querido, 1968).

Along with moves towards care in the community, there was an emphasis on improving mental health care in the National Health Service (NHS) and social services, as outlined in the document, *'Modernising mental health services: safe, sound and supportive'* (DoH, 1998a). This policy framework aimed to provide 24-hour crisis teams to support individuals with acute mental health problems. In addition, the implementation of the National Service Framework for Mental Health (NSF; DoH, 1999) set out seven standards of service delivery for mental health care, three of which considered the improvement of care for individuals in mental health crisis.

The NHS Plan (DoH, 2000) outlined the development of three types of specialist mental health team: Assertive Outreach (AOT), Crisis Resolution and Home Treatment (CRHT) and Early Intervention in Psychosis (Mental Health Policy Implementation Guide; MHPIG; DoH, 2001). The main function of CRHT was to reduce pressure on inpatient wards by 30 per cent, via reduction of admission rates and days spent in hospital. The service provision was made a national priority in England, with the plan to establish 335 teams by 2004 (DoH, 2000).

This recognition of the demand for community mental health services for people in acute mental health crisis was one of the reasons for the development of the home treatment approach (Johnson & Thornicroft, 2008). In addition, increasing service user dissatisfaction with inpatient services was another factor in the development of such services.

1.2.1.2 Service User Dissatisfaction with Inpatient Care

As well as government policy, a growing body of evidence highlighted service user dissatisfaction with inpatient care compared with community services (e.g. Sainsbury Centre for Mental Health; SCMH, 1997a, 1998; Henderson et al., 1999; Rose, 2001; Quirk & Lelliott, 2001; Glasby & Lester, 2005; MIND, 2004; NAO, 2007b). This evidence comes from a number of sources, including mental health charities and service user perspectives (Rose, 2001; MIND, 2004), government bodies (SCMH, 1997a; 1998; NAO, 2007b), reviews (Quirk & Lelliott, 2001) and research studies (Henderson et al., 1999; Wood & Pistrang, 2004; Glasby & Lester, 2005).

Quirk & Lelliott (2001) conducted a literature review to establish a snapshot of life on acute psychiatric inpatient wards. This was in response to the authors' observation of the lack of research on conditions on inpatient wards. More than 170 studies were identified, which included participant observation and interviews or surveys with service users. A range of issues were highlighted, including a failure to address service users' social and psychological needs (Muijen, 1999; Baker, 2000), as well as violence, sexual harassment, rapid staff turnover and low staff morale. In addition, Wood & Pistrang (2004) completed a qualitative study to explore the experiences of nine service users on acute inpatient wards. The authors identified service users' experiences as characterised by feelings of overwhelming vulnerability and helplessness. Furthermore, Muijen (1999) suggested that the inpatient experience was '*atherapeutic'* for service users, and considered inpatient care to be inefficient, ineffective and poorly organised.

In what was considered a unique initiative for reviewing the care and treatment of service users on inpatient wards, the Sainsbury Centre for Mental Health (SCMH, 1997a) conducted an unannounced, one day visit of 309 acute psychiatric wards in England and Wales (representing around 47 percent). The unexpected nature of the visit allowed for a snapshot of life in inpatient settings. The aim was to investigate a range of issues, including the deployment of nursing staff and the safety and privacy of female service users. The results pointed to considerable pressures on inpatient units, including low staff levels and high workload, little service user-staff interaction and a lack of safe facilities for female service users.

The following year, SCMH (1998) published a major piece of research which tracked over 200 people through their time in acute inpatient care. This was examined in a representative sample of nine psychiatric wards in England. The results highlighted a failure in inpatient services to tackle the social needs of service users and in providing long-term support. Service users identified a lack of activity, little interaction with staff, boredom and a lack of therapeutic input. Women in particular reported feeling dissatisfied with hospital care.

Furthermore, it has been documented that due to the detrimental impact of previous experiences of inpatient wards, service users may try to avoid contact with mental health services for fear of admission (DoH, 2002).

Overall, this body of evidence points to the negative experience faced by service users and deficiencies in standards on inpatient wards, as well as low staff morale. The lack of available therapeutic input in these settings also suggests that inpatient admission may even act as a hindrance to the recovery process for service users. Furthermore, these criticisms should be taken alongside the high cost of inpatient care, which will be summarised in the next section.

1.2.1.3 Cost of Inpatient Care

There are convincing financial arguments for the development of community services, when contrasted with the cost of inpatient care. Indeed, the cost of inpatient care provision has traditionally taken up the most significant share of mental health expenditure (SCMH, 1997a). However, Muijen (1999), in a critique of inpatient care advocated the use of hospitalisation as a last resort. The documented limitations were given as the rationale, and the use of crisis services or other community settings were suggested as alternatives. This is in line with the view of proponents of CRHT who traditionally argued for their cost effectiveness, which has been borne out by evidence (e.g. NAO, 2007a).

1.2.2 Development of CRHT: Summary

In summary, the documented limitations of inpatient settings, including low staff morale (SCMH, 1998) and service user dissatisfaction (Rose et al., 1998; Rose, 2001) led to the rapid expansion of CRHT as a method of service provision from the late 1990s (Johnson & Needle, 2008). This was in parallel with requests from service users and carers for community based alternatives (Audit Commission, 1994), and in line with the drive toward increased community care. In addition, evidence suggesting the improved cost efficacy of such services compared to inpatient care (NAO, 2007a) has been another driving factor in the development of CRHT services. It can therefore be seen that the development of CRHT service provision intended to improve the acceptability of mental health care to service users, carers and staff. In addition, the service development was linked to policy requirements to widen service

provision to include a range of community services. In the following section, an overview of the aims and roles of CRHT service provision will be outlined, as well as the intended service user population and team composition. The section will conclude with an overview of CRHT implementation.

1.2.3   CRHT Service : Aims, Roles, Target Population and Composition

1.2.3.1 CRHT Service Aims

CRHT aims to offer a specialist service to individuals aged between 16 and 65 years, who present with *'an acute psychiatric crisis of such severity that, without the involvement of a CRHT, hospitalisation would be necessary'* (NIMHE, 2006, p9). The main role of CRHT is to offer service users an alternative to inpatient care, and reduce hospital admission by providing assessment and short-term community support until crisis resolution (SCMH, 2001).

While the NSF (DoH, 1999) laid out standards regarding the need for service provision for people in mental health crisis, the model of care was outlined by the Sainsbury Centre for Mental Health (SCMH, 2001). The delivery of standards was supported in the NHS Plan (DoH, 2000) and the Mental Health Policy Implementation Guide (MHPIG; DoH, 2001). The MHPIG provided the framework for the development of CRHT service provision, and outlined the necessary criteria. Within this, it emphasised the need for care to be provided *'in the least restrictive environment with the minimum disruption'* (MHPIG; DoH, 2001, p11). This meant

that care could be provided in a range of settings, with an emphasis on the homes of service users. The MHPIG recommended that CRHT should provide:

- *'Immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week, 365 days a year'.*

- Input which is *'intensive'*, *'time-limited'*, and supports the *'active involvement of the service user, family and carers'.*

- *'Involvement with the client until the crisis has resolved'.*

- A remit to *'act as a 'gate keeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service'.*

1.2.3.2 Roles of Crisis Teams

According to guidance for the delivery of CRHT services (MHPIG, DoH, 2001; Welsh Assembly Government; WAG, 2005b), there are four phases to crisis resolution, each of which should be linked to the functions of CRHT. These are: *assessment, planning, intervention and resolution.* Johnson & Thornicroft (2008) highlight the key function of CRHT to support service users' adaptive coping skills to enable crisis resolution. CRHT assessment and intervention also includes the importance of service users' social networks in mental health crises (Bridgett, 2006).

It should be noted that the terms *'crisis resolution'* and *'home treatment'* are used interchangeably in MHPIG (DoH, 2001), viewing them as functions within one team.

However, Hoult (2006) commented that the interpretation has been diverse on a national basis, with some services set up into crisis resolution teams and home treatment teams as separate entities. Hoult (2006) views both functions as integral parts of the same team (i.e. effective home treatment leads to crisis resolution).

1.2.3.4 CRHT Target Service User Population

According to guidance for CRHT services, those with diagnoses of severe mental health problems such as schizophrenia, bipolar disorder or severe depressive disorder are suitable for CRHT input (MHPIG; DoH, 2001; NIMHE, 2006). Individuals not considered to be appropriate include those with a presentation of mild anxiety disorder, a primary diagnosis of alcohol or substance misuse, an organic condition, brain damage or learning disability, or a crisis related only to relationship issues (MHPIG; DoH, 2001; NIMHE, 2006).

Initially, and controversially, those with an exclusive diagnosis of personality disorder, as well as individuals who engaged in self-harm without a significant mental health problem were considered not to meet the inclusion criteria for CRHT treatment (MHPIG, DoH, 2001). However, changes in mental health provision for those with personality disorders (*'Personality Disorder: no longer a diagnosis of exclusion'*; NIMHE, 2003) documented that mental health care and crisis provision could not be withheld from such individuals. This guidance suggests that the decision to assess or treat such individuals should be made according to individual presenting need (NIMHE, 2006).

1.2.3.5 CRHT Team Composition

The MHPIG recommends a *'discrete, specialist team that has staff members whose sole (or main) responsibility is the management of people with severe mental health problems in crisis'* (DoH, 2001, p 19). The importance of the skill mix is referred to (DoH, 2001, SCMH, 2001, NIMHE, 2006), as well as the need to develop links with local mental health services.

According to the MHPIG (DoH, 2001), each CRHT is likely to cover a population of around 150,000 service users, with a typical caseload between 20 and 30 service users at any time. The approximate staffing level is suggested at 14 staff members, to include Community Psychiatric Nurses, Approved Social Workers, a team leader and administrative assistant. The MHPIG suggests that the skill mix should include those from Occupational Therapy, Psychology and Social Work backgrounds. The specific skills of psychologists are recognised, and the MHPIG (DoH, 2001) recommends that psychologists should be included in the team composition.

1.2.3.6   CRHT Implementation

Of the projected development of 335 CRHT in England by 2004 (DoH, 2000), 168 teams had been established according to the document *'National Service Framework for Mental Health: five years on'* (DoH, 2004). In Wales, the development was prioritised in 2005, in response to a growing awareness of the need for CRHT service provision (Service and Financial Framework 2005-2006 target; Wales Audit Office; WAO, 2005). The revised Welsh National Service Framework for Mental

Health, *'Raising the Standards'*, (WAG, 2005a) supported the development of CRHT services, and guidelines were developed (WAG, 2005b) to outline CRHT function. In Wales, 18 CRHT were established by 2010 (Jones & Jordan, 2010).

In summary, this section has considered the key aims and roles of CRHT care as an alternative to hospital admission for those presenting in mental health crisis. The recommended staff team composition has been considered, which includes the role of psychology. In addition, a perspective of CRHT implementation in England and Wales has been given. It can be seen that CRHT as a method of service provision in mental health care has expanded in recent years, despite the fact that home treatment as an alternative to inpatient care was relatively rare in the United Kingdom as recently as the early 2000s (Orme, 2001). In the following section, the literature base on evidence for CRHT as a method of service provision will be given.

2. CRISIS RESOLUTION HOME TREATMENT TEAM LITERATURE

An overview of the relevant literature regarding CRHT will be provided in this section, in order to provide a context for the current study. This will consider evidence regarding the effectiveness of CRHT, as well as service user perspectives. A literature search was performed using psychological and medical journals and databases, through PsycInfo, Google Scholar and The Cochrane Library. The following search terms were used as a basis for the search: *'crisis', 'crises', 'resolution', 'home treatment team' 'CRHT', 'intervention', 'cost effectiveness', 'availability', 'acceptability'* and *'acute inpatient care'.* The years 1980-2011 were

included, and a total of 67 relevant articles were identified at this point. In addition, bibliographies were hand-searched for additional references. It is important to acknowledge that although a number of papers were identified in the literature search, space restrictions mean that it has not been possible to report on all of the studies identified. As such, the following review will give a broad perspective of the relevant issues.

2.1 Evidence Base for the Effectiveness of CRHT

According to Hoult (2006), research into the effectiveness of CRHT services has been limited and sporadic, although the need to consider this in the context of limited evidence for the effectiveness of Community Mental Health Teams (CMHTs) and inpatient services is emphasised. Investigations have focused on admission rates and other outputs of CRHT, and there is currently no clear perspective regarding their clinical effectiveness in relation to service users' mental health functioning (Johnson & Bindman, 2008).

2.1.1 Early Literature on the Effectiveness of CRHT

The literature base for CRHT involves work in Europe, America and Australia, dating over thirty years. Early research highlighted the limitations of hospital admission, such as neglect of crisis triggers and loss of coping skills, instead pointing to the efficacy of services for those in mental health crisis in the community (e.g. Hoult, 1986).

Of the initial studies of CRHT services, findings generally pointed to improved cost effectiveness compared to inpatient care (Hoult & Reynolds, 1984; Knapp et al., 1994), preference by service users and carers (Dean & Gadd, 1990; Muijen et al., 1992; Marks et al., 1994), reduction in hospital admission and length of stay (Hoult & Reynolds, 1983, 1984; Reynolds & Hoult, 1984; Stein & Test, 1980; Muijen et al., 1992) and improved service user functioning (Marks et al., 1994).However, methodological limitations have hindered these studies, impacting on their generalisability. Specific limitations have included a difficulty in elucidating the specific aspects of home treatment which were effective and the age of some of the studies, leading some to criticise them for being outdated (Pelosi & Jackson, 2000). In addition, typical comparisons in these studies were home treatment with hospital care, as opposed to other community services. The fact that some studies were conducted internationally also limits the generalisability of the findings to the United Kingdom health care system.

However, despite these criticisms, on the whole, early research demonstrated the benefits of community services for individuals in acute mental health crisis. It is important to note that these studies included a range of community services, and did not exclusively focus on CRHT. Along with the arguments for the development of CRHT services outlined earlier in this chapter, this led to the widespread development of CRHT as a distinct method of service provision (Johnson & Thornicroft, 2008). Research studies following the roll-out and implementation of CRHT in the United Kingdom will be considered in the following section.

2.2.2 CRHT Evidence Base Following United Kingdom Implementation

A number of studies have considered CRHT as a method of service provision since the widespread implementation in the United Kingdom. These studies have considered issues relevant to individuals receiving home treatment versus hospitalisation (e.g. Brimblecombe, O'Sullivan & Parkinson, 2003; Tomar, Brimblecombe & O'Sullivan, 2003; Gould et al., 2006; Yung, Organ & Harris, 2003), as well as factors relevant to outcomes for service users and cost effectiveness (e.g. Minghella et al., 1998; Johnson et al., 2005a, 2005b). In contrast to previous studies, recent research has addressed some of the methodological limitations of previous research, by using robust methodologies (e.g. Randomised Controlled Trial; RCT, Johnson et al., 2005a).

It is beyond the scope of this review and the aims of the current study to discuss the evidence base on CRHT service provision in depth. As such, the outcome research on CRHT will be considered on a general level, with specific findings and limitations identified.

At a broad level, two systematic Cochrane reviews have been conducted (Catty et al., 2002; Joy, Adams & Rice, 2006, updated 2010). Catty et al., (2002) considered all the available research on CRHT, including 91 studies over a 30-year period. The authors documented the benefits of home treatment over hospital admission in terms of days in hospital compared to inpatient services. They also noted particular

benefits of home treatment teams making regular home visits and taking responsibility for health and social care. They cautioned that the advantages over other community alternatives was inconclusive, and called for more research. However, the study included a broad review area of a range of varied services, and therefore the studies included were not specific to CRHT.

Joy, Adams & Rice (2006, updated 2010) systematically reviewed all the available evidence for CRHT, compared with inpatient services for those with severe mental health problems. In their 2006 report, they concluded that crisis intervention service provision resulted in equal or better service user outcomes than inpatient care alone. In addition, it was found to be preferable to service users and carers and more cost effective. However, the findings suggested that crisis intervention services could not prevent hospitalisation in 45 per cent of cases. Despite this, crisis intervention services had a role in reducing the frequency of repeat admissions, and were effective in supporting service users in the community when an ongoing home treatment plan was available. However, in this review, the findings did not focus exclusively on CRHT services (all studies used a form of home care, which included elements of crisis intervention). In addition, inpatient care was the method of comparison, opposed to community care.

In the 2010 update, the authors reviewed all RCTs of crisis intervention models versus '*standard care*' for people with severe mental health problems. It should be noted that in line with the 2006 update, the studies included did not exclusively investigate crisis intervention. The main conclusions from this review were in support of the 2006 update; forty five percent of the crisis/home treatment group were unable to avoid hospitalisation during their treatment period. However, the authors again

acknowledged the role of home treatment in supporting the avoidance of repeat admissions, and the improved acceptability to service users and families. Furthermore, the authors found that all studies found home care to be more cost effective than hospital care. In line with the previous conclusions, the authors suggested that home treatment for those in crisis was a viable and acceptable treatment approach, when coupled with an ongoing home care package.

In line with the conclusions from the Cochrane reviews, evidence has shown that CRHT services have reduced pressure on inpatient mental health care (Ford et al., 2001; Cullberg et al., 2002; Gould et al., 2006, Glover, Arts & Babu, 2006). This finding is strengthened in particular when CRHT services are provided on a 24/7 basis, suggesting that CRHT can offer positive cost implications to mental health services (NAO, 2007a; NIMHE; 2006). In addition, a number of studies have identified decreased admission and bed occupancy rates following implementation of CRHT (Keown et al., 2007; Jethwa, Galappathie & Hewson, 2007). Evidence has also shown that when admission to hospital does occur, the support of CRHT services can have a beneficial effect on length of stay, reducing it by up to 80 per cent (Audini et al., 1994).

In order to contextualise the findings of the above research studies with regard to service user views, the evidence base on service user perspectives of CRHT will be considered in the following section.

2.2.3 Service User Perspectives

Along with the literature base regarding the efficacy of CRHT services, there is a body of evidence which considers the views of service users. This literature adds to the outcome research on CRHT by providing an overview of the experience of CRHT care from a service user perspective. This will be reviewed in the following section.

Studies which have specifically focused on service user experiences of CRHT care have largely reported positive findings (e.g. Hopkins & Niemiec, 2007; Faulkner & Blackwell, 2008). In a study by Bristol MIND (2004), the perspectives of 65 people who had experienced a mental health crisis over a two year period were explored. Of these, 42 individuals had used either a CRHT or CMHT. Service users' experiences of mental health crises were considered using interviews and questionnaires, and areas assessed included help sought and received, and their views of this support. The most frequent service used was CRHT, which was generally found to be helpful, respectful, empathic and able to meet the needs of service users.

Furthermore, a national audit has considered service user experiences of the role of CRHT in supporting mental health crises (NAO, 2007b). Findings suggested that service users and carers were more satisfied with CRHT than other mental health services, and the value of an alternative to hospital was highlighted. Service users and carers expressed appreciation of the *'holistic'* approach to CRHT, consistency of staff and the importance of personal engagement, which was placed as highly as the expertise of clinicians. Limitations included a lack of consistency with CRHT professionals making it difficult to develop therapeutic relationships (NAO, 2007b).

In addition, a number of research studies have focused on the views of service users regarding non-hospital alternatives for mental health care, including CRHT and crisis houses. For example, in two research studies, Killaspy et al., (2000) and Johnson et al., (2004) pointed to the reported value of crisis houses for women. These findings suggested that recovery was promoted by a home-like environment, with admission seen as less stigmatising than hospital. However, the generalisability of these studies may be limited by the exclusive focus on women's subjective reports. In addition, these studies did not focus specifically on CRHT services.

2.3 Summary of CRHT Literature

Taken together, the evidence base on CRHT generally suggests that the service is preferable for service users and carers, and offers a cost effective alternative to hospital admission. In addition, the development of CRHT has been shown to reduce hospital admission rates in some service user groups. However, methodological limitations and poor generalisability of some of the research studies have made it difficult to ascertain the specific factors predictive of positive outcomes in CRHT. Therefore, although the literature to date suggests some promising findings, further research is needed to establish the effectiveness of CRHT.

3. MENTAL HEALTH CRISES

As the previous sections have considered the evidence base on CRHT as a method of service provision, attention will now be given to factors relevant to mental health

crises. This will serve as a background for an understanding of conceptualisations of crises, and of the service users who use CRHT services. In addition, the section will include definitions of the term *'crisis'*, and psychological conceptualisations of the impact on clinicians of working with service users in crisis.

3.1 What is a 'Crisis'?

According Caplan (1964), a crisis may be the result of a breakdown in an individual's normal coping mechanisms, which leaves the person unable to manage a situation. It may also describe a period of transition experienced by individuals in response to psychosocial stressors (Caplan & Caplan, 2000).

'Crisis theory' (Caplan, 1964) originally sought to inform the prevention of mental illness occurring after stressful life events, and was not taken to refer specifically to those with mental health problems. Indeed, although the breakdown in coping strategies in a crisis can be *'associated with an acute episode of mental illness'* (Bridgett & Polak, 2003, p 424), a crisis is not considered to be a specific mental health problem in itself. Caplan & Caplan (2000) outlined the *'crisis approach'*, based on the empirical finding that when individuals are confronted by problems they perceive as inescapable, their coping strategies are overworked. In these situations, individuals may become temporarily confused, anxious or depressed, leading to dependency on negative coping strategies. The approach suggests that intervening at a very early point in a crisis may prevent the adoption of unhelpful coping strategies, such as denial of difficulty and avoidance of help. In turn, this may

engender the possibility of enhancing the strengths and coping strategies of the individual. For effective crisis resolution, the individual should learn new coping mechanisms which may be used should the crisis re-occur in future (Aguilera, 1994; Caplan & Caplan, 2000).

For service users of mental health care, crises have been more typically defined in terms of emotional distress. These have included depression, despair and powerlessness (Bristol MIND, 2004). In addition, typical causes of crisis have been identified as low self-esteem, traumatic experiences or relationship problems. Service users have identified common responses to crises as self-harm, suicidal ideation and behaviour (Bristol MIND, 2004). However, there is a lack of research on the factors which lead individuals to use CRHT services.

However, according to Brimblecombe (2001), the constitution of a crisis in CRHT is the perception of individuals' psychosocial problems and associated risks by mental health professionals as severe enough to consider inpatient admission. Furthermore, NIMHE (2006) highlighted the broad range of characteristics of service users who may present to CRHT in *'psychiatric crisis'*:

- *people with no previous contact with mental health services, who may not have a mental health problem and are experiencing a psychosocial crisis.*

- *people with recurrent psychosocial crises who have an identifiable mild to moderate mental health problem, substance misuse issues or personality difficulties.*

- *people with crises related to long-standing mental health difficulties, such as psychotic or depressive disorders, where a relapse of symptoms or social difficulties have potentially serious consequences.*

3.2 Clinicians Working with Individuals in 'Crisis'

VandeCreek & Knapp (2007) argue that the nature of crises can place a significant emotional burden on practitioners, which may be considered in the context of CRHT work. Barker (2003) acknowledges that the emotional work of being with a person in crisis is demanding, and describes *'psychiatric lifesaving'* as '*sensitive, yet challenging, testing the stamina, resolve and creativity of the professional'* (2003, p13).

Although there is a paucity of research in this area, Edward (2005) conducted a study to explore the experiences of clinicians working with crisis in CRHT. Six professionals from a CRHT in Australia were the focus of investigation, drawn from a range of professional backgrounds. The purpose of the research was to explore the phenomenon of resilience in *'a highly complex, specialized, stressful and demanding area of clinical practice'* (2005, p143). It was noted that *'the nature of such complex and often unpredictable situations accompanied by the ever-present potential risk of harm is an added stressor on the mental health clinician in intervening in such crises'* (p.143, 2005).

In terms of psychological conceptualisations of the impact on clinicians of working with service users in crisis, Fusco & Freeman (2007) offered a framework for understanding this phenomenon. With a focus on clinicians working with individuals in crisis in a range of settings, they noted that therapists may experience negative reactions in the therapeutic context. They describe *'counter-transference stress'* as the session to session reactions of the therapist to the client, and *'counter-transference structure'* as a more enduring therapist-service user reaction, which becomes the typical way of experiencing such individuals (Freeman & Fusco, 2005). It is considered that when working with such individuals, the '*counter-transference structure'* of negative assumptions and helplessness occurs, which can lead to episodic '*counter-transference stress'.* This can then lead the therapist to expect session to session stress, and to respond in an intense and exaggerated manner. Freeman & Fusco (2005) therefore note the importance of therapist self-care and awareness of internal experiences during supervision.

In summary, although little is known about the experiences of clinicians working with service users in crisis, there is a body of evidence which explores the experiences of clinical psychologists in teams. This will be reviewed in the following section.

4. CLINICAL PSYCHOLOGY AND WORKING WITH TEAMS

As the chapter thus far has considered the evidence for CRHT service provision and information pertaining to mental health crises, this section will consider a number of aspects of team working of relevance to the current study. These include policy, research findings regarding psychologists in multidisciplinary teams and relevant

theory. In view of the lack of evidence regarding the experiences of clinical psychologists in CRHT, the literature regarding their experiences in AOTs and CMHTs will serve as a basis for comparison.

4.1 Team Working in Mental Health Care: Policy

The importance of multidisciplinary team working in mental health care has long been emphasised in policy documents in the United Kingdom (DoH, 1997; 1998b). It has also been well documented in the literature (Borrill et al., 2000). With the assumption that multidisciplinary team work has a positive impact on service user care, it has become a common phenomenon in many areas of health and social care (Ovretveit, 1992). Guidance suggests that multidisciplinary teams should encompass a range of knowledge and skills to reflect the complex needs of mental health service users (SCMH, 1997b). The separation of core from discipline or person-specific responsibilities is considered important to preserve the diversity in team work, whilst enabling integrated practice to develop. This balance was established in line with the development of training in mental health services (SCMH, 1997b), and designed to allow individual practitioners to identify with the team and their individual disciplines. This is considered important to maintain staff morale and the viability of teams in the long-term (Onyett, Pillinger & Muijen, 1997).

Government policy has called for better collaboration between staff working in health and social care settings (e.g. DoH, 1998b), as well as the need to enhance teamwork between staff in mental health services. Effective team working is considered to be associated with a range of factors, including clear and achievable

outcomes, effective communication, a culture and history of shared decision making, strong leadership and mutual respect (DoH, 2007).

4.1.1 Clinical Psychology Workforce in Acute Mental Health

Appelby (2003) assessed the impact of the publication of the NHS Plan (DoH, 2000) and NSF for Mental Health (1999) on mental health services in the two years following publication. The biggest rise in mental health staff was in the clinical psychology workforce, with a rise of 50 per cent by 2002. Taking into consideration policy documentation regarding multidisciplinary teamwork on a broad level, an overview of the relevant policy for clinical psychologists in teams will be provided in the next section.

4.1.2 Working Psychologically in Teams: New Ways of Working for Psychologists

In line with recent policy developments concerning *'New Ways of Working for Psychologists'* (British Psychological Society; BPS, 2007a) clinical psychologists are required to adapt their ways of working to include further integration into teams. They can support the development of improved outcomes from team working, and it has been suggested that they should be integrated within teams, if they can retain their unique identity and contribution (BPS, 2007a). Clinical psychologists are required to ensure a commitment of their time to be a useful resource for the team (BPS, 2001b, p 56). According to guidelines for clinical psychology services (BPS, 1998), there should be a clear agreement between the team, clinical psychologist and psychology manager as to the time they should allocate to the pursuit of the team's objectives.

Furthermore, the knowledge, skills and experience of clinical psychologists can be utilised to educate teams about the conditions for effective team working (BPS, 2001b, p 56).

According to the document *'New Ways of Working for Applied Psychologists in Health and Social Care: Working Psychologically in Teams'* (BPS, 2007b), psychologists have traditionally been considered to take a peripheral role in teams. This has been attributed to their relatively small workforce compared to other professionals, and their perceived specialist expertise. Indeed, research has shown that psychologists have been associated with the greatest ambivalence about team working (Mistral & Velleman, 1997), and the most likely profession to view team membership as conflicting with their professional identification (Anciano & Kirkpatrick, 1990; Searle, 1991; Onyett, 1997). However, the integration of clinical psychologists into teams is considered to offer a counter-balance to the *'medical model'*, as a result of the perceived status of psychologists as a skilled, valued and autonomous discipline (BPS, 2007b).

4.2 Team Working in Mental Health Settings: Research Findings

Given the lack of literature on clinical psychologists working in the team context of CRHT, consideration will be given to the factors relevant to teamwork for other professionals in multidisciplinary teams. This will include CMHTs and AOTs, and the small body of unpublished research on professionals in CRHT will also be given. Although not specific to clinical psychologists, it will give a picture of the impact of

team working on mental health professionals. This will serve as a background context for issues relevant to working in teams, which will be linked to clinical psychologists' experiences in later sections of the chapter.

4.2.1 Multidisciplinary Teamwork in CMHT: Research and Theory

Onyett (2011) recently reviewed the available literature on job satisfaction, stress and burnout in CMHT staff between 1997 and 2010. The purpose of this was to update the findings of the first ever comprehensive national study of CMHTs in England, which drew on 445 professionals from 57 multidisciplinary CMHT (Onyett, Heppllestone & Bushnell, 1994). Onyett (2011) concluded that many of the studies included in the review reported high levels of emotional exhaustion in professionals, but there was no evidence of a decline in staff morale. The author noted lack of resources and high workload pressures as a consistent source of concern for professionals, in support of previous findings. Factors including strong leadership, management, effective team work, supervision and support were documented as protective factors for staff. However, Onyett (2011) noted that the literature base was inconsistent, with methodological limitations present in many of the studies including small sample sizes, low response rates and the use of different dependent measures.

In addition, research on team work in CMHT suggests that it is fraught with interprofessional conflict, and often characterised by over-ambitious, unfocused aims and confusion about accountability and responsibility (Norman & Peck, 1999). Possible reasons for this included loss of faith in the mental health system, a strong

adherence to individual professional cultures, absence of a strong and shared philosophy and a mistrust of management (Norman & Peck, 1999).

According to Firth-Cozens (1992), there is a growing recognition that group decisions differ from individual decisions in health care. It is noted that, for example, even when a team signs up to a particular guideline, an individual doctor may choose not to follow that guideline (Kievit, 1997). However, according to Onyett (2003) '*social-identity theory*' (Hogg & Abrams, 1993) may predict that there will be less role conflict for professionals working in multidisciplinary teams, when the objectives of the team are clear.

Furthermore, wider theoretical frameworks can be considered in relation to multidisciplinary work in CMHTs. Lembke & Wilson (1998) consider that team work is a function of how members perceive the team and their role in it. Highly productive teams are linked to members' recognition of the team as a unit. In addition, role theory offers an exploration of the roles, or behaviour patterns assigned to and displayed by individuals within different team situations (Tajfel & Turner, 1979).

Finally, models of professional identity development (e.g. Bucher & Stelling, 1977) can inform an understanding of individual professionals' positioning within multidisciplinary teams. This model considers the importance of a range of factors in contributing to the development of professional identity, including a sense of mastery and the ability to provide a valued contribution.

4.2.2 Professionals in CRHT settings

Before the discussion on clinical psychologists in other team settings, including CMHTs and AOTs is considered, an overview of research regarding professionals' experiences of teamwork in CRHT will be given. Although the findings below do not focus on clinical psychologists' experiences in CRHT, it may be possible to generalise from the findings to an extent. In this, it may be hypothesised that some of the experiences reported may be related to the nature of CRHT working on a general level. Following this, the limited available unpublished research on clinical psychologists in CRHT will then be given to contextualise these findings.

Woodbridge (2006) recognised the varying pressures faced by CRHT professionals in working with diverse values in their practice. To attempt to understand the ways in which values impacted on working in this service setting, Woodbridge (2006) conducted an unpublished pilot study of CRHT staff members' values, and how they were able to work with diverse and conflicting values. Seven participants were drawn from a CRHT in London, from a variety of cultural and professional backgrounds (not including psychology). Staff valued the team approach, in particular the shared responsibility for clinical work, and the team approach to problem-solving and decision-making. The opportunities to work intensively with service users were also appreciated by staff. However, a cause of interpersonal conflict within the team was attributed to different opinions regarding decisions related to service user care.

In addition, in an unpublished doctoral thesis, Freeman (2009) explored the experiences of CRHT staff members of working in this service setting. The five

participants in this study included nurses and healthcare workers, and were interviewed about their experiences. They were also specifically asked about aspects of their work they found enjoyable and stressful, and how they coped with any challenges. Participants in this study spoke of: *'motivating factors'* (including making a difference to service users and providing a helpful service), *'stressors'* (including inter-personal conflict with professionals, unpredictability and other services' negative perceptions of CRHT) and *'coping strategies'* (including team emotional support and individual emotional regulation).

It has also been acknowledged by Hoult (2006) that in CRHT, professionals can gradually drift from time-consuming and uncomfortable tasks, such as being willing to manage risk, and involving the social network. He argued that this may lead the team to deal mainly with medication monitoring, and that the team leader should have a role in resolving this. He also suggested that the leader should share some clinical work with the team to understand their work and help with difficult cases.

The evidence above gives an overview of the limited body of unpublished research which has focused on a range of professionals' experiences of CRHT work. In lieu of the lack of available published research on clinical psychologists' experiences in CRHT, an outline of the unpublished research will be given in the following section.

4.2.3 Clinical Psychology in CRHT: Unpublished Research

There are no available published research studies which explore the experiences of clinical psychologists in CRHT. However, one unpublished report has investigated the views of CRHT staff regarding the input provided by a clinical psychologist (Woolls, 2008). This described the impact on one CRHT of direct input from a clinical psychologist, for one day a week. The feedback from eight team members during a focus group was overwhelmingly positive. Particular positive functions of the role included the speed at which service users could be seen, improved access to psychological skills, effective intervention and recognition of difficulties which were otherwise missed. The broad training and range of skills of the psychologist were recognised, as well as the role in supporting staff. Negative aspects related to misuse of the input by other teams attempting to gain quick access to psychology, and the limitations of the role. Participants suggested that role expansion, longer-term input, training, increased presence and protected time for staff support would be beneficial. Clarity of the clinical psychology role at a number of levels was recommended, including in the team and in the remit to CMHT, as well as the benefits of increased integration into the team. However, the study was limited by the focused remit, and the fact that less than half of the team were captured in the focus group.

In addition, an unpublished doctoral thesis (Revell, 2010) which explored CRHT nurses' experiences of individuals with Borderline Personality Disorder (BPD) acknowledged the role of clinical psychologists in CRHT. Revell (2010) highlighted the National Institute of Clinical Excellence (NICE, 2009) recommendation that treatment for individuals with BPD should primarily be psychotherapy. It was regarded that due to the complex nature of this group, the specialist skills of clinical

psychologists should be used to work with such individuals presenting to CRHT. Revell (2010) also noted the lack of evaluation of the input of Clinical Psychologists to CRHT in the United Kingdom (Onyett, et al., 2007). A need for further research to evaluate the role of Clinical Psychologists in CRHTs was suggested.

It can therefore be seen that there is limited knowledge at present regarding the experiences of clinical psychologists in CRHT. As such, it is important to draw on the evidence base on clinical psychologists in other team settings.

4.2.4 Clinical Psychologists' experiences in team settings: AOTs and CMHTs

As mentioned above, there is a dearth of available research on clinical psychologists in CRHT settings. In light of this, the available evidence considering the experiences of clinical psychologists in other team settings, including CMHTs and AOTs will be considered in this section. This will provide a background to elements which may be similar to psychologists working in acute settings in general, including CRHT. However, direct generalisation is not possible, due to the differences in service provision.

Specifically to clinical psychologists working in CMHTs, research has shown that clinical psychologists have reported high levels of stress and emotional exhaustion (Onyett et al., 1997). This finding is drawn from the national survey of 445 staff members in 57 CMHTs mentioned above. Although other team members also reported high levels of emotional exhaustion (specifically consultant psychiatrists, nurses and social workers), it was noted that clinical psychologists reported

comparatively low personal and team role clarity and low team identification, which may help to account for this finding. This may also be linked to the previously mentioned finding which suggests that clinical psychologists perceive team membership to conflict with their professional identity (Onyett, 1997).

According to Wright (2005), AOT teams may be particularly challenging for clinical psychologists. This is reflected in the difficulty in recruitment and retention to posts despite MHPIG guidance (DoH, 2001) recommending a psychologist in each team. A possible reason has been that AOTs have typically been closely aligned with the medical model of mental health problems (Wright et al., 2003), which may be at odds with psychological perspectives. Anecdotal accounts have also suggested that clinical psychologists in such settings may feel isolated and frustrated by this way of working (Yates, 2004; Plunkett, 2006). In a study by Cupitt et al., (2006) it was suggested that the AOT emphasis on flexible role allocation may contrast with clinical psychologists' view of themselves as specialist practitioners. In addition, the authors noted that clinical psychologists have traditionally provided minimal input to service users in receipt of care from such settings (Cupitt et al., 2006). Evidence has suggested that despite opportunities for innovative working in AOTs, clinical psychologists in these settings have felt deskilled and confused about their role and identity (Cupitt, 1997; 2001, Plunkett, 2006).

This finding is supported by Yates (2004), who completed a specific study of the experiences of clinical psychologists in AOTs, using a Delphi survey. This aimed to consider the experiences of 34 clinical psychologists' views of AOT working, with a

specific focus on supervision and hours of work. Many of the participants reported a lack of role clarity, and did not receive sufficient support and training, but generally enjoyed the opportunities afforded to working creatively and collaboratively with other professionals. However, this study was completed in 2002 when AOTs were newly established, so the results perhaps reflect the challenges inherent in being in new teams, rather than difficulties with the AOT model.

In recognition of the lack of research on psychologists in AOT settings, Pipon-Young, Cupitt & Callanan (2010) aimed to expand the knowledge base. This was in acknowledgement of clinical psychologists' experiences in AOTs since the establishment and development of such teams. A Delphi survey methodology was used to consider the experiences of 26 clinical psychologists in AOTs. The authors contrasted their findings to earlier studies (Yates, 2004), and suggested that with the bedding down of AOT services, clinical psychologists had adapted their ways of working to this setting. Participants reflected positively on the opportunities for varied role allocation, which was attributed to the fact that psychologists had developed an identity in the teams. The authors suggested that the development of professional network groups played a role in this, by affording opportunities for sharing practice. The results highlighted additional benefits of AOT working, including opportunities for creative working, support between professionals and the use of consultation skills, possibly making the clinical psychologist in this setting more distinct. However, specific challenges included the difficulty in offering different perspectives without feeling attacked or isolated, and trying to work psychologically in a predominantly medical setting. They importance of a robust supervision structure for clinical psychologists in AOTs was emphasised. In this study, the methodology avoided the

risk of areas being overlooked or participant views misunderstood due to the multiple rounds of the Delphi survey. However, there was no comparison group and the inclusion only of the views of NHS clinical psychologists in the United Kingdom limited the generalisability of the findings.

4.3 Clinical Psychologists in CRHT

As noted in the literature review section, most CRHT studies have considered issues relevant to CRHT efficiency (NAO, 2007a) and the impact of CRHT on reduction of hospital admission rates (Johnson et al., 2005a; 2005b). However, no published research has considered the role of clinical psychologists within such teams. In this section, the available published guidance will be considered regarding the role of clinical psychologists in the team setting of CRHT.

4.3.1 The Role of Psychology in the Team Setting of CRHT

As acknowledged previously, the experiences of clinical psychologists working in CRHT have not been explicitly explored in published research, with no clear guidance on how the role should be defined. However, a briefing paper has been produced to consider the role of psychology in these settings (BPS, 2008). Relevant guidance for psychologists working in multidisciplinary teams, outlined in the '*New Ways of Working for Psychologists'* agenda (BPS, 2007 b) may be also drawn on for clinical psychologists working in CRHT.

The BPS briefing paper (BPS, 2008) highlights the recommendation that psychologists should be included in the CRHT team structure (DoH, 2001). It also acknowledges the lack of psychologists working in CRHT, and calls for the development of more posts across the United Kingdom. The BPS briefing paper (2008) outlines a number of recommendations. It is acknowledged that although psychologists in CRHT are integrated into the team, the need to be separate from the core work of the team is encouraged. The importance of protected time for psychologists to engage in interventions such as research and service development is also highlighted. It is noted that their position in the team is different as they may seek external professional line management, yet they may be line managed within the team. Psychologists in CRHT may be involved in specific processes within the team, including attending relevant meetings. However, they may not perform some of the more generic roles, such as acting as care co-ordinator for service users. Instead, they may consider their skills to be best used in this context by supporting others in this role, thus contributing more specific psychological expertise (BPS, 2007b). Psychologists in these settings may typically use their skills to support others to deliver interventions, or provide supervision or consultation in light of resource restrictions. It is acknowledged that psychologists in these settings should be clear about their specific role and ensure that this is communicated to the team, with negotiation of the role with the team and manager. The need to consider the receptiveness of the team to psychological ideas and the developmental stage of the team is also emphasised.

In addition, psychologists based in CRHT may adapt their working practice to match the needs of the team, according to their own style of working (BPS, 2007b). Nevertheless, psychologists' core training means that common skills are evident in all ways of working (see BPS, 2001a). Psychologists in CRHT settings are required to adapt psychological interventions creatively, in order to meet the needs of service users who present in crisis, typically in a short time frame. Moreover, working with individuals in crisis, who typically present with high levels of risk and distress may also place additional demands on psychologists. They are therefore required to match their interventions to meet the needs of individual service users, which may be lessened as a result of high levels of distress. The importance of support from experienced supervisors in supporting the work of psychologists, as well as specific support networks is recognised.

Multidisciplinary teams in community settings are considered to be dominated by the medical model (Snelgrove & Hughes, 2000), and this may also apply to CRHT regarding treatment and understanding of service user difficulties. In addition, life in a CRHT is considered to be *'stressful, pressured and reactive in nature, providing few opportunities for reflective practice and formulation-based approaches'* (p 59, BPS, 2007b). As a consequence, it is considered important for psychologists to encourage a *'whole-person approach'* to CRHT working, with a particular emphasis on recovery (NIMHE, 2005).

Clinical psychologists' broad training and core competencies in assessment, formulation, intervention and evaluation (BPS, 2006) may equip them to manage multidisciplinary teams working with people with severe and enduring mental illness (see BPS, 2000). According to the BPS (2007c), Highly Specialist Psychologists (Agenda for Change Band 8a – 8b) provide a direct service for service users and work with the most complex and risky individuals. A banding of at least 8a is recommended for psychologists working in CRHT (BPS, 2008), and at this level, psychologists should have the ability to extend the capacity of the team through supervision, training and consultancy. They may also deliver clinical leadership (see NHS Institute for Innovation and Improvement, 2006). Psychologists in CRHT should also have the experience and status to match the demands of a particular team (BPS, 2001b).

According to the BPS (2008), psychologists in CRHT can provide a service on a number of levels: '*psychological assessment*',' *formulation*', '*intervention*' and '*skills applied to relapse prevention*', which may be linked to the four functions of CRHT service provision identified above (section 1.2.3.2). These are in line with the core skills of clinical psychologists (BPS, 2006). While the application of psychological knowledge may involve direct work with service users and their relatives or carers, there is also a role for psychologists to work systemically in teams. This may be via the provision of consultation and supervision to other professionals, training, team support, facilitating reflective practice and contributing to research, audit and service development.

5. STUDY AIMS AND RATIONALE

5.1 Study Rationale

The rationale for the current study is reflected in the paucity of research on the experiences of clinical psychologists working in team settings, including CMHT and AOT, and in particular the dearth of evidence on clinical psychologists in CRHT. The findings outlined in this chapter highlight that the CRHT service provision is still in its infancy, with a corresponding lack of research. Most of the research to date has focused on the output of CRHT services, such as impact on hospital admission and cost effectiveness. In addition, most of the research has used quantitative methodology to explore CRHT outcomes. There has been some qualitative research on the views of service users of CRHT services, but this is clearly an under-used methodology and area of study.

Furthermore, published research on the experiences of clinical psychologists working in CRHT, their relationships with other professionals as well as their perceptions of working with service users in crisis is not available. Due to the lack of available evidence, there is a limited understanding regarding this subject area, which has implications for clinical psychologists working in these settings, and for the profession as a whole. Increased understanding will be important to inform, support and sustain the role of psychology in CRHT.

5.2 Study Aims

A focus on clinical psychologists' individual experiences of working in CRHTs, their relationships with other professionals and perceptions of working with service users in crisis were the areas of investigation in the current study. A qualitative research methodology was used, as this was considered the most appropriate means to gain access to the experiences of individual participants (Charmaz, 2003). In addition, the lack of available qualitative research indicated that this approach would enable a broad understanding of the relevant issues. The aim of the study was to identify emergent themes from within the data, using the Grounded Theory approach.

A qualitative investigation of CRHT clinical psychologists will provide a rich and detailed understanding of their experiences of working in this specialist service. It will provide an important piece of evidence in an area where there is no other research available at present. Given the relatively new service provision of CRHT and the positioning of clinical psychologists within them, the research will be important for service development. Also, it may have an impact on recruiting and facilitating the retention of clinical psychologists in CRHT. It is expected that exploration of clinical psychologists' work will inform practice, and link with wider service provision on the changing role of the clinical psychologist in the NHS. The study may also inform psychological ways of working with service users in crisis.

CHAPTER TWO – METHODOLOGY

2.1 OVERVIEW

In line with the aims of the research, a qualitative methodology was employed within this study, using semi-structured interviews as the means by which to collect data. Interviews were conducted with individual participants who were qualified clinical psychologists, working in CRHT settings across England and Wales at the time of the study. Data were analysed using the Grounded Theory approach, which was chosen to explore and develop a deeper understanding of clinical psychologists' views of working within CRHT, as well as their perceptions of service users in crisis. This chapter will outline the research methods adopted, their rationale, and a description of the process of data collection and analysis. An overview will be given of the study design, including the procedures used for recruiting participants, as well as a description of the participants. The chapter will conclude with an overview of ethical issues and the means by which methodological rigour was ensured.

2.2 QUALITATIVE METHODOLOGY

2.2.1 Philosophy of the Approach

The qualitative research tradition includes a number of epistemological and theoretical assumptions that focus on the development of an understanding of human experience, and in particular, which explore issues related to meaning making, interpretation and subjectivity (Silverman, 2000). As a result of these assumptions, qualitative approaches are seen to have a particular relevance in psychological research. Qualitative approaches are grounded within *'phenomenological interpretivism'*. This notion relates to the view that reality is socially constructed, and suggests that the social world consists of multiple, subjective realities, as opposed to one objective reality. Qualitative research methods use a range of inductive methods to access, describe and explain individual meanings and constructions of the world. The researcher, when engaged in the process of qualitative research, is required to enter the world of the research participants as a means of becoming fully immersed in the approach. It is considered vital for the researcher to reflect on the ways in which their own values, experiences and beliefs shape their understanding of the experiences of research participants, and to maintain a critical and open-minded approach to the research (Miles & Huberman, 1994, Silverman, 2000). This is guided by a reflexive approach which allows the researcher to reflect on his/her individual standpoint. However, the extent to which the researcher can be an unbiased observer in the research process has been queried, and it has been argued that their involvement in the research inevitably and fundamentally influences the process and findings (Willig, 2001).

2.3 GROUNDED THEORY

2.3.1 Introduction to Grounded Theory

Grounded Theory was developed by Glaser & Strauss (1967) as a counterbalance to what was regarded as the dominant quantitative and positivist perspectives shaping research in the social sciences during the 1960s. The approach was devised to consider how qualitative data can be used to provide rich descriptions of the experiences of individuals, to identify concepts and relationships between them and generate theory which is *'grounded'* in the data. Since the initial inception of the approach, Grounded Theory has further evolved and gained in popularity as a systematic qualitative research method (Strauss & Corbin, 1998). The method is considered to bridge a gap between *'theoretically uninformed empirical research and empirically uninformed theory'* (Goulding, 1999, p6). The resultant theory is therefore a specific, as opposed to general theory (Pidgeon & Henwood, 1996; Barker, Pistrang & Elliot, 2002). It is also a product of the interplay between data collection and analysis, which is closely linked to the theory formulation by an overlapping and reciprocially related process. Consequently, the search for meaning through data interpretation commences in the early stages of data collection.

The method of conducting Grounded Theory involves a set of well-established guidelines (Strauss & Corbin, 1997; Willig, 2001). During the process of Grounded Theory, the researcher aims to identify themes in a set of unstructured data (e.g. interview transcripts). The strategies in this process include *'coding'* the data, using *'constant comparative analysis'* to capture all the variation within each category and *'negative case analysis'* to analyse instances that do not fit the emerging theory. In addition, records are kept throughout the process of data collection and analysis to enable a continuous process of evaluation via the use of *'memo writing'*. The process allows the researcher to shift between gathering and analysing data, until

'theoretical saturation' is achieved. This means that the researcher is required to stay in the field until no further data emerges. The strategies involved in the process in the current study will be discussed in greater detail in the data analysis section (Section 2.8).

2.3.2 Rationale for the Selection of the Grounded Theory Approach

The current research study sought to collect data on the experiences of clinical psychologists working within CRHT, their relationships with other professionals and perceptions of working with service users in crisis. This stance was taken in order to explore their views and experiences, without holding significant preconceptions about what these may be. The Grounded Theory approach was adopted in order so that the issues raised by participants could be explored, in order to enhance understanding (Strauss & Corbin, 1997). Furthermore, Grounded Theory is compatible with a range of data collection techniques including individual interviews (Willig, 2001), as used in this study. In addition, Grounded Theory is usually used to generate theory in areas where little is already known, which is appropriate for the current study. For these reasons, the Grounded Theory Approach was considered most suitable for the current study. According to Erikson (1986), the qualitative approach can be used to allow an exploration of areas in which research literature is currently limited, and this is particularly apparent in the phenomenon under investigation in the current study. In addition, qualitative research methods allow access to personal experience and meaning of research participants, in order to build a broad understanding of the research topic. It is also considered that the development of an understanding of individual experiences is difficult to investigate

quantitatively (Strauss & Corbin, 1998). It has also been suggested that qualitative approaches are suitable when there is an interest in exploring a substantive area, as opposed to a specific research question (Orona, 1997). As the primary aim of this study was to explore the individual experiences of participants in an attempt to gain new understandings into this area, as opposed to testing out hypotheses based on existing theory, it was deemed that a qualitative methodological approach to data collection and analysis would be most appropriate.

The constructivist version of Grounded Theory (Charmaz, 2003) was considered most suitable for the present study. This version adopts a flexible approach to the research process, and is in contrast with the standpoint taken by Glaser & Strauss (1967), which views theory discovery as emerging from the data, separate from the researcher. This approach considers that neither data nor theories are discovered, and that researchers are integral to the world of study and data collected. Also, theories are considered to develop through past and present interactions and involvements with people, perspectives and research practices. Inherent in this approach, it is made explicit that the resultant theory offers an interpretative portrayal of the studied world, and not an exact picture of it (Charmaz, 2006). Participants' implicit meanings, experiential views and researchers' finished grounded theories are therefore considered as constructions of reality. In this study, the Grounded Theory *approach* was used to explore the key issues raised by participants, and not to develop a complete 'theory'.

2.4 ENSURING QUALITY IN QUALITATIVE RESEARCH

Qualitative research methods in psychology have been subject to criticism on the grounds of a lack of scientific rigour, over-reliance on anecdotal evidence and a lack of reproducibility and generalisability (Mays & Pope, 1995). However, it has been suggested that due to the different epistemological positions of qualitative and quantitative methodologies, the approaches should not be judged in the same way (Henwood & Pidgeon, 1992; Chamberlain, Stephens & Lyons, 1997).

As a response to the various criticisms of the methodology, researchers working within the qualitative field have attempted to develop evaluative guidelines for use with the various qualitative approaches (e.g. Henwood & Pidgeon, 1992; Elliott, Fischer & Rennie, 1999). The current study utilised the guidelines developed by Elliott et al., (1999) to ensure methodological rigour. These guidelines were chosen over other methods as it was deemed that they provide a wider range of areas in which to assess rigour. These guidelines are outlined below, along with a description of how they have been addressed during the design of this study:

1. **Owning one's own perspective:** Researchers are required to specify their theoretical orientations and assumptions to attempt to allow the reader to consider the ways in which these may have influenced the analysis of the data. In the current research, this was achieved by explicitly stating factors

relating to the researcher which may be relevant to the study and analysis. The researcher's position is outlined in section 2.5.2.

2. **Situating the sample:** The research participants should be described in order to assist the reader to judge the range of individuals and situations to which the findings may be relevant. Section 2.6.4 highlights details regarding participants, including age, gender and the length of time they had worked in CRHT, which may be pertinent to the research findings.

3. **Grounding in examples:** In order to demonstrate the methods of analysis used in the study, examples of raw data should be provided, along with the understanding they have generated. This allows the reader to appraise the fit between the data and the interpretations made by the author. Illustrations of themes and concepts gained from the data in this study are provided in the results section (Chapter Three). In addition, an extract of a sample of interview transcripts can be found Appendix Eight.

4. **Providing credibility checks:** In order to check the credibility of the data, researchers should use multiple analysts and triangulation with data from other sources. In this study, the researcher discussed the analysed transcripts and emergent concepts and categories with the clinical and academic supervisors. The clinical supervisor had been working in a CRHT for over two years at the time of the study, and the academic supervisor had four years prior experience of working in a CRHT.

This process resulted in a number of changes to the data which emerged. For example, at the point of open coding the researcher identified hundreds of codes. Following a meeting with the academic and clinical supervisors, the links between the codes developed and they were then collapsed to a manageable number. The researcher achieved this by merging similar quotes together after comparing them, making links between them and allowing abstraction of the data to a theoretical level. The researcher then provided the supervisors with an overview of the quotes and relevant sub-categories, categories, core categories and themes (see Appendix Nine for a summary of the resultant themes and number of sources). They independently checked this for quality assurance purposes. Triangulation was also sought via presentation of the theory to a sample of the research participants, so that feedback and verification could be obtained (see Appendix Ten, personal communication).

5. **Coherence:** This suggests that presentation of data, analysis and findings should take place in a consistent and integrated way, through diagrammatic maps or frameworks, and a coherent narrative account. As above, the data was discussed with the academic and clinical supervisors throughout the process of data analysis. The diagrams, narrative and interpretation of the data can be found in the Results and Discussion sections (Chapters Three and Four).

6. **Accomplishing general vs. specific research tasks:** Researchers must provide clarity about whether the research aims to develop a general

understanding of a phenomenon, or to provide an in-depth insight into a specific instance or case. It should be ensured that limitations of the applicability of the findings beyond their original context are addressed. The current study is representative of a sample of clinical psychologists based in CRHT across England and Wales. The findings are not considered to be generalisable to any other group. However, despite this, details are provided regarding the participants, including the length of experience in CRHT. This is so that the reader can decide the degree to which the findings can be applied to other research settings. The limitations of the design of the research are outlined in Chapter Four.

7. **Resonating with readers:** The research material and emergent theory should clarify and increase readers' understanding of the study area, and aim to make sense to readers. In order to verify whether this was the case, draft versions of the theory, as well as the final version were read by the supervisors, and a sample of participants were presented with the theory for feedback (see Appendix Ten and section, 4, above). Furthermore, an overview of relevant clinical and theoretical issues in relation to the research is outlined within the literature review in Chapter One. Also, the resultant subcategories, categories, core categories and themes are presented in Chapter Three, in order to facilitate ways for the reader to assess the extent to which the theory resonates.

2.5 DESIGN

As highlighted above, a qualitative design was adopted as a means of exploring participants' experiences of working in CRHT, and their perceptions of service users who present in crisis. Data were collected through individual interviews with 11 clinical psychologists working in CRHT in England and Wales. Participants were invited to an individual interview, led by the researcher, and were encouraged to discuss their experiences of working in CRHT, as well as their views on working with service users in crisis. The interview was based on six main question areas generated by the researcher, clinical and academic supervisors prior to the interviews (see Appendix Six). Reflexivity in the research process was considered by reviewing the data collected after each interview, and adapting subsequent interviews to focus on more or less relevant areas of study. This process was in line with the inductive nature of the Grounded Theory approach (Strauss & Corbin, 1997). Participants were also asked to complete a very brief personal details questionnaire (see Appendix Five). The individual interviews were audio recorded and transcribed. The transcripts were then analysed using the Grounded Theory approach.

2.5.1 Research Context

The research was conducted within a range of NHS CRHT across England and Wales. The service provides home treatment to adults between the ages of 18 and 65 years who experience mental health difficulties, and present in crisis. These teams consist of staff members from a range of professional backgrounds, employed by both local health and social services. Staff members include nursing staff, support

workers, occupational therapists, social workers, clinical psychologists and psychiatrists. The researcher travelled to interview individual participants in their place of work at mutually convenient times.

2.5.2 Researcher's Position

As noted above, it is paramount that the researcher should take the position of reflexivity in the process of qualitative research. The guidelines provided by Elliott et al., (1999) state that the researcher must *'own'* his/her own perspective, which involves disclosure of their own values and assumptions to allow the reader to consider the ways in which these may have influenced the data analysis. In addition, it is recommended that the qualitative researcher *'present appropriate reflections on their role in the dynamic process of analysis'* (Brocki & Wearden, 2006, p 92). In order to facilitate transparency, a reflective journal was written throughout the research process. An extract of the reflective journal is provided in Appendix Eleven.

2.5.2.1 Position

The researcher is writing from the perspective of a 29-year old, white, unmarried female, born and brought up in a South West Wales town. During the research process, the researcher was working as a trainee clinical psychologist and had been based within an inpatient service, providing psychological input to adults with mental health problems as part of an elective placement. The researcher has a clinical interest in working with people with severe mental health difficulties and in psychological and biopsychosocial approaches to working with this service user

group. Prior to the interviews taking place, the researcher had not met any of the research participants.

Before gaining a place on the clinical psychology training course, the researcher had worked in a range of settings, including a community mental health team for adults with mental health problems, as well as inpatient settings for adults with severe and enduring mental health problems. She was aware of the workings of CRHT from becoming familiar with this provision during the first placement on the training course, and indeed referring a service user to this service. Experiences of working within adult mental health settings, and particularly with service users with severe mental health difficulties stimulated the researcher's interest in the experiences of clinical psychologists in working with service users in crisis. This interest was further inspired by discussions with the researcher's clinical and academic supervisors. During the research process the researcher did not consider herself to be explicitly aligned with a particular epistemology. However, she acknowledged being influenced by biopsychosocial and systemic models.

2.6 PARTICIPANTS

2.6.1 Ethical Considerations

Ethical approval was sought from the South East Wales Local Research Ethics Committee, and was granted in July 2010, following presentation of the project to the committee (Appendix One). Approval was also sought from the local NHS Research

and Development (R&D) Committee, and this was granted in July 2010 (Appendix One).

2.6.2 Sample

All clinical psychologists who were members of the CRHT Psychologist Network within the Psychosis and Complex Mental Health Faculty, Division of Clinical Psychology of the BPS were invited to take part. The network has a total of 44 members, which include both clinical and counselling psychologists. The sample was therefore selected from participants across England and Wales.

The researcher recruited a total of 11 participants to take part in individual semi-structured interviews. Participants were required to have held their post for a minimum of six months for inclusion in the study. Exclusion criteria were those who were employed for less than six months, or who worked outside of the NHS. However, no participants who identified themselves were excluded from the study based on these criteria.

2.6.3 Recruitment Procedure

Once R&D and Ethics approval had been obtained, preliminary enquiries were made via telephone contact to the CRHT Psychologist Network Lead, with regard to the feasibility of potential access to participants. Discussion between the researcher, academic and clinical supervisors and the CRHT Psychologist Network Lead

focused on ways to access participants. The CRHT Psychologist Network Lead agreed to act as a contact point for access to participants. The researcher then sent all potential participants an information sheet via email, detailing the nature of the study and their proposed involvement (Appendix Two). When each participant responded to the initial email to confirm their interest in taking part, an invitation letter was sent via email (Appendix Three) and a time and date was arranged for the researcher to meet with them to complete the individual interview.

2.6.4 Description of Participants

Table 2.1 outlines the details relevant to the 11 people who agreed to take part in the project.   All of the research participants were qualified clinical psychologists, accredited by the BPS and regulated by the Health Professions Council at the time of the study. All adhered to the BPS Code of Ethics and Practice (2009).

All participants had been employed by the NHS since qualification as clinical psychologists. Of the participants, one worked in a CRHT on a full-time basis. Of the remaining participants, some split their time between CRHTs and other clinical settings, such as inpatient wards and CMHTs. In addition, some worked for the NHS on a part-time basis. Demographic data regarding participants is presented in the following table:

Table 2.1: Participant Characteristics

Participant	Gender	Years Qualified as a Clinical Psychologist	Years Employed in CRHT	Weekly CRHT Sessions
Max	Male	11	2.5	5
Sophie	Female	6	2	10
Lauren	Female	3	2	9.5
Angela	Female	13	5	5
Leighton	Male	9	2	2
Catherine	Female	3	2	1.5
Natalie	Female	4	4	5
Louisa	Female	1	1	5
Eleri	Female	2.5	2.5	4
Olive	Female	11	5.5	4.5
Karen	Female	4	2	3
		Mean = 6 years	Mean = 2.7 years	Mean = 4.95 sessions

2.6.5 Informed Consent and Confidentiality

Consent was sought from participants to ensure that they could make an informed decision about whether or not to take part. In order to aid this choice, the participants were provided with an information sheet (see Appendix Two), which detailed:

- The aims and purpose of the research study

- Information about the procedures and what would be required of participants

- Information about how the data would be stored and analysed

- A statement about their right to withdraw from the study at any time

Before the commencement of each interview, participants were given the opportunity to ask questions in relation to the study. After any questions were answered, participants were asked to complete a personal details form (Appendix Five). In addition, they were asked to sign an interview consent form (Appendix Four) prior to participation. Their consent for the interview to be recorded was also checked prior to the interview taking place. Participants were reminded that they were free to withdraw from the study at any point and should this instance arise, any data they had provided would not be used in the analysis.

The researcher ensured the confidentiality of information given by participants by ensuring all personal details were kept anonymous. Participants were made aware that quotes they provided during the interview process were likely to be included in the final write-up. Each participant was informed that, should their quotes be used during the written manuscript, they would be ascribed a pseudonym to attempt to protect the confidentiality of their responses. Research participants were also reminded of the importance of maintaining client confidentiality.

The length of each interview ranged between 55-70 minutes. Following each interview, the data was transcribed verbatim by the researcher. The participants'

details obtained through the personal details form were not associated with the quotations on the transcripts. The completed transcripts were available to the researcher only, and were kept in a locked filing cabinet.

2.7 PROCEDURE

2.7.1 Process of Individual Interviews

The qualitative semi-structured interview schedule was chosen as a method of gathering research data that was detailed and personal to the participants' own experiences. The interviews took place in a number of CRHT clinical bases across England and Wales during September and November 2010. Written and verbal assurance of confidentiality and anonymity was given at the start of each interview, and the researcher reiterated the aims of the research, answering any outstanding questions from participants. The researcher introduced the interview and asked each interviewee to answer questions based on six stem questions, developed in collaboration with the academic and clinical supervisors, and the available literature.

The stem questions (see Appendix Six) explored issues pertaining to clinical psychologists' experiences of working in CRHT, conceptualisations of the role in relation to other team members and direct clinical work, as well as their perceptions of service users in crisis. The stem questions were used flexibly, as the collection of interview data was considered to be an evolving process. The conceptualisations and interpretations from early interviews were regarded to constantly impact on later data collection, and any initial themes were followed up in further interviews. This

meant that emphasis on particular areas was guided and adapted by data gained from previous interviews. This resulted in the constant adaptation of preliminary ideas as further data was produced and analysis continued. The interview schedule also included prompts for participants to expand on their comments, which were used flexibly depending on the richness of the material provided by each participant. This enabled responses to be more specifically and fully revealed, and concepts to be clarified.

2.7.2 Data Recording and Management

Each interview was recorded on a digital audio recorder. The material from each interview was then fully transcribed by the researcher, to include a verbatim copy of all speech (see Appendix Eight for a sample of transcript extracts). The names of each participant were not used in the transcripts – each participant's name was replaced with a letter to ensure that the data were anonymous. A dedicated computer package (NVivo9; QSR International, 2010) was used to facilitate the process of organising and coding the data.

2.8 DATA ANALYSIS

2.8.1 Transcription of Interview Data

The researcher transcribed each interview within two days of the interviews taking place. The preparation of the data throughout the process of transcription is considered a form of analysis (Riessman, 1993), because of the many theory-guided decisions that must be made throughout the process. The process of transcription was a labour intensive process, but enabled the researcher to be fully immersed in the data collected. Transcribing varied according to the richness of the data provided by each participant, but generally the process took between 3 ½ and 6 hours per interview. Interviews were transcribed verbatim, with non-word utterances excluded. Each transcript was assigned a label summarising the date the interview took place, time, duration and loaction.

Following each interview, the researcher completed an interview summary sheet (see Appendix Seven for an example). This was used to note down any process issues that occurred during the interviews, such as themes generated, emergent ideas and additional information to be gathered in subsequent interviews, and is in line with the Elliott et al., (1999) guidance, with the aim of increasing confidence in quality issues. The process of exploring emergent ideas to potentially explore in subsequent interviews was considered important as it was in line with the iterative process of ground theory. At this point, the reflective journal was also used to identify initial ideas regarding possible themes (Appendix Eleven).

2.8.2 Analysis of Interview Data

The researcher listened to the audio recordings and read through the transcripts several times prior to in-depth analysis in order to gain an initial sense of the data. This immersion in the data was considered important, in order allow the researcher to gain an overall feel for the data's scope and meanings (Barker et al., 2002).

The data analysis was informed by the Grounded Theory approach. A decision was made to use a dedicated computer package (NVivo9; QSR International, 2010) to aid the process of data analysis. The use of computer software in qualitative analysis has been criticised on the grounds of a potential loss of context for the data, and too narrow an approach to analysis (Coffey & Atkinson, 1996; Dey, 1999). It has also been stated that software can possibly result in a more comprehensive search of coded segments (Coffey & Atkinson, 1996). In this study, the computer software was used to organise the data in order to search for them, and not for the purposes of analysis of the data. As such, the core tenets of grounded theory were followed:

Coding: The process of coding leads to the identification of categories. Initially, this took place on a line-by-line basis for each transcript, in order to produce as in-depth an analysis of the data as possible. Following the coding process, a number of descriptive, or low level categories were developed. The next step was to use the most frequent or significant codes to further sort and analyse the data, which was a more focused and selective process. These categories were then integrated into higher-level analytic categories (Charmaz, 2003).

Constant Comparative analysis: This stage aims to link and integrate categories in order to capture all instances of variation within the emerging theory. This enables

the process of identification of similarities and differences between categories to remain constant. It is important to focus on differences within each category to identify any emerging sub-categories.

Negative case analysis: The researcher collapsed and refined the emerging theory via the identification and removal of the cases that did not fit with the emerging theory. This allowed the further development of the emerging theory, adding greater depth to the analysis. This process served as a way of increasing the validity of the results, as each emerging category was evidenced in line with the data. This led to an increased likelihood of the full complexity of the data being captured in the analysis.

Memo-writing: The researcher maintained a written record of theory development in the form of memos throughout the process of the data collection and analysis. These memos were used to document definition for codes and categories, making comparisons between codes and categories, providing support for definitions of categories and identifying gaps in the analysis (Charmaz, 2003). An example of memo writing can be found in Appendix Twelve.

As outlined above, quality was also ensured by consultation with academic and clinical supervisors, in order to discuss the process of data analysis.

CHAPTER THREE – RESULTS

3.1 OVERVIEW

This chapter presents the Grounded Theory arising from analysis of the data collected from the 11 individual interviews. Three key **THEMES** were identified, along with five CORE CATEGORIES**,** 13 **categories** and 40 <u>sub-categories.</u> For ease of reading, **THEMES** are highlighted in capital and bold lettering, CORE CATEGORIES in capital lettering, **categories** in lower case and bold lettering and <u>sub-categories</u> in lower case and underlined lettering.

A diagrammatic summary of the three **THEMES**, five CORE CATEGORIES and 13 **categories** is presented in Figure 3.1. In addition, a diagram of each of the five CORE CATEGORIES, associated **categories** and <u>sub-categories</u> can be found in figures 3.2-3.6. These diagrams serve as visual representations of the relationships between the **THEMES**, CORE CATEGORIES, **categories** and <u>sub-categories</u>. Each sub-category has also been described in detail and provided with illustrative quotes. Information regarding the number of quotes from participants and supporting references can be found in Appendix Nine. This is to allow for an assessment of the relative strength of each of the core categories, based on the richness of the data.

Figure 3.1 DIAGRAMMATIC SUMMARY OF THEMES, CORE CATEGORIES AND CATEGORIES
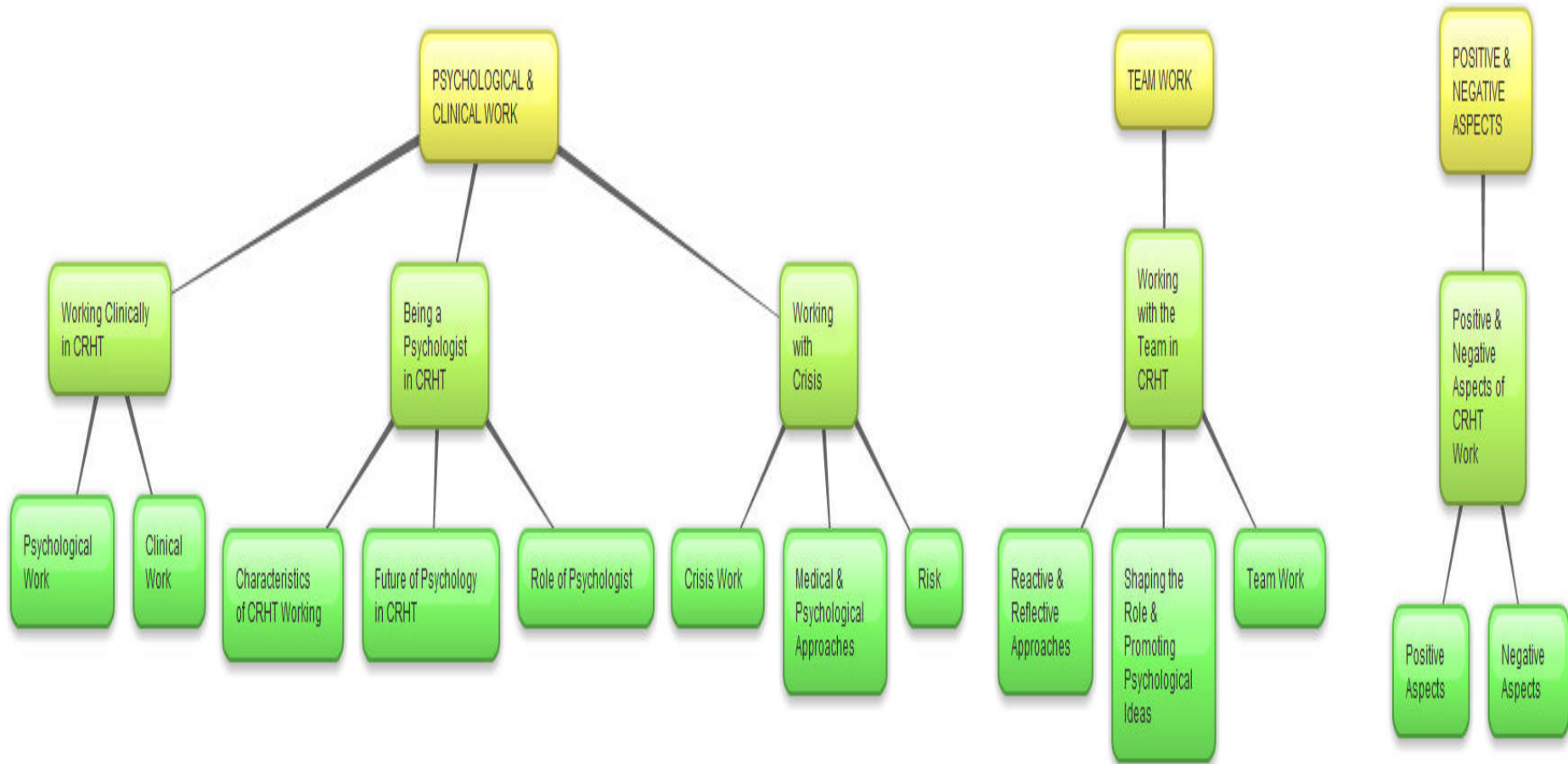
FIGURE 3.2 CORE CATEGORY ONE: WORKING CLINICALLY IN CRHT (CORE CATEGORY, CATEGORIES AND SUB-CATEGORIES)
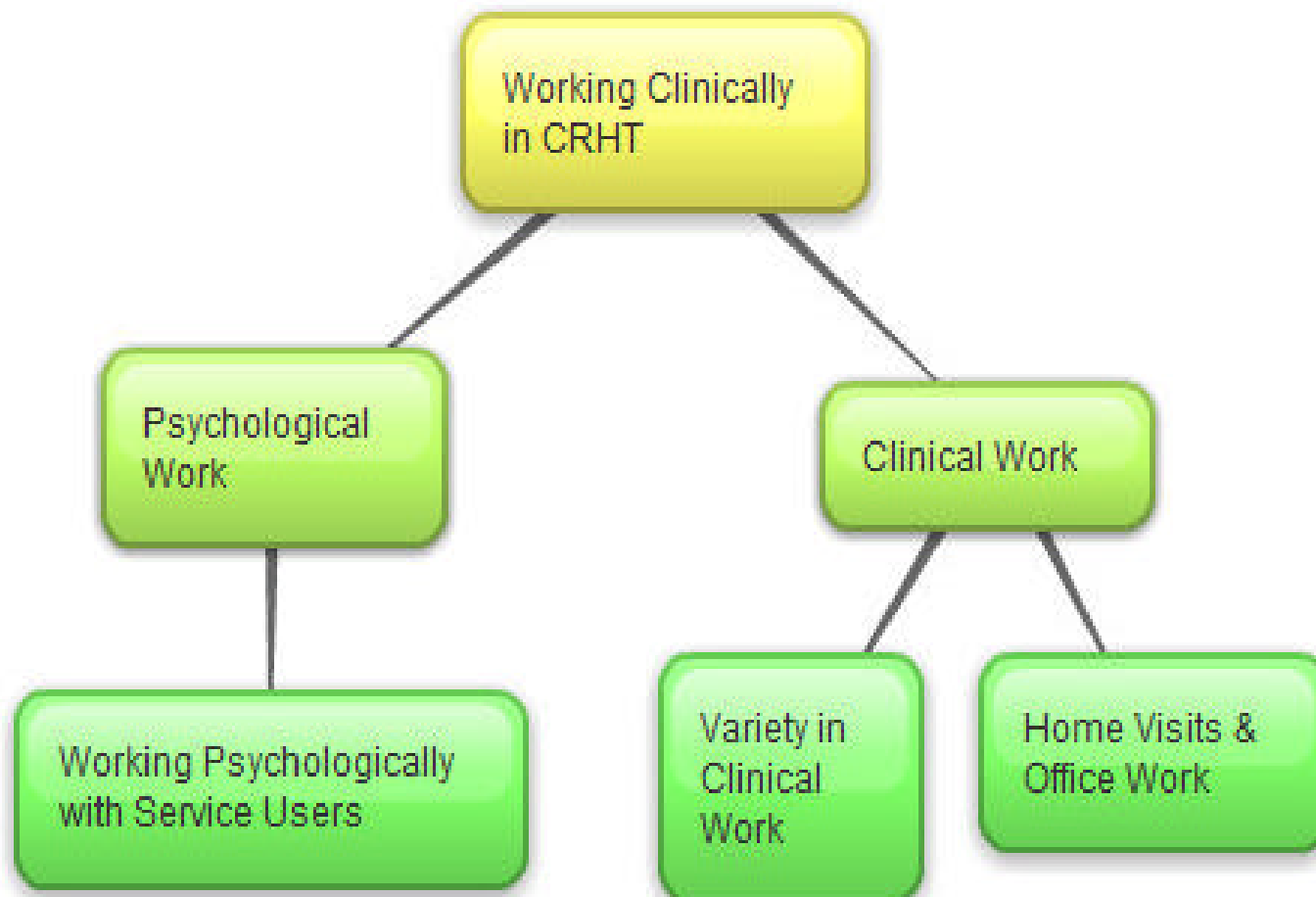
3.2 PRESENTATION OF RESULTS

3.2.1 THEME ONE: PSYCHOLOGICAL AND CLINICAL WORK

This theme captured both psychological and clinical work in CRHT, such as the role of psychology and working with service users in crisis. Each core category and sub-category will be considered in turn in the following sections.

CORE CATEGORY ONE: WORKING CLINICALLY IN CRHT

This core category is composed of participants' reflections of their clinical work in CRHT, and includes two categories: *'Psychological Work'* and *'Clinical Work'*. Within these categories are a further three sub-categories: '*Working Psychologically with Service Users', 'Variance in Clinical Work'* and *'Home Visits and Office Work'*.

Category One: Psychological Work

This focused on the factors relevant to the psychological aspects of clinical work, in relation to working with service users.

Sub-category One: Working Psychologically with Service Users

This sub-category specifically related to participants' perceptions of working with service users in CRHT, and in particular their needs as psychologists, as well as the needs of service users. Some felt that working with service users on a short-term

basis was a frustration, and compensated for this by working in other services where they could work with service users on a longer term basis. This was also linked to participants' fears that not working in the *'traditional'* way of providing therapy would lead to a loss of skills. Others did not find the short term nature of the work a limitation, and felt that weaving in therapeutic skills to the assessment was a way to utilise psychological interventions. For some participants, the short-term work was seen as providing an opportunity to meet many service users with varied presentations.

Max: I guess some of the challenges are adapting to the very short time frame, typically four weeks people will be with us for and yeah, it requires a shift in thinking to intensive intervention in terms of what you are trying to intervene with. It's often thinking about the here and now and helping people get over the worst of their current difficulties, you are not offering treatments for underlying longer term difficulties and there can be a little bit of, you know, some frustration in that and that means you don't get to do the longer term traditional therapeutic role.

Lauren: Psychology-wise, I guess it's a real mixture between assessment and doing a bit of an intervention at the same time. So, even if meeting someone just once, it'll often be that I'm doing a bit of an assessment and at the same time often doing a lot of...a lot of kind of assessment running into formulation, both in terms of kind of longer term understanding things, but usually framing the current crisis in the context of the background history.

Karen: I do do longer term therapy, I realised in my previous job on a ward and in a Crisis Team, I didn't do any long work and I missed something there. So I've negotiated always having two long-term cases, and I think all Psychologists should do that. The difficult stuff of long-term therapy is a lot less glamorous, and the processes you have to go through, not knowing what to address in the next session and all sorts of things. It's really interesting, but I think we have to do it, for that reason.

Angela: I don't necessarily use formal diary keeping with people very often, but it's more about weaving those things into conversations with people.

Category Two: Clinical Work

As well as discussing ways of working psychologically with service users, participants discussed other aspects of clinical work, such as the variety inherent within it and the nature of home visits and office work.

Sub-category One: Variety in Clinical Work

This sub-category considered participants' views that the variety in their work was both a positive and a negative. Participants commented on the fast pace of the work, the perceived benefits in seeing many service users and making a difference through the psychological input they could offer in a short time frame. They commented on the appeal of working both directly and indirectly with service users, and in working creatively in this setting. It was considered that working as a psychologist in a CRHT could offer diverse experiences which were contrasted to the role of psychology in other settings. However, the variety in the clinical work was sometimes described as overwhelming, with numerous competing demands.

Karen: What I like about this job is the variety, it's a very fast turnover, you can see people for very short, intense periods, and you can really make a lot of difference in that short time, which is very satisfying as well.

Angela: I think it's really broad, I think it's a lot broader than being your average CMHT or primary care psychologist. There's so much about the system working in acute generally. I think that people stick around here because there's so many things that they can get involved in. Reflective practice training, audits, service evaluation, clinical work and groups. Yeah, it is pretty varied day to day, I would say that. My diary is very varied Yeah, there's lots of different stuff that goes on.

Catherine: I really liked the idea of this indirect work, alongside the service user work. Because I think that's really, really important. So having a job that encompassed all that. You have to be quite creative and inventive. I think, from

comparing the work I do, it's much more varied. It's not just the one to one therapy work. I know it can be varied in the community as well, but my sense is, recently in our team, we did pie charts looking at how our work splits up in terms or direct and indirect work, training and those sorts of things. When we produced the pie chart, mine was this big, colourful, all these different things, and the guys in the community were much more direct, one to one work focus. So it was really interesting seeing the difference.

Angela: The variety is the best thing and the worst thing in a sense. It's great because it keeps you interested and involved, but the downside is that it can feel quite overloading, because there's so many things that you are trying to juggle at once. So it's quite hard to sometimes feel like you are doing anything very well, which for a control freak like me is not good. That's the downside really.

Sub-category Two: Home Visits and Office Work

This sub-category related to the perceived advantages and disadvantages of home visits and office work, as seen by participants. It was regarded by some participants that home visits were very important when working with service users in crisis, as this afforded a broad overview of the circumstances linked to the crisis. However, some felt that conducting psychological assessments was only feasible in an office environment, due to some of the perceived limitations of home visits, such as other family members being present and confidentiality issues. Some participants also considered that the community aspect of working in CRHT was a particular advantage to the work.

Karen: That's the other thing about crisis team psychologists, it's visiting people at home. I hope the others do, but that's not to be taken for granted. The psychologist in post before me got clients to come to her, to try and fit more in. I think we have to see people at home, and it has to be part of what it is we do.

Max: I like getting out of the office and that's one of the things I enjoy about working within the home treatment team, travelling around the borough and not just being stuck in the consulting room and seeing a stream of outpatients. So that's one thing, I think, , it's quite appealing going out and going to people's houses, andand I think that's quite useful, you get to see or know a bit more about people's lives than you would do if they were just coming to see you in a department somewhere.

Leighton: When I'm doing formal work it will be here, it's in a formal setting. So I'm not trying to do an MCMI in someone's living room. I do believe that the setting is important, if you are doing a formal assessment, it needs to be somewhere like this. I just don't think that the home setting is appropriate.

Angela: I think there are definite benefits in having people come in, because when I used to do home visits, although you would get a lot of extra information about people which was great, trying to do anything psychological when the TV's on and the dog's jumping on your lap, you know. I've actually been on home visits where I've had a father hoovering under my feet when I've been trying to talk to the service user. It's really difficult on home visits I find, to ask for things to be different, because you are there in somebody's home, so that's a bit awkward. And it's a lot easier for me, and I think with the clients that are able to make it in, they get a bit more out of it because they have this slightly quieter environment where we can sit and think about things together.

Natalie: I do both. It really depends on the situation. I think it is good to see people at home, but I also think it's very difficult sometimes, you are trying to assess someone and the TV's on, the dog's jumping all over you, you don't know who else is in the house. So I think there are pros and cons of doing both. I do get people to come and see me here, particularly if they can come here. And if I'm asked to see a lot of people, I ask the team, I say 'What would you rather, do you want me to see all these people and they are going to have to come here'. And what would suit the clients as well.

FIGURE 3.3 CORE CATEGORY TWO: BEING A PSYCHOLOGIST IN CRHT (CORE CATEGORY, CATEGORIES AND SUB-CATEGORIES)
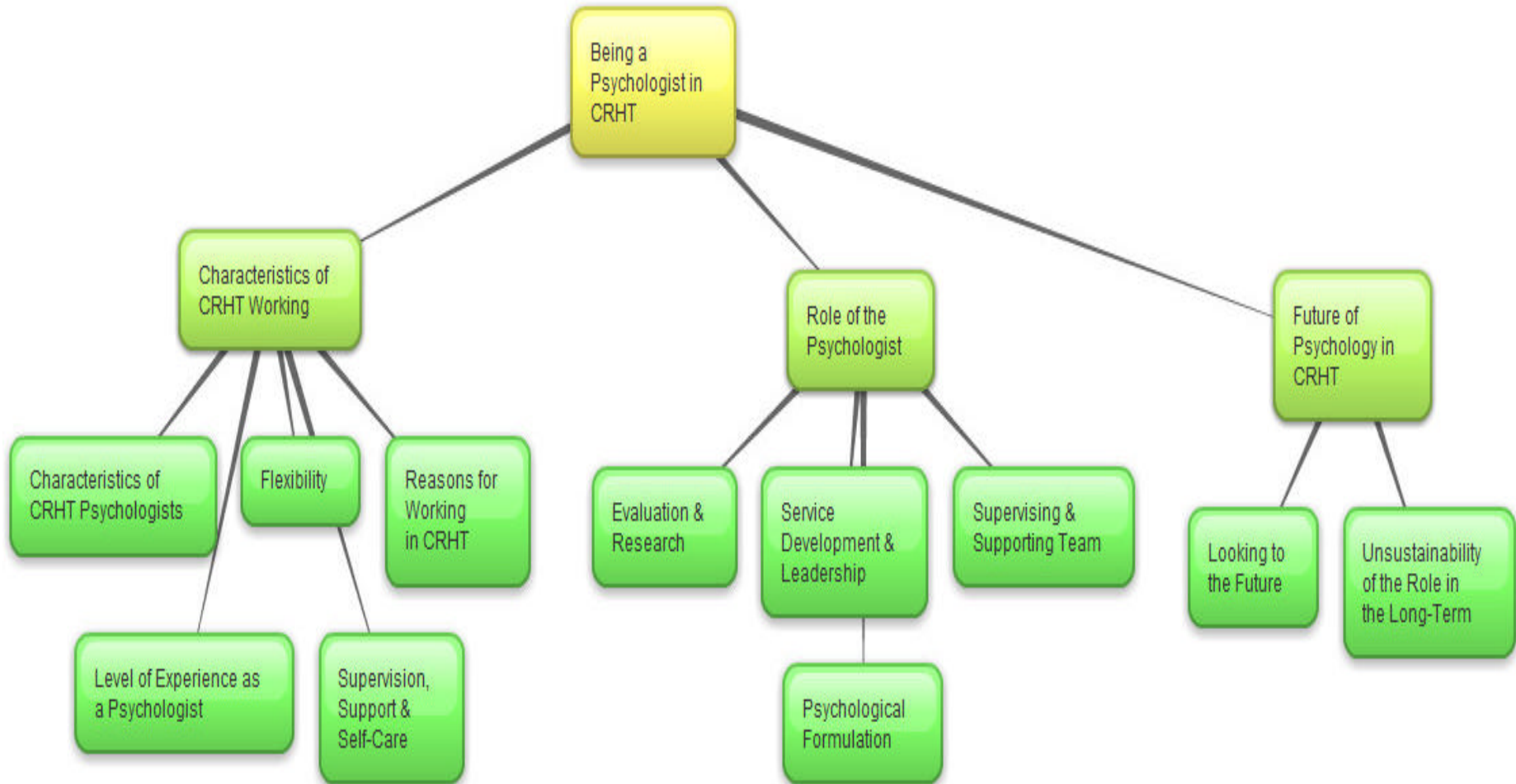
<u>CORE CATEGORY TWO: BEING A PSYCHOLOGIST IN CRHT</u>

As well as clinical work, participants discussed a range of issues specific to their experiences of being a psychologist in CRHT. This included three categories: *'Characteristics of CRHT Working', 'Role of the Psychologist'* and *'Future of Psychology in CRHT'*. Within these categories are further sub-categories, which will be considered in turn.

Category One: Characteristics of CRHT Working

This category focused on a range of issues which were considered to be specific and unique to CRHT working for psychologists. Within this, five sub-categories are identified, which pertain to aspects relevant to characteristics of CRHT psychologists, flexibility in CRHT, reasons for working in CRHT, supervision, support and self care and level of experience as a psychologist.

<u>Sub-category One: Characteristics of CRHT Psychologists</u>

This sub-category related to the characteristics participants felt were important to work in a CRHT, both when working in this setting (for example, with risky, complex service users) and for dealing with complex group dynamics. In addition, participants reflected on a number of attributes within themselves that they considered important for working in this setting (for example being *'thick skinned'*, resilient and using humour).

Louisa: You need to be very calm, unflappable. You are dealing with people who are

very, very distressed. I don't think you need it to come into it, but I think you learn to have a very high tolerance of risk. And actually not panicking when someone is very, very distressed and expressing lots of suicidal thoughts, that's helpful.

Karen: I would say, these earlier stages with psychologists being involved in crisis teams, it takes a certain type of person to be able to sit with the frustration, but also to be pretty assertive, in order to begin to get yourself heard, but in a way that's gradual enough to gain credibility, with usually quite a tough group of people. I've realised I cope with that by having rather thick defences, probably not great, but I've built up a, slightly 'Water off a duck's back'.

Leighton: I think there probably would be some personality characteristics as well, I think you've got to be fairly thick skinned. I think you have to be a team player, you can't be precious at all.

Angela: I think you have got to have a sense of humour in order to keep going. I think you have got to believe in what you are trying to achieve, and feel fairly passionate about what you are trying to do. I think that all helps, otherwise it would have been easy to have folded along the way, on the different occasions.

Natalie: I think you've probably got to be quite resilient. I think you have got to be able to tolerate risk and uncertainty. It helps to be very organised and to make sure you document everything properly, and be able to manage your work. You've got to be able to get on with a wide range of people, which I think psychologists generally can, anyway. Just to be quite approachable really.

Sub-category Two: Flexibility

This sub-category reflected the views of participants of the importance of being flexible and adaptable when working in CRHT. Participants spoke about flexibility in relation to service user input, meeting service user needs, working with the team and utilising psychological models. In addition, participants perceived that their work could be more flexible than the work of other staff, which they saw as a benefit.

Louise: I think that flexibility, because you can't have very rigid ideas about what therapy is, or what psychological interventions are. You need to be prepared to be flexible with what you do, and think outside the box in terms of how you work with people, and what psychological interventions are. But there is that flexibility that not everybody has, so it's good.

Sophie: I work 9 to 5, but saying that, I am flexible. I think flexibility is key. So sometimes I see people two or three times a week if I need to, and I might spend

with them an hour and a half if I need to. I need to adapt to whatever presents. Apart from that, apart from my agreement with the team, with the client it is negotiable on an ongoing basis, it feels very much responding to whatever the team brings.

Max: I guess sort of flexibility to work with different presentations, but also within the time frame, not knowing how long someone's going to be with the team for, what you are going to be able to achieve, how many sessions you've got with someone.

Olive: I think definitely, to be flexible. I think you need a lot of flexibility and order. Flexibility is one of the main things. The number of times I've cancelled annual leave, or have had to come in on someone's birthday at home because something's happened. But that seems really important to do that at the time.

Lauren: It kind of means that you work a lot more informally, which I think probably suits my style. I don't think I could ever be a really kind of formal CBT or psychodynamic kind of worker, where I think its super boundaried and super structured. And so it's a much more informal and unboundaried in some ways, way of working which probably suits me better.

Sub-category Three: Reasons for Working in CRHT

This sub-category referred to participants' various reasons for choosing to work in a CRHT, including a desire to work with adults with severe and enduring mental health problems and personal interest in this service user group. Participants noted that their background experience had been working within adult mental health settings, and they chose to work in CRHT to build on their experiences. Many stated that although they did not initially set out to work in CRHT, their background interests offered an attraction to work in this environment. As such they reflected that CRHT work seemed to offer an inherent appeal. Some spoke of the CRHT environment as having a particular *'fit'* with their personality and personal experiences. In addition, participants' personal interest in working with individuals with severe mental health problems served to balance some of the difficulties of working in this environment, such as managing uncertainty in relation to risk.

Max: It was enough of a similarity to the inpatient ward to feel familiar and comfortable, but also enough of a change for me to want to move on. I hadn't worked

in home treatment team specifically before starting this post. But I had done home visits as part of my CMHT job and I liked the idea of being out and about in the community. I've always had an interest in the more long-term and severe end of mental health problems so I've always worked in that field. So working with psychosis, people who are floridly psychotic or manic or long-standing depressive difficulties doesn't faze me in a sense, I'm fairly used to that.

Olive: I've always been really interested in working with people in acute crisis, and people with serious mental illness, because that's been my whole experience, really. Just the opportunity to help people recover, in the least restrictive environment, has also appealed to me. Because, the thought of being somewhere different, in hospital, when you are feeling at your most vulnerable, with people you don't know, must be quite frightening for people. So I think the whole crisis model really appeals to me, about helping people deal with whatever has brought them to the crisis, in the environment that it's happened, at home, where they are most comfortable, and helping people recover that way. That makes logical and intuitive sense to me.

Lauren: I've always been interested in, I've always thought and I've always been told during my training that I'd be likely to end up working with severe and enduring. This was the first one that I was offered, so I took it. I was thinking that I'd probably be here for a year, and then I'd move on to something else. But, I'm still here two years later, so obviously something about it appeals to me.

Sub-category Four: Supervision, Support and Self Care

Participants reflected on issues relevant to their own self-care when working in this setting. This related to the importance of having supervision to allow reflection on the issues relevant to working in CRHT. These included discussion of the personal impact of working with service users in crisis, thinking through complex cases, and reflecting on team dynamics. It was considered that supervision was vital for supporting and validating and containing participants' experiences. In addition, participants felt that the wider network of psychologists and specialist CRHT network was helpful in enabling feelings and frustrations to be shared. Furthermore, it was considered that working in other settings on a part-time basis allowed participants to protect themselves from the complexities of working in this setting.

Karen: Sometimes, you leave a house, and you can come away with a lot going on inside yourself. You can feel quite weird because there is so much stuff going on, and you can end up carrying quite a bit out of that house. Obviously there's a need for supervision, and to feel secure in your supervision about the personal impact of it. I think it's particularly necessary for us to talk about processes, and the impact of the work. I am very good at compartmentalising my thinking, just stopping thinking at that point, which is really important to just switch into the mode of being at home. Some people can't do that, but I can, as long as you also reflect on the need to talk about it at a later date, in supervision.

Leighton: As a psychologist I have got much, much more support in terms of clinical supervision, and peer support as and when I need it. I suppose it sounds like a platitude really, but clinical supervision is what I really seek my refuge in. I've got a really good supervisor, and I use those sessions to not only gain some support with thinking about particular difficult clinical presentations, but thinking about the dynamics with the team, thinking about my own reactions. So I think without the clinical supervision, it would be a little bit risky really, to do this kind of work.

Sophie: I think on a day to day basis, because of the severity of the difficulties, it's an ongoing challenge to be able to be there with the client, to be open, not to shut off emotionally. I feel really lucky with supervision. I have an hour supervision on an almost weekly basis. So this is extremely helpful.

Louisa: Probably psychology is a bit easier, because we do have better relationships with other psychologists and other teams, and do support each other. And have those lines of communication, try to keep those much more open. I think that's how I try to manage it. In terms of the rest of the team, I think that's much harder.

Angela: Keeping links with the network and faculty has been enormously helpful in terms of support, just knowing that you've got a network of other psychologists struggling with similar things. I've made some good friendships with people through the network, and it's really good to know you can just pick up the phone and go, 'You wouldn't believe what so and so has done', and they go, 'Yeah, I've had that sort of experience'. It's really important to have that informal support from psychologists. I always try to make the time to go to along them.

Sub-category Five: Level of Experience as a Psychologist

This considered issues such as the level of experience of participants for working in CRHT. Participants felt that it was challenging entering the role as a first post from qualification. They reflected on the specialist nature of CRHT work, and the associated implications of experience level and confidence when newly qualified. Participants felt that it was important to gain generic skills in other settings, and that working in a CRHT could lead to a rapid honing of skills. This was linked to possible

difficulties regarding future career progression. In addition they reflected on the perceived utility of being at a more senior level in CRHT.

Eleri: It can perhaps lead you to feel out of touch as a band seven. Having only done this job, I'm starting to wonder if I'm feeling a bit out of touch with doing more longer term therapy. Whereas I think if you were coming into it one day a week as a consultant, having spent the first ten years of your career doing more traditional work, it might be different. So I think you need to work to keep up your professional knowledge base, and I think that perhaps, I think it is a challenge in this job, I think less so in a community team post.

Lauren: It does feel a bit, there's always an anxiety that I'm becoming de-skilled, or that I'm not developing the skills. I think it might be one to come back to later on. You know ideally, I would have consolidated what I'd learned in training in working longer term with clients in a more conventional setting, and then specialised in...it feels like I've gone into a specialism without actually having the grounding of working in a more conventional, longer term way with people.

Natalie: It isn't the easiest setting to go into, and I wouldn't recommend it when you are newly qualified. I think it's more about how it can knock your confidence. I certainly find it very difficult. So it's better to go into a role that are used to having psychologists, there are lots of people around you, so you know what you are doing. I managed it by always having 'No' in my head. I don't now, but that was my default position. Because I was asked to do so many things that were ridiculous, that I always had 'No' in my head.

Category Two: Role of the Psychologist

In addition to characteristics relevant to CRHT working, participants focused on specific aspects of the role of the psychologist within CRHT, including formulation, research, service development, supporting the team and bringing a different perspective. These elements are contained within this category, and the associated sub-categories are discussed below.

Sub-category One: Psychological Formulation

The important role of formulation was emphasised by participants, both with the team in relation to service users, and for the team. The use of formulation skills were noted as particularly helpful for the team in understanding *'stuck'* cases. Participants reflected on the perceived value of formulation for service users, in bringing an understanding of their difficulties that made sense to them. The use of different psychological models in formulating crises was considered, and participants discussed the rewarding aspect of offering a useful psychological formulation to service users and the team.

Catherine: The really nice thing about crisis, is often this is the first time people have had a psychological perspective on their difficulties. There's been a few times when I've seen someone, and they've been like 'Oh, someone understands', and I'm like 'That's great'! So you get a real buzz from it when you do get it. So that's lovely, that side of the job. Also, that's where all your models really come into their own when working in crisis. Because you've got a framework to hang on the different things people are saying. That just instils some confidence in terms of making some structure out of the chaos.

Max: Formulation is certainly a key role, yes, I think in terms of, for the service's understanding of the user, but also in terms of helping the person themselves to make sense of their current difficulties and an opportunity that gives to normalise and de stigmatise. Perhaps helping people to make sense of the crisis, as opposed to diagnosis and intervention based on that. Not just describing the symptoms and saying we are going to do this, but actually thinking about what's precipitated this and what's maintaining it.

Leighton: So I try and understand the kind of crux of what's causing the distress for them. I think as psychologists, we can be really, really valuable in starting to unpack when there's an incident, that this is just because of a person's illness. Because usually, there are very clear reasons as to why that person was triggered in the way that they were. We are the only ones that are in a position to have that awareness of lots of different approaches.

Karen: I love formulation, psychological formulation, bringing in all sorts of different models, and integrating them is brilliant in crisis. My general models are around, 'Where is the vulnerability', that basic structure of predisposing, precipitating, and all that sort of stuff. So, I always have that in my mind, the four Ps. I tend to think of formulation as a bit of a target shape, the red bit being the crisis and the other layers.

Olive: One of the things I find most enjoyable, because I'm quite a structured and organised person, is trying to get a handle on someone's formulation, and someone's formulation in crisis. Formulation is key really, and especially when you

are working on holding people, and working with people who are at an acute risk and in acute crisis - it's key to my work. Also, sharing that with the team. They often ask for an opinion if they are stuck, so I guess that supports the argument that they find formulation quite useful for working with clients.

Sub-category Two: Evaluation and Research

Some participants spoke of their role in research and evaluation, although not all participants had allocated time to complete research within their roles. Participants also identified the lack of available time to complete research as a difficulty. Some had a role in supervising other team members to complete research, and they identified potential research ideas to improve the service provision. In addition, participants reflected on the need for research in CRHTs, both to consider the role of psychologists in CRHT and the service provision more generally.

Louisa: I'm trying to do an audit at the moment, looking at our assessment process to see if we can improve it. There's a perception of inconsistencies, and looking what those are and if there's things we can do to address that, or what's going on. I think at the moment, it's more exploratory, seeing if there are changes we can make to the service. No one else wants to do it.

Angela: Time for research, not so much. It is part of my job, but again it's sort of in different levels really. We have, since I started done regular service user satisfaction surveys. As time's gone on, I've not been involved in doing those interviews with people, we've always had an assistant that I've supported to go and do that. So that's been an important part of it.

Max: I also have a role in research, we've done some looking at service user and carers' experiences of service response to crisis, and I had sort of a lead role in this piece of research and we're currently writing that up at the moment, so that also takes up some of my time. I think we could do more, some further work on service user evaluation of our service.

Sophie: That's a big, significant part of my role. I'm involved in a service user and carers evaluation project, and that is ongoing. The team is fairly keen for us to be doing this work, so there is protected time, both for myself, and for some of my colleagues who are involved in this project. Also, I have to make sure that I protect the time as well. Also, the area is fairly new, we all need to be doing a lot of research. That's why this is an important project, because I think we need to capture what we do. I think there is a need there, in terms of clarifying our role, clarifying what we are offering.

<u>Sub-category Three: Service Development and Leadership</u>

This related to participants' ideas regarding the role of psychology in developing the team via service development initiatives. Participants regarded themselves as playing a role in leadership and management, as a result of their senior role within the team. However, they spoke of the challenges of being a team member in parallel with being involved with management.

Karen: A big role is half a day pretty much running a care planning meeting. Partly because it was very ropey when I joined the team, and I feel Clinical Psychologists have a bit of a leadership role that they can use in a team. I think, more and more, the phrase 'Leadership' is going to be important in our profession. I've tended to sort of chair it. Also, because I'm at band 8a, I think I have more confidence talking with the manager about processes. So I do see there is a role in that, and in development.

Angela: I'm part of the management team for the crisis and home treatment. I think one of the tensions always is between the service needs, the business plan, the management side of what needs to happen, and then the clinical side.

Leighton: I have a role as a manager within the home treatment team and we have a management meeting one a month, where we think about the direction of the team, what our aims and objectives are, what is required to meet those, what are the areas that we need to develop, our ideas for going about that, sort of service development initiatives, so I have a role in thinking a bit more strategically about the team.

<u>Sub-category Four: Supervising and Supporting Team</u>

This considered the ways in which participants saw their role as offering supervision and support to the team, on a formal and informal basis. They saw the need for psychology to offer support after adverse incidents, and many took the lead in facilitating team discussions. The support offered was considered to be valued within the team.

Leighton: In terms of individual clinical supervision and support, that's been taken up more. Yes, that's done informally, I mean sometimes it's done almost after the event, when people are really, really stressed out.

Catherine: I'm also involved, in terms of providing supervision for some of the guys in the team that are doing CBT courses, to think about the cases they are working with.

Max: I guess in some ways like consultation but infacilitating different members of the team to express their opinions. So it's not in some sense someone bringing a case to me for my opinions on, more me facilitating a series of reflections within the team for people to contribute their ideas and understanding.

Olive: Especially at the Crisis Recovery Unit, where clients are in for the whole day. Some of the OTs there might approach me for supervision on a treatment programme for people while they are there. That works quite well.

Category Three: Future of Psychology in CRHT

Along with characteristics relevant to CRHT working and the role of the psychologist in CRHT, participants spoke of their ideas regarding the future of psychology in CRHT. This considered their views on how the role could evolve, as well as their perceptions on what made sustaining psychological input in these settings difficult.

Sub-category One: Looking to the Future

This sub-category considered participants' ideas of how CRHTs would evolve, and the future roles of psychologists within such teams. Participants reflected on both local and national issues regarding psychologists in CRHT service provision. Many felt that there was a need for psychologists to justify and promote their skills in line with current changes in the NHS, although they considered that the role of the psychologist was an important one.

Angela: I think one of the things that would influence that is it is all the top down stuff in terms of targets, what kind of targets are the government going to be looking for

from these sorts of teams. I don't think we are under threat as a functional team, probably because the CRHT plays such a role in allowing places to cut costs by closing beds, I think it's unlikely that CRHT would be decommissioned.

Catherine: Ultimately, what the commissioners want to know is our impact having an influence on cost effectiveness and quality of the service. We need some way to be able to measure and show that. But my sense is, we are getting lots of people that are trained up to do the one to one therapy. So we need to be offering things that are additional to that, and showing our specialism in other ways. And I think the CRHT work and the open work really allows you to do that.

Karen: It's been very disappointing, there was an expansion, but it just seems to have stopped. The worry is that it's not becoming part of the idea of crisis teams at some level, it's like something hasn't sunk in, nationally. I have a bit of a worry about that, because we are all contracting, all clinical psychologists, there's going to be fewer and fewer of them, unfortunately. We are re-designing the whole of the service across X. I would say that they are not really prioritising crisis teams in that, at all. I think crisis team psychologists are going to get pressured to do less time and their role is going to change. It's going to be very hard for them, because it's hard enough to get supervision going when you are half a week, let alone half a day.

Lauren: Training, and reflective practice, and having input into meetings and all of that. That's always an uphill struggle, but I guess that's the way that, if psychology input into home treatment teams were to evolve, I'd like to see that's the direction it would evolve in. Maybe being able to share our knowledge, understanding and experience in a way that the whole team can draw on. So it's not just that we do a bit of psychological work with the people that happen to get referred.

Olive: I think it's a really important role, I think there is a role for psychology. It should continue, obviously I am going to say that, but it should. I think there are always going to be acute psychiatric needs for people, so to spread yourself across that service, whatever that will look like in the future, is quite a good idea. I think in terms of cost cutting, and psychology not being present in the NHS, the more useful and visible psychology can be, obviously, the better.

Sub-category Two: Unsustainability of the Psychology Role in the Long-term

Some participants felt that it was not possible to work in CRHT on a long-term basis, and did not see themselves as able to work in the setting in the long-term. This was attributed as being partly due to the perceived dominance of the medical model in the setting, and the frustrations in not working with service users on a long-term basis. In addition, the lack of feedback regarding their input as a result of the short-

term nature of the work was considered to contribute to the unsustainability of the role. It was considered that working in CRHT on a long-term basis could lead to 'burnout'.

Eleri: I don't think it's something I would do for a long time. I think there's a general feeling it's something you can't do for a long time, you get burned out too quickly. Also, what's worrying, is your perception of risk changes, and you can become very detached from what's going on outside. It's probably not going to be helpful to say here for that long.

Karen: I think full-time in acute services, you would probably need a bit of a break, for a while. I've had four years in acute, and for me, it did feel like I have been wanting that long in it. But only now do I feel the benefit of reducing it, and the need to reduce it. It's funny, because part of me is still saying surely we can sustain it longer, surely it's not going to be a result that Psychologists can't keep going permanently in this role. And part of me doesn't want that, but I'm beginning to think that maybe it's true. We are taking in a lot, all the defences in the system, all the strain. I'm very reluctantly coming to a conclusion that psychologists may only be able to do it for a certain amount of time.

Karen: I realised over time that I was getting stressed in a way that I didn't even know. I'm down to three days in acute services, and the rest is Clinical Tutor, which is so great, it's utterly, utterly different, it's such an antidote. I'm happier, I'm just more balanced. I come to my work feeling psychologically more prepared. I just don't feel threatened by it anymore. I didn't realise that I was feeling more anxious about things than I'd realised, or more heavy. I think I always find it difficult to say that, because I love the work so much. But I think it needs to be acknowledged that full-time in acute mental health, no matter how resilient, and how much good supervision, something starts to grind you down.

Max: I don't think I would want to have or want to do that solely for years on end without there being an opportunity also to do some long-term work as well. So I think my job being split with the CMHT components allows me to do a little bit of a full range of interventions.

Natalie: I'm not so keen on the client work, and that's the main reason why I've decided to go full time in the CMHT as opposed to here. Because I like the longer term work. I think if you are a psychologist who is very CBT, or work in a particular way, then perhaps it might suit you a bit better, the client work. So I don't get so much satisfaction from that side of things.

FIGURE 3.4: CORE CATEGORY THREE: WORKING WITH CRISIS (CORE CATEGORY, CATEGORIES AND SUB-CATEGORIES)
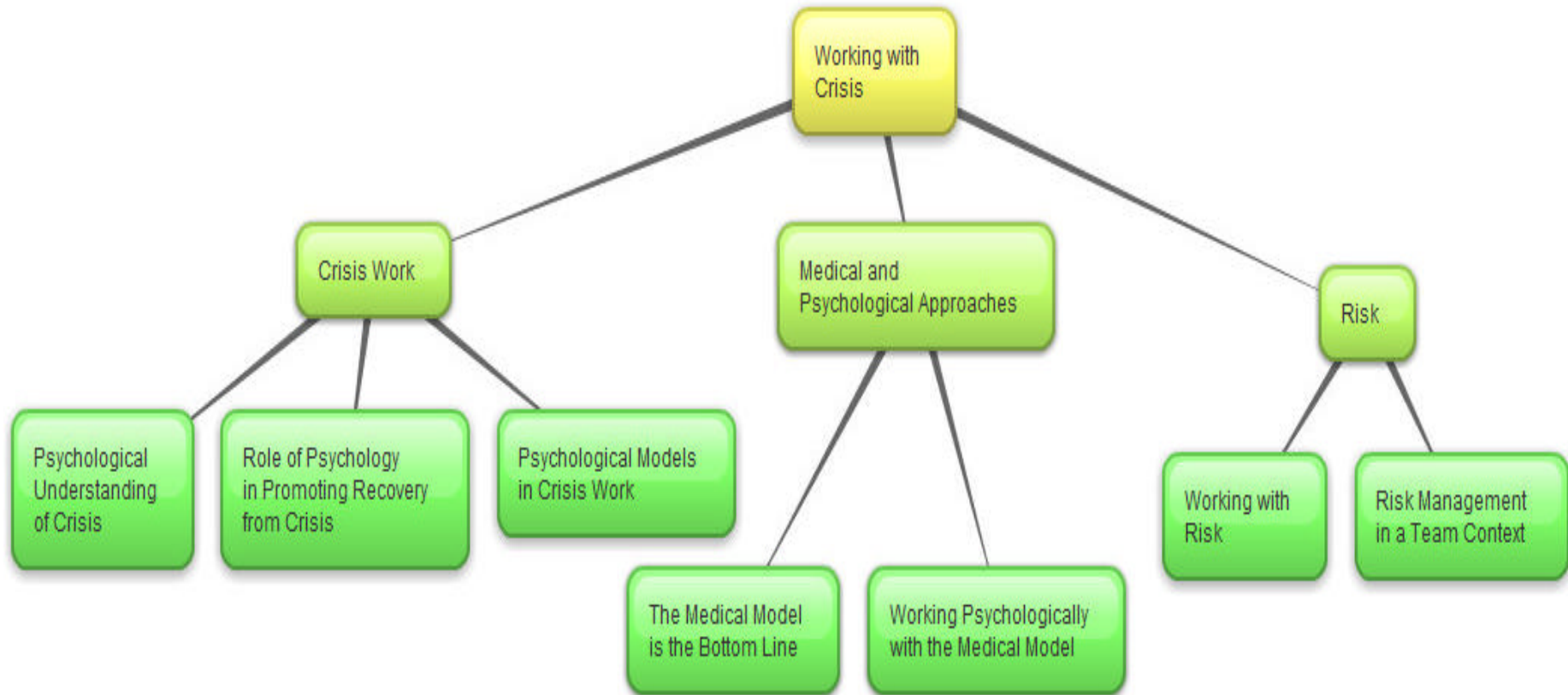
CORE CATEGORY THREE: WORKING WITH CRISIS

Along with factors relevant to working clinically in CRHT and being a psychologist in CRHT, participants commented on factors specific to working with crisis. This core category related to issues relevant to participants' experiences of working with service users in crisis in CRHT. Within this, the categories included crisis work, medical and psychological approaches and risk were considered. Furthermore, within this, a further seven sub-categories were identified, which will be considered in turn.

Category One: Crisis Work

This category specifically considered issues relevant to psychological working with service users in crisis. This included psychological perspectives of crisis, the use of psychological models and the role of psychology in promoting recovery from crisis.

Sub-category One: Psychological Understanding of Crisis

This focused on participants' comments regarding the application of psychological understanding to the reasons why people present in crisis. A range of factors were highlighted, including internal and external factors such as individual vulnerability, stressors, life events and personality traits. Participants identified factors linked to the workings of the CRHT as playing a role in service user crises (e.g. staff

turnover). Participants acknowledged the role of the service in supporting those with the first presentation of a crisis, and in supporting *'recurring'* crisis.

Louisa: People who are long-term severe and enduring mental illness, bipolar and schizophrenia, people who are very depressed, high risk of suicide, self harm, we see a lot of those. For other people, we see a lot of people who've had changes in care coordinators or psychiatrists, a lot of people find that very, very distressing, and will react with a crisis in response to that. Some people who have just come into services for the first time, they've had a big life crisis and just don't know what to do or how to cope, they often come to us. Probably 75% of people who come in have probably been in and out for a very long time.

Karen: The vulnerability for me is usually around trauma and attachment difficulties, A mental health crisis, it's a massive instability of mental state, and for that, there's some deep vulnerability.

Leighton: For some people, crisis is about some form of transition that they are going through, so whether that's a loss, or whether it's some sort of crisis that's occurred through a relationship dissolving, so I'm informed by an existential model for that.

Angela: It's often people with difficulties containing emotions, and don't have a sense of the range of normal emotions that it is normal for the population to have. I think it is often the high degree of self-criticalness people have. It's the lack of distress tolerance I think that people have. Also, the stress vulnerability for people with histories of some sort of abuse or neglect that then make them more vulnerable as they get older.

Eleri: Why might people find themselves in crisis is, it is stress vulnerability, and there's usually some kind of trigger, even if the trigger is not immediately obvious when someone is referred. Many people are already in the service somewhere, and return to some or another part of the service. We very rarely have people who appear out of nowhere and who return just to GP care.

Sub-category Two: Role of Psychology in Promoting Recovery from Crisis

This considered the ways that psychologists in CRHT tried to promote recovery from crisis for service users. It was noted that, amongst other factors, the use of psychological containment and sense-making were key in promoting recovery from crisis. Participants reflected on the elements they considered helpful in the recovery process, such as psychological validation, promoting hope and empowering service

users to change. They also considered social issues as important in the recovery

process, such as changes in the service users' environment and social support.

Participants also played a role in educating service users about the nature of mental

health crises, and in relapse prevention strategies.

Max: Stress and what buffers against stress in terms of social support. Things like promoting hope for recovery. The sense that actually as a service quite often people feel the home treatment team can be a source of support, when maybe they don't have things in place to support them in their own lives, the sense that someone else cares about them. Working with them so that they are not alone is a general factor that helps promote recovery. If you communicate that recovery is possible you normalise problems, talk about other people who have got through similar difficulties, share strategies, provide plans about ways forward.

Leighton: For a genuine sustainable recovery it will usually be something will have changed in the environment. Getting them out of a toxic environment that they just need to get out of. So it's being mindful of that, and thinking about how you can help people get out of environments that might kind of be repeating that.

Karen: You sometimes have almost transformative conversations with your clients, because the metal is hot, at that point. We have an enquiry and a curiosity, as well as our theory base, to sit with somebody, and just tune in. Particularly in crisis teams, we need to tune in quite quickly, and rapidly, we need to really listen, intensely. I think psychologists really do shoot down a lot of negativity that's going on about clients. That's really important.

Angela: The process of the problem being acknowledged to start off with is important for people. For clients, I think very often there's a validation and acknowledgement of the problem from family and friends, if they go into a crisis and they are involved with services, I think that makes a difference.

Eleri: Sometimes it helps people to make sense of things, but also in a way that gives them ownership of it. Our nurses also help people make sense of things, but in a way it comes from a model that leaves that person at the mercy of pharmaceuticals. 'There's something about giving people space to make sense of things in their own time, that leaves them feeling in control of it.

Sophie: A theme for me is, whatever skills and resources people have, there comes a point where these are not working anymore. This is the time to re-think, this is the finding meaning in the crisis. If we can make good plans with them, in terms of not only overcoming the crisis, but how can we prevent it as well. I think the most important is human nature. The self has its own process for healing itself, and as health professionals, we can only be there to guide people to access their internal resources. This is our work, and sometimes to add a bit of knowledge and skills as to how to do that. But I think the type of knowledge that allows people to recover, is the type of knowledge that is within.

Sub-category Three: Psychological Models in Crisis Work

Along with participants' views on the role of psychology in promoting recovery from crisis, they reflected on the idea that CRHT psychologists have a role in supporting service users who appear to present to the service for a variety of reasons. They talked about the wide range of specific models used when working with service users in crisis. Many identified both using specific models, and integrating a range of models within their psychological work with service users in crisis.

Louisa: CBT almost exclusively. Sometimes CAT, because a lot of the personality disorder clients coming in have got CAT formulations or have done CAT work, and using those to understand, perhaps what's going on with the team and those other dynamics. Solution focused is a big one when you are working with people very briefly. Motivational Interviewing, not a huge amount though. And mindfulness as well, I find helpful with some clients.

Karen: My favourite predisposing models are attachment theory. I also really like Schema Therapy, and I think they can work together, I integrate them so that I think about the negative core beliefs that are also making someone vulnerable. I think in crisis and schema, the core belief aspect, rather than the thought aspect, is really important. I think what's happening often in crisis, is an activation of negative schema, and that's really important to link that to what happened briefly in childhood.

Angela: I think I'm fairly eclectic. I quite like schema therapy approaches, so if clients are interested and if they seem to have the capacity, then quite often we'll talk about that. Quite often I'll give people bits of reading around those sorts of things so they can try and put things together. There's quite a lot of solution focused stuff inevitably, because a lot of the clinical work is about containing a crisis and getting somebody through. So there's a fair amount of problem solving and solution focused stuff, informed by CBT ideas if I see people with great cognitive patterns, and errors that they make, you know people that are very dichotomous, people who personalise a lot, who are very self-critical, that's part of the intervention. DBT in that group, and mindfulness.

Max: I don't know if I have an overarching model for crisis, perhaps maybe thinking more about individual psychological models for different presenting difficulties. So thinking a bit about models for voice hearing or paranoia or bipolar or anxiety, but within that I guess you might think of, often it's not just internal factors you need to think about in home treatment teams, a lot of environmental, social, economic,

factors that precipitate the crisis.

Natalie: CBT. I do look at three states of mind in DBT, I use that a lot with people. And a lot of people that come into crisis are either in emotional mind and they are the people who tend to self harm. Also psychodynamic. I guess I really work on the principles of containment and holding. I think obviously a lot of the clients that we see in this team are in a lot of distress. And just having someone who (I do take a different approach to a lot of psychologists) won't reassure, won't offer any practical help, but just sit there and cope with that emotion, and help them to make sense of it. I think that's huge, and that's what I mainly try and do. Often clients just have people that just want them to shut up, or that won't listen, or can't bear their distress.

Category Two: Medical and Psychological Approaches

As well as participants' views on how they intervened with service users in crisis, they reflected on the place of psychological approaches and medical approaches in CRHT. This category thus reflected the role of both psychological and medical approaches when working with service users in crisis, and the perceived dominance of the medical model, as well as ways to work alongside the medical model.

Sub-category One: The Medical Model is the Bottom Line

This related to participants' perceptions that despite the skills of multidisciplinary professionals in CRHTs (including training in psychological interventions), the care provided ultimately came down to the *'medical bottom line'*. This related to the use of medication, sectioning and potential hospitalisation when individuals presented in crisis, which was seen as being linked to risk and safety. It was also considered that when working with *'risky'* individuals, psychological skills were not always drawn upon by other professionals, as the medical bottom line was utilised to contain risk in crisis. This was, however, considered as useful from a safety point of view. Despite

this, some participants noted that although the team was ultimately medically-oriented, there was an emphasis on social and psychological interventions

Max: The bottom line approach tends to be medical. Sometimes things can be reduced to the lowest common denominator of delivering medication and I guess that's what people might tend to fall back on as an intervention. I think sometimes the lack of time means that happens as well, the huge number of people to be worked with, the large number of home visits people have to do in a day, the short amount of time people have to actually spend with service users and carers means that sometimes it can be reduced to medication drop.

Karen: Because that's all they do in X, they just deliver medications. We even have a Pharmacist in our team. It must be one of the most medically based teams.

Lauren: I think the reality is that if you've only got five or ten minutes for a session, all you are going to be able to do is go in there, give them the medication, monitor the risk and monitor the mental state.

Natalie: It just seems to be very quick. They'll go in there, 'How are you doing', they'll check out the risk, they'll check out the medication, then they are off. I think they are very medically orientated. There still very much is, 'Oh we've got to get this person to see the doctor, we've got to think about their medications'. But ultimately, yeah, there is a big emphasis on medication.

Sub-category Two: Working Psychologically with the Medical Model

Following on from participants' ideas regarding the *'medical bottom line'*, this considered their views regarding the perceived dominance of the medical model in CRHT, and the role of psychologists within medically dominated teams. They considered the dominance of the medical approach as applied to the system, team members and service users. The view of some participants was that the medical model needed to be accepted in order to work successfully in CRHT. Some also felt that their time working in acute settings led to an acceptance of the approach. Participants did, however, consider that medication sometimes had a role in supporting the psychological engagement of service users. Participants talked about ways to consider promoting psychological ideas in a medically orientated climate,

and ways for the models to work more cohesively. In addition, they considered ideas

regarding formulation about the team, which was unique to the psychologists.

Leighton: I'm not a great advocate of the medical model. But I accept that I am working in a system where it is the dominant paradigm, and I suppose I see my approach as extremely pragmatic, as to how I can work alongside individuals that have a lot of power in those systems, and get them to change from working with them.

Louisa: The medical model is very dominant, there's a very strong focus on biological symptoms and psychological symptoms. So if someone comes in with depression, and it seems very biological...it's odd, because I've never had that split before. If it's biological, we'll treat it with medication, and anything that's left over, that's psychological, and that's what a psychologist does. Whereas I always understood that to be very much interrelated.

Karen: Where I just realise I've built a defence is against the medical model, because working in acute, in a Crisis Team is Psychiatry at it's strongest, and previously, even before training, I was anti-psychiatry. So I've immersed myself in Psychiatry, and I've realised I cope with that by having rather thick defences, probably not great, but I've built up a, slightly 'Water off a duck's back'…I've tried to challenge things, and I've found it's added too much stress. So I do it very, very, very subtly, and only at certain times.

Lauren: Oh, they are very medically focused. I think I probably work with it better than a lot of psychologists do, I think I'm more open to it. So as much as I find that a frustration, I think I'm also quite realistic with it. And I do think that when you are seeing people that desperate and that unhappy, I think if you give them some medication, that's probably going to help them to feel a bit better right now. But at the same time, I think you know, medication is a bit of a quick and easy fix in a lot of cases. I think you need to be willing to work with the medical model, because it wouldn't work if you were going in there and not able to co-operate with that. You'd very quickly become very unpopular, and wouldn't get many referrals, and people wouldn't be very open to working with you, I imagine.

Max: I guess the very psychiatrically dominated way of working home treatment team generally is – in our team it does function in many ways quite like a ward system and a lot of the thinking about clients is diagnosis and medication. I think people in the team do have other skills that they bring, but I think it's partly just that the system of processes in the team like having a handover each day which is similar to a ward handover, or the weekly medical review which functions a bit like a ward round. I think in some ways those systems are a result of a medical model and also reinforce it, that's not to say that people aren't open to other ways of working.

Category Three: Risk

Along with observations regarding crisis work and medical and psychological approaches, issues relevant to working with risk in CRHT were considered by participants. The importance of managing risk issues within a team context was discussed, along with the value of the team approach in CRHT in containing risk. Participants reflected on the high level of *'riskiness'* of service users in CRHT leading to a possibility of becoming desensitised to risk.

Sub-category One: Working with Risk

This related to the nature of working with risk in CRHT, and participants reflected on the nature of risk desensitisation as a result of working with *'risky'* service users in this setting. Participants acknowledged the need to be mindful of this, but also recognised the need for a degree of detachment from the emotional impact of the work. They reflected on ways to manage risk in this setting, with increased experience and the use of risk formulation.

Lauren: There have been plenty of times when I walk away and I'm thinking, 'I hope I don't come in tomorrow and find out they've killed themselves'. And that's very real, but I think you possibly become desensitised to it as well. I think there's a certain level of becoming automatically detached from it, emotionally at least. I think most psychologists are probably like that. I think you probably learn quite early on that on some level you just have to switch off from it.

Natalie: It is stressful, and I have had some visits where I've come back and felt worried. But I think a lot less so now, I think experience really helps. I'm a lot less anxious about risk than I was when I first started.

Olive: I think the times when people become desensitised to risk are the times, probably, when people rely more on their gut instinct of risk, or more intuitive appraisals of risk. But, people can become desensitised. My view of risk is more to do with formulating someone's particular presenting problem...it would be difficult then, to become desensitised, because you've almost got a map. I think the thing that keeps practice safe is having a good formulation and a good understanding.

Natalie: I have had a couple of trainees recently that have been more concerned

about risk than me, and it has made me question that. I have thought, 'Am I being a bit blasé about this?' But no, I think certainly, Crisis Team members probably do get a bit, but I don't think I have yet.

Sub-category Two: Risk Management in a Team Context

This appeared to be linked to the importance of team working to contain and manage

risk issues. In addition, processes in the team which served to contain risk, such as

shared decision making were considered. This was contrasted to other settings,

where working in a CRHT was considered to be more conducive to sharing factors

associated with risk, despite the fact that service users were objectively considered

to be more *'risky'* in this setting. In addition, participants reflected on their awareness

of the impact of risk on the team, and their role in supporting team members with risk

issues.

Sophie: I think that the type of work that we are doing, and the levels of risk that we are managing is only manageable within a team context. I think it is also great for us to work alongside other people, because I don't think that this work can ever be done in isolation.

Olive: I think often that's quite containing for people that are wondering either how to manage people, how to assess their risk, how to understand their risk, and what to do about it really – whether to admit to hospital or whether to treat with home treatment. And, as well, I think what keeps people safe is having a number of different viewpoints as to people's risk. I think that's really healthy, and it's something from our Sainsbury's Centre training right at the beginning, that was really emphasised to us.

Louisa: I also love the fact that you are within a team, so all the risk is within the team, the whole team takes responsibility for that client which is fantastic compared to the CMHT, where you can guarantee Friday afternoon, you are going to go home with the most worrying client in the world. You don't have that as well, which is great.

Olive: You can always say to clients that they can call whenever they need to. That's part of the way I manage the risk, being able to say to clients, 'There is always somebody here if things deteriorate, or there can be somebody a bit later on to go out and check things are ok'. So it doesn't feel as isolated as working in a CMHT, where you go home on a Friday, and hope for the best over the weekend. Here, it feels very much as if it's an ongoing ward, almost.

Natalie: I saw somebody last week, and really, the only reason I was asked to see

her was because everybody was completely stuck, and they just wanted to check out that if I saw her, there was nothing that I thought that we could do as well. So it's almost like getting another stamp on their assessment really, which is kind of unnecessary in a way, but I suppose it's defensive practice really, which is not ideal. We have had a few suicides, so I can understand why people are worried really.

3.2.2 THEME TWO: TEAMWORK

This theme focused on a range of issues relevant to participants' ideas of working with the team in CRHT. These included their observations of CRHTs as *'reactive'*, and their positioning as psychologists within such teams. They discussed the perceived challenges in promoting psychological ways of working in such teams, and ways in which they had succeeded in establishing psychological thinking in their teams. Participants also reflected on the importance of other professionals being psychologically minded, as a source of support. Each core category and sub-category will be considered in turn in the following sections.

FIGURE 3.5 CORE CATEGORY FOUR: WORKING WITH THE TEAM IN CRHT (CORE CATEGORY, CATEGORIES AND SUB-CATEGORIES)
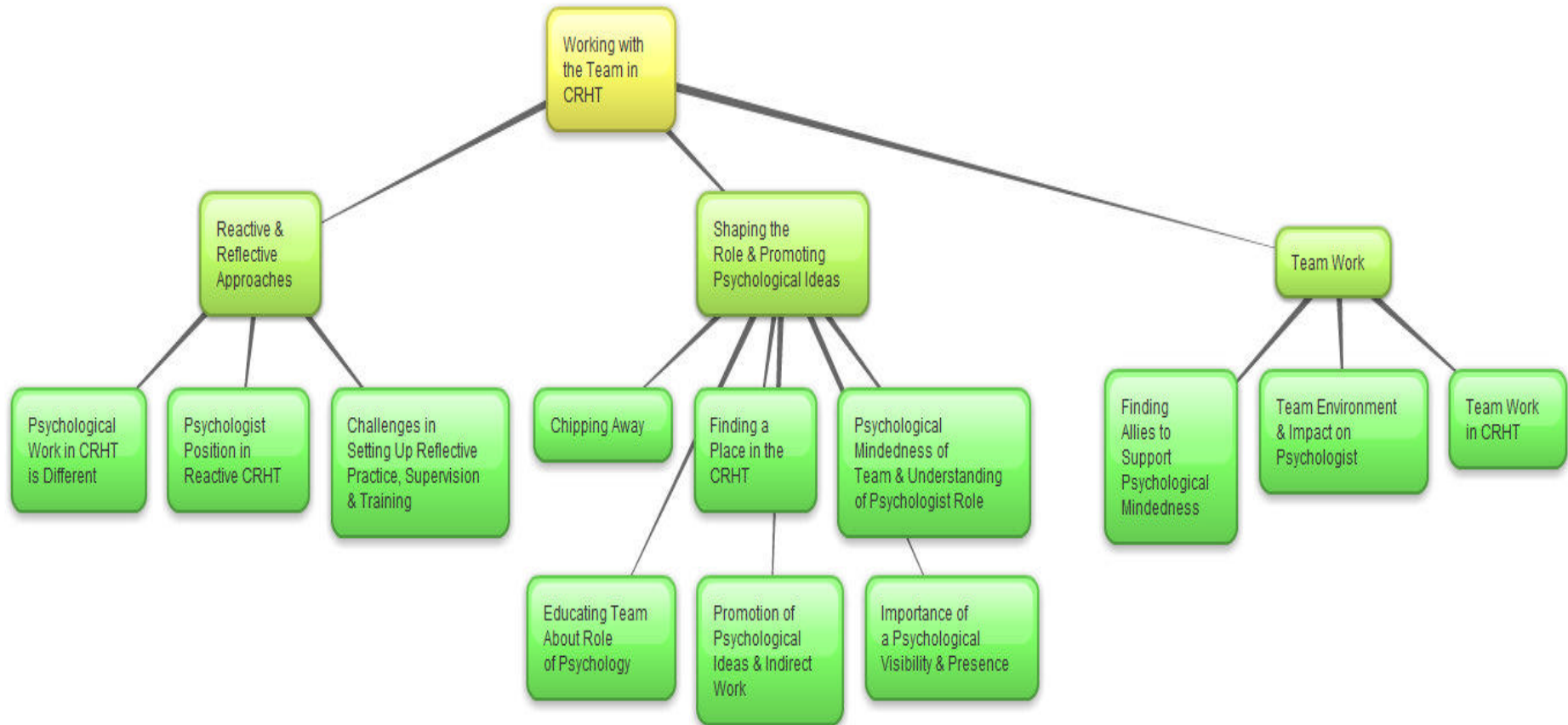
CORE CATEGORY FOUR: WORKING WITH THE TEAM IN CRHT

This core category considered issues relevant to working within the team in CRHT, and contains three categories which relate to the role of the psychologist alongside the team: *'Reactive and Reflective Approaches'*, *'Shaping the Role and Promoting Psychological Ideas'* and *'Teamwork'*. The sub-categories contained within the three categories will be considered in the subsequent sections.

Category One: Reactive and Reflective Approaches

This considered some participants' views regarding the difference between the *'reflective'* approach taken by psychologists in CRHT, and the *'reactive'* style of other team members. Participants discussed some of the issues they considered to be linked to this, which are outlined below.

Sub-category One: Psychological Work in CRHT is Different

This related to the fact that participants considered psychological work to be different to the work of other professionals, and this was perceived to have benefits for service users in the longer term. Participants seemed to believe that psychological work afforded a view of the *'bigger picture'*, and more *'forward thinking'*. However, they felt that the different way of working when contrasted to other team members caused some tensions within the team.

Lauren: So, it's difficult, you know, I'll often feel like I'll come along and start asking questions and take ages talking about one person, and then we've got no time to talk about the rest of them, you know. Yeah, I guess there would probably be a lot more

conversation as well, because if I'm seeing people then...it won't always happen in the meetings, but there will be other members of staff, or the doctors, I'll often go away and have conversations with them or in the meetings, we'll probably talk for quite a bit longer because I know a lot more about them.

Eleri: I generally see people for much longer periods of time than other team members.

Lauren: I think once you do a psychology assessment, you really get in there, and you probably find out a lot more that needs to be done than maybe some of the other people do. So they may end up then getting longer input from home treatment, or more input from home treatment than somebody else might. You create work for yourself, but I think you also probably create work for the team, possibly. I've never thought about that before, but I imagine that happens.

Louisa: When you are doing a neuropsychological assessment and you need two to three hours sat in the office in front of a computer, that's the kind of thing that would get rubbed out, and I think that's frustrating. The team don't have that kind of work, and I don't think they appreciate what that entails. I think they think you are sat in the office, and therefore you should be going out and helping them. It's nice to go in, and go out and get straight on with things and have a nice busy day, it's great. But there's times, when it's the third day in a row that you've had to postpone and that gets quite frustrating.

<u>Sub-category Two: Psychologist Position in Reactive CRHT</u>

This considered the participants' observations that the CRHT team were *'reactive'* in nature, and they considered the fast pace of the work as affecting the ability of team members to stop and think about the impact of the work. They also considered that this may have served to act as a defence for team members from reflecting on the emotional impact of the work. Participants spoke of the *'fit'* between themselves and the fast pace of the work, and they considered themselves as *'reflectors'* within *'reactive'* teams. In addition, participants noted the added value they thought they could bring to the CRHT, in supporting team members to step back and think about wider issues when working with service users in crisis.

Angela: Sometimes the reactiveness of the team can be quite a good defence mechanism really, against sitting and thinking about what you are doing with people.

So I think that's been some of my formulations, why people have found it very, very hard to actually come and meet with me and talk about what they are doing with clients.

Natalie: So, there is a bit of a conflict there because I think, Crisis Team, are very reactive, they go out. Whereas I think I'm a lot more reflective, and I want people to stop and think. It almost doesn't fit really, trying to be a psychologist in a team that doesn't want to think.

Louisa: I think a lot of what happens in crisis teams is very reactive and very focused on the here and now. It's been highlighted to us that we are not very good at looking back at longitudinal factors with that person and look to understand how that can inform our current formulation. We can bring that to the team and get them to actually think about what is going on for this person rather than just focussing on the immediate crisis. It's actually looking at the broader picture.

Lauren: So, if you've got a choice between doing absolutely essential visits to people that need to happen, that are very high risk, or having a training session, it's always going to take priority. In a way, that's just representative of what happens on a bigger scale, you have less and less resources, the less able you are to think in terms of more of a preventative, recovery type model of doing things, it needs to be much more reactive, here and now, what are we going to do to minimise the risk right now.

Sub-category Three: Challenges in setting up Reflective Practice, Supervision and Training

Associated with participants' views of their work being different and their position in the *'reactive'* CRHT, they talked of the differences in professional background between themselves and other team members. They highlighted that psychologists were trained to reflect on the emotional impact of the work, and they felt that this was not the case for other team members. Participants reflected on this, and felt that there was an inherent difficulty in team members taking the time to reflect on the nature of CRHT work. They played a role in setting up reflective practice, supervision and training sessions, and spoke of the challenges in getting team members involved in such sessions.

Louisa: I think we've got the people who want to do it, and will go. And there's always the people who aren't interested and will hide and make any excuse not to go. It's supposed to be protected time, people should go, and we do work hard to get people to go. But some people find it very unhelpful, or just don't want to do it, or for whatever reason try and avoid it all costs.

Karen: I offer, once a month, a clinical supervision group, or reflective practice. This has gone very well on the ward, so I don't think it's me, but it just has not worked very well with the Crisis Team. I tend to get a couple of people, the OT is always regularly there, and one or two support workers who are psychology graduates and are keen. But there's the bulk of the team just avoidant of supervision. But that's what I offer, and I offer it anyway, whatever happens, and at least the OT will be there.

Angela: I see that part of the service, the group programme, which is mainly run by psychology and OT, that's quite a strong psychosocial arm. I started off with the hope that we could get the nurses and the social workers in this team a bit more up to speed with psychosocial stuff, so that they could actually deliver it. But that's not really happened, for the reasons I said earlier about consistency and it's difficult to get people trained up in reflective practice groups.

Max: Within the first year of my post I offered a one day introduction to staff on the solution focused approach. Trying to follow through with that was problematic and there is an issue about training happening in the team, full stop, which is quite hard to make happen for a variety of reasons, particularly any longer training I think. A: it's the sort of pressure of caseloads and people being able to make time or be freed from their clinical work to be able to attend; B: people don't have any formal rooms for meeting to hold any training of our own. Practicalities around holding longer term training that I think would be quite helpful.

Catherine: I run educational sessions for the team, for them to come and reflect on certain issues, because we hope in the longer term they will turn into reflective practice sessions. But it is quite challenging for the team to sit back and reflect on the work that they do, I think because it is quite crisis-driven. Looking at risk and making decisions, and then going back and looking at them in retrospect has sometimes been quite difficult for them. So they've been happier with coming and doing educational sessions, and then having a reflective component to that, so we've been introducing it that way, and that's gone quite well, really.

Category Two: Shaping the Role and Promoting Psychological Ideas

Along with their ideas regarding both *'reactive'* and *'reflective'* approaches, participants also seemed to be saying that they felt able to shape the role of psychology within CRHT. They talked about how they felt able to develop

psychological thinking within the team by a range of means, including gradually promoting psychological ideas, being visible and educating others about the role of psychology.

Sub-category One: Chipping Away

This referred to the need felt by participants that they should feel their way into their roles slowly, or *'chip away'*. This reflected a way of trying to influence the team regarding psychological ideas, whilst respecting that others were differently trained. It also referred to the rewards felt when team opinions began to change as a result of the work of the psychologist.

Louisa: I think you've got to work, chip away slowly. It's being in the team, people trusting you, getting to know you, and actually feeling that your opinion is helpful. I think forcing it upon them in the early stages is not going to be helpful, it's a slow process.

Karen: It was really, very much about needing to get the team more educated, rather than trying to challenge every time there was negativity. Because actually, it's quite natural to feel negative with those clients as well, at times, they push you into that position. So it's more about understanding, and increasing reflection in the team, and I think we've got there.

Angela: It's been chipping away. At the beginning, we had this policy of just pushing where the door was slightly open, so I would target people in the team that seemed a bit more psychologically minded. And I would go and have more conversations with them, and try and involve them in reflective practice groups.

Natalie: It's been nice to see how they've developed and how they've become more psychologically minded. It's that chipping away; things will potentially change but take a long time. I've always tried to make a bit of a balance, because you can't jump on everything the team says, as you've got to get on with them. So it's trying to intervene and get in there when you can, to just promote a bit of psychological thinking, and hopefully that benefits clients as well.

Sub-category Two: Finding a Place in the CRHT

Along with the importance of *'chipping away'*, this related to participants' views of finding a place in the team, working with, and learning how to interact with it. Participants considered their position in relation to the rest of the team, and talked about how they felt able to establish and shape the psychology role in line with their interests, with the support of the team. They also noted that developing relationships with the team was a gradual process, enabling them to earn respect from their colleagues. Participants felt that they had the freedom to develop and shape the role, as a result of CRHTs being a new service development.

Leighton: This is a long standing home treatment team, I'm the first psychologist working in it. I think that's pretty typical, in X at least, it's only been the last couple of years there's been any attendance. So in many ways, I've been able to carve out my role within that team as they just haven't known what to expect from psychology.

Max: X and I have worked hard to build up psychology and it is now seen as an integral part of the service. When I first started it was a bit like establishing psychology from scratch and thinking with people about what we can offer in the team and what our role is. In some ways we had the freedom to do that, but it also meant it was initially a bit slow in getting referrals within the team to see people.

Natalie: They had not had a psychologist in post before. Psychologists working in crisis teams are new, and crisis teams are new, so I didn't know what I was meant to be doing, they didn't know what I was meant to be doing...it was a big learning curve, and lots of trial and error. So it wasn't a case of I was going to tell them what I was going to do, it was collaborative. But I've got to a position now where people generally know what I'm doing, I know what I'm doing!

Catherine: Initially there was lots of work I did in terms of relationship building with the team. I'd spend time going out on visits, talking to them about their work, letting them ask me about my interests, and just gaining their trust. I think that was really important.

Natalie: You have to go in slowly with these teams, and see where they are at. I don't think you can go in with a fixed agenda. It takes a long time to build up the trust. It just develops as the team develops. As the team get to know you, as they grow and develop, your role will grow and develop. It is good, because you can shape the role how you want to. You can be quite creative and think about what you want to do, and what you don't want to do.

Sub-category Three: Psychological Mindedness of Team and Understanding of Psychologist Role

This suggested participants' ideas regarding the perceived psychological mindedness of other team members, and how this had implications for the work of the psychologist. Participants seemed to believe that team members were generally open to psychological ways of working, and reflected on how working with other team members in this way was beneficial to developing relationships with the team. However, some participants reflected on the fact that other team members' understanding of the role of psychology was limited, and talked about how they felt they were attempting to develop the team's psychological understanding by joint work and promotion of psychological ideas.

Louisa: I think the team are quite good at thinking about who would be appropriate. I think the people we get are very, very complex, and I think the team are very anxious about bringing a psychologist in and what people perceive a psychologist does. I think they still have quite fixed ideas about what a psychologist does. I think they have a very narrow idea of people with depression, people with anxiety, and that's it. There isn't a realisation I don't think, that psychosis, personality disorders, all sorts of things can be worked with psychologically as well.

Catherine: I've found people are generally quite open to the psychological perspective and the psychological model. Also, working with the staff in terms of the psychological approach is great, because for some of them, they haven't thought about the cases in that particular way. We've got a number of practitioners that are skilled, or are becoming more skilled in psychological approaches, and are quite good at doing formulations themselves.

Sophie: The team are very psychologically minded, so it's a two way process, because their perspectives inform my formulation. So it's weaving in all the information that is shared in meetings, and talking to them about what I feel that the clients might be communicating to us in an indirect way at times.
Lauren: I honestly think that it helps that the team are very welcoming to psychology.

Sub-category Four: Educating The Team About the Role of Psychology

This related to participants' ideas that it was important to educate team members regarding the role of psychology. Participants noted that it was important to ensure that team members were aware of their role, and they shared ideas about their work by informally talking with team members about the role, or doing joint work with team members.

Leighton: The initial work, the legwork, is getting people past the idea that psychologists just do therapy. So, it's getting people more keyed into the assessment work that we do, the formulation work that we do and kind of just work with the team. So once you can get people to see that oh right, they are not just doing, I don't know psychodynamic therapy with people, it starts to get people to have a different way of thinking about what we do and what we don't do and what's within the remit.

Max: I would more informally talk with them about what we do or what they learn from us talking with them a bit about our work in handovers.

Catherine: Initially there was lots of work I did in terms of relationship building with the team. Because I think their experience of psychology in the past was almost like psychologists helicoptering in, doing a little bit of group, or an odd bit of work, and then helicopetering out again.
Olive: I don't tend to do many generic assessments. I did more in the beginning, and I think that was really important, because a lot of the staff hadn't had much awareness, or hadn't worked much with psychologists. And because it was quite new, I think it's different working with a CMHT psychologist and working with a psychologist in a Crisis Team as well. So I felt it was really important to go out with the staff in the beginning, and to do double-handed assessments.

Sub-category Five: Promotion of Psychological Ideas and Indirect Work

This related to participants' opinions regarding working psychologically in the team, and the promotion of psychological ideas in this way. Participants talked about working indirectly through other staff members, and viewed this as the most effective use of their time. They noted the importance of meetings to relay psychological thinking, and talked about their attempts to use psychological ideas for the benefit of the team as a whole.

Catherine: The way I work with the team is doing lots of indirect work. That's at the request of the team manager, and also my manager. So from her perspective, the best way that she thought to disseminate the knowledge or skills I had was to work indirectly with the staff, and to train up and support them. Also, I guess it's about supporting the staff. And I'm involved in the handovers, in terms of giving a psychological perspective.

Leighton: You are trying to do your bit for psychology, just in terms of introducing a more reflective and psychological way of thinking about people's experiences.

Angela: I wanted to do something to improve the psychological mindedness of the team, just hanging around the team, being at clinical review meetings and handovers, so that psychological ideas could go into the ether a bit more. I tried to get a lot of joint work up and running at the beginning as a way of helping the team to develop psychosocial skills.

Eleri: Sometimes there might be a piece of work I might undertake, which may be indirect work. I try and encourage conversations that build a team approach, and have that handed over. Sometimes I think people are doing more psychological work than they realise. You can help them to name that and understand that that is a psychological intervention, or they could make it into more of a psychological intervention. It's definitely a whole team approach, and I try to add bits of psychology into the conversation and turn bits of the conversation into psychological themes.

Max: I've been involved in setting up a reflective practice space, we hold two a month which is an opportunity to think about a case in more detail...it's an opportunity for them also to demonstrate that they are actually quite thoughtful about people's care and looking at things from a different perspective.

Sub-category Six: Importance of a Psychological Visibility and Presence

Participants commented that it was both important and valuable for psychologists to be visible in CRHT. They noted the need for them to be physically present in order to shape ideas and influence the psychological development of the team. In addition, participants reflected on the difficulty in showing a presence when they worked in CRHT on a part-time basis.

Leighton: I think you have got to be very visible. And again that's just thinking of the frenetic nature of the team's work, if they don't see you, then they forget you, so you've got to be very visible, you know, really getting involved with the team at all sorts of different levels. But I think if you do that and you stay visible, then they are more than happy to kind of welcome you and to encourage your contribution.

Olive: I think the role is probably one that's more visible, I don't know if this is contentious, but I think it's probably more visible than a lot of other psychology roles. You do get involved with services on the front line, either in A&E, or on the inpatient wards. So I think people seem to value it, because they can see you, and meet you, and you are tangible – you're not somewhere else, seeing clients, and you are there in a crisis. I think people seem to value that.

Louisa: For the other people, who perhaps aren't quite so psychologically minded, I think just you being there reminds them that there is a psychological point of view, and actually you could do this. Trying to force any kind of education on them is just a waste of time sometimes.

Category Three: Teamwork

Along with participants' reflections on shaping the psychology role and promoting psychological ideas, and their comments on *'reactive'* and *'reflective'* approaches, they talked about working with the team in CRHT. Within this category, they also talked about the position of the psychologist within the team. Participants considered the importance of having psychologically-minded allies in the team as a source of support. They also reflected on the environment of the team and the importance of a shared team vision to promote recovery for service users. In addition, they highlighted the value of effective teamwork.

Sub-category One: Finding Allies to Support Psychological Mindedness

This related to the importance of having allies in the team, in order to support psychological ideas and thinking. Participants reflected on the benefits of senior

team members being psychologically minded, as this served to support the psychologist in developing psychological initiatives within the team. In addition, participants spoke of the value of other team members being interested in psychological ways of working, and this also acted as a source of support for participants. Furthermore, they noted the value of having other psychologists in the team, in order to share ideas.

Angela: I have found allies in the team, there have been certain members of social work and nursing who are much more keen on psychosocial interventions, and they get a buzz out of it when they do it. They've often co-facilitated some of the groups that we've run, some of the psychoeducation groups, and that's been really important, to have allies in the team that you can go and have a bit of a chat to when things are not good.

Angela: As much as it's influenced by the team leaders, it's also influenced by the medics in the team. So when I joined, the first medic wasn't very senior, didn't have a great deal of say that was respected by the other members. Whereas now, we've got two consultants in the two crisis and home treatment teams, one of them in particular, the one that I work more closely with, he's very psychosocially minded. So it's about trying to find your allies in the team.

Max: Our largest referrers have always been the psychiatrists. Both the Consultants in the team are pro psychology and have quite a good understanding of our role and who we might work with.

Natalie: I'm quite lucky because I share an office with the inpatient psychologist, who is also my supervisor. So that's been really good. I think if she hadn't been here, it would have been awful. I've really relied on her. I think it would be quite a lonely place to be really, if you are the only psychologist and there's no other psychologists around.

Karen: The other thing for me, there was a full time Psychiatrist there, and you were either in or you were out. For some reason, with her, I won favour, and the power base in the team was around her. So, as I won favour with her, it was great, because then I was doing one hour trainings after handover, once a month, then I reduced it to half an hour. When the Psychiatrist was there, she loved this. She made that happen, but when she went, no one would stick around.

Sub-category Two: Team Environment and Impact on Psychologist

This reflected participants' ideas regarding issues relevant to the environment of the team, and how environmental factors such as staff turnover had a detrimental impact

on participants. The importance of healthy team dynamics was emphasised, as well as the importance of a shared vision to promote recovery for service users, despite differences in professional background. Participants also talked about their role in understanding the dynamic of the team, and their perceived ability to formulate and understand team cultures. This referred to the ways in which they felt able to make sense of the way that team members responded to different service user presentations and other professionals within the team.

Leighton: There has been a lot of staff turnover and partly in key roles. I've already seen four team managers in the two years I've been around. So in terms of keeping a sense of a philosophy going, I think, if I'm being frank with you, there have been some difficulties on that front.

Natalie: The psychodynamic model has been really useful in this setting. Not really in terms of the client work, although a little bit, but more about understanding the team and what's going on. Because it's so obvious, when you've got a client with a personality disorder, then you've got one member of staff really stating a very strong opinion, and another member of staff stating the complete opposite. You can see that splitting is going on. So it just helps to understand what is going on between the team, really.

Sophie: The team environment is healthy, and I feel very lucky in terms of that. Although there is a hierarchy within the team, all voices are heard. We have the same intention to help the client to recover, and that's what we are working from. Even though I might hold in my mind a different perspective, I can trust that whatever the difference of opinion is about, it is coming from a case of wishing the same that I do. That allows me to stay connected, and work through the difference, rather than split and feel isolated and feel that this cannot be talked about.

Olive: We seem to gel quite well as a team, I think we've got a similar understanding, ethos and vision as to what we believe. Because we believe quite strongly that people can be managed, and can be held outside of hospital, and don't need admission in order to improve. And that sometimes admission can be just like a pause button for people, and can halt their recovery rather than aid it. From the beginning, we've tried really hard to keep people in the surroundings that are least restrictive, and most comfortable for people - most aiding of their recovery. A number of us that have been here from the beginning seem to share that ethos, and value that vision.

Lauren: There's always going to be political things, there's always going to be tensions. I think the team could be a hell of a lot more dysfunctional than it is. I certainly think that there's at least some level that we do manage to work together quite well. There's been other teams that I've worked in or other teams in the trust which are really messed up. So I think it could be a lot worse than it is, of course.

<u>Sub-category Three: Teamwork in CRHT</u>

This related to the views of participants that teamwork was important as a source of support, and the value of effective teamwork. Participants felt that team working was an integral aspect of CRHT work, and that it was important to draw on the expertise of other team members to share ideas. Participants also reflected on the benefits of a shared ethos regarding client care, and the positive aspects of effective teamwork for service user outcome.

Eleri: My colleagues are excellent in home treatment and when it all comes together, it's brilliant to be part of something that is a new way of working, that keeps people out of hospital. Sometimes people get really well, really quickly, and that can be great to be part of that. Particularly, our team feels particularly strongly about young people, first episode, we've kept them out of hospital. In a crisis team, the role of the team, it's nice to be part of that.

Lauren: I think it's quite containing, because you are working in a team, crucially. I prefer being in a team and having both that general social thing that you are in a team, but also a sense of you're working together, and you are cooperating, and you are helping each other out, and talking together about work.

Sophie: If someone has an idea about what I might be able to do, I don't usually discuss this in isolation. What I mean is, all decisions about what we all do, not only myself, happen within the team context. So I suppose my thoughts about what I need to be doing with a given client, and the team expectations about what I need to be doing with a given client, we have a forum to discuss that, and to be very open, and to have a rationale about that.

Sophie: What's important is to be able to create a coherent narrative with the team as to how we understand the clients' difficulties, and to be very coherent in terms of how we communicate this to the client and to other services. I think we all have the same intention to help the client to recover, and that's what we are working from. So it is about this weaving in of information. Because we are aware, because of the nature of the problems, that a different person would connect with different experiences, and they are all very important. And we need to bring them all together.

3.2.3 THEME THREE: POSITIVE AND NEGATIVE ASPECTS OF CRHT WORK

This theme related to positive and negative aspects of CRHT working, as perceived by participants. Positive aspects were regarded as the unique way of working afforded by CRHT, the important role of psychological work and the learning opportunities afforded by CRHT working. Negative aspects considered issues such as lack of resources and competing demands.

Figure 3.6 CORE CATEGORY FIVE: POSITIVE AND NEGATIVE ASPECTS OF CRHT WORK (CORE CATEGORY, CATEGORIES AND SUB-CATEGORIES)
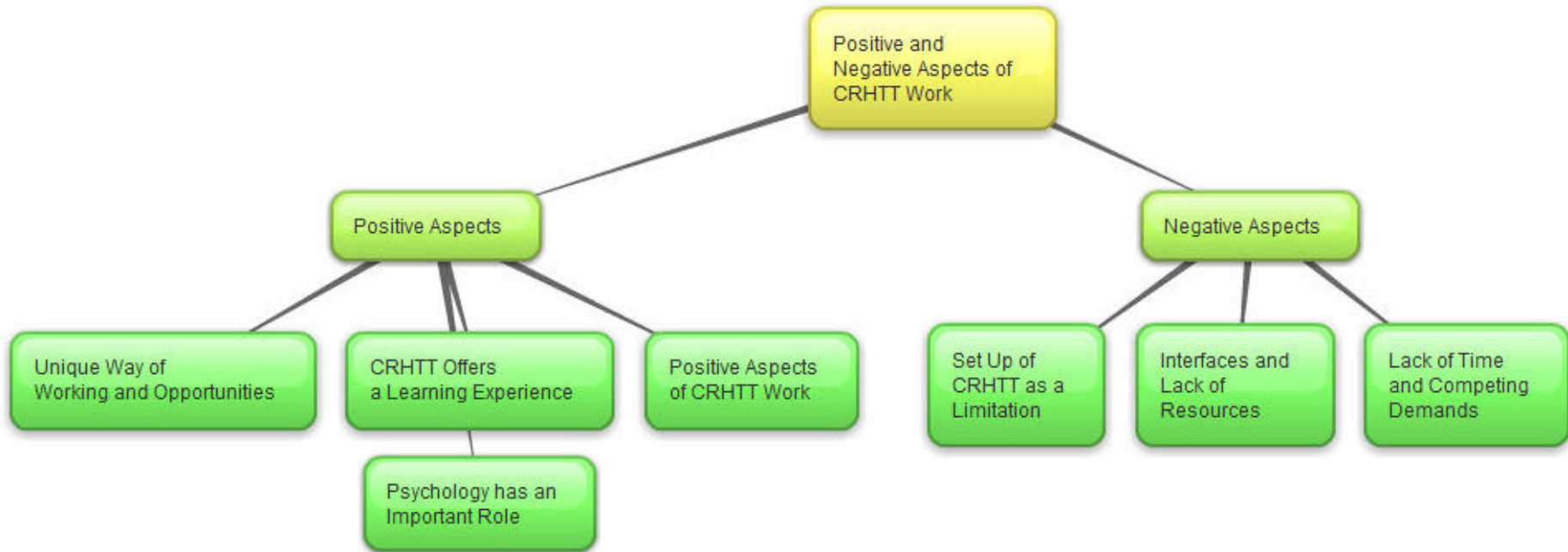
<u>CORE CATEGORY FIVE: POSITIVE AND NEGATIVE ASPECTS OF CRHT WORK</u>

This core category reflected both positive and negative aspects of CRHT working. Each of the associated sub-categories will be considered in turn.

Category One: Positive Aspects

This category considered the positive aspects of CRHT working for participants, and contains four associated sub-categories: *'Unique Way of Working and Opportunities', 'CRHT offers a Learning Experience', 'Positive Aspects of CRHT Work'* and *'Psychology Has an Important Role'.*

<u>Sub-category One: Unique Way of Working and Opportunities</u>

This related to participants' consideration that working in CRHT settings was unique when compared to other service contexts. Participants also noted the opportunities they felt CRHT afforded in terms of skills and competency development. In addition, they considered they were able to work in a broad and varied way in this setting.

Leighton: I think there is a massive opportunity for us as psychologists, as clinical psychologists to make a significant contribution working at this kind of interface.

Louisa: What drew me to the role was more about the way of working. I find working in a CMHT with one hour, one client after another, I find that quite monotonous and don't part enjoy that way of working.

Louisa: Obviously it's very, very different, you are not getting experience of the one to one client work that you would in a standard band seven job. But you are getting much more experience of the consultation process, working with teams, a much more systemic way of working, understanding the relationships between the different services as well and working at that level. It's sold to me as developing those 8a skills. Perhaps it should be an 8a post, I think it actually was an 8a post, but they couldn't recruit. So in that sense, those are the skills that you develop that you don't get elsewhere at this level.

Sub-category Two: CRHT offers a Learning Experience

In addition to the views of participants that the CRHT environment was unique, they also commented that CRHT working afforded an opportunity to learn. They felt that it was valuable to learn from both colleagues and service users in this setting. Participants noted the lack of research evidence to guide their interventions in these settings, and saw this as an opportunity to learn and develop new skills.

Louisa: I guess it's a good learning experience, being thrown in at the deep end. Crisis teams are new as well, and the role of psychologists within them are new, so I guess it's a good opportunity to learn all of those things. And there's not a huge amount of evidence, is there? So I don't know what's going to work in three sessions. It's trial and error as much as anything.

Leighton: I think I would have to say it would be it's a learning experience. Every day, I'm coming away enriched, I'm learning so much from people I'm working with and trying to help, so it's very stimulating.

Catherine: You are constantly learning. I'm constantly going back to my books and back to my colleagues and back to conferences saying I need to find out more, what's the latest in this area, that's really exciting.

Sophie: I'm learning a lot from my clients, from my colleagues. I think the aspect of managing risk has been a huge learning curve for me, so I feel this is something that I am learning quite a lot, in addition to very complex presentations. I think it is also a great learning experience, in terms of responding to risk and maintaining a psychological perspective that we do that.

Sub-category Three: Positive Aspects of CRHT Work

This related to participants' ideas regarding what they felt were the most positive aspects of working in CRHT. Factors included the diversity and pace of the role, as well as the feeling that the service provided made a difference to the lives of service users.

Karen: I really love it all. I love the clinical work. You feel like you are making a

difference, sometimes. I see such a range, and this is what I love about it, a lot of them go back to their GP eventually.

Angela: When you get to the end of a piece of work and the client turns around and says 'Actually, you know, seeing you had made a real difference and I think very differently about things now, and if it wasn't for you and the team, I'm not sure that I would have got through'. That's probably the most rewarding part of it. And you go home remembering why you trained, and why you are here.

Sophie: I suppose there's also the potential to get very close to people, to develop a really strong therapeutic relationship even though you are aware that you will be seeing them for a very short time. Because of what they are going through at the time, but also very often because of the openness and the things that are discussed within this period of time. So, it feels very intense, and it feels very meaningful.

Sophie: I enjoy very much the different types of presentations that I wouldn't see in other services. It's an amazing opportunity to develop one's skills, because of the various presentations of clients. Understanding the clients' difficulties and understanding perspectives, what the nursing perspective would be and the medical perspective, and of the social worker and occupational therapist, so that's what makes the work very rewarding.

Olive: I think there is a role for psychology. I feel quite privileged to be in a role, in the front line, it's really good.

Sub-category Four: Psychology has an Important Role

This was relevant to the ways that the participants felt that their role was valued by the team and by service users. Participants talked about the important role they brought in offering a different perspective, and in making sense of issues via the use of psychological formulation. They also reflected on how service users and the team seemed to value the ways in which they could contain complex issues, and in offering a consistent face for service users which other team members were not always able to provide. In addition, psychological work was considered to have an impact on relapse prevention for service users. Furthermore, participants felt that team members valued the role of psychology in sharing the workload of the team.

Olive: I think clients do really value having a psychologist, and sometimes, it's the first time they've talked about certain things, or it's the first time they've understood

links between certain things. So I think it is really important for people, and really important for families as well. Sophie: There is a role for psychology within this period of time. I do feel that I do bring in a different understanding. I think it's the psychological formulation. The way it is communicated through team meetings, in terms of how we understand the client. And also, in terms of the way I try to communicate in team meetings my ideas about keeping a psychological understanding of the clients' difficulties, and how that informs the way the client relates to us, and the way that we would be relating to the client, in order to help them to overcome their difficulties.

Angela: I think some of it comes back to the really basic stuff. The fact that I'm a consistent face that they see on a regular basis for a set period of time each time. I think that makes a huge difference for people. Making sense of the crisis, being less critical, more compassionate mind stuff about how they feel about what's going on, normalising it, destigmatising what they are going through, trying to put it in context of life-long patterns and earlier experiences, all of those things make a difference to people.

Catherine: The psychiatrists here, they were talking the other day, one of them said 'I've noticed a few times, we'll get people out, but its only when they have the psychology as well that they don't come back in'. Which is lovely. Yey! So they are quite supportive.

Angela: Going back to the containment word. If they are struggling and they don't quite know what to do with someone, I think if you can get involved and suddenly things stabilise and settle down, I think the team feel quite contained by that, as well as clients feeling contained by it, so that's important. I think they value the input that I have into care planning, through our clinical review meetings, I think I share a fair amount of the workload with people that I am involved with, the client, I think that makes a big difference.

Category Two: Negative Aspects

Along with the positive aspects of CRHT work, participants reflected on the limitations of CRHT working. This category includes three sub-categories: *'Set up of CRHT as a Limitation', 'Interfaces and Lack of Resources'* and *'Lack of Time and Competing Demands'.* Each of these will now be considered in turn.

Sub-category One: Set up of CRHT as a Limitation

The way that the CRHT was set up was considered as a limitation by participants. This was in relation to the lack of consistency in team members seeing service users, which was contrasted to the role of psychology in offering more regular input to service users. In addition, time pressures and the pace of the work, in contrast to other settings was regarded as a limitation. Participants regarded that the set up of the CRHT was detrimental to service users with certain presentations, such those with diagnoses of Personality Disorder.

Angela: Ultimately, if you are a worker in the team, as a nurse or a social worker, you don't necessarily see that client very often, so to build rapport and do a piece of work with them, I think is blocked a little bit by the nature of the system and the way the system is set up.

Catherine: One of the challenges for the home treatment team is because they work on shifts often, the service user might not see the person for more than three visits, so they are constantly having someone new popping up, and that's really tough.

Natalie: I think it's about pacing yourself, and really not expecting. I think if you are going to come into this setting, don't expect to be able to do a lot very quickly. In relation to the team, or anything in acute care, really.
Karen: Often, actually, they go to the CMHT first, and start to develop a more enmeshed problem with the system, and the system makes everything worse. Then they start to come to the Crisis Team, and what we see is this pattern of, they come into the Crisis Team for a while, they see all this, and then they know about the inpatient ward, that's the next step, and they sort of push towards more and more, and the system is uncontained and gives it to them. I think that's not helpful to the patients, and it's not helpful to the system.

Sub-category Two: Interfaces and Lack of Resources

This was relevant to participants' observations of the interfaces with other teams as a frustration, particularly regarding the long waiting lists in community teams. Participants pointed to the value of joined up working, and saw this as particularly exasperating when it did not happen. It was considered that the training of psychologists allowed them to see ways of improving the service provision.

Olive: I think it needs to be more joined up than it is at the moment here, because there's very little input to the inpatient wards, it's only crisis psychology and community psychology. So it does need to be more joined up, and perhaps thought of more as an acute job, rather than just a crisis team job. Because there is such a gap on inpatient services, and a number of people are discharged, that we've had quite serious concerns about, with no input, without psychological input.

Leighton: If we've got somebody who is in and out of crisis and the pragmatics are going to be that I can do the assessment and formulation, and then refer to psychology in the CMHT who are going to have a waiting list of up to a year, the likelihood is they are not going to be contained and they are just going to come back in.

Eleri: I think partly because there is significant understaffing in our mainstay intake and treatment psychology service, where there's a very long waiting list. I think sometimes, the team's view is that it's not a good use of my time to take one or two people off that waiting list; that basically our resources shouldn't be used to plug a gap in another part of the service.

Catherine: One of the big tensions is the psychology resource in the community and resources for talking therapy. So even if you go out and assess someone and make some recommendations, often it's really tough because realistically, they are going to have a wait for the talking therapy they need.

Sub-category Three: Lack of Time and Competing Demands

This related to participants' comments about the lack of resources and time available to carry out psychological work, along with competing demands and the frustrations they felt were linked to this. They seemed to regard the lack of time to complete psychological work as being linked to stressors and the feeling that there were high demands placed on them. Also, participants reflected on a need to accept the limitations of the work they could do.

Angela: I'm pulled in lots of different directions with different things. So that's where some of my stresses come in, because I feel like if my attention is over there, doing these organisational things, then there the focus slips on the clinical side.

Olive: I've got nineteen hours here, it's not that much A lot of the work here is clinical work at the moment, and supervision. But I guess that's really because of time constraints, as well. One of the main frustrations is just not having enough hours to do the other bits I would like to be doing.

Lauren: It's often taking in the whole thing, because it's difficult if you work with someone, and you can see all these other things that need to be done, but know that the team doesn't have time to do them. I think that's a big downside to it, and something that I struggle with. That's probably one of the most challenging things of working in the team.

3.3 SUMMARY

The aim of this study was to gain an understanding of the experiences of clinical psychologists working in CRHT. Specifically, this was in relation to their roles, relationships with other professionals and work with service users in mental health crisis. The study was conducted with the expectation that this could support the sustainability and development of clinical psychologists in this service context by increasing understanding of their experiences of working in CRHT. The study yielded a large amount of rich data from the individual interviews, and Grounded Theory was used to understand the experiences of participants. The analysis identified three themes: *'Psychological and Clinical Work'*, *'Teamwork' and 'Positive and Negative Aspects of CRHT Work'*.

The theme of *'Psychological and Clinical Work'* captured aspects of working both clinically and psychologically in CRHT. Participants reflected on aspects of working clinically in CRHT, being a psychologist in CRHT and working with crisis. The theme of *'Teamwork'* encapsulated factors relevant to working with the team in CRHT. The *'Positive and Negative Aspects of CRHT Work'* focused on elements relevant to the advantages and disadvantages of CRHT work.

The core categories, categories and sub-categories captured within each of the three

themes have been outlined within this chapter. In the next chapter, the data yielded will be linked to relevant research findings and the clinical implications will be considered.

4.1 OVERVIEW

Within this chapter, a summary of the results of the study and a discussion of the main issues in relation to the existing literature will be provided. The clinical and service implications will be discussed, along with methodological strengths and limitations of the study and recommendations for further research.

4.2 RESEARCH FINDINGS AND THE EXISTING LITERATURE

The principal aim of this study was to explore clinical psychologists' individual experiences of working in CRHT, their relationships with other professionals and perceptions of working with service users in crisis. To the researcher's knowledge, this was the first study to investigate this phenomenon, and analysis of the data yielded a very rich and interesting overview of themes relevant to the experiences of clinical psychologists working in this service context.

Three key themes were identified from the analysis: '*Psychological and Clinical Work', Teamwork'* and *'Positive and Negative Aspects of CRHT Work'*. In the sections below, the main findings of the study will be presented in relation to the available literature on CRHT, clinical psychologists, teamwork and service users in crisis. Although all of the findings will be outlined, specific results will be linked to the available literature at both a broad and specific level. For ease of reading, **THEMES**

will be highlighted in capital and bold lettering, CORE CATEGORIES in capital lettering, **categories** in lower case and bold lettering and <u>sub-categories</u> in lower case and underlined lettering.

4.2.1 THEME ONE: PSYCHOLOGICAL AND CLINICAL WORK

The theme **'PSYCHOLOGICAL AND CLINICAL WORK'** related to aspects relevant to the ways in which participants worked clinically and psychologically in CRHT. The key findings relevant to the three core categories: 1) 'WORKING CLINICALLY IN CRHT', 2) 'BEING A PSYCHOLOGIST IN CRHT' and 3) 'WORKING WITH CRISIS' will be reviewed in the following section.

1) Within the core category: 'WORKING CLINICALLY IN CRHT', participants spoke of a range of issues, incorporated under the categories, **'Psychological Work'** and **'Clinical Work'.** Within these, the sub-categories <u>'Working Psychologically with Service Users'</u>, <u>'Variety in Clinical Work'</u>, and <u>'Home Visits and Office Work'</u> were included. Participants reflected upon factors relevant to the short-term nature of working with service users, and their need to work with service users for longer in other settings to maintain their psychological skill base. They discussed creative ways to link therapeutic skills into their clinical work, for example by weaving in elements of specific psychological interventions to their psychological assessments. These findings are similar to research regarding the experiences of psychologists in AOTs. Yates (2004) found that AOT psychologists felt they were not doing *'real'* psychology as a result of a demand for them to conduct both generic and specialist

work. They acknowledged the difficulty in applying traditional therapies in AOTs, possibly because of poorer motivation from service users to think about the work between sessions, compared to other groups. They also recognised the need to work creatively for this reason. Participants in the current study also talked about the variety in their work, and the need to be creative regarding the setting in which service users are seen.

2) 'BEING A PSYCHOLOGIST IN CRHT': This core category included the category, **'Characteristics of CRHT Working'.** Within this, the following sub-categories were identified: 'Characteristics of CRHT Psychologists', 'Flexibility', 'Reasons for Working in CRHT', 'Supervision, Support and Self Care' and 'Level of Experience as a Psychologist'.   Participants' views regarding the characteristics they felt were important to work as psychologists in CRHT were acknowledged. These included resilience, flexibility, humour and *'thick skin'*, which are reflected in the BPS (2008) briefing paper for psychologists in CRHT. Although these characteristics may be true for psychologists in other settings, in CRHT they may be particularly relevant for working with service users in crisis and working within a dominant medicalised approach. In particular, the importance of resilience in professionals working in CRHT has been supported by Edward (2005), in a study of six professionals working with service users in crisis in CRHT.

Participants also discussed the importance of supervision and reflection in this setting. The value of the wider network of psychologists and specialist CRHT network in facilitating support and self care was identified. This finding may also

reflect the experiences of psychologists in AOT settings, as Pipon-Young, Cupitt & Callanan (2010) suggested that a networking strategy with other psychologists in new service settings can serve to allow psychologists to share practice. Cooper et al., (2008) noted the importance of specialty meetings and peer discussion for psychologists to reflect on specific issues to AOT working, which may be similar to the CRHT setting. The value of psychologists in offering supervision and support to the team is supported by a finding by Woolls (2008), regarding the perceived value of psychologists in teams by other CRHT members.

Participants' views regarding the challenge of entering the specialist nature of CRHT as a first post from qualification were also reflected on. They also noted the perceived utility of being at a senior level in CRHT. This is reflected in the BPS (2008) guidelines that psychologists working in CRHT should be employed at least at 8a Agenda for Change banding.

The second category under the core category, 'BEING A PSYCHOLOGIST IN CRHT' related to **'Role of the Psychologist'**, and included the sub-categories, 'Psychological Formulation', 'Evaluation and Research', 'Service Development and Leadership', and 'Supervising and Supporting Team'. Participants highlighted the key role of formulation for CRHT psychologists, and it was identified as a role which distinguished psychologists from other professionals. Indeed, according to the BPS (2006), psychological formulation is recognised as one of the core competencies of clinical psychologists. Again, Cooper et al., (2008) in a survey of AOT staff found they perceived formulation skills to be the area where psychology was most helpful.

This was because formulation enabled the team to expand their understanding of service users and incorporate psychological ways of working into care plans, which was discussed by participants during this study.

Participants commented on the importance of service development and leadership, which may be linked to the *'New Ways of Working for Psychologists'* agenda, where psychologists are considered to have a key role in leadership (BPS, 2007b). Participants in this study spoke of ways to improve team processes via leadership. This may be linked to research evidence regarding transformational leadership, which may *'transform'* team members by stimulation of their self-interest via alteration of morale, values, and by improving motivation (Bass, 1985). This can positively influence reflexivity through the formation of a shared vision, which in turn may influence team performance (Schippers et al., 2008; Bass & Riggio, 2006). In addition, participants acknowledged the important role of psychology in completing evaluation and research, linked to service development. This is reflected in the BPS (2008) briefing paper regarding the value of psychologists in facilitating or leading research initiatives in CRHT.

Also under the core category, 'BEING A PSYCHOLOGIST IN CRHT', the category, **'Future of Psychology in CRHT'** was captured. This included the sub-categories 'Looking to the Future' and 'Unsustainability of the Psychology Role in the Long-term'. Participants reflected on the uncertainty of their roles in line with wider changes in the NHS, and spoke of their need to justify their roles in light of, for

example, Improving Access to Psychological Therapies (IAPT) developments (see Clark et al., 2009). This reflected the training of other professionals to deliver psychological therapies, and participants felt that it would be important for them to emphasise their broad range of skills to justify their value in teams. Participants also spoke about why they felt it was not possible to work in CRHT on a long-term basis, largely because of the dominance of the medical model. This may reflect a finding by Firth-Cozens (1992), who acknowledged that some team members in other settings considered their opinion to be less valued by their own team than by professionals outside. It was also acknowledged that medical opinions were perceived as more valuable. Although this was not explicitly identified in this study, it may reflect the power of the medical model on a wider level in mental health. In addition, Lucas (2004) pointed to research evidence which highlighted the high levels of stress experienced by clinical psychologists in CMHTs, and suggested that this was despite the fact that the profession have at their disposal skills which could be of particular assistance in ameliorating stressors.

3) In the core category, 'WORKING WITH CRISIS', the category **'Crisis Work'** included the sub-categories: <u>'Psychological Understanding of Crisis', 'Role of Psychology in Promoting Recovery from Crisis'</u> and <u>'Psychological Models in Crisis Work'.</u> Participants spoke of their roles in working psychologically with crisis, drawing on a range of models. Their understanding of the factors which led to crisis may reflect the value of formulation in this setting, and can be linked to the value of understanding mental health difficulties from a biopsychosocial perspective (Borrell-Carrio, Suchman & Epstein, 2004). Participants in this study reflected on the range

of factors linked to the development of crises, including biological, social and psychological factors. Participants' observation of the role of social factors in crises may be considered in the context of findings which suggest that CRHT may offer a greater capacity to address the social factors contributory in crisis-onset (Johnson, 2004). Their acknowledgement of their role in identifying such factors and in supporting service users' awareness of these factors, as well as the awareness of the team may be considered as important in contributing to effective service user care.

In this study, participants also spoke of the role in the breakdown of coping strategies in the development of crises. This is in line with '*crisis theory*' (Caplan, 1964) and the '*crisis approach*' (Caplan & Caplan, 2000). Participants reflected on the ways they could promote recovery from crisis, which reflects the agenda for recovery in mental health settings (NIMHE, 2005). Furthermore, Johnson & Thornicroft (2008) highlighted the important role of CRHT in supporting service users' adaptive coping skills to enable crisis resolution, which was acknowledged by participants in this study. Participants acknowledged ways in which they could support service users to develop coping skills, and their role in supporting other team members to help service users to develop these skills, using psychological techniques.

The second category, '**Medical and Psychological Approaches'** contained within the core category, 'WORKING WITH CRISIS' considered a further two sub-

categories: <u>'The Medical Model is the Bottom Line',</u> and <u>'Working Psychologically with the Medical Model'.</u> Participants spoke of the perceived dominance of the medical model in this setting, as reflected in their view that CRHT care ultimately came down to the medical approach when working with service users in crisis. This included the use of medication, which was seen as a way to contain risk and to deal with resource limitations. This may be considered in the context of the work of Stokes (1994), who suggested that the dominance of the medical model in other team settings may serve as a way to support professionals when working with service users with high levels of distress. This finding is very similar to participants' observations in the current study. Participants also spoke of ways to work alongside the medical model, such as by accepting that it had a place in the team. This finding fits with the recommendation that psychological approaches should complement medical approaches in CRHT (NSF, 1999, p 66). In addition, the importance of a holistic approach to CRHT is in line with service user and carer feedback (NAO, 2007b), as well as guidance on the underpinning of the CRHT model (SCMH, 2001; WAG, 2005b). The perceived dominance of the medical model in community multidisciplinary teams is supported by Snelgrove & Hughes (2000), suggesting that this finding is not specific to CRHT. In addition, Onyett et al., (1994) found that social workers may experience difficulties in team working as a result of a clash of values and beliefs between the *'medical'* and *'social'* models of mental health care, as well as working in a medically dominated hierarchy (Carpenter & Barnes, 2001). It may be that this finding can be linked to psychologists in CRHT, and psychologists in CRHT may value the opportunity to bring a different perspective when working with service users in crisis. Also, in this study, participants spoke of the rewards of making a difference in their psychological work, which may contrast with the

frustrations linked to working with the medical model in this setting. Furthermore, participants highlighted the role of medication in supporting engagement for service users. This can be linked to the finding by Cooper et al., (2008) that psychologists in AOT can work psychologically with service users to promote insight and the need for concordance with a medication regime.

Factors relevant to working psychologically in a medical setting are supported by Plunkett (2006) and Yates (2004). In these studies, the authors reflected on anecdotal accounts of psychologists in AOT settings feeling isolated and frustrated by the perceived privileging of the medical model. Pipon-Young (2010) also suggested that the power of the medical model could represent a challenge for clinical psychologists of the ongoing dominance of psychiatric understandings of mental distress.

Participants also spoke of working with risk and sharing risk within the CRHT. This is supported by the MHPIG (DoH, 2001), as well as Onyett et al., (2006). In a national audit of all CRHT services in England, Onyett et al., (2006) identified that one of the most common forms of input provided by CRHT professionals was risk assessment, amongst other findings. This may reflect the complexity of service users in these settings, which inevitably will require a high degree of discussion and reflection on risk issues. Furthermore, discussion of risk may serve to reduce the impact of working with risk on professionals, which was discussed by participants in this study.

4.2.2 THEME TWO: TEAMWORK

This captured a range of issues relevant to participants working with the team in CRHT under the core category, 'WORKING WITH THE TEAM IN CRHT'. This included three categories: **'Reactive and Reflective Approaches', 'Shaping the Role and Promoting Psychological Ideas'** and **'Teamwork'**. The key findings pertinent to this theme will now be outlined.

1) Within the core category, 'WORKING WITH THE TEAM IN CRHT', the first category related to **'Reactive and Reflective Approaches'.** This included three sub-categories: 'Psychological Work in CRHT is Different', 'Psychologist Position in Reactive CRHT' and 'Challenges in Setting up Reflective Practice, Supervision and 'Training'. Participants spoke about the way they perceived their role to be different compared to other professionals. Whilst this was considered beneficial for service users, the different way of working was considered to cause tensions within the team. These tensions related to other professionals' perceptions of the nature of psychological work, and the impact of this on participants. For example, participants talked about the length of time needed to write psychological reports, and how other team members may not have fully appreciated the nature of such work. Some participants reflected the observation that their colleagues believed that if they were not visible, and visiting service users, they were not fully contributing to the work of the team. This finding may be taken alongside the recommendation of the BPS (2008), that psychologists in CRHT should be separate from the core work of the team, and protect their time to engage in activities relevant to their work. This may also be linked to a finding by Firth-Cozens (1998), who noted that differences in

professional backgrounds, practices and roles can cause tensions in multidisciplinary teams. This specifically related to the ways in which those considered to make *'rational'* decisions (often doctors and managers) conflicted with those who made decisions based on *'values and people'* (often nurses and therapists). Furthermore, research has suggested that a team's diversity can have a negative effect, as team members with shared backgrounds often organise themselves into opposing cliques (Ancona & Caldwell, 1992). According to Onyett (1999), teams where staff celebrate their differences and honestly discuss issues regarding hierarchy and power are most likely to be successful. Finally, these findings can be linked to theoretical understandings of teamwork (e.g. Janis, 1972; Turner, 1987; Hogg & Abrams, 1993) in relation to the ways in which individuals engage in teams. These findings can also be linked to theoretical frameworks, such as professional identity theory (Bucher & Stelling, 1977) to consider the development of clinical psychologists' professional identity within CRHTs.

Participants also commented on their perceptions of the team as *'reactive'*. This was connected to their expressed frustrations in the difficulty they faced in setting up training and reflective practice sessions. This was considered to be linked to the *'reactive'* nature of the team, and time constraints faced by other team members. CRHT work has been considered as '*stressful, pressured and reactive in nature, providing few opportunities for reflective practice and formulation-based approaches*' (BPS, 2007b, p 59). In addition, Hall (2005) highlighted that individual professionals in health care have different values, beliefs, customs and behaviours, which are reinforced during their individual training. It may be that such variations can impact on the effectiveness of multidisciplinary teamwork in CRHT. Furthermore, team

reflexivity has been identified as a key factor in the effectiveness of work teams and in achieving group tasks (Firth-Cozens, 1998; West, 1996).This finding may be taken in the context of the role of clinical psychologists as *'reflective scientist practitioners'* (BPS, 2006), and suggests the importance of clinical psychologists drawing on their skills in reflection when working in teams. Participants in this study talked of the challenges of working as reflective practitioners in *'reactive'* teams, and the lack of *'fit'* between being reflective in a *'reactive'* team. This may be considered with research findings which have suggested that clinical psychologists consider their professional identity to be particularly threatened by team membership (Anciano & Kirkpatrick, 1990; Searle, 1991).

The core category, 'WORKING WITH THE TEAM IN CRHT' also included the category, **'Shaping the Role and Promoting Psychological Ideas'.** This included the sub-categories, <u>'Chipping Away', 'Finding a Place in the CRHT', Psychological Mindedness of the Team and Understanding of Psychologist Role', 'Educating the Team about the Role of Psychology', 'Promotion of Psychological Ideas and Indirect Work'</u> and <u>'Importance of a Psychological Visibility and Presence'.</u>

Participants spoke of ways in which they felt able to shape the role and find a place within the CRHT, in light of CRHT being a relatively new service initiative. They talked of the benefits in other team members being psychologically minded, and the importance of educating other team members about the psychology role. Interprofessional education has been advocated as a way to develop the necessary

attitudes, knowledge and skills required for effective teamwork across health care settings (National Health Service Executive, 1996). Evidence has highlighted the positive effects of interprofessional education, such as addressing negative attitudes towards members from different professional groups (Carpenter & Hewstone, 1996); improving knowledge of one another's roles (Reeves, 2000) and enhancing teamwork skills (Virgin, Goodrow & Duggins, 1996). In addition, evidence has suggested that if different team members are unaware of the skills and experience of their colleagues, the skills will not be used effectively (Bond et al., 1985). Participants reflected on the benefits of indirect work with colleagues to promote psychological ideas, which is supported by findings regarding clinical psychologists in AOTs (Cooper et al., 2008). In addition, Liberman et al., (2001) noted that professionals in other teams have been able to use their time more effectively when they teach and supervise others, via indirect work (Christian, Hannah & Glahn, 1984). Participants also acknowledged the importance of psychologists being visible in CRHT, and the limitations of part-time work in CRHT. The importance of psychologists being available in teams, in order be useful to the work of the team is highlighted by the BPS (2001b).

In the third category, **'Teamwork'**, a number of sub-categories were identified: <u>'Finding Allies to Support Psychological Mindedness'</u>, <u>'Team Environment and Impact on Psychologist'</u> and <u>'Team Work in CRHT'</u>. Participants spoke of the importance of having allies in the team to support psychological ideas and thinking, especially senior team members. This may be linked to the finding by Onyett (2011) of the protective nature of strong leadership for staff working in multidisciplinary teams, which may reflect participants' observations of the support felt by having

allies in the team. Participants also talked about the value of other team members being psychologically minded, and ways to promote psychological mindedness by joint working in the team. The role of psychologists in promoting the psychological mindedness of CRHT professionals is outlined in the BPS (2008) briefing paper for CRHT psychologists.

In addition, participants discussed the importance of healthy team dynamics and a shared vision to promote recovery in service users. This may be linked to a finding by Onyett, Hepplestone & Muijen (1995), who found that team working itself was a source of reward and support for professionals. The *'metacognitions'* of team members may be related to reflexivity and reflection on the learning process (Brown, 1978). In team settings, this may refer to sense making and learning from actions (Senge, 1990). Reflexivity has been seen as a key aspect of the ability of teams to monitor and react to their environment (West, 2000). In this study, some participants reflected on the ways in which reflexivity was developed, via the sense of all voices in the team being heard. Participants felt that this engendered the ability for team members to learn from each other. In addition, they reflected on the importance of working together to provide an effective service for service users and carers, which may also be linked to the team reflexivity.

Along with reflexivity of the team, the importance of effective multidisciplinary team work in CRHT was discussed by participants. In addition, the need to draw on the expertise of other team members to share ideas was considered. Liberman et al., (2001) suggested that practitioners in multidisciplinary psychiatric rehabilitation

teams must blend competencies from the team and individual levels. The authors noted that on an individual level, practitioners should work collaboratively and respectfully with other team members to create a more effective team. Furthermore, in a national survey of CRHT in England, Onyett et al., (2006) found CRHT professionals noted lack of team cohesion as a key difficulty in providing an effective service. The authors identified a need for greater integration with other mental health services and within the team, as well as additional training. The importance of teamwork in CRHT may be considered in the context of the finding that 45 per cent of CRHT in the United Kingdom are made up of multidisciplinary staff (Hogan & Orme, 2000).

4.2.3 THEME THREE: POSITIVE AND NEGATIVE ASPECTS OF CRHT WORK

The final theme captured both positive and negative aspects of CRHT working under the core category: 'POSITIVE AND NEGATIVE ASPECTS OF CRHT WORK'. The findings will be considered in the following section.

The core category: 'POSITIVE AND NEGATIVE ASPECTS OF CRHT WORK' included the category, **'Positive Aspects'**. Within this, four sub-categories were included: 'Unique Way of Working and Opportunities', 'CRHT offers a Learning Experience', 'Positive Aspects of CRHT Work' and 'Psychology has an Important Role'. Participants spoke of the unique way of working in CRHT, the learning opportunities afforded and positive factors relevant to the diversity in the role, when

compared to their experiences in other settings. The positive aspects of CRHT psychological working may be contextualised by research evidence which highlights that there remain low numbers of clinical psychologists in CRHT in England (Onyett et al., 2008). The important role of psychology in CRHT was also acknowledged by participants, and this may be linked to the MHPIG recommendation (DoH, 2001) for psychologists to be included in the team structure of CRHT.

In the category, **'Negative Aspects'**, a further three sub-categories were contained: <u>'Set up of CRHT as a Limitation'</u>, <u>'Interfaces and Lack of Resources'</u> and <u>'Lack of Time and Competing Demands'.</u> Participants expressed their views of the less positive aspects of CRHT work, such as the limitation in the way the CRHT was set up, with regard to the lack of consistency in team members seeing service users. This finding reflects service user and carer feedback regarding the importance of consistency in home visits (NAO, 2007b). In addition, factors relevant to lack of resources and competing demands were associated with frustrations, levels of stress and acceptance of the limitations CRHT work. These can be supported by findings regarding psychologists in other settings (Onyett et al., 1997). In the above survey of staff in CMHTs, Onyett et al., (1997) found that clinical psychologists reported high levels of emotional exhaustion in teams. In addition, lack of resources was considered to be a major source of stress in a survey of CMHT members by Onyett et al., (1995). Also, Onyett (2011) reviewed the literature on job satisfaction, stress and burnout in community mental health teams between 1997 and 2010. Whilst acknowledging methodological limitations inherent in the literature, the author concluded that many research studies reported high levels of emotional exhaustion in professionals, but no evidence of a decline in morale. Lack of resources and

workload pressures were the most consistent sources of concern among staff, which is in support of previous findings (Onyett, et al., 1995). This may also have wider implications for the mental health of psychologists in CRHT, as a study by Bonde (2008), suggested that workplace stressors were associated with an elevated risk of subsequent depression.

In summary, the data gathered in this study reflects an insight into the experiences of clinical psychologists working in CRHT. Participants highlighted both positive and negative aspects of the work, their experiences of working with other professionals in the team setting of CRHT, and factors related to psychological and clinical work.

4.4 CLINICAL AND SERVICE IMPLICATIONS

The clinical and service implications of the results of this research will now be provided, in relation to implications for clinical psychologists in CRHT, other professionals in CRHT and wider services. These will also consider recommendations for the development of CRHT service provision and the role of clinical psychology within such teams. The recommendations will aim to facilitate the provision of effective CRHT, by improving the understanding of the experiences of clinical psychologists who work in such settings.

4.4.1 Clinical and Service Implications for Clinical Psychologists in CRHT and the Wider Psychology Workforce

4.4.1.1 Reflection on the Study Findings

In light of the lack of available research on psychologists working in CRHT, it will be important for the psychology workforce, including CRHT, AOT and CMHT psychologists to reflect on the findings of this study. With consideration of the range of factors which are specific to psychological work in CRHT, psychologists should consider their work in CRHT in the context of the findings. In addition, it may be helpful for psychologists to consider ways to manage some of the more challenging aspects of CRHT work, such as the dominance of the medical model. Furthermore, it will be particularly important for the findings relevant to the unsustainable nature of the psychology role in the long-term to be given thought, so that this may perhaps be remedied.

4.4.1.2 Continued Use of Support Networks

The benefits of support networks, such as the CRHT Network for Psychologists were identified in this study. In addition, participants spoke of the positive impact of allies in teams, and the importance of supervision and support. This should be continued so that psychologists in CRHT do not feel isolated, and so that they can use such methods as a forum for sharing ideas and supporting each other. In addition, it may be beneficial for links with psychologists in other settings, such as acute inpatient units and AOTs to be further strengthened. It may be that similar issues are present in psychological working in such settings, such as the dominance of the medical model. In addition, this may serve to maintain the psychology role in CRHT.

4.4.1.3 Promotion of Psychological Work in CRHT

The positive aspects of CRHT work as highlighted in this study could be promoted as part of a distinctive CRHT psychology role. Based on participants' observations of the positive aspects of CRHT work, it may be useful to consider these in a wider context. For example, the perceived differences of psychological work in this setting compared to other settings could be explicitly and positively framed, for example opportunities for working creatively, offering consultation to others and the support of the team. It may be helpful for a set of guidelines to be developed to promote the development of psychological services in CRHT, as perceived by clinical psychologists working in these settings.

4.4.1.4 Increased Visibility of CRHT Psychology

In this study, psychologists reflected on the importance of being visible in CRHT in order to effect change, and the need to work in other settings in order to sustain CRHT work. However, they also reflected on the part-time nature of their involvement in CRHT as impacting on their ability to show a presence. In order to lessen the impact of clinical psychologists working in teams on a part-time basis, they may find it beneficial to consult with a named staff member to act as a link for the development of psychological ways of working. In addition, regular meetings with team leaders to discuss future care planning and the provision of a psychological service may be important.

4.4.2 Clinical and Service Implications for CRHT Professionals

4.4.2.1 Increased Development of Teamwork in CRHT

Participants in this study talked about the important role of teamwork in CRHT. However, there remained an element of psychological work being seen as separate to the work of the team. It may be important for there to be an increased emphasis on all professionals in CRHT working together to improve service user outcome. For example, issues pertinent to risk, and the division of the medical perspective (medication, sectioning) and psychological perspective (psychological risk formulation) should be considered. In this, ways for the team to consider how the psychological perspective may inform medical perspectives, for example in relation to risk should be established. This may help to form a more cohesive treatment approach. Increased training, consultation and support may be helpful in establishing such initiatives. The CRHT clinical psychologist may play a key role in delivering training and providing consultation to others, and in developing creative ways for the team to develop a more holistic approach to service user care.

4.4.2.2 Team Formulation Sessions

The perceived value psychological formulation was reflected on in this study. Therefore, it may be advantageous for CRHT to implement a forum for team discussion of formulation. In such sessions, individual cases may be presented for discussion, and this may serve to enhance the skills and understanding of the team regarding formulation. The psychologist in CRHT may play a role in facilitating such sessions. The value of psychological formulation in teams has been supported in other research (e.g. Summers, 2006; Wainwright, 2010). These studies have included staff in adult psychiatric rehabilitation units (Summers, 2006), with benefits including improved staff satisfaction and team working, via increased understanding

of service users, bringing together different staff perspectives and encouraging more creative thinking. In addition, staff based on older adult inpatient wards (Wainwright, 2010) have reported benefits of psychological formulation including improved psychological understanding in other staff, improved relationships between staff and service users and improved team work.

4.4.2.3 Protecting Time for Reflective Practice, Supervision and Training

Participants talked about the difficulty they faced in establishing reflective practice and training for other team members, which they considered to be important for the development of the team. It may therefore be beneficial for CRHT psychologists to endeavour to establish the reasons for this within individual teams, including other team members' opinions of the relevance and utility of such sessions for them. It may also be helpful for psychologists to play a role in educating CRHT professionals of the benefits of reflective practice, supervision and training. If there is an argument for the development of such sessions, CRHT psychologists may be involved in developing recommendations to improve the success of such initiatives. These may include scheduling protected time for such activities, and this taking place at times when there are more staff members available, such as during handover. Furthermore, it may be useful to develop a framework to support the engagement of team members in such sessions, including the joint contraction of sessions to include, for example ground rules and session structure (Hawkins & Shohet, 2000). Participants in this study identified more success in the running of training, reflective practice and supervision with the support of the team leader. It may therefore be worthwhile for CRHT psychologists to play a role in working with individual team

leaders to facilitate their understanding of the importance of such sessions. This may help to support psychologists in promoting this work.

Alternatively, it may be helpful for reflective practice, training and supervision to be led by an external facilitator. Although there were mixed views in this study regarding the success of this method, participants reflected on their role within the team and the tensions in establishing such initiatives whilst also being a team member. The facilitation of such groups is regarded to be within the remit of the CRHT clinical psychologist, (BPS, 2007b), however, in light of the study findings, it may be more beneficial to consider the use of an outside facilitator. This may positively impact on the number of staff wishing to access this provision, as well as addressing the issue related to the psychologist position in the team.

4.4.2.4 Service User Research Initiatives

The importance of service user research was identified in this study, and the use of service user feedback should continue to be used to inform ways of working in CRHT. This then may guide ways for CRHT psychologists to develop training and supervision initiatives based on service user feedback. This could also serve to ease the task of the psychologist in establishing training sessions, as these sessions may be more successfully received if they are developed as a result of service user feedback.

4.4.2.5 Joint Work with Other Services and Improved Communication

Participants in this study reflected on the lack of joined-up working with other services, such as CMHTs. This was considered to be at the detriment to service users, in light of long waiting lists and poor understanding of the remit of the CRHT psychologist. As such, it may be beneficial for CRHT services to consider ways to promote more joined-up working with other settings, including inpatient settings and community services. This may take the form of improved methods of communication between such services, and education for other services regarding the remit of the CRHT psychologist. In addition, increased joint work within the CRHT itself may serve as a useful method of developing this way of working.

4.5 STRENGTHS AND LIMITATIONS OF THE STUDY

Participants in this study were recruited from a range of CRHT settings across England and Wales, so it may be considered that the sample is generally representative of clinical psychologists working in CRHT. It may also be that given the diversity of the sample of CRHT (for example, across affluent and deprived areas) the findings reflect a rich understanding of the experiences of clinical psychologists working in CRHT service contexts.

However, with this in mind, the number of female participants (n=9) outnumbered the male participants (n=2) in this study. Another possible limitation is that all but one of the participants worked in other settings as well as CRHT, and so the issues may not reflect those clinical psychologists working in CRHT on a full-time basis. The CRHT sampled were largely based in urban, predominantly inner-city areas. It is important to bear in mind how much the research findings reflect CRHT work more generally, team working or the experiences of clinical psychologists working in teams, and this

will need to be borne out with further research. Furthermore, it has been acknowledged that the set up of CRHT varies across teams, in that some provide only a home treatment remit, and others provide both a crisis and home treatment service. Due to the nature of the study, it was not possible to separate out individual teams in this way, and the sample was sourced from both types of teams. Participants were also recruited to the study on a voluntary basis, and may have had a greater interest in the research due to personal interest. Furthermore, the study focused only on clinical psychologists in CRHT, and did not reflect the experiences of other psychologists who may work in such settings, such as counselling psychologists.

In terms of improving the validity of the research findings, the study may have benefitted from the use of other forms of data collection to triangulate the data. It may have been appropriate to conduct a focus group to feedback the initial analysis to participants, and gain comments and feedback on this. This may have provided additional data and a means to validate the analysis. However, due to practical reasons, it was not possible to organise a focus group following the initial data analysis in the time frame available. Instead, feedback was sought from a sample of the participants, who covered 100 per cent of the data between them. The participants who were asked to provide feedback on the data noted that the findings accurately reflected their experiences in CRHT (see Appendix Ten).

In addition, the reliability of the findings may have been improved by including a second rater during the analysis, who may have rated the list of categories and

definitions. However, reliability was attempted by asking both supervisors to provide a quality check on the data. The clinical supervisor looked at a ten per cent sample of the data, and the academic supervisor looked at 100 per cent of the derived themes, core categories, categories and sub-categories. In addition, the researcher kept a reflective journal and memos throughout the process, to attempt to improve the quality of the findings (see Appendices Eleven and Twelve).

4.6 RECOMMENDATIONS FOR FURTHER RESEARCH

This study offers a preliminary investigation into CRHT psychology practice. Therefore, there are a number of recommendations for further research which have been identified from this study.

The results showed a number of factors relevant to being a psychologist in CRHT. It would be useful to further explore the experiences of psychologists in this service context by means of a larger study, to include all psychologists working in CRHT in the United Kingdom. It would also be useful to compare the findings with the experiences of psychologists in CRHT in other countries, to serve as a means to compare similar findings.

In addition, there are particular aspects of the study which could be explored in more detail, for example issues relevant to team working in CRHT. Findings relevant to psychologists working in teams in other settings, such as inpatient units or

community teams could then be used to contextualise the findings and draw out similarities and differences.

The current study employed a qualitative methodology, and it could be useful for a quantitative study to further validate the research findings. For example, factors relevant to emotional wellbeing or teamwork could be explored using questionnaire measures, in order to explore, for example, factors relevant to stressors in CRHT work.

Furthermore, a research study to explore specific issues raised in this study may be beneficial. For example, participants in this study reflected on the challenges of establishing reflective practice and training for other team members. It may therefore be valuable for CRHT psychologists to endeavour to establish the reasons for this within individual teams. Therefore, a research study within CRHT settings in order to gather other team members' opinions of the relevance and utility of such sessions may be useful. This may take the form of research within CRHT settings to gather other team members' opinions of the relevance and utility of such sessions for them.

4.7 CONCLUSIONS

CRHT is a relatively new method of mental health service provision, and the role of psychology in such settings continues to develop. There is a dearth of available research evidence on the experiences of clinical psychologists in CRHT, and this

study serves as an important piece of research evidence to address this deficit in the literature.

The current study aimed to explore the experiences of clinical psychologists working in CRHT, including their roles within teams, their relationships with other professionals and their experiences of working with service users in crisis. The research explored participants' experiences of working in CRHT, by means of individual interviews with 11 clinical psychologists working in CRHT in England and Wales. The method of Grounded Theory was used to make sense of the data.

The study identified positive and negative aspects of the work, clinical psychologists' experiences of working with the team and psychological and clinical work within the CRHT setting. Some of these findings can be linked to previous findings relevant to the experiences of clinical psychologists working in other settings, such as AOTs. This is in light of the lack of research on the experiences of clinical psychologists in CRHT.

The study provided a detailed and interesting overview of the experiences of clinical psychologists working in CRHT. The findings may help to facilitate the development of the psychology role in CRHT by improving understanding of life as a clinical psychologist in this service context. More research is needed to replicate the findings of this study, to validate the findings using quantitative methodology and to compare the findings with the experiences of clinical psychologists in CRHT in other countries.

In addition, further research will need to establish how accurately the findings reflect CRHT work, team working or the experiences of clinical psychologists working in teams.

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