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A Systematic Review and Narrative Synthesis Examining the Facilitators and Barriers of Psychological Intervention Delivery in Crisis Resolution Home Treatment Teams

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ABSTRACT

Background: Mental health crisis rates in the United Kingdom are on the rise. The emergence of community mental health models, such as Crisis Resolution Home Treatment Teams (CRHTTs), offers a vital pathway to provide intensive assessment and treatment to individuals in their homes, including psychological interventions. Previous qualitative literature has identified facilitators and barriers to the implementation of psychological interventions within CRHTT settings; however, a synthesis of this literature has not yet been conducted. To address this gap, a systematic review was undertaken with the aim of identifying the reported facilitators and barriers of implementing evidence-based psychological interventions in CRHTTs.

Method: A systematic review and narrative synthesis were conducted. Studies were included if they examined the implementation of evidence-based psychological interventions in a CRHTT setting. The study population had to be 18 and over and could include healthcare professionals working in CRHTTs, service users of CRHTTs, or family and carers of CRHTT service users. Studies of any formal research methodology were included. Four databases were searched (MEDLINE, CINAHL Plus, Embase and PsycINFO), along with Google Scholar, to identify eligible studies.

Results: Six studies were identified, using mixed qualitative and quantitative methodologies, with the predominant focus being the exploration of stakeholder perspectives on care implementation within CRHTTs, encompassing aspects including but not restricted to psychological care implementation. The literature was deemed to be of moderate to high quality. Facilitators included adapting psychological therapies, prioritizing the therapeutic relationship, increasing psychological skills and training of CRHTT staff and psychologically informed CRHTT models. The barriers identified included a medical model bias within teams, resource constraints and elements pertaining to CRHTT services.

Conclusions: Further robust research in this area is imperative. We recommend that future research be implemented in the form of service evaluations and randomized controlled trials (RCTs) and that the principles of implementation science be used to assess and develop the evidence base for psychological intervention delivery in CRHTTs.

1 | Introduction

The evolving landscape of crisis support healthcare has witnessed significant transformations, marked by a heightened increase in community-based interventions and the reduction of hospital admissions over the last few decades (Crisp, Smith, and Nicholson 2016). In response to this shift, in 1999, the National Health Service (NHS) Framework for Mental Health

Summary

- Crisis Resolution Home Treatment Team (CRHTT) staff should be provided with training and supervision from psychological professionals on psychologically informed interventions to improve access and implementation.
- Psychological interventions delivered in CRHTTs should be delivered flexibly in order to meet the needs of patients in crisis and prioritize building a therapeutic relationship.
- Due to the limited research in this area, further research, service evaluation and quality improvement projects are required to develop the psychological interventions' evidence base in CRHTTs.

In England mandated the introduction of Crisis Resolution Home Treatment Teams (CRHTTs) throughout England (Department of Health 2001; Johnson 2013). In England, CRHTTs have emerged as vital conduits of intensive assessment and treatment to service users in their homes, who would otherwise be considered for hospitalization (Johnson 2013; NHS Digital 2019).

CRHTTs are an international model of care that emerged from the deinstitutionalization movement. Developed by Polak and Kirby (1976) in Colorado and Denver, these services favour 24-h home treatment and integration of hospital and community care for patients in crisis (Baumgardt et al. 2021; Polak and Kirby 1976; Wheeler et al. 2015). Despite regional variations, the CRHTT model includes 24/7 care, brief interventions (2–5 weeks), and a 'gatekeeping' function to provide home-based alternatives to hospitalization (HTAS 2022; Onyett et al. 2008).

CRHTTs use a multidisciplinary team within a community-based model, offering personalized, short-term interventions based on the biopsychosocial approach (Klevan, Karlsson, and Ruud 2017). These interventions include medical care, crisis planning, psychological and social support, practical assistance, relapse management and family involvement, all aimed at symptom management and crisis resolution (RCoP 2022).

The CRHTT model has been adopted in the United Kingdom and integrated into NHS policy (Minghella et al. 1998; Department of Health 2001). In Germany, guidelines recommend home treatment for severe mental illness, which is well-accepted by users (Gühne et al. 2019; Hubbeling and Smith 2022). Norway, Belgium and the United Kingdom incorporate CRHTTs into their national mental health policies (Johnson 2013). While CRHTTs are widely accepted globally, there is limited consensus on optimal service delivery (Lloyd-Evans and Johnson 2019). Service-level evaluation is needed to determine the best components and configurations for effective mental health crisis care (Lloyd-Evans and Johnson 2019).

Despite their significance, the performance of CRHTTs has revealed substantial gaps in adhering to best-practice guidelines in England. Variations in national service delivery, including psychological interventions, are documented, and UK CRHTTs have been reported as having low-moderate fidelity (Lloyd-Evans et al. 2016). Furthermore, this study found that the operation of CRHTTs was poorest in relation to providing rapid responses to referrals and frequent visits. Data from NHS Digital indicated a decline in contacts between CRHTT staff and service users, accentuating gaps in service provision.

The Quality Network CRHTT (QN-CRHTT 2022) recommends that all CRHTTs include psychological practitioners to offer evidence-based assessment and treatment to service users and their families. The duration of these interventions varies, typically lasting 4–5 weeks. Given the time constraints, interventions comprise short and select medium-term approaches (Royal College of Psychiatrists [RCP] 2022). The Royal College of Psychiatrists (Home Treatment Accreditation Scheme [HTAS] 2022), the British Psychological Society, and the Association of Clinical Psychologists (Ebrahim and Wilkinson 2021) endorse adapting evidence-based interventions to meet service users' needs, aligning with guidelines from the National Institute of Clinical Excellence (NICE). NICE guidelines recommend that psychological therapies should start in the acute phase (NICE 2014). HTAS (2022) emphasizes the importance of a diverse range of therapeutic approaches, including but not limited to cognitive-behavioural therapy, dialectical behavioural therapy, interpersonal psychotherapy, family intervention and relapse prevention.

Previous studies have identified several barriers and facilitators to implementing psychological therapies in community settings. Organizational barriers include insufficient management support and resource shortages (Berry and Haddock 2008; Ince, Haddock, and Tai 2016). Service user-related challenges involve difficulties in engagement due to distressing symptoms, overmedication and stigma (Berry and Haddock 2008; Ince, Haddock, and Tai 2016). Facilitators include educational workshops for staff, service user involvement and specialist clinical supervision (Berry and Haddock 2008).

In inpatient settings, primary barriers to implementing psychological therapies for people in crisis are the busy ward environment, insufficient training for multidisciplinary professionals and the acute nature of service users' mental health issues (Evlat, Wood, and Glover 2021). Key facilitators include adapting interventions, training multidisciplinary professionals, leadership support for therapy delivery and prioritizing therapeutic support over other interventions (Evlat, Wood, and Glover 2021). Although these reviews focus on community mental health and inpatient settings, their findings may also inform the delivery of psychological therapies in CRHTTs.

Previous qualitative studies have delved into the barriers and facilitators of implementing care within CRHTTs, including but not limited to psychological care. Individuals in crisis highly value CRHTTs for their accessibility to psychological interventions and highlight the importance of building therapeutic relationships in delivering these interventions (Hopkins and Niemiec 2007; Lyons et al. 2009; Morant et al. 2017; Wheeler et al. 2015). Nevertheless, certain challenges have gained prominence within the realm of implementing psychological therapies within CRHTTs, including

an overfocus on the medical model, causing psychological models to be neglected (Carpenter and Tracy 2015; Hopkins and Niemiec 2007). CRHTT staff members emphasize the complexities in committing to frequent, scheduled home treatment appointments for individuals in crisis. Competing demands posed by new referrals and the imperative for rapid response, while coping with resource restraints and staffing shortages, make the delivery of care, including psychological care, difficult within CRHTTs (Hasselberg et al. 2021; Morant et al. 2017).

No systematic review on psychological intervention implementation in CRHTTs exists to our knowledge. In light of the NHS long-term plan intention to expand CRHTT across every region in England (NHS 2019), the identification of facilitators and barriers to psychological intervention delivery in CRHTTs holds the potential to address challenges and improve outcomes for individuals offered care by CRHTTs.

This systematic review will investigate psychological intervention implementation in CRHTTs. The aims are as follows:

1. To identify the reported facilitators that promote the implementation of evidence-based psychological interventions in CRHTTs.

2. To identify the reported barriers of implementing evidence-based psychological interventions in CRHTTs.

2 | Methods

2.1 | Protocol and Registration

The present study undertook a systematic review and narrative synthesis adhering to the Preferred Reporting Items For Systematic Reviews and Meta-analysis (PRISMA) guidelines (Moher et al. 2009). A completed PRISMA checklist can be found in Table S1). The study protocol was pre-registered before the searches commenced (*CRD42023417291*).

2.2 | Eligibility Criteria

Studies were included if they (a) were conducted in a CRHTT setting; (b) included sample populations of 18 and above, healthcare professionals, key stakeholders or service users who had received care from the CRHTT in the past or present, irrespective of their diagnosis; (c) examined implementation and use of psychological interventions, based on psychological principles to alleviate mental health problems or to promote wellbeing as a primary component of the intervention (NICE 2014); (d) were of formal methodological research design, that is, qualitative or quantitative research methods; and (e) examined the facilitators and barriers of psychological interventions in CRHTTs.

Studies were excluded if they (a) were conducted in other crisis settings such as inpatient, psychiatric liaison, crisis cafes, assertive community treatment or any form of hospitalization; (b) did not follow an experimental or formal research methodology, that is, opinion pieces or commentaries; (c) sample did not have a primary mental health diagnosis, for example, a learning disability; and (d) did not directly example the facilitators and barriers of psychological interventions.

2.3 | Search Strategy

The search was conducted in June 2023, encompassing four electronic databases: MEDLINE, PsycINFO, CINAHL Plus, and Embase. These databases were selected to ensure a comprehensive search spanning across the disciplines of psychiatry, healthcare, community nursing and psychology.

To facilitate ease of data synthesis, research only published in English was included, while no restrictions were imposed on the publication date or study location due to the anticipation of limited research based on a preliminary search. The search terms were developed through an extensive literature review and discussions with three clinical psychologists who had experience of working in CRHTTs. Full details of the search terms used in four electronic databases can be found in Table S2.

Google Scholar was employed to identify relevant material pertaining to both concepts. Search terms related to Concept 1 and Concept 2 were entered, and Boolean operators were used to refine and combine the searches. The screening process involved an examination of the first five pages of Google Scholar to identify pertinent research.

2.4 | Data Extraction

Duplications were initially removed using Covidence automation, followed by a manual search for further deduplication. The screening of titles and abstracts from the four electronic databases was carefully performed by the primary author on the Covidence platform. To assess interrater reliability, a random 20% sample of articles underwent independent review by a second reviewer, resulting in an adequate interrater reliability score (Kappa = *0.93*). Any disagreements were judiciously resolved through discussion between the reviewers.

The primary author assessed the full-text articles based on the predefined inclusion and exclusion criteria. Additionally, reference lists of included full-text papers were searched to identify any other pertinent papers. To assess interrater reliability, a second reviewer screened 100% of the full-text articles achieving an adequate interrater reliability score (*Kappa = 0.98*). Any discrepancies were addressed through collaborative discussions among the reviewers.

Two independent reviewers extracted the key study characteristics into a predefined data extraction table, which included details of the author, year of publication, setting, sample, aims, methods, intervention and key findings. A predefined table was developed to extract codes from the data pertaining to the facilitators and barriers. Further detail about the extraction and coding process is in the synthesis section below.

2.5 | Quality Assessment

Mixed Methods Appraisal Tool (MMAT; Hong et al. 2018) was used to evaluate study quality. The MMAT employs two primary screening questions: one addresses the clarity of research objectives, while the other evaluates the appropriateness of the collected data in addressing the research question. This appraisal involved two independent researchers, each utilizing one of five tailored checklists corresponding to specific study methodologies: qualitative, quantitative, randomized control trials, quantitative nonrandomized control trials, quantitative descriptive studies and mixed-method designs. Each checklist comprises five criteria, rated as 'yes', 'cannot tell' or 'no'. Utilizing the MMAT (Hong et al. 2018), we assessed both the robustness and methodological quality of the included studies. We did not exclude low-quality studies as this is discouraged in the MMAT guidelines (Hong et al. 2018).

2.6 | Synthesis of Results

A narrative synthesis following the guidance of Popay et al. (2006) was conducted to comprehensively examine the facilitators and barriers related to the implementation of psychological interventions in CRHTTs. To ensure transparency in reporting, the review adhered to four key elements of a narrative synthesis.

A preliminary synthesis systematically tabulated identified studies based on key characteristics to facilitate cross-study comparisons. Following Braun and Clarke's (2006) thematic analysis guidance, a coding reliability analysis was performed on the results and discussion sections to identify facilitators and barriers. The primary author used an inductive, data-driven approach to extract and synthesize findings, involving immersion in the data through rereading the studies. Codes from the results and discussion sections were grouped into facilitators or barriers, represented by short phrases (e.g., 'medically oriented teams'). These codes were organized into descriptive themes, which were then synthesized across the six studies to develop overarching themes and subthemes capturing facilitators and barriers of delivering psychological interventions in CRHTTs.

3 | Results

3.1 | Study Selection

Following the deduplication of studies, a total of 2915 studies were screened at title and abstract against the eligibility criteria. This led to 2883 studies being excluded. Thirty-two studies were screened at full text, and 26 studies were excluded for not meeting the eligibility criteria (reasons listed in Figure 1). A list of the excluded studies can be found in Table S3. A total of six studies were included in the review. The study selection process is outlined in Figure 1.

3.2 | Study Characteristics

The review encompassed six studies. Two were mixed-method designs, which included quantitative components in the form of questionnaires and qualitative components in the form of semistructured interviews (Mulligan et al. 2022; Loftus 2020). One study used a survey with open-ended questions (Ebrahim 2022), and three utilized semistructured interviews, all analysed using a thematic analysis (Carpenter and Tracy 2015; Morant et al. 2017; Morris 2011). The diverse

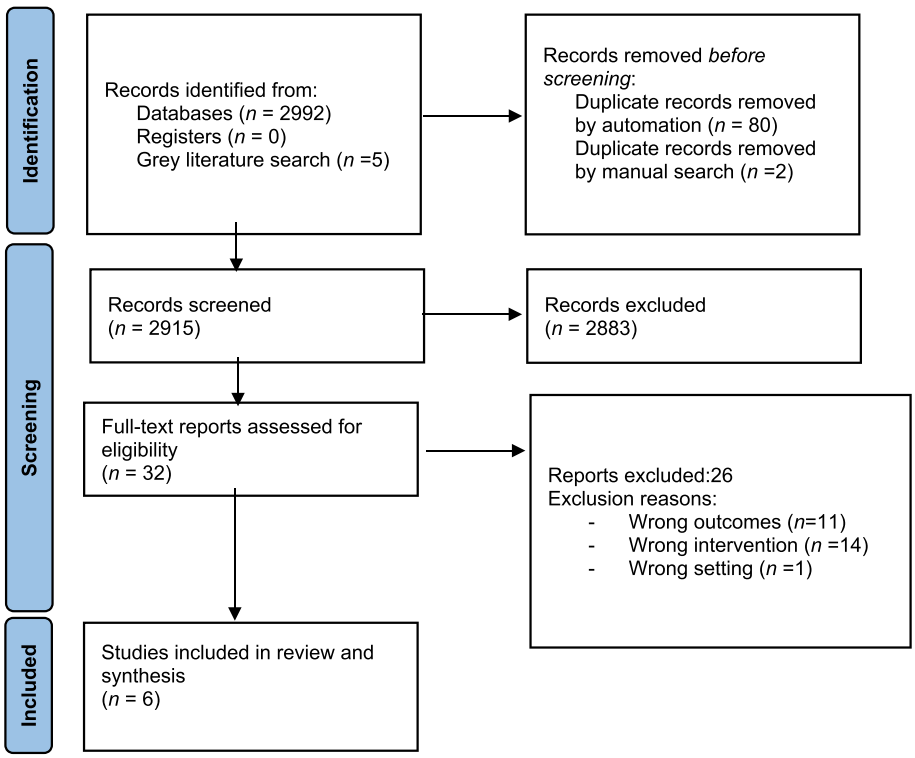

FIGURE 1 | PRISMA flowchart for study selection for systematic review.

studies pursued varying objectives, with the predominant focus being the exploration of stakeholder perspectives on care implementation within CRHTTs encompassing aspects including but not restricted to psychological care implementation (Carpenter and Tracy 2015; Ebrahim 2022; Loftus 2020; Morant et al. 2017; Morris 2011). Notably, one study aimed to assess an adapted psychological intervention tailored to a CRHTT during the COVID-19 pandemic (Mulligan et al. 2022). Key characteristics of these studies are summarized in Table 1.

3.3 | Quality Assessment

The six studies included in the synthesis were found to be of moderate-to-good methodological quality according to the MMAT (Hong et al. 2018). Regarding qualitative methods and data collection, four studies utilized semistructured interviews which were audio-recorded and transcribed verbatim. Findings were robustly derived from the collected data, and the interpretations of results were robustly substantiated by the available data. Furthermore, coherence between qualitative data sources, collection techniques and subsequent analysis and interpretation was evident across studies (Carpenter and Tracy 2015; Loftus 2020; Morant et al. 2017; Morris 2011). However, Mulligan et al. (2022) exhibited inadequacies in qualitative data collection methods, involving interviews conducted over the phone and transcribed by researchers during the call. Furthermore, this study received a 'no' rating in terms of effectively integrating the questionnaire and semistructured interview to address the research question. Five studies did not explicitly report under what theoretical framework was being used to guide the thematic analysis (Carpenter and Tracy 2015; Ebrahim 2022; Loftus 2020; Morant et al. 2017; Mulligan et al. 2022). Overall, the quality assessment was found to be of moderate to good methodological quality according to the MMAT. The individual MMAT ratings for each study can be found in Table S4.

3.4 | Facilitators and Barriers of the Implementation of Psychological Therapies in CRHTTs

The facilitators and barriers affecting the implementation of psychological therapies within CRHTTs are outlined in Table 2.

3.5 | Reported Facilitators to Implementing Psychological Therapies

The overarching facilitators identified in this synthesis include adapting psychological interventions, prioritizing therapeutic relationship, increasing psychological skill training and psychologically informed CRHTTs. Details of the themes identified from the studies are summarized in Table S5.

3.5.1 | Adapting Psychological Interventions

Five out of the six studies identified that adapting psychological interventions was effective in the implementation of psychological therapies in CRHTTs (Ebrahim 2022; Loftus 2020; Morant et al. 2017; Morris 2011; Mulligan et al. 2022). This involved tailoring the intervention to the service user's needs, conducting an in-depth crisis formulation and having the family involved in assessment and intervention.

Adapting the intervention to service users' needs was valued by the service user in addressing specific aspects of their crisis (Mulligan et al. 2022). Psychologists successfully did this by adapting psychological models such as cognitive-behavioural therapy, dialectical behavioural therapy and compassion-focused therapy, according to the formulation, which focused specifically on the crisis, to empower service users, help them problem solve and manage their distress relating to the crisis (Ebrahim 2022). Adapting the intervention length in duration and delivery mode was also argued to be a facilitator of successful psychological implementation. For example, delivering psychological interventions at a convenient time for the service user or via telephone was argued to aid the implementation of psychological therapies because it avoided disruption to daily life, a core aspect of the CRHTT model (Loftus 2020; Morant et al. 2017; Morris 2011; Mulligan et al. 2022).

Incorporating psychological perspectives in the initial formulation process for HTT care helps establish a shared understanding of the crisis with the service user (Ebrahim 2022; Morris 2011). This approach improves access to psychologically informed interventions, including individual, group and family interventions (Ebrahim 2022). Despite stakeholder advocacy, few service users report receiving psychological treatments in CRHTTs. However, those with psychological input during the initial HTT assessment are better able to access interventions, and psychologists can implement them more effectively (Morant et al. 2017; Morris 2011).

Family involvement in both assessment and intervention emerged as a critical factor in conducting assessments and in guiding or being involved in CRHTT interventions, including psychological interventions (Morant et al. 2017). Studies highlighted the importance of the social system model incorporated within CRHTTs by the family giving psychological support to the service user and being involved in family therapies, which may be overlooked in other crisis settings (Ebrahim 2022; Morant et al. 2017). Incorporating caregiver views throughout interventions was advised for successful implementation (Morris 2011). Yet, family involvement can hinder psychological intervention implementation, as one study highlighted confidentiality challenges when others were present in the house during home assessments and interventions (Morris 2011).

3.5.2 | Prioritizing Therapeutic Relationship

In five of the six studies, the therapeutic relationship was crucial for successful psychological therapies in CRHTTs (Carpenter and Tracy 2015; Loftus 2020; Morant et al. 2017; Morris 2011; Mulligan et al. 2022). Service users valued non-judgmental, actively listening psychologists who displayed genuine curiosity (Mulligan et al. 2022). Interpersonal skills such as approachability, receptiveness and friendliness fostered positive connections, aiding intervention delivery

TABLE 1 | Data extraction of selected studies.

Study (first author, year of publication and title)	Location and setting	Sample	Aims	Method	Intervention	Key findings
Acceptability of the 'Crisis Toolbox': a skills-based intervention delivered in a Crisis Resolution and Home Treatment Team during COVID-19. Mulligan. L 2022.	Greater Manchester, United Kingdom. CRHTTs.	*n* = 58 46.6% male 53.4% male CRHTT service users.	To evaluate client satisfaction of the CTB in CRHTTs during COVID-19.	Mixed methods approach, questionnaire and semistructured interview. Data analysed using thematic analysis.	'Crisis toolbox' a brief skill-based intervention based off psychological approaches including dialectical, cognitive and behavioural therapies.	Facilitators identified: Tailored interventions, therapeutic relationship. Barriers identified: Need for more sessions, lack of continuity of care.
Crisis resolution and home treatment: stakeholders' views on critical ingredients and implementation in England. Morant, N. 2017.	England, United Kingdom. 10 NHS trusts CRTTs covering metropolitan, mixed and rural areas.	*n* = 219 Service users = 31 Carers = 20 CRT staff, managers and referrers = 147 CRT international developers = 11	To investigate stakeholders' experiences and views of CRTs and understand what is important in good quality home-based crisis care.	Semistructured interviews and focus groups. Data analysed using thematic analysis.	Psychological interventions defined as assessing needs for further psychological input, guiding staff in using principles from CBT or family therapy.	Facilitators identified: Family involvement, therapeutic relationship and regular home visits. Barriers identified: Lack of continuity of care, medical-focused approach and resource restraints.
Home treatment teams: what should they do? A qualitative study of patient opinions, Journal of Mental Health. Carpenter. R. 2015.	Bromley Southeast London, United Kingdom. CRHTT.	*n* = 10 4 male 10 female CRHTT service users.	To investigate opinions of HTT service users on the care they received to guide future research and service provision.	13-item semistructured interview schedule. Data analysed using thematic analysis.	Crisis care including evidence-based psychological interventions.	Facilitators identified: Therapeutic relationship, interpersonal skills of psychologist. Barriers identified: Resource restrictions, overfocus on the here and now and time restrictions when delivering psychological interventions.

(Continues)

TABLE 1 | (Continued)

Study (first author, year of publication and title)	Location and setting	Sample	Aims	Method	Intervention	Key findings
A grounded theory study of the experiences of clinical psychologists working in crisis resolution and home treatment teams. Morris N. 2011.	England and Wales. CRHTTs.	$n = 11$ Clinical psychologists.	To understand clinical psychologists' individual experiences of working in CRHTTs and their perceptions of working with service users in crisis.	Semistructured interviews. Data analysed using thematic analysis and a grounded theory approach.	Care provided in crisis including evidence-based psychological interventions.	Facilitators identified: Brief interventions, psychological flexibility, formulation approach, psychological supervision, recovery promotion, adapting and integrating psychological models and promoting psychological thinking in teams. Barriers identified: Medical focused approach, demands of working in crisis, setting limitations and time restrictions when delivering therapies.
An evaluation of staff views on the provision of psychological services in Intensive Home Based Treatment Teams within Kirklees and Calderdale. Loftus. L. 2020.	Southwest Yorkshire. Kirklees and Calderdale. England. Home-based treatment team.	$n = 30$ Nurses, medics and healthcare support workers.	To develop an understanding of staff perceptions of psychological services in intensive home-based treatment teams.	Mixed methods design including a short online questionnaire open to all staff and two focus groups with representation of staff from each CRHTT.	Range of evidence-based psychological services provided by intensive home treatment team.	Facilitators identified: Psychologist flexibility, formulation approach and therapeutic relationship. Barriers identified: Resource restrictions, brief psychological intervention concerns, over-focus on medical model and ambiguity of the role of psychologists.

(Continues)

TABLE 1 | (Continued)

Study (first author, year of publication and title)	Location and setting	Sample	Aims	Method	Intervention	Key findings
Psychologists' perspectives on the contribution of psychology to acute adult mental health inpatient, crisis response home treatment and mental health liaison services. Ebrahim, S. 2022.	England, Wales and Northern Ireland, United Kingdom. CRHTTs, inpatient services and mental health liaison services.	$n = 49$ CHRTT psychologists	Psychologists' perspectives on the contribution of psychology to acute adult mental health inpatient, crisis response home treatment and mental health liaison.	Open-ended questionnaire-based survey.	Psychological services offered in CRHTTs.	Facilitators identified: Formulation approach, various psychological interventions for patient management. Barriers identified: Increased need for psychological skills in the workforce, limited psychological resources, overemphasis on the medical model, practical and emotional demands of the work, lack of access to psychological informed understanding and treatment and need for more service evaluation.

Abbreviations: CBT, cognitive-behavioural therapy; CRHTT, Crisis Resolution Home Treatment Team; CRT, crisis resolution team; CTB, crisis toolbox; HTT; home treatment team; NHS; National Health Service.

(Carpenter and Tracy 2015; Loftus 2020; Morant et al. 2017). Trusting relationships helped service users feel less isolated and more understood (Morant et al. 2017). Given the short intervention period, establishing a strong therapeutic relationship quickly was vital (Morris 2011).

Furthermore, psychologists who were reliable by being consistent in their communication and showed adherence to schedules were vital in building positive psychologist–service user relationships. Flexibility of the psychologist was valued, particularly, the availability of the psychologists' visiting hours, and availability outside of working hours was valued by the wider CRHTT team (Loftus 2020). The psychologist's willingness to employ a wide range of psychological models was identified as a facilitator in delivering effective psychological support and encouraged engagement for people in crisis (Morant et al. 2017; Morris 2011).

3.5.3 | Increasing Psychological Skills and Training

Shared psychological skills and increased training among CRHTT staff emerged as facilitators in five of the six studies (Ebrahim 2022; Loftus 2020; Morant et al. 2017; Morris 2011; Mulligan et al. 2022). Shared understanding and skills increased confidence in implementing psychological interventions (Ebrahim 2022; Loftus 2020; Morant et al. 2017). Practitioners emphasized the importance of education on the social system model and psychological practices for successful care implementation (Morant et al. 2017). Understanding the benefits of psychological input within crisis care could increase its implementation (Ebrahim 2022).

Methods to enhance psychological skills included increased supervision from psychologists and training for all staff. Supervision helped staff incorporate psychological care in complex cases and supported service user experiences (Ebrahim 2022; Morris 2011). Training enhanced intervention delivery and holistic care (Loftus 2020; Morris 2011). Increasing psychological skills and thinking among CRHTT staff improved accessibility to psychological perspectives and interventions (Ebrahim 2022; Morris 2011; Mulligan et al. 2022). Training on formulation, trauma and psychosis promoted psychological ways of working and better implementing interventions (Ebrahim 2022).

3.5.4 | Psychologically Informed CRHTT Models

Three of the six studies highlighted CRHTT service model elements aiding psychological intervention implementation (Morant et al. 2017; Morris 2011; Ebrahim 2022). A recovery-based model, including psychological care, was highly valued for engagement and reassurance (Morant et al. 2017; Morris 2011). This model involved staff being hopeful, nonstigmatizing and forward-looking, which empowered service users and promoted hope through prevention strategies and crisis planning (Morant et al. 2017; Morris 2011).

There is a need for increased service evaluations in CRHTTs, particularly for psychological interventions (Ebrahim 2022). Ebrahim (2022) noted that evaluations in other acute services showed positive outcomes in reducing distress and mental health issues. Increased evaluations ensure that CRHTT interventions are psychologically informed and evidence-based. Rigorous evaluation would help implement interventions more widely within teams by embedding organizational and staff support changes, improving recovery outcomes and service satisfaction and reducing inpatient treatment and iatrogenic harm (Ebrahim 2022).

3.6 | Reported Barriers to Implementing Psychological Therapies

The overarching barriers identified in this synthesis include the medical model bias, resource restraints and service coordination.

3.6.1 | Medical Model Bias

Five out of the six studies indicated a prevailing emphasis on the medical model within CRHTTs, constraining the integration of

TABLE 2 | Summary of the facilitators and barriers to delivering psychological therapies in Crisis Resolution Home Treatment Teams.

Facilitators	Barriers
Adapting psychological therapies	Medical model bias
Tailoring the intervention to service users' needs	Medically orientated teams
In-depth psychological assessment of the crisis	Lack of psychologically informed ways of working and treatment integration
Family involvement in assessment and intervention	
Prioritizing therapeutic relationship	
Interpersonal skills	Resource restraints
Reliability of the psychologist	Psychological professional staffing issues
Psychologists' flexibility to adapt	
Increasing psychological skills and training	Limited capacity to deliver psychological therapies
Team understanding of psychological models and treatments	
Increased clinical supervision for staff	Limited availability of psychological models
Increased psychological training among multidisciplinary staff team	
Psychologically informed CRHTTs	CRHTT service coordination
Regular visits from psychologists	Lack of continuity of care
Promoting the recovery model	Referral barriers
Increasing service evaluation	

psychological models in treatment (Carpenter and Tracy 2015; Ebrahim 2022; Loftus 2020; Morant et al. 2017; Morris 2011). CRHTTs were reported to predominately adopt a medical orientation, with professionals prioritizing medical interventions and assessment during crises, in turn, neglecting psychological interventions (Morris 2011). The focus on medical strategies, such as medication administration in CRHTTs, meant that other forms of support were excluded, thereby hindering discussions about social and psychological dimensions of the crisis with the service user (Carpenter and Tracy 2015; Morant et al. 2017). In turn, this creates obstacles for psychological interventions to be implemented within CRHTTs, because the medical model dominates understanding of mental health problems in crisis and guides clinical decision-making (Ebrahim 2022; Loftus 2020).

3.6.2 | Resource Restraints

All studies included in the review cited resource limitations as an obstacle to effective implementation of psychological interventions within CRHTTs (Carpenter and Tracy 2015; Ebrahim 2022; Loftus 2020; Morant et al. 2017; Morris 2011; Mulligan et al. 2022). This encompasses psychology-orientated staffing issues, limited time to deliver psychological interventions and limited use of varying psychological models.

Limited protected time to deliver psychological interventions was a challenge in maintaining fidelity to psychological interventions due to staffing constraints. This resulted in a reduced number of sessions offered (Mulligan et al. 2022). Moreover, the studies in the review highlighted the dearth of psychologically orientated staff within CRHTTs, stressing the necessity to increase the number of psychologists to effectively enhance psychological intervention implementation to ensure their availability to deliver within CRHTTs (Ebrahim 2022; Loftus 2020).

The scarcity of psychological professionals within CRHTTs yields interconnected repercussions for intervention quality, duration and frequency. Morant et al. (2017) noted that professionals offer brief interventions due to staffing limitations, resulting in shorter and less frequent delivery of psychological interventions. Additionally, the paucity of staff correlates with delays in delivering psychological interventions to service users in the first instance (Ebrahim 2022).

The absence of interventions like occupational therapy and psychotherapeutic interventions in CRHTTs, despite their appropriateness for service users, was highlighted (Carpenter and Tracy 2015). The authors suggested adapting these therapies for CRHTTs, noting that dynamic interpersonal therapy adapted to four condensed sessions led by nurses in inpatient units reduced self-harm and suicidal thoughts and increased patients' ability to recognize and manage interpersonal issues causing psychological distress (Carpenter and Tracy 2015; Guthrie et al. 2001). Similar adaptations were recommended for effectively implementing evidence-based psychological interventions in CRHTTs (Carpenter and Tracy 2015).

3.6.3 | Service Coordination

The final barrier pertained to the elements of CRHTT services which hinder the effective implementation of psychological interventions, as cited by four out of the six studies. This includes lack of continuity of care and the challenges in referrals to CRHTTs (Carpenter and Tracy 2015; Loftus 2020; Morant et al. 2017; Mulligan et al. 2022).

Lack of continuity of care was highlighted as being a substantial barrier to effective psychological intervention implementation. Lack of continuity refers to the suboptimal psychological care provision upon completing psychological interventions, for example, through lack of forward planning, lack of relapse prevention or poor communication and collaboration with other mental health services (Carpenter and Tracy 2015; Morant et al. 2017). Lack of continuity of care was reported as leaving service users uneasy, and some expressed dissatisfaction over the absence of additional psychological interventions from CRHTTs (Mulligan et al. 2022). The mismatch between psychological input and the availability of continued psychological support created unmanaged expectations for service users in CRHTTs (Carpenter and Tracy 2015; Mulligan et al. 2022).

Another barrier was inappropriate referrals to the CRHTT psychologist from wider services, such as emergency departments, due to a lack of communication and uncertainty of the role of the psychologist within CRHTTs. This resulted in delays in referring and referral approval, thus impeding the delivery of psychological interventions within CRHTTs (Loftus 2020; Morant et al. 2017).

4 | Discussion

This systematic review aimed to examine the facilitators and barriers to implementing psychological interventions within CRHTTs. The review identified six studies reporting on qualitative reports of psychological implementation within CRHTTs. The narrative analysis identified four facilitators and three barriers for the implementation of psychological interventions.

The narrative analysis identified adapting psychological interventions as a facilitator to psychological intervention delivery in CRHTTs (Ebrahim 2022; Loftus 2020; Morant et al. 2017; Morris 2011; Mulligan et al. 2022). Previous literature has highlighted the importance of adaptable staff who tailor psychological interventions to individual service user needs for effective implementation in inpatient and community crisis settings (Evlat, Wood, and Glover 2021; Ince, Haddock, and Tai 2016).

In CRHTTs, service users highly value psychologists' interpersonal skills, reliability, integrity and adaptability for effective intervention delivery. Establishing therapeutic relationships is crucial due to the short-term care model, similar to other crisis settings (Evlat, Wood, and Glover 2021; Ince, Haddock, and Tai 2016). This review emphasizes forming therapeutic relationships with both service users and their families, unlike typical individual interventions like cognitive-behavioural therapy (Ebrahim 2022; Morant et al. 2017; Morris 2011). The

social system model provides ongoing support throughout the intervention and at discharge. Incorporating family perspectives in crisis assessment enhances the effectiveness of home-based interventions, often overlooked in other settings (Morant et al. 2017; Morris 2011). HTAS (2022) recommends considering the impact of social systems on mental health symptoms and involving the family in discussions and decisions regarding care, addressing their psychological needs individually.

Effective integration of psychological interventions in CRHTTs hinges on staff's psychological understanding and skills, acquired through training and supervision (Ebrahim 2022; Loftus 2020; Morant et al. 2017; Morris 2011; Mulligan et al. 2022). This aligns with previous research in inpatient and community crisis settings, emphasizing the importance of comprehensive training and proficiency in psychological skills for successful intervention implementation (Evlat, Wood, and Glover 2021; Ince, Haddock, and Tai 2016). This training approach is also beneficial in inpatient crisis contexts delivering psychosocial interventions (Raphael et al. 2021). The importance of psychological training and psychologists undertaking indirect work such as supervision of staff delivering therapies is highlighted in the HTAS (2022).

Uniquely, fostering psychologically oriented teams has been recognized as a strategy to counteract the medical model bias observed in CRHTT services, which can hinder the incorporation of psychological approaches (Carpenter and Tracy 2015; Ebrahim 2022; Loftus 2020; Morant et al. 2017; Morris 2011). Given the pervasive influence of medical models in clinical decision-making, assessment and treatment observed in the reviewed literature, enhancing the psychological skillset and acknowledging the value of psychological interventions through training and supervision appear particularly relevant in CRHTTs compared to other crisis contexts. HTAS (2022) best-practice guidelines recommend providing CRHTT staff with training in psychological concepts, including family and social system intervention, and psychologically informed approaches to addressing self-injurious or suicidal behaviours.

Service coordination such as promoting the recovery model and implementation of crisis-planning interventions and evaluating such interventions was highlighted as facilitators in implementing psychological interventions in CRHTTs (Ebrahim 2022; Morant et al. 2017; Morris 2011). Due to psychological intervention research in CRHTTs being historically neglected, service evaluations were suggested to expand the implementation of evidence-based psychological interventions across teams, benefitting recovery outcomes and service satisfaction, and potentially reducing inpatient treatment and unintended harm (Ebrahim 2022). HTAS (2022) further emphasizes the importance of conducting regular audits to ensure the CRHTT model's consistent provision of care, including psychological interventions, around the clock, 7 days a week, to ensure appropriate implementation.

Similar to this review, previous reviews in inpatient and community crisis settings have also identified resource limitations such as understaffing and lack of protected time to deliver therapies as barriers to delivering psychological interventions (Evlat, Wood, and Glover 2021; Ince, Haddock, and Tai 2016). To address these challenges, ACP (2021) recommends allocating protected time for intervention delivery within acute pathways, establishing accountability mechanisms and providing leadership support for intervention implementation.

Inadequate service coordination leads to unmet expectations for psychological care in CRHTTs (Carpenter and Tracy 2015; Morant et al. 2017; Mulligan et al. 2022). Best-practice guidance recommends establishing locally agreed-upon acute pathways to ensure care continuity, encompassing coordination with primary care, emergency departments, community teams and inpatient care. Enhanced access to health records for broader care services can improve communication and streamline referral processes (HTAS 2022).

4.1 | Strengths and Limitations

This review has several strengths. It adhered rigorously to PRISMA guidelines (Liberati et al. 2009), with transparent preregistration and adherence to the PROSPERO protocol, enhancing its methodological rigour. By integrating qualitative and mixed-method studies, it effectively explored nuanced barriers and facilitators of psychological implementation within CRHTTs. The inclusion of forward searching and comprehensive searches of grey literature reduced the risk of publication bias, providing a well-rounded evidence base (Paez 2017). Additionally, the included studies had moderate to good MMAT ratings, indicating adequate quality.

However, there are limitations. The search was confined to English, potentially overlooking relevant research from non-English speaking countries where CRHTT models are used, such as Belgium and the Netherlands. This limitation reduces the generalizability and diversity of the findings, possibly missing cultural and contextual influences on psychological therapy delivery in CRHTTs (Neimann Rasmussen and Montgomery 2018).

Moreover, the review included data on CRHTT service delivery broadly, which might obscure specific details on psychological intervention implementation resulting in underreporting of psychological interventions due to ambiguity in the included articles. The literature did not explore specific nuances of the facilitators and barriers in CRHTTs, such as the unique challenges of referrals, factors enabling robust therapeutic relationships and why resource constraints are significant barriers. With only six studies identified, further research is needed to fully investigate these factors.

The quality of the studies ranged from moderate to high according to MMAT criteria (Hong et al. 2018). However, most qualitative studies lacked reporting on reflexivity and the frameworks used for thematic analyses. The reliability of this review depends on the integrity of the primary data, and potential researcher bias may be present.

4.2 | Clinical Practice Implications

This review provides essential guidance for clinicians delivering psychological interventions in CRHTTs. Establishing a

strong therapeutic relationship quickly is crucial due to the brief 3–5 week intervention period (Middleton et al. 2011; Morant et al. 2017). Adaptability and tailoring interventions to patient preferences are pivotal (QN-CRHTT 2022). However, the reviewed studies do not delve into the specific nuances of the identified facilitators and barriers, such as how to best engage family and carers in assessment and intervention in CRHTTs. Future research should explore these nuances to better inform clinical practice.

A key clinical implication is integrating psychological skills and training for CRHTT staff. Supervision and training help transfer psychological skills to nonpsychological staff, improving the handling of complex cases. HTAS (2022) recommends training in psychosocial, family and social system interventions and competence in approaches like cognitive-behavioural therapy. Enhanced psychological proficiency boosts intervention confidence. Additionally, integrating psychological skills across staff can address barriers such as limited resources and medical model bias, promoting effective implementation of psychological interventions (Ebrahim 2022).

This review introduces a unique perspective with significant implications for future service evaluations within CRHTTs. The guidance from HTAS (2022) and QN-CRHTT (2022) aligns with the NHS long-term plan for optimal practices (NHS 2019). The majority of UK CRHTTs have been reported as having low-moderate fidelity highlighting disparities in national service delivery (Lloyd-Evans et al. 2016). To ensure proper alignment of psychological intervention implementations with guidance and intended service models, we propose the integration of service evaluations and audits, as highlighted in this review (Ebrahim 2022). This integration can involve using pre- and postoutcome measures to assess the adherence of implementation of psychological interventions according to guidance.

In the absence of robust RCT evidence, we recommend using service evaluations to address referral challenges, enhance CRHTT visibility and clarify the role of psychological interventions (Rosen and Salvador-Carulla 2022). These evaluations help identify successful implementation areas and areas needing improvement. Conducting evaluations at local, regional and national levels is essential for standardizing psychological intervention implementation across the country (Lloyd-Evans et al. 2018), thereby mitigating geographical disparities in access and equity to these services, known as 'post-code lottery' (Cunningham and Galloway 2019).

4.3 | Research Implications

With only six identified studies in this review, the need for further research in this area becomes evident, especially as no studies, except Mulligan et al. (2022), exclusively address psychological intervention implementation in CRHTTs. Given the limited research landscape, we emphasize the importance of forthcoming investigations guided by implementation science principles (Wilson and Kislov 2022).

For comprehensive evaluation, adopting clustered RCT methodologies is recommended. This approach can effectively assess various dimensions of CRHTTs' contributions to implementing psychological interventions, including resource allocation, staffing ratios and crisis-adapted interventions. This aligns with implementation science's framework, ensuring effective and sustainable integration of psychological interventions into CRHTTs (Wilson and Kislov 2022), which in future can allow CRHTTs to be analysed using an implementation framework.

Additionally, the included studies did not report participant ethnicities. Ethnic minority groups often face health inequalities and barriers to accessing psychological therapies (Memon et al. 2016). Future research should prioritize diverse participant samples and provide demographic details to identify barriers or enablers specific to ethnic minorities in implementing psychological interventions within CRHTTs (NHS 2019).

5 | Conclusion

In conclusion, the literature reveals that barriers to effective psychological implementation in CRHTTs include the medical model bias, limited resources and referral barriers alongside lack of continuity of care. This review recommends fostering quick therapeutic alliances and tailoring psychological therapies according to crisis contexts. Significantly, addressing several barriers can be achieved through increased service evaluations to improve the implementation of psychological interventions into CRHTT care. Subsequent research should prioritize further investigation of delivery of psychological therapies using RCTs and implementation science principles.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.