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RESEARCH ARTICLE

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Single-session Comprehend, Cope, and Connect intervention in acute and crisis psychology: A feasibility and acceptability study

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Abstract

Comprehend, Cope, and Connect (CCC) is a third-wave cognitive behavioural approach developed for acute mental health services. The aim of this study was to assess feasibility and acceptability of a newly developed, manualized single-session CCC intervention delivered face-to-face with service users in acute and crisis psychology services in South London. The study adopted a within-subjects pre-post-test design. Participants (N = 23) were recruited from five acute psychiatric wards and a crisis resolution home treatment team. Service users had a range of diagnoses of complex and severe mental health conditions, in particular mood, personality, and psychotic disorders. Feasibility data were gathered for number of times the CCC formulation was accepted, duration of CCC intervention, clinician adherence to manualised protocol, and frequency of goal-based activity completion. Acceptability data on pre- and post-CCC mood and post-CCC helpfulness were self-reported by participants. Findings indicated a significant increase in positive mood (large effect) and moderate–high helpfulness rating postintervention. Most participants reported goal-based activity completion. There was high fidelity to the protocol, high percentage of acceptance of the formulation and formulation components completed, and frequent single-session completion. Single-session CCC appears feasible and acceptable in acute and crisis psychology services and yields formulation-driven goal-based activities intended to stabilize mental health crisis. High fidelity to formulation protocol suggests broader applications for single-session CCC, for example, to support clinical staff to manage crisis situations in their work environment or to train nonpsychologist clinicians to deliver the intervention for service users. A randomized controlled trial of single-session CCC would increase validity and generalisability of findings.

KEYWORDS

cognitive behavioural therapies, mental health crisis, personality disorders, psychological formulation, psychological interventions, psychosis

1 | INTRODUCTION

Mental health crisis occurs when stressors impact an individual's ability to maintain psychological equilibrium (Everly & Lating, 2019). Crisis is thought to comprise three features: disturbance of psychological homeostasis, functional impairment, and reduced capacity to apply established means of coping (Flannery & Everly, 2000). Resolution of crisis is understood to occur naturally within weeks following onset of crisis (Cavaiola & Colford, 2018), and durations of stay in crisis services are therefore typically brief. Average length of stay in adult acute wards, for example, was reported to be 31 days in the United Kingdom between 2017 and 2018 (National Health Service [NHS] Benchmarking Network, 2018). Crisis services are consequently tasked with delivering brief, intensive support for individuals experiencing acute distress (Glover & Johnson, 2008). Hoult and Nolan (2008) suggest that this brevity affects the capacity with which psychological intervention can be designed and carried out in acute settings, as direct individual work typically spans only a limited number of sessions.

Aguilera (1998) suggests two levels of crisis intervention. The first involves a process of relieving symptoms to foster equilibrium, considering immediate precipitants to crisis, and encouraging access to support from others. The second level of intervention is then developing a shared understanding of crisis progression and acquiring further coping skills. A similar two-level approach is put forward by Brimblecombe (2001) who suggests the primary task—when risk is high—is to use core therapeutic competencies to allow the person to voice their distress. For Brimblecombe, the secondary task is then to explore key stressors and develop strategies that enhance capacity to cope. Such early interpersonal and intrapersonal experiences have been shown to improve subsequent intervention outcomes, irrespective of motivational incongruence (Gmeinwieser, Hagmayer, Pieh, & Probst, 2019).

National standards do not endorse specific psychological models to implement for individuals in crisis (Division of Clinical Psychology, 2008; NHS England, 2019a; NICE, 2009). However, exploring psychological causality during crisis is thought necessary for compassionate systems of psychological care (Kennedy, 2009). Subsequent increases in insight can improve efficacy of future intervention (de Jong et al., 2019). Traditional assessment and formulation methods, however, present a challenge in crisis services; they require individuals to provide detailed histories when this might exacerbate disequilibrium (Clarke, 2009).

Clarke (2009) developed a cross-diagnostic, emotion-focused model to be coherent enough to "penetrate a state of panic and confusion" (p.68) and sufficiently valid that individuals can comprehend their situation. The method represents a central aspect of the Comprehend, Cope, and Connect (CCC) approach (Clarke, 1999). In its entirety, it entails four individual formulation sessions followed by a 12-session group course (Clarke & Nicholls, 2018). CCC's theoretical underpinnings originate in Teasdale and Barnard's (1993) Interacting Cognitive Subsystems model. The model proposes nine subsystems, where two central meaning making systems, the Propositional ("Reasonable Mind" in Dialectical Behaviour Therapy [DBT] terms) and the Implicational ("Emotion Mind" in DBT terms), share overall control. At high or low arousal, the emotional, Implicational subsystem takes over, in connection with the body's threat system. At such times, past threat becomes added to current adversity, as the context giving influence of the Propositional is unavailable. This can set up vicious cycles where threat and stress take over, leading to emotional distress (Barnard, 2004). CCC integrates third-wave CBT approaches—including DBT, Compassion-Focused Therapy, and Acceptance and Commitment Therapy (Gilbert, 2005; Hayes, Strosahl, & Wilson, 1999; Linehan, 1993)—to meet the demands of this disequilibrium. The clinician's aim with CCC is to work collaboratively to provide service users with space to express emotional experience, build a comprehensible understanding of crisis progression (including the impact of past trauma on current difficulties), and to identify means to break maintaining cycles and enhance self-efficacy.

There is emerging evidence for CCC for people with diagnoses of complex and severe mental health conditions in acute settings. Durrant, Clarke, Tolland, and Wilson (2007) found significant increases in self-efficacy and internal locus of control and improvements in emotional expression using CCC in an acute setting. Nearly two thirds of participants achieved one of the goals identified in formulation. Duration of intervention was mostly one individual session and one-to-two group contacts (Clarke & Nicholls, 2018). The study was subject to several challenges due to the setting, for example, unpredictable and sudden discharge from service, which resulted in a small sample (N = 14; Durrant & Tolland, 2009). Araci and Clarke (2016) found high feasibility for CCC, significant decrease in distress, and significant increase in confidence in self-management in four acute psychologically informed environments, with a larger sample (N = 141). Paterson et al. (2018) found positive outcomes for self-efficacy and distress using CCC. However, both Durrant et al. (2007) and Paterson et al. (2018) highlight challenges in collecting data in acute settings,

Key Practitioner Message

- Clinicians were able to adhere to a newly developed, manualized approach for single-session Comprehend, Cope, and Connect.
- Single-session Comprehend, Cope, and Connect appears helpful to service users in acute and crisis psychology services and yields formulation-driven, goal-based activities intended to stabilize mental health crisis.
- Findings indicate potential for psychologists to train multidisciplinary staff in single-session Comprehend, Cope, and Connect to expand the available provision of psychological input to acute and crisis services.

including discharge of participants from services and difficulty contacting participants for follow-up.

This study developed and evaluated an adapted CCC intervention that could be delivered in a single session that included assessment, formulation, and intervention. This adaptation was developed to meet the demands of the acute services in which the study was based, in particular the brief contacts with service users. The study aimed to assess feasibility and acceptability of single-session CCC.

2 | METHODS

2.1 | Design

The study adopted a within-subjects pre-post-test design. Quantitative data were gathered to evaluate feasibility and acceptability. The study was approved by the South London and Maudsley NHS Foundation Trust, London.

2.2 | Participants

Participants were recruited from two crisis services in South London: an acute inpatient psychology service and a crisis resolution home treatment team (CRHT). The acute inpatient psychology service provided input to five acute psychiatric wards (two female, two male, and one male Psychiatric Intensive Care Unit) with an average number of 16 service users per ward (range 10–20). CRHT had, on average, a caseload of 34 service users (range 25–44 over 6 months prior to data collection). Single-session CCC was the routine offer for all psychology referrals in both services and adhered to the cross-diagnostic approach endorsed by Clarke (2015).

2.3 | Procedure

Facilitators were trained in CCC by IC. An adapted single-session CCC intervention was developed and manualised by SR, JB, and CW in consultation with IC. Although designed for a single session, the intervention could span several sessions based on individual need. Single-session CCC was delivered face-to-face by a clinical psychologist, a trainee clinical psychologist, or a senior assistant psychologist. It comprised a process of identifying eight components: (1) the "horrible feeling" (the distressing or disturbing felt experience that prompts the individual's behaviour), (2) triggers (event or set of circumstances that contributed to worsening of horrible feeling), (3) vulnerability factors (difficult past experiences that contributed to worsening of the horrible feeling), (4) containing factors (personal strengths, social supports, skills, and abilities that mitigate effects of difficult experiences), (5) maintenance cycles (detailed behavioural analyses of unhelpful responses), (6) cycle breaks (potential point at which each maintaining cycle can be broken), (7) specific, measurable, achievable, realistic, time-limited (SMART) goals (ways in which individual can and would like to break maintaining cycles), and (8) goal-based activities (activities selected to move towards achieving identified goals).

Facilitators drew the CCC model with pen and paper in the session, in collaboration with participants. The session began by identifying the horrible feeling, which was written in the centre of the model with a jagged shape drawn around it (the "spikey diagram"). Above the horrible feeling, triggers were written and above that vulnerability factors, with both boxed-off to indicate events held in the past and arrowed to indicate how they were potentially causally implicated in the development of the feeling. The model was surrounded at the top by a "strengths bow," which listed containing factors and wider connections. The final stage of developing the model with the participant was identifying maintenance cycles—depicted by drawn arrows leading from the horrible feeling to response, reinforcer, and consequence(s), then back to the horrible feeling. For example, a horrible feeling of "grief" might have induced a behaviour, such as substance misuse, from the participant. This may have provided an initial relief—or reinforcer (e.g., forgetting)—but over time may have produced unintended consequences, which led to a worsening of grief. Or, to give another example, a behaviour, such as avoiding social situations, might have stemmed from a horrible feeling of "anxiety" about social situations. Avoidance may have provided initial relief, by removing the feared stimulus, but then led to an unintended consequence (e.g., isolation), which may in turn increase the feeling of social anxiety. Cycle breaks were then identified and depicted on the model by a line breaking through the section of the vicious cycle at which the cycle could be broken. Finally, a goal-based activity was identified, for example, reducing substance misuse or graded exposure to social situations, and participants were invited to carry out this activity in their own time after the session. DBT coping skills, such as self-soothing or distraction techniques, were also commonly suggested activities that aimed to achieve intended goals.

2.4 | Measures

2.4.1 | Feasibility

Feasibility was measured by number of times offer of CCC session was accepted relative to number of times offered, number of sessions taken to complete formulation, duration of session, adherence to session checklist, and whether the formulation was completed collaboratively—a central tenet of CCC. The clinician protocol (Figure 1) provided a checklist of session components to which facilitators aimed to adhere. A follow-up session was organized, or a phone call made, to establish whether the individual was able to complete the goal-based activity. Follow-up data were collected to determine whether participants were able to complete the goal-based activity and how many days there were between formulation and follow-up (relative to a 7-day follow-up target).

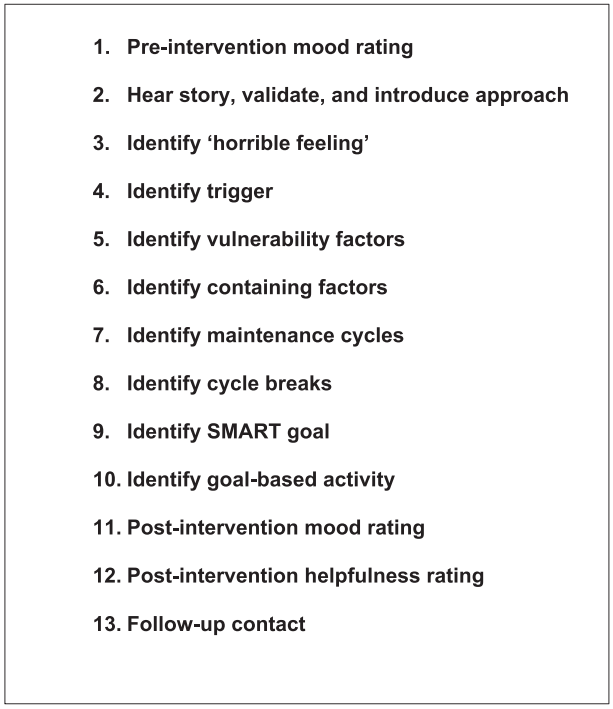

FIGURE 1 Clinician protocol for single-session Comprehend, Cope, and Connect evaluation

2.4.2 | Acceptability

Acceptability was measured with presession and postsession mood ratings, from 0 (*most negative mood*) to 10 (*most positive mood*), and postsession helpfulness ratings, from 0 (*not helpful*) to 10 (*extremely helpful*), as self-reported by participants. Mood ratings were used in a precautionary way to ensure that the approach did not have a marked detrimental effect on mood, rather than with the aim of having a positive effect.

2.5 | Service user review

The CCC protocol and study design was reviewed by two service user panels. Suggestions from these consultations included ensuring participants were informed of the nature of the study, were given the option of declining to participate, were informed of the evaluation, and that a decision to decline CCC would not detrimentally impact access to treatment or services. The study adhered to all recommendations.

2.6 | Analysis

Data from both services were pooled in the analysis. Microsoft Excel was used for analysis of descriptive statistics and IBM SPSS Version 24 for inferential statistics. Feasibility was evaluated for the whole sample by reporting mean number of components completed, mean number of each component completed, and completion frequency of goal-based activities. Acceptability was evaluated by comparing mean (*SD*) mood rating presession and postsession (within-group) and reporting mean helpfulness rating postsession. A Wilcoxon signed-rank test (Wilcoxon, 1945) was used due to assumption violation to compare preformulation and postformulation mood ratings. Effect size was calculated using the test's *z* score and reported as a Pearson's correlation coefficient.

3 | RESULTS

3.1 | Sample characteristics

Twenty-three participants were included in this study. Thirteen participants were from four acute inpatient wards, and 10 were from CRHT. Nine (39.1%) participants were female. Half of participants were White British, and a quarter Black/Black British. Participants had a range of diagnoses of complex and severe mental health conditions, in particular mood, personality, and psychotic disorders. Table 1 reports participant demographic characteristics.

3.2 | Feasibility

Twenty-two out of 23 participants (95.5%) engaged in the CCC session when offered. When accepted, it was completed in a single session (81.8%) of the time and in two sessions (9.1%) of the time. Two participants did not complete the formulation (9.1%). Average duration of session was 64.5 min (*SD* 16.9). Formulation was completed collaboratively in 100% of cases. Number and percentage of components completed are displayed in Table 2. Components (1–3) "Horrible feeling," "triggers," and "vulnerability factors" were completed in every session. Component (6) "cycle-break" was completed least frequently but still had a high completion rate (73.9%). Follow-up contact was attempted for 20 participants (87%) but was not attempted if participants were discharged before completion or if a participant declined. Follow-up attempts were successful for 14 (70%) participants. Reasons for unsuccessful follow-up included participants being discharged from the service, participants disengaging with the service, and participants being unavailable at the time of scheduled follow-up (all $N = 2$; 33.3%). Of those participants able to be contacted for follow-up, nine completed their goal-based activity (64.2%). The average number of days between formulation and follow-up was 6.9 (SD 3.1).

3.3 | Acceptability

Preformulation and postformulation mood ratings were collected for 19 participants (82.6%). Participants reported a significant increase in mood preformulation (Mdn 5, range 0–9) to postformulation (Mdn 7, range 2.5–9), $z = -3.22$, $p = .001$, $r = -.52$. Mean (*SD*, range)

TABLE 1 Demographic characteristics of participants

Demographics	Frequency*n* (%)
Age (M, *SD*)	33.3 (11.1)
Gender	
Female	9 (39.1)
Male	14 (60.9)
Ethnicity	
Asian/Asian British	3 (13.0)
Black/Black British	6 (26.1)
Middle Eastern	1 (4.3)
Other	1 (4.3)
White/White British	12 (52.2)
ICD-10 Block	
F10-F19 Mental and behavioural disorders due to psychoactive substance use	1 (4.3)
F20-F29 Schizophrenia, schizotypal, and delusional disorders	4 (17.4)
F30-F39 Mood (affective) disorders	7 (30.4)
F40-F48 Neurotic, stress-related, and somatoform disorders	1 (4.3)
F60-F69 Disorders of adult personality and behaviour	6 (26.1)
F99 Unspecified mental disorder	4 (17.4)
Primary diagnosis	
Anxiety disorders	1 (4.3)
Bipolar affective disorders	1 (4.3)
Depression disorders	6 (26.1)
Depression disorders with psychotic features	1 (4.3)
Dissocial personality disorder	1 (4.3)
Emotionally unstable personality disorder	5 (21.7)
Not specified	1 (4.3)
Paranoid personality disorder	1 (4.3)
Psychotic disorders	6 (26.1)

TABLE 2 Fidelity to components of single-session Comprehend, Cope, and Connect intervention

Session component	Frequency*n* (%)[a]
1. Horrible feeling	22 (95.7)
2. Triggers	22 (95.7)
3. Vulnerability factors	22 (95.7)
4. Containing factors	20 (87.0)
5. Maintenance cycle	20 (87.0)
6. Cycle break	17 (73.9)
7. SMART goal	19 (82.6)
8. Goal-based activity	18 (78.3)
Total completed over all sessions	160 (87.0)

[a]Number of sessions in which component was delivered.

postformulation helpfulness rating (*n* = 19; 82.6%) was 7.8 (1.8, 4–10). Of those missing paired mood ratings, two had neither preformulation nor postformulation mood ratings (8.7%), one had preformulation only (4.3%), and one postformulation only (4.3%).

4 | DISCUSSION

This study aimed to assess feasibility and acceptability of single-session CCC for service users in acute and crisis services. The findings indicate that single-session CCC is both feasible and acceptable to service users in acute and crisis settings. There was a significant increase in positive mood and high helpfulness rating post-CCC. The intervention had high uptake rates, high fidelity, and high completion rates and was collaborative. The sample size of this study compares favourably with both Durrant et al. (2007) and Paterson et al. (2018) who reported fewer participants completing formulation (*N* = 14 and 16, respectively). The high uptake rate suggests that participants were willing to engage in CCC, supporting Kennedy's (2009) observation that individuals experiencing crisis seek psychological formulation. The high completion rate differs from the approach detailed in Clarke and Nicholls (2018; four sessions) and the median number of formulation sessions reported in Paterson et al. (2018; 3.5 sessions). High levels of component completion, however, suggest having fewer sessions did not adversely impact feasibility. Neither did the single-session structure appear to impede collaboration. However, lower completion rates for the latter part of the intervention might indicate increased fatigue as the session progressed for some participants or possibly be a by-product of chaotic environments in which sessions were undertaken (e.g., on acute wards).

Increases in positive mood seen in the current study can be compared with observed reductions of distress reported in previous evaluations (Araci & Clarke, 2016; Paterson et al., 2018). These evaluations used the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) to measure distress. Decreases in mean CORE-OM score reported in Araci and Clarke (2016) were of a similarly large effect size to the mean increase in mood indicated by this study. Only subjective mood change was measured in the current study, however, and therefore comparisons with changes in level of distress should be treated with caution.

The current study found marginally higher goal-based activity completion rates than Durrant et al. (2007), who reported 57.2% of participants meeting at least one goal completely. These similarly modest success rates might reflect the impact of functional impairment observed during crisis when emotional distress is highest (Flannery & Everly, 2000).

4.1 | Strengths and limitations

Strengths of the study include the development of a manualised single-session intervention, collaboration and input from people with lived experience, the naturalistic setting, which allowed for increased

ecological validity, and the feasibility and effectiveness of the intervention in managing crisis in people with diagnoses of complex and severe mental health conditions. Limitations include lack of a control group, lack of formal measures, and a relatively small sample size, which limits the capacity for findings to be generalized but also demonstrates the complexity of collecting data in crisis services. Lack of control group means that reported effects cannot be attributed conclusively to the intervention in comparison with treatment as usual. Further research would be required to investigate such differences. Given power differentials in acute mental health services (Cappleman, Bamford, Dixon, & Thomas, 2015), self-reported mood and helpfulness ratings may have been subject to response bias. This may have overinflated helpfulness ratings or improvements in mood post-formulation. However, this would have been mitigated by clinicians, asserting that participation would not affect care.

4.2 | Clinical applications

Development and training of multidisciplinary staff is an important agenda for the NHS (NHS England, 2019b; NHS England & National Collaborating Centre for Mental Health, 2019). High fidelity to formulation protocol suggests that nonpsychologist clinicians, such as nurses and support workers, could be trained to undertake single-session CCC in acute and crisis settings. As an individual intervention, goal-based activity completion could be aided by assigning ward staff or care coordinators to support service users, both on the ward and for when service users are discharged. Common goals identified in session, for example, mindfulness practice and increased self-compassion, are well-suited to ward-based group programmes, increasing psychology provision across inpatient services. Team case formulation is another important psychological intervention in acute and crisis services (Berry et al., 2016), and CCC might inform a shared emotion-focused understanding of distress. The approach may also have applications for supporting frontline clinical staff who are working in crisis situations, such as those working under heightened stress during the COVID-19 pandemic.

4.3 | Future research

Future research might evaluate single-session CCC in a randomized controlled trial with a larger sample of service users, which would improve generalisability of findings and reduce likelihood of assumption violation. A control group would increase the validity of findings, and an increased sample size could facilitate further analyses, such as comparison of model feasibility and acceptability between diagnostic categories and between inpatient or outpatient settings. Such designs could allow exploration of the impact of single-session CCC on care or discharge planning and at follow-up. Qualitative research would be valuable in gaining a richer understanding of the impact of CCC in crisis services from both service user and staff perspectives. There is also potential to investigate use of the intervention to support staff who might be experiencing crisis in their clinical work. It would be beneficial also to explore how single-session CCC formulation can be incorporated at the multidisciplinary team level in acute services—particularly in evaluation of risk—and in other acute services where unhelpful maintaining cycles inhibit service user motivation for change, for example, psychiatric liaison services.

4.4 | Conclusions

This study indicates that single-session CCC is feasible and acceptable in acute and crisis psychology services and highlights potential for psychologists to train multidisciplinary staff in the intervention to expand the available provision of psychological input to acute and crisis services.

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CONFLICTS OF INTEREST

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

DATA AVAILABILITY STATEMENT

Data unavailable due to privacy/ethical restrictions.

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REFERENCES

Aguilera, D. C. (1998). *Crisis intervention: Theory and methodology* (8th ed.). St Louis: Mosby.

Araci, D., & Clarke, I. (2016). Investigating the efficacy of a whole team, psychologically informed, acute mental health service approach. *Journal of Mental Health*, *26*, 307–311. https://doi.org/10.3109/09638237.2016.1139065

Barnard, P. J. (2004). Bridging between basic theory and clinical practice. *Behaviour Research and Therapy*, *42*, 977–1000. https://doi.org/10.1016/j.brat.2004.04.002

Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, C. (2016). Feasibility of a ward-based psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*, *55*, 236–225. https://doi.org/10.1111/bjc.12082

Brimblecombe, N. (2001). Intensive home treatment for individuals with suicidal ideation. In N. Brimblecombe (Ed.), *Acute mental health care in the community: Intensive home treatment* (pp. 122–138). London: Whurr Publishers.

Cappleman, R., Bamford, Z., Dixon, C., & Thomas, H. (2015). Experiences of ward rounds among in-patients on an acute mental health ward: A

qualitative exploration. *BJPsych Bulletin*, *39*, 233–236. https://doi.org/10.1192/pb.bp.113.046409

Cavaiola, A. A., & Colford, J. E. (2018). *Crisis intervention: A practical guide*. Thousand Oaks, CA: Sage Publications.

Clarke, I. (1999). Cognitive therapy and serious mental illness: An interacting cognitive subsystems approach. *Clinical Psychology & Psychotherapy*, *6*, 375–383. https://doi.org/10.1002/(SICI)1099-0879(199911)6:5<375::AID-CPP216>3.0.CO;2-C

Clarke, I. (2009). Pioneering a cross-diagnostic approach founded in cognitive science. In I. Clarke & H. Wilson (Eds.), *Cognitive behaviour therapy for acute inpatient mental health units: Working with clients, staff, and the milieu* (pp. 65–76). Hove: Routledge.

Clarke, I. (2015). The emotion focused formulation approach: Bridging individual and team formulation. *Clinical Psychology Forum*, *275*, 28–33. Retrieved from. https://www.researchgate.net/publication/289505197_The_Emotion_Focused_Formulation_approach_Bridging_individual_and_team_formulation

Clarke, I., & Nicholls, H. (2018). *Third wave CBT integration for individuals and teams: Comprehend, cope and connect*. Oxford: Routledge. https://doi.org/10.4324/9781315281292

de Jong, S., Hasson-Ohayon, I., van Donkersgoed, R. J., Timmerman, M. E., van der Gaag, M., Aleman, A., … Lysaker, P. H. (2019). Predicting therapy success from the outset: The moderating effect of insight into the illness on metacognitive psychotherapy outcome among persons with schizophrenia. *Clinical Psychology & Psychotherapy*, *26*, 650–660. https://doi.org/10.1002/cpp.2388

Division of Clinical Psychology. (2008). Briefing paper no 30: The role of psychologists working in crisis resolution home treatment teams. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Divisions/DCP/The%20role%20of%20psychologists%20in%20Crisis%20Resolution%20Home%20Treatment%20%28CRHT%29%20Teams.pdf

Durrant, C., Clarke, I., Tolland, A., & Wilson, H. (2007). Designing a CBT service for an acute in-patient setting: A pilot evaluation study. *Clinical Psychology & Psychotherapy*, *14*, 117–125. https://doi.org/10.1002/cpp.516

Durrant, C., & Tolland, A. (2009). Evaluating short-term CBT in an acute adult inpatient unit. In I. Clarke & H. Wilson (Eds.), *Cognitive behaviour therapy for acute inpatient mental health units: Working with clients, staff and the milieu* (pp. 185–196). Hove: Routledge.

Everly, G. S., & Lating, J. M. (2019). Crisis intervention and psychological first aid. In G. S. Everly & J. M. Lating (Eds.), *A clinical guide to the treatment of the human stress response* (pp. 213–225). New York, NY: Springer. https://doi.org/10.1007/978-1-4939-9098-6_10

Flannery, R. B., & Everly, G. S. (2000). Crisis intervention: A review. *International Journal of Emergency Mental Health*, *2*(2), 119–125. Retrieved from. https://ncbi.nlm.nih.gov/pubmed/11232174

Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. London: Routledge. https://doi.org/10.4324/9780203003459

Glover, G., & Johnson, S. (2008). The crisis resolution team model: Recent developments and dissemination. In S. Johnson, J. Needle, J. P. Bindman, & G. Thornicroft (Eds.), *Crisis resolution and home treatment in mental health* (pp. 23–34). New York: Cambridge University Press. https://doi.org/10.1017/CBO9780511543906.004

Gmeinwieser, S., Hagmayer, Y., Pieh, C., & Probst, T. (2019). General change mechanisms in the early treatment phase and their associations with the outcome of cognitive behavioural therapy in patients with different levels of motivational incongruence. *Clinical Psychology & Psychotherapy*, *26*, 550–561. https://doi.org/10.1002/cpp.2381

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hoult, J., & Nolan, F. (2008). Symptom management. In S. Johnson, J. Needle, J. P. Bindman, & G. Thornicroft (Eds.), *Crisis resolution and home treatment in mental health* (pp. 121–136). New York: Cambridge University Press. https://doi.org/10.1017/CBO9780511543906.011

Kennedy, F. (2009). The use of formulation in inpatient settings. In I. Clarke & H. Wilson (Eds.), *Cognitive behaviour therapy for acute inpatient mental health units: Working with clients, staff, and the milieu* (pp. 39–62). Hove: Routledge.

Linehan, M. (1993). *Cognitive-behavioural treatment of borderline personality disorder*. New York: Guilford Press.

NHS Benchmarking Network. (2018). 2018 mental health project: Results published. Retrieved from https://www.nhsbenchmarking.nhs.uk/news/2018-mental-health-project-results-published-read-our-news-piece-for-the-highlights

NHS England. (2019a). Crisis and acute care for adults. Retrieved from https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/

NHS England. (2019b). The NHS long term plan. Retrieved from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

NHS England & National Collaborating Centre for Mental Health. (2019). The community mental health framework for adults and older adults. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

NICE. (2009). Depression in adults: Recognition and management. Retrieved from https://www.nice.org.uk/guidance/cg90

Paterson, C., Karatzias, T., Harper, S., Dougall, N., Dickson, A., & Hutton, P. (2018). A feasibility study of a cross-diagnostic, CBT-based psychological intervention for acute mental health inpatients: Results, challenges, and methodological implications. *British Journal of Clinical Psychology*, *58*, 211–230. https://doi.org/10.1111/bjc.12209

Teasdale, J. D., & Barnard, P. J. (1993). *Affect, cognition and change: Remodelling depressive thought*. Hove: Lawrence Erlbaum Associates.

Wilcoxon, F. (1945). Individual comparisons by ranking methods. *Biometrics Bulletin*, *1*, 80–83. https://doi.org/10.2307/3001968

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