Working with Men in Crisis: A Psychological Framework for Crisis Intervention in Home Treatment Teams

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Crisis Resolution Home Treatment Teams or Home Treatment Teams (CRHTTs/HTTs) form a key part of the mental health acute care pathway in the UK. CRHTTs provide an alternative to hospital admission for people in acute mental health crises, with a focus on those who present with risks to themselves, to others or from others. They are crucial in managing the limited acute care resources available to people in a mental health crisis because it is not possible to afford or accommodate all the patients who require admission (Hollander and Slater 1994). CRHTTs allow people to receive an intensity of treatment needed during a crisis whilst in their own homes, often their preference but also allowing them to maintain valued connections.

Reducing mental health admission rates in the UK is and has been a service priority (Keown et al. 2011). Between 1988 and 2008, there was 62% reduction in inpatient services in the UK. Inpatient services have been an integral intervention for the management of risk, including the risk of suicide. Whilst there has been a significant reduction in the number of suicides occurring in inpatient settings in the UK, the prevention of suicide

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in CRHTTs remains a challenge. Since 2003, the number of suicides occurring in CRHTTs has more than doubled (Hunt et al. 2014, 2016).

Despite men having taken their own lives at much higher rates since records began, it was only in 2012 that the male gender was recognised nationally as a specific risk factor (DoH 2012). Men are known to access health and mental health services later in the course of illness progression, if at all. They are less likely to access preventative psychological services at primary care level and more likely to come into services when difficulties are at the point of crisis (Sullivan 2011). This may in part be due to men not seeing depression and anxiety as a serious problem (Edwards et al. 2007) or being more inclined to deal with the problems on their own (Meltzer et al. 2003).

CRHTTs may be well placed to offer gender sensitive psychological intervention to men who may not otherwise have accessed to services or seen them as relevant to their needs. Unfortunately, although recommended by the Royal College of Psychiatrists (Buley et al. 2017) and the British Psychological Society (BPS 2008), clinical psychologists/practitioner psychologists are not a requirement and many CRHTTs in the UK do not have access to psychologists.

Part of the reason for the absence of clinical psychologists could be attributed to the view that that psychological work during acute crisis periods could make things worse or 'open a can of worms'. Combined with the unhelpful belief that there is not enough time to work psychologically in these settings, interventions are often ad hoc or taken from other models applicable to non-acute settings. Consequently, there is currently a dearth of evidence to support the applicability and effectiveness of psychological interventions across the crisis care pathway (Jacobsen et al. 2016). The result is that there exists no evidence-based psychological model for working with people in acute care despite some attempts (Clarke and Wilson 2009). CRHTT psychologists are often adapting other models to fit the setting (Jacobsen et al. 2016). Those which are well tolerated by service users with high levels of distress or disturbance may be promising (Linehan 1993; Mason and Hargreaves 2001).

Whilst there are important constraints to consider when working with people in an acute crisis, there are great outcomes that can be achieved during this period. This is because symptoms including problematic thoughts, feelings and behaviours are often more accessible (Jacobsen et al. 2016), and in our experience, people are willing to engage and work psychologically. The National Institute of Clinical Effectiveness, services users, and best practice guidelines are all clear that Psychology has a role within acute care. What is less clear is the kind of psychological work that is appropriate and effective in this setting.

Any model of psychological intervention for acute and crisis presentations need to take into account a number of key constraints. These include the likely short but intensive time frame of CRHTT treatment episodes and the need for interventions that are focused and readily available. A focus primarily on promoting the management and reduction of risks and the need to be deliverable at scale given limited resources and high numbers of service users. Hypothesising possible factors maintaining the crisis and risks can allow the provision of discrete and focused elements of psychological interventions rather than whole psychological therapy protocols for broader problem or particular diagnoses (Spring and Neville 2010).

The increasing rates of suicide in home treatment would indicate the need to continue to develop better and more effective interventions in the area, particularly interventions that help people to manage and reduce suicidal ideation, planning and intent. With men accounting for three-quarters of all completed suicides, crisis services likely to play an important role supporting men in crisis and encouraging them to make use of other available services.

This chapter presents a trans-diagnostic psychological model for working with people in crises (Sullivan 2018), combined with important considerations when working with men in this setting. Models and interventions draw on a broad base of cognitive and behavioural theories and a particular attention to 'third wave' CBT and metacognitive models.

Men's Use of Services in the UK

Men generally make less use of health and mental health services, which contributes to poorer health outcomes (White 2001). Men are less likely to voluntarily use mental health care services, including psychological therapies (Glover et al. 2010; NHS Information Centre 2010; ONS 2010; Sullivan et al. 2015); more likely to present to services at a later stage of illness (White 2001); and more likely to be entering services under coercion. Men take more risks with their health; are more likely to present with behavioural problems and externalise their distress (and therefore be over-represented in drug and alcohol services, homelessness and prison populations), they risk exclusion from mental health services; often receive less empathic responses; are less likely to be diagnosed with common mental illness; less able to identify and communicate psychological difficulties; and more likely to somatise (Sullivan 2011). Men's approach to seeking help is a major contributor to poorer health and mental health outcomes and crises become more inevitable.

Psychological Crisis Presentations

Crises are defined as times of intense difficulty and danger in which difficult or important decisions must be made. This simple definition highlights two important factors: the activation of the threat/stress system and decision making. Slaiku (1990) describes personal crises as:

> temporary state(s) of upset and disorganisation, characterised chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving, and the potential for a radically positive or negative outcome.

Crisis situations are characterised by overwhelming stress, emotional disturbances, vulnerability, breakdown in coping, somatic symptoms, disorganisation in functioning, reduced defensiveness, cognitive biases and disturbance in thinking (Murphy et al. 2015). They are also periods in which outcomes can be influenced even when damage is inescapable.

Crises carry threat and condition us into states that activate thought and action to reduce harm and identify acceptable resolutions to the perceived problem(s). When we find safety and resolution, we find relief as the uncomfortable signalling emotion(s) dissipates (see Fig. 1). The greater and more immediate the threat, the more time and attention are allocated.

Some people manage to resolve crises through application of their internal and intuitive coping strategies; some may look to others for support, whilst some may benefit from specialist crisis intervention. Some people may benefit from offloading and sharing their thoughts and feelings whilst others prefer action, guidance and direction from others. In terms of gender, we could consider that, on average, men may be more likely to try to 'go at it alone'

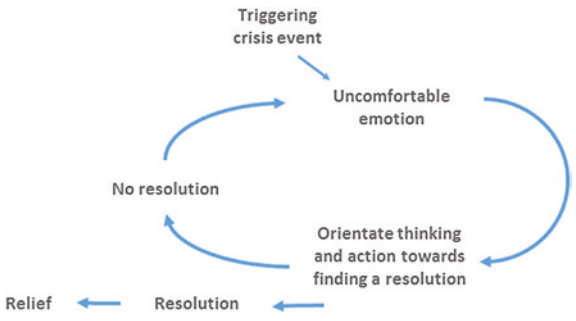

Fig. 1 Problem-solving challenging situations

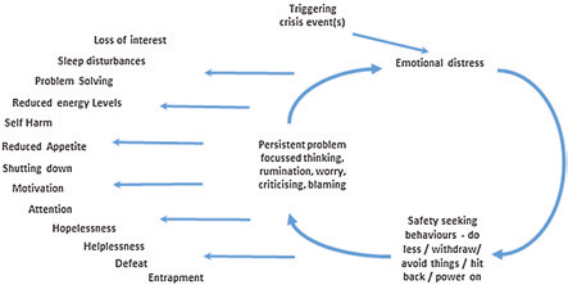

Fig. 2 Psychological mechanisms underlying crisis presentations

and women more likely to seek support from others (Galdas et al. 2005; O'Brien et al. 2005).

People who come to the attention of CRHTTs will have tried many times to find resolutions to their difficulties. In the absence of an acceptable resolution, people can become trapped within a threat-focused cycle leading to common crisis symptoms including hopelessness, helplessness, entrapment and defeat (see Fig. 2). It is at this stage that the intuitive problem-solving methods described above become part of the problem.

Hopelessness, helplessness, entrapment and defeat are the most significant risk factors for people who take their own lives (O'Connor and Nock 2014). These are all felt experiences, unintended consequences of crises and targets for intervention when working with people in acute care services, particularly for people presenting a risk of suicide. Gender may also impact on how this is experienced with ancient expectations for men to be fighters and winners (Seager et al. 2014).

The Causes of Crises?

Crises are often caused by financial difficulties, workplace stress, relationship issues, bullying, major life loss, changes in circumstances, bereavement, trauma, abuse, threat to self/others, isolation, self-neglect, sleep problems, poverty, loss of security, health and mental health difficulties. All of the above can happen to us all at some stage in our lives, with or without a diagnosable mental illness. The impact of any of these precipitating factors can be negatively impacted by contextual factors such as marginalization, alienation and poverty (Hatzenbueler et al. 2014) although importantly crises

also occur in the context of privilege and affluence. We can also consider an intersectionality of male gender and other characteristics such race and ethnicity which may exacerbate the severity of risk and crisis.

Precipitating events can be situational and caused by factors within our environment such as a physical assault or the loss of a job. They can also be linked to transitional developmental life stages and the challenges involved in moving from one stage to the next: for example, leaving home and heading to university (Erikson 1956; Maslow 1943).

The Role of Emotion

Emotions are our 'sixth sense'. They signal to us at any point in time where we stand in relation to ourselves, others and the world around us. They signal to us when problems arise that need our attention and when good things are happening. They are central to human functioning, social connectedness and survival.

Emotions are central to intervening with people in crisis and across the acute care pathway (Clarke 2015). Low emotional literacy has also been found in people diagnosed with Emotionally Unstable Personality Disorder (EUPD), where frequent crises and emotional dysregulation are common (Linehan 1993). The over-control of emotion can also lead to crises (Lynch 2018) and can be seen in people who report the absence of feeling numbness.

Low emotional awareness and literacy are hypothesised to be more common in men (Levant et al. 2009). For men and boys, the message throughout development and into later life is that emotions should be shut down and expressed in more limited ways. This results in fewer opportunities for learning and developing an adaptive relationship with emotional experience. In later life, this may place men at greater risk of adverse outcomes during times of crisis. It may also account for low social and emotional connectedness.

Emotional literacy has been considered a central component in developing psychological resilience and is often an underdeveloped skill in many disorders. The starting point for emotion-focused work with men will be different as for many the language around emotions is likely to be less developed. Being able to help men see the utility of emotions for themselves is important and should not be avoided.

Suicidality and Crises

Whilst mental illness increases suicidal risk, with some estimates citing evidence of a mental health problem for 90% of suicides (Cavanagh et al. 2003), it is not a causal factor. Seventy-two percentage of all suicides occur outside mental health settings, with many people not presenting as mentally unwell. Suicide itself must therefore be thought of as a distinct problem. Thinking in terms of crises may help us to understand suicidality and intervene more effectively.

Psychological theories of suicidal thoughts would suggest that suicide and suicidal ideation occurs in the context of a psychological difficulty in which a lack of belongingness and burdensomeness (Joiner 2005; Joiner et al. 2012), as well as defeat and entrapment from stressful, humiliating or defeating circumstances, occurs (O'Connor and Nock 2014).

Suicidality often occurs at the endpoint in the search for a solution. In the absence of an acceptable solution, people can find themselves trapped in a cycle of intolerable and unabating emotional distress (see Fig. 2). Suicidal thoughts themselves can bring a sense of control, reduce emotional distress and offer a possible solution in the absence of any other. The emotional relief can act as a negative reinforcer leading to more planning and intent to act. The relief can be interpreted as an indicator that suicide is a credible option. Indeed, people who act on their thoughts describe a sense of peace prior to the act (SpeshulSnek 2018).

Psychological Crisis Intervention in Crisis Resolution Home Treatment Teams

The Setting

CRHTTs (or HTTs) were introduced into NHS services in 1997, in an attempt to reduce the need for inpatient services by providing intensive support to people in acute crisis within their home environment. Although CRHTTs vary across the UK, the universal ambition is to provide support that is accessible to people with mental health problems in crisis, 24 hours a day, all year round. CRHTTs work with cases where there is a significant and immediate risk to self or others due to a psychological disorder. They provide home visits primarily by nurses and psychiatrists and where possible other professionals including social workers, occupational therapists,

psychological practitioners and clinical psychologists. Support can be provided through a combination of home-based or clinical-based contact on average once or twice a day. On average, people are estimated to stay with a service between four and six weeks.

This level of contact provides a considerable window in which a piece of psychological work can be carried out. Many of the tasks of a clinical psychologist working in this setting overlap with the shared tasks of the wider service, particularly psycho-social interventions. However, clinical psychologists in this setting provide additional benefits by offering more advanced and specialist intervention, particularly for complex cases. Additionally, they can provide support for the wider team in order to develop the psychological skills they already have, build resilience in challenging environments as well as learn and apply new skills and knowledge.

The following intervention provides a framework for working psychologically in CRHTT. It also includes a shared direction for psychological work in this area and attempts to provide a common and consistently shared language.

Making Safe

Under the care of CRHTTs, people present with actual and immediate risks to themselves, to others or from others. The first intervention and primary task of a CRHTT are to ensure that adequate risk management care plans are in place in order to minimise the potential for harm, starting with the most immediate risks and then providing support to prepare for more distal risk and potentially destabilising future events. This is a shared task for all HTT practitioners, including psychologists, and is a particular strength of CRHTT practice.

Risk assessment and intervention are crucial in helping to reduce the anxiety and fear that surrounds crises and should be shared with service users and formed collaboratively. CRHTTs provide additional practical and cognitive resources to help people find safety. The very presence of a service that offers hope that a resolution may be found can provide that safe framework which may have been missing.

Crises bring with them vulnerability. Being able to identify, acknowledge and accept vulnerability may be more challenging for men and can be masked by other emotions, including anger, which often serves to push people away. Whether men agree with dominant masculine values (such as independence) or not, there will be an impact on the person about how well they

live up to the dominant masculine archetype, particularly for those with less cognitive flexibility (Pleck 1995). Sensitivity to the relationship between masculinity and help-seeking is likely to be helpful in engaging men in crisis.

Psychological Crisis-Specific Assessment and Formulation

Psychological assessment and formulation in CRHTTs should be crisis specific. Providing a psychological framework for individuals' crisis presentations helps to validate a person's experience, which can act as an intervention in itself. Service users will have experienced an assessment of their crisis at the initial point of contact and probably at other stages in their journey. Duplication should be avoided as it can be a source of frustration or potentially retraumatising. A psychological crisis assessment and formulation can be partially established from recent assessments, team discussions and clinical notes. Being able to summarise what is already known avoids additional assessment whilst also communicating to the person that you understand what is going on for them. In our experience, service users fill in any gaps in knowledge or inaccuracies, which subsequently leads to collaborative reformulation. Considerations of the impact of gender should be integrated into the working formulation and will help to identify the right starting point for any further psychological work.

Validation of the Journey

When working with people in crisis, it is important for them to know that the causes of their crises have been understood by individual practitioners and the wider team. Validation, a term often used in Dialectical Behaviour Therapy (DBT), is communicating to service users that their responses make sense and are understandable given what is currently taking place in their lives (Linehan 1993). Note that this does not mean that we agree with them.

Validation includes listening and observing, accurate reflection, articulating the unverbalised, validating in terms of sufficient (but not necessarily valid) causes, validating as reasonable in the moment and radical genuineness (treating the person as valid) (Van Dijk 2012).

Helping to identify what is not being said may be particularly important when working with men. Careful consideration may also be needed as to the

level of emotional literacy and the use of language to describe a felt experience. The journey into services can be a challenging one, particularly for men where dominant masculine gender roles downplay help-seeking. Framing help-seeking as a strength and legitimising the act may be important, and implicit functional validation may be a powerful tool given men's hypothesised preference for action orientated intervention (Emslie et al. 2007).

Addressing Welfare and Essential Needs

For many people coming into contact with crisis services, their social security may have been compromised due to the problems meeting their basic needs, including difficulties with accommodation and lack of financial support. Helping people access welfare support with accommodation, financial and social needs helps to provide the essential foundations for functioning and security. This type of intervention is an example of implicit functional validation (Van Dijk 2012) and is a core task many CRHTTs work with. Specialist welfare support from within or outside of the team is often required before psychological crisis work will be effective.

Modelling Problem-Solving and Establishing Reasons for Living

During periods of crisis, people's ability to problem solve is often impaired by unhelpful cognitive biases and ruminative/worrying problem-focused thinking. Stepping into support someone in finding new and alternative resolutions contributes towards re-establishing hope, whilst helping to release people from feelings of entrapment. The specialist skills of CRHTTs can offer new and previously unthought-of possibilities. Modelling problem-solving and working collaboratively alongside people is important.

Some people may be resistant to alternative solutions or not ready to let go of their struggle. Work to facilitate this may be required and finding the motivation to begin recovery a starting point. This may be particularly true in relation to loss/bereavement, situations where it is difficult to see a future worth living and people who present with anger. Re-connecting people with things that are not lost to them helps to identify possible future goals. Identifying reasons for living often forms an important element of work within CRHTTs, particularly with people who are suicidal.

Psycho-Education on Psychological Responses to Crisis

Human beings are sense-making. For many people, perhaps particularly men, it can be difficult to make sense of how they arrived at their crisis point. For example, they may not have known or been able to see that they had a problem until the last minute. Helping people to understand how they arrived at the point of crisis helps to validate the experience as an understandable response given the situation.

By explaining how people react intuitively during crises, we are able to introduce key concepts for psychological work. By doing this in the third person, the discussion becomes less threatening and helps to normalise individual reactions. By describing psychological crisis responses and maintenance factors, people are able to confirm how it relates to their current experience, giving credibility to a psychological approach to psychological crisis intervention. It will also help people towards understanding how some of the distress can be created by our relationship to the problem rather than the problem itself (Harris 2009). This is likely to be a novel solution for most people, which can again offer hope and help people to feel less trapped within their own minds.

Addressing Emotional Disturbances

Emotional Under-Control

We have seen that crisis presentations are often driven by emotional distress, which persists in the absence of a resolution to crisis events and by the meaning attached to these events. Isabel Clarke in her work with people on inpatient wards states that work in acute services should start with a focus on emotion (Clarke and Nicholls 2018).

Emotions are messengers that indicate to us when we need to pay attention to a situation of importance. The stronger the emotion the more attention we give to it. Emotions can help us to determine whether we are under threat, whether we have lost something important, if we have done something to upset someone, if we are safe, comfortable or happy. The emotions we experience need deciphering, which we primarily do through cognition and thought. Once understood, we can put something in place to either resolve distressing emotions or seek out those which give a sense of comfort

and pleasure. Distressing emotions are prioritised as they have a greater potential for harm.

We all have the capacity to feel so emotions must be helpful and useful to us. Many people want to avoid unpleasant emotions, push them away or numb them (Harris 2009). The problem with this is that people miss the opportunity to understand and make sense of their emotions, their origins and meaning. Avoidance of emotion in the long term affects our ability to cope.

High emotional dysregulation affects our capacity to think. Unabating emotional dysregulation and the absence of a resolution to intolerable emotions can become difficult to bear. At this point, the emotional experience can become the problem and the threat. In such circumstances, it is important to help people see their emotional arousal as the source of their distress and to support them in learning strategies to manage emotional dysregulation. This includes breathing techniques, self-soothing and relaxation strategies, and mindfulness techniques that are adapted for practice with people in crisis.

Sometimes it may not be possible or safe to do these practices. However, helping people to recognise emotional dysregulation as a source of their distress may increase the likelihood of them learning more about these techniques at a later date.

Over-Control of Emotion

It is not just emotional instability that can become a problem, but also over-control of emotion (Lynch 2018). For some people entering into crisis, there may have been a numbing, dulling or shutting down of emotion in order to find relief. By over-controlling emotions in this way, people also numb themselves to more desirable emotions such as joy, pleasure and connectedness. It can also lead to a disconnect with the world and with our social and emotional connectedness (Lynch 2018).

For some people, emotions may not have played much of a part in their experience, and the disconnect and over-control may have happened much further back in their development. Whilst it would be challenging to address this experience in crisis services, being able to identify a problem as one of over-control can help to explain the nature of the difficulties that come with this way of coping, which include low social and emotional connectedness. Again, this may peek curiosity in the service user and offer a possible avenue for recovery.

In these circumstances, it is important to reconnect people with emotional experience and upregulate emotion. Interventions are likely to involve increasing social connectedness and emotional involvement in rewarding and pleasurable experiences. As people re-engage with emotion, it is helpful for them to have an understanding of managing distress as an alternative to shutting down and numbing. This is particularly important for people who also experience emotional dysregulation.

Re-establish Cognitive Effectiveness

As problems present themselves, our thinking will naturally be drawn towards them and we are designed to give our attention to threatening situations over and above nice, pleasant and pleasurable experiences (Mathews and MacLeod 1994; MacLeod et al. 1986; Mogg and Bradley 1998). This bias in attention and processing is believed to be adaptive and beneficial to our survival, as it primes us for rapid detection and response to threat (Bar-Haim et al. 2007). This attentional bias towards threat has been found in a range of disorders.

In situations, where our thinking becomes overly focused on problems, there is a risk of entering into patterns of problem-focused thinking such as rumination, worry, blame, self-criticism and judgement. These styles of thinking can become particularly pervasive and maladaptive during time of crisis, with cognitive biases clouding judgement and reducing problem-solving capabilities. Cognitive biases in attention, memory and interpretation play a key role in the aetiology and maintenance of emotional disorders. Nevertheless, the persistence of the mind in its conviction of its usefulness allows thoughts to continue to dominate cognitive space in hope that a resolution will be found. This is particularly true for people who hold positive beliefs about these styles of thinking (Wells 2000).

Continued use of problem-focused thinking is likely to lead to a range of problems, including unachieved goals (Burwell and Shirk 2007), impaired problem-solving (Hong 2007), impaired concentration (Nolen-Hoeksema et al. 2008) and maladaptive emotion regulation (Burwell and Shirk 2007). Therefore, symptoms will persist and the mood disturbance will perpetuate (Nolen-Hoeksema 2000).

Psychological crisis intervention in HTT involves a reboot of the cognitive system which at some point has unintentionally become part of the problem. Attentional control training, present moment focus and mindfulness practices can help to divert the attention away from threat, thus

preventing preoccupation and overwhelming constant problem-focused thinking (Mobini and Grant 2007).

Baseline Functioning, Behavioural Activation and Graded Recovery

During times of crises, our actions and behavioural responses will be orientated towards dealing with the crisis, and other things will become less important and relevant. Priority will be given to the crisis until an acceptable resolution is found, which makes sense as it decreases the likelihood of harm occurring.

Our primary behavioural response to threat is the flight-or-fight response. Helping people in crisis to understand this threat response system is important, as regulation of the threat system is integral to dealing with crisis situations. This is especially true in instances where running, fighting or freezing leads to a worsening of the situation. Understanding the fight-or-flight system can help people to understand how their actions are inadvertently leading to a worsening of the problem, particularly when withdrawal and avoidance become the main strategies. This lays the foundation for behavioural activation and graded exposure.

Crisis situations leave little time for engaging with anything other than the crisis itself. This can be problematic when focus on the problem situation is unabating and all-consuming. It becomes hard to find time for other things, and people lose motivation and interest in activities that previously gave them enjoyment, satisfaction and pleasure. Whilst activated to deal with threat energy levels can become depleted, appetite becomes reduced as digesting food is difficult, sleep patterns become disrupted and contact with others often too effortful.

Even the smallest task can appear insurmountable as people withdraw and disengage from tasks, they would normally do without thinking, which can be a source of frustration. Some people may try too hard to get back to functioning fully, which can lead to further collapse and despondency about not being able to do the things they expect of themselves.

The aim behaviourally is to build the right foundations from which to be able to function optimally. During periods of extended crisis, people's basic physiological functioning becomes impaired and their safety compromised. Without the right foundations, the more complex demands of daily life become difficult to sustain. Helping people to accept what they can and

Fig. 3 Adaptation of Maslow's Hierarchy of Needs (Maslow and Lewis 1987; Maslow 1954)

cannot do and helping to build the right foundations allows them to begin to refocus and reclaim their lives. Maslow's Hierarchy of Needs can be helpful here (Fig. 3).

Building Social and Emotional Connectedness

Social and emotional isolation are major predictors of mental health problems (Lynch 2018). They may also be the cause, a contributor or an outcome of crises. The more alone we find ourselves the more likely we are to find ourselves alone with our minds searching for a solution in the depths of 'problem focused thought'. Building social connections are supportive in many ways, as they can be a valuable source of comfort and distraction as well as a source of help to resolve or overcome challenges.

Sometimes when working with people in crisis, there is a sense of being let down by important others. People may have reached out for help and support, but the person they reach out to may not know how to help them. In the event of not being able to help and when faced with the possibility of suicide, the helper may feel overwhelmed and 'move away'. This can sometimes be misinterpreted as the person not caring. In such situations, it is important to help people reach out to those who have been of importance in their lives and reconnect with them where possible.

Social connectedness and isolation is an important factor for men. After the age of 30, men's relationships narrow and shrink. The reasons for this could be related to the role of emotions in forming and sustaining relationships or potentially due to attachment styles. Either way, improving social and emotional connectedness is an important intervention, as it is believed to be a protective factor in suicide prevention.

It is possible then for people to have a relatively small social network and feel connected or have a large social network and feel 'lonely but not alone'. It is therefore important to emphasise quality over quantity; a meaningful connection with people is crucial to feelings of connectedness, and it should be prioritised over the number of one's social interactions. Likewise, it should not be assumed that having frequent social interactions precludes one from feelings of loneliness.

Follow-up, Self-Help and Ongoing Support

For some people who present in crisis, there may be a need for referral on to other services for additional support, where there is an identifiable need. There may be some pre-crisis mental health difficulties, histories of unhelpful and maladaptive coping, unresolved distress from the current crisis or other issues activated by the crisis that require further intervention.

The types of services available will be dependent on the local service provision both within and outside of the NHS. This may involve care-coordination, medication management, practical social support or psychological interventions. For some people, it may be appropriate to discharge them back to their GPs with no further follow-up or a link to IAPT services. Some additional work may be required to support men in making use of follow-up services.

Psychological therapy in the UK from the NHS can involve a long wait. It is worthwhile encouraging and directing people towards self-help material to build on their learning during their crisis. Self-help material is effective in treating common mental health problems and prepares people for psychological interventions when the opportunity comes around.

For many people, this may be the first time they have been in contact with mental health services. It may also be the first time they have considered that they might be experiencing a psychological problem. Encouraging people to further develop their understanding of the problems they have been experiencing should be part of their discharge planning and can be continued as they progress to other services.

The intensive nature of HTT intervention and the difficulties people present with at the time of crisis means that stepping down into less intensive community service requires sensitivity and thoughtful planning. Attachments will be forged in the relationship with crisis services, and preparing people for leaving is an important aspect of the work as this can be a time of increased risk.

Relapse Prevention and Crisis Contingency Planning

Throughout a CRHTT contact, it is important to help people develop their understanding of how to respond in the event of further relapse or mental health crises to increase the likelihood of greater self-management. A good crisis plan should include information on relapse indicators, things that are helpful during a crisis, calming and soothing techniques, reasons for living, ideas for others about how to support them, people and services to call and places of safety in the event of immediate risk. Crisis and contingency plans should be shared with people involved in the individual's care, and the aim should be for everyone to leave with one (Stanley and Brown 2012).

Discussion

Given the increasing rates of suicide and the dearth of psychological intervention in CRHTT, there is an urgent need for a psychological model for working with people in crisis who present with significant risks. This above model provides a framework for one such approach which may also be applicable in other settings.

In the UK, CRHTTs work directly with people in crisis. By developing an easy understandable and focused framework for working with people in crisis across the acute care pathway, it is hoped that psychological intervention becomes more accessible in this setting. It also helps to move away from ad hoc use of interventions from other settings and towards a more structured acute care specific model.

It is within crisis theory that we find a potentially useful model. By focusing on crises, we are able to identify trans-diagnostic psychological processes which are associated with suicide and crisis more so than mental health diagnoses. Focusing on crises also provides a more manageable approach to intervention given the range of diagnostic presentations seen in this setting.

NHS services and psychological interventions are effective for both men and women. However, there is evidence that a gender sensitive approach is beneficial when working and engaging with both men and women. When working with men, it is important to recognise that this may be the first time they have had contact with services. Their journey into services may have been challenging, and they may have less awareness of the problems they have been experiencing. When men do access services, it is important that the experience is one which encourages help-seeking and reinforces this as a strength. It is also important to meet me where they are at in their psychological journey.

Some of the challenges when working with men include access to services for men, helping men to identify and understand their psychological problems, adapting interventions to fit where men are at in their emotional psychological journey, legitimising help-seeking, promoting social connectedness and promoting the acceptance of help.

Evaluating the efficacy and effectiveness of psychological interventions in this setting has always been challenging. There are often many different interventions happening alongside each other and working our which are causal factors is often not possible. Nevertheless, a challenge is just that and together we may be ready to take this on. The proposed model offers a point of reference for the development of psychological interventions in acute care and more specifically CRHTTs. The interventions are orientated towards the shared task of crisis resolution and risk reduction. Many aspects of the model are also deliverable by other members of the MDT under the direction of the psychologist.

By creating distance and safety from the problem, re-establishing cognitive effectiveness and identifying more effective and acceptable resolutions, people can create the best conditions to put themselves in the best possible place to get the best possible outcome from difficult and challenging circumstances. This does not mean loss and harm will not occur.

With 72% of suicides occurring outside of mental health services, and many of these people may not meeting the criteria for a mental health diagnosis or even identify with having mental health difficulties, translating this model to other at-risk groups could be helpful. This model may be applicable to other settings and is currently being translated into a self-help guide. This may be particularly important for populations who may find it difficult to mental health services, including men.

A consistent approach for intervening psychologically within acute care services would allow for a common language to be used that reinforces evidence-based practices that are applicable within this setting.

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