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Experiences of a Community Crisis Intervention Service

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ABSTRACT

This qualitative study explores the experiences of persons who utilised a community crisis intervention service (CCIS) whilst in emotional distress. An anonymised database provided a quantitative overview of all service users profiles. Interpretive Description was used to analyse interviews from five service users about their experience(s) of the CCIS. Findings from the overall client database are reported in terms of gender, proportion of self-referrals ($n=102$ of 187) and proportion requiring no other de-escalation services at that point ($n=117$ of 187). Within the qualitative interviews, three themes evolved: (1) a more appropriate setting than the ED, (2) states of suicidal crisis; risk factors and fluctuations and (3) unmet needs. The non-clinical setting and the utility of the intervention in de-escalating states of crisis were valued. Findings are discussed in terms of the delivery of crisis intervention services, with emphasis on early identification and effective management through brief interventions in community settings.

This article explores the experiences of persons who availed of a community crisis intervention service (CCIS) whilst in emotional distress. Crisis intervention is an important part of suicide prevention. States of suicidal crisis can fluctuate, and it is possible to prevent suicidal behaviours (Zalsman et al., 2016). Efforts must focus on early intervention before crises such as a suicide attempt or self-harm incident occur (Department of Health Northern Ireland, 2019).

Much crisis intervention happens in Emergency departments (EDs) (Betz et al., 2016; McCabe et al., 2018). The health records of those who had died by suicide were compared with those of an age and sex matched control group (O'Neill et al., 2019b). Results showed an ED attendance within the previous 3 months and a recent hospital admission as predictors of death by suicide (O'Neill et al., 2019b). The ED offers opportunities for implementing suicide prevention initiatives, but it requires investment and comes with challenges (Betz et al., 2016; McCabe et al., 2018). Considerations around suicide prevention initiatives include evidence-based content and how this aligns with delivery setting and outreach.

Brief psychological interventions are best practice in reducing suicide and suicide attempts (McCabe et al., 2018). As they currently are, the majority of EDs are not the best setting for suicide prevention initiatives (Betz et al., 2016). Those in suicidal crisis do not positively evaluate their experiences in the ED (Harris et al., 2016). "Emergency rooms are cold and clinical", "They talk to you like you're a crazy person", and "You get put away against your will" were the themes identified from qualitative interviews about user's experiences within the ED (Harris et al., 2016). Likewise, ED staff also perceive the setting as inappropriate for meeting the need of those with mental illness or emotional crises.

Descriptions such as challenging, instilling fear and anger are typically used to describe such patients (Clarke et al., 2014). Levels of self-efficacy in suicide assessment and management are below average among nurses in the ED (Maina et al., 2019).

The patient experience is an important index of health care quality (Coulter, 2017). It predicts outcomes such as intent to return for care, promptness in seeking help on future occasions, adherence to treatment and quality of life (Zendjidjian et al., 2014). This is particularly important in the context of crisis intervention, where early engagement by the client themselves is a core component of positive outcomes (Department of Health Northern Ireland, 2019). Contrary to reports from ED settings, preliminary findings suggest that suicide prevention initiatives in community-based crisis intervention services are perceived as helpful and non-judgemental (Shattell et al., 2014).

Suicide prevention initiatives must also consider their outreach (Department of Health Northern Ireland, 2019). They need to extend beyond formal mental health services to consider all individuals as opposed to just high-risk groups (Department of Health Northern Ireland, 2019). Mental illness, self-harm behaviours and prior suicide attempts are all strong risk factors for suicidal behaviours (Franklin et al., 2017; O'Connor & Nock, 2014; O'Neill & O'Connor, 2020). However, only one in five of those who died by suicide (18.2% and 23.9% for males and females respectively) had presented to either primary care (the General Practitioner), secondary care (outpatient mental health treatments) or tertiary care (psychiatric inpatient care) in the 2 weeks prior to their death (O'Neill et al., 2014). Suicidal behaviours are also associated with life events

(Franklin et al., 2017; O'Connor & Nock, 2014; O'Neill et al., 2016; O'Neill & O'Connor, 2020) and area level factors including deprivation (Department of Health Northern Ireland, 2019).

Qualitative approaches play an important role in developing our understanding of behaviours such as suicide and self-harm (Alexander et al., 2018). The objective of this article is to examine the experiences of individuals who found themselves in a state of suicidal crisis and used a community crisis intervention service (CCIS). This pilot Community Crisis Intervention Service (CCIS) opened in January 2019, with this evaluation being undertaken in November 2019. Those in need can self-refer by directly phoning the service themselves, or be directed via certain public, community, voluntary or statutory services (e.g. search and rescue teams or the police service), all of whom have been briefed about the service and referral pathway. With an open referral pathway from these partners, the facility provides a place of safety for those distressed and in crisis and provides a welcoming space for users. Key beneficial features of the service are; (1) a non-clinical environment (individual rooms wherein clients can engage in de-escalation interventions), (2) accessible to all – physically and geographically (an urban setting in Northern Ireland covering a large urban and rural catchment area), and (3) specialist and non-specialist support provided by community workers and counsellors trained in de-escalation interventions. On average, participants' engagements with the CCIS on their first visit tend to be between 90 minutes and 4 hours in duration.

In line with best practice, CCIS interventions consist of (1) an initial brief assessment and triage (including a needs assessment and risk assessment), (2) de-escalation through evidence-based STORM (Skills-based Training on Risk Management) or ASIST (Applied Suicide Intervention Skills Training) interventions, (3) stabilisation through identification of further supports and interventions to target the underlying problems, and (4) onward signposting to sources of help to address the underlying issues. The service is based in a non-clinical environment in a geographically accessible location. Service users can either self-present or be referred. In addition to in-depth interviews with a subsample, a description of the overall profile of all service users will also be provided.

Methodology

Recruitment and participants

Details of all services users are collected by CCIS, with an anonymised version of this provided to the research team for descriptive purposes. For the qualitative interviews, CCIS staff informed all service users (18 years old plus) of the research, and passed the contact details of those who were interested to the research team. Table 1 shows details of the participants.

Design and analysis

Semi structured interviews were conducted at CCIS premises (November 2019). These focused on general experiences of the visit and aftercare, and also recommendations for service improvement. The research was approved by the ethics committee of the host academic institution. Consent was written. All interviews were digitally audio-recorded, transcribed verbatim and anonymised.

Analysis was through Interpretive Description (ID) (Thorne et al., 2004). This methodology has been used by other researchers (Digel Vandyk et al., 2018). It is an appropriate methodology in settings where researchers are interested in both individual variations and themes in the experiences of topics related to the delivery of health care and practice (Thorne et al., 2004). The main emphasis of ID is to understand what is happening, challenging preliminary interpretations and seeking to understand the constructed truths within the data (Thorne et al., 2004).

Thorne et al. (2004) see several stages within ID. In the initial stage of beginning the analytic process, the researchers must move beyond the self-evident. This “earliest analytic stage has to do with recognizing the nature and shape of the preliminary theoretical scaffolding that has been used to construct the study, and gradually taking distance from it as alternative conceptual emphases and intrigues arise” (Thorne et al., 2004). In this earliest analysis stage began with each of the researchers independently reading the transcripts several times to obtain a general sense of the whole experience (Thorne et al., 2004). Of relevance to this, both researchers recognised their professional backgrounds which are academic/research based. Both researchers are

Table 1. Service-user interview participants.

Pseudonym	Age (yrs)	Access route	No of previous visits	
Derek	60–64	Referred	3+	Physical health difficulties, mental health difficulties and suicidal behaviours in family members, diagnosed and medicated mental health difficulties, long standing suicidal ideation and planning, availed of mental health services
Frank	45–49	Referred	0	Diagnosed mental health difficulty and medicated, availed of hospital previously but not specialised mental health services, some crisis situations had involved PSNI, suicidal thoughts
Peter	35–39	Referred	0	Previous mental health difficulties and use of mental health services, use of alcohol and illegal substances, intoxicated, not actively suicidal
Cathy	18–24	Self-referred	4+	Medication for diagnosed mental health difficulty and safety plan in place, had previous inpatient admissions.
Crystal	18–24	Referred	0	Traumatic event (undisclosed to family prior to CCIS visit), no mental health diagnosis, intoxicated at time of visit, no prior service use, guided by family, engaged with primary care and counselling after

independent of the CCIS and neither work in any applied settings. It is felt that this allowed the team to hear the actual experience of engaging with the CCIS, as opposed to holding preconceptions of what how engagement with the service is expected to be.

The second stage involves “Enacting the analytic process: Engaging the mechanisms of interpretation” (Thorne et al., 2004). Here, “the mechanics of interpretation, therefore, depend far less on coding, sorting and organizing than they do on the processes of intellectual inquiry. The researcher constantly explores such questions as: Why is this here? Why not something else? And what does it mean?” Therefore, the researchers identified and recorded patterns of experiences (Thorne et al., 2004). Patterns were then combined and catalogued into themes and subthemes (Thorne et al., 2004). Initial coding was conducted independently at first and subsequently over the course of five, 1- to 2-hour meetings, codes and theme development were refined, debated, interrogated, and finalized.

The final stage involves “Concluding the analytic process: Envisioning the research product” (Thorne et al., 2004). This process has several stages. Firstly, “patterns and themes within the data are ordered into a story, or a professional narrative, in order that we might make sense of the most important ideas to be conveyed” (Thorne et al., 2004). In other words, the results and discussion of the research article are written. However, in addition to this, “issues of rigor and credibility become an important consideration in the creation of an interpretive description product” (Thorne et al., 2004). It is about the researchers ensuring the trustworthiness of the findings. For example, to reduce bias, each of the researchers maintained notes concerning their processes of coding and refining. Participants were offered the opportunity to review their transcripts, but none availed of this. Similarly, limitations of design were reviewed and some are outlined in the discussion section. Of course, there is always the issue that these are people who have received help, either through self-referral to the CCIS or being referred. The journey may be very different for those individuals who for whatever reason do not receive help to manage their suicidal thoughts and behaviours.

Findings

Qualitative analysis

Participants’ experiences were expressed using three themes: (i) a more appropriate setting than the ED, (ii) states of suicidal crisis; risk factors and fluctuations, and (iii) unmet needs (Figure 1).

A More appropriate setting than the ED

Clients considered their experiences in the CCIS setting as more appropriate to their needs rather than the ED. This was discussed in terms of both the setting of the CCIS and the service providers within it. Several unique benefits of the service were noted. The CCIS was viewed as discreet, warm

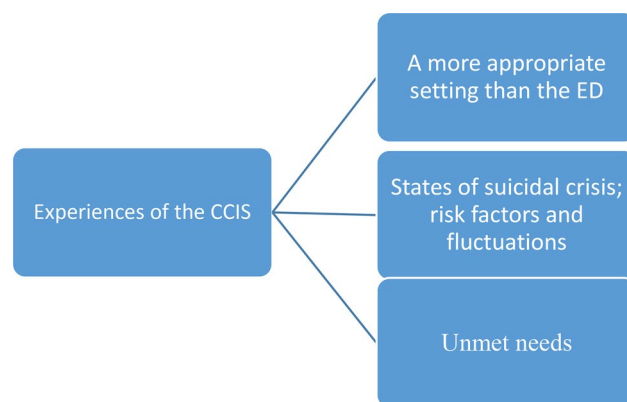


Figure 1. Thematic diagram of study findings.

and non-clinical. The interventions were perceived as successful in de-escalating states of crisis. Over and above this, they were also considered impactful in developing more adaptive coping methods to reduce the likelihood of any further harmful behaviour. These opinions were contrasted with adverse experiences or expectations in an ED setting. The ED brought connotations such as drama, fear, stigma and long waiting times. This was considered as something which may serve to exacerbate a crisis situation rather than resolve it. Interactions with the CCIS staff made clients feel at ease and were noted as key elements of the success of the intervention. The use of lay language was an important component within this. Other welcomed elements included the provision of a cup of tea and a blanket for warmth, as well as the space to speak at their own pace with no time restrictions. From these features, participants perceived the approach of the staff as gentle, respectful and compassionate.

You don't want to go into hospital – it's not a pleasant place to be. (Frank)

I think if I wasn't brought here then I probably would have went back to [specific location noted] and I probably would have killed myself. (Crystal)

They came up with this plan, a safety plan. I did keep it for a while, it's probably in my other coat. They just went through lists of all the things, what to do, what makes you, what do you like to do that improves your thoughts. (Derek)

You know when you know you can trust somebody, he's [reference to CCIS staff member] got a [swear word] lovely energy about him place that you can go that doesn't involved the police, doctors anything that's going to mess up your career or life. (Peter)

States of suicidal crisis; risk factors and fluctuations

The participants defined what placed them at heightened states of suicidal behaviours. Their background difficulties ranged from chronic mental health diagnoses to more acute situational crises. All participants reported difficulties in managing their respective problems and most admitted to adopting poor coping strategies. Some reported using alcohol and recreational drugs at their time of crisis, while others disclosed engaging in dangerous behaviour such as driving

to piers and repeatedly walking along a river as a “cry for help.” Participants varied in terms of whether or not they had an intention to die at the time of their crisis. They reported fluctuations in their intent to die across different time periods. They were also aware of the possibility of them engaging in impulsive suicidal behaviour. As a protective strategy, participants recognised the importance of early help seeking. They discussed the CCIS as a service where they felt comfortable to seek help at an early enough point to prevent a situation from escalating to the point where there is self-injury and the need for hospital care. All of the participants said that they benefited from attending the CCIS. However, guilt and embarrassment were expressed among some who felt that by needing a service such as the CCIS, they were being a burden. Participants also felt a sense of burden in discussing their problems with their family.

I was [experience of a traumatic event noted]... that was my main problem, my drinking. That was trying to forget about it and like I took up. I would have smoked a lot of grass and stuff to try and chill myself out and then that's not good either because my head was all over the place. (Crystal)

So I was like [swear word]!... I'm not [reference to method of completion of death by suicide]. (Peter)

Definitely not, I would never think about taking my life....my friends and people I know have killed themselves and I've seen first hand how it affects the family but then one night I wasn't thinking about it. (Crystal)

I said, I'll ring them [CCIS].... I had to talk to someone and I knew I was wobbling I don't know what would have happened if it [CCIS] hadn't have been here because although I say I won't jump in the river, you never know an impulse. (Derek)

My mental health was bad and I was suffering with suicidal thoughts. So I came here to get help. (Cathy)

You can let a problem build up in your head and it just engulfs you I hadn't known about it before but I just know from my point of view there's times in the past that I ended up in hospital that maybe if I had been able to avail of something like this at an earlier stage it mightn't have got to hospital stage you know.... timing is very important factor in all this. (Frank)

I'd find it easier to talk to people I don't know. What I'm talking to you about I wouldn't say usually to family or friends. (Derek)

Unmet needs

Service-user participants were predominantly very satisfied with the service they received at the CCIS. However, some suggestions for improvement were put forward. These included extended opening hours and greater awareness of the service. Participants noted that there were no specific patterns to times when crisis situations developed. They suggested that the CCIS could evolve to include an adjunct drop-in clinic during the week as a means of preventing personal levels of risk from escalating. If service opening hours were extended, this might allow the incorporation of aftercare.

Alright, they say statistically Thursday, Friday and Saturday is the most likely time and that's mostly the impulse people who had a fight or kicked out or taken the wrong drugs and they

just go do something stupid and if that's mostly likely to happen on the weekend—but there's other days of the week—it's not exclusive to weekends. (Derek)

Aftercare for service usersI think that would be amazing. (Peter)

Of the five individuals who were interviewed, only one had heard of the service before they had been brought there. The one individual who did had contact with a related organisation, who informed them about the service. The interviewees commented on the need for greater awareness about the “middle” tier service existing which can be directly accessed through self-referral.

I think their biggest challenge is awareness. (Frank)

Discreetly—that's the word. A discreet service—but how do you do that and get the word out there at the same time....I'd never heard of it and it's weird because you want to tell people about it but you don't want someone asking – how do you know about it? (Peter)

Quantitative overview of all service users

In the 11-month period from the opening of the service in January to the 30th November 2019, the CCIS had 187 service users. These were 98 males (52.4%), 88 females (47.1%) and one transgender individual (0.5%). Numbers of service users were 16 in January, 8 in February, 14 in March, 9 in April, 22 in May, 22 in June, 14 in July, 19 in August, 15 in September, 20 in October and 28 in November. In terms of access routes, of the 187 service users, 102 came to the service themselves or via their family or a member of the community. This holds for both males ($n=44$) and females ($n=58$). Foyle Search and Rescue (FSR) brought 57 individuals (34 males and 23 females) to the service and the Police Service of Northern Ireland (PSNI) brought 18 individuals (15 males and three females). The referral rates from other voluntary and community groups was very low (four males and two females). With reference to where users went after they attended the service, the majority used no further services (at that time) ($n=117$; 62 males and 54 females). A further 17 individuals (12 males and five females) only required signposting to other non-emergency services. Only 45 clients (18 males and 27 females) required liaison with other emergency services such as the ED, PSNI or FSR.

Discussion

Uptake and the user experience are important parts of pilot evaluation of initiatives such as the CCIS. Background difficulties of the interviewees ranged from chronic mental illness to more acute situational crises. This variation mirrors the profiles of those who have died by suicide in NI (O'Neill et al., 2016). Those who used the CCIS appeared to find it empathetic and successful in de-escalating their state of crisis. Experiences could be understood through three themes; (1) a more appropriate setting than the ED, (2) states of suicidal crisis; risk factors and fluctuations, and (3) unmet needs.

In keeping with the literature, the non-clinical nature of the experience was valued as opposed to a hospital setting (Calear & Batterham, 2019; Harris et al., 2016). In terms of the specific features noted, the approach of the CCIS staff was valued. It was perceived as non-judgemental and compassionate. These perceptions were inferred from small actions e.g. a blanket or a cup of tea. This is important in the context of suicide prevention as promotion of feelings of connectedness and belonging are identified as protective factors in the face of suicidal thoughts and behaviours (O'Connor & Nock, 2014).

The value of the non-clinical nature of the service would also appear to be reflected within the high proportion of self-referrals within service users. ED attendance and hospital admission represent significant predictors of death by suicide (O'Neill et al., 2019b), suggesting that these facilities are not used for early intervention by those with suicidal thoughts or behaviours. Similarly, as was noted earlier, many have not engaged with formal healthcare services in the two weeks prior to their death (O'Neill et al., 2014). However, within the CCIS, the majority of participants ($n=102$) came to the service themselves or via their family or a member of the community. This suggests that outreach into a community non-medicalised environment supports early intervention, which is a recognised priority (Department of Health Northern Ireland, 2019; World Health Organization, 2014). Self-referral across service users as a whole is encouraging to see, considering that perceived burdensomeness was also a strong feature in the interview reports. This was in relation to use of the service itself, but particularly with regard to discussing problems within the family. Perceived burdensomeness often accompanies suicidal thoughts and behaviours (O'Connor & Nock, 2014).

Males in particular typically show low service use and maladaptive coping strategies (e.g. consumption of alcohol or drugs or social withdrawal) in their times of crisis (Department of Health Northern Ireland, 2019; O'Neill et al., 2014). Conversely, females have increased engagement with services prior to suicide (O'Neill et al., 2014). However, within the CCIS, males and females showed comparable use of the service. These findings are preliminary but outreach into a community non-medicalised environment appears to support service engagement by males, which is a recognised priority (Department of Health Northern Ireland, 2019; World Health Organization, 2014).

As recognised in the literature (World Health Organization, 2014), participants reported risk factors such as difficulties in managing their respective problems and maladaptive coping strategies, and recognised fluctuations in their states of suicidal crisis. Although it is a non-clinical environment, participants recognised the efficacy of the brief psychological interventions within the CCIS in the provision of timely individualised intervention to prevent the escalation of suicidal thoughts and behaviour in a calm unpressurised environment. The brief psychological interventions within the service was solely sufficient to de-escalate the crisis for many ($n=117$). Some others only required additional signposting to other non-emergency services ($n=17$).

Service users' perceived satisfaction with their experience meant that they were willing to re-engage if the need arose. The poor approaches to problem solving iterate the importance of interventions such as the CCIS as part of a prevention or suicide risk mitigation approach across the community, with safety planning as an essential component (National Institute of Clinical Excellence (NICE), 2011; Stanley & Brown, 2012). These interventions also align with perspectives such as trauma informed care (SAMHSA, 2014). As such continuous professional development for staff in settings such as the CCIS is essential (Department of Health Northern Ireland, 2019). However, reports did outline several areas of unmet need.

Unmet needs included extended opening hours beyond the weekend period, the building in of follow-up appointments and better service awareness. Rather than extending opening hours, the opposite has actually been forced since this evaluation was done. At the time of the evaluation, the CCIS was initially open from Thursday evening straight through to Monday morning. However, however financial pressures have forced opening hours to be reduced to Thursday 8pm–midnight, Friday and Saturday 6pm–3am and Sunday 4–6pm. This is concerning given the positive patterns of engagement with the non-clinical service. Funding bodies and service providers need to debate opening hours.

Consideration of opening hours for non-clinical suicide prevention services such as the CCIS may be informed by patterns of usage observed across other relevant services. For example, the Northern Ireland Registry of Self-Harm Annual Report 2017/18 (Public Health Agency, 2019) shows that the frequency of self-harm presentations increases over the course of the day. Also, the number of ideation presentations is highest at weekends. Similarly, calls to a mental health and wellbeing crisis line showed strong daily and weekly patterns (O'Neill et al., 2019a). The peak time for calls to Metropolitan Police Service for support with mental health-related incidents was between 3pm and 6pm Monday to Friday (HMICFRS, 2018).

Follow up care is an essential component of safety planning and risk mitigation within suicide prevention (McCabe et al., 2018; NICE, 2011; World Health Organization, 2014), and was recognised as an unmet need within the current service. This can be considered within the service itself, and across other services. Given that follow-up care is recommended as best practice, funding bodies and service providers need to discuss the extent to which this ideal is manageable within service provision. Whilst their non-clinical nature is a strength of initiatives such as the CCIS, the fact that they are not part of statutory health services does play a role in the planning and monitoring of follow-up care. For personalised and recovery orientated care which is evidence based to be achieved (Department of Health Northern Ireland, 2019), there needs to be strategic information sharing and collaboration across services.

A final unmet need was the desire for awareness of the service to be promoted, but in a discreet manner. Results

are conflicting on this matter of community awareness. As was noted earlier, the majority (102 of the 187) of service users had referred themselves. However, four of the five who were interviewed had not heard of the service until they were brought there. In some cases, the service-users who were interviewed felt that had they have known about the CCIS sooner, they could have avoided the need for previous hospitalisation.

It is possible that there may be certain groups or sub-populations who are aware of the service, but certain others who are not. Further qualitative examination of this would be warranted, engaging groups which represent sectors of society that have increased vulnerabilities to suicidal behaviours e.g. LGBTQ individuals. Campaigns around awareness of the CCIS should also focus on the staff across informal referral services. This means organisations who are likely to be dealing regularly with individuals in suicidal crises (e.g. police services). For example, Metropolitan Police Service reported that they receive a call about a mental health concern once every four minutes, and physically respond to a mental health-related call every 12 minutes (HMICFRS, 2018). However, police officers often feel that they are dealing with those in crisis and are not equipped to do so (HMICFRS, 2018). Initiatives such as the CCIS is therefore one way of supporting this aspect of police officers' work. In planning awareness campaigns, participants' felt that discretion was an essential component in awareness campaigns. This emerged from the fact that although all of the interviewed participants benefited from attending the CCIS, perceived burden, guilt and embarrassment were expressed among some.

Limitations and future research

Limitations and recommendations for future research must be noted. Further research is necessary surrounding family members of those in suicidal crisis, and their experiences of the help-seeking process. Economic analyses are also key in the evaluation of initiatives such as the CCIS. This would allow assessment of whether the initial and recurring investment represents a good use of available resources. How do these interventions contribute to the overall aim of reducing the rate of suicide and suicidal behaviour and improving emotional and physical wellbeing?

In the current situation, it is impossible to know alternative paths or outcomes had the CCIS not existed. Hospital costs as outlined by Tsiachristas and colleagues may prove useful (Tsiachristas et al., 2017). In the case of the community crisis intervention service, an economic analysis (incorporating direct and indirect costs) would necessitate the collection of longitudinal data. Important considerations might be health services use, the cost to other services and also future earnings. This would need to be done for those who accessed the service and a control group who were eligible to use the service and who would have chosen to use the service, but for whom the service was not available. This could be in a randomised controlled trial (or variation of an RCT), or as a study with a matched control group

from elsewhere. These research designs were not feasible in the current situation as the initiative was on a pilot basis.

The current findings suggest that community crisis intervention services are availed of and positively evaluated. Further research is necessary to assess their long-term efficacy in reducing suicidal behaviours and cost efficiency. This will facilitate discussions of how these might feed into overall suicide prevention strategies.

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Disclosure statement

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