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Practitioner opinions of crisis plans within early intervention in psychosis services: A mixed methods study

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Abstract

The efficacy of crisis planning in mental health services is contested. As recovery and self-management are core to Early Intervention in Psychosis (EIP) services and the Care Programme Approach (CPA), the views of EIP practitioners of the most useful aspects of crisis planning can inform this vital aspect of practice. We conducted a mixed methods study using a national cross-sectional survey ($n = 70$) and semi-structured interviews ($n = 12$) with EIP practitioners in England in 2019. Data were analysed using non-parametric tests and thematic analysis. A Joint Crisis Plan (JCP) template was used as a benchmark to judge current practice by (Sutherby et al., 1999; Henderson et al., 2004; Thornicroft et al., 2013). The most useful crisis plan themes identified by practitioners included early warning signs, triggers and helpful treatments, although not all elements were considered useful. Additionally, the interviews identified that collaboration with clients, carers and other services; personalisation; and self-management were all considered important in effective crisis planning. The practitioners also identified barriers to effective crisis planning, such as the electronic records system, lack of time and lack of available service provision. The research highlighted the important aspects of EIP and was significant in impacting the service and wider EIP network further. While crisis planning is a significant part of EIP, it does not appear to be consistently applied in practice. Fully implementing collaborative crisis planning in EIP services may require changes to policy, practice and local systems to ensure that crisis planning is as effective as possible.

1 | INTRODUCTION

Refocusing the Care Programme Approach (CPA) outlined the need for improved individualisation and crisis planning. This was reiterated in the National Health Service (NHS) long-term plan (NHS, 2019), which highlighted the importance of prevention and self-management within services. Focussing on prevention and the 'right care at the right time' (NHS, 2019), early intervention in psychosis teams (EIP) were introduced by the national service framework as a specialist biopsychosocial service to improve outcomes for individuals experiencing symptoms of psychosis (Neale & Kinnair, 2017).

The ethos of EIP includes hope for recovery, while maintaining early intervention throughout an individuals' recovery journey. Quicker access to treatment can have a number of significant benefits including community treatment as opposed to hospitalisation; individual well-being; and positive wider economic impacts (NHS England, 2014, 2016). Early intervention for psychosis is vital in reducing the likelihood of long-term illness, and identification of a

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relapse signature is one of the key components of this. This can facilitate early action, which can address prodromal psychotic symptoms that may indicate impending relapse (Birchwood et al., 1998). Crisis interventions are also required in a timely manner to ensure safety and reduce pressure on hospital beds (NHS England, 2014), suggesting that crisis plans are an important component of EIP.

Although CPA policy outlines the need for crisis plans, there is limited guidance on what they need to include. However, the use of templates may reduce individualisation and creative flexibility (Kindell et al., 2014), particularly as they can be driven by service needs (Burt et al., 2014). This was found in an audit where only 15% of crisis plans had individualised content, which were otherwise largely determined by process requirements (Farrelly et al., 2016).

It has been suggested that collaborative approaches may improve compliance and increase the therapeutic relationship, making the content of the plan of secondary importance (Thornicroft et al., 2013). This is in line with Rogers' (1951) theory, suggesting person-centred approaches and collaboration promote recovery through empowerment. Stovell et al. (2016) also suggested that collaboration and a strong therapeutic relationship can increase empowerment, identified as a significant aspect of recovery (Leamy et al., 2011), inferring crisis plans can support recovery.

Joint crisis plans (JCPs) involve the client, care coordinator and an independent facilitator, implementing least restrictive care (Thornicroft et al., 2010). However, results surrounding JCPs have been mixed. Some studies have found that they reduce hospital admissions (Henderson et al., 2004) and re-admissions (Thornicroft et al., 2010). Ruchlewska et al. (2014) also identified a reduction in compulsory admissions, even without the use of an independent facilitator in the process. However, Thornicroft et al. (2013) identified no impact on admissions, but stated this could be due to incorrect implementation. Overall, Molyneaux et al. (2019) found that crisis plans were associated with a 25% reduction in risk of compulsory admissions for those with bipolar or psychotic diagnoses.

An independent facilitator can reduce power imbalances (Farrelly et al., 2016; Henderson et al., 2015), but the lack of an existing therapeutic relationship may negatively influence effective crisis planning. Farrelly et al. (2014) suggested that clients' inclination to speak freely may be reduced by the presence of unknown clinicians and independent facilitators, therefore negatively impacting the JCP. Crisis plans may therefore be better formed with clients and their care coordinator or whoever they have a significant professional relationship with. This was supported by Ruchlewska et al. (2014) who identified that reductions in involuntary admissions were higher in those who completed crisis plans with their care coordinator in contrast to an independent advocate. The overall consensus regarding involvement of an independent facilitator is mixed and may depend on the quality of the relationship clients have with their care coordinator. Some clients have reported feeling uninvolved in their care and feeling their allocated clinician holds power over them (Farrelly et al., 2016). However, if practice was truly person centred and equality in the therapeutic relationship was demonstrated through shared decision-making, this would promote client empowerment (Hummelvoll et al., 2015; Rogers, 1951). Conversely, it could be argued that although person-centred practice is promoted throughout policy, it has not been rigorously evaluated within services and therefore implementation may be inconsistent (Goulding et al., 2018).

In further justification for the current study, while studies have explored client choices within crisis plans (e.g. Sutherby et al., 1999), few UK studies have explored clinician opinions about the content of crisis plans, although this has been undertaken in other countries such as the United States (e.g. Elbogen et al., 2006). One UK study found that both clinicians and clients experienced joint crisis planning as a positive process, with both parties feeling empowered during shared decision-making (Henderson et al., 2009). Additionally, only one study on crisis plans has included a Northern city (Thornicroft et al., 2010), with most research being conducted in London (e.g. Farrelly et al., 2014; Henderson et al., 2004; Sutherby et al., 1999). None have examined crisis planning within EIP.

A recent audit of an EIP team in the North of England found that 96% included staying well plans, 84% had early warning signs and 96% included what helps and does not. However, only 29% included a plan for dependants if the service user became unwell (Tees, Esk, & Wear Valleys NHS Trust, 2019). This may imply that service user did not find this important in their planning, or that clinicians did not consider it relevant. To explore this, this study aimed to identify what information practitioners find useful when facilitating crisis planning in EIP services; and to identify whether and how crisis plans can be improved within EIP services.

What is known about this topic

- As demonstrated in CPA policy, crisis planning is seen as a vital component in order to support clients through challenging experiences, in conjunction with their care plan
- Joint crisis plans have been used in developing plans with patients in hospital and there has been a number of elements which patients find important
- Some studies have identified that crisis plans can reduce inpatient admissions, although there has been some contrasting outcomes to this

What this paper adds

- Clinicians find crisis planning important when working with service users and appreciate the collaborative process with them and their families
- Aside from having a plan for managing crises, crisis planning can have numerous functions including psychoeducation, relationship building and support for families
- Clinicians identified a number of barriers to crisis planning, some of which can be overcome with some service changes, and may contribute to inconsistencies in application to practice

2 | METHODS

2.1 | Design

This study used a cross-sectional survey and separate semi-structured interviews. Multiple methods allows for both exploration and explanation around crisis planning within EIP and acknowledge the complexity of service users' experiences which clinicians are reporting on, addressing this by covering both depth and breadth (Bronstein & Kovacs, 2013). The two distinct parts of the study allow for triangulation of results and for the strengths of each method to be utilised (Carr, 1994; O'Cathain et al., 2010). Data were collected between January and July 2019 and ethical approval was obtained from the University of York Department of Social Policy and Social Work Ethics Committee [Ref: SPSW/MTA/2018/32].

2.2 | Survey

2.2.1 | Sample

Targeted snowball sampling was utilised for recruitment, using the researchers' personal social media, word of mouth and a recruitment email was also sent to the national EIP network. Facebook and Twitter were utilised, pushing through the networks to gain EIP practitioners by sharing it with prominent social media influencers within the field and requesting them to share. This sought a national representation of opinions (Baltar & Brunet, 2012) in a timely and cost-effective manner (Dusek et al., 2015). However, the researchers acknowledge that there are limitations to the use of social media, such as the audience reach and the bias it may introduce. The national EIP network was utilised with the aim of reducing this.

Procedures: An online questionnaire (Appendix A) was used for easy, timely and convenient access to participants (Baltar & Brunet, 2012). Participants were provided with an online information sheet prior to the start of the survey and gave online consent to participation. Recruitment was limited to EIP practitioners via purposive sampling and the questionnaire had a deduction function if participants answered 'no' to working in EIP currently.

Participants were given a template of the JCP components (Henderson et al., 2004; Thornicroft et al., 2013) and asked to rate usefulness using a 7-point likert scale of 'extremely useful' to 'extremely useless'. This template was used as a benchmark to judge current practice by, but the JCP process of production was not asked about, as independent facilitators are not present for the purpose of this study. Clinicians were asked about usefulness to them regarding supporting their clients in a crisis. There was no assumption made as to whether they were already using JCP template components to create crisis plans. A 7-point scale was used due to increasing reliability and validity when compared to those with fewer options (Dawes, 2008). The 45-question survey took about 14 min to complete. Demographic data were also gathered and there was a free text section for practitioners to make suggestions for additional elements of a crisis plan. Ethical considerations around demographic data including confidentiality were managed by assuring anonymity.

2.2.2 | Analysis

Data were analysed using SPSS v.25, ranking the mean ratings of usefulness in increasing order to identify JCP items practitioners considered to be most and least useful. Independent non-parametric Kruskal–Wallis tests were utilised to test null hypotheses of no difference between professions; length of experience in EIP; gender and region. The 'profession' variable was recoded to explore if there was any difference between medical and non-medical backgrounds using a Mann–Whitney *U* test. While EIP has the aim of using a biopsychosocial model (NHS England, 2016; Neale & Kinnair, 2017), it was important to explore if disciplines maintained separate viewpoints. This was an exploratory analysis as there was genuine uncertainty if and what causes variation in crisis planning. Length of experience, however, has been found to have an impact on completion of crisis planning—with less experience increasing likelihood of completion (Ruchlewska et al., 2016). Therefore, attempts to identify possible reasons for variation, including demographic differences, were important to this research. The significance value was set at $p < .05$ for all hypotheses. Free text responses were inputted into NVivo to code categories and a Venn diagram was created to illustrate the frequency of categories by sizing each circle according to frequency, using the diameter for scaling.

2.3 | Semi-structured interviews

Semi-structured interviews were used as they enabled us to focus on our research questions via a topic guide, which also allowed for probing and a deeper understanding of the issues practitioners face (Carr, 1994).

2.3.1 | Sample

Convenience sampling was utilised by asking all members of one EIP team within an NHS Trust in the North of England to participate. The purpose of this was to gain maximum information, and as wide a range of views as possible from a small sample, a method widely used in qualitative elements of mixed methods research (Palinkas et al., 2015). Recruitment emails were sent by the team administrator and clarity was given in terms of the role of the researcher to reduce risk of feelings of obligation (McEvoy, 2001). EIP practitioners were purposively recruited as they possessed extensive knowledge of crisis planning in an EIP setting.

2.3.2 | Procedure

Semi-structured face-to-face interviews were conducted following obtaining informed consent from all participants. The interviews lasted on average 24 min, ranging from 13 to 43 min and were audio recorded. Participants were asked what they considered important to include within a crisis plan generally and what they believed service users and carers find useful. Participants were asked broad questions to allow themes to emerge from the data. They were also asked for examples of using crisis plans. Interviews took place in a private room to ensure confidentiality.

2.3.3 | Analysis

All data were anonymously transcribed verbatim and coded using qualitative data analysis software NViVo. Codes were developed using framework analysis (Ritchie & Spencer, 1994), initially using a thematic framework from previous research, used as a benchmark to measure practice against (Henderson et al., 2004). This was the JCP template used within the survey. This allowed for a systematic approach to interpreting the data but also flexibility to encourage emergent themes (Ritchie & Lewis, 2003). One randomly selected transcript was blind coded by an independent researcher. Although there was natural variation within the coding, the interpretation was largely the same. Emergent themes were identified by reviewing the coding framework and grouping codes together which related to higher level, more abstract themes. The four themes presented here—personalisation, self-management, collaboration and barriers—were those which clinicians talked about most frequently in relation to our research questions.

3 | RESULTS

3.1 | Survey findings

Seventy participants completed the survey. The characteristics of the sample are summarised in Table 1.

The sample was predominantly female (*n* = 52, 74.3%) and a majority were nurses (*n* = 32, 45.7%) or social workers (*n* = 16, 22.9%). Although not representative of the national workforce, the sample was drawn from all regions of England. Most had up to 9 years' experience in early intervention services (*n* = 60, 85.7%), although half the sample had over 10 years' experience in mental health services (*n* = 35, 50.0%) (Table 1).

A ceiling effect in responses was found (Ho & Yu, 2015), with many respondents selecting 'extremely useful' for most components of the JCP. However, in contrast, one participant reported none of the items to be useful. Table 2 ranks the mean usefulness ratings for JCP themes on the scale of 1 ('extremely useful') to 7 ('extremely useless').

The most useful components to pracititoners were early warning signs, triggers and treatments which have been helpful in the past, demonstrating the importance of using the plan for crisis prevention (Table 2). Conversely, many of the contact details were deemed as less useful by practitioners. It is possible that these contacts were not involved in care within their service, or they may already have these contacts elsewhere and therefore do not feel the requirement for inclusion on the crisis plan.

TABLE 1 Survey sample characteristics

	n	%
Gender		
Male	15	21.4
Female	52	74.3
Other	3	4.3
Profession		
Psychiatric nurse	32	45.7
Social worker	16	22.9
Psychologist	7	10.0
Occupational therapist	1	1.4
Psychiatrist	10	14.3
Other	4	5.8
Region		
North East England	4	5.7
South West England	7	10.0
East Midlands	2	2.9
East of England	8	11.4
North West England	5	7.1
Yorkshire and the Humber	20	28.6
Greater London	6	8.6
South East England	2	2.9
West Midlands	16	22.9
Length of time employed in mental health services		
<1 year	7	10.0
2–9 years	28	40.0
10–19 years	24	34.3
20–29 years	8	11.4
Over 30 years	3	4.3
Length of time employed in early intervention services		
<1 year	22	31.4
2–9 years	38	54.3
10–19 years	9	12.9
20–29 years	0	0
Over 30 years	1	1.4

Statistical testing revealed no differences between professional groups in usefulness ratings for JCP themes. However, practitioners rated eight items from the JCP differently ($p < .05$) according to length of EIP experience (nos. 1, 2, 3, 4, 5, 6, 8, 15 in Table 2). As these were predominantly the highest ranked items, it is possible that any difference was exacerbated by the outlier (one person with over 30 years' experience of EIP of items who rated each item as a

TABLE 2 Usefulness of Joint Crisis Plan themes

Rank	JCP Theme	Mean rating
1	What happens when the service user starts to become unwell	1.16
2	Circumstances which may lead the service user to become unwell or which have done in the past	1.21
3	Treatments or other things which have been helpful during crises or relapses in the past	1.26
4	Care coordinator contact details	1.27
5	Arrangements for children/dependants/relatives/pets	1.29
6	Nominee contact details (e.g. friend or family member)	1.39
7	Contact details for a nominated person to request taking care of certain tasks for the service user	1.43
8	What the service user would like to happen when they first become unwell	1.43
9	Preferred treatment or social care during a crisis or relapse	1.44
10	Service user contact details	1.49
11	Current care or treatment plan	1.49
12	Current medication and dosage	1.49
13	Specific refusals regarding treatment or social care during a crisis or relapse	1.53
14	Circumstances in which the service user would wish to be admitted to hospital for treatment	1.73
15	Other information the service user would like hospital to know (e.g. special diet)	1.74
16	List of agencies or people to have copies of the plan	1.79
17	Mental health problem or diagnosis	1.81
18	Physical illnesses or allergies	1.90
19	Consultant contact details	1.93
20	Social worker contact details	1.93
21	GP contact details	2.03
22	Other contact details (e.g. probation)	2.10

'7'). This may indicate burn out and cynicism, widely seen in mental health services (Morse et al., 2012).

Predominantly, there was no difference by gender in usefulness ratings, but there was one item (no. 3, Table 2) where there was a small significant difference ($p = .043$). There was also no difference by geographical region or profession (medical ($n = 42$) versus. non-medical ($n = 28$)) in any of the items.

The predominant theme that emerged from the free text responses was 'contact details' (Figure 1). However, 'collaboration' was prominent, alongside 'with family', 'with service user' and 'other services', suggesting the importance to participants of working with others to prevent crises.

Interestingly, this contrasts with Table 2 which shows that many of the contact detail items were rated as less useful by practitioners. One reason for this may be the specificity of the template given during this research, perhaps clinicians would prefer to have personalisable contact details, which was not specified in this research.

3.2 | Semi-structured interviews

Twelve participants were recruited for the interviews. They were from professions commonly found in EIP services: psychologists, psychiatrists, support workers and care coordinators (social workers, nurses and occupational therapists). Participants were aged between 23 and 55 and had between 3 months and 18 years EIP experience at time of interview. Although the ratio of females to males was 2:1, our sample provided a higher representation of male viewpoints than average, as about 80% of the health and social care workforce are women (Kingsfund, 2013; NHS Employers, 2016). The diverse sample allowed for a range of perspectives to be obtained.

Table 3 summarises the frequency of JCP themes (Sutherby et al., 1999) mentioned in interviews.

Practitioners identified triggers, early warning signs and helpful treatments as particularly useful (Table 3). Interestingly, specific contact details were mentioned less, but generic ones were deemed as important. This supports the survey findings.

There was also specific focus on practical things that need to happen in the event of a crisis, such as a plan for dependants, including pets, for example:

> she was so worried about who would clean, who would water the plants, who was going to watch the house, who was going to erm feed the cat [
> participant 1].

Practitioners found the focus on practical matters useful in order to reduce a service user's anxiety about crises. However, it was often something they had not thought about to include within plans, although knew it to be important for their service users. This needs to be documented so other practitioners know how to respond during a crisis. It was clear that practitioners found information for prevention more useful than care in a crisis. Additionally, advance decisions and refusals were viewed as less important or not mentioned, but this may be due to many people in EIP not having had a previous admission, making this more challenging to complete.

Table 4 summarises elements of crisis plans which practitioners viewed as important in addition to the JCP themes; the most frequently mentioned of which are explored in more depth below.

3.3 | Personalisation

Personalisation was a significant emergent theme, with many practitioners stating plans needed to be individualised. This differs

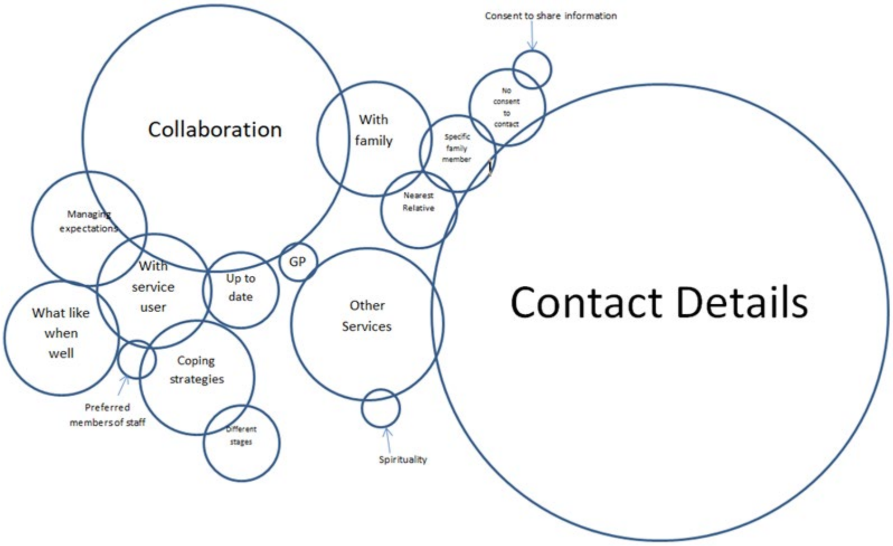

FIGURE 1 Survey free text comments, sized according to frequency

from personalisation within personal budgets (Care Act, 2014), instead linking to person-centred practice (National Institute for Health and Social Care, 2011; Mental Capacity Act [MCA], 2005). For example:

> you can't do a plan for everyone, it needs to be for them so they need to feel that you've listened to them and you understand their certain things that will help them [
>
> Participant 3].

Practitioners identified the importance of individualisation to not only support and empower their service users but also to ensure they felt heard and valued. Many practitioners felt that it was not just the document that can support the service user, but the process itself can allow for psychoeducation, increased understanding and awareness, and building of the therapeutic relationship, demonstrated by service users feeling listened to; for example:

> not just a document, it's a piece of work that results in a document... I think its about the persons understanding as well so for me I'd much rather there was a piece of work that happened over a month with a service user and their family rather than someone just putting something on for the sake. [
>
> Participant 2].

3.4 | Self-management

Encouraging empowerment for service users to take responsibility for their own difficulties and managing these independently was a significant emergent factor. It was stated that services may not always be around the service user, and therefore the focus was on recovery oriented practice and independence. This links to the CHIME model of recovery (Leamy et al., 2011), including hope and empowerment for the service user that they are able to manage themselves, and knowing the steps they can take to self-soothe or seek help when required. Contrastingly, one participant discussed the difficulties with self-management within the service:

> we're adding in behavioural interventions into a non behavioural framework so I think that's why people don't use their crisis plans very often or they do but they use it to ring the crisis team or care coordinator. [
>
> Participant 8].

This could potentially demonstrate iatrogenic harm if individuals are relying on services to tolerate this distress, but equally can be harmful if people are forced to self-manage or self-soothe when they are unable to. Although service users can be taught skills, the participant said that if they are not reinforced, they can struggle to use such skills, particularly if traumatised and hypervigilant. Therefore, there may have to be alternative plans for supporting these clients in times of distress, but how this can be done remains unclear.

3.5 | Collaboration

This theme again highlights the importance of the process rather than the plan just being a document. Significant collaboration was identified with the family, for example:

> If we can involve people right from the beginning I think its, you'll produce a much more collaborative and useful plan for everybody and I think that also saves time and empowers family members in supporting people at home erm cos I think a lot of what drives

TABLE 3 Frequency of JCP themes mentioned during interviews

JCP Theme	JCP Subthemes	No. of practitioners referring to theme	No. of mentions
Practical help in a crisis		5	7
	Arrangements for dependants	5	6
	Contact to carry out tasks if admitted	1	2
	List of agencies to have copy	1	2
	Other info, for example, special diet	0	0
Current care and treatment plan			
	What happens when I start to become unwell	10	23
	Treatments or other things which have been helpful in the past	12	40
	Physical illness or allergies	0	0
	Mental health problem or diagnosis	3	4
	Current treatment plan	3	3
	Current medication and dose	2	2
	Circumstances which have led to becoming unwell in past	6	10
Contact details		9	20
	Social Worker	0	0
	Service user	0	0
	Other (e.g. probation)	2	2
	Nominee	5	6
	GP	1	1
	Consultant	0	0
	Care coordinator	2	2
Care in a crisis		1	2
	What I would like to be done when I first become unwell	2	2
	Specific refusals	0	0
	Preferred treatment or social care	4	5
	Circumstances for admission	1	2

> families and carers to phone us is their own anxieties about 'am I doing the right thing?' [
>
> Participant 2].

It was also suggested that this level of collaboration is important to relieve pressure on services and to save time, while also ensuring high-quality support for the clients. Personalisation was also identified when discussing this, for example:

> I think it's important that we sort of include that wider definition of family cos it's no longer nuclear family, mum dad two kids and a dog, its life partner, unicorn pet and whatever other random definition [
>
> Participant 6].

Self-management and collaboration can be challenging at times due to service users not wanting to engage with the process, or being unable to. For example:

> I know sometimes people don't wanna engage fully in that work so its about trying to sell the rationale and trying to do a bit of engagement around kind of doing that work [
>
> Participant 2].

Many practitioners discussed the importance of 'selling' crisis planning to service users to ensure they understand its potential use. Completing it without the person was consistently stated as being far from ideal.

Due to a number of serious incident reviews that highlighted limited multi-agency practice and communication, there was also a focus on collaboration with other agencies (Institute & for Excellence, 2016). Although important to many practitioners, it was evident that communication between teams and inter-agency working was not as effective as it could be, due to constraints such as time.

TABLE 4 Emergent themes of useful elements of crisis plans

Theme	No. of practitioners referring to theme	No. of mentions
Personalisation	10	30
Collaboration with carers and families	11	27
Self-management	12	25
Different stages of crisis	10	21
Collaboration with service user	9	18
Collaboration with other agencies	5	17
What is unhelpful	9	14
Prevention	9	14
Process of completing a crisis plan	5	13
'Selling it'	7	11
Consistency	6	10
Being a live document	5	9
Consequences of not having a plan	4	7
The relationship	3	7
Evaluation	3	5
Goals and what 'well' looks like	3	5
Sharing good practice	3	4
Role of care coordinator	3	3
Psychoeducation	2	2
Who is helpful	1	2

TABLE 5 Barriers to crisis planning identified by practitioners

Theme	No. of practitioners referring to theme	No. of mentions
Electronic system	7	19
Time	5	12
Engagement	7	11
'Tick box exercise'	5	9
Other services	3	8
Lack of training	4	6
Culture/understanding of staff	2	4
Lack of reinforcers	2	4
The plan itself	2	3
Staff perception of risk	1	3
Limited flexibility in staff approaches	2	2
Consent	1	1
GP system—difficulties in sharing information	1	1

3.6 | Barriers

Table 5 summarises key barriers in crisis planning which practitioners identified.

Many practitioners felt that while they could co-produce a personalised crisis plan based on self-management, the availability of other services to support this was limited. This was viewed as being due to cuts to third sector services, services not being available when they are required or some being perceived by service users as unhelpful. The most significant barrier, although, was the electronic system for recording crisis plans (Table 5).

The existing electronic system embeds the crisis plan in a small box within the care plan for the whole team, and therefore can sometimes be difficult to find. The practitioners suggested that a clearer and more accessible location within the system is needed. As crisis plans are updated on a regular basis, many practitioners discussed the importance of it being a live document; at present it cannot be edited after being signed off.

Throughout the EIP recovery journey service users are learning about themselves constantly and to have a document which is not live nor easily updatable, limits its relevance and practitioner engagement with it. One participant suggested the following improvements:

> I guess just having those considerations and us having to evidence that we have considered them with the client… because I think if we just had a standardised complete document I think people would think it's just a tick box task where we don't want it to be that. We want it to include everything it needs to include but still needs to be individualised [
>
> participant 10].

The practitioner was highlighting the need for a personalisable template, to ensure required topics were considered, but also to ensure individualisation, which is in line with JCP principles. As the JCP process specifically is not currently utilised within this service, it may be helpful to consider this as an option for service improvement. This again highlights the importance of consistency to practitioners, to ensure all service users receive the same level and quality of services, while maintaining individualisation.

4 | DISCUSSION

Both the survey findings and interview data highlighted the usefulness of themes within the JCP template, with triggers, early warning signs and treatments being deemed as the most useful. It is possible that interviewing practitioners from the same team limited the breadth of data due to a shared team language and training. However, the interview findings were mirrored in the national survey, which supports their validity. Similarly, there is consistency throughout the survey findings, with geographical location, gender and profession having limited impact on opinions.

Collaboration was a common theme throughout both the survey and interviews. This supports previous research that suggests that the therapeutic relationship through which crisis planning occurs is more important than the content of the plan itself (Thornicroft et al., 2013). Additionally, contact details are important within crisis planning. While the survey findings suggested they were less important, free text responses and the interview data indicated that the JCP template asked about within the survey could be too specific in terms of contact details. Potentially, more personalised options are required for individuals, including other available services.

The survey data suggested high usefulness for all JCP themes, yet many of these were not discussed in the interviews (Table 4). The emergent themes from the interviews suggest that practitioners may find other aspects more important, highlighting a potential strength of a multi-method design. Alternatively, it is possible that although practitioners find JCP themes useful, they may not use them in practice, perhaps due to some of the barriers discussed. Social desirability bias may also explain the ceiling effect within the survey sample, with practitioners suggesting all elements are useful although not necessarily drawing upon them in their practice. This continues to be a barrier when researching mental health practitioner opinions (Corrigan et al., 2015).

There are some similarities in our findings with Sutherby et al.'s (1999) study; both identified current care and treatment as the most popular theme, and practical help in a crisis was considered less. Conversely, Sutherby et al. (1999) found that all service users chose to have consultant contact details within the plan, but this was considered by practitioners in our study to be one of the least useful items of the JCP template. This may be due to changes in the roles of care coordinators in the last 20 years following the modernisation of the care programme approach. Additionally, it is possible that consultants are now more likely to be part of the multi-disciplinary team rather than having sole responsibility for service users, and therefore the team contact details are more important. Service users have requested a move away from solely medical approaches, with increasing holistic care (Gould, 2012).

Farrelly et al. (2016) identified limited individualisation within crisis plans, although this was viewed as one of the most important aspects within our findings. It is possible that although practitioners may strive for personalisation, they encounter barriers that make this challenging. Additionally, our results support Stovell et al.'s (2016) findings that collaboration is vital in empowering the service user to engage in their own recovery. This study arguably minimises the role of the independent facilitator with JCPs (Thornicroft et al., 2010), as many of the practitioners identified that it was the process, collaboration and the therapeutic relationship that was vital in crisis planning, supporting Thornicroft et al.'s (2013) findings. This research contributes to existing research a specific focus on EIP practitioners' views of crisis planning.

The limitations of this study include the focus on staff views rather than service users and carers. Further research is required to compare and contrast EIP service user and carer opinions with practitioners. This would help to explore the usefulness of the different aspects of crisis planning for service users themselves. Additionally, interviews took place in one team and therefore could be dominated by shared, rather than discordant, perspectives. The researcher was a member of the team, which could also have influenced responses.

Although the surveys allowed for geographical spread, in-depth interviews could also be completed on a national basis in future research. Furthermore, a national sampling frame rather than just using social media may have helped to achieve a larger and more representative sample of EIP practitioners (particularly as recruiting through social media tends to amplify the views of those with the loudest voices). With approximately 5,370 clinical staff employed within EIP in England (Health Education England, 2016), our sample of 70 represents a small proportion of only 1.3%. The ceiling effect may also limit the survey data and future research may consider using more open-ended questions to probe crisis planning in practice.

Despite this study's limitations, it raises a number of questions about current crisis planning in EIP. This is important as CPA and mental healthcare is under review, with a focus on secondary preventative work, early intervention and recovery, and a reduction of compulsory admissions (Department of Health [DoH], 2018; NHS, 2019). There is a tension between having standardised templates for crisis plans and the flexibility to personalise them. Further work is required to discuss how electronic systems can accommodate personalised plans to improve the responsiveness of services during a crisis. Our findings suggest that it needs to be a 'live' and more easily accessible and updatable document within the electronic records system.

5 | CONCLUSION

EIP Practitioners participating in this study reinforced the importance of crisis planning for recovery, self-management and for the therapeutic relationship through personalisation and collaboration. Support for the JCP template elements was consistent across professions, regions and demographic characteristics of practitioners. It is possible that more robust guidance is needed within national policy, but local barriers such as inflexible computer systems also need to be overcome to improve practice and service users' experience.

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CONFLICT OF INTEREST

No conflict of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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APPENDIX A

	Extremely useful	Moderately useful	Slightly useful	Neither useful or useless	Slightly useless	Moderately useless	Extremely useless
Contact details							
Service user contact details							
GP contact details							
Consultant contact details							
Care coordinator contact details							
Social worker contact details							
Other details (e.g. probation officer)							
Nominees contact details							
Current care and treatment plan							
My mental health problem or diagnosis							
Physical illnesses or allergies							
My current care or treatment plan							
Current medication and dosage							
Circumstances that may lead me to becoming unwell or which have done in the past							
What happens when I start to become unwell							
Treatments or other things which have been helpful during crises or relapses in the past							
Care in a crisis							
What I would like to be done when I first start to become unwell							
Preferred treatment or social care during a crisis or relapse							

(Continues)

APPENDIX A (Continued)

	Extremely useful	Moderately useful	Slightly useful	Neither useful or useless	Slightly useless	Moderately useless	Extremely useless
Specific refusals regarding treatment during a crisis or relapse							
Circumstances in which I would wish to be admitted to hospital for treatment							
Practical help in a crisis							
If I am admitted to hospital, please contact the person below and ask if they would carry out the following tasks for me (e.g. pay bills, ensure house is secure)							
If I am admitted to hospital, I would like the following arrangements for children/dependants/relatives/pets							
Other information I would like to be known or taken into account (e.g. special diet)							
Agencies or people that I would like to have copies of this plan							
Are there any other elements which you would suggest are useful to have included on crisis plans?							
If you have any other comments, please enter them here							