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THRIVE: Feasibility, Acceptability, and Social Validity of a Brief Recovery-Focused Intervention in Crisis Stabilization Centers

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ABSTRACT

Background: Crisis Stabilization Centers (CSCs) are a critical component of the crisis response system and the 988 Lifeline expansion that may promote ED diversion. To maximize CSC care quality and effectiveness, brief psychotherapy interventions that focus on recovery, match CSC workflows, and have the potency to reduce suicide attempts and deaths are needed but do not exist. The purpose of this study was to establish the feasibility, acceptability, appropriateness, and social validity of a novel, ultra-brief, 60-min psychotherapy intervention—Toward Hope, Recovery, Interpersonal Connection, Values, and Engagement for Crisis (THRIVE-C).

Methods: We recruited CSC stakeholders ($n = 15$) and CSC study therapists ($n = 5$) to complete surveys, followed by a pilot study of THRIVE-C with CSC guests ($n = 54$).

Results: CSC stakeholders, study therapists, and guests found THRIVE feasible, acceptable, appropriate, and socially valid. CSC guests experienced THRIVE-C as satisfactory, established a positive therapeutic alliance (bond), and 91% of guests endorsed behavioral intentions to attend outpatient psychotherapy appointments after discharge. Further, 94% of guests completed all phases of THRIVE, demonstrating clinical readiness to work on suicide recovery beyond physical safety or stabilization from suicide alone.

Conclusion: Preliminary findings suggest that further development and testing of THRIVE are needed.

Trial Registration: This study was registered with ClinicalTrials.gov (Identifier NCT05558891)

1 | Introduction

Suicide is a growing public health concern that requires innovative approaches to reduce deaths in care systems along the crisis services continuum (Stanley and Mann 2020). After slight declines in suicide rates during the COVID-19 pandemic, suicide rates increased in the United States in 2022 to 14.21 per 100,000—the highest rate recorded in the United States since 1941 (Curtin and Garnett 2023; Garnett and Curtin 2024). Suicide deaths occurring in 2022 represent more than 974,786 years of healthy lives lost, impacting the individuals who died and their loved ones (Cerel et al. 2019;

Curtin et al. 2023). Despite national efforts in suicide prevention, continued increases in suicide deaths suggest novel approaches are needed (U.S. Department of Health and Human Services 2024).

1.1 | Crisis Stabilization Centers Need Evidence-Based Interventions

Increasing the quality of care in Crisis Stabilization Centers (i.e., CSCs) is critical to delivering effective suicide prevention services in communities (US Department of Health and Human Services 2024). More than 600 CSCs nationwide operate 24 h per day, accept crisis walk-ins, provide services regardless of ability to pay, and collaborate with local law enforcement to divert suicidal persons from emergency departments and jails (Substance Abuse and Mental Health Services Administration (SAMHSA) 2020). SAMHSA recently released a model behavioral health crisis services definitions guide, which describes various CSC types (e.g., high vs. low acuity) and operational functions (SAMHSA 2025). In CSCs, interdisciplinary teams (e.g., psychiatrists, nurse practitioners, counselors, social workers, case managers, peer-support specialists) work together to provide safe, short-term (i.e., 1–3 days) stays for suicidal persons in crisis (Hogan and Goldman 2021; Puttahiah and McCann 2022). Services typically include suicide risk assessments, safety planning, medication management, peer support, psychoeducation, and individual counseling (McNeil 2020; Saxon 2018), in addition to CSCs' focus on recovery through community-based linkage to psychosocial services, personal growth, and quality of life (Balfour and Carson 2024; Saxon 2018; TBD Solutions 2018). People who seek services are often referred to as "guests" instead of "patients" to promote a recovery culture. CSCs have high satisfaction among guests and are a preferred alternative to emergency departments (i.e., EDs) and psychiatric inpatient services (SAMHSA 2020).

Although CSCs are a promising, community-based alternative to EDs, research outcomes on CSC services are surprisingly scarce. To date, there have been no empirical studies or clinical trials examining suicide risk outcomes among CSC guests or examining CSC guest outcomes compared to medical facility alternatives (e.g., ED, Inpatient). Program evaluations of CSCs have found reductions in suicidal ideation at discharge and reductions in statewide suicide-related psychiatric hospitalizations (Adams and El-Mallakh 2009; Boyer and Kane 2010; Mark et al. 2024). A systematic review of 27 studies suggests CSC care may improve quality of life, reduce psychiatric symptoms, and improve treatment satisfaction; however, findings were inconclusive due to small sample sizes and methodological problems (Lloyd-Evans et al. 2009). More research is needed on CSCs to ensure care quality and to support the 988 expansion along the crisis continuum (Coates 2018; Fix et al. 2023; Lloyd-Evans et al. 2009).

For CSCs to become a viable mainstream alternative to EDs, brief, effective, recovery-oriented interventions with the potency to decrease suicide attempts and deaths are needed and do not exist. Existing evidence-based suicide-specific psychotherapies are not recovery-focused (other than clinical recovery as safety or psychiatric stability), focus exclusively on suicide attempts, or do not yet have demonstrated effectiveness as abbreviated forms of much longer outpatient interventions. For example, the Safety Planning Intervention (Stanley and Brown 2012) reduces suicidal behavior within 6 months and enhances treatment engagement among individuals who are help-seeking (Stanley et al. 2018). However, the Safety Planning Intervention focuses on physical safety from suicide (not recovery), may not be sufficient to facilitate recovery when health disparities are present, and CSC readmission rates when using the intervention remain high (Gamarra et al. 2015; Lloyd-Evans et al. 2009; Na et al. 2025). Although brief suicide-specific interventions such as the Attempted Suicide Short Intervention Program (ASSIP) (Gysin-Maillart et al. 2016) and the Teachable Moment Brief Intervention (TMBI) (O'Connor et al. 2020) are short and focus on suicide attempts, suicide attempts do not prompt CSC stays for most guests (Lloyd-Evans et al. 2009). Existing effective outpatient psychotherapy treatments for treating suicidal behaviors (e.g., Dialectical Behavior therapy, Brief Cognitive Behavior Therapy for Suicide Prevention, Collaborative Assessment and Management of Suicide) require between 6 weeks and 2 years of treatment to yield desired effects on suicidal behaviors, and ultra-brief versions of these treatments (i.e., 1–2 sessions) with established effectiveness do not exist (Santel et al. 2023; McNeil 2020). To maximize the quality of care for suicide prevention as described in goal 9 of the 2024 National Strategy for Suicide Prevention, CSCs need brief interventions that match their workflows, staffing, guests, and recovery philosophy (US Department of Health and Human Services 2024).

1.2 | THRIVE Intervention

Toward Hope, Recovery, Interpersonal Relationships, Values, and Engagement (THRIVE) is a suite of psychotherapy and peer-based interventions that mechanistically target interpersonal contributions to suicidal ideation (Joiner 2005; Van Orden et al. 2010), hope, self-efficacy to stay safe from suicide, and recovery (e.g., meaning made of stress; Lockman and Servaty-Seib 2016, 2018). THRIVE was developed by the first author and later adapted to CSCs through a partnership-based research process with the study site. Specifically, stakeholders met with the first author to review existing evidence-based treatments for suicide risk, to examine CSC implementation needs, and to systematically consider adapting existing treatments versus developing new interventions (Kirk et al. 2020). The THRIVE Crisis Intervention (i.e., THRIVE-C) consists of a single psychotherapy session lasting up to 60 min that includes four components: (a) Creating a safe emotional space to facilitate suicide disclosure, (b) telling the suicide crisis narrative, (c) conducting an autobiographical life review to make meaning of the suicidal experience, and (d) creating a written Meaningful Living Plan for recovery. THRIVE-C includes interpersonal process psychotherapy techniques (Steuwe et al. 2016; Teyber and Teyber 2016) to create a reparative emotional experience within the therapeutic alliance, help suicidal persons recognize interpersonal strengths and contributions (Joiner 2005), and explore novel pathways of clinical and personal recovery. THRIVE-C includes facilitated exposure and meaning-making strategies from Narrative Exposure

Therapy (NET; Steuwe et al. 2016) that have been strategically adapted to treat suicide risk.

1.3 | Purpose of This Study and Hypotheses

The purpose of this study was to examine the feasibility, acceptability, appropriateness, and social validity of THRIVE-C among CSC stakeholders, study therapists, and guests. We sought to achieve stage 1b aims of the Stage Model of Behavioral Therapies Research (i.e., research recruitment/procedural viability, feasibility/acceptability of intervention; Rounsaville et al. 2001) before proceeding to randomized pilot clinical trials to test the THRIVE-C intervention target engagement and outcomes. In the absence of universally agreed upon cut-off scores for feasibility, acceptability, and social validity (Teresi et al. 2022; Thabane et al. 2010), we chose a threshold of ≧75%. Specific to CSC stakeholders and study therapists, Hypothesis 1 (H1) was: CSC stakeholders and study therapists will rate the feasibility, acceptability, appropriateness, and social validity of THRIVE as ≧75% (H1a), and at least 75% of study therapists will complete the THRIVE-C intervention at ≧75% fidelity. Specific to CSC guests, Hypothesis 2 (H2) was: Ratings of THRIVE-C feasibility, acceptability, appropriateness, and satisfaction will be ≧75% (H2a), and at least 75% of guests will complete all four phases of the intervention within 60 min (H2b). As an exploratory aim, we examined CSC guests' alliance (bond) during the ultra-brief intervention and behavioral intentions to engage in suicide safety (e.g., safety plan use), recovery (e.g., meaningful living), and outpatient treatment (e.g., counseling) after discharge. We also examined participant safety immediately after receiving THRIVE-C until discharge using an electronic medical record (i.e., EMR) review form.

2 | Method

2.1 | Participants

2.1.1 | CSC Stakeholders

CSC stakeholder participants in this study were CSC administrators throughout the United States who were members of the Crisis Residential Association Listserv or Members of the National Consortium for Crisis Innovation. For the purpose of this study, we considered "stakeholders" to be individuals working in community-based CSCs who could provide feedback as future possible end-users of THRIVE-C. Inclusion criteria were (a) 18 years or older, (b) English-speaking, and (c) employed at a CSC. The exclusion criteria were less than 1 year of work experience at a CSC. We sent an online recruitment email and survey to 35 CSC administrators. Of these, 22 individuals consented to the study, yielding a response rate of 63%. We removed seven participants from the sample due to not providing data on any measure after consent, leaving a final sample of 15 CSC administrators. The final sample ($n = 15$) included 13 (87%) biological females and 2 (13%) biological males. The mean age of participants was 45 (SD = 10.32). Regarding race/ethnicity, participants self-identified as Caucasian American ($n = 13$, 87%), Black or African American ($n = 1$, 7%), and Multiracial ($n = 1$, 7%). Most participants endorsed having a master's degree or equivalent ($n = 12$, 80%).

2.1.2 | CSC Study Therapists

CSC study therapists were employed at the 15-bed Mental Health Cooperative Crisis Stabilization Center (MHC-CSC; Nashville, TN) at the time of this study. Inclusion criteria were (a) 18 years or older, (b) English-speaking, and (c) employed at a CSC. The exclusion criteria were less than 1 year of work experience at a CSC. CSC study therapists learned about the study from the treatment director and volunteered to participate. Study therapists ($n = 5$) were biological females ($n = 3$, 60%) and biological males ($n = 2$, 40%). Regarding race/ethnicity, study therapists self-identified as Caucasian American ($n = 4$; 80%) and Hispanic, Latino, or Latina ($n = 1$, 20%). Two study therapists held master's degrees in professional counseling ($n = 2$, 40%) and were independently licensed. Three study therapists were in training programs in professional counseling ($n = 2$, 40%) and social work ($n = 1$, 20%).

2.1.3 | CSC Guests

CSC guest participants in this study were recruited from the MHC-CSC. Inclusion criteria were: (a) At least 18 years old, (b) English-speaking, (c) Davidson County resident, (d) able to provide informed consent, (e) able to provide at least one emergency contact, (f) at risk for suicide as determined by the Patient Health Safety Screener (Boudreaux et al. 2015, Item 2 or 3 is "Yes"), (g) medically cleared, (h) willing to discuss personal experiences of suicide. Exclusion criteria were: (a) Acute psychosis warranting inability to complete a narrative intervention (i.e., according to the clinical judgment of the on-site psychiatrist or nurse practitioner) and (b) inability to communicate with the research team (e.g., due to medical state, emotional state, cognitive disability).

Participant demographics are provided in Table 1. Participants ($n = 54$) included 24 (44%) biological females and 30 (56%) biological males. The mean age of participants was 39 (SD = 11). Participants predominantly identified as Caucasian, White, or of European descent ($n = 25$, 46%) and African American or of African descent ($n = 19$, 35%), heterosexual ($n = 47$, 87%), having a 12th-grade education or less ($n = 33$, 61%), single ($n = 43$, 80%), unemployed ($n = 38$, 70%), and housing transient or homeless ($n = 28$, 52%). All participants endorsed suicidal ideation within the past 2 weeks ($n = 54$; 100%). Most CSC guests endorsed one or more lifetime suicide attempts (i.e., 70%; $M = 2$ attempts; SD = 1). Three participants ($n = 3$; 1%) experienced a non-medically serious suicide attempt, prompting this CSC episode of care, and self-presented to the CSC as walk-ins for their care.

2.2 | Procedures

This study was approved by the Western WCG IRB Board and registered at clinicaltrials.gov.

TABLE 1 | Baseline characteristics of CSC guest participants ($n = 54$).

Variables	Yes ($n = 54$)	% ($n = 54$)
Sex		
Female	24	44
Male	30	56
Race/Ethnicity		
African American or of African descent	19	35
Asian or Asian American	1	2
Caucasian, White, or European descent	25	46
Hispanic, Latino, or Latina	4	7
Multiracial	5	9
Sexual orientation		
Gay or lesbian	4	7
Heterosexual	47	87
Other (self-defined)	2	4
Prefer not to say	1	2
Highest education		
8th grade or less	2	4
11th grade or less	10	19
12 grade (high school diploma/GED)	21	39
Some college	15	28
Associates degree	4	7
Bachelors degree	2	3
Relationship status		
Single	43	80
Coupled	2	4
Married	1	2
Married but separated	1	2
Divorced	3	6
Widowed	3	6
Employment status		
Unemployed	38	70
Employed part-time	4	7
Employed full-time	4	7
Disabled and unable to work	8	15
Annual income		
Less than $9999	14	26
$10,000–$49,999	11	20
$50,000–$99,999	4	7
$100,000–$149,999	2	4
More than 150,000	1	2
Unsure	22	41
Housing status		
Owned by you or someone in the household	4	7
Rented by you or someone in the household	13	24
Occupied without payment or rent	1	2
Live with friends or family	8	15
No permanent residence/ homeless	28	52

2.2.1 | CSC Stakeholders

CSC stakeholders were recruited through partnerships with the Crisis Residential Association and the National Consortium for Crisis Innovation. Participants received a recruitment email and were prompted to review and complete an electronic consent form. Stakeholders were provided a link requesting that they watch brief video clips showing the first author conducting THRIVE-C with a standardized patient actor. They were directed to a brief survey asking them to rate the feasibility, acceptability, appropriateness, social validity, and implementation climate of THRIVE. Participants were provided a $5 Starbucks E-gift card for participating in the study.

2.2.2 | CSC Study Therapists

After receiving THRIVE-C training, study therapists were invited via email to review and sign an electronic consent form agreeing to (a) submit THRIVE-C audio recordings for fidelity coding and (b) participate in a brief survey after the THRIVE-C study on intervention feasibility, acceptability, and appropriateness. Study therapists were not compensated or incentivized for participating in the study or relevant surveys.

2.2.3 | CSC Guests

Potential participants were identified by introducing the research study at the CSU morning group and going door-to-door to discuss the study. Participants were invited to complete a research interest form to indicate interest in learning about the study. The treating psychiatrist or nurse practitioner reviewed interested participants for medical clearance (i.e., non-clearance status if the individual had a transmissible medical condition, cognitive or physical disability preventing consent, or recent aggression). Medically cleared individuals were randomized using a pre-determined numeric randomization

table to determine the order of approach for the screen. The research assistant approached potential participants individually to complete a brief screening measure (i.e., 15 min) and consent procedure (i.e., 10 min) in the guests' room or an adjoining treatment room. Participants were advised that they could withdraw from the THRIVE-C research study at their discretion.

Consented participants participated in the THRIVE-C intervention on the same day of consent. THRIVE-C psychotherapy sessions were held in a private treatment room and were recorded to examine fidelity to the treatment. CSC guests self-administered the discharge survey in a private room with a glass observation area. Participants were provided a $10 Walmart gift card.

2.3 | THRIVE-C Intervention

2.3.1 | THRIVE-C: Proposed Mechanisms of Change

THRIVE-C is a brief psychotherapy intervention (i.e., 45–60 min) that clinically targets interpersonal contributions to suicidal ideation, hopefulness, self-efficacy to avoid suicidal actions, and recovery (i.e., as meaning made of stress) as core mechanisms of change. The Interpersonal Theory of Suicide (ITS; Joiner 2005; Van Orden et al. 2010) suggests that suicidal ideation occurs when individuals experience perceived burdensomeness, thwarted belongingness, and hopelessness about these conditions. More than a decade of research suggests that ITS constructs are associated with suicidal ideation (Chu et al. 2017). The association between hopelessness and suicidal ideation and attempts is firmly established (Gerner et al. 2023; McMillan et al. 2010; Ribeiro et al. 2018; Riera-Serra et al. 2024). In THRIVE, we draw specifically from the neurotransactional model of hope, where narrating possible futures, sequencing autobiographical events, and helping guests behaviorally experience new life events within 48 h of discharge help instill hope and prevent suicide (Baker and White-McMahon 2019; Weis and Speridakos 2011).

Self-efficacy to prevent suicide attempts is individuals' "perceived ability to refrain from suicidal action in different situations that might trigger a suicidal crisis" (Czyz et al. 2019, 6). Lower levels of self-efficacy to prevent suicide attempts are associated with suicidal ideation and more frequent suicide attempts (Czyz et al. 2014). Self-efficacy to prevent suicide attempts may help individuals stay alive while working to get their critical psychosocial needs met, thereby assisting suicidal persons in recovery (Fuller-Thomson et al. 2019; Thompson et al. 2002).

Meaning made of stress is a multifaceted process in which individuals work to reconcile their beliefs about specific stressful life events (i.e., situational meaning) with their core beliefs about the world, the self, and others (Park 2010; Janoff-Bulman 1992). Meaning made of stress is associated with the complex processes of integrating cognitions, emotions, and physiological experiences specific to stressful memories (Vanderveren et al. 2020). Higher levels of meaning made of stress are associated with recovery as reduced mental health symptoms and adverse outcomes, including suicidal thoughts (Holland et al. 2017; Lockman and Servaty-Seib 2016, 2018). Meaning-making is also included as a component in proposed theoretical models of suicide recovery (Rogers and Soyka 2004).

2.3.2 | THRIVE-C Procedures

THRIVE-C includes up to four phases depending on the clinical indication of participant readiness: (a) Develop therapeutic alliance using rapid interpersonal process psychotherapy techniques; (b) narrate the suicide crisis story; (c) narrate the life story and engage in meaning-making; (d) create a meaningful living plan to facilitate behavioral exposure to living (i.e., actualized hope), self-efficacy to stay safe from suicide, and suicide recovery. Each of these phases is described below. THRIVE-C includes common factors that exist across many suicide-specific interventions (e.g., collaborative alliance, suicide narrative) yet goes beyond these by integrating novel treatment strategies and recovery targets as soon as the guest demonstrates readiness.

2.3.2.1 | Phase 1: Therapeutic Alliance. In THRIVE-C, therapists are trained to use interpersonal process psychotherapy techniques (i.e., IPPTs) with a focus on promoting empowerment, building therapeutic belonging, and supporting suicide recovery (Tengland 2008; Teyber and Teyber 2016). IPPTs include immediacy interventions that focus on the "here and now" alliance between the therapist and guest, which creates a safe haven to fully explore one's thoughts, emotions, and interpersonal relationship style (Altenstein et al. 2013; Bedics et al. 2015; Blanchard and Farber 2020). An example of an immediacy intervention is, "I notice you are looking away and sharing only a few words. Perhaps you are wondering if I truly want to or can help you. Perhaps you are afraid of sharing too much or are just tired. What is happening right now between you and me?" IPPTs offer a corrective emotional experience by helping guests consider how *this* therapeutic alliance may be different from others, which were experienced as unhelpful (Huggett et al. 2022). As an example, THRIVE-C therapists begin by describing the core values guiding the intervention (i.e., whole personhood, freedom, collaboration, and non-judgment) that align with their *personal values* of helping suicidal people achieve not only safety from suicide but also recovery. In this way, THRIVE-C offers an opposite or "corrective" emotional experience for guests who may be reluctant to share suicidal thoughts due to past difficult experiences with providers who were exclusively focused on suicide safety or anxious due to undertraining (Awenat et al. 2018). IPPts promote accurate disclosure of experiences, facilitate empowerment, communicate ethnocultural empathy, and promote recovery (Blanchard and Farber 2020; Tengland 2008; Teyber and Teyber 2016; Van Orden et al. 2010; Wang et al. 2003).

2.3.2.2 | Phase 2: Suicide Crisis Narrative. In phase two, THRIVE-C therapists invite the suicidal crisis narrative that prompted the immediate CSC episode of care. THRIVE-C therapists offer accurate empathy for the CSC guests' wish to die and prompt collaborative discovery focused on suicidal experiences and recovery using interpersonal process techniques (Teyber and Teyber 2016).

2.3.2.3 | Phase 3: Life Story and Meaning-Making. In phase three, CSC guests are invited to explore the suicidal narrative in the broader context of the guests' autobiographical life story and multicultural identity. Specifically, CSC guests are guided to construct visual life stories using safe, physical items made available to them (i.e., string, flowers, stones) using Narrative Exposure Therapy (i.e., NET) techniques adapted for suicide-specific care (Elbert et al. 2015; Schauer et al. 2011). CSC guests participate in narrative meaning-making of the suicidal crisis narrative by helping guests integrate cognitions, emotions, and physiological experiences associated with both the desire to die and the urge to live. THRIVE-C therapists assist guests in meaning-making, self-compassion, social justice, and possible "turning points" in recovery (Neimeyer et al. 2010; Lockman and Servaty-Seib 2016, 2018).

2.3.2.4 | Phase 4: Meaningful Living Plan and "My Hope for You". In phase four, THRIVE-C therapists work collaboratively with CSC guests to create Meaningful Living Plans (i.e., MLPs) that define the "first steps" in suicide recovery. Importantly, THRIVE-C emphasizes gradual behavioral exposures to tasks of living and recovery that facilitate actualized hope. THRIVE-C guests engage in guided exercises to prompt exploration and testing of possible recovery pathways that include avoiding suicidal behaviors while "re-learning life." Through the MLP, THRIVE-C guests learn strategies to work on physical safety from suicide and suicide recovery simultaneously. THRIVE-C therapists serve as social justice advocates where clinically indicated, promoting empowerment and new task mastery (Decker et al. 2016; Sakunpong 2018). The MLP includes "mindset" exercises to cultivate hardiness, resilience, grit, dignity, self-compassion, and gratitude to help guests overcome psychosocial barriers to care linkage after discharge (Bohlmeijer and Westerhof 2021; Bonanno 2004; Duckworth et al. 2007; Kobasa et al. 1982; Maddi 2004, 2016). The THRIVE-C Intervention ends with an audible caring letter called "My Hope for You," which summarizes recovery themes.

2.4 | Training

Training for THRIVE-C included one 6-h live training and up to two simulated patient-actor experiences conducted by the PI. CSC study therapists were provided training in psychological theories of suicide risk and recovery, narrative meaning-making skills, behavioral exposure skills, and social justice advocacy skills. THRIVE-C therapists were required to achieve fidelity scores greater than or equal to 75% during the simulated patient experience to begin providing THRIVE-C in the study. Four out of five study therapists (80%) achieved fidelity during the first simulated patient role-play, with the remaining study therapists achieving fidelity within two simulations.

2.5 | Measures

As this study sought to examine the feasibility, acceptability, satisfaction, and appropriateness of the THRIVE-C intervention for CSC environments, we collected data from three separate key stakeholder groups: administrators and leaders in CSCs, therapists at the study site CSC, and CSC guests. Table 2 includes a list of all measures and to which participant group(s) they were administered.

2.5.1 | Demographic Questionnaire

All participants provided demographic information, including age, sex/race/ethnicity, and education. CSC guest participants reported additional information about sexual orientation, relationship status, employment status, Veteran status, income, insurance status, and suicide history.

2.5.2 | Feasibility, Acceptability, and Intervention Appropriateness

We used implementation scales developed by Weiner et al. (2017) to assess THRIVE-C's feasibility (FIM; 4 items), acceptability (AIM; 4 items), and appropriateness (IAM; 4 items). The Feasibility of Implementation Measure (i.e., FIM; 4 items; Weiner et al. 2017) assesses the degree to which a new intervention can be delivered in an intended practice setting. An example item from the FIM is "THRIVE seems doable." The Acceptability of Intervention Measure (i.e., AIM; 4 items; Weiner et al. 2017) accesses the perception that a new intervention is desirable and satisfactory. An example item from the AIM is, "I like THRIVE." The Intervention Appropriateness Measure (i.e., IAM, 4 items; Weiner et al. 2017) assesses the perceived fit of the intervention for the practice setting. An example item from the IAM is, "THRIVE seems fitting." Participants rated items from 1 (*completely disagree*) to 5 (*completely agree*). Higher summed scores indicate greater levels of each construct. The scales demonstrate strong test–retest reliability, structural reliability, sensitivity, and validity (Cronbach's alphas 0.85–0.91; Weiner et al. 2017). In this study, Cronbach's alphas were 0.90 (i.e., feasibility), 0.92 (i.e., acceptability), and 0.89 (i.e., appropriateness). CSC guests provided additional feedback through open-ended survey questions.

2.5.3 | Social Validity

We used the Intervention Rating Profile (IRP; Witte and Martens 1983) to measure the social validity of THRIVE-C for CSC environments. Specifically, social validity "refers to the evaluation of the degree of acceptance for the immediate variables associated with a procedure or program designed to change a behavior" (Carter 2010). The IRP was developed for use in schools. For the purpose of this study, we changed the term "teacher" to "CSC staff" and "children" to "guests" for each item. An example item from the adapted IRP is, "THRIVE is practical in the amount of time required for CSC guests." Participants (i.e., CSC stakeholders) rated their agreement on each item on a Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*), with a total score of 70 indicating moderate (i.e., acceptable) levels of social validity (Carter 2010). The IRP has strong psychometric properties (Carter 2010). In this study, Cronbach's alphas on the IRP scores were 0.80.

TABLE 2 | Study measures and administration.

Scale	Scale ranges	CSC stakeholders	Study therapists	Guests
Demographics		X	X	X
Feasibility of implementation (FIM)[a]	1 (*completely disagree*) to 5 (*completely agree*)	X	X	X
Acceptability of intervention measure (AIM)[b]	1 (*completely disagree*) to 5 (*completely agree*)	X	X	X
Implementation appropriateness measure (IAM)[c]	1 (*completely disagree*) to 5 (*completely agree*)	X	X	X
Intervention rating profile (IRP)[d]	1 (*strongly disagree*) to 6 (*strongly agree*)	X	X	
Implementation climate scale (ICS)[e]	0 (*not at all*) to 4 (*to a very great extent*)	X	X	
Fidelity[f]	0% to 100% adherence/competence		X	
Client satisfaction questionnaire (CSQ)[g]	1 (*poor*) to 4 (*excellent*)			X
Working alliance inventory, short, revised (WAI-SR)[h]	1 (*seldom*) to 5 (*always*)			X
Behavioral intentions after discharge[i]	1 (*none of the time*) to 5 (*all of the time*)			X

Note: Higher scores indicate more favorable outcomes across all measures.
[a]Feasibility of Implementation Measure (FIM) assesses whether THRIVE-C can be delivered in its intended setting.
[b]Acceptability of Intervention Measure (AIM) assesses how satisfactory and desirable THRIVE-C is to participants.
[c]Intervention Appropriateness Measure (IAM) assesses the perceived fit of THRIVE-C for the practice setting.
[d]Intervention Rating Profile (IRP) evaluates the social validity or acceptability of THRIVE-C in CSC environments.
[e]Implementation Climate Scale (ICS) assesses the organizational climate toward using evidence-based practices.
[f]The Fidelity Scale measures both adherence to and competence in delivering THRIVE-C components.
[g]Client Satisfaction Questionnaire-8 (CSQ-8) assesses overall satisfaction with THRIVE-C services.
[h]Working Alliance Inventory-Short, Revised (WAI-SR) bond subscale measures the quality of the therapeutic relationship.
[i]TPB-based Behavioral Intentions Measure assesses intentions to engage in suicide safety, recovery, and treatment post-discharge.

We also used the 18-item Implementation Climate Scale (ICS; Ehrhart et al. 2014) to measure the social validity of THRIVE-C specific to organizational cultures of CSCs. An example item from the ICS is "Using evidence-based practices is a top priority in this team/agency." Participants rate items on a Likert scale from 0 (not at all) to 4 (to a very great extent), yielding a total score range of 0 to 72, with higher scores indicating a stronger organizational climate for implementing evidence-based practices. Psychometric evaluations of the ICS have demonstrated high internal consistency, reliability, and validity (Ehrhart et al. 2019; Peters et al. 2022). In this study, Cronbach's alphas on the ICS scores were 0.87.

2.5.4 | Fidelity

The first author developed a fidelity rating scale to measure THRIVE-C fidelity as adherence (i.e., completing each intervention component) and competence (i.e., clinical quality of completion; Cross and West 2011). The fidelity scale was pilot-tested and refined with 1,522 individuals completing a program evaluation of THRIVE-C components prior to implementation in this study. For this study, the first author and a bachelor's-level pre-medical student completed fidelity coding on 100% of THRIVE-C cases ($n = 54$). We created fidelity scores for THRIVE-C adherence and THRIVE-C competence by summing the items of each sub-scale, then dividing the subscale score by the total possible points to obtain a percentage (i.e., 0%–100%).

2.5.5 | Satisfaction

We used the Client Satisfaction Questionnaire-8 (CSQ-8; Attkisson and Zwick 1982) to measure CSC guests' satisfaction with THRIVE-C. An example item is, "(Therapist) and I respect each other." An example item from the CSQ-8 is, "To what extent has our service met your needs?" Participants rated their agreement with each item on a Likert-type scale ranging from 1 (e.g., *Poor*) to 4 (e.g., *Excellent*). We summed the items to create a total scale score, with higher scores indicating a greater working alliance. The CSQ-8 has demonstrated strong internal consistency (i.e., Cronbach's alphas ranging from 0.80 to 0.90) and criterion validity (Bickman and Kelley 2001; Larsen et al. 1979). The CSQ-8 demonstrated excellent reliability in this study, with a coefficient alpha of 0.92.

2.5.6 | Working Alliance—Bond

We used the four-item "bond" subscale of the Working Alliance Inventory, Short, Revised (WAIS-SR; Munder et al. 2010) to measure the quality of the therapeutic alliance. An example item is, "(Therapist) and I respect each other." Participants rated their level of agreement with each item on a 5-point scale ranging from 1 (*seldom*) to 5 (*always*). Items were summed, with higher scores indicating greater working alliance–bond levels. The WAI-SR has demonstrated strong psychometric properties in outpatient populations, with Munder et al. (2010) reporting

high internal consistency (Coefficient alpha = 0.90) and validity across its subscales. In the present study, the WAI-SR also demonstrated excellent reliability, with a coefficient alpha of 0.86.

2.5.7 | Behavioral Intentions After Discharge: Suicide Safety, Recovery, Treatment Engagement

After a thorough literature review, we determined that established psychometrically valid measures of *behavioral intentions* to engage in (a) suicide safety practices (e.g., safety plan use), (b) suicide recovery practices (e.g., meaningful living behaviors), and (c) treatment engagement post-discharge do not exist. Therefore, we worked with CSC partners to create a tailored questionnaire to measure these constructs using the Theory of Planned Behavior (Appendix A; TPB; Fishbein and Ajzen 2010). Specifically, we (a) defined the target behavior specific to the population, (b) generated sample items, (c) pilot tested the measure, eliciting feedback via cognitive interviewing questions, and (d) revised and finalized the measure (Dunstan et al. 2012). An example item measuring treatment engagement intentions is, "After leaving the CSU, how often do you plan to attend outpatient counseling/therapy appointments?" Participants were asked to rate each item on a scale ranging from 1 (*none of the time*) to 5 (*all of the time*). We examined descriptive statistics for each item, with higher scores indicating greater behavioral intentions.

2.5.8 | Safety: Electronic Health Record Review

We completed chart reviews for THRIVE-C guests to assess the safety of the THRIVE-C intervention. Specifically, we examined guests' treatment notes and discharge summaries to assess (a) changes in suicidal ideation during the CSC stay, (b) suicide attempts at CSC, and (c) care environment escalations (e.g., transfer to inpatient) during the CSC stay.

2.6 | Analytic Approach

We conducted the analysis using IBM SPSS 30.0 and NVIVO 15. We used descriptive statistics to examine THRIVE's feasibility, acceptability, appropriateness, social validity, and safety. We used classical content analysis (Krippendorff 2013) to extract themes about THRIVE-C acceptability, uniqueness, and potential benefits from open-ended prompts. We used an Electronic Health Record (i.e., EHR) review form to document safety after receiving THRIVE-C and before CSC discharge.

3 | Results

3.1 | Feasibility of Research Study Procedures

During the recruitment period (June 2, 2022 to November 29, 2022), 199 individuals indicated interest in the study via the research interest form (Consort diagram, Figure 1). Of these, 179 individuals (90%) were medically cleared to participate. Due to the resource limitations of this pilot study, only 61 (34%) individuals who were medically cleared and interested in the study were approached for screening and enrollment. Fifty-four participants (90% of those approached) met enrollment criteria and consented to the study. Due to earlier-than-expected CSC discharges, 51 (94%) of the consented participants completed the THRIVE-C intervention.

3.2 | Analysis of Hypotheses

3.2.1 | CSC Stakeholders and Study Therapists (H1)

For H1a, we hypothesized that CSC stakeholders and study therapists would rate the feasibility, acceptability, appropriateness, and social validity of THRIVE at or above 75%. Ratings of THRIVE-C by CSC stakeholders and study therapists are shown in Table 3. CSC stakeholders ($n = 14$) rated THRIVE-C as follows: feasibility (i.e., FIM; 80%, $M = 4.00$, SD = 0.39), acceptability (i.e., AIM; 82%, $M = 4.12$, SD = 0.52), appropriateness (i.e., IAM; 80%, $M = 4.00$, SD = 0.50). CSC study therapists ($n = 5$) rated THRIVE-C as follows: feasibility (i.e., FIM; 94%, $M = 4.70$, SD = 0.38), acceptability (i.e., AIM; 95%, $M = 4.70$, SD = 0.38), and appropriateness (i.e., IAM; 97%, $M = 4.90$, SD = 0.19). CSC Stakeholders rated the social validity of THRIVE as 94%. CSC Stakeholders reported overall "moderate" implementation climate readiness for adopting Evidence-based practices (ICS Total Score = $M = 2.00$, SD = 0.78). H1a was supported.

For H1b, we hypothesized that at least 75% of study therapists would complete the THRIVE-C intervention with at or above 75% fidelity. In this study, 100% of study therapists completed THRIVE at or above 75% fidelity. Study therapists achieved an average of 13 out of 15 (i.e., 86.67%) points on adherence and 12 out of 15 (80%) competence scores. H1b was supported.

3.2.2 | CSC Guests (H2)

For H2, we hypothesized that CSC guests' ratings of THRIVE-C feasibility, acceptability, appropriateness, and satisfaction would be at or above 75% (H2a), and at least 75% of guests would complete all four phases of the intervention within 60 min (H2b). CSC guests ($n = 54$) rated THRIVE-C as follows: feasibility (i.e., FIM; 94%, $M = 4.32$, SD = 0.46), acceptability (i.e., AIM; 96%, $M = 4.52$, SD = 0.45), appropriateness (i.e., IAM; 98%, $M = 4.47$, SD = 0.46), satisfaction (87%; $M = 3.61$, SD = 0.33). THRIVE completion rates were 94%, and the average completion time was 56 min (SD = 3.02 min). H2a and H2b were supported.

As an exploratory aim, we examined CSC guests' therapeutic alliance (bond) during the ultra-brief THRIVE-C intervention and their behavioral intentions to engage in suicide safety and recovery behaviors after CSC discharge. CSC guests' mean score on the WAIS-SR (Bond) was 4.85 (SD = 0.23), indicating they experienced mutual respect, appreciation, and care "very often." CSC guests receiving THRIVE-C rated their behavioral intentions to participate in suicide safety and recovery behaviors after discharge as follows: Safety plan use (89%; $M = 4.46$, SD = 0.71), lethal means restriction (93%; $M = 4.64$, SD = 0.53), meaningful living plan use ($M = 94\%$; 4.72,

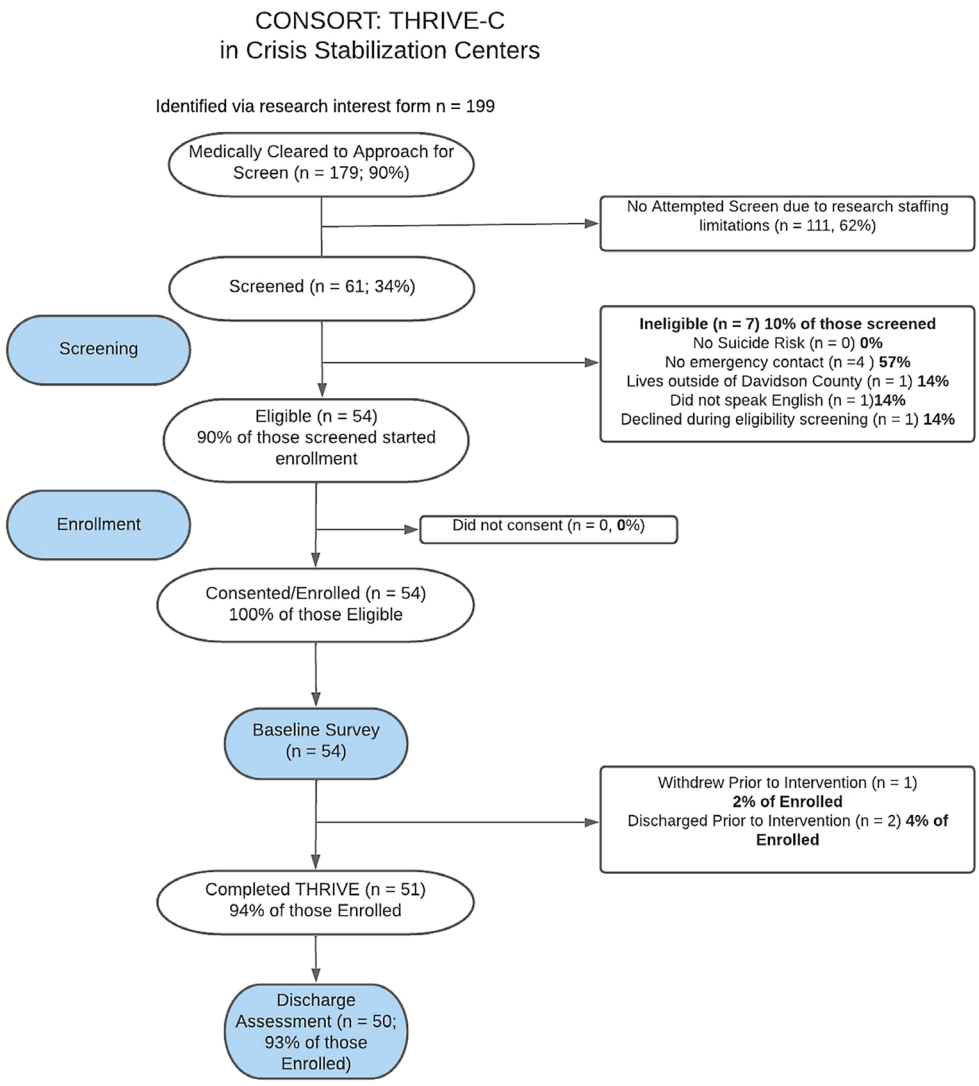

FIGURE 1 | CONSORT diagram: THRIVE-C in crisis stabilization centers.

TABLE 3 | Feasibility, acceptability, and intervention appropriateness of THRIVE in CSCs.

	Stakeholders ($n=14$)			Study therapists ($n=5$)			Guests ($n=54$)		
Measure	**% Achieved**	***M***	**SD**	**% Achieved**	***M***	**SD**	**% Achieved**	***M***	**SD**
Feasibility of implementation (FIM)	80%	4.00	0.39	94%	4.7	0.38	94%	4.32	0.46
Acceptability of intervention measure (AIM)	82%	4.12	0.52	95%	4.8	0.38	96%	4.52	0.45
Implementation appropriateness measure (IAM)	80%	4.00	0.50	97%	4.9	0.19	98%	4.47	0.46

Note: H1 and H2 goals for percentage achieved were greater than or equal to 75% for allgroups. All scale ranges include: 1 = completely disagree, 2 = Disagree, 3 = Neither agree nor disagree, 4 = Agree, 5 = Completely agree.

SD = 0.40), help-seeking for suicidal thoughts (95%; $M = 4.76$, SD = 0.25), taking medication as prescribed (97%; $M = 4.86$, SD = 0.58), attending outpatient psychotherapy appointments (91%; $M = 4.56$, SD = 0.58), following CSC discharge recommendations (96%; $M = 4.80$, SD = 0.34). We present CSC guests' feedback on the acceptability, uniqueness, and potential benefits of THRIVE-C in Table 4.

3.2.3 | Safety

Participants completed the THRIVE intervention safely. No participants were withdrawn from THRIVE-C for safety concerns by the Investigative team, and no participants experienced increased suicidal ideation, care escalation (i.e., transfer to inpatient), or suicide attempt after participating in THRIVE-C. All

TABLE 4 | Guest feedback on acceptability, uniqueness, and potential benefits of THRIVE-C.

Acceptability of THRIVE-C	Uniqueness of THRIVE-C	Potential benefits of THRIVE-C
I felt comfortable participating because I got a chance to look at myself inside out. And I learned things I didn't know I needed to work on about myself	I think the difference was that I let my story counsel both of us. I was able to see that my testimony provided counsel to both me and my counselor	I felt like the weight was lifted off of me about suicide after the meeting. Now that I have a plan, I'm ready to move forward and make progress
I was nervous about talking about my problems, but I felt a little better afterwards. She helped me look at everything from a different perspective. This is the most I've smiled	The most helpful part was the lifeline. It helped me put on a line where the goodness was, and it helped me realize that there was more good than I thought	Liked that you create a plan afterwards and don't just talk about your life. It doesn't leave you up in the air with your emotions
It was very freeing in a sense. My therapist was so amazing. The last few times I came in, I didn't see a therapist, and I forgot what it was like to connect with somebody, and I just feel really hopeful now	Past experiences (in therapy) have never made me feel this happy. It made me feel like there's worth, and I'll be helping someone else	Seeing how much life I have left. Use the things you learn as a guide to help make a plan for the future
It was something I did not expect to have when I came here, but I'm very glad I got to participate because it gave me a way to break down my biggest traumas in my life into a more concise way of thinking about them. I've never done that before. This was very enlightening for me personally, so I can move forward	I feel like this was more open. I really liked the timeline with the string. It gave me the opportunity to see the things I've been through, positive and negative, which gave me a lot to think about	I really liked it. I feel like it really helped me get more concise, actionable steps toward finding more joy and happiness. Putting myself and my self-care needs first to find more positivity in my everyday life. I have to incorporate those things in order to be better, to feel better. I think I would go to therapy if it were more like this

THRIVE-C participants ($n = 54$; 100%) were discharged safely to their communities.

4 | Discussion

Results indicate that THRIVE-C is feasible, acceptable, appropriate, and socially valid for CSCs. Stakeholders and study therapists rated these dimensions highly ("agree" to "completely agree"). Study therapists achieved fidelity after brief training (i.e., 7 h), demonstrating high adherence and moderate competency. CSC guests strongly endorsed the intervention, with 94% completing all phases within 60 min, supporting both study hypotheses. CSC guests reported strong behavioral intentions to engage in safety, recovery, and treatment engagement in outpatient care following discharge.

This study provides support for the study procedures used to examine THRIVE-C in a CSC setting. In this study, only 34% of individuals who expressed interest in research and were medically cleared were approached for screening due to resource limitations. However, of those approached, 90% of screened individuals met enrollment criteria and consented to research. These findings demonstrate strong recruitment viability and allow us to calculate staffing resources needed to fully capitalize on available patient flow in future trials. Although this study was not designed to test retention after discharge, participant characteristics suggested high levels of homelessness and housing transience. Thus, future research in CSCs may need to use retention procedures uniquely designed for and used successfully with homeless and housing-transient persons (Strehlau et al. 2017).

As an exploratory aim of this study, we examined CSC guests' behavioral intentions to engage in suicide safety, recovery, and treatment engagement post-discharge. CSC guests receiving THRIVE-C reported high levels of behavioral intentions to engage in suicide safety behaviors (e.g., using their safety plans, engaging in lethal means safety), suicide recovery behaviors, and treatment engagement after discharge. This finding is consistent with other studies' findings that brief suicide-specific interventions are feasible and acceptable, although support for treatment engagement across other ultra-brief suicide-specific interventions has been mixed (Britton et al. 2012; Stanley et al. 2023; Stanley and Brown 2012; O'Connor 2015, 2020) THRIVE-C's potential influence on post-discharge treatment engagement warrants further investigation.

This study examines a recovery-focused psychological intervention designed to align with community-based CSC philosophies. Although existing suicide-specific treatments typically prioritize physical safety and stability from suicide or suicide safety skills prior to working on recovery (Jobes 2024; Linehan 2020), 94% of persons receiving THRIVE-C demonstrated readiness for recovery work by creating a Meaningful Living Plan. This suggests that suicidal persons in CSCs may be able to engage meaningfully and safely with recovery goals earlier than expected. A focus on recovery (i.e., clinical and personal recovery) in suicide-specific interventions is consistent with preferences shared by persons with lived experiences of suicide, including in The Way Forward Report (National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Taskforce 2014). Additional research through controlled trials is needed to further evaluate the timing and implementation of recovery-focused interventions in crisis care settings.

4.1 | Study Strengths and Limitations

Increasing the quality of care in CSCs is a goal in the 2024 National Strategy for Suicide Prevention and has been highlighted in recent funding applications from the National Institute of Mental Health. This study suggests that CSC guests may be highly interested in participating in suicide prevention research, able to meet enrollment criteria common in suicide studies, and able to consent independently. To our knowledge, this study is the first to examine a recovery-focused psychological intervention in a CSC setting.

This study has several limitations. The study stakeholders in this study are a convenience sample ($n = 15$), and their views may not generalize to the population of CSC Stakeholders. CSCs have diverse staffing structures and offer diverse treatment options (TBD Solutions 2018), suggesting that future research on implementation facilitators and barriers for interventions such as THRIVE-C is needed. We were unable to find similar studies of brief suicide-specific interventions that assessed feasibility and acceptability using the measures that we have included, hence making comparisons about feasibility, acceptability, and appropriateness to similar interventions difficult. Our sample of THRIVE-C guests ($n = 54$) is sufficient for a feasibility study; however, the number of participants is too small for generalizability to the population of guests seen in CSCs. We adapted the social validity measure of this study, which may affect its validity. Although we used recommended procedures to create scales of behavioral intentions according to the Theory of Planned Behavior (Dunstan et al. 2012), we do not know the degree to which these measured intentions are associated with actual behaviors post-discharge. Demand characteristics are a limitation in studies involving suicidal individuals' self-report data, which may have influenced the outcomes of this study (Blanchard and Farber 2016). Whereas this study was designed as a pilot study to achieve stage 1b aims of the Stage Model of Behavioral Therapies Research (Rounsaville et al. 2001), the lack of a comparison group prohibits causal inference of study outcomes.

5 | Conclusion

This study demonstrates that THRIVE-C is feasible, acceptable, appropriate, and socially valid according to CSC guests, study therapists, and stakeholders. THRIVE-C matches the recovery philosophy, workflows, and staffing needs of CSCs. CSC guests indicated high levels of satisfaction with THRIVE-C, a therapeutic bond with their therapist, found the recovery focus of the intervention unique and personally meaningful, and reported high behavioral intentions to engage in outpatient treatment post-discharge. Further development and testing of THRIVE-C are warranted.

Author Contributions

Jennifer D. Lockman: conceptualization (equal), data curation (lead), formal analysis (lead), funding acquisition (equal), investigation (lead), methodology (equal), project administration (lead), writing – original draft (lead), writing – review and editing (lead). **Anthony R. Pisani:** conceptualization (equal), funding acquisition (equal), methodology (equal), supervision (lead), writing – review and editing (supporting). **Breanna P. Angerer:** writing – original draft (supporting), writing – review and editing (supporting). **Adam C. Graham:** conceptualization (supporting), methodology (supporting), project administration (lead), writing – review and editing (supporting). **Jacob Henry:** project administration (lead), writing – review and editing (supporting). **Fallan Lloyd:** project administration (lead), writing – review and editing (supporting).

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Conflicts of Interest

The authors declare no conflicts of interest.

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Appendix A

Treatment Engagement Intentions Questionnaire (TEIQ)

Response Options:

None of the time	Occasionally	Some of the time	Most of the time	All the time
1	2	3	4	5

Directions: After you leave the CSC, how often do you intend to...

_____a. Use your suicide safety plan.

_____b. Restrict your access to lethal means of suicide (e.g., locking up guns, pills).

_____c. Use your meaningful living plan.

_____d. Seek help for your suicidal thoughts when needed.

_____e. Take your medications as prescribed.

_____f. Attend outpatient counseling/therapy appointments.

_____g. Follow the discharge recommendations provided by the CSC.