

Joint crisis plans and inpatient care: a qualitative study

G.C.R. van Asperen

Student number: 4301927

Final version

29-06-2017

Universiteit Utrecht, Master Clinical Health Science, Master Nursingscience, UMC-Utrecht

Supervisor: Roland van de Sande

Course tutor: Thora Hafsteinsdottir

Institution: Parnassia Groep, Rotterdam

Journal: International Journal of Mental Health Nursing

Reference style: Vancouver

Words: 3799

Criteria transparant reporting: COREQ guidelines

Words abstract: 299

ABSTRACT

Joint crisis plans and inpatient care

Background: Patients suffering from a severe mental illness (SMI) are likely to face relapse and psychiatric readmission. Although joint crisis plans (JCP) are clinically relevant aids to avoid coercion, this complex intervention is prone to implementation and sustainability barriers. The effectiveness of JCPs is evaluated in robust quantitative studies, but the process of establishing a JCP seems to be under researched.

Aim: To gain insight in the beneficial and impeding factors in the process of establishing a JCP with a SMI patient.

Method: A generic qualitative study was conducted using semi-structured interviews. Twelve healthcare professionals were selected, having experiences in the process of establishing JCPs on an inpatient ward of a psychiatric hospital in the Netherlands, in 2017. The interview findings were recorded, transcribed, content-analysed and thematised. In the second stage, these findings were made available for peer review and member check.

Results: Three core themes were identified as influencing factors: the validation of the JCP, the engagement of the patient and the patient-centered support. The successful validation of the JCP is associated with the shared decision-making in the triad: patient, healthcare professional and carer. The engagement of the patient depends on the level of motivation, the symptom profile and corresponding abilities. The patient-centered support depends on the abilities of the healthcare professional during the process and the collaboration between the healthcare professionals.

Conclusion: This study revealed three themes serving both as beneficial and impeding factors. The combination of engagement of the patient and patient-centered support leads to the validation of the JCP: the key concept to make the process work.

Recommendations: Further research should focus on the use of JCPs once the patient is discharged to a community based context.

Keywords: joint crisis plan, severe mental illness, qualitative research, thematic analysis

1. INTRODUCTION AND RATIONALE

In Europe, 27% of the population experienced at least one mental illness in the past year¹. A small proportion of the population, about 6%, suffer from severe mental illness (SMI)². In the Netherlands, the definition of Delespaul (2013) is widely used. More specifically: SMI includes the long-term consequences of severe (uni- and bipolar) mood disorders, psychotic disorders, and (borderline) personality disorders³. In addition to this, SMI patients suffer from SMI more than two years combined with significant deterioration in social functioning which is defined in a cut off score below 50 measured by means of the Global Assessment of Functioning Scale (GAF)⁴. Poor social functioning in combination with severe psychiatric symptoms often cumulate in high levels of emotional distress, loss of control or even coercive interventions^{3,5-6}

Risk factors for readmission are sudden symptom exacerbations, prior (involuntary) psychiatric admissions, the lack of social support and drugs and alcohol abuse⁷⁻⁸. Involuntary admissions are associated with the negative consequences on the patient's autonomy and may evoke traumatic experiences which could result in a next barrier for future help-seeking behavior⁹⁻¹⁰. Those revolving door involuntary psychiatric admissions increase health care costs whereas some relevant research findings indicate that those events are at times preventable¹¹⁻¹². Internationally rates of readmissions are difficult to compare, due to inconsistent data collection procedures. However, it is widely known that several West European countries are facing a clear increase of involuntary admissions in the last decade¹³.

A recent meta-analysis of relevant RCT's showed a significant risk reduction in involuntary admissions by advance statements of patients¹⁴. Ideally a joint crisis plan (JCP) includes the patients (future) de-escalation preferences in observed early signs of relapse. The key element of these personalized advanced directives is that patients are involved in the shared decision-making process in a relative stable condition. Listing and agreeing on specific warning signs are key elements in the process of negotiating on individual preferences of action in specific escalation scenario's¹⁵. The agreed JCP is given to the patient in a written document and can be used to supply information to healthcare professionals in potential escalation scenario's. Most of these crisis plans contain lessons learned (positive and negative) from previous crisis episodes¹⁶.

Although JCPs are clinical relevant aids to avoid coercion, this complex intervention is also prone to implementation and sustainability barriers¹⁷. The view and attitude of healthcare professionals may be a very important vehicle in the success rate of JCPs¹⁸. On the other

hand, a phenomenological study on the use of JCPs revealed that the intervention helped patients to regain some control over their lives¹⁹. The origin of the apparent inconsistencies may lay in the under researched topic of the process of establishing a JCP. Especially the process of sound implementation of such evidenced based interventions in hectic working environments²⁰. Therefore, focus on the views and attitudes of healthcare professionals towards JCPs needs further exploration. This exploration is aimed to gain insight in the beneficial and impeding factors in the process of establishing a JCP. Insight in these factors may facilitate refinements in clinical utility and sustainability process of JCP's for SMI patients.

2. METHODS

This study was conducted in accordance to the standards of Good Clinical Practice, in agreement with the Declaration of Helsinki²¹, Dutch law in general and with the Medical Research Involving Human Subjects Acts (WMO) in particular²². This study does not need approval by the regional medical ethical committee; no patients were exposed to extra intrusive interventions. In this study only healthcare professionals were interviewed on a voluntary basis under informed consent. Results in the final report will be non-traceable to individual participants.

Study design

This study is focused on qualitative data collection and data-analysis as the aim of the study is to promote an in-depth understanding the process of working with a complex intervention²³ such as the establishment of a JCP. This results in a generic qualitative research design²⁴.

Setting and subjects

This study has been conducted in a psychiatric hospital in an urban catchment area in the Netherlands. The study was focused on exploring the views and attitudes of healthcare professionals in the process of establishing a JCP during the admission episode. The respondents were selected on the basis of having experiences in the process of working towards at least three JCPs with SMI patients. Participants with a range of variations were selected by purposeful sampling. The dimensions interesting for this study were gender, education level, function and experience. Maximum variation sampling was used to ensure the representation of the dimensions. A guiding principle during recruiting participants was data saturation²⁵.

Data collection

Semi-structured interviews were conducted to elicit participants focus on establishing a JCP²⁵. To structure the process, an interview guide was used (Appendix 6.1), based on a literature review on therapeutic relationships and previous research on barriers for the implementation of shared decision-making^{18,20}. The topic-list was organised around two topics: the experienced beneficial and impeding factors establishing a JCP. To refine the topic guide, a pilot interview took place, without consequences for the topic guide. The participants were recruited in February 2017. The interviews were conducted by a student nurse scientist / licensed mental health nurse (RvA). A colleague (RS) from another psychiatric hospital monitored the interview data collection and analysis process. The interviews took place in the wards after obtaining informed consent in a three-month period. The duration of the interviews was 30 - 40 minutes. The interviews were audio-recorded and the interviewer made field notes during and after each interview²⁵. After each interview, the researcher summarized the findings, so the interviewee could directly comment on it. This member check was conducted to be sure of the valid representation of the experiences of the participants²⁵.

Data analysis

Data were analyzed according to the thematic analysis²⁶ by two independent researchers (RvA and RS) and were discussed with a third researcher (RvdS). All interviews were transcribed verbatim immediately after each interview (RvA). Data analysis was supported by NVivo 11.0 software. The phases of thematic analysis from Braun & Clark (2006) were used to carry out the analysis²⁷. Memo writing supported the process of analysis. During the first phase, two researchers (RvA and RS) read the interviews and made an initial list of ideas about what was in the data and what was interesting about them. The second phase consisted of generating initial codes. Two researchers (RvA and RS) created separately initial codes. The separately created codes were discussed by the researchers until agreement has achieved after four interviews. The code tree was determined and used to code the next interviews. Hereafter, two researchers (RvA and RS) discussed after every new interview until agreement has achieved. The third phase consisted of searching for themes. This phase started when twelve interviews were coded. A researchers (RvA) analyzed the codes and created initial themes. A thematic file was created to give insight into the relationships between codes and themes. The fourth phase consisted of reviewing the themes. The researchers (RA and RS) discussed whether the created themes covered the codes and a thematic map was created. The fifth phase consisted of defining and naming the themes according to the beneficial and impeding factors in the process of establishing a JCP. A researcher (RA) identified the essence of the themes and determined what aspect of the data each theme covered in the final analysis.

3. RESULTS

The sample characteristics of the healthcare professionals are showed in Table 1. The sample consisted of nine female and three male healthcare professionals. All approached respondents fully participated in the study. Data saturation was achieved after eight interviews. The next four interviews were already scheduled and continued to ensure data saturation.

Three overarching themes were identified in the data: 'Validation', 'Engagement' and 'Support'. Depending on the context the three themes can serve as beneficial or impeding factors. A diagram provides an overview of the themes (Figure 1).

Theme 1: Validation

All respondents mentioned the personalized value of the JCP as the most important beneficial factor of the establishing process. Almost all respondents emphasize the early warning function for the patient, the healthcare professional and the carer.

“A JCP is important for the patient himself, for the carers, for the patient’s environment and for the healthcare professional. They need to recognize the early warning signs when the patient’s mental state is getting worse”.

(Participant 6)

But they also mention the validity of this complex intervention: it is believed by some respondents that not all patients experience the same benefits from JCP. According to some respondents the expected benefits of listing the personalized warning signs in a JCP for the long term often seems the driving force in the process of establishing a plan. The validation then serves as an impeding factor. It is argued that the process can both be therapeutic and in some cases evoke traumatic experiences, which may threaten the patient’s stable condition.

“The patient doesn’t have to think about it all the time, this helps nobody, nothing. Everything has been said and done and then they have to tell it again; crying, upset, insomnia: and another drug”.

(Participant 4)

Some respondents stated that a JCP must also be considered as valid by the professionals as this plan can serve as a tool to choose the right interventions for the specific patient. In addition to this some healthcare professionals mentioned that the preferred interventions should always be judged in the specific context (both inpatient and outpatient scenarios). In

other words, the JCP must be appropriate for the situation of the patient to avoid that patients and staff lose their confidence in the established JCP.

“Using a JCP at home is really different from using it at the clinic. Maybe it also ends with calling the crisis service, or letting someone call it. But the interventions at home are different, there is no healthcare professional at home”.

(Participant 12)

Most respondents agreed that the JCP can also serve as a tool for the carer to act in the peak of a crisis situation. The JCP is valid enough for this purpose if the patient allows the carer to take a role in the recognition of early signs and the steps in the action plan. Some respondents even stated that the JCP can be valid for the carer, even when shared decision-making with the patient is nearly impossible due to the lack of insight or severe paranoid thoughts. The JCP then serves only as a tool for the carer and not for the patient. However, not all respondents agreed on this subject.

“I discussed with my colleges about this. If the patient doesn’t cooperate, I wonder if you can go to the carer and say: can you do something with this. But a JCP is very personal, so I wonder if this is the purpose of the intervention”.

(Participant 10)

The citation above illustrates that validation of the JCP stands with the shared decision-making in the triad: patient, healthcare professional and carer.

Theme 2: Engagement

The validity of the JCP depends on the way the patient wants to get involved during establishing a plan. All respondents agreed that engagement is a crucial part, that should be verified in the first steps of establishing of a JCP, otherwise it serves as an impeding factor.

“As a patient, you have to collaborate, you have to see the benefit. Around here you see of course a lot of people who want to participate voluntary on the treatment, they have the insight to make this possible”.

(Participant 1)

An important part of the engagement is the level motivation which is illustrated in the citation below

“Some patients are very serious, they work extensive so to say on JCP, I know someone with many sheets. Yes, and some other patients think it is just a formality, you have to make it, but it has no point at all”.

(Participant 7)

Almost all respondents stated that there must be a level of motivation to start with the JCP. Some patients have a lot of resistance against the JCP which needs to be overcome, other patients are intrinsically motivated from the start.

All respondents mentioned the symptom profile of the patient as an impeding factor.

“We have different people with different mental illnesses. Not all people have a bipolar disorder, it is per person, very individual, not universal”.

(Participant 8)

Every mental illness has its own pitfalls, mentioned by different respondents. Patients with psychotic disorders often have a lack of insight in the consequences of the symptoms and need external motivation to create a JCP. Some respondents state that most patients with depression are more often able to create a JCP, but have troubles using it. They know what to do, but they cannot act adequately in a crisis situation. Patients with a personality disorder are quite capable to design their own JCP. Some respondents state that unfortunately they sometimes misuse JCP to externalize or justify their loss of control or impulsive behavior.

All respondents agreed on the importance of insight in the mental disease as a beneficial factor on the establishing process.

“A JCP is a good idea for someone with insight in his disease. A patient must establish his own plan and there is not much added value when the carer of someone else fills in the plan. Insight in the disease is crucial for the establishing”.

(Participant 9)

There are strong beliefs that reflection leads to warning signals that are specific for the patient. These efforts can however only work if the interventions are linked in a personalized way to prevent a next crisis. According to this, most respondents mentioned the importance of a relatively stable condition of the patient. Some healthcare professionals argue that during the crisis, the patient's self-reflection is blurred by high arousal in the brains. Therefore, they are convinced that the crisis episode should be over before touching confronting elements of the reflection, otherwise you may even provoke another crisis.

“There is a target population where you mention it won't work, you cannot finish it. Those patients are in a phase where they cannot handle it. That can happen. Too less insight or not stable enough”.

(Participant 1)

Half of the respondents stated that the patient must understand why it is useful to have an early warning intervention to prevent a former crisis situation. This requires knowledge about

the JCP structure, provided by the healthcare professional. An impeding factor in this process can be (partial) cognitive impairments of the patient.

“I think it is demanding a lot from someone’s intelligence to realize the importance of a JCP”.

(Participant 2)

Theme 3: Support

The validity of the JCP also depends on the way the healthcare professionals act during the establishing process. Almost all respondents mentioned patient-centered support as a beneficial factor for the establishing.

“It also depends on the patient. One patient can do it almost by himself and the other needs more support”.

(Participant 3)

This process urges to remain focused on achieving a JCP by shared decision-making principles with the patient and carer during the process. Diverse aspects of the supporting role of the mental health professionals were mentioned by different respondents. All respondents mentioned time management aspects. Time is needed for conversations about the JCP, which is challenging because of the experienced work pressure. The process of establishing a JCP also strongly rely on the motivation of the healthcare professional, in fact he or she needs to prioritize the JCP during the conversations with the patient. In-depth knowledge of the pros and cons of JCPs is crucial to guide the process according some respondents.

“I also think the healthcare professional is important, it depends on the healthcare professional. Do we all know there is a JCP?”

(Participant 8)

Most respondents mentioned that support can come from outside the triad: external motivation. Mostly other healthcare professionals, like psychiatrists or outpatient therapists are referring to other healthcare professional to establish the JCP before discharge. Some respondents appreciate this external motivation, others do not. They want to make their own decision about the most appropriate period to establish the JCP.

Support is also mentioned by all respondents as collaboration between healthcare professionals. The JCP is an on-going document which needs to be refined when the situation of the patient changes, but mostly the responsible healthcare professional changes too. This appeals to good communication during the transfer of a patient, to continuing the support with the JCP. Most respondents suggested this collaboration needs to be improved.

“In the future, we need to collaborate better, it is crazy how much information gets lost when a patient goes home, how many things will be done again, asked again, searched again. This is more work for us and frustrated for the patient”.

(Participant 5)

4. DISCUSSION

Based on respondent narratives, three themes were identified as influencing factors to establish a JCP: 1.) the validation of the JCP, 2.) the engagement of the patient and 3.) the patient-centered support. Depending on the context the three themes can serve as beneficial or impeding factors. The gained insight from the interviews revealed that engagement of the patient depends on the level of motivation, the symptom profile and corresponding abilities are seen as the most important influential aspects. The support depends on the abilities of the healthcare professional, the motivation of the carer and the collaboration between them and the environment. The combination of engagement and support leads to the validation of the JCP.

Several of the findings of this study were in line with other studies²⁸⁻³⁷. The respondents clearly seem to value the early warning function of the JCP. A randomized controlled trial involving the views of patients towards JCPs showed that patients felt more in control over their psychiatric symptoms²⁸. However, the respondents also stated that a JCP is not valid for all patients. A review on the literature on early warning signs in patients with schizophrenia confirms this type of statements. It concluded that the time interval between the first early warning signs and the crisis situation is long enough for early de-escalation intervention strategies. In a small majority (around 10%) the psychotic outbreak occurs so rapidly that early recognition fails and time to use appropriate de-escalation is critical or even chanceless²⁹.

In line with the relevant scientific literature the respondents mentioned the triad as an important mechanism in establishing a JCP³⁰. Literature on this subject underscore this mechanism. The carer diagnoses, acts in crisis situations and serves the interests of the patient. Carers suffer also from the mental illness of the patient. Good contact with healthcare professionals is good for the patient and the carer himself³¹. A qualitative study focused on these aspects, even revealed that JCPs can improve the therapeutic relationship between patients and healthcare professionals³².

Engagement and support leads to the validation of the JCP, according to the respondents in this study. A review on the literature on treatment engagement of SMI patients also connects those three themes. SMI patients are difficult to engage in ongoing treatment, but person-centered care, including shared decision-making, affect the engagement in a positive way³³.

The respondents stated that a level of motivation is necessary for a patient to use appropriate de-escalation actions. The relevant literature on the stages of change showed that patients suffering from a mental disorder differ greatly in their readiness to take action³⁴. Lesson learned from scientific evaluations (2002) reveal that about 40% do not recognize that they have psychiatric symptoms. Another 40% are aware of the problem but are not yet ready to act. Only 20% are currently taking action³⁵. It is important that support from the healthcare professional connects to the stage of change the patient is in.

Patient-centered care is mentioned by the respondents as a main condition for providing support with the establishing process. This matches with the new concept of health as 'the ability to adapt and to self-manage, in the face of social, physical and emotional challenges'. This concept empowers the patient³⁶. A study to the facilitators and barriers of person-centered care shows that collaboration and external guidance from the environment of the triad is important. A qualitative study to person-centered care revealed that leadership is important to support the healthcare professional and the patient during the process³⁷.

An important strength of this study was that data were independently analyzed by two researchers and discussed with a third researcher during the entire process. Although the results of this study were based on twelve patients, maximum variation sampling increased the likelihood of diversity in the collected data, which contributed to the transferability of the study. There was no withdrawal of respondents. Data-saturation was achieved and confirmed. Due to this, the aim of the study to reveal beneficial and impeding factors has been achieved.

There are also limitations. The respondents worked on a ward of a psychiatric hospital, so all JCPs were established during the admission period. This period is not stable for the patient and could have influenced the ability to participate on the process. The involved healthcare professional will change after discharge, so the benefits for the therapeutic relationship will not persist. On the other hand, during the admission period there is enough time to reflect on the crisis situation. If this reflection provokes traumatic experiences, those will be seen by healthcare professionals and they can directly react. Another limitation could be that one interviewer conducted interviews. If two researchers conducted the interviews, this would have strengthened the findings.

This study provides guidance for healthcare professionals to deliver and adapt the establishing of a JCP in daily practice. To gain the necessary in-depth knowledge of the process, a recommendation is to train healthcare professionals to establish a JCP, so the support they must give can be strengthened. The knowledge revealed in this study can be used to shape the training. Further qualitative research is required on the clinical practice of JCPs with outpatients, so the full spectrum of the establishing process can be mapped and

collaboration between inpatient and outpatient healthcare professionals can be strengthened. When the implementation barriers are solved, a RCT towards the effect of JCPs on readmissions and relapse is indicated to reveal the added value.

This study provided insight into the influencing factors on healthcare professionals to establish a JCP with SMI patients. Three themes were identified in the data and confirmed by literature on this subject as both beneficial and impeding factors. The JCP must be valid for the patient, the healthcare professional and the carer. Validation can be found in engagement of the patient and support from the healthcare professional and the environment. Important for engagement is the level of motivation of the patient and the profession of the healthcare professional to connect with the patient's stage of change. Important for the support is the patient-centered way it must be provided.

5. REFERENCES

- (1) WHO Regional Office for Europe. Data and statistics. Prevalence of mental disorders. 2016; Available at: <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics>. Accessed 03/21/2016.
- (2) Borges G, Angst J, Nock M, Ruscio A, Walters E, Kessler R. A risk index for 12-month suicide attempts in the National Comorbidity Survey Replication (NCS-R). *Psychological Medicine* 2006;36(12):1747-1757.
- (3) Delespaul P. Consensus regarding the definition of persons with severe mental illness and the number of such persons in the Netherlands | Consensus over de definitie van mensen met een ernstige psychische aandoening (EPA) en hun aantal in Nederland. *Tijdschrift voor psychiatrie* 2013;55(6):427-438.
- (4) Parabiaghi A, Bonetto C, Ruggeri M, Lasalvia A, Leese M. Severe and persistent mental illness: a useful definition for prioritizing community-based mental health service interventions. *Social Psychiatry and Psychiatric Epidemiology* 2006;41(6):457-463.
- (5) Ruggeri M, Leese M, Thornicroft G, Bisoffi G, Tansella M. Definition and prevalence of severe and persistent mental illness. *British Journal of Psychiatry* 2000;177:149-155.
- (6) Johnson DL. Overview of severe mental illness. *Clinical Psychology Review* 1997;17(3):247-257.
- (7) Donisi V, Tedeschi F, Salazzari D, Amaddeo F. Pre- and post-discharge factors influencing early readmission to acute psychiatric wards: implications for quality-of-care indicators in psychiatry. *General Hospital Psychiatry* 2016;39:53-58.
- (8) Rylander M, Colon Sanchez D, Keniston A, Hamalian G, Lozano A, Nussbaum A. Risk Factors for Readmission on an Adult Inpatient Psychiatric Unit. *Quality Management in Health Care* 2016;25(1):22-31.
- (9) Swartz M, Swanson J, Hannon M. Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals. *Behavioral Sciences & the Law* 2003;21(4):459-472.
- (10) Katsakou C, Rose D, Amos T, Bowers L, McCabe R, Oliver D, et al. Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study. *Social Psychiatry and Psychiatric Epidemiology* 2012;47(7):1169-1179.

- (11) Durbin J, Lin E, Layne C, Teed M. Is readmission a valid indicator of the quality of inpatient psychiatric care? *Journal of Behavioral Health Services & Research* 2007;34(2):137-150.
- (12) Byrne S, Hooke G, Page A. Readmission: a useful indicator of the quality of inpatient psychiatric care. *Journal of Affective Disorders* 2010;126(1-2):206-213.
- (13) Salize H, Dressing H. Epidemiology of involuntary placement of mentally ill people across the European Union. *British Journal of Psychiatry* 2004;184:163-168.
- (14) Jong de MH, Kamperman AM, Oorschot M, Priebe S, Bramer W, vandeSande S, vanGool AR, Mulder CL. Interventions to reduce compulsory psychiatric admissions. A systematic review and meta-analysis. *JAMA Psychiatry* 2016;73(7):657-664.
- (15) Henderson C, Swanson J, Szmukler G, Thornicroft, Zinkler M. A typology of advance statements in mental health care. *Psychiatric Services* 2008;59(1):63-71.
- (16) Sutherby K, Szmukler GI, Halpern A, Alexander M, Thornicroft G, Johnson C, et al. A study of 'crisis cards' in a community psychiatric service. *Acta Psychiatrica Scandinavica* 1999;100(1):56-61.
- (17) Thornicroft G, Farrelly S, Szmukler G, Birchwood M, Waheed W, Flach C, et al. Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. *The Lancet* 2013;381(9878):1634-1641.
- (18) Henderson C, Farrelly S, Moran P, Borschmann R, Thornicroft G, Birchwood M, et al. Joint crisis planning in mental health care: the challenge of implementation in randomized trials and in routine care. *World Psychiatry* 2015;14(3):281-283.
- (19) Daggenvoorde T, Goossens PJJ, Gamel C. Regained control: a phenomenological study of the use of a relapse prevention plan by patients with a bipolar disorder. *Perspectives in Psychiatric Care* 2013;49(4):235-242.
- (20) Farrelly S, Lester H, Rose D, Birchwood M, Marshall M, Waheed W, et al. Barriers to shared decision making in mental health care: qualitative study of the Joint Crisis Plan for psychosis. *Health Expect* 2016;19(2):448-458.
- (21) Association WM. WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. *Asoc Médica Mund* [Internet]. 2013;(June 1964):1–8. Available from: <http://www.wma.net/es/30publications/10policies/b3/>
- (22) Nederlandse Overheid. Wet medisch-wetenschappelijk onderzoek met mensen [Internet]. 2016. Available from: <http://wetten.overheid.nl/BWBR0009408/2016-08-01>

- (23) Creswell J. 2007. *Qualitative inquiry & research design: choosing among five approaches*. SAGE Publications IT edition.
- (24) Caelli K, Ray L, Mill J. 'Clear as mud'. Towards a greater clarity in generic qualitative research. *Int J Qualitative Methods* 2003;2(2):1–23.
- (25) Polit, Denise F., Beck Cheryl T. *Nursing research: Generating and assessing evidence for nursing practice*. Ninth ed. Philadelphia: Wolters Kluwer Health; Lippincott Williams & Wilkins; 2008.
- (26) Percy W, Kostere K, Kostere S. Generic qualitative research in psychology. *Qual Rep*. 2015;20(2):76–85.
- (27) Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology* 2006; 3: 77-101.
- (28) Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szumukler G. Views of service users and providers on joint crisis plans: single blind randomized controlled trial. *Social Psychiatry and Psychiatric Epidemiology* 2009;44(5):369-376.
- (29) Meijel van B, Gaag van der M, Sylvain RK, Grypdonk MHF. Recognition of early warning signs in patients with schizophrenia: A review of the literature. *International Journal of Mental Health Nursing* 2004;13:107–116.
- (30) Bovenkamp van de HM, Trappenburg MJ. Niet alleen de patiënt centraal: Over familielieden in de geestelijke gezondheidszorg. *Instituut Beleid en Management Gezondheidszorg*. Erasmus MC Universitair Medisch Centrum Rotterdam; 2008.
- (31) Bovenkamp van de HM, Trappenburg MJ. De moeizame relatie tussen hulpverleners en familieleden in de GGZ. *Maandblad voor Geestelijke Volksgezondheid* 2009; 64(1-2):27-38.
- (32) Farrelly S, Lester H, Rose D, Birchwood M, Marshall M, Waheed W, et al. Improving Therapeutic Relationships: Joint Crisis Planning for Individuals With Psychotic Disorders. *Qualitative Health Research* 2015;25(12):1637-1647.
- (33) Dixon LB, Holoshitz Y, Nossell I. Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry* 2016;15:13–20.
- (34) Norcross JC, Krebs PM, Prochaska JO. Stages of Change. *Journal of clinical psychology* 2011 Feb;67(2):143-54.
- (35) Norcross JC, Prochaska JO. Using the Stages of Change. *Harvard Mental Health Letter* 2002;5-7.

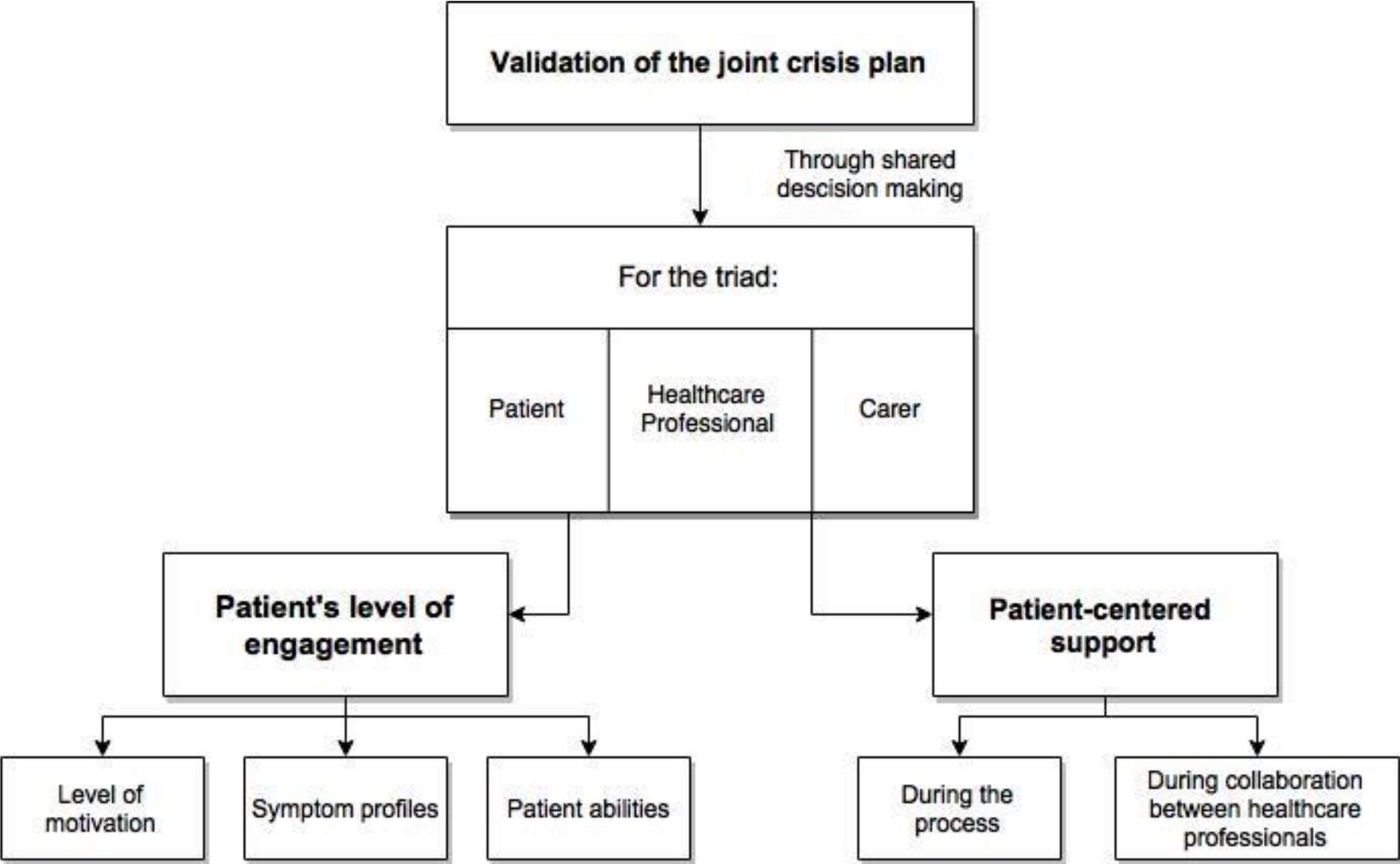
(36) Huber M, Vliet van M, Giezenberg M, Winkens B, Heerkens Y, Dagnelie PC, Knottnerus PA. Towards a 'patient-centred' operationalisation of the new dynamic concept of health: a mixed methods study. *BMJ Open* 2016;5:e010091.

(37) Moore L, Britten N, Lydahl D, Naldemirci O, Elam M, Wolf A. Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences* 2016;1-12.

Table 1. Baseline characteristics

Characteristics	N = 12
Gender, N(%)	
Female	9 (75)
Male	3 (25)
Age, year	35 ± 10,6
Education, N (%)	
Nurse, masters' degree	3 (25)
Nurse, bachelors' degree	3 (25)
Community worker	3 (25)
Social worker	2 (17)
Different	1 (8)
Function, N(%)	
Masters' degree	6 (50)
Bachelors' degree	6 (50)
Working experience	10 ± 9,2

Figure 1. Influencing factors for establishing a JCP with a SMI patient



6. APPENDIX

6.1 Interview guide

General information

Date:

Place:

Interviewer

Interviewee:

Age:

Gender:

Education level:

Function:

Years of experience:

Workplace:

Topic guide

1. Performing a joint crisis plan

What is your opinion about establishing a joint crisis plan?

Facilitators: What are the advantages?

Barriers: What are the disadvantages?

Can you tell me about the last joint crisis plan you performed?

Facilitators: What went well?

Barriers: What did not go well?

Are those experiences comparable with previous experiences in performing a joint crisis plan or are those unique for this case?

2. Facilitators

What helps you to perform a joint crisis plan with a patient?

Process: What do you need to perform a joint crisis plan with a patient?

Content: What should be in a joint crisis plan? How do you make sure you and your patient reach this?

Use: What helps the patient to use the joint crisis plan? How do you reach this?

Impact: What are your experiences with the impact of the joint crisis plan? Does the joint crisis plan reach the goal of less relapse and/or readmission?

Can you tell me if there are more facilitators for performing a joint crisis plan?

3. Barriers

What disturbs you to perform a joint crisis plan with a patient?

Ambivalence regarding crisis plans: Can you tell me about the value a joint crisis plan for the patient?

Added value of crisis plans: Can you tell me if joint crisis plans have an added value compared with the regular healthcare? Are there other kinds of care which fits the same goals?

Appropriateness of service users' choices: What are your experiences with the choices patients make in their joint crisis plan? Do they meet your choices? What if the patients choices do not compare your choices? How do you handle discussions?

Availability of service users' choices: Can the patients choices for the joint crisis plan carried out in your healthcare organisation? How do you handle discrepancies?

Can you tell me if there are more barriers for performing a joint crisis plan?

4. Ending

Is there anything you want to say after this interview about your experiences with performing a joint crisis plan?