ACUTE MENTAL HEALTH ASSESSMENTS DISENTANGLED

Assessments by Mobile Crisis Teams of patients with acute manic/psychotic symptoms: communication, collaboration and continuous learning opportunities

Thea Daggenvoorde

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Assessments by Mobile Crisis Teams of patients with acute manic/ psychotic symptoms: communication, collaboration and continuous learning opportunities

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CHAPTER 1

General introduction

General Introduction

Example Case: Paula
The first study in this thesis is about the lived experiences of patients with acute symptoms with an assessment conducted by a mobile crisis team.

Some months after the above mentioned assessment, participant Paula (22) reported:
…..I had been confused for a long time, but I usually managed to hide it well from others. Only my mother noticed something. And then I fell in love and things quickly went wrong.
…..Late one night I decided to enter my friends' house. I was very angry, I hit them, and accused them of all kinds of things.
…..Someone called the police, and when they came I calmed down a bit. They took me away.
…..I was terribly embarrassed on the street, because neighbors had come out and saw me like that.
…..At the police station I was in a cell. I had to put on some kind of overalls. I screamed, cried; the next moment I laughed, and I thought I was getting married (which was not true). I thought all this had meaning. Everything was mixed up in my head.

In my career as a community psychiatric nurse (CPN), I have worked as a mobile crisis team (MCT) professional. In this role, assessing patients with acute manic/psychotic symptoms has always been challenging for me for several reasons, but primarily because manic/psychotic symptoms are signs of a serious psychiatric condition, and in the interest of the patient's health, emergency mental health care is necessary. There may be problems with the patient's reality testing, which can hinder the establishment of a working relationship. Immediate danger to the patient themselves or those around them can be an issue. The call for help often comes from people other than the patient. There is usually time pressure to carry out an assessment quickly and adequately. My working experience was that daring to use a creative mix of all kinds of interventions and skills and trusting my own intuition as an experienced mental health professional often helped me provide appropriate care in these assessments. After such an assessment, I noticed that the emotional impact on myself lingered for some time not only because of the serious psychiatric symptoms but also because of the vulnerable condition of the patient. Often, I thought afterwards: "Did I do the right thing?" From colleagues I heard similar experiences: They also described their search for an accurate approach, and also improvised, using their intuition in such assessments. The possibility to evaluate and reflect afterwards often proved to be essential

to buffer emotional impacts. At the same time, MCT professionals have mentioned that conducting these assessments was also positively challenging and satisfying, despite all the emotions surrounding them.

Often, as MCT professionals, we heard from patients and their families[1] that an assessment by an MCT for them was also a profound experience. In peer consultation with professionals from other services (e.g., police officers, ambulance nurses), similar experiences also emerged.

Example Case: Paula
…..Two people from the mobile crisis team arrived. I talked a bit with the woman; I did not like the man.
…..She advised me to take medication, but I did not want that.
…..After a huge struggle with police officers, I got an injection.
…..That calmed me down, and then I was happy again, looking forward to my coming marriage.
…..Then, I was asked to put my own clothes back on and go with the ambulance, which was fine with me.

Emergency Mental Health Care

In the Netherlands, when emergency mental health care for patients in the community is needed, referrers like general practitioners or police officers contact the local mental health care organization where an MCT is available 24/7. An MCT offers comprehensive assessments and organized differently per institution, intensive home treatment to outpatients with acute mental health problems. Referrers report their request for emergency mental health care for their patient to an MCT professional. After triage, the MCT decides whether and where an assessment will take place—preferably at the home of the patient and in the presence of family members. MCT professionals are trained to conduct a quick assessment of the psychiatric condition of the patient in often chaotic circumstances. Both beforehand and during an assessment, attention is always paid to factors like substance use, living conditions, relationships, physical health, and security issues (Johnson, 2013). With intensity, MCT professionals will try persistently to establish contact with the patient and family. Interventions, such as starting medication or setting limits to guide the patient's behavior during an assessment, may be necessary. Thus, police assistance can be needed to help keep the situation safe for everyone. If the decision is made for compulsory admission at a mental health hospital, ambulance transport of the patient is organized. In addition to the patient's severe psychiatric symptoms, family and

1 In this thesis the word "family" stands for all informal caregivers of a patient.

friends may be exhausted from the patient's worsening psychiatric condition, so they may need support for themselves (Johnson, 2013).

Assessments of patients with acute manic/psychotic symptoms due to chronic psychiatric disorders like psychotic and bipolar disorders may be complicated because there is often a lack of agreement with the patient who needs emergency mental health care. In the Netherlands, over 25% of assessments by MCTs in big cities are of patients with a psychotic disorder; 13.9% of patients have depressive disorders; and 7.4% of patients have affective disorders other than depressive disorders (De Winter et al., 2017). Despite not knowing exactly under which category bipolar disorders were to be scored in this study, the authors overall concluded that in a third of the assessments, patients with acute manic/psychotic symptoms were involved.

Bipolar and Psychotic Disorders

Psychotic and bipolar disorders are both severe chronic mental disorders, described in the fifth edition of the *Diagnostic and statistical manual of mental disorders* (DSM-5; American Psychiatric Association, 2013). Bipolar disorders are defined as disorders characterized by extreme mood swings. Patients with bipolar disorder experience depressive and at least one (hypo)manic episode. A (hypo)manic episode means a distinct period of abnormal and persistently elevated, expansive, or irritable mood and increased goal-directed activity or energy. If this behavior is present for at least 1 week and causes serious problems during most of the day, it is called manic. Depressive episodes are diagnosed by five (or more) symptoms, present during a 2-week period, including depressed mood (most of the day, nearly every day), diminished interest or pleasure in activities, significant weight loss or gain, sleeping problems, psychomotor changes, fatigue, feelings of worthlessness or guilt, concentration problems, and/or possible suicidality. The lifetime prevalence of bipolar disorders for persons between 18 and 65 years of age is 2.1% in the Netherlands (Ten Have et al., 2023). The worldwide prevalence is 0.8% (Ferrari et al., 2016).

In the DSM-5 (American Psychiatric Association, 2013), psychotic disorders are described as "schizophrenia spectrum and other psychotic disorders" (pp. 87). Characteristic symptoms of this disorder are two (or more) symptoms from the following list, each present for a significant portion of time during a 1-month period (or less if successfully treated): delusions, hallucinations, disorganized speech, thinking, and behavior, and/or negative symptoms like diminished emotional expression and a decrease in purposeful activity. The lifetime prevalence of schizophrenia spectrum disorders is 0.3–0.7%, although variation has been reported by race/ethnicity, country, and geographic origin of (children of) immigrants (American Psychiatric Association, 2013, pp. 102).

Manic/Psychotic Symptoms

Patients suffering from psychotic and bipolar disorders and their families must deal with periods of acute manic/psychotic symptoms in their lives because such acute episodes (i.e., "relapses") are inherent to the nature of these disorders. Emergency mental health care is often indispensable in such periods, given the severe psychiatric problems and their future consequences. Acute symptoms can develop at a variable pace. For the patient and their family, it often turns out to be difficult to call in appropriate emergency mental health help in a timely fashion, especially during a first manic/psychotic episode. Anticipating acute symptoms in an early stage can be difficult for a patient and also for their family, while at the same time, the family often feels a lot of concern over the behavior of the patient. Even in patients already diagnosed with a bipolar or psychotic disorder and being treated for mental health, it turns out to be quite a challenge to recognize in a timely manner whether such an acute episode is imminent (Goossens et al., 2010).

Example Case: Paula
…..I was taken to a psychiatric hospital, and in my confusion I thought that I was going to a hotel for a big party.
…..The ambulance nurse asked me to lie down on the stretcher, but I preferred to sit, and luckily I was allowed to do so.
…..And then in the hospital that woman from the crisis team was there again; that reassured me—a familiar face. Together with her I was able to make appointments with a nurse there, and I went to sleep, exhausted.

Literature Search

Besides my job as a CPN, I have also worked as an educated scientific researcher, so in answer to the aforementioned search for an accurate approach and the experience of improvising and using intuition, I searched the literature for an adequate substantiation of the deployed skills and evidence-based interventions by MCT professionals during crisis assessments of patients with acute manic/psychotic symptoms. There appeared to be few scientific studies available on how MCT professionals perform these assessments. No reports on evidence-based interventions were found. The literature on emergency mental health care mainly described the organization of emergency mental health care at policy levels, along with procedures and legislation around compulsory care. Emergency mental health care shows a great (inter)national diversity in its organization and provision. Since the end of the last century, there have been many developments from clinical to ambulatory mental health care in many different European countries (World Health Organization – Regional Office for Europe, 2013).

My search in the scientific literature produced only four qualitative studies and descriptive reports about lived experiences with assessments in emergency mental health care provided to patients with acute manic/psychotic symptoms in the community. Access and availability to these mental health services are important issues to help individuals get help at the right moment, as described in a qualitative study about the experiences of people with bipolar disorder in Australia (Highet et al., 2004). Long waiting times hindered the patients and their families from connecting with a specialist when needing emergency mental health care. The family members of people with psychosis also reported difficulties in accessing emergency mental health care when they needed it most, in Gerson et al. (2009). In that study, some families reported another issue: how a police intervention appeared "drastic," or similar. Also mentioned was "stigma" associated with having a mental illness, and therefore feelings of shame. In both studies, the families experienced how health care professionals often asked for the assistance of police or ambulance personnel, which according to them reinforced the idea that people with bipolar and psychotic disorders are dangerous and unwilling to seek care.

Negative experiences with contacting emergency services were also reported by service users with major mental disorders in Norway (Gudde et al., 2013), which for these users meant that they had to overcome a hurdle in asking for help. Also, the users had the experience of not feeling actively involved in decision-making during emergency care. According to them, a deeper understanding among the professionals during the patients' experiences in mental health crisis is important to improve care. Bruce and Thayer's (2005) report for the Continuing Education Coordinating Board for Emergency Medical Services (EMSs) describes a single case of prehospital management by EMS professionals of a man with bipolar disorder. Interventions of the EMS professionals and the importance of an appropriate approach are described; it was emphasized that professionals need to be able to establish collaboration with the patient through good communication skills. It is important that the involved professionals recognize and manage their own feelings, too. Professionals at the scene do need knowledge of psychopathology to understand why patients are acting the way they do.

The remaining scientific literature found relating to the work of MCTs mainly discusses the organization of the work and efficacy of their care. Sjølie et al. (2010) conducted a literature review on the structure, process, and outcomes of crisis resolution and home treatment teams in England and Norway. Three years later, Johnson (2013) described the main characteristics and core interventions of these teams, after these teams were introduced throughout England per an evolving model.

In the Netherlands, the working methods of emergency mental health services were described in a descriptive research article (Stobbe et al., 2016). The authors concluded that the information about working methods, interventions, and their effects was limited because not all the teams were able to provide the information researchers asked for, or their methods were not recorded.

Considering the existing knowledge about the complex work of MCTs in carrying out assessments, it appears that descriptions of and scientific research into the complex interventions of MCTs and the effectiveness of their work are scarce. The skills needed and actually deployed during interventions by MCT professionals are almost undefined. Thus, more scientific research is needed. At the same time, it is clear that in building a richer body of knowledge, research methods have to suit practice circumstances in this unique care context, namely emergency care within the community. Qualitative studies are arguably the most appropriate to enhance this body of knowledge.

Overall, I felt challenged to design useful scientific research into the performance of assessments by MCT professionals. The fact that the scientific literature and research on the daily work and tasks of CPNs working as MCT professionals were so scarce was an additional motivation for me to conduct research on the interventions by these professionals, which is why I, together with a research team, started this PhD project.

At the start of this research project, the initial plan was to begin with a qualitative study to gain more insight into the lived experiences of both patients with acute manic/psychotic symptoms and their families per assessments provided by MCTs. Our hypothesis was that, with these findings, we would gain useful insight into the interventions of the professionals who perform such assessments. Ultimately, however, our plan was to develop guidelines for MCT professionals with the aim of attuning this kind of emergency mental health care to the needs of patients with acute manic/psychotic symptoms.

After the first qualitative study, intensive discussion within the research team followed, pertaining to insight into the lived experiences of patients and their families with an assessment by an MCT—which is the perspective of service users on an assessment as a whole. From a scientific point of view, we concluded that it was essential to know more about the full breadth of the lived experiences of all involved in such an assessment. Thus insight in the perspective of the involved professionals was of importance. Thereafter those perspectives can be used to take a substantiated step towards, for example, the development of interventions or guidelines. Therefore, the research team decided to change the original PhD project-plan, choosing to develop and conduct a series of solely qualitative studies, described below.

Aims of the Thesis

The primary aim of this thesis was to gain a broad understanding of the lived experiences of people suffering from acute manic/psychotic symptoms, including their families, with an assessment performed by an MCT. Additionally, the lived experiences of involved MCT professionals and those of involved police officers and ambulance nurses were investigated.

Our second aim was to formulate recommendations for all involved to optimize the effectiveness of the interventions and the collaboration between the parties to personalize and improve the emergency mental health care for patients.

Outline of the Thesis

This thesis includes a general introduction (Chapter 1) which describes the central concepts, leading to formulated research aims. In the four following chapters, qualitative studies with patients, families, MCT professionals, police officers, and ambulance nurses regarding their lived experiences and their collaboration during these assessments are presented. To unravel the lived experiences of all involved during assessments, the research team explicitly chose to start with a study about the experiences of patients and their families. Therefore, we conducted a phenomenological study that explored the lived experiences of patients who suffered from acute manic/psychotic symptoms during an assessment and their family who were present at the assessment by MCT professionals. This study is presented in Chapter 2. Initially, we wanted to learn the perspectives of patients and families regarding their interactions with MCT professionals. Beforehand, it was clear that during and after the assessments, other professionals than MCTs were involved, for example ambulance nurses.

In Chapter 3 we present an explorative, qualitative, generic-design study on the lived experiences of ambulance nurses involved in emergency care for patients with acute manic/psychotic symptoms. The ambulance nurses provided emergency care during the transport of patients to mental health institutions after admission decisions following assessments.

Chapter 4 contains a report of a hermeneutic-phenomenological study with unstructured in-depth interviews with police officers and MCT professionals. This study was from a somewhat broader perspective. In the Netherlands, as in many other countries, the label of “nuisance” attached to people with “confused behavior” in society has grown during the last decade. Confused behavior is often manifested by people with acute manic/psychotic symptoms. In general, during the assessments of MCT professionals with these patients, police officers are regularly asked to assist them, to ensure the safety of everyone involved.

Finally, Chapter 5 presents a qualitative, descriptive phenomenological study on the lived experiences of MCT professionals’ assessment of patients with acute symptoms, and Chapter 6 contains a general discussion where we reflect on and discuss the outcomes of the research project, looking back at the research methods used. Implications for future practice and research are described. Last, Chapter 7 presents a summary of this project, in addition to information about the author and acknowledgments.

1

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CHAPTER 2

Emergency care in case of acute psychotic and/or manic symptoms: Lived experiences of patients and their families with the first interventions of a mobile crisis team. A phenomenological study

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Abstract

Purpose To explore the lived experiences of patients with a psychotic or bipolar disorder and their families with emergency care during the first contact with a mobile crisis team. **Methods** Open individual interviews were held with ten patients and ten family members. Content data-analysis was conducted. **Findings** Communication and cooperation was difficult in several cases. Personal crisis plans were not always used. Stigma was felt, especially when police-assistance was needed. A calm, understanding attitude was appreciated. **Practice Implications** Focus explicitly on communication with the patient, despite the acute condition, enhances the chance of cooperation. Taking time for contact is important.

Key words
mobile crisis team, psychotic, bipolar, patients, family members

Introduction

In cases of acute mental health crisis, patients in many countries are typically referred to some sort of mobile, mental health, crisis team. A large part of the patients that need emergency care from a mobile crisis team are patients with acute psychotic and/or manic symptoms (C. Mulder et al., 2005; C. L. Mulder & Van Hemert, 2011). Most of the time, these patients are in a confused and disorganized state, often experiencing delusions and/or hallucinations. These symptoms can severely hamper attempts to communicate and interact with the patient, which can be further complicated by stress caused by the patients' distrust of mental health workers and others involved and the unpredictability of what is happening at that moment. The family and relevant others can also be under severe stress and exhaustion, which further complicates the activities in the emergency care for these patients.

The National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients with psychosis and schizophrenia (National Institute for Health and Care Excellence, 2014b) and patients with bipolar disorder (National Institute for Health and Care Excellence, 2014) recommend the offering of crisis services 24 hours a day for the support of patients in crisis. Assessment at home and further treatment in the community is first choice to be considered when possible, and before recommending admission to an inpatient unit (National Institute for Health and Care Excellence, 2014b, 2014a). The NICE guidelines also recommend that assessment be conducted a) by an experienced health care professional who is qualified for crisis work, b) within 4 hours of referral, and c) include a comprehensive exploration of the situation. Providing clear information for the patient and caregivers is also important (National Institute for Health and Care Excellence, 2011). The practice guidelines of Substance Abuse and Mental Health Services Administration (Substance Abuse and Mental Health Services Administration, 2009) describes values and principles essential to any response to mental health emergencies. Nevertheless, standard procedures or protocols about the activities and attitude of professionals during the first contact with the patient and family members are not available. The activities of the mobile crisis team professionals are mostly practice based. Wheeler et al. (2015) describe in their review about Crisis Resolution Teams the diversity of these teams, and state that suggestions about optimizing these services are based on experience, personal views and consensus processes. So far, little research has been conducted about the experiences of patients with acute psychotic and/or manic symptoms and their family members with the first contact with a mobile crisis team. The topic of this study is important because improving services is only possible if we take the lived experiences of these vulnerable patients and their family members into account.

A mental health crisis often has a great and long-lasting emotional impact for both patients and their families (Highet et al., 2004). In clinical practice, patients often

complain about the lack of involvement into the communication with the professionals of the mobile crisis teams. Patients frequently experience this emergency care as threatening (as opposed to reassuring) and even traumatizing (as opposed to helpful). Systematic information on the experiences of these patients and their families during the first contact with the mobile crisis team has yet to be gathered.

In sum: The activities provided by mobile crisis teams during a mental health crisis are mostly practice based. Systematic information on the activities, attitude and interventions provided by mobile crisis teams during the first contact is not available. The understanding of the perspectives of patients and family members is an important first step in describing the context of interventions (Bartholomew et al., 2011). The aim of the present study was therefore to explore the lived experiences of patients with a psychotic or bipolar disorder and their families with emergency care during the first contact with a mobile crisis team.

Methods

A qualitative, phenomenological study design was used to explore the lived experiences of patients and their families. Qualitative research focuses on the lived experiences, interactions and language of human beings. Phenomenology seeks to describe the common meaning for several individuals of their lived experiences of a phenomenon, which leads to a description of the universal essence (Creswell, 2013).

Professionals working in teams from four mental health organizations providing treatment for outpatients with psychotic and bipolar disorders in the Netherlands were asked to inform their patients about this study. Variation in age, gender and diagnosis of the participants was pursued. Patients were asked if they would be willing to participate, if interest was showed they were given further, written information about the study. They were contacted one week later by phone to answer any questions. When the patient agreed to participate, an interview appointment was scheduled. All patients who were initially informed about the study were asked to share the written information that they had been provided with a family member in order to recruit family members for participation in the study as well. When it became clear that very few family members became available using this procedure, we turned to the organizations for patients with schizophrenia and patients with a bipolar disorder for the recruitment of family members.

Written Informed Consent was provided by all participants before conduct of the interview.

Inclusion criteria for patients

- age > 18 years
- an Axis I DSM IV diagnosis of a psychotic disorder or bipolar disorder

- experienced a crisis with psychotic and/or manic symptoms, and were visited by the mobile crisis team during the past two years
- able to speak understandable Dutch
- a stable condition, according to him/herself and a professional, at the time of the interview

Inclusion criteria for family members

- age > 18 years
- present during the visit of the mobile crisis team when their family member had a crisis with psychotic and/or manic symptoms during the past two years
- able to speak understandable Dutch

For each group of participants, the target sample was set at 10 participants. For qualitative studies, no rigid rules apply as to the minimum number of participants.

Ethical considerations

The proposal for this study was approved by the Dutch Central Committee on Research Involving Human Subjects and by the Scientific Research Committee from the mental health organizations involved in the study. Each participant received both oral and written information on the study. An informed consent form was signed prior to the start of the interview.

Data Collection

The participants were interviewed individually, starting with the question: *How did you experience the (last) crisis in which you or your family member had acute psychotic and/or manic symptoms and a mobile crisis team intervened?* After each of the open interviews, a brief impression of the interview was written in the study logbook. The interviews were audio-recorded and later transcribed verbatim.

Data Analysis

Within the same time frame, two separate sets of data analysis were performed: one for the data from patients and one for the data from family members. The MAXQDA 2007 computer program (VERBI GmbH, Berlin, Germany) was used for the analyses. To start with, the entire interview was read and reread along with the information in the logbook. Sentences in the interview texts associated with the research question were selected and coded. The first interview for each group was coded by two investigators independent of each other. The coding was discussed until consensus was reached. The first author then went on to code the remainder of the interviews. Discussion within the research team during the course of the data analysis helped refine the categories in the separate analysis. The process of data collection and data analyses was interfering. Attention was

taken that the coding categories could always be traced back to the original data. Certain categories were relevant for the coding of the data from both the patients and the family members. We therefore decided to describe the outcomes of the analyses as a whole and thus combine those categories that overlapped for patients and family members. Quotes from the interviews were added to the text of the findings.

Findings

Sixteen crises were analyzed with information coming from 10 patients and 10 family members who were interviewed between April 2013 and November 2014. For further demographic information, see Table 1.

Six themes emerged from the data with similarities in the information provided by the patients and family members for four of these themes: the experience of the crisis, experiences with the emergency care provided by the mobile crisis team, experiences with the crisis professionals, and the role of the outpatient treatment team. "Stigma" was an additional theme among the patients. And "family members as caregivers" was an additional theme among the family members.

Experience of the crisis: 'Feeling trapped'

Patients reported feeling trapped in psychotic thoughts and inner confusion during the crisis, which made communication with others during the crisis quite difficult.

> *Yes, I was caught up in delusions. I was stuck in myself and just couldn't speak with others at that moment. (patient 08)*

Patients also mentioned experiencing feelings of suspicion during the crisis.

> *I lived in a fantasy world…I was paranoia and thought people would come and get me…. That kind of things… (patient 04)*

Both patients and family members reported seeing that things were going wrong but found seeking professional help to not be easy because most patients were ambivalent about this. Family members reported feeling very worried and frustrated as they saw the situation worsen and heard the patient deny that professional help was needed. They felt powerless.

> *I did ask my eldest brother to come too, just to feel more safe. The whole evening, we tried to convince him to go see a doctor. (family member 21)*

Table 1 Demographic information

Crisis	Patient Female/ male	Family member Female/ male	Diagnosis of the patient	Relation family member-patient	Number of months between interview and crisis	Number of Crisis+ Mobile Crisis Team Intervention	Place where assessment was done	Police Assis-tance Yes/No	Hos-pitali-zation Y/N *=forced admission	Domestic situation 1=alone 2=+parents 3= with partner/ family
1	**m**	**m**	Bipolar I Disorder	Child	8	3	Police station	Y	Y *	1
2	f	m	Schizoaffective Disorder	Partner	14	10	At home	N	Y	3
3	m	m	Psychotic Disorder Not Otherwise Specified	Parent	6	1	Emergency Hospital	N	Y *	2
4	f	m	Bipolar I Disorder	Partner	18	1	At home	N	Y	3
5	f	-	Psychotic Disorder Not Otherwise Specified	-	10	1	At home	N	N	3
6	f	-	Schizophrenia	-	7	>3	Mental Health Organization	N	Y *	1
7	f	-	Bipolar I Disorder	-	18	>3	Mental Health Organization	Y	Y *	1
8	m	-	Bipolar I Disorder	-	24	>3	At home	N	N	1
9	f	-	Schizoaffective Disorder	-	7	1	Police station	Y	Y *	1
10	m	-	Bipolar I Disorder	-	16	1	Mental Health Organization	N	Y *	1
11	-	f	Schizoaffective Disorder	Parent	6	3	At home	Y	Y *	2
12	-	f	Bipolar I Disorder	Partner	18	5	At home	Y	Y	3
13	-	f	Bipolar I Disorder	Parent	10	1	Mental Health Organization	N	N	1
14	-	f	Schizophrenia	(Ex)Partner	10	3	At home	Y	Y *	3
15	-	f	Schizoaffective Disorder	Parent	6	2	Police station	Y	N	1
16	-	m	Bipolar I Disorder	Sibling	18	1	Mental Health Organization	N	Y *	1

Both patients and family members reported experiencing such feelings as despair, helplessness, shame, and sadness during the crisis.

> *Another crisis, again. Why don't we have control? With all our strength and that of her too... we have insight into the disease… and still this happens. Yes, it's hard. And sometimes we blame ourselves… (family member 16)*

Although patients reported not being able to remember everything that happened during the crisis, some of them did recall the sincere commitment of a family member. In a number of the crisis situations, the family member experienced the behavior of the patient as becoming dangerous and therefore had to call the police. Police involvement to secure safety was experienced as intrusive and hard to witness and accept for the family members. The family members emphasized that the patient was ill and should therefore not be treated as a criminal.

> *He did not want to open the door [for the police]. Then they forced the door open and got ahold of him. This was very traumatic for him and also for all the other people who were around. It was in the middle of the night and everybody was upset. (family member 19)*

Experiences with the emergency care of the mobile crisis team: 'a bumpy road'

It often took a long time for the mobile crisis team (sometimes together with the police) to arrive, according to both patients and family members. As a result, and as they saw the situation — often quickly — deteriorate, the family members were left to feel helpless and still in need. Placement in police custody pending assessment by a crisis team, however, was experienced as very inappropriate by both patients and family members.

> *The police took control at such a moment. I felt like a criminal. Which was idiotic because I had not done anything wrong. I had not stolen anything or something like that. (patient 05)*

The way the mobile crisis team acted was sometimes unclear to both patients and family members. In many of the crisis situations, both the patients and the family members reported not knowing who they were speaking with or the profession of that person.

> *I do not know if they are doctors…or nurses? It could be… I do not know who they are. (patient 03)*

In general, the family members felt sufficiently informed about the diagnosis and the reasons for the activities and interventions conducted.

> *They explained to us what was going on, what the diagnosis was, and which decisions they made…(family member 21)*

Those patients who sought professional help during an early stage of the crisis reported that the crisis team did not always understand the call for help and that they thus felt that the crisis team did not always take them seriously.

> *They should not think: "Oh she's talking calmly and clearly so she's okay." If I say, I myself, that things are going wrong and that I do not feel good, then they should listen to me! And not just send me away… (patient 04)*

Those family members who received a follow-up call to see how they were doing reported this as highly appreciated.

> *Afterwards it is important to hear what's going to happen next. They also asked what we needed… I could tell my own story as well…. (family member 01)*

Experiences with the crisis professionals: 'closing the gap'

A number of patients experienced no communication with the crisis team about their condition, and about the decisions being made. According to the patients, they had no influence at all. They felt powerless.

> *Other people have the power over you. I could not say what was wrong with me. And even if I could, they decided what to do. At such a moment, I am at the mercy of that power, of the mental health institution. That's how it is… (patient 05)*

Other patients told us that the professionals from the crisis team were kind and they felt reassured by them; also that they felt heard and taken seriously. They felt at ease.

> *That professional talked to me in a quiet and normal way. Just like a normal person, that was really nice (patient 09)*

The attitude of the crisis professionals was described most of the time as calm, empathic, and understanding.

> *They came to my house, and they were very friendly. Very friendly and very reassuring. That calmed me (patient 03)*

In contrast to what patients told about not being asked about their condition, family members reported frequently being asked about the condition of the patient. Also they were informed about the viewpoint on the problems and their plans and interventions. That gave confidence.

> *They took us apart to explain to us what was going on and which interventions might be used. He could go home, but that would not change his situation, which was unstable. Or he could voluntarily go to a hospital… (family member 21)*

Family members mentioned that they thought that it was essential that the emergency care provided for the patient was in concordance with the needs and the severity of the crisis.

> *The psychiatrist explained the need for forced hospitalization. On the one hand that was threatening, but the way he told it was okay… he acted well… (family member 21)*

Family members also mentioned that attention to their own emotional state — as people closely involved— was important.

The role of the outpatient treatment team: 'being prepared'

Fourteen of the patients involved in a crisis were already in treatment at an outpatient treatment organization when the crisis developed. If there was a crisis plan formulated and discussed earlier by the patient and a professional from the outpatient treatment team, this was reported to help some of the patients and their family members during the crisis: they knew what to do and who to call. This was experienced as reassuring.

> *We are doing better all the time! We are not unsure about what to do anymore: We have the telephone numbers, we know who we have to call, what to do.... That is something you have to learn. (family member 16)*

Most patients, however, said they did not know what was in their crisis plan or whether the mobile crisis team had used their crisis plan or not.

The communication with and support of the professionals from the outpatient treatment team, especially during the crisis situation, was mentioned as very important by both the patients and family members. The patients said that they probably would have followed the advice of a familiar professional from the outpatient treatment team if the professional had been available at the time of the crisis.

A conversation between the crisis team, my therapist, and me: that would have been helpful. The most important people would have been together then and could have shared all the information. (patient 01)

Stigma: 'feeling humiliated'

Patients reported that they felt treated like a criminal when the police took them into police custody pending assessment by a crisis team. They experienced the stay as horrible.

I felt so helpless. It was a sort of desperate feeling; I could do nothing about it. You lose your freedom; you are just left sitting in a cell at the police station. (patient 01)

These patients felt stigmatized. People in the neighborhood saw them get taken off in a police car, sometimes in handcuffs. All such patients felt that they were treated as a crime suspect and therefore being picked up rather than being cared for as a patient and picked up.

I thought I had done something wrong. I was given some sort of blue overall, and they said I should put it on. (patient 10)

Family members as caregivers: 'going to the edge'

Family members told how they tried to take responsibility for the condition of the patient during crisis, even when the situation got dangerous. They felt they acted more and more as caregiver instead of as family member.

Of course we try to do as much as we can by ourselves. I ask for help at the last moment. Simply because I want to solve our own problems. (family member 17)

Most of them described feeling incapable of doing anything as the crisis evolved at times. They reported feeling that they could not handle the situation any longer. When finally the crisis team arrived they felt great relief.

My partner [patient] wasn't well. Totally not well. And I.. I was at my wits' end, physically and mentally… (family member 19)

They also reported feeling a conflict of interest during crisis: they did not want to damage the confidence of the patient but, at the same time, they saw the need for professional help. This was experienced as very uncomfortable.

I have to be careful not to lose the confidence of my son. He still trusts me. (family member 20)

Discussion

In this study, we explored the lived experiences of patients with acute psychotic and/or manic symptoms, and their families during the first contact with a mobile crisis team.

The main findings of this study are: most patients reported feeling trapped in psychotic thoughts and inner confusion during crisis, whereby communication was difficult. Family members mentioned how powerless they were to handle the situation any longer. In general, the family members felt heard by the professionals of the crisis team. According to the participants it often took a long time for the mobile crisis team to arrive. Calmness, empathy, and understanding on the part of the professional were experienced as essential by both patients and family members. Most of the patients did not know if the crisis team had used their crisis plan. Some participants reported they used the plan, which was experienced as helpful. Patients often felt stigmatized when the mobile crisis team was called in to help and especially when the police had to get involved. Family members felt great relief when the mobile crisis team stepped in since they felt overloaded when the crisis evolved.

Some of the participants in this study experienced a lack of communication and contact with the involved professionals, others felt understood and heard. Participants in general described their confused and disorganized state and quite a lot of them experienced that the activities and interventions of the professionals did not fit with this condition. These experiences do not give a clear, unambiguous picture of the way professionals carry out the first contact. Roberts and Ottens (2005) describe stages in a crisis intervention model, in order to come via assessment, rapport and collaboration to stabilization, resolution and mastery. The first stages handle about a biopsychosocial assessment and establishing rapport. For professionals of the mobile crisis team conducting the first contact especially with patients with psychotic and/or manic symptoms, there is nevertheless still little guidance on how to interact with these patients. The stories of the participants seem to endorse a hypothesis as: 'when professionals are able to find a tailored way of working, suitable for that specific case, the chance of collaboration enhances'.

When the crisis occurred for the first time, both patients and family members were particularly in need of information on the activities and interventions being considered and decisions being made by the mobile crisis team during this first contact. This is in line with the advised values and principles mentioned in the practice guideline of SAMHSA (Substance Abuse and Mental Health Services Administration, 2009). For patients already in treatment, early involvement of the family in this treatment is important; this provides possibilities to enhance cooperation with patients and family members during crisis (Beentjes et al., 2015).

Participants in this study underlined that the already existing contact with the community mental health team was important for them, also during crisis. But when crisis

occurred, they often had to deal with to them unknown professionals, like those from the mobile crisis team. A personal crisis plan or relapse prevention plan helped some patients, and their family members, to know what to expect from professionals during crisis. Participants in this study told they did not know whether the professionals of a mobile crisis team used the personal crisis plan of the involved patient in the first contact with the patient and family members. This is in sharp contrast with the recommended role of a crisis plan or relapse prevention plan at all stages of treatment (Daggenvoorde et al., 2013; Kupka et al., 2013; National Institute for Health and Care Excellence, 2014a, 2014b; Ruchlewska et al., 2014). The same applies to continuity in the long-term relationship between professional, patient and family members (Beentjes et al., 2015).

Many of the patients referred to stigma in relation to the need for emergency care. Some were afraid of being stigmatized while others already felt stigmatized. In both cases, label avoidance was mentioned as a reason for *not* seeking professional help in case of acute psychotic and/or manic symptoms. Others felt stigmatized following the first contact with a mobile crisis team; many mentioned feeling treated like a criminal, especially when the police was involved to secure safety. On the one hand particularly family members told that the assistance of the police sometimes was needed for the purpose of safety, on the other hand patients and family members were clear that police interference should be as minimal as possible, because patients need care, and no stay in a police station. In a policy paper between the Dutch Association of Mental Health and Addiction Care and Dutch National Police force (Politie & GGZ Nederland, 2012) closer cooperation between these two was recommended to make sure that patients get the emergency care they need as soon as possible and that assessments takes place in a secure and appropriate location, not being a police station. In England the Mental Health Crisis Care Concordat (Department of Health and Concordat signatories, 2014) describes how patients, family and responding services can work together to make sure that immediate mental health support at a time of crisis is available at any moment in the right way.

Study strengths and limitations

Participants in this study were drawn from both urban and rural regions of the Netherlands and mobile crisis help was provided by teams coming from a variety of mental health organizations within the Netherlands. In addition, the data is rich, which increases the credibility of the findings reported here.

A potential limitation of the present findings is the possibility of selection bias. It is not clear if the patients who agreed to participate in the study are representative of the more general group of patients with acute psychotic or manic symptoms requiring the emergency care of a mobile crisis team. Patients may obviously have decided against participation in the study because they did not want to be confronted with the crisis situation yet again. The recruitment method also excluded patients who did avoid further

treatment after the contact with the mobile crisis team. All participating patients were in mental health treatment. Maybe they are a specific group, motivated to receive help and having some insight in their problems. Recall bias is a second potential limitation, as in many retrospective studies. The time between the experienced crisis and the interview for this study ranged from 6 to 24 months. It is thus unclear if the patients relied upon their own memories or on what others have told them: cognitive dysfunctioning may have influenced the recollections of the interviewed patients. Nevertheless, the retrospective design was chosen deliberately, suitable to the research question. Finally, the majority of the data analyses was conducted by one individual, but the findings were regularly discussed within the research team to enhance the confirmability of the findings.

Implications for nursing practice

The chances of cooperation during crisis enhance when the professionals of the mobile crisis team focus explicitly on communication with the patient with acute psychotic and/or manic symptoms, despite the confused and disorganized condition of the patient, and possible delusions. Taking time to gather information about the patients' condition and the opinion and wishes of the patient and family members, described in a crisis plan, could contribute to less stigmatization and escalation. The crisis plan needs to be used on the spot during the first contact. Repeated information about activities and interventions has to be given to make understandable for the patient and family members which care is given with what reason. Future research should strive to gain insight into the activities, interventions and experiences of the professionals of a mobile crisis team and other professionals involved during the first contact with the patient. So a more complete picture can be obtained, including the perspectives of all people involved.

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CHAPTER 3

Experiences of Dutch ambulance nurses in emergency care for patients with acute manic and/or psychotic symptoms: A qualitative study

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Abstract

Purpose To explore the experiences of ambulance nurses in emergency care of patients with acute manic and/or psychotic symptoms. **Methods** In this qualitative study, 14 interviews were conducted and analyzed using thematic analysis according to Braun and Clarke (2006). **Findings** Psychiatric emergency care causes stress and uncomfortable feelings for ambulance nurses due to a lack of information on the patients, being alone with the patient in a small place and the unpredictability of the situation. **Practice implications** More information about the specific patient, education, and good collaboration with other professionals could improve care.

Keywords

Ambulance nurse, emergency care, mental health, manic, psychotic

Introduction

Manic and/or psychotic symptoms could lead to a mental health crisis, defined as "any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community" (Brister, 2018, pp. 5).

Psychosis is characterized by the presence of hallucinations without insight, delusions, or both (American Psychiatric Association, 2013). Mania is a period of elevated, tense moods and increased activity or energy during a period of at least one week for most of the day (American Psychiatric Association, 2013). A large portion of patients who need psychiatric emergency care have manic and/or psychotic symptoms. Barker et al. (2011) report 22 % patients with bipolar and schizoaffective disorders and schizophrenia. Mulder et al., (2005) describe in their study 37 % patients with psychotic disorders and 29% patients in a manic state.

During a psychiatric crisis care takes place in a chain of care providers with different tasks and angles of approach. Mobile crisis teams aim to offer ambulatory psychiatric care for patients in a psychiatric crisis and their family (Johnson et al., 2008; Karlsson et al., 2008; Sjølie et al., 2010). Police officers are involved in case of unsafe situations (McKenna et al., 2015). In the case of compulsory hospitalization, ambulance services are responsible to transport the patient to a psychiatric hospital.

In an earlier study, experiences of patients with acute manic and/or psychotic symptoms and their family members with psychiatric emergency care were explored (Daggenvoorde et al., 2017). Communication and cooperation was experienced as difficult in several cases. Personal crisis plans were not always used. Stigma was felt, especially when police-assistance was needed. Family members often felt powerless to handle the crisis. A calm, understanding attitude of the professionals was appreciated (Daggenvoorde et al., 2017).

As mentioned, ambulance services are one of the care providers that deliver psychiatric emergency care. Dealing with cases of mental illness is a significant component of ambulance nurses' working life (McCann et al., 2018; Roberts & Henderson, 2009). In the Netherlands registered nurses are only permitted to work on an ambulance if they successfully completed an additional 18 month ambulance nurse training. To our knowledge, few studies (McCann et al., 2018; Prener & Lincoln, 2015; Roberts & Henderson, 2009) have been published about experiences of ambulance nurses with psychiatric emergency care. Ambulance nurses were frustrated by "filling the gaps for other healthcare services" in caring for patients with mental health problems (Prener & Lincoln, 2015, pp. 617). Another study described the working relationship between ambulance nurses and mobile crisis teams as ineffective. These teams extended their

scene time and were often difficult to contact. Ambulance nurses emphasized a need for clear policy relating to the interaction between mobile crisis teams and ambulance nurses (Roberts & Henderson, 2009). The results of previous studies cannot be generalized to Dutch psychiatric emergency care due to differences in legislation, healthcare processes, and culture. In this study, the experiences of Dutch ambulance nurses in emergency care for patients with acute manic and/or psychotic symptoms are explored. It is important to create a broader view on emergency care for patients with acute manic and/or psychotic symptoms to find leads to improve the quality of care.

Methods

Design

An explorative, qualitative, generic design was used because little knowledge is available about the experiences of ambulance nurses in psychiatric emergency care (Percy et al., 2015).

Participants and recruitment

Ambulance nurses from five regional ambulance services (RAVs) in the eastern Netherlands (see Figure 1. Participating Regional Ambulance Services) were selected by a convenience sampling strategy (Braun & Clarke, 2006). Participants in this study had to be involved in emergency care of patients who experienced acute manic and/or psychotic symptoms at least five times in the last three years. The sample size of this study was determined by theoretical saturation (Holloway & Galvin, 2016). The study was conducted from January 2019 until July 2019.

The manager of each selected RAV received an explanation of the study by email and informed the ambulance nurses. Interested nurses were asked to email the principal researcher. They received an information leaflet and had the opportunity to ask questions. After one week, they were contacted to ask if they still were interested to participate in this study. All consented to participate. Time and location for the interview were arranged. Before the start of the actual interview, written informed consent was obtained.

Data collection

Unstructured, non-standardized interviews were used to follow thoughts and interests of participants (Holloway & Galvin, 2016). Each interview started with collecting demographic characteristics followed by the general question: "*What are your most memorable experiences in the care for patients with acute manic and/or psychotic symptoms?"* An aide-mémoire (Table 1) was used to guide the participants back to the topic of study if distracted during the interview. This aide-mémoire was based on the literature and was

Figure 1. Participating Regional Ambulance Services

presented to an experienced nurse researcher working in a mobile crisis team and by a physician assistant employed in an RAV. Afterwards, the aide-mémoire was discussed in the research team, and after consensus was reached it was validated for this study. A pilot interview was conducted with an ambulance nurse, transcribed verbatim, and discussed with the coordinating researcher to receive feedback on the interview style and to evaluate the aide-mémoire.

Table 1. Aide-mémoire

Starting question: ***What are your most memorable experiences in the care for patients with acute manic and/or psychotic symptoms?***
Contact with the patient
Contact with the family
The contact with CRT professionals
Information transfer between ambulance nurses and CRT, on beforehand and during the contact
Collaboration with the police
Experiences prior to transport
Experiences during the transport
Experiences during the transmission to the psychiatric hospital
Afterwards emergency care

All individual interviews were conducted at the work location of the participants by one researcher (second author). The research team consisted of a clinical health science student who has work experience in mental health nursing (second author); a researcher who also has experience as nurse in a mobile crisis team (first author); an MD with experience as psychiatrist in a mobile crisis team (third author); a coordinating researcher, professor, and nurse specialist in mental healthcare (last author); and a professor in nursing science, nurse and, clinical epidemiologist (fourth author). To enhance confirmability, the second author critically reflected on her own assumptions by writing them down prior to the start of the study.

Field notes were written down by the researcher directly after the interviews in a logbook. All interviews were audio recorded and transcribed verbatim, and checked for errors. Reflections and field notes were regularly discussed with the research team to stay aware of prejudices (Holloway & Galvin, 2016).

Data analysis

Thematic analysis according to Braun and Clarke (2006) was used. After the first three interviews, initial codes were generated by the second and last author individually. These initial codes were discussed to achieve consensus. The other interviews were coded by the second author, and initial and new codes were discussed within the research team. Next the research team identified and discussed subthemes. In an ongoing process checks were made whether the themes could be traced back to the original data set. Thereafter, main themes were identified by the research team. Memos were made during analysis, containing thoughts and ideas about data and the clustering of codes. This process of identifying and clustering main themes was repeated several times before consensus was reached within the team. During the continuous process of gathering and analyzing data the researcher team was aware of the point where no further dimensions, insights or themes were found. After the twelfth interview two additional interviews were held to be sure that data saturation was achieved (Holloway & Galvin, 2016). The use of researcher triangulation and peer debriefing during the analysis enhanced the creditability and conformability. Member checking was used to enhance the credibility (Creswell & Poth, 2017; Holloway & Galvin, 2016). All fourteen participants received a first concept of the findings, eight of them reacted: they agreed with the description. Two of them had an addition about difficulties in getting enough information of the mobile crisis team and their wish to evaluate the given care in a specific situation. This information was added to the findings. NVivo, version 12, QRS international, Australia, was used to organize the data.

Ethical considerations

This study was conducted according to the principles of the Declaration of Helsinki (World Medical Association, 2008). Formal approval from the Dutch Central Committee on Research Involving Human Subjects was not needed because participants were not subject to procedures or required to follow rules of behaviour (http://www.ccmo.nl/en).

The research proposal was assessed by the scientific committee of the mental health organization where the coordinating researcher works. All data were anonymized and stored on a secure data storage for fifteen years, according Dutch legislation. No one besides the research team had access to the data.

Findings

Fourteen ambulance nurses participated in this study. Nine participants were male. The average age of the participants was 50 years (range 38–61), and the average years of working experience as an ambulance nurse was 16 years (range 5–27). See Table 2, Demographic characteristics. Eleven interviews took place at the ambulance station, and three interviews took place at the home of the participants. Theoretical saturation was reached after 12 interviews. Two extra interviews took place to confirm saturation. The interviews lasted 47 minutes on average.

Table 2. Demographic Characteristics

Participant	Regional Ambulance Service Location	Gender	Age (in years)	Work experience as ambulance nurse(in years)
1.	A	Female	41	8
2.	A	Male	58	22
3.	A	Male	58	22
4.	B	Female	54	18
5.	A	Female	41	8
6.	A	Male	51	16
7.	C	Male	58	18
8.	C	Male	61	26
9.	D	Male	38	7
10.	E	Female	58	18
11.	E	Male	47	15
12.	E	Male	40	5
13.	C	Female	53	10
14.	B	Male	53	27

Two main themes emerged from the data.
The first theme is "It is not my cup of tea, but some like it." It characterized the beliefs of participants on psychiatric patients, mental healthcare, and their professional identity relating to the emergency care for patients with manic and/or psychotic symptoms.

The second theme is "You never know what you're gonna get." This theme describes tasks and responsibilities of ambulance nurses, multidisciplinary collaboration, and the experience of transporting patients with acute manic and/or psychotic symptoms. Some subthemes overlapped.

Theme 1: It is not my cup of tea, but some like it.

It is a different world

A minority of participants described their experiences with mental health as "interesting" and "fascinating." Most referred to it as elusive and a "different world."

> *Psychiatry felt unsatisfactory, because you can't help the patient. You don't see that the patient is getting better.*

Most participants expressed uncertainty about an ambulance being the most suitable means of transport for patients with acute manic and/or psychotic symptoms.

> *The ambulance contains a lot of medical equipment. It's a restless environment.*

Participants stated that they were insufficiently trained to guide psychiatric patients.

> *In our education as a nurse, we learned something about psychiatry. But this was very limited; we just have too little knowledge.*

Many participants explained that in emergency care the focus is on quickly assessing the condition of the patient, immediately followed by adequate interventions. In their view, in (emergency) psychiatric care the focus is on communication and taking time; this does not fit with their regular way of working.

> *As an ambulance nurse, I am used to action and quick interventions. But with these patients, sometimes you have to use the handbrake…. Going too fast may have the opposite effect.*

I am the captain of my ship

Participants characterized their work as practical, quick fixes, and solving problems. They saw themselves as a short link between the mobile crisis team and clinical care. When on

call, participants collect as much information about the patients as possible, describing it as having a de-escalating effect on the patient somehow. Participants expressed the need to follow their "gut feeling."

> *The mobile crisis team can say that it's safe to transport the patient, but that doesn't interest me. I will take it into account, but it isn't decisive for me. I make my own decision; it's my transport, not theirs.*

Participants mentioned that a relaxed attitude, clear communication, and taking time to act are important during their work with psychiatric patients. Most of the participants expressed trying to be themselves and communicating on the same level as the patient. Limiting stimuli was considered important during transport.

> *I dim the light, no music, no distracting things. It's important to stay calm, both verbally and physically.*

There were contrasting perspectives on how competent participants felt in psychiatric emergency care. When participants mentioned feeling competent, they mostly said this was caused by having work or personal experience in mental healthcare.

> *As a child, I lived on the grounds of a psychiatric hospital. Psychiatry is 'everyday habits' for me.*

When participants stated that they were feeling incompetent, they experienced a lack of education and sometimes feelings of fear for these patients.

> *Our interventions after a car accident are clear; the approach is structured. Psychiatric disorders are harder to understand. You cannot learn them from paper.*

It can be freaking scary

Some participants described feeling uncomfortable transporting a patient with acute manic and/or psychotic symptoms. They were sitting alone with the patient in a literal small space in the ambulance.

> *You can't go anywhere. You can't evade. You can't leave; nobody can leave. That makes it risky; that's hard.*

Participants mentioned that they have a feeling that other involved professionals were not aware that ambulance nurses are alone with the patient during transport in the ambulance.

When we arrived at the psychiatric hospital, four to six people were waiting. I was alone with the patient.

Theme 2: You never know what you're gonna get.

Ambulance nurses described two scenarios about how they were involved in care for patients with acute manic and/or psychotic symptoms. Scenario A: The ambulance was the first on the scene. Ambulance nurses made executive decisions and proceeded to care. Scenario B: The mobile crisis team was already involved, calling an ambulance specifically for the transport of the patient to a psychiatric hospital.

Going in and doing your thing

In the case of scenario A, participants described trying to create an overall picture of the patient to indicate what care is needed.

We collect as much information as possible. Did he use medication? Did he drink 20 bottles of beer? You try to get clear which route you should follow.

In the case of scenario B, nurses received the notification for transport from the control room. Participants described experiencing an unpleasant and unpredictable feeling when on route. This was partly determined by the limited information provided from the control room. When participants arrived at the location, they needed to be informed by professionals of the mobile crisis team. Some participants mentioned that it is hard to get information.

Information can make or break our actions. Psychiatrists don't realize that. It feels like being just a taxi. That's a bit like a degradation of our profession.

Is there anybody out there?

In the case of scenario A, there is a difference in consulting general healthcare specialists versus mental healthcare specialists, especially psychiatrists. Participants noted that a couple of years ago, it was impossible to contact mobile crisis teams directly. Nowadays, it is possible, which is seen as an improvement. Due to the optimization of consultation, participants experienced more understanding about the way mobile crisis teams act. Some participants noticed difficulties in collaboration. They stated sometimes feeling deserted by mobile crisis teams.

Professionals of the mobile crisis team often said, 'The deal was he shouldn't drink'. Now he drank, so we do nothing.

When the mobile crisis team is unwilling or unable to respond and there is an acute need for care, patients were transported to the emergency department (ED). However, participants expressed that psychiatric patients do not belong in an ED.

> *Psychiatric patients are sitting in a booth, start walking back and forth, and ask for attention, but that kind of attention is hard to give in an ED.*

Another option the participants used is consulting the general practitioner (GP) by telephone to guarantee care. Thereby, they try to create support for the patient. Generally, participants have little contact with family members of psychiatric patients, partly due to the small social network many psychiatric patients have. When family members are involved, participants try to estimate what influence they have on the patient's well-being. Participants also expressed feeling frustrated when the mobile crisis team or a GP indicated that it was acceptable for ambulance nurses to leave the patient.

> *You are afraid of letting someone go who is possibly a danger to himself or his environment.*

In the case of scenario B, participants stated that the course of action was clearer and experienced the collaboration as more effective. However, participants mentioned that even in this case, effort has to be made to get sufficient information.

> *The legal correspondence is faxed to the control room; we don't get that information. That's a shame.*

Participants mentioned that when they want to evaluate their work, they could go to a so-called "relief team," which is unusual to do. The purpose of the relief team is to evaluate the provided care in a specific case, to share experiences and thus to conclude the case.

Meanwhile, conversing with colleagues during coffee breaks was more common and was experienced as helpful. Other than "coffee-break consultation," multidisciplinary debriefings rarely happen, according to participants. A lack of money, staff shortage, and differences within organizations make it complex.

Mind your step

In both scenarios, the assessment of safety was mentioned as an important task before transporting a patient. Participants stated that the assessment consisted of collecting information from family members, police, and/or the mobile crisis team. Thereby, the behavior and the cooperativeness of the patient were seen as important indicators for

decision making. When participants felt they could not guarantee their own safety or that of the patient, the mobile crisis team was asked to administer a sedative before transport. However, participants noted that the mobile crisis team is reluctant on this topic.

> *I asked the mobile crisis team, 'Did he take his medication?' 'No, he didn't. He won't take it'. The mobile crisis team respects the autonomy of the patient, while we think the transport has to be safe.*

Another option is to call for assistance from police or security guards and/or using restraints during transport. When police are involved to reduce the risk of dangers, or disruptive behaviors in scenario A, some participants experienced that the police had another approach, stricter and more heavy-handed, which, in some cases, evoked more aggression.

> *The police are always really quick to be heavy-handed, force a patient down on the floor, and use handcuffs. I think this can be done in a different way.*

When police or security guards provide assistance in scenario B, they could drive behind the ambulance or sit in the ambulance. This depends on the wishes of ambulance nurses. Involvement of the police gave participants a feeling of safety.

Transport exceptionnel

Some participants experienced that transport of patients with acute manic and/or psychotic symptoms could feel uncomfortable.

> *When someone is staring at you for 45 minutes and says nothing, that doesn't feel good at all.*

Collaboration with ambulance drivers was seen as important, although the interpretation of this collaboration varied. Some participants mentioned they debated with drivers about a plan of action before transport. Others mentioned the importance of having a driver in the background, silent but alert.

> *I communicate with the driver through the mirror. One facial expression says it all.*

Participants described having different preferences in the means of transport. Some participants mentioned always transporting patients on a stretcher. Other participants mentioned preferring psychiatric patients sitting in a chair, because they believe this way of transport is less threatening for these patients.

Discussion

This study explored the experiences of Dutch ambulance nurses in emergency care for patients with acute manic and/or psychotic symptoms. The theme "It's not my cup of tea, but some like it" referred to the beliefs of participants on psychiatric patients, mental healthcare, and their professional identity relating to emergency care for patients with manic and/or psychotic symptoms. Participants (a minority) who saw mental health as "interesting" frequently felt competent. In contrast, many participants who saw mental healthcare as a "different world" felt incompetent and uncomfortable due to a lack of education and/or feelings of fear in caring for psychiatric patients. Participants indicated that the transport of patients with acute manic and/or psychotic symptoms rarely occurs. Thus, feelings of unfamiliarity could be experienced. A recent Australian study about the experiences of ambulance nurses in care for men with mental health or substance abuse problems suggested that feelings of incompetence were caused by the focus of ambulance nurses' education on the physical aspect (McCann et al., 2018). It is possible that the patient notices the ambulance nurse feelings of uncertainty and incompetency in dealing with acute symptoms of mania or psychosis evoking or increasing feelings of unsafety or anxiety.

3

The theme "You never know what you're gonna get" is characterized by the description of tasks and responsibilities of ambulance nurses, multidisciplinary collaboration, and the experience of transporting patients with acute manic and/or psychotic symptoms. When the ambulance was the first on the scene, ambulance nurses made executive decisions and proceeded to care. In that case, a lot is being asked of ambulance nurses. They must be able to identify psychiatric symptoms, while participants mentioned that they are not adequately trained to do that.

In the basic nursing training in the Netherlands, psychiatry is rather a limited part of the curriculum. Most of our participants, as can be seen in Table 2, followed this training a long time ago. Psychiatric patients were often referred to an Emergency Department (ED). An Australian study examined the effects of a specialized mental health team (SMHT) on the length of stay of psychiatric patients in an ED (Skopek & Francis, 2016). The presence of a SMHT increases pressure and minimizes the length of stay of psychiatric patients in an ED. Participants in our study mentioned that it can be hard to arrange appropriate psychiatric care when they are the first on the scene. This finding is in line with experiences of ambulance nurses in Australia: Faddy et al. (2017) investigated the effects of a mental health acute assessment team (MHAAT). This team consisted of a specialized mental health nurse and a paramedic. The MHAAT assessed the need of care at home, offered follow-up care within three days, or referred and transported the patient to a psychiatric hospital if needed. The study rated MHAAT as highly successful;

69% percent of the patients were able to refer to a destination other than EDs or did not need transport (Faddy et al., 2017). Although our study focused only on emergency care for patients with manic and/or psychotic symptoms, the findings are in line with studies that focused on the experiences of ambulance nurses with general mental healthcare (McCann et al., 2018; Prener & Lincoln, 2015; Roberts & Henderson, 2009).

Strengths and limitations

This study has several strengths. Firstly, five RAVs in the eastern Netherlands were included to compile a varied range of experiences, which enhances the transferability (Holloway & Galvin, 2016). Secondly, more than half (n=8) of the participants reacted on the member check, as described in the section Data analysis. Using a member check enhances the credibility (Creswell & Poth, 2017; Holloway & Galvin, 2016). Thirdly, theoretical saturation was reached, and with the use of peer debriefing, bias or inappropriate subjectivity was detected (Holloway & Galvin, 2016).

This study also has some limitations. Firstly, most participants have many years of work experience as ambulance nurses (on average, 16 years). This makes the sample unrepresentative for ambulance nurses and may affect transferability. Secondly, ambulance nurses were mainly recruited by managers. Ambulance nurses with less affinity for psychiatric patients might not have been asked or willing to participate in this study, which could lead to selection bias and is a limitation in generalizability. Thirdly, we included only ambulance nurses in the eastern Netherlands, which influenced the generalizability. Participants mentioned that psychiatric emergency care in other parts of the Netherlands is better organized. Therefore, to create a complete view of experiences of Dutch ambulance nurses, it is recommended to examine experiences in all parts of the Netherlands.

Implications for nursing practice

Reduction of stress and uncomfortable feelings could be achieved when ambulance nurses are better informed about patients by other involved professionals. The use of transfer documents could be helpful: in this document the acute psychiatric condition of the patient is explained. Feelings of incompetence about mental healthcare can be addressed by education about disorders and used interventions, as well as practice simulation, in a continuous learning process. It is important to learn together with other professionals involved in interdisciplinary consultation and make agreements about collaboration and the performance of care. In this way, the quality of psychiatric emergency care could be improved.

Conclusions

Ambulance nurses in emergency care of patients with acute manic and/or psychotic symptoms often experience stress and uncomfortable feelings due to different factors: a lack of information on the patients, being alone with the patient in a small space and the unpredictability of the situation. Besides the collaboration and communication with the other professionals in the chain of emergency care is not always optimal.

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CHAPTER 4

Emergency care to ‘persons with confused behavior’: Lived experiences of, and collaboration between, police and members of a mobile crisis team – A hermeneutic-phenomenological study

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Abstract

Background Police officers and members of a mobile crisis team (MCT) are the two actors who respond to nuisance in Dutch society related to 'persons with confused behavior' and serious violent incidents. Their collaboration creates tension and dissatisfaction about roles and responsibilities. **Aim** To explore the lived experiences of, and collaboration between, police officers and members of a MCT. **Methods** A hermeneutic-phenomenological study with unstructured in-depth interviews of eight police officers and eight members of a MCT. **Findings** The main findings in this study are that in the emergency care of 'persons with confused behavior' two very different professions are forced to work together, and that this collaboration is quite challenging. It becomes clear that different visions and expectations cause frustration in the collaboration. Police want the participation of the MCT as soon as possible after they are called in. The MCT wants to be easily accessible for police and can identify the great diversity of problems adequately but cannot solve all problems. There are shortcomings in adequate follow-up care provided by other health-care facilities. **Conclusion** It turns out that it is extremely important for police officers that members of the MCT explain to them why a crisis assessment has a certain outcome. The exposed frictions and stagnation in the collaboration should be discussed openly as part of the process in order to acknowledge this and resolve it together. A recently started project called "street triage", in which the police and MCT work together as one team and give a joint response, seems to remove a lot of the friction and stagnation. Further studies are needed to explore the effects of street triage by testing the validity of the hypothesis that street triage can close the gap between the two professions.

Keywords
mobile crisis team, police, mental health, collaboration

Introduction

Since 2011 the police in the Netherlands register people with deviant behavior under code E33: “persons with confused behavior.” The number of these registered persons has an annual increase of 14% (Politie, 2017). A recent study showed that this is not a homogenous group: 45% of the reports consist of people with a mental disorder, 31% consist of persons with difficult, potentially dangerous behavior causing a public nuisance, 23% of the reports include substance use, 7,6 % refer to dementia, and 3 to 4 % refer to intellectual disability (Koekkoek, 2017).

Since early 2015, much attention has been given, in both media and professional literature, about nuisance in Dutch society related to persons with confused behavior and serious violent incidents. Mobile crisis teams (MCT) that are part of mental health care institutions provide acute psychiatric care. Police and MCT, both with 24/7 availability, play the leading role in handling persons with confused behavior. Although they are mutually dependent, the collaboration creates tension and dissatisfaction about roles and responsibilities. The police–mental health care covenant (Convenant Politie-GGz Nederland. [Policy Paper Dutch Association Mental Health and Addiction Care and the Dutch National Police Force], 2012) provides the national framework: “In a crisis situation in which a confused person disrupts public order or safety, police and mental health care recognize their complementary responsibility for resolving the situation.” Police officers, often the “first responders,” indicate that they miss the presence of mental health workers on the spot (Kisely et al., 2010; Lancaster, 2016; Lee et al., 2015; McKenna et al., 2015).

Since January 2017 the national Dutch police no longer provide care and transport to persons with confused behavior who have not committed a criminal offense. Dutch police chiefs state that caring for people with confused behavior is not policework but a task of mental health care (NOS nieuws, 2017). Mental health care workers responded to this statement by stating that not all persons with confused behavior have psychiatric problems, and that psychiatric care might not be the proper response to all E33 reports (*Reactie GGz Nederland Op Uitspraak Rotterdamse Politie over Toename Overlast Verwarde Personen*, 2017). This discussion is still ongoing, causing collaboration problems between police and MCT in the emergency care for persons with confused behavior.

Steadman et al. (2000) describe two essential factors that seem essential for a successful collaboration between police and MCT: first a low threshold mental health care crisis service with a no refusal policy for police referrals, and second, an acknowledgment by the police that response to deviant behavior reports is an essential part of their work. Lee et al. (2015) found that police officers appreciated the possibility of on-site assessment with a mental health worker as particularly valuable. Because it improved knowledge and understanding of mental health problems, and contributed to a faster and better response. Consequently this approach increased the availability of police units

to do standard police work. MCT members had a less positive opinion, due to unjustified referrals: cases involving psychiatric patients already being in treatment in which they found that their own health care providers should respond and cases not involving acute psychiatric disorders.

Although police and the MCT are the two actors with 24/7 availability who respond to crisis situations, there is no systematic information available about the experiences of, and collaboration between, police officers and members of a MCT. The aim of the present study was therefore to explore these lived experiences and bring both sets of opinions together in order to improve practice.

Methods

Design

A hermeneutic-phenomenological method (Dowling, 2007; Thirsk & Clark, 2017) was chosen to examine the experiences of police officers and members of the MCT when collaborating in emergency care for persons with confused behavior. We considered the "bracketing" of prejudgments as impossible due to the participating researchers' working experience as nurses. Instead, we used our nursing experiences as a "preunderstanding" to guide the iterative process of data collection and analysis. Hermeneutical phenomenology is an iterative-narrative method of data gathering and data-interpretation. It entails an analytic procedure wherein each preunderstanding of a phenomenon is a possible conceptualization that becomes clearer by repeated back- and forward analysis until a contextual understanding of that concept is reached. At that point the data is saturated.

Research setting and participants

The participants of this study were purposefully selected to create a heterogeneous group with a sampling variation in age, gender and working experience representative for the population of police officers and MCT members. The sole inclusion criterion was that both groups of respondents should have at least two years' recent work experience with people with confused behavior.

Ethical considerations

According to the regulations for medial ethical review as set by the Dutch Central Committee on Research Involving Human Subjects (http://www.ccmo.nl), there were no objections to conducting this study. The Scientific Research Committee of Mediant Mental Health granted ethical approval. All participants signed their consent after receiving written and spoken information. The data gathered in this study were treated confidentially and anonymously.

Data collection

Data was collected through individual face-to-face interviews, between December 2018-March 2019. The average duration of interviewing was approximately one hour. Each interview started with a question concerning the participants' view of the term "persons with confused behavior." A literature-based topic list was used by the interviewer to guide the interviewee's narratives, while the interviewer made observational notes to direct interpretations during analysis. The interviewer searched for disconfirming evidence by so-called negative cases to collect new information and increase the credibility of this study. The interviews were digitally recorded and transcribed verbatim.

Data analysis

Data analysis started with two analysts who read and re-read the transcripts. Both analysts, independently, coded the transcribed interviews in ATLAS.ti 7. Member checking was conducted by sending the participants a summary of the main themes of the transcripts in order to verify whether the interpretations of the researcher represented the lived experiences of the participants. The insights of the observational notes, received comments of member checks and a reflective journal were also used to guide coding and interpretation. The interpretations were compared and discussed during peer debriefing until consensus was reached about the meaning of the concepts. After a total of sixteen interview analyses showed no new topics, we decided that data saturation was achieved.

Findings

Findings come from 16 interviews with eight police officers (five female and three male; median age of 43 years, range 32; median work experience of 19 years, range 36) and eight MCT members (four female and four male; median age of 42 years, range 33; median work experience of 8.5 years, range 20). See Table 1. Demographic characteristics.

Findings are organized around six themes emerging from the analyses: (1) confused behavior a misleading catch-all term, (2) task definition police and MCT, (3) mutual expectations, (4) urgency experience, (5) sharing information and (6) vision toward a comprehensive approach.

Confused behavior a misleading catch-all term

Both police officers and members of the MCT described a heterogeneous group of people whose problems are diverse. Police officers said they are satisfied with the term "persons with confused behavior" because this term makes it clear that mental health care should have the leading role, but members of the MCT indicated that this definition is too comprehensive

Table 1 Demographic characteristics

Participant	Gender	Working experience (in years)
Police officer 1	Female	6
Police officer 2	Female	34
Police officer 2	Male	42
Police officer 4	Male	20
Police officer 5	Female	18
Police officer 6	Female	10
Police officer 7	Male	21
Police officer 8	Female	12
MCT member 1	Female	4
MCT member 2	Female	4
MCT member 3	Female	7
MCT member 4	Female	15
MCT member 5	Male	10
MCT member 6	Male	3
MCT member 7	Male	10
MCT member 8	Male	17

If someone needs help in any form, they call the police because we are available 24/7. People with confused behavior need care and not police. There should be a hotline where people can call 24/7 for an expert assessment. (police officer 3).

It doesn't say much yet when I hear that a person with confused behavior stabbed someone. I want to know the background, the origin of the behavior labeled as confused. It is quite a difference whether it is a person with schizophrenia who stabs someone from a paranoid psychotic state or a person with an antisocial personality disorder in conflict. (member of the MCT 6).

Members of the MCT pointed out the importance of properly identifying the problem, because this determines the approach. Members of the MCT unanimously agreed that it is regrettable that the term “persons with confused behavior” has created the incorrect notion that every confused person is a psychiatric patient. They also pointed out the danger of viewing anything that deviates from the social norm as an expression of a psychiatric disorder, and of referring to mental health care as the one who can solve all problems. Both police officers and members of the MCT described having noticed

a reduced tolerance in Dutch society and a high social demand on police and MCT to remove persons with confused behavior from the street and from society.

> *Someone is crazy, causes nuisance and has to leave society. We don't want to be bothered anymore. (police officer 3).*

> *There is a risk of taking a step back in social resistance, prejudice and exclusion of behavior that deviates from the norm. (member of the MCT 8).*

Task definition police and MCT

Police officers indicated that they are ideally suited to maintain order, but are not trained as care providers or mental health specialists.

> *The main problem is that we don't have the knowledge, but end up in the position of care provider. If I leave and have not estimated it correctly, the next day I hear that the person has taken his own life… This great responsibility does not belong to us and it's fearful. (police officer 5).*

Police officers also declared that they only see their task as being a guide to the MCT if there is no criminal offense, and that they are insufficiently equipped to do anything when people with confused behavior require immediate attention. They indicated that well-intentioned interventions escalate, people with confused behavior sometimes need to be overpowered and handcuffed by several officers and they need the MCT to appear immediately to prevent restrictive action. Also they indicated that their police task is under pressure with insufficient staff and that there is no time to accommodate people with confused behavior.

> *This task does not belong to us and our basic task, ensuring safety, is compromised if we are occupied with it anyway. (police officer 3).*

Both police officers and members of the MCT considered the fact that nowadays police officers themselves can call in the MCT and make use of an assessment room in a mental health organization as an improvement. This way patients will no longer be detained in police custody. All participants agreed with this improvement but the police officers mentioned that this takes more of their time: waiting time until the transfer to the MCT, and sometimes a waiting time in which they have to stay for security reasons. Members of the MCT described themselves as playing an important role in making their knowledge and skills available in the assessment of confused behavior. They said they wanted to differentiate social, somatic and psychiatric problems and they wanted to be available for other professions in the chain of emergency care.

Mutual expectations

Both police officers and members of the MCT indicated that the collaboration between them is highly dependent on the personal and professional qualities of the individual police officer and member of the MCT, their acceptance of a shared problem and their willingness to cooperate. Members of the MCT said it is problematic that good collaboration requires time while police officers say they have insufficient time and that it is not their job to take care of people with confused behavior. Members of the MCT indicated that it is imperative that police officers accept that initial care for people with confused behavior is an essential part of their work. The MCT stated that they believe that they should be easily accessible for police, but also feel the need to screen whether there is a need for a crisis assessment. Members of the MCT also state that their services should be deployed when there are indications of an acute psychiatric condition, while police officers want the MCT to be on the spot without discussion beforehand.

> *If I am asked for a crisis assessment on a man who is in despair after loss of a child due to an accident, I would find it bad advice if we respond from mental health care for such a non-pathological reaction. (member of the MCT7).*

> *The MCT must learn to trust our judgement. The moment we tell you to come, you must feel the urgency to come. (police officer 7).*

Police officers indicated that they see admission in a psychiatric hospital, preferably forced, as the best possible outcome of a crisis assessment, and derive peace of mind from knowing that the person is getting help and will not cause a nuisance in society.

> *A recurring frustration is that we think someone is so crazy that we think that admission is necessary, is not crazy enough according to the MCT. (police officer 1).*

> *If we do not proceed to a psychiatric admission, the police are often dissatisfied with being busy with someone and no solution is offered. While something is done but that is an ambulatory intervention. (member of the MCT 7*

> *Ambulatory help is no guarantee that the police will not be called again for this same person. (police officer 6).*

Police officers also have found the explanations of the outcome of a crisis assessment by the MCT are sometimes insufficient. In addition, they indicated that advice from the MCT to ignore certain behavior, such as suicidal behavior, is not feasible for the police. Police officers explained that they explicitly assign the responsibility for the outcome after crisis assessment to the MCT, while the MCT find this unjustified and leave this responsibility

with the patient after having performed a careful assessment. Both police and the MCT see collaboration problems mainly arise in patients with a very complex interplay of psychiatric problems, addiction, intellectual disability and psychosocial and behavioral problems. This group of persons does not accept care easily and it is often difficult to find suitable care for them.

> *Then we all get stuck just like that patient and we express our frustrations to each other. If you work together, toward what you can do it remains frustrating work but we deal with it together. (police officer 5).*

Both police and the MCT indicated that in cases of stagnation in the collaboration, the problem is not discussed. The cooperating parties leave dissatisfied and report their frustration to their management. Lack of time, difficulties with addressing members of the other profession and lack of confidence in a meaningful outcome were given as reasons why the stagnation is not discussed. Police officers said they express their concerns about the incomprehensible outcomes of the mobile crisis team’s assessments, which contributes to the negative perception of the MCT.

Urgency experience

The MCT indicated that they do not act from urgency 1 as police do, where the norm is to be on site within 15 minutes. They act from urgency 2, where the norm in cases of the highest urgency is to be on site within an hour. Police officers said they expect the MCT to be on site within between 15 minutes and half an hour because only then can the MCT see what they see and what loved ones and neighbors see, when the crisis is at its peak. Police officers described time spent waiting for the MCT as lost time, and stated that this was a regular occurrence. According to them this was problematic because thereby MCT members might not recognize the seriousness of the acute crisis.

> *We arrive in the heat of the moment and the MCT for the peace talks.(police officer 7*

Police officers reported that there have been incidents where police officers stir up a person with confused behavior to show the MCT the seriousness of the situation if the person had calmed down and police feared the MCT would decide the person “is not crazy enough for admission.

> *We had been fighting with that man for more than two hours before the MCT arrived. We have provoked the man who was calm again with the text ‘the next one who opens this door is going to do very nasty things to you’ so that at least it was seen that this man was really crazy. (police officer 4).*

Police officers confirmed that this is done out of helplessness, not knowing an alternative to clarify the urgency and to ensure that the MCT will hospitalize the person, butt disapprove of it themselves.

Sharing information

Police officers unanimously stated that there are no obstacles in sharing their information about the patient with other involved professionals. They say it is needed to jointly resolve the crisis. Police officers indicated that the fact that the MCT does not easily provide information about the patient is an impediment. Members of the MCT indicated that they constantly consider whether it is necessary and permitted under privacy legislation to provide information to the police, viewing privacy as something that needs to be protected. They indicated that they do not always comply with the legislation, but in such cases, they can legitimize sharing information that is necessary to solve the crisis. A number of members of the MCT expressed their fear of exceeding the rules and disciplinary law. Both police officers and the MCT express confidence that the other profession is careful with information and are using ways to share sufficient information to resolve the crisis without providing personal informative.

> *Sometimes I choose, taking into account privacy legislation, not to speak about the specific problems of this patient but, more general, about people with such problems. I explain the possibilities and limitations of mental health care. (member of the MCT 2).*

Vision toward a comprehensive approach

Both police and the MCT stated that the acute chain is not conclusive, the route to various chain partners is difficult and adequate follow-up care is insufficiently organized. Examples of missing follow-up care: acute admission in addiction care is not possible outside office hours, a scarcity of psychogeriatric admission places, crisis care for people with intellectual disabilities is not available. The MCT indicated that if confusion arises in response to a social problem, neither the police nor the MCT can solve the underlying problem, and the social domain must offer a sustainable perspective.

> *The two of us are fighting about the non-acute world that is not available 24/7. We are always busy with the follow-up care that the two of us cannot complete if no admission to mental health care and no follow-up from the police is indicated. (police officer 7).*

Both police and the MCT were enthusiastic about the pilot “street triage” since January 2019, in which a police officer, a member of the MCT and an ambulance nurse respond as one team, daily from 15:00 to 23:00, to reports of “persons with confused behavior.” Both

cited joint responsibility to tackle the problem together and having no other option than to work well together with one objective as success factors.

Discussion

The main finding in this study is that in emergency care of “persons with confused behavior” two very different professions are forced to work together and that this collaboration is quite challenging. It becomes clear that different visions and expectations cause frustration in the collaboration. Dealing with confused people is a difficult task without a clear-cut solution. Nevertheless our study provides several points of discussion that might show some light upon improvements.

Police and the MCT are the only actors who are available 24/7, which means that police or MCT are obliged to respond and solve the crisis. According to the police officers addressed in this study, they only see their task as referring to the MCT, and need them to arrive on the scene without waiting time because only then can the MCT see the person’s state during the acute crisis. Urgency perception is essential in the collaboration between police and the MCT. In the Netherlands MCT uses the mental health triage guide, part of the practical guideline acute psychiatry (Akwa GGz, 2018), in determining the urgency of a request for crisis help. The assessment of psychological problems, somatic characteristics, course of the crisis and state of safety results in an urgency degree. As mentioned the MCT acts from urgency 2, where the norm in cases of the highest urgency is to be on site within an hour. Police officers describe the waiting time as too long, and say that how dramatically a situation can escalate becomes clear when police officers talk about incidents in which they stir up the person to show the MCT the case’s severity and the need for hospitalization. Police officers indicate that they are not trained and skilled as care providers, that well-intentioned interventions can escalate the situation and that their restrictive interventions are inappropriate for persons in need of medical care.

Daggenvoorde et al. (2017) indicate that acute crisis care can be experienced by patients and loved ones as threatening and traumatizing. Confrontation with police officers and placement in police custody pending assessment from the MCT is perceived as inappropriate and terrible by many patients, who feel they are being treated as crime suspects rather than as patients. McKenna et al. (2015) described police-led response as stressful and traumatic, since restrictive interventions were perceived as arising from a lack of understanding and a limited access to mental health services, leaving patients powerless in a state of emergency. At the time of the current study, patients were no longer placed in police custody, and assessment on the spot or in an assessment room

in a psychiatric hospital is experienced as a significant improvement, but this requires a greater time investment from police.

Koekkoek (2017) points to the great diversity of problems encompassed by the term “persons with confused behavior,” stating that a generalist is needed to differentiate the problems in each crisis. In this study members of the MCT say they want to be easily accessible for the police but also find the need to critically screen whether there is a need for a psychiatric crisis assessment. They stated they can identify the great diversity of problems adequately, and that not all people with confused behavior have psychiatric problems, which means that the MCT cannot solve all the problems they are presented with. The findings of this study indicate shortcomings in the mental health care system; both police and the MCT expressed concerns that the acute chain is not conclusive. The results of this study imply that improvement of adequate follow-up care from other health-care domains (addiction care, psychogeriatric nursing homes, admission possibilities for minors, acute crisis care for people with intellectual disabilities, and the social domain) is needed.

Whereas the MCT try to prevent hospitalization, based on the belief that people recover best in their own environment, police officers to see admission as the best possible outcome because this guarantees that the person will receive help and that the police can rest the case. These findings are consistent with literature on acute mental health care. Lohuis (Lohuis, 2006) reports that in a crisis, bystanders often want to be released from a problem and have high expectations of mental health care and optimistic expectations of the outcome of treatment. Lohuis (Lohuis, 2006) points to the importance of the explanation of the MCT at the spot about what is and what is not possible in mental health treatment, especially to those involved. They are entitled to good reasoning of concerning the course of action, because they are needed to make recovery at home possible. In line with this, police officers in the current study express a need for explanation about the outcome of a crisis assessment and express their desire to be included in the decision-making process. A finding in this study is that both members of the MCT and the police seldom talk to each other in a constructive manner when frustrated expectations arise. The exposed frictions and stagnation in collaboration should be discussed openly as part of the process in order to acknowledge this and resolve this problem jointly. According to both members of the MCT and police officers, initial experiences of a joint response in street triage, in which the police and MCT work together as one team, indicate that joint response removes a lot of the friction and stagnation. Research into the experiences of the MCT and police with street triage showed that joint response resulted in joint decision making with improved outcomes for patients, improved knowledge and understanding of the other profession’s roles and responsibilities, and improved collaboration(Evangelista et al., 2016; Horspool et al., 2016). Further studies are recommended to explore the effects of street triage by

testing the validity of the hypothesis that street triage can close the gap between the two professions.

Scope and limitations of the Study

The present study is a qualitative study with a relatively small number of participants. It is not clear whether the results can be generalized for the larger population of police officers and MCT members. A potential limitation of the current study is the possibility of selection bias. It is possible that police officers and members of the MCT who have a particular interest in the researched phenomenon participated more than others.

Declaration of conflicting interest

The authors declared no conflicting interests.

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CHAPTER 5

Lived Experiences of Mobile Crisis Team Professionals in the Assessment of Patients with Acute Symptoms. A Qualitative Phenomenological Study

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Abstract

Background Patients with bipolar or psychotic disorders are at risk of acute relapse of symptoms. In case of relapse an assessment by a Mobile Crisis Team (MCT) can be required. Such an assessment, provided by a Community Psychiatric Nurse and a psychiatrist, proves to be a comprehensive and challenging task. Therefore it is subject to reflection leading to improvement of care and professional development. **Aim** To explore the lived experiences of MCT professionals during the assessment of patients with acute symptoms. **Methods** We conducted a qualitative, descriptive phenomenological study: 15 individual, open, in-depth interviews with MCT members were completed by one focus group interview. We conducted a data analysis according to Braun and Clarke (2006). **Findings** The lived experiences of MCT professionals can be described in five main themes: urgency of an assessment; the impact on the professional; organization of the work environment; interaction with the patient and their family; and the role of experiential knowledge of all involved. **Conclusion** As experts in the field MCT professionals experience their role in the assessments as essential and leading. They feel affected, and above all responsible for the organization of the work environment and for establishing a relationship with the patient and their family to provide high-quality care. These insights can be used to develop a system of ongoing evaluation of, and reflection on, assessments for continuous improvement and professional development, wherein the lived experiences of all people involved are heard: those of patients, family, and professionals of different organizations.

Keywords
emergency psychiatric nursing, crisis intervention, research – qualitative, quality improvement, community mental health

Introduction

Patients with bipolar or psychotic disorders (American Psychiatric Association, 2013) and their families have to deal with episodes wherein patients are suffering from acute manic/psychotic symptoms. Patients may experience symptoms such as confusion, agitation, or disinhibition, which hinder their functioning in daily life. Coping with acute symptoms is a profound experience with huge impact for all involved. This burdens and emotionally distresses their families (Szkultecka-Dębek et al., 2016; Van der Voort et al., 2009). Often interventions by emergency psychiatric care professionals are urgently needed to handle these acute symptoms and their consequences. When this occurs, professionals of a Mobile Crisis Team (MCT) are called in to assess the psychiatric condition of the patient with acute symptoms and investigate what emergency care is needed. For instance, if appropriate care and safety in the home environment cannot be guaranteed, the possibility of admission to a psychiatric hospital can be considered.

In the Netherlands MCT professionals provide emergency psychiatric care 24 hours a day and seven days a week. This is comparable to how emergency psychiatric care is organized in several European Countries (Johnson, 2013; Sjølie et al., 2010). In the Netherlands, a Community Psychiatric Nurse (CPN) is always involved in such assessments.

In addition to the confused patient often other persons can be involved, such as, family members, police officers, and ambulance staff. In our previous studies we concluded that collaboration with these persons turns out to be quite challenging because of different visions and expectations (Daggenvoorde, Van Klaren, et al., 2021; Daggenvoorde, Van Eerden, et al., 2022). An assessment focuses on the acute symptoms of the patients and it includes attention to safety risks, physical health, medication, substance use, and the social context of the patient. Symptom management, psycho education for patient and family members and use of relapse prevention plans are important, as are stimulating engagement and cooperation with all people involved (Johnson, 2013).

For the sake of readability, in this article the term ‘acute symptoms’ is used. By this we mean manic/psychotic symptoms. In describing the lived experiences of the participants in this study on beforehand we used the term “crisis interventions” as the collective term for interventions deployed by MCT professionals.

Although the Dutch standard for Acute Psychiatric Care (Akwa GGz, 2018) describes elements of outreaching and timely emergency psychiatric care, it lacks descriptions of concrete crisis interventions, including the assessment. Furthermore, in other scientific resources such information is not available. Before being able to describe such interventions and to know how best to perform such assessments, we first need to know how MCT professionals experience these assessments. What are their lived experiences

in these interactions, and which issues are important according to them? Knowledge of these experiences can improve the quality of emergency psychiatric care and support their development as reflective health-care professionals. In addition, it can contribute to strengthening the cooperation between all parties involved.

Therefore, the aim of this study is to explore the lived experiences of MCT professionals in the initial contact in providing emergency care for patients with acute manic/psychotic symptoms.

Methods

Design

In line with the aim of this study a qualitative descriptive phenomenological design was chosen to explore the lived experiences of MCT professionals. We undertook individual interviews with open questions and with a holistic view (Creswell, 2013). After the analyses of the data from these interviews, we organized a single focus group with participants to discuss the preliminary findings. In order to enhance completeness in reporting we used the Consolidated criteria for Reporting Qualitative research checklist (Tong et al., 2007).

Participants and Recruitment

Purposive sampling was used to recruit participants of two MCTs of two mental health organizations in the eastern part of the Netherlands. A selection of professionals from these teams was asked to participate. We tried to differentiate between participants based on gender, age and years of working experience. All those professionals who were asked were willing to participate. In advance it was estimated that a total of about 15 to 20 interviews would be needed to achieve data saturation (Polit & Beck, 2017). Proportionately more nurses than psychiatrists were asked to participate because a nursing professional is always present at an assessment.

Ethical Considerations

The Scientific Research Committees of the participating organizations approved the study protocol. According to Dutch legislation there was no need for a formal medical ethical research approval since participants were not subject to procedures and not required to follow rules of behavior (www.english.ccmo.nl).

Each participant received written and oral information about the study and signed an Informed Consent prior to the start of the interview.

Data Collection

The individual open interviews were held between July 2021 and January 2022 by two researchers, both qualified to conduct qualitative research. Both interviewers had substantial experience of working in an MCT. The other four members of the research team involved two senior researchers who are also Advanced Nurse Practitioners, a psychiatrist and a research professor all holding a PhD.

Bracketing (Polit & Beck, 2017) was used by all researchers to identify their own preconceived beliefs before and during the study. The interviews were held at the location of the mental health organization. Both interviewers interviewed mainly participants from the organization where they themselves were not employed in order to guarantee objectivity as much as possible. Each interview started with the question "What are your experiences as an MCT member during the assessment of a patient with acute symptoms, and their families?" Interviews were audio-recorded and transcribed verbatim. Field notes were made in a logbook after the interviews in a logbook, and were regularly discussed among the research team. A second moment of data collection was planned after the data analysis of the individual interviews. We performed one focus group interview with five of the fifteen participants. This was because we wanted to discuss, validate and deepen the preliminary findings. The senior researcher (PG) was the leader of this interview, with the first interviewer reading out the findings by theme. The second interviewer noted on a flipover-board the main issues discussed during the interview. This focus group interview was also recorded and transcribed verbatim.

Data Analysis

Data collection and data analysis were performed in an iterative process. Thematic analysis (Braun & Clarke, 2006) was used and supported by the software program ATLAS. ti (version v5.14.1-2023-09-25).

The first two interviews were coded individually by two researchers, and thereafter discussed till consensus about the codes was reached. From the regular evaluations of the interview style we concluded how important it was to keep a clear focus on the lived experiences of the participants rather than on the process of the assessment about which the participants were eager to talk. The first researcher coded the rest of the interviews, while the second researcher also read all the interviews to keep an overview of all the data. During the data analysis process several checks were made as to whether existing and initial codes still corresponded with the original data. After coding five interviews the complete research team discussed the codes and the first thoughts about themes were exchanged. After ten interviews, no new codes emerged. In the later process, sometimes the name of a code was changed, but only when consensus was reached in the research team. The themes were presented and discussed in the focus group interview with five participants. At this stage no changes were made or discussed regarding the five main themes. The focus group members recognized the themes and descriptions as

appropriate and complete. The findings were definitively established, and quotes were added to the text.

Findings

Fifteen participants (8 female, 7 male) were interviewed individually. Participants had an average of 8.5 years of working experience in the MCT (range 0.5–21 years), and an average age of 43.5 years (range 31–57 years). Ten Community Psychiatric Nurses, one Advanced Nurse Practitioner, and four psychiatrists were interviewed.

The findings are described in five interrelated and partly overlapping main themes. The quotes are followed by the profession of the participant and the number of years of working experience (YWE) in an MCT.

1. Acute Manic/Psychotic Symptoms: Urgency

Participants described that a request for a crisis assessment of a patient with probably acute symptoms triggered immediate alertness: because of the severity of such symptoms, the possible unpredictable behavior and circumstances. They noted that patients did not always foresee the consequences of their behavior, and their psychiatric condition could worsen quickly. Such a request required a prompt and adequate assessment by the MCT, seen as the experts in this field.

> *You know that the faster you act, the shorter that short-circuit in the brain is, the sooner people recover, the smaller the chance that people will get it again, the smaller the damage for the patient and family. (Psychiatrist, 4 YWE)*

> *Then I just try to act quickly, with the least possible burden on patients and family. To motivate a patient to take medication or whatever is deemed most appropriate at the time. (CPN, 21 YWE)*

> *Specific for this group I think that our specialism is to determine how psychotic or manic the patient is at the moment, we have the ability to assess efficient in terms of diagnostics. Is it still reversible or is it irreversible and is unvoluntary care needed? Or is there imminent danger? (CPN, 17 YWE)*

Therefore such a request for a crisis assessment was regarded by all participants as a core task: it was essential to speak with this patient in person as quickly as possible and establish a therapeutic relationship, in safe circumstances, in order to be able to do a proper assessment and apply the right care.

And what you also see is that a disruption can occur quickly: I want to start interventions quickly to prevent further disruption. (CPN, 1.5 YWE)

Several participants mentioned that these assessments are what drives them to do this MCT work. Negotiations with referrers beforehand and during the assessment taking place under (time) pressure are what gives tension. At the same time this is experienced as a challenge.

That's what we're here for. I am of course in the MCT precisely for these kinds of conditions, to see those people quickly and act, so you can support a quick recovery, to put it quite literally. That's why I do this work. (Psychiatrist, 4 YWE)

2. The Impact on the Professional

Often the seriousness of the psychiatric condition of the patient made a deep impression on the participants. They told how they were touched by acute symptoms and their knowledge about the harmful consequences for the patient increased their compassion. Most of the patients showed a great lack of awareness of illness, so the request for help came from others.

It is very poignant…. we have to intervene, because otherwise she will incur so much damage… (Psychiatrist, 8 YWE)

Yes, I see the vulnerability of those patients as: it just happens to someone. You can't give any further direction to this yourself. Someone can only get out of it with the help of others. (ANP, 14 YWE)

Participants told how they were focused on keeping the stress low for the patient and, above all, on limiting further damage. They preferred to use "persuasion rather than coercion." Several participants described the need for decisions regarding forced hospitalization, coercive measures or emergency medication. To minimize trauma risk they tried to avoid them as much as possible.

Yes, our interventions at that moment can be experienced as traumatic by the patient: you often have the police involved, or emergency medication is given. For me it is a challenge to guide it in such a way that we make the least bad outcome. (CPN, 1.5 YWE)

Participants described that not being able to intervene because of a lack of criteria for forced care gave them feelings of powerlessness, which touched them emotionally.

You see someone's condition worsening, but you can't do anything yet: we are also bound by the law. This is distressing: I can see this is going wrong, but I can't do anything yet. (Psychiatrist, 8 YWE)

Mania or psychosis... then I find it so moving because those people have indeed lost control. (Psychiatrist, 13 YWE)

Participants talked about their need to share their emotions afterwards, by evaluating of and reflecting on assessments.

The major impact on the professionals involved is noticeable in the need to talk about it the following days, to evaluate interventions and to share experiences. (Psychiatrist, 4 YWE)

3. Organization of the Work Environment

An assessment of someone with acute symptoms, often at the request of others, means that conflict in the contact must be taken into account, and safety aspects must be weighed. The location of assessments differ – at home; at the mental health organization; or sometimes a police station – as can the number of people involved. In addition to a patient and family, other professionals such as police, other healthcare professionals and ambulance staff were often present. The participants described how, at the start of the assessment, they immediately tried to frame their work environment in such a way that they could obtain adequate information about the patient's psychiatric condition in a safe manner.

You try to create a quiet setting… Where are we going to sit and who will attend the assessment? Maybe you want a specific family member to join or to leave. Sometimes you want to get rid of the dog, or have the TV turned off. (Psychiatrist, 4 YWE)

The participants unanimously stated that the MCT professional was the person who took leadership and directed the care to be provided, as the experts in this field.

As an MCT professional you have to take control. You get into situations where everyone looks at you: What are we going to do? We have the experience and knowledge to take the lead. (CPN, 1,5 YWE)

According to the participants, it was important to remain calm, to maintain an overview and cooperate with all people present.

> *And in a way MCT members have to rely on being confident that they know what they are doing. I mean, you have uncertainty and you have things that you don't know for sure, yet you have to be convinced in a way: I'm going to do this and I'm going to get this done. (CPN, 1,5 YWE)*

In an assessment, the simultaneous deployment of professionals from different organizations was often needed. Collaboration could easily be under pressure due to different objectives and insights. Often the expectation was felt that "the MCT members would solve it."

> *And you have to work together. Often the police or ambulance is involved. That's a challenge every time, because you never know which policeman will come or which ambulance nurse. Sometimes police don't get at all what's happening, and another time a policeman understands it better than I do. (Psychiatrist, 4 YWE)*

Participants described that they were focused on collaboration, and actively encouraged this. Often there was (considerable) pressure to make treatment decisions quickly, and it was seen as "an art" to handle that pressure adequately, and to form your own opinion before making choices regarding treatment policy. By others, "admission to hospital" was often suggested to be the best solution.

> *At that moment you have to deal with a father, and with the professionals of a residential location, who all immediately see only one solution: hospitalization elsewhere. And you have to negotiate with a patient who does not want help, but who does need urgent help. And all eyes are on you: You are going to bring the solution today. (ANP, 14 YWE)*

Participants reported that, according to them a standard approach is not available because of the unique circumstances of each crisis: "it was always a matter of customized care at that moment."

> *Because every situation and patient is unique and even with patients you know it is still important to explore without prejudice what's going on at that moment. You can't capture that in standard rules or approaches. (CPN, 10 YWE)*

4. Interaction with the Patient and Their Family

Participants described how they immediately focused on establishing contact with the patient in question as a priority. Making contact with the family involved is of secondary importance.

In my opinion someone who is psychotic is naturally anxious ... so then I go to the patient first. And I say to the family: I'll come back to you right away... and ask what happened today. That is often a good question for everyone: What happened today? (CPN, 21 YWE)

This required a specific attitude; being curious, showing respect, reflecting on your own feelings.

That's your best tool: reflect on your own feelings, look at them, use them. (Psychiatrist, 15 YWE)

Providing reassurance and using de-escalation skills were mentioned as important, especially for people with psychotic symptoms. Asking short, specific questions about the actual situation often clarified things. Framing and limiting the patient was seen as helpful.

With someone who is (probably) psychotic, I use short, clear questions, and I take time to understand answers. I am calm, talk calmly. (CPN, 10 YWE)

…some completely float away in answering an open question. Then you start structuring, and making it smaller and smaller. Yes/no questions... (Psychiatrist, 15 YWE)

In mania I often notice that, above all, people are either irritated, or agitated. That may make it a bit more difficult in mania than in psychosis to connect with someone. (CPN, 2 YWE)

5. The Role of Experiential Knowledge

Participants described how their work experience with patients with psychosis or mania helped them to connect with the patient with acute symptoms, and their families.

Through work experience you know what's coming…what you can do…that your intuition is right,. (CPN,10 YWE)

That is what I think: The theoretical framework is helpful, but the work experience is actually more important. (CPN, 21 YWE)

Participants said that it matters whether family had a previous experience with this condition of the patient: Then they knew better what worked and what to do. Family

members were seen by the participants as an important source of information, “it is always important to involve them.”

> *Communication with family is always important because they know the patient best, and therefore often know what works or helps. They are an important source of information.* (CPN, 10 YWE)

Discussion

The aim of this study was to explore the lived experiences of MCT professionals during crisis assessments of patients with acute manic/psychotic symptoms. Insights can fuel quality improvement and continue professional development. Five main themes were identified. First, participants mentioned the urgency of conducting assessments of these patients because of their severe psychiatric condition, with possible unpredictable behavior and circumstances. Second, they described the impact of such assessments on themselves as human beings. Three other mentioned themes were: the importance of being able to organize their work environment; interaction with the patient and their family; and tapping into and using the experiential knowledge of all involved. According to the participants, a tailor-made approach is needed in each assessment. Overall, as experts in the field of emergency psychiatric care for outpatients MCT professionals experience their role as essential and leading. They feel affected by the condition of the patient and above all responsible for the organization of the work environment and establishing a relationship with the patient and their family, providing high-quality care.

The first theme is the urgency felt by MCT professionals when referrers ask for an assessment of a patient in a severe psychiatric condition, which can worsen quickly. It is seen as a core task to obtain in a short time an overview of the psychiatric symptoms and circumstances of the patient, and to react adequately to possible unpredictable behavior and circumstances. There is time pressure in these negotiations with referrers and other involved professionals, and in assessing the patient, which is experienced as stressful. But at the same time taking control of the assessment and turning the situation around for the better gives satisfaction to MCT professionals. It adds a lot of value to the work to be able to do the right thing in a short time under high pressure.

The second theme is about the emotional impact on the MCT professional because of the severe psychiatric condition of the patient. MCT professionals describe that they feel affected by the vulnerability of the patient, also based on their knowledge and experience of the possible major consequences of the severe psychiatric condition for the future of the patient, and for their relations with others. They feel compassion and try

to avoid further damage or coercive measures when possible. At times MCT professionals describe feelings of powerlessness because of not being able to intervene immediately, but knowing that the condition of the patient will worsen. Experiencing this emotional charge seems to be linked to their drive to do this work and to do it to the best of their ability. MCT professionals feel a strong need to talk about these experiences with their colleagues after an assessment.

The third theme relates to participants describing that the moment the MCT professional arrives at the scene of the assessment they immediately take leadership and organize their work environment. MCT professionals experience being seen as the experts and that people count on their leadership. MCT professionals take control in order to make the circumstances for an assessment as favorable as possible. Acute decisiveness about where they sit, with whom they consult, and the deployment of other necessary care is needed, despite the fact that there are often still many uncertain factors. MCT professionals have to be aware of their own feelings and reflect on them and react accordingly. Such skills are important in an assessment, and evaluation afterwards is also essential to develop and maintain these skills. Ongoing professional development and supervision are important in a team that provides emergency psychiatric care. The Dutch guideline for acute psychiatric care (Akwa GGz, 2019) describes the importance of continuous evaluation of care due to the enormous impact of crisis on patients and family. However, until now nothing has been said about the impact of crisis on professionals involved, and how to deal with it.

The fourth theme is about the ongoing focus of the MCT professional on the interaction with the patient and family in order to establish a therapeutic relationship. Specific aspects of attitude were described: being curious, showing respect for everyone, and being able to reflect on one's feelings. De-escalating skills are essential. Each assessment requires a tailor-made approach, which suits that specific situation. The communication skills of the MCT professional are important to receive adequate information. In addition to knowledge of standards of care, these skills are constantly trained in practice, in conducting assessments, and learning through reflection and evaluation afterwards (experience-based knowledge). Due to the nature of the work in an MCT, the learning process lends itself more to a watching, participating and discovering learning style than to a style aimed at acquiring knowledge (Kuipers & Rijnders, 2017).

The last theme is about the use of their professional knowledge but, possibly even more, their own experiential knowledge and intuition, and also how to tap into the experiential knowledge of others. There may be an assumption about how an assessment will proceed, but MCT professionals have to be flexible all the time to provide tailored care. Circumstances can change and so too can the condition of the patient.

The aforementioned themes about establishing a working relationship with patient and family, using experiential knowledge and framing the context of care are fundamental elements in nursing care theory (Kitson, 2018). This theory describes how nurses, patients and family work together around three core dimensions: establishing the nurse-patient relationship; integrating physical, relational and mental care in the patient's care plan; and ensuring that the context of treatment is suitable to the patient's needs. The lived experiences of the participants in our study describe how in their daily work, on a micro level, they take leadership to build a relationship with patient and family, and work at the integration of care in the context of the patient at that moment. Afterwards reflecting on the interventions and care provided makes them aware of the integration of care and influences of the system and policy level within their own organization and other professional organizations with which they collaborate: police, ambulance care, social services. On a macrolevel awareness of the healthcare system and political influences are of importance.

This fundamentals of care framework could be a useful theoretical framework to use for evaluation and reflection in order to keep developing the complex work and interventions of MCT professionals. Continuing professional development is important to improving patient care (O'Loughlin et al., 2012). This could further improve the quality of emergency psychiatric care to patients with acute psychotic/manic symptoms, and their family.

Strengths and Limitations

To the best of our knowledge, a qualitative study specific to these kinds of lived experiences of MCT professionals has not been carried out before. The demographic characteristics of the participants varied in gender, age and years of working experience in an MCT and discipline (nursing professionals and psychiatrists), which led to a participant file with sufficient variation.

Limitations to our study are that the findings are not generalizable to each setting: The organization and work processes in emergency psychiatric care differ per country, so the findings cannot automatically be generalized to other countries.

Conclusion

As experts in the field MCT professionals experience their role in the assessments of patients with acute symptoms as essential and leading. They feel affected by the situation, and above all responsible for the organization of the work environment and establishing a relationship with the patient and their family to provide high-quality care. These insights can be used to develop a system of ongoing evaluation and reflection on assessments for continuous improvement and professional development, wherein the lived experiences of all people involved are heard: those of patients, family and the professionals of different organizations.

Implications for Nursing Practice

Knowledge and use of these lived experiences is important as part of the ongoing training of MCT professionals now and in the future, to keep them competent and enthusiastic. In practice, after each assessment a structural evaluation and reflection should take place. Insights about their leading role as experts in the field and the persons to establish a therapeutic relationship might enhance their self-efficacy and lower stress levels. Gaining more knowledge about how patients and family experience the emergency psychiatric care of an MCT through ongoing case evaluation with all involved is also recommended.

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CHAPTER 6

General discussion

General Discussion

The primary aim of this thesis was to gain a broad understanding of the lived experiences of people (and their families) suffering from acute manic/psychotic symptoms with an assessment performed by an MCT (mobile crisis team). Additionally, the lived experiences of involved MCT professionals, and those of involved police officers and ambulance nurses, were investigated. The second aim was to formulate recommendations for all involved to optimize the effectiveness of interventions and the collaboration between the parties to personalize and improve the emergency mental health care for patients (Chapter 1).

Main Findings

The exploration of the lived experiences of patients suffering from acute symptoms showed that most patients reported feeling trapped in psychotic thoughts and inner confusion during crisis. In such a state, communication was difficult. Calmness, empathy, and understanding on the part of the involved professionals in emergency mental health care were experienced as essential. Most of the interviewed patients did not know whether the MCT had consulted the patient's relapse-prevention plan before or during the assessment. Often, the patients felt stigmatized when others called the MCT in for help and when the police got involved during an assessment, the stigmatization was felt even more. According to the patients and families, after their call for help it often took a long time for the MCT to arrive. Family members described how powerless they felt to manage the situation (already for a long time), and that they experienced great relief when an MCT professional stepped in. In general, the family members felt "heard" by the MCT professionals (Chapter 2).

During assessments, MCT professionals work in duos: In general, a Community Psychiatric Nurse (CPN) together with a psychiatrist are at the scene. The MCT professionals who were interviewed about their lived experiences during assessments of patients with acute symptoms mentioned they felt a sense of urgency while conducting the assessments. They related this to the combination of the patient's severe psychiatric condition and potentially unpredictable behavior and circumstances.

The professionals described the impact of such assessments on themselves as human beings; in particular, they were emotionally affected by acute symptoms, and their knowledge about the possible harmful consequences for the patient. According to the MCT professionals, their main roles were to organize the work environment, establish a therapeutic relationship with the patient and their family, and tap into and use the experiential knowledge of all involved. A tailor-made approach was needed for each assessment in which there was no clear-cut solution. Overall, as experts in the field of emergency mental health care for outpatients, the MCT professionals experienced

their role as leading and essential. They felt responsible for directing situations, often in collaboration with other professionals, for example, police officers. Their main task as MCT professionals was to provide appropriate emergency mental health care for patients with serious acute symptoms and their families. The professionals also aimed at preventing further deterioration of the patient's psychiatric condition (Chapter 5).

The police officers involved in emergency care for "people with confused behavior" reported that in those situations, two quite different professions must work together, and that this collaboration was experienced as challenging. It became clear that different visions and expectations could frustrate collaboration during assessments (Chapter 4).

Ambulance nurses could also be involved at the end of the assessments when a patient needed nursing care during transport to a psychiatric hospital. They experienced that their emergency mental health care often triggered stress and uncomfortable feelings in themselves. This was reportedly often due to insufficient information about the specific patient, being alone with the patient in an ambulance (a small place), and the unpredictability of the patient's behavior. Several ambulance nurses mentioned that they realized that they lacked the knowledge and training around how to guide patients with a psychiatric disorder (Chapter 3).

Communication, Collaboration, and Continuous Learning Opportunities

Within the large number of experiences collected and analyzed during our studies, we distinguished the following main themes—the 3 Cs:

- communication between people involved in an assessment;
- collaboration between professionals; and
- continuous learning opportunities in practice during and after assessments, also linked to the education of the professionals.

Interrelated, these themes sometimes overlapped.

Communication

Communication, contact, and establishing relationships or the lack thereof emerged as themes across the four studies. For patients with bipolar or psychotic disorder, communication during a period with acute symptoms was often difficult. This handicap of the patient, who may be confused and can have difficulties in clear thinking, is central. The patients reported feeling "trapped" in psychosis with disorganized thoughts and inner confusion during a period of acute symptoms. In many cases, the patient was not the person who called for help from an MCT; frequently, others, like family members, a general practitioner, or police officers, or a professional of a regular ambulatory mental health treatment team asked for the help of an MCT. For several patients, making contact and communicating with family and professionals was difficult during assessments. In fact, patients often felt vulnerable and in distress, although the patient was likely

to mask this, and this state of confusion frequently bothered them. In that sense, the patient was dependent on the efforts and abilities of others who focused explicitly on establishing contact and involving the patient in conversation. The professional's calm, understanding attitude was appreciated (Chapter 2). Some patients felt "heard" and reassured by MCT professionals, whereas others had the experience that their condition was not discussed with themselves, and they felt left-out of decision-making. In contrast, most family members felt sufficiently informed by the MCT professionals about the employed interventions, which were tailored to the patient's mental condition. Family members reportedly felt better informed than the patients. Thus, at junctures, the phase of establishing contact with the patient could be improved.

The fundamentals of care framework (Kitson, 2018) could be used in establishing improvements in this emergency mental health care. This framework explains, guides, and potentially predicts the quality of nursing care provided to patients and their families. The framework focuses on the nurse's (in this thesis, the MCT professional's) relationship with the patient (in this thesis, the patient in crisis manifested in manic/ psychotic symptoms) and their family. The framework promotes three key premises of fundamental care, including: (1) developing trusting and positive relationships between nurses/care providers and patients/families; (2) attending to physical, psychosocial, and relational needs; and (3) being aware of how context affects the ability to meet needs and develop relationships (Kitson, 2018). Practicing empathy, active listening, and appropriately reacting to help patients stay calm, along with supporting and involving family and informal carers are described in this framework as important skills, and this fits well with the results found in our research.

If professionals want to develop a trusting and positive relationship with patients with acute symptoms, efforts are especially needed to connect and stay in touch with these patients. Tielens (2012), inspired by Amador (2010), published a communication approach called the connecting conversation technique (CCT). This technique involves a basic attitude on the part of the care provider (or other person) towards someone in psychosis. Amador (2010) wrote about the listen, empathize, acknowledge, and partner (LEAP) method. The importance of listening in an unbiased way and appropriately connecting to the patient's story is emphasized. The CCT is also about advising, establishing contact and being decisive in the event of danger. At all times, the goal is to gain the other person's trust and create motivation for, in any case, contact and treatment. This matches with the descriptions of De Winter and Van de Sande (2017) and Kupka (2017). They described specific attitudinal and approach aspects such as calmness, empathy, tact, and decisiveness in relation to people with acute manic and psychotic symptoms. Although the CCT is not specifically developed for situations like the assessments in our studies, we do suggest investigating whether elements of the CCT can be useful in cases where a quick opinion about the mental health condition of the patient with acute symptoms is needed.

When MCT professionals have formed an opinion about the mental health condition of the patient, options of emergency care treatment need to be discussed by the MCT professional with the patient and family. As to the framework of fundamentals of care, engaging, informing, and involving patients and families in discussions are essential nursing skills. Moreover, nowadays in health care settings, a healthcare professional's shared decision-making (SDM) is preferred, in order to provide appropriate person-centered care (Zorginstituut Nederland, 2022). Person-centered care is a practice of caring for patients (and their families) in ways that are meaningful and valuable for the individual patients. SDM is about user involvement and strengthening the decisional position of the patient: Information about the patient's health condition is shared, and treatment options are presented (Slade, 2017). Haugom et al. (2020) described that the professionals' understanding and explanation of SDM related to patients with psychotic disorders is inconsistent with the definition used in the literature. A recent review (Chmielowska et al., 2023) concluded that SDM interventions and experiences in current mental health care do not meet the needs of patients and family members. If applying SDM is difficult in regular mental health care, it is a logical assumption that this is even more complex in emergency care contexts because of the inner confusion that patients in a manic or psychotic state experience. Our findings underline the importance of SDM in building a trusting and positive treatment relationship, where possible. An eye for building connections and collaboration with the patient and family is always important, even though a patient with acute symptoms may have limited opportunities to participate in contact and decision-making. In any case, it is important to try to involve and inform the patient.

The MCT professional also needs to be aware of any uncomfortable feelings family members may have towards the patient. Some of the family members interviewed (Chapter 2) reported a fear of damaging the relationship with the patient due to conflicting opinions about the need for professional help when the patient did not agree with the request for help. The MCT professionals' focus on building a trusting and positive relationship with the patient and also with the family was important. Taking the time to acknowledge both their positions seemed to be a key component to improve communication and collaboration between all the people involved in an assessment.

Collaboration

During assessments, MCT professionals work in duos: In general, a CPN works together with a psychiatrist. The practical guideline of emergency psychiatry in the Netherlands (Akwa GGz, 2018) describe that an MCT duo conducts assessments. The CPN acts as a "spider in the web"; other professionals see the CPN as the expert who takes and holds the lead. The nursing competencies described in CanMEDS roles, such as being a communicator and taking leadership, are essential (Landelijk Overleg Opleidingen Verpleegkunde, 2023). A CPN is proactive in managing relationships, this being a specific

skill of their profession. The CPN is multi-partisan, and actively promotes this (VenVN-SPV, 2023). In their professional education, a CPN is trained to invest in the relationship with the people needing assistance, their families, and the other involved professionals, tending to their mutual interactions.

The different professionals on the scene during an assessment experience time pressures to find a “quick solution” to the problem. But the concern in these cases is a patient in a confused condition, more or less able and willing to describe what they are experiencing. So, first, time is needed to make contact and gain an understanding about this individual and their condition at that particular moment. In practice, a CPN models the taking of sufficient time to establish contact during assessments by an MCT. At the same time, the interventions of MCT professionals are aimed at acute psychiatric symptoms, as the main goal is to stabilize or improve the patient’s condition. The CPN is trained to provide leadership and guidance in this regard. They continuously manage relationships and need to be empathetic and simultaneously decisive.

Again, the MCT professionals take the lead in these assessments. Other organizations acknowledge that the MCT professional is the expert in the care of patients with acute psychiatric symptoms. The MCT professionals take the lead and are usually the ones to invite other professionals to contribute, like requesting police assistance to guarantee the safety of everyone and ambulance nurses to facilitate nursing care during the transport of a patient to a psychiatric hospital (Chapter 5). Collaboration between all these professionals on the scene is essential to both provide appropriate emergency mental health care for a patient and also support the family. Our multiple-study findings described in chapters 3 and 4 reflect how each professional has their own task and responsibilities unique to their profession and organization. Our studies show that differences in working methods and mismatched expectations between professionals of different organizations can easily cause friction in collaboration during assessments. For instance, police officers might demand that MCT professionals arrive at the scene immediately when they are confronted with a patient acting confused. They do not want discussion around the necessity of an assessment beforehand. Some police officers also stated it was not their job to care for these people, and that they have too-little time to do so. A frequently heard comment was that admission to a psychiatric hospital is the best possible outcome of such an assessment, which is a potentially conflicting recommendation. MCT professionals, however, tend to emphasize the mutuality of the task of caring for people with confused behavior. The MCT professionals want to be available for the police officers, but they also want to screen the situation beforehand to differentiate whether the person in focus actually needs mental health care or not. We discovered that during these assessments, the police officers sometimes needed more of an explanation on the background of decisions made by the MCT professionals (Chapter 4).

An MCT assessment may involve police assistance from the start to ensure the safety of all those present. In other cases, police assistance is requested during the assessment,

and police officers might have to intervene to guarantee the safety of everyone. When safety is at stake, police officers temporarily tend to take the lead with the aim of making the continuation of the assessment possible after their intervention. This shows how the cooperation between MCTs and police on the scene is necessary in both word and deed. When the assessment results in a decision of compulsory admission, the ambulance service is called in for help. After the ambulance's arrival, and after a handover from the MCT professionals, the ambulance service provides nursing care during the transport of the patient to a psychiatric hospital. So, during the process of an assessment there may be several moments in which the control over a situation is transferred from one professional to another. Naturally, this requires collaboration and coordination at those transfer moments. Sometimes, the participants experienced that the involved professionals thought too one-sidedly from their own professional vantage point, and that adequate information was not always conveyed (chapters 3–5). Several professionals also indicated that, at times, the professionals' collaboration could be improved in practice.

Professionals on the scene all have a range of tasks and working methods drawn from their own profession and organization. Expectations about their interventions in an assessment therefore differ, for example about urgency and time management: In general, police officers and ambulance nurses are used for making quick decisions (under time pressure), and then they move on to their next emergency call (chapters 2–3). However, the MCT professionals in our studies often used time as "part of the solution." For them, the factors time and patience are essential ingredients in their establishing contact with patients and families and in their de-escalating interventions. In the collaboration between the professionals on the scene, a middle ground must be found so that, in addition to the patient's needs, possible different professional interests may also be accounted for. When many people are involved, it can be difficult to pay sufficient concurrent attention to everyone's opinions and needs. Therefore, it could be a consideration regularly putting the assessment on hold during the execution of an assessment and checking with the involved parties whether they are still "okay" was glimpsed as necessary. Such "time-outs" could be helpful in both making immediate adjustments if someone does not feel heard and promoting collaboration between the professionals involved.

Another aspect that patients in our first study (Chapter 2) touched on was they felt "treated" like a criminal and stigmatized when the police were involved in an assessment. For the families, police assistance also often felt emotionally burdensome, although in some circumstances the families could see the need for police because of the patient's behavior that involved confusion and delusions. Some patients were placed in police custody peding an assessment by an MCT, which was experienced as highly inappropriate by both patients and family members (Chapter 2). Presently in the Netherlands, a patient will only stay at a police station when there is a judicial reason for the patient's detainment. For a few years now, mental health organizations are required

to hold a special room available where an MCT can conduct assessments. The availability of such a room was experienced as an improvement by both the patients and MCT professionals (Chapter 5). The availability of such a room in a mental health organization was an important recommendation in the evaluation of the 2012 agreement between the police and Dutch Mental Health Services (de Nederlandse GGz, 2023).

During assessments, between the involved professionals there is an agreement that the MCT professionals are the experts in diagnosing and treating the psychiatric symptoms (chapters 3–5). In that sense, the MCT professional is decisive; they take and hold the lead. Thus, an MCT professional needs to be capable of explaining the hypotheses about the patient's psychiatric symptoms, the decisions made, and the interventions used in an evidence-informed and objective manner. For the patient, family, and other involved professionals, going along with and agreeing with the decisions held significant importance (Chapter 4). Also, each professional still manned their own field of expertise and held decision-making authority per their own domain—the MCT professionals facilitated the mental health care, and the police officers saw to safety aspects, while the ambulance nurses administered nursing care during the transport of the patient to a psychiatric hospital. An MCT professional who properly executes this leadership will provide the greatest opportunity to truly collaborate in the interests of good patient care. The findings from our studies (chapters 3–5) show that improvements in the collaboration between the involved professionals are needed. The findings underline just how important it is that the professionals on the scene communicate about their interventions and decisions made and convey relevant information. Understanding and having knowledge of each other's professional tasks and responsibilities are important in order to collaborate and complement each other on the scene, and in collaboration with the patient and family, to intervene in the crisis situation as effectively as possible. Such joint reflection and evaluation over assessments, especially between professionals of different organizations, is necessary, but still not standard, according to our results.

Continuous Learning Opportunities

The gathered lived experiences of our participants reflect the major impact of assessments on the different groups involved: patients, families, MCT professionals, police officers, and ambulance nurses. Some patients reported that they could not remember everything about an assessment because they felt confused, whereas others explained that their cognitive functioning was impaired (Chapter 2). The professionals did not always consult with the patients or explain the decisions made. The patients often did not know whether their relapse-prevention plan had been used, a plan that typically contains important tips and instructions for crises. However, for the future, to learn from a crisis, moments of evaluation and reflection per an assessment with patients and the involved professionals are important, and this typically cannot take place in a short time because the patient first needs to partially recover. Following being given a reasonable recovery window,

the patient is also then consulted over the assessment. The patient's regular practitioner of the ambulatory treatment team should play an essential role in the timing of this evaluation. In collaboration within the patient-family-professional triad, they strive to update the personal relapse-prevention plan (Goossens et al., 2010; Van den Heuvel et al., 2015). Also, evaluation and reflection could lead to new knowledge and the opportunity to update and improve the relapse-prevention plan, and these could help empower both the patients and families (Johansen et al., 2021). The experiences of the patients and families are taken seriously this way, and everyone can be better prepared for a possible relapse to prevent a future crisis.

Also, for the professionals, opportunities for evaluation and reflection during assessments were reported as immensely important. The MCT professionals described how conducting assessments of patients with acute symptoms for them was a challenging task in which there was no clear-cut solution. Whether the attitude of (MCT) professionals in an assessment is experienced as pleasant by a patient seemed to be partly based on the aforementioned attitudinal factors such as calmness, empathy, and understanding. The MCT professionals drew their interventions from their professional training and theoretical knowledge about psychiatric disorders and treatment options. And both their professional and personal experiences were important, too. The patient's and family's experiential knowledge also figured in.

Learning how to implement an appropriate attitude is a continuous learning process, however. One needs to get feedback about the interventions and attitudes used during an assessment to become an experienced and effective MCT professional. MCT professionals reported that they are in need of regular feedback themselves, in the days after an assessment takes place. Often these "day-after" talks facilitated sharing experiences, yet these talks could be transformed into productive evaluations. As far as we know, planning such joint evaluations with the involved professionals is not a standard operating procedure for MCTs. Such evaluations could be framed as continuous learning opportunities for the MCTs and also for the professionals from the different organizations involved in an assessment. They would represent an opportunity to develop the skills of the professionals, to improve patient care, and to enhance collaboration (chapters 3–5). In Chapter 5, we suggested that the fundamentals of care framework (Kitson, 2018; Kitson et al., 2023) could be a useful theoretical frame for evaluation and reflection on the complex work and interventions of MCT professionals.

Apart from building relationships with the patient and integrating patient needs into care, it also appeared important to determine whether the context of care suited the patient and their family. In or after each assessment, a joint search for the best way to both provide appropriate care and regulate the situation as best as possible probably requires creativity and the commitment of all the professionals involved. Emergency care should be tailor-made. Also, being able and willing to shepherd individual cases through necessary adaptations at organizational and more general policy levels that transcend

organizations appeared important. Ideally, a common professional evaluation model would be considered useful for achieving this exchange of ideas.

Besides standard assessments, the surveyed professionals mentioned the desire for improvements of their expertise in emergency care: For instance, the ambulance nurses wanted more training in dealing with psychiatric patients (Chapter 3). The police officers wanted this, too, and especially wanted to be better informed on the decisions made by the MCT professionals during assessments (Chapter 4). Agreements between MCTs, police, and the ambulance service regarding the development of joint expertise in which knowledge and experience are exchanged would strengthen collaboration. Since 2019, in some regions of the Netherlands, joint teams of police officers and MCT professionals—so-called "street triage teams"—are active first responders to situations involving people on the street with confused behavior, and initial reports were positive from both sides. So far, no research has been shared on this subject in the Netherlands.

Methodology

In this project's first study (Chapter 2), a phenomenological approach was chosen to explore the lived experiences of patients and families during an assessment. "A phenomenological study describes the common meaning for several individuals of their lived experiences of a concept or phenomenon" (Creswell, 2013, pp.76). In addition to the patient, family, and MCT professionals, others are often involved in assessments, such as police officers or ambulance nurses. During the execution of the first study, the importance of obtaining qualitative information about the subject became, once again, clear: Lived experiences show the immense and diverse impact of assessments on patients and families. After the first study, the research team discussed the strategy of the study design of follow-up studies that would help increase scientific knowledge about the phenomenon studied—the experience of an MCT's assessment in emergency mental health care. The outcome of our discussion on the methodology of follow-up studies was that quantitative research did not suit that assessment moment, considering the scarce scientific knowledge about the work of MCT professionals, especially around conducting assessments with patients manifesting acute symptoms. For example, a randomized controlled trial was decided unfeasible in this context of emergency care because the conditions are not standardizable. The MCT professionals stated that each assessment was unique and had no clear-cut solution. Besides, on ethical grounds, recruiting a control group was untenable: A patient with serious acute (mental) health problems should not be denied emergency (mental) health care. Thus, conditions could not be standardized first on behalf of scientific research before emergency care is provided, and then, a study design involving a comparison between an intervention group and a control group could not be easily realized. Overall, the provision of emergency mental health care at home

for patients with acute symptoms—which are partly determined by the unique context in which the patient lives—is, by definition, the provision of care in a non-standardizable situation.

So, the outcome of the research team's discussion was that, first, qualitative knowledge on the perspectives of all the people involved was needed initially to fully understand the phenomenon under investigation. Knowledge collected via a qualitative research design would be fundamental for future research on the emergency mental health care for these patients. Moreover, phenomenology is a deep-rooted qualitative research tradition. This is an approach to understand the lived experiences of people and the meaning of their experiences (Creswell, 2013, pp. 76). The choice was made to use this approach in our research because a broad understanding of the lived experiences of the involved people was essential: Each participant has their own lived experiences, personal perspectives, and different roles and relationships that matter. However, the broader scientific knowledge provided by qualitative research does not change the fact that a following step might also include gathering more-structural, quantitative data, for example about unique patient characteristics, circumstances, and contexts of assessments. But again, first, the gathering of descriptions of interventions and outcome parameters of emergency mental health care needed to be accomplished in order to be able to then compare the methods and effects of different MCTs. Afterwards, it might be possible to conduct a study that compares teams that use regular evaluations of assessments versus teams that do not implement such regular evaluations. In general, looking at evidence hierarchies and levels of evidence, it is clear that different kinds of evidence, gathered by qualitative and quantitative studies, are in themselves building blocks of research to strengthen overall knowledge (Polit & Beck, 2017, pp. 25).

Implications for Future Practice

Communication

For the MCT professionals, the ongoing training of skills (e.g., making contact with people with acute manic/psychotic symptoms, being able to quickly analyze acute problems and prioritize interventions, maintaining an "overall" perspective, and showing leadership) is reported as necessary, including (1) educating and training MCT professionals in the knowledge and use of aspects of the CCT; and (2) making evaluations of assessments a standard procedure in MCT work. A key evaluation agenda item should be whether in an assessment a trusting and positive relationship with the patient and family was achieved.

Collaboration

A continuous information and meeting cycle between professionals from different involved organizations in order to be informed about everyone's professional tasks,

domain and responsibilities is important to promote collaboration, and will support patient care.

Continuous Learning Opportunities

Subsequent agreements between MCTs, police, and ambulance professionals regarding joint expertise development could enhance collaboration. For example, the fundamentals of care framework or the CanMEDS roles for nurses might provide an educational structure. Finally, setting up regular meetings with professionals from different organizations involved in the assessments, and bringing case-specific evaluations into meetings might prove useful.

Implications for Future Research

In our studies we collected qualitative information, and hereafter make a number of suggestions for quantitative follow-up research. For quantitative research it is necessary to make use of concrete measurement tools, such as outcome measures or questionnaires. These should focus on important items within emergency mental health care as the building of a therapeutic relationship with patient and family, the used interventions, the degree of recovery, but also the number of forced admissions and duration of admission could be outcome measures.

The first step could be to set up a Delphi study with CPNs to reach consensus about the description of nursing diagnoses, interventions, and outcomes related to the assessments. The structure of the North American Nursing Diagnoses Association (NANDA) (Herdman et al., 2021), the Nursing Interventions Classification (Butcher et al., 2018), and the Nursing Outcomes Classification (Moorhead et al., 2023) could be used as a fundament. With the outcomes of this study in future quality of assessments could be measured, in a quantitative design. For example by conducting a study that compares teams that use regular evaluations of assessments versus teams that do not implement such regular evaluations. Stakeholders should support opportunities for patients, families, MCT professionals, police officers, and ambulance professionals to jointly agree on future research questions and study designs linked to practice. Case studies about collaboration between all involved parties, described from different perspectives, including those of the patient and family are also suggested. Ensure that representatives of all stakeholders are involved in each study (design, conduct and implementation of outcomes). The set up of a scientific evaluation of new projects as street triage teams and their effectiveness is important.

Finally

As an MCT professional, I have often wondered after an assessment of a patient with acute manic/psychotic symptoms, "Did I do the right thing?" The first study in this thesis made clear that our knowledge about how such an assessment is experienced by everyone involved is very limited. This insight was decisive in my choice of qualitative research. In the discussion of this thesis, we reviewed the 3 Cs—communication, collaboration, and continuous learning opportunities—as fundamental elements in the work of MCT professionals. In my opinion, our belief in the necessity and ability to learn with and from each other in our work as MCT professionals, converted into concrete actions per the reviewed themes, reveals numerous opportunities and possibilities to further improve emergency mental health care. During the subsequent research, it became increasingly clear that my key question in fact was not whether I, in my role as MCT professional, *did* the right thing, but rather *how* I deployed my interventions and actions was the issue. Being sure of my role in an assessment was more related to satisfaction with being able to establish a therapeutic relationship and collaboration in an assessment than to some final outcome. Krishnamurti wrote: "The whole movement of life is learning. There is never a time when there is no learning. Every action is a movement of learning, and every relationship is learning" (Krishnamurti, 1981,pp. 30).

I give the last word to Paula, whom I introduced in the introduction of this thesis. I asked her what she thought was the most important thing MCT professionals should do in an assessment of a patient with acute manic/psychotic symptoms. Paula reported:

Example case Paula:
Above all, stay friendly, but also be clear, and empathetic! Empathy is very important. Try to get a sense of what someone is like. Just remember that we are all human. And that means that people can continue to remember all this. Try to act as gently as possible. An assessment … it's all so intense ...

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CHAPTER 7

Summary
Samenvatting (Nederlands)
Data management
PhD portfolio
Publications
Curriculum Vitae
Dankwoord

Summary

Summary of the Main Findings

Assessments of patients with acute manic/psychotic symptoms carried out by MCT (mobile crisis team) professionals are complex and intense for all involved. In addition to patients, families, and MCT professionals, police and ambulance nurses are also regularly present. The aim of this thesis was to unravel what happens during such assessments to gain a broad understanding of the lived experiences of all the people involved in these assessments. A literature search revealed that there is hardly any scientific literature on the performance of assessments by an MCT. In the introduction of this thesis (Chapter 1), the background of this PhD project was delineated.

The primary aim of this thesis was to gain a broad understanding of the lived experiences of people (and their families) suffering from acute manic/psychotic symptoms with an assessment performed by an MCT. Additionally, the lived experiences of the involved MCT professionals, police officers, and ambulance nurses were investigated. Our second aim was to formulate recommendations for all involved to optimize the effectiveness of interventions and collaborations between all involved, and to further personalize and improve emergency mental health care for these patients.

Chapter 2 describes a phenomenological study about the lived experiences of patients (and their families) suffering from acute manic/psychotic symptoms with an assessment by MCT professionals. Open individual interviews were held with 10 patients and 10 family members. Content data analysis was conducted. The findings in this study show that communication and cooperation were difficult in several cases, and the personal crisis plans of patients were not always consulted. Also, stigma was felt, especially when police assistance was needed, whereas a calm, understanding attitude of MCT professionals was appreciated. Implications for practice included that MCT professionals should focus explicitly on communication with the patient, despite the acute condition, aiming at enhancing the chances of cooperation. Also, taking time to gather information about the patient's condition and assessing the opinion and wishes of the patient and family members (as possibly described in a personalized crisis plan) could reduce stigmatization and help de-escalate situations. Such a plan should be used at the crisis scene. Information about the interventions employed should be provided (and repeated in many cases) to make clear to the patient and family which emergency care is provided and why.

Chapter 3 presents the findings of our qualitative study with the aim to explore the experiences of ambulance nurses providing emergency care to patients with acute manic/psychotic symptoms. Fourteen interviews with ambulance nurses were conducted and analyzed using thematic analysis. The findings show that providing emergency mental health care can cause stress and uncomfortable feelings for ambulance nurses due to a lack of information on the individual patient, being alone with the patient in the

small place of an ambulance, and the potentially unpredictable behavior of the patient. An in-practice transfer of sufficient information about the psychiatric condition of the specific patient remains an area of needed improvement. Also, several ambulance nurses wanted extensive and ongoing education and training about psychiatric disorders. According to the nurses, enhanced collaboration with other professionals during assessments would improve the emergency mental health care of these patients.

In Chapter 4, we present a hermeneutic-phenomenological study about emergency care to "people with confused behavior." The lived experiences of—and collaboration between—police and MCT professionals were explored in unstructured in-depth interviews with eight police officers and eight MCT professionals. The main findings in this study were that in the emergency care of people with confused behavior, two highly different professions are essentially forced to work together, and that this collaboration was often perceived as quite challenging. It became clear that the different visions and expectations of these professionals, back and forth, caused frustration during collaboration in the care of people with confused behavior. Both the MCT professionals and police officers reported difficulties in collaborating during assessments. For the police officers, explanations from MCT professionals about the outcomes of assessments would help during collaboration. The exposed friction areas and stagnation points in collaborations should be discussed openly between them in joint evaluations as part of the process in order to acknowledge these areas and seek resolution. The so-called "street triage team" project, in which MCT professionals and police officers work together as a team in the chain of emergency care, can be part of strengthening cooperation between professionals from different organizations. Scientific research into the effectiveness of such projects is of importance.

The lived experiences of MCT professionals during assessments of patients with acute symptoms is described in Chapter 5. In a study with a qualitative phenomenological design, 15 individual open-format, in-depth interviews were conducted, and a focus group meeting completed the data collection phase. Five main themes emerged after data analysis: the urgency of providing an assessment; the various impacts on the professional; the organization of the work environment; the interactions with the patient and their family; and the role of experiential knowledge of all involved. The final conclusion was that, as experts in the field, MCT professionals experience their role in assessments of patients with acute symptoms as essential and leading. They felt affected by the situation. And above all responsible for the organization of the work environment and establishment of an empathic relationship with the patient and their family to provide high quality care.

The insights collected during the studies could be used to make working agreements between professionals to ensure continuous evaluation and reflection per assessment. With the aim of continuously improving their communication and collaboration skills.

In these evaluations, the experiences of everyone present during an assessment are important, especially those of the patient and family.

The primary aim of this thesis to gain a broad understanding of the lived experiences of people suffering from acute manic/psychotic symptoms who experience assessments performed by MCTs was achieved. Successive studies revealed different perspectives on assessments and the immense impact they can have on those involved. One limitation of our studies was that the number of participants per study was limited in absolute terms. This did not alter the fact that we were able to collect rich data through a qualitative research design. The gathered insights made it clear how assessments are complex due to several factors, including: the acute and severe condition of the patient; the family who feels exhausted by the patient's deteriorating condition; the MCT professionals who take the lead and have to focus on several aspects and tasks during assessments; and the necessity of collaboration with other involved professionals. There is no clear-cut solution, yet the main areas for improvement appear to be communication, collaboration, and continuous learning for all the professionals involved. The described implications of our findings for future practice and research could help refine concepts and inspire to continuous evaluations of interventions.

Implications for Future Practice

Communication: For the MCT professionals, the ongoing training of skills is important, including training them in the knowledge and use of aspects of the CCT; and making evaluations of assessments a standard procedure in MCT work.

Collaboration: A continuous information and meeting cycle between professionals from different involved organizations in order to be informed about everyone's professional tasks, domain and responsibilities is important to promote collaboration. Subsequent agreements regarding joint expertise development could enhance collaboration.

Continuous Learning Opportunities: Subsequent agreements between MCTs, police, and ambulance professionals regarding joint expertise development could enhance collaboration. Finally, setting up regular meetings with professionals involved in the assessments, and bringing case-specific evaluations into meetings might prove useful.

Implications for Future Research

In our studies we collected qualitative information, and hereafter we make a number of suggestions for quantitative follow-up research. For quantitative research it is necessary to make use of concrete measurement tools, such as outcome measures or questionnaires. A first step could be to design a Delphi study with CPNs to reach consensus about the description of nursing diagnoses, interventions, and outcomes related to the assessments. With the outcomes of this study in future quality of assessments could be measured, in a quantitative design.

Stakeholders support opportunities for all involved to jointly agree on future research questions and study designs linked to practice. Case studies about collaboration between all involved parties, described from different perspectives are also suggested. Ensure that representatives of all parties are involved in each study (design, conduct and implementation). The set up of a scientific evaluation of new projects as street triage teams and their effectiveness is important.

Above all, we hope our findings contribute to improving collaborations between all stakeholders in assessments, in facilitating the process of continuous learning, and enhancing the quality of emergency mental health care for this vulnerable patient group.

Samenvatting

Samenvatting van de belangrijkste bevindingen

Beoordelingen van patiënten met acute manische/psychotische symptomen uitgevoerd door MCT-professionals (mobiel crisisteam) zijn complex en intens voor alle betrokkenen. Naast patiënten, families en MCT-professionals zijn ook politie- en ambulanceverpleegkundigen regelmatig aanwezig. Het doel van dit proefschrift was om te ontrafelen wat er gebeurt tijdens dergelijke beoordelingen om een breed inzicht te krijgen in de ervaringen van alle mensen die bij deze beoordelingen betrokken zijn. Uit wetenschappelijk literatuuronderzoek is gebleken dat er nauwelijks literatuur bestaat over het uitvoeren van beoordelingen door een MCT. In de inleiding van dit proefschrift (hoofdstuk 1) werd de achtergrond van dit PhD-project geschetst.

Het primaire doel van dit proefschrift was om een breed inzicht te krijgen in de ervaringen van mensen (en hun families) die lijden aan acute manische/psychotische symptomen, met een beoordeling uitgevoerd door een MCT. Daarnaast zijn de ervaringen van de betrokken MCT-professionals, politieagenten en ambulanceverpleegkundigen onderzocht. Ons tweede doel was het formuleren van aanbevelingen voor alle betrokkenen om de effectiviteit van interventies en de samenwerking tussen alle betrokkenen te optimaliseren, en om de spoedeisende geestelijke gezondheidszorg voor deze patiënten verder te personaliseren en te verbeteren.

Hoofdstuk 2 beschrijft een fenomenologisch onderzoek naar de ervaringen van patiënten (en hun families) die lijden aan acute manische/psychotische symptomen, beoordeeld door MCT-professionals. Er zijn open individuele interviews gehouden met 10 patiënten en 10 familieleden. De data analyse leidde tot de volgende bevindingen: de communicatie en samenwerking verliep in een aantal gevallen lastig en de signaleringsplannen van patiënten werden niet altijd geraadpleegd. Ook werd er stigma ervaren, vooral wanneer politiehulp nodig was, terwijl een rustige, begripvolle houding van MCT-professionals op prijs werd gesteld. Implicaties voor de praktijk waren onder meer dat MCT-professionals zich, ondanks de acute aandoening, expliciet zouden moeten richten op de communicatie met de patiënt, met als doel de kansen op samenwerking te vergroten. Ook het nemen van de tijd om informatie te verzamelen over de toestand van de patiënt en het exploreren van de mening en wensen van de patiënt en familieleden (zoals mogelijk beschreven in een signaleringsplan) kan stigmatisering verminderen en situaties helpen de-escaleren. Een dergelijk plan zou op de locatie van de beoordeling moeten worden gebruikt. Informatie over de gebruikte interventies dient worden gegeven (en in veel gevallen herhaald) om voor patiënt en familie duidelijk te maken welke spoedeisende zorg wordt verleend en waarom.

Hoofdstuk 3 presenteert de bevindingen van ons kwalitatieve onderzoek met als doel de ervaringen te onderzoeken van ambulanceverpleegkundigen die spoedeisende zorg verlenen aan patiënten met acute manische/psychotische symptomen. Er zijn

veertien interviews met ambulanceverpleegkundigen afgenomen, en geanalyseerd met behulp van thematische analyse. De bevindingen laten zien dat het verlenen van deze spoedeisende zorg stress en ongemakkelijke gevoelens kunnen veroorzaken bij ambulanceverpleegkundigen vanwege een gebrek aan informatie over de individuele patiënt, het alleen zijn met de patiënt in de kleine ruimte van een ambulance en het potentieel onvoorspelbare gedrag van de patiënt. Een overdracht in de praktijk van voldoende informatie over de psychiatrische toestand van de specifieke patiënt blijft een item dat voor verbetering vatbaar is. Ook wilden verschillende ambulanceverpleegkundigen uitgebreide en permanente educatie en training over psychiatrische stoornissen. Volgens de ambulance verpleegkundigen zou een betere samenwerking met andere professionals tijdens beoordelingen de spoedeisende zorg voor deze patiënten verbeteren.

In hoofdstuk 4 presenteren we een hermeneutisch-fenomenologisch onderzoek naar spoedeisende hulp aan 'mensen met verward gedrag'. De ervaringen van – en de samenwerking tussen – politie en MCT-professionals werden verkend in ongestructureerde diepte-interviews met acht politieagenten en acht MCT-professionals. De belangrijkste bevindingen uit dit onderzoek waren dat in de spoedeisende zorg voor mensen met verward gedrag twee zeer verschillende beroepsgroepen feitelijk gedwongen worden samen te werken, en dat deze samenwerking vaak als behoorlijk uitdagend werd ervaren. Duidelijk werd dat de verschillende visies en verwachtingen van deze professionals over en weer voor frustratie zorgden tijdens de samenwerking in de zorg voor mensen met verward gedrag. Zowel de MCT-professionals als de politieagenten meldden moeilijkheden bij het samenwerken tijdens beoordelingen. Voor de politieagenten zou uitleg van MCT-professionals over de uitkomsten van beoordelingen helpen tijdens de samenwerking. De blootgelegde knelpunten en stagnatiepunten in de samenwerking moeten openlijk worden besproken in gezamenlijke evaluaties als onderdeel van het proces, om de knelpunten te onderkennen en naar een oplossing te zoeken. Het project 'street triageteam', waarin MCT-professionals en politieagenten als team samenwerken in de keten van de spoedeisende hulp, kan onderdeel zijn van het versterken van de samenwerking tussen professionals uit verschillende organisaties. Onderzoek naar de effectiviteit van dergelijke projecten is van belang.

De ervaringen van MCT-professionals tijdens beoordelingen van patiënten met acute symptomen worden beschreven in hoofdstuk 5. In een onderzoek met een kwalitatief fenomenologisch ontwerp werden 15 individuele, open diepte-interviews gehouden, en een focusgroep bijeenkomst voltooide de fase van gegevensverzameling. Na de data-analyse kwamen vijf hoofdthema's naar voren: de urgentie van het uitvoeren van een beoordeling; de emotionele impact op de professional; de organisatie van de werkomgeving; de interacties met de patiënt en zijn familie; en de rol van ervaringskennis van alle betrokkenen. De eindconclusie was dat MCT-professionals, als experts in het veld, hun rol bij de beoordeling van patiënten met acute symptomen als essentieel en

leidend ervaren. Zij voelden zich geraakt door de situatie. En vooral verantwoordelijk voor de organisatie van de werkomgeving en het opbouwen van een empathische behandelrelatie met de patiënt en zijn familie om kwalitatief hoogwaardige zorg te kunnen bieden.

Met de inzichten die tijdens de onderzoeken zijn verzameld, kunnen werkafspraken tussen professionals worden gemaakt om continue evaluatie en reflectie per beoordeling te garanderen. Met als doel hun communicatie- en samenwerkingsvaardigheden voortdurend te verbeteren. Bij deze evaluaties zijn de ervaringen van alle aanwezigen tijdens een assessment van belang, vooral die van de patiënt en familie.

Het primaire doel van dit proefschrift om een breed inzicht te krijgen in de ervaringen van mensen met acute manische/psychotische symptomen met beoordelingen, uitgevoerd door MCT's, werd bereikt. Uit opeenvolgende onderzoeken kwam naar voren dat er verschillende perspectieven zijn tijdens en op de beoordelingen, en de enorme impact die beoordelingen kunnen hebben op de betrokkenen. Een beperking van onze onderzoeken was dat het aantal deelnemers per onderzoek in absolute termen beperkt was. Dit nam niet weg dat we via een kwalitatieve onderzoeksopzet rijke data konden verzamelen. De verzamelde inzichten maakten duidelijk hoe complex beoordelingen zijn vanwege verschillende factoren, waaronder: de acute en ernstige toestand van de patiënt; de familie die zich uitgeput voelt door de verslechterende toestand van de patiënt; de MCT-professionals die het voortouw nemen en zich tijdens beoordelingen op meerdere aspecten en taken moeten richten; en de noodzaak van samenwerking met andere betrokken professionals. Er is geen eenduidige oplossing, maar de belangrijkste verbeterpunten lijken de communicatie, samenwerking en continu leren voor alle betrokken professionals te zijn. De beschreven implicaties van onze bevindingen voor de toekomstige praktijk en onderzoek kunnen helpen concepten te verfijnen en te inspireren tot voortdurende evaluaties van interventies.

Implicaties voor de toekomstige praktijk

Communicatie: Voor de MCT-professionals is het voortdurend trainen van vaardigheden belangrijk, inclusief het trainen van de kennis en het gebruik van aspecten van de CCT; en evaluaties na beoordelingen als standaard in de werkwijze van het MCT-werk op te nemen.

Samenwerking: Een continue informatie- en ontmoetingscyclus tussen professionals uit verschillende betrokken organisaties om op de hoogte te blijven van ieders professionele taken, domein en verantwoordelijkheden is belangrijk om de samenwerking te bevorderen. Vervolgafspraken over gezamenlijke expertiseontwikkeling kunnen de samenwerking versterken.

Continue leermogelijkheden: Vervolgafspraken tussen MCT's, politie en ambulanceprofessionals over gezamenlijke expertiseontwikkeling kunnen de samenwerking bevorderen. Ten slotte zou het nuttig kunnen zijn om regelmatig bijeenkomsten te organiseren met professionals die betrokken zijn bij de beoordelingen, en om casus-specifieke evaluaties in bijeenkomsten op te nemen.

Implicaties voor toekomstig onderzoek

In onze onderzoeken hebben wij kwalitatieve informatie verzameld en hierna doen wij een aantal suggesties voor kwantitatief vervolgonderzoek. Voor kwantitatief onderzoek is het noodzakelijk gebruik te maken van concrete meetinstrumenten, zoals uitkomstmaten of vragenlijsten. Een eerste stap zou kunnen zijn het opzetten van een Delphi-onderzoek met CPN's om consensus te bereiken over de beschrijving van verpleegkundige diagnoses, interventies en resultaten gerelateerd aan de beoordelingen. Met de uitkomsten van dit onderzoek zou in de toekomst de kwaliteit van beoordelingen kunnen worden gemeten, in een kwantitatief ontwerp.

Belanghebbenden ondersteunen de mogelijkheden voor alle betrokkenen om het gezamenlijk eens te worden over toekomstige onderzoeksvragen en passende designs die verband houden met de praktijk. Er worden ook casestudies voorgesteld over de samenwerking tussen alle betrokken partijen, beschreven vanuit de verschillende perspectieven. Zorg ervoor dat bij elk onderzoek (ontwerp en uitvoering) vertegenwoordigers van alle partijen betrokken zijn.

Het opzetten van een wetenschappelijke evaluatie van nieuwe projecten als 'street triageteams' en hun effectiviteit is belangrijk.

Bovenal hopen wij dat onze bevindingen bijdragen aan het verbeteren van de samenwerking tussen alle belanghebbenden bij beoordelingen, aan het faciliteren van het proces van continu leren, en het verbeteren van de kwaliteit van de spoedeisende geestelijke gezondheidszorg voor deze kwetsbare patiëntengroep.

Data management

For the four studies in this thesis (Chapter 2, 3, 4, and 5) the study protocols were approved by the Scientific Research Committees of participating organizations. According to Dutch legislation there was no need for a formal medical ethical research approval since participants were no subjects to procedures and not required to follow rules of behavior. All participants of the different studies declared informed consent to participate in the study, on paper. These consent statements have been digitized and stored in the secure environment as mentioned below.

Collected data in face-to-face interviews were audio recorded and transcribed verbatim . The original recorded data as well as the text on paper were checked on accuracy and completeness.

The raw and analyzed research data were stored in secured digital files on a local server of the Dimence Group Mental Health Care Centre, Deventer, The Netherlands. The original Informed Consent forms were stalled in a central, secured repository for research data within the same organization.

PhD portfolio

Name PhD candidate	T.H. Daggenvoorde
PhD periode	2014-2024
Graduate school	Radboud University Medical Center, Nijmegen
Department	Institute for Health Sciences IQ Healthcare
Promotoren	Prof. H. Vermeulen
	Prof. P.J.J. Goossens
Co-promotoren	Dr. H.J. Gijsman
	Dr. T.A.A. Beentjes

Training Activities	Year	ECTS
a. Courses and workshops		
Masterclass Synthesizing and reporting complex interventions. University Hospital Lübeck, Germany	2012	1
Introduction Computer Assisted Qualitative Data Analysis Software (CAQDAS) S van den Heuvel, Radboud UMC	2013	0,5
Scholing Kwalitatieve analyse mbv software (G. Hesselink) Radboud UMC	2013	0,5
Cursus (2 daags) Kwalitatieve Analyse (Drs. Evers, Prof. Dr. Staring) Erasmus Rotterdam	2014	0,75
PhD introduction course Radboud UMC Nijmegen	2014	1
BROK course Radboud UMC Nijmegen	2014	1,5
b. Seminars and Lectures		
PhD meetings, Radboud UMC Nijmegen	2014-2017	0,5
c. Symposia and Congresses		
Nordic Conference of Mental Health Nursing. Helsinki. Sept. 2010. Oral presentation	2010	1
ISBD conference, Istanbul. February 2012. Poster presentation.	2012	1
16th Annual Conference of the International Society for Bipolar Disorders. Seoul Korea. March 2014. Poster presentation.	2014	1
KenBiS Klinisch Wetenschappelijke vergadering. Klinische zorg patiënten met acute manie. Oral presentation.	2015	1

APNA 29th Annual Conference. Lake Buena Vista USA, November 2015. Poster presentation.	2015	0,5
5th European conference on mental health. Prague Czech Republic, September 2016. Poster presentation.	2016	0,5
Jaarcongres V&VN SPV. Oral presentation.	2016	1
Nationaal Congres GGz verpleegkunde, "van presentie tot evidence based practice". Amersfoort. Oral presentation.	2016	1
Sympopna congres 'Over de schutting', Ede. Poster presentation.		0,5
European Conference on Mental Health, Berlin, September 2017. Oral presentations.	2017	1
APNA 32th Annual Conference, Columbus Ohio, USA, October 2018. Poster presentation 0,5 punt		
European Conference of Mental Health, Belfast, October 2019. Oral presentation.	2019	1
European Conference on Mental Health, Lisbon, 14-16 September 2022. Oral presentation.	2022	1
KenBiS Klinisch Wetenschappelijke vergadering. Klinische zorg patiënten met acute manie. Oral presentation.	2015	1

Teaching Activities	Year	ECTS
d. Lecturing		
Dimence Group.Treatment teams Bipolar Disorder. About Life Chart Method and Relapse Prevention Plan. 3 Oral presentations.	2014-2016	1
Dimence Group, Treatment teams Bipolar Disorder. About the Film Intervention (Development and implementation of a new intervention). Oral Presentations.	2020-2022	1
Symposium Vakgroep Verpleging en Verzorging Dimence Groep. "Ga op reis en volg je eigen kompas". Mei 2022. Workshop gegeven: het signaleringsplan.	2022	1
Refereermiddagen Dimence Bipolair (Acht) Oral presentations over onderzoeken betreffende bipolaire stoornissen en specifieke thema's.	2011-2022	3

e. Supervison of internships/other

Onderzoeksbegeleiding van zes studenten Klinische Gezondsheidswetenschappen, richting Verplegingswetenschap, Universiteit Utrecht**.**	2017-2023	6
Onderzoeksbegeleiding van zes Verpleegkundigen in opleiding tot Verpleegkundig Specialist GGZ, Stichting GGz VS, Utrecht.	2016-2024	6
Total		**35,25**

Publications & presentations

Publications

Daggenvoorde, T. H., Goossens, P. J. J., & Gamel, C. J. (2013). Regained Control: A Phenomenological Study of the Use of a Relapse Prevention Plan by Patients With a Bipolar Disorder. *Perspectives in Psychiatric Care*, *49*, 235–242. https://doi.org/10.1111/ppc.12009

Daggenvoorde, T., Geerling, B., & Goossens, P. J. J. (2015). A Qualitative Study of Nursing Care for Hospitalized Patients with Acute Mania. *Archives of Psychiatric Nursing*, *29*(3), 186–191. https://doi.org/10.1016/j.apnu.2015.02.003

Daggenvoorde, T. H., Gijsman, H. J., & Goossens, P. J. J. (2018). Emergency care in case of acute psychotic and/or manic symptoms: Lived experiences of patients and their families with the first interventions of a mobile crisis team. A phenomenological study. *Perspectives in Psychiatric Care*, *54*(4), 462–468. https://doi.org/10.1111/ppc.12247

Stevens, A. W. M. M., Daggenvoorde, T. H., van der Klis, S. M. D., Kupka, R. W., & Goossens, P. J. J. (2018). Thoughts and Considerations of Women With Bipolar Disorder About Family Planning and Pregnancy: A Qualitative Study. *Journal of the American Psychiatric Nurses Association*, *24*(2), 118–126. https://doi.org/10.1177/1078390317711251

Testerink, A. E., van Lankeren, J. E., Daggenvoorde, T. H., Poslawsky, I. E., & Goossens, P. J. J. (2019). Caregivers experiences of nursing care for relatives hospitalized during manic episode: A phenomenological study. *Perspectives in Psychiatric Care*, *55*(1), 23–29. https://doi.org/10.1111/ppc.12275

Goossens, P. J. J., Daggenvoorde, T. H., Groot Lipman, H. G., Verhaeghe, S., & Stevens, A. W. M. M. (2019). Show yourself, a short film to show professionals at an admission ward your 'euthymic being' during an admission for mania. *International Journal of Bipolar Disorders*, *7*(1), 2. https://doi.org/10.1186/s40345-018-0136-6

Lankeren, J. E., Testerink, A. E., Daggenvoorde, T. H., Poslawsky, I. E., & Goossens, P. J. J. (2020). Patient experiences with nursing care during hospitalization on a closed ward due to a manic episode: A qualitative study. *Perspectives in Psychiatric Care*, *56*(1), 37–45. https://doi.org/10.1111/ppc.12370

Goossens, P. J. J., Daggenvoorde, T. H., Groot Lipman, M. H. G., Bendegem, M. A., & Kars, M. C. (2020). Show yourself, experiences of patients with bipolar disorder recording a film to show their "euthymic being": A qualitative study. *Perspectives in Psychiatric Care*, *56*(2), 455–461. https://doi.org/10.1111/ppc.12456

Peter J. J. Goossens, Rita de Velde Harsenhorst, Jacobine E. van Lankeren, Annelies E. Testerink, Thea H. Daggenvoorde, Nursing Care for Patients With Acute Mania: Exploring Experiential Knowledge and Developing a Standard of Good Care—Results of the Delphi Study, *Journal of the American Psychiatric Nurses Association*, https://doi.org/10.1177/1078390320960519

Thea H. Daggenvoorde RN, MSc Josette M. van Klaren RN, MSc, Harm J. Gijsman MD, PhD, Hester Vermeulen PhD, Peter J.J. Goossens RN, APRN, PhD, FEANS, Experiences of Dutch ambulance nurses in emergency care for patients with acute manic and/or psychotic symptoms: A qualitative study, *Perspectives in Psychiatric Care*, https://onlinelibrary.wiley.com/doi/10.1111/ppc.12691

Thea H. Daggenvoorde RN, Miranda van Eerden, Silvio C.G.H. van den Heuvel, Harm J. Gijsman MD, PhD, Hester Vermeulen PhD, Peter J.J. Goossens RN, APRN, PhD, FEANS Emergency care to 'persons with confused behavior': Lived experiences of, and collaboration between, police and members of a mobile crisis team – A hermeneutic-phenomenological study, *International Journal of Social Psychiatry*, https://doi.org/10.1177/0020764021994606

Daggenvoorde, T.H., Van Eerden, M., Gijsman, H.J., Beentjes, T.A.A., Goossens, P.J.J. & Vermeulen, H. (2024) Lived Experiences of Mobile Crisis Team Professionals in the Assessment of Patients with Acute Symptoms. A Qualitative Phenomenological Study.
Submitted

Eikelenboom-Valk, Johanna J., Goossens, Peter J.J.., & Daggenvoorde, Thea H. The lived experiences of people with bipolar disorder with adapting their lifestyle to their condition. *Archives of Psychiatric Nursing*. October 2024. Accepted.

Artikelen in Nederlandstalige bladen

Daggenvoorde T.H., Geerling B., Goossens P.J.J. (2016) Verpleegkundige zorg bij een acute manie. *TVZ*, 3/2016

Jongma, M.L., Daggenvoorde, T.H., Stevens, A.W.M.M., S. Zandvliet (2019) Zwangerschap en depressie; kwalitatief onderzoek naar de ervaringen met ggz-behandelingen van zwangeren met een depressieve stoornis. *De Verpleegkundig Specialist*, sept., 2019.

Thea Daggenvoorde, Josette van Klaren, Harm Gijsman, Hester Vermeulen, Peter Goossens, Ambulancezorg voor psychiatrische patiënten, TVZ Verpleegkundige praktijk en wetenschap, 16-03-2022 (2), 48-49. https://www.tvznext.nl/magazine-artikelen/kritisch-bekeken-ambulancezorg-voor-psychiatrische-patienten/

Kupka, R.W., Goossens, P.J.J., van Bendegem, M.A., Damen, P., Daggenvoorde, T.H., Daniels, M., A. Dols, Hillegers, M.H.J., Hoogelander, A., ter Kulve, E., Peetoom, T., Schulte, P.F.J., Stevens, A.W.M.M., van Duin, D., (2015) *Multidisciplinaire richtlijn bipolaire stoornissen Derde, herziene versie 2015*, ISBN 978 90 5898 275 9, Utrecht: De Tijdstroom.

Oral presentations/posterpresentations

Daggenvoorde, T.H., & Goossen, P.J.J. (2010). *Regained control: Lived experience of patients suffering from a bipolar disorder with a relapse prevention plan, a fenomenological study.* Nordic Conference of Mental Health Nursing. Helsinki. Sept. 2010. Oral presentation.

Daggenvoorde, T. & Goossens, P.J.J. (2012). *Regained Control: Lived experience of patients suffering from a bipolar disorder with a relapse prevention plan, a phenomenological study.* ISBD conference, Istanbul. February 2012. Poster presentation.

Daggenvoorde T., Geerling, B. & Goossens P.J.J. (2014). *Nursing care for hospitalized patients with acute mania: a descriptive study.* 16th Annual Conference of the International Society for Bipolar Disorders. Seoul Korea. March 2014. Poster presentation.

Daggenvoorde T.H., Goosens P.J.J. *Lived experiences of patients with acute psychotic an/or manic symptoms, and their caregivers with the first interventions by a crisis team.* (poster) APNA 29th Annual Conference. Lake Buena Vista USA, November 2015. Poster presentation.

Goossens P.J.J., Daggenvoorde T.H., Geerling B. *Nursing care for hospitalized patients with acute mania: a descriptive study.* 5th European conference on mental health. Prague Czech Republic, September 2016. Poster presentation.

Stevens, A.W.M.M., Daggenvoorde, T.H., van der Klis, S.M.D., Kupka, R.W., Goossens, P.J.J.: *Thoughts and considerations of women with bipolar disorder about family planning and pregnancy: a qualitative study.* ISBD congress, Washington, May 2017. Poster presentation.

Goossens, P.J.J., Stevens, A.W.M.M., Groot Lipman, M.H.G., Daggenvoorde, T.H.: *'Show Yourself': a short film to show professionals at an admission ward your 'euthymic being' during an admission for mania or depression.* ISBD congress, Washington, May 2017. Poster presentation.

Daggenvoorde, T.H, Goossens, P.J.J. *Emergency care in case of acute psychotic and/or manic symptoms: Lived experiences of patients and their families with the first interventions of a mobile crisis team. A phenomenological study.* European Conference on Mental Health, Berlin, September 2017. Oral presentation.

Groot Lipman, M.H.G., Goossens, P.J.J., Daggenvoorde, T.H. *Show yourself, experiences of patients with bipolar disorder recording a film to show their "euthymic being": A qualitative study.* European Conference on Mental Health, Berlin, October 2017.

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Goossens P.J.J., Groot Lipman M.H.G., Daggenvoorde T.H., Verhaeghe S., Stevens A.W.M.M. *'Show Yourself': a short film to show professionals at an admission ward your 'euthymic being' during an admission for mania.* APNA 32th Annual Conference, Columbus Ohio, USA, October 2018.

Daggenvoorde, T.H, Goossens, P.J.J.: *Experiences of ambulance nurses in emergency care for patients with acute manic and/or psychotic symptoms.* European Conference of Mental Health, Belfast, October 2019. Oral presentation.

Daggenvoorde, TH, Goossens, P.J.J. *Emergency care 'to persons with confused behavior': Lived experiences of, and collaboration between, police and members of a mobile crisis team – A hemeneutic – phenomenological study.* European Conference on Mental Health, Lisbon, 14-16 September 2022. Oral presentation.

Daggenvoorde, T.H., Van Eerden, M., Gijsman, H.J., Beentjes, T.A.A., Goossens, P.J.J. & Vermeulen, H. (2024) Lived Experiences of Mobile Crisis Team Professionals in the Assessment of Patients with Acute Symptoms. A Qualitative Phenomenological Study. European Conference on Mental Health, Krakow, 9-11 September 2024. Oral presentation.

Nationale presentaties / posters

Daggenvoorde T.H., *De verpleegkundige zorg aan patiënten met een acute manie op een opnameafdeling: een beschrijvend onderzoek*. KenBiS ,December 2015. Oral presentation

Daggenvoorde T., Gijsman H. Goossens P.J.J. *Ervaringen van patiënten met acuut psychotische en/of manische symptomen, en hun naastbetrokkenen, met de eerste interventies door een crisisdienst*. Jaarcongres V&VN SPV, Mei 2016. Oral presentation.

Daggenvoorde, T., *Ervaringen met de eerste interventies door de crisisdienst bij patiënten met acuut psychotische en/of manische symptomen en hun naastbetrokkenen*. Nationaal Congres GGz verpleegkunde, Amersfoort. Juni 2016. Oral presentation.

Goossens, P.J.J., Stevens, A.W.M.M., Groot Lipman, M.G.H., Daggenvoorde, T.H.: *'Show Yourself': a short film to show professionals at an admission ward your 'euthymic being' during an admission for mania or depression*. Sympopna congres 'Over de schutting', Ede, juni 2017. Poster presentation.

Daggenvoorde, T. H. Symposium Vakgroep Verpleging en Verzorging Dimence Groep. "Ga op reis en volg je eigen kompas", Deventer, Mei 2022. Workshop: het signaleringsplan.

Curriculum vitae

Thea Daggenvoorde werd geboren op 8 juli 1960 te Diepenveen.
Na het voltooien van het VWO op het Geert Groote College in Deventer startte zij met de opleiding tot B-verpleegkundige bij het psychiatrisch ziekenhuis Sint Elisabeth gasthuis te Deventer. Na het voltooien van deze opleiding werkte zij tot 1991 als verpleegkundige op verschillende afdelingen van deze instelling en volgde naast haar werk de HBO Opleidingen Inrichtingswerk, en Maatschappelijk Werk. In 1991 startte zij in de functie van Sociaal Psychiatrisch Verpleegkundige (SPV) binnen het Sint Elisabeth Gasthuis. In 1994 was er, door de start van de samenwerking tussen het genoemde psychiatrisch ziekenhuis en de Riagg Almelo de mogelijkheid om te gaan werken als SPV in een ambulant behandelteam in de regio Almelo. De MGZ-GGz opleiding werd gevolgd, en naast het werk in een ambulant behandelteam startte zij tevens met het werken als SPV in de crisisdienst.

In de Geestelijke Gezondheidszorg waren in die jaren veel veranderingen en bewegingen gaande, waarin het samengaan van psychiatrische instellingen met RIAGG's, binnen verschillende regio's, leidde tot (grotere) GGz instellingen. Vanaf 1998 werkte Thea als SPV bij Adhesie, wat in 2007, door het samengaan van nog meer instellingen, in de Dimence Groep opging, een grote GGz instelling met drie verschillende regio's in Overijssel. Daar werkte ze in verschillende ambulante zorgprogramma teams in de regio Almelo: Crisisdienst, Team Toegang en het Eerstelijnsteam. Haar hart lag en ligt bij een aantal specifieke gebieden binnen het werk van de Sociaal Psychiatrisch Verpleegkundige: de crisisdienst, diagnostiek (intakes), SPV behandelingen, en de SPV als beroepsprofessional.

Thea volgde van 2002-2004 de Voortgezette Opleiding tot SPV, en dacht zelf voorafgaand aan die opleiding, dat daarmee haar opleidingsroute wel compleet zou zijn. Niets was minder waar: bij het afsluiten van de VO-SPV wist zij dat ze alsnog een universitaire studie wilde gaan volgen. Van 2007-2010 genoot zij van de parttime studie Klinische Gezondheidswetenschappen, richting Verplegingswetenschap aan de Universiteit Utrecht, in 2010 afgerond met het behalen van haar bul, en de MSc titel. Het afstudeeronderzoek van deze studie was onder begeleiding van Peter Goossens vanuit het Specialistisch Centrum Bipolaire Stoornissen (SCBS) binnen Dimence.

Naast de directe patiëntenzorg was Thea een aantal jaren docente op een parttime post-HBO Verpleegkunde opleiding (2007-2015) op Saxion Hogeschool, en tevens als docente aan de POH-GGz opleiding intern bij de Dimence Groep verbonden. Ook was zij parttime docent aan de POH-GGz opleiding bij de RINO (2011-2017). Zij verzorgde de lesdagen over het onderwerp diagnostiek en de uitvoer van het intakegesprek.

Vanaf 2011 zette ze binnen de Dimence Groep haar werk voort in twee functies: als SPV in de directe patiëntenzorg in een ambulant behandelteam Angst en Stemming, en

daarnaast als Wetenschappelijk Onderzoeker voor het Specialistisch Centrum Bipolaire Stoornissen van de Dimence Groep, sinds 2012 een Top GGz afdeling.

In 2012 ontving zij de ‘Peter Koopman Award’, een award die jaarlijks wordt uitgereikt binnen de Dimence Groep aan een verpleegkundige die een voortrekkersrol vervult in het werken met patiënten en heeft laten zien over bijzonder verpleegkundig leiderschap te beschikken. Kandidaten worden voorgedragen door de eigen vakcollega’s.

Rond diezelfde tijd zette zij de stap om een promotietraject te starten, met als onderwerp de ervaringen met de beoordeling door de crisisdienst van patiënten met acuut manische/psychotische symptomen. Dit traject liep een behoorlijke vertraging op door een ernstige ziekte, maar kon toch weer voortgezet worden, en komt nu in 2024 tot een afronding.

In haar functie als wetenschappelijk onderzoeker werkt zij binnen de SCBS van de Dimence Groep in de Onderzoekslijn Bipolaire stoornissen en zelfmanagement aan verschillende onderzoeken mee, zij begeleidt Verplegingswetenschappers in opleiding en Verpleegkundig Specialisten in opleiding bij hun onderzoek, is (mede) auteur van wetenschappelijke artikelen, doet presentaties hierover, en draagt bij aan deskundigheidsbevordering binnen deze Top GGz afdeling.

Dankwoord

'De aanhouder wint', 'een mens is nooit te oud om te leren' en 'onderzoek doen doe je niet alleen' zijn voor mij belangrijke overtuigingen die me op allerlei momenten geholpen hebben tijdens mijn promotietraject. Ik ben heel dankbaar dat ik dit proefschrift nu afrond.

Allereerst wil ik al die mensen bedanken die als participanten hebben willen meewerken aan de onderzoeken. In het bijzonder de mensen in het eerste onderzoek: mensen met een ernstige psychiatrische aandoening, en hun naasten. In die interviews zaten voor mij de belangrijkste emoties, die me verder in de route steeds sterkten om met dit traject door te gaan, en hopelijk bij te dragen aan kennis om de zorg voor deze mensen, in crisissituaties, te versterken. Alle professionals die deelnamen in de andere onderzoeken (vanuit Dimence en Mediant, en van politie en ambulancedienst) leverden ook belangrijke informatie. Meer in het algemeen wil ik de Dimence Groep, en in het bijzonder het Specialistisch Centrum Bipolaire Stoornissen bedanken voor de mogelijkheid en steun om dit proefschrift tot stand te brengen.

Als je wilt promoveren heb je een promotor en co-promotoren nodig met wie je kan samenwerken. Peter Goossens wil ik als eerste noemen: Peter, ik ben jou als promotor veel dank verschuldigd. Ik zocht contact met jou toen ik rond 2007 overwoog de Studie Klinische Gezondheidswetenschappen, richting Verplegingswetenschap te gaan volgen, en ik daarover wilde brainstormen. Jij juichte mijn plan meteen toe, en dat was het begin van een jarenlange plezierige en vruchtbare samenwerking. Ik heb veel van je mogen leren, over onderzoek doen in de breedste zin van het woord, altijd samenhangend met verpleegkundige zorg. Op momenten dat ik dacht dat iets niet goed kon komen wist jij me weer te motiveren, en gaf je me een zetje in de juiste richting. Ik hoor mezelf tegen de mensen die ik nu zelf begeleid met onderzoek vaak lessen herhalen die ik van jou leerde. Helaas heb je door ziekte het laatste deel van mijn traject meer aan de zijlijn meegemaakt. Ik ben blij dat je er vandaag toch bij bent. Heel veel dank voor alles.

Hester Vermeulen, jij bent vanuit het RadboudUMC mijn 'laatste' promotor geweest, sinds een aantal jaren. Ondanks dat jouw verpleegkundige achtergrond in de somatische zorg is en niet in de GGz was de aansluiting goed, en heb ik altijd je vertrouwen in een goede afloop van dit traject gevoeld. Je kennis over onderzoek, verpleegkundige theorieën en leiderschap kwamen me goed van pas. Dank voor je steun en begeleiding tot de eindstreep.

Ik wil ook Theo Achterberg en Lisette Schoonhoven bedanken voor hun steun en de samenwerking.

Harm Gijsman, jij bent sinds een flink aantal jaren lid van mijn promotieteam, waarbij jouw bedaardheid en inhoudelijke kennis voor mij van belang waren. Dat je uiteindelijk ook bij Dimence werkt maakt dat we elkaar ook wel in andere rollen ontmoet hebben, en ook zullen blijven ontmoeten. Dank je wel voor je betrokkenheid en kennis.

Titus Beentjes, jij bent laat toegevoegd aan mijn promotieteam, en wel op een prominente plek: als mijn dagelijks begeleider. Wij kennen elkaar onze hele beider werkcarrière al, en kwamen elkaar altijd weer tegen. Jij bent me vaak een slag voor geweest, ook met het promoveren, en daardoor kon ik mooi van je leren. Dank voor je steun, je collegialiteit en humor. Ons hart voor zowel patiëntzorg als onderzoek zit op dezelfde plek volgens mij, en 'doe maar gewoon' typeert ons ook.

De manuscriptcommissie: Art Schellekens, Nynke Boonstra en Gerrit Glas dank ik ook voor hun werk, en de feedback op mijn proefschrift.

Carla ten Have, jeugdvriendin, en Rolf Egberink, studiegenoot, jullie zullen als mijn paranimfen naast me staan op dit belangrijke moment in mijn leven. Carla: dank voor alle vriendschap en steun op allerlei momenten in het leven. Rolf: dank voor al je kennis en kunde, en de flinke portie humor bij het op en neer rijden naar de UU gedurende de drie jaren studie daar. En heerlijk dat jullie allebei meteen enthousiast 'ja' zeiden op mijn vraag of je mijn paranimf wilde zijn.

Al mijn collega's vanuit het SCBS dank ik voor de steun, voor de belangstelling, voor de samenwerking rondom onderzoek, en alles wat ik van jullie leer, in het licht van 'het goede doen voor de mens met een bipolaire aandoening'. Evengoed dank ik mijn collega's van het behandelteam Angst en Stemming Almelo: in mijn SPV-werk samen met jullie (voor een andere patiëntengroep) vind ik nog elke dag voldoening en plezier, mede dankzij jullie. Jullie volgden mijn onderzoekswerk meer aan de zijlijn, maar waren en zijn niet minder belangrijk om mijn werk (als onderzoeker én SPV) te doen. Daarmee zeg ik meteen ook 'dank je wel' tegen alle collega's van Dimence en haar rechtsvoorgangers in de 45 jaar dat ik in de GGz werk. Ook bedank ik de mensen met wie ik samen mijn onderzoeken voor dit proefschrift uitvoerde, ik noem in het bijzonder Josette van Klaren (UMCU), Silvio van den Heuvel (Saxion) en Miranda van Eerden (Mediant). Zonder jullie bijdrages en inspiratie waren de onderzoeken niet gelukt. Ik wil daarbij ook Ciska Wilms-de Lange bedanken voor het uitwerken van al die lange interviews: ook dat is een onderdeel van onderzoek doen.

Binnen de Dimence Groep heerst een goed en ondersteunend onderzoeksklimaat, ook zichtbaar in het bestaan van de Commissie Wetenschappelijk Onderzoek. Ook dat gaf me steun en inspiratie, CWO leden: dank!

Alle mensen die privé naast me staan zijn onmisbaar om in werk, opleiding en ontwikkeling te kunnen excelleren. Ik bedank mijn vriendinnen/vrienden: Gerda, Nicolet & Peter, mijn 'jeugdvriendinnenclub' Carla, Agnes en Wilma en jullie partners, Anja, Anja & Henk, en nog een heleboel andere vriendinnen/vrienden/oud-collega's, voor de vriendschap, humor en afleiding, door vele jaren heen.

Elk leven begint natuurlijk bij de basis, bij mijn gezin van herkomst: Pa & Ma, Annie & Piet, Willy & Wilma, Ria & Richard (in herinnering), Joke & Laurens (in herinnering) en Martin & Yvonne. Het contact met jullie, de warmte en gezelligheid, het 'samen', en het 'doe maar gewoon dan doe je al gek genoeg', het is allemaal belangrijk als fundament in mijn leven, waarop ik veel heb kunnen opbouwen. DANK! En dan heb ikzelf het leven ook weer door mogen geven aan mijn zonen Floris en Lennart: de twee grootste geschenken in mijn leven! Mijn moederrol is essentieel voor mij. Een groot geluk dat wij elkaar hebben!, jullie zijn onvervangbaar.

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