Supplementary Materials

Interview sampling frame and topic guide

*Extracted from an Excel spreadsheet used to track recruitment and sample variation

INTERVIEW SAMPLING FRAME & TOPIC GUIDE
SAMPLE DEMOGRAPHICS
Agency type
NHS
Vol orgs
Police
Policy
Independent/social enterprise
Academic
Location
England
Scotland
Wales
NI
Person role
Professional - strategic
Professional - service delivery
Service user
Carer
Area type
Urban
Rural
Mixed urban/rural
INTERAGENCY WORKING
Information sharing
Lot of talk about info sharing - what is the specific useful information shared? What does it mean for staff? (Less likely to use restrictive practices?) What does it mean for service users? (Not repeating self?) What about IT structures?
Joint training
Are the benefits the knowledge gained? What about the social side of things - does getting to know people socially matter? Why?
Shared assessment
What does a good shared assessment do? (Save time, repetition, enable needs to be identified)
Job shadowing
How does this work? Is it about learning how other roles in the system work? Or is it about interpersonal relationships that develop?
Rapid mental health support
Some initiatives try to have this for non MH staff e.g. police. Why is this so important? How does it change things for the police / ambulance How does it change things for the service user?
Service navigation
Some services use this as a way of steering people through. Do you think this is a beneficial / essential?
Colocation
What do people gain from this? Immediate specialist advice? Interpersonal relationships?
Planning and reviewing multi-agency working
What is the purpose of these? What do they achieve? Who needs to be at them most and are they?
COMPASSIONATE CRISIS CARE

Psychologically safe care
What do you think is a psychologically safe environment for somebody in crisis? Do you think crisis houses/voluntary organisations are the better option for everyone? In what ways? Can you provide examples? Has the use of a crisis house or a voluntary organisation changed the way you think or feel? Is there anything you would change about how they work? How do you think crisis houses make a difference to people?
There are concerns about emergency departments being restrictive, chaotic and the environment being unsuitable for people experiencing a mental health crisis. Has it worked at all like that for you or in your experience? Can you give an example? What makes a difference in how it works? If you could change something about the care in the emergency department, to be more effective, what would you change and why?
Risk and decision making
Some of the literature points to a gap between national aspirations and reality. How easy is it to practice in accordance with i) your own values/philosophy ii) the values/philosophy of your organisation iii) The wider agenda for example recovery focused, personalised, trauma informed care?
One idea is that mental health practitioners are unsuccessful in striking a balance between promoting choice and exerting control, due to organisational and social requirements to manage risk. Has it worked at all like that in your experience? Can you give an example? How do you think the requirements to manage risk impact on the service user or service outcomes? Is it the same for everyone? In all areas? There is a sense that visible leadership, reflective practice, debriefing and supervision helps clinicians to tolerate risk. Has that been the case in your experience? If you could change something about the care, to be more effective here, what would you change and why?
URGENT ACCESS
An urgent response seems to be important to everyone but people seem to have different ideas about what urgent responses should include, how quickly they should be delivered and who should deliver this.
How do you understand an urgent response? Does the timing of the response make a difference to outcomes? Why? How? Is this in every situation? Do you have examples? How should urgency be decided? Who should decide? Should the service provide more than assessment? What esle is needed? why? What difference would this make to outcomes?
We have noticed that involving the person and their family in making decisions about urgency may be important.
Is it important that people have a say in how urgently they are seen/assessed? Why is this important? Does it make a different to outcomes?
Sometimes people get fed up waiting for a response during a crisis. We think that there may be times when waiting is OK and other times that people are not able to cope with waiting. This may have something to do with what happens or what staff/services do/provide during any wait.
How long are people prepared to wait for a mental health assessment in a crisis? What should happen while they are waiting? Why? Do you have an example of what happens during a wait for crisis assessment/intervention?
People talk about not feeling that they were taken seriously when they seek help in a crisis. We think that this may relate to what staff/services do to assess and prioritise/triage people at first contact.
How do services prioritise who is seen? Why? Does this work in every situation? Are specific tools/processes used to prioritise? How are these used? By whom? What difference do they make to the outcome?
We are very interested in the idea of a 'first response' or first responder. It is a term that is used more in the emergency services at the moment. (ambulance, police etc)
What does this term first response mean in a mental health crisis? Who provides a first response? How does a first response fit into the process of crisis care? What happens during a first response intervention? Does the first response have an impact on the crisis outcome? For whom? How? Why?

People and their family/carers say that it is difficult to naviage and access services in a crisis. We wonder if this leads people to call 999, attend A&E or come into contact with the police.
What would be needed to enable people to more easily make contact mental health services in a crisis? How would this work/make a difference? What would make people choose mental health crisis services as first contact over 999 or A&E? Why? What informs the choices people make about which service to contact in a crisis? Are there any differences between people making contact for the first time and people who have received a mental health service before? Why is this different?
There is an idea that there should be 'no wrong door' for people in mental health crisis.
What does thie idea of no worng door mean for services? and people in crisis? What is needed to make this improve access? How does this work/or not work?
We wonder if accessing crisis services is different for people who are already receiving a mental health service or are known to services.
Are there any differences between people making contact for the first time and people who have received a mental health service before? Why is this different? How does this impact on crisis outcomes?
There are a number of specific groups of people who have additional barriers to accessing crisis services. This includes people with protected characteristics due to age, gender, ethnicity, disability, sexuality. There are also marginalised groups related to where they live (rural communities) or their living circumstances (homelessness, traveller) or legal status (prisoners, refugees, asylum seekers). There are two main approaches to improving access, 1) bespoke services 2) improvement in the existing service to benefit all.
Do you have any examples of these approaches working? Who are they working for? How are they working? What else is needed to improve access to crisis services for these groups? who do these different approaches work for? How?
Service user involvement
We are very curious about what service user involvement looks like in community mental health crisis services. How do you think involvement has impacted on service user or service outcomes? Do you think service user involvement impacts on how people who use community mental health crisis services think or feel about the services they receive in any way? In what ways? Can you provide examples? Has involvement changed the way you think or feel? How would you know a service had involved services users? Does the level of involvement inform which service you choose to access?
There are lots of different ideas about involvement and why it is important, and we think what is important is probably different in different places and for different people. But, one of those ideas is that service user involvement at all levels shapes service activity; services feel safer and more compassionate and there is increased engagement and satisfaction with services. Has it worked at all like that here/for you? Can you give an example? What is it about involvement that stands out the most for you? What makes a difference about how involvement works? We've seen that ideas around involvement vary in different places. What is it about (place) that works well or less well? If you could change something about involvement to be more effective, what would you change and why? What else do you think we need to know, to really understand how involvement has worked?
Who else should we speak to?