MASTER THESIS ASTRID EMMINK

Inviting mental healthcare professionals to become sensitive for the changing healthcare practice

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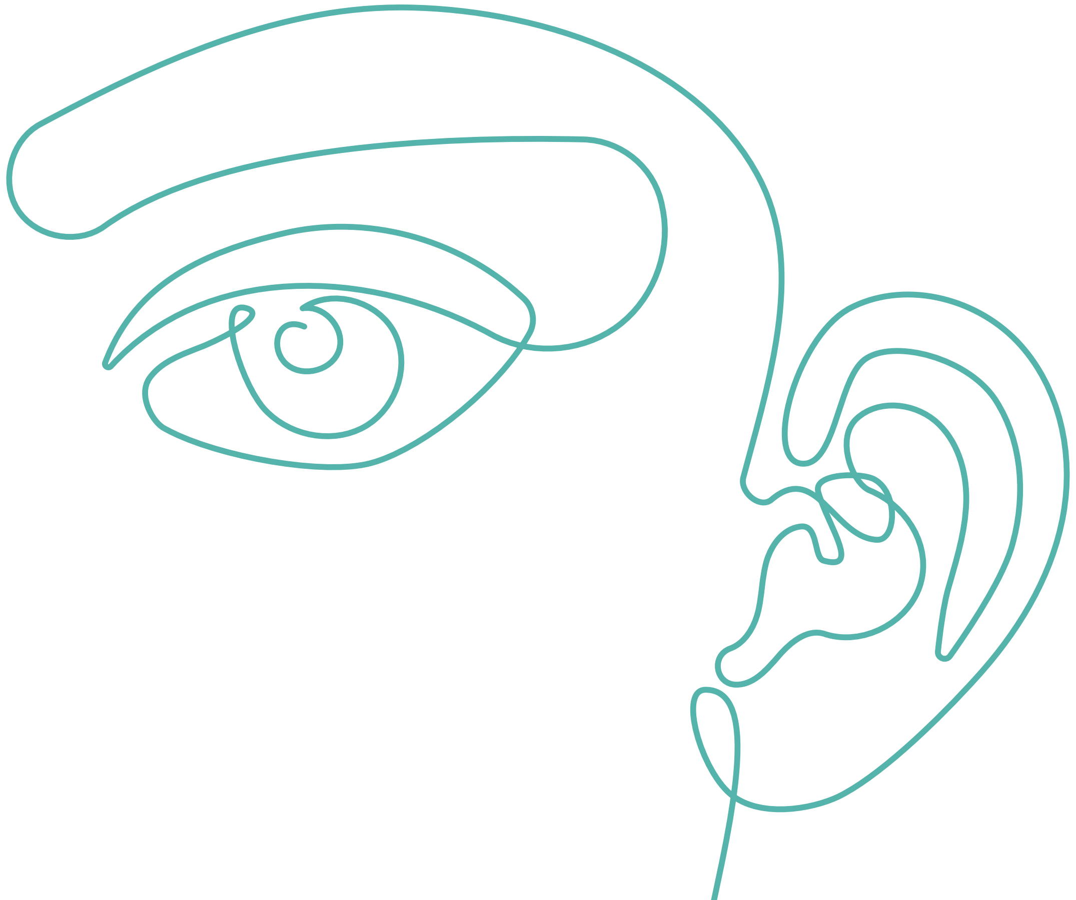

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PREFACE

This report is my master's thesis for the completion of the study Industrial Design Engineering at the University of Twente. For the Master Track Human Technology Relations, in which I could specialise myself to become a human-centred designer and researcher. This report presents my process and the results of the research and design project which I executed for the Research Group IT Innovations in Health Care at Windesheim University of Applied Sciences.

This research focuses on the changing Dutch mental healthcare practice that was forced to rapidly switch to care at a distance at the emergence of the COVID-19 pandemic. The project explores the impact of technology on mental healthcare practice, in order to support mental healthcare professionals in recognizing, discussing and considering these changes, so the choice for the form of therapy can be made more deliberately.

I am grateful that the Research Group has given me the opportunity to apply my knowledge in this graduation project. The Research Group offered me a challenge, resources, research data and a network that allowed me to fulfil my passion; collecting and analysing stories from the field and translating them into a meaningful concept.

This project would not have existed without Annemarie's faith in me. Every week I have felt our shared dedication and passion during our (often exceeded) Monday morning coffee sessions. I had the pleasure of discussing a lot of inspiring literature and research findings with you. Together we determined the direction of my research, in which you gave me all the space I needed to determine my own path. Thank you for offering me this opportunity, your trust and our meaningful and reflective discussions.

Secondly, I would like to thank Marike, for her worthy succession of Annemarie as my mentor from the Research Group. In particular, for her qualities in separating the main and secondary matters, in setting the focus on the long term and, above all, in critically reading along with me. Thank you for being there, whenever I got stuck or when I needed a second pair of eyes.

Apart from my valued mentors of the Research Group, I would like to thank my colleagues of the Research Group for the informal contacts and their interest in my research. Within the group of colleagues, a special thanks to Loes, for allowing me to express my thoughts when I got stuck and for reading along in the materialisation of the final product.

This project would not have been the same without Wouter's guidance. Thank you for listening to and discussing with me about my thoughts, ideas and concerns. For the substantive discussions that we were able to have, as well as our reflective conversations. And of course, for critically reading along with me. You have stimulated me to further develop myself as a design researcher, for which I am very grateful.

Apart from my mentors, I would like to thank the researchers involved in the KIEM project: 'Blended Care in the GGZ: learning from best practices' for sharing your research data with me. The collaborative exploration of the nuances in the insights, and your cooperation in my own research. Ammarens, thank you for the opportunity to work together with you, it was very valuable to be able to partially do research together. Michael, thanks for sparring and the openness in our discussions. Nynke, thank you for your critical input regarding the practical feasibility and content of my final product.

The ones it's all about: the mental healthcare professionals. Twelve care professionals have been involved in both the research as well as the evaluation of the final product. Many thanks for giving me the opportunity to collect your stories. And thank you for the opportunity to exhibit my final product in your care organisations.

Critical peers and fellow students: Patrick and Suzan, thank you for the digital coffee moments and the physical dinners. That we could talk about our projects, and especially about the things that were going on in between.

Patrick and Marlies, thanks for polishing the Dutch language of the final product.

Finally, I would like to express my deepest gratitude to my partner, family and friends who have always believed in me. In particular, I would like to thank my parents, who have always given me the opportunity to grow and develop myself. Rina, thank you for asking specifically about how I was doing and not necessarily about how my research was going. Rob, thank you for your interest in my research, for sparring, for providing me with literature and for understanding when I felt it did not match my study. Dear parents, my sincere thanks for your unconditional faith in all the challenges I have faced. Additionally, I would also like to thank my parents-in-law for their interest in my research and the necessary distraction when I needed it. Unfortunately, one of them will never be able to read this, but I would like to express my sincere thanks for their interest in my research, especially during these times.

Nienke, thank you for being my "Rubber Duck", a very special one, one who did talk back, without any judgement.

Last but not least, my special thanks go to Mario. For the most constant unconditional support, your humorous comprehension and the rock-solid confidence.

Dear reader, thank you for your time, I hope you will enjoy reading this thesis.

Astrid Emmink

SUMMARY

Mental health care, “Geestelijke Gezondheidszorg” (GGZ) in the Netherlands, focuses on prevention, treatment and cure on the one hand, and learning to cope with your condition and being able to participate in society (again) on the other hand. Mental healthcare professionals use a wide range of interventions and skills to treat patients with mental illnesses. The use of technology to inform and support the recovery process of patients with a mental illness is called eMental Health. The application of eHealth in mental health care has developed rapidly in recent years. The use of eHealth is strongly encouraged by the government, with the perspective that it would benefit the quality, efficiency and affordability of health care. However, these expectations have not been fulfilled in recent years.

The COVID-19 pandemic gave a new impulse to eHealth. During the pandemic, mental healthcare professionals were forced to provide care at a distance, or in other words “telecare”. The pandemic resulted in a complete switch from face-to-face contact towards telecare. However, after the initial peak of the pandemic, health care professionals almost completely returned to the ’business as usual’ face-to-face contacts. The main reason for this was that healthcare professionals believed that they were unable to sufficiently integrate telecare into their daily activities, and the assumption that patients prefer face-to-face contact. It seems that no conscious use is made of the benefits of blended care that have been experienced such as: the increased flexibility of therapy, reduction of travel time and the new ways of contact it is offering. Whilst telecare initially had to be used as an alternative to face-to-face contact, its potential of supportive means in combination with face-to-face contact, mostly referred to as “blended care”, did not stick. The question is therefore what the mental healthcare practice can learn from this period and how the advantages of different forms of therapy can still be used well-considered for the patient’s recovery process in the future.

Because of the complex health care practice, blended treatment should be offered tailored to the patient. The result, personalised care, is established in the relationship between the health care professional and patient, including his environment. It is essential to keep into account that when introducing technology in the care relation, technology would also change care. However, practice shows that these changes cannot automatically be recognized and discussed by practitioners.

This study focuses on finding out how mental healthcare professionals have dealt with the rapid implementation of technology in their care practice at the emergence of COVID-19 and how this has changed their care practice. Several design research methods have been applied to reveal obvious as well as more subtle changes that occur when introducing technology in the care relationship in order to support mental healthcare professionals to recognise, discuss, and consider the changing context when switching between the different ways of therapy and how this can positively contribute to the care process.

The aim of this study is defined as to invite the mental healthcare professional to become sensitive for the choice between face-to-face, telecare or blended care, by drawing upon their existing knowledge and experience. To become aware of when which form of therapy can be of added value to the treatment. By the means of a Tool that invites the mental health professional to start interprofessional conversations. In order to think about the changing context when switching between the different ways of therapy and how this can positively contribute to the recovery process. This way blended care can be used more considered, well-balanced and personalised for the patient and professional.

For the development of the Tool a Research through Design approach has been applied. Due to the nature of the practice that has been researched, different qualitative research methods have been combined iteratively in which the power of design is deployed and interwoven. In order to do justice to the diversity and the story of the mental healthcare practice. Within the project, scenarios are used to enable a holistic approach in exploring the current practice and designing new concepts within a desired future practice.

To map the current practice scenarios of mental healthcare, a literature study, secondary analysis of existing data, two focus group sessions, several expert interviews, a workshop, a peer review, and member checks have been executed. The stories of the mental healthcare experts and professionals resulted in the insight that we are dealing with a layered, complex and diverse care practice. All kinds of factors and events play a part in the decision-making of the form of therapy. In which the relationship between these factors per patient, event and phase of recovery can have a different impact on how care is shaped. This results in numerous decision moments. ‘The story’ is different every time and consists of a combination of these different factors and events in the recovery process. To map these multiple stories, eight current practice scenarios were formulated. From a comparison of these scenarios three pillars emerged: “technology changes care”, “personalised care”, and “existing patterns”. These pillars best illustrated the relationship between the theoretical framework and the work practice, as the empirical evidence confirmed the theoretical notions.

The three pillars were used as starting points for the formulation of three possible desired future practice scenarios. Based on theoretical insights one focal desired future practice scenario, concerning stimulating the reflective attitude towards the changing mental healthcare practice could be selected.

The chosen desired future practice scenario combined with the theoretical framework and the insights into the current practice led to the formulation of eight design guidelines. Six concepts were created and evaluated with mental healthcare experts. Subsequently, a development process materialised the chosen concept in the form of a poster series with line art. The aim of the poster series is to stimulate a reflective attitude towards the changing healthcare practice, how to make use of the changes that come along with the arrival of technology in mental healthcare practice and what the impact of the choice for different forms of therapy has on shaping care. By making these changes and possibilities more explicit, the choice for the form of therapy can be made more deliberately.

Afterwards, the poster series has been exhibited in two mental healthcare organisations in the Netherlands and discussed with mental healthcare professionals. The validation results provided insight into the influence of the poster series as a conversational trigger both among mental healthcare professionals and in conversations with their patients. In which mental healthcare professionals confirmed that they discussed alternative forms of treatment more than they did intuitively before. This indicates an increased sensitivity to the various choices that mental healthcare professionals have. However, whether this has also led to an increased use of alternative forms is unclear.

Even though the articulated knowledge led to topics for discussion and reflection, which is extremely valuable for understanding the changes and possibilities in care practice, I believe that the next step, being able to gain experience, is necessary and perhaps even more important, since in order to become an expert (again) gaining experience is necessary. Therefore, I would find it relevant for follow-up research to look at the relationship between the From novice to expert model and the type(s) of support(s) that care professionals need in mastering care at a distance.

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INTRODUCTION

In the introduction, the approach of the project is briefly explained. First of all, the context of the research is discussed, including the problem statement and the design challenge arising from it. Secondly, I describe the research and design approach and the methods applied within the graduation project. Subsequently, the introduction describes the structure of the thesis.

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The Dutch mental health care association "de Nederlandse GGZ" shows that approximately 43% of the Dutch population will suffer from at least one mental illness during their lifetime (GGZ Nederland, 2018). Mental health care, "Geestelijke Gezondheidszorg" (GGZ) in the Netherlands, focuses on prevention, treatment and cure on the one hand, and learning to cope with your condition and being able to participate in society (again) on the other hand (Ruiter, Greuningen & Luijk, 2017). In general, a short treatment is sufficient, consisting of for instance: a few sessions with the general practitioner or the general practice-based nurse specialist, short-term therapy or a brief admission. In other cases, long-term care is required. Mental healthcare professionals use a wide range of interventions and skills to treat patients with mental illnesses. Mental health care is characterised by its multidisciplinary nature consisting of various professionals with diverse disciplines, in order to be able to offer personalised care for the patient.

The use of technology to inform and support the recovery process of patients with a mental illness is called eMental Health (GGZ Standaarden, 2020). The application of eHealth in mental health care has developed rapidly in recent years. This resulted in various applications for different target groups and types of interventions focused on different phases of the care process. eHealth supports care, where patients and professionals can have contact at a distance or patients can use online forms of self-care. eHealth can be combined with face-to-face contacts, leading to blended care. The use of eHealth is strongly encouraged by the government, with the perspective that it would benefit the quality, efficiency and affordability of health care (VWS, 2018). However, these expectations have not been fulfilled in recent years.

The COVID-19 pandemic gave a new impulse to eHealth (Boer, 2021). During the pandemic, mental healthcare professionals were forced to provide telecare, or in other words care at a distance. The pandemic resulted in a complete switch from face-to-face contact towards telecare. However, after the initial peak of the pandemic, health care professionals almost completely returned to the 'business as usual' face-to-face contacts.

The main reason for this was that healthcare professionals believed that they were unable to sufficiently integrate telecare into their daily activities, and the assumption that patients prefer face-to-face contact (Boonstra & Kaptein, 2020). It seems that no conscious use is made of the benefits of blended care that have been experienced such as: the increased flexibility of therapy, reduction of travel time and the new ways of contact it is offering (Boonstra & Kaptein, 2020). Whilst telecare initially had to be used as an alternative to face-to-face contact, its potential of supportive means in combination with face-to-face contact, blended care, did not stick. The question is therefore what the mental health care practice can learn from this period and how these advantages can still be used well-considered for the patient's recovery process in the future.

Because of the complex health care practice, blended treatment should be offered tailored to the patient. The result, personalised care, is established in the relationship between the health care professional and patient, including their environment (Wentzel et al., 2016; Van Hout et al., 2016; Ventegodt et al., 2016). The ongoing dialogue between the patient and the health care professional, but also the professionals among each other, contribute to the provision of good care (Van Hout et al., 2016; Wentzel et al., 2016). Care is not only about the patient, but also everything that surrounds them, including family and spouses but also animals and plants (Van Hout et al., 2015). It is essential to keep into account that when introducing technology in the care relation, technology will also change care (Van Hout, et al., 2016). These changes cannot automatically be recognized and discussed by practitioners.

This study therefore focuses on finding out how mental health care professionals have dealt with the rapid implementation of technology in their care practice at the emergence of COVID-19 and how this has changed their care. Trying to reveal obvious as well more subtle changes that occur when introducing technology in the care relationship in order to support mental health care professionals to recognise, discuss, and consider the changing context when switching between the different ways of therapy and how this can positively contribute to the care process.

DESIGN CHALLENGE

The aim of this research and design graduation project is therefore to invite the mental health care professional to become sensitive for the choice between face-to-face, telecare or blended care. To become aware of when which form of therapy can be of added value to the treatment, by means of a *Tool* that draws upon their existing knowledge and expertise. A *Tool* that invites the mental health professional to start interprofessional conversations. In order to think about the changing context when switching between the different ways of therapy and how this can positively contribute to the recovery process. This way blended care can be used more considered, well-balanced and personalised for the patient *and* professional.

APPROACH

For the development of the *Tool* the approach of Research through Design will be applied. Research through Design draws on design's strength as a reflective practice, in which the problematic situation is constantly reinterpreted and reframed through a process of making and critiquing artifacts that function as proposed solutions (Schön, 1983 as cited in Zimmerman & Forlizzi, 2014). This links to the design challenge, as this reflective attitude towards the impact of the different choices mental healthcare professionals have needs to be stimulated in me during my research. As well, ultimately, stimulating the reflective attitude in mental healthcare professionals towards the changing care practice and its impact by the means of the *Tool*.

Due to the nature of the practice that will be researched, qualitative research methods will be combined iteratively in which the power of design is deployed and interwoven. In order to do justice to the diversity and the story of the mental health care practice. Zimmerman and Forlizzi (2014) describe that Research through Design requires exploring the desired future, probing on what the world could and should be. Before the desired future practice can be envisioned, insight into the current health care practice is needed. Within the project, scenarios will be used to enable a holistic approach in exploring the current practice and designing new concepts within a desired future practice.

THESIS OVERVIEW

This thesis consists of several parts. Starting with (chapter 1) the theoretical framework describing the theoretical concepts which are used during the research. Followed by (chapter 2) the methodology in which the process, the research methods, and the analysis procedure are described. After this, the insight gained into current care practice is described in four phases, concluding with the current practice scenarios (chapter 3). Based on the (1) theoretical framework and the (3) insights into current practice, the desired future practice direction was chosen (chapter 4). This resulted in design guidelines that guided the concept development of six concepts. From the reflection on the concepts, a concept choice was made. The materialisation of the chosen concept is presented hereafter (chapter 5). Followed by the validation of the concept (chapter 6). The thesis ends with the conclusion and recommendations for implementation and future research (chapter 7).

THEORETICAL FRAMEWORK

The goal of this research and design project is to support mental health care professionals to become sensitive for the choice between face-to-face contact, telecare or blended care, by drawing upon their existing knowledge and experience. Before diving into the theoretical concepts for this research, I will elaborate on the three different forms of contact according to scholars, in order to support those who are reading my thesis without a background in mental healthcare. After setting the contextual stage, I will go deeper into the core concepts that have been applied. For this, the design challenge is divided into three parts: (1) the choice between the different forms of therapy, (2) drawing upon existing knowledge and experience and (3) becoming sensitive for the choice.

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1.1 FACE-TO-FACE CONTACT, TELECARE OR BLENDED CARE

With the arrival of technology, mental healthcare professionals no longer just have the choice between face-to-face contact at their office or at the patient's home, but now have additional ways to provide care: at a distance, or in other words, telecare. Telecare provides a variety of ways to stay in touch with patients, such as calling, with or without video, in groups or individually. Next to that, different kinds of messaging applications such as Signal or WhatsApp can be used, as well as patient portals or email. Although telecare was mainly introduced as a way to maintain 'regular' contact during the pandemic, there are interesting opportunities for continuing treatment remotely as well. An example of this is online modules that provide patients with information as well as assignments. In addition, there are self-help platforms and numerous YouTube videos available that may be of value to the recovery process. Protocolised treatments also seem to be able to be translated well into online mediums, such as EMDR therapy or psychoeducation (Van Beek, 2020; Van der Vaart et al., 2014).

Care at a distance offers a number of opportunities for healthcare efficiency: it offers possibilities for more frequent contact (Postel et al., 2013; Van der Vaart et al., 2014; Wentzel et al., 2016), shorter but more goal-oriented contact (Van der Vaart et al., 2014), flexible planning and it disregards travel time (Van Beek, 2020; Van der Vaart et al., 2014). Furthermore, it has the potential to positively impact therapeutic relationships: the patient's living environment adds a new dimension, resulting in new topics of conversation (Van Beek, 2020; Crowe et al., 2020). Some patients feel more comfortable opening up about what is bothering them because of the physical distance (Van Beek, 2020). Care at a distance can benefit a patient's self-management and insight into their treatment process. Accessibility to care increases as patients can access information and assignments in their own time, which enables therapy to continue in between appointments (Van Beek, 2020; Postel et al., 2013; Van der Vaart et al., 2014; Wentzel et al., 2016). Making assignments and being able to read in between appointments can also support patients in preparing for contact moments (Van der Vaart et al., 2014).

The shorter duration of online contacts also has its flip side, as it may involve a surplus of superficial contact (Van Beek, 2020; Van der Vaart et al., 2014). Introducing technologies comes along with some worrying factors related to privacy and safety (Van Beek, 2020; Blandford et al., 2020; Schuster et al., 2020; Wentzel et al., 2016). Technical problems are also a point of friction (Van Beek, 2020; Crowe et al., 2020; Wentzel et al., 2016), especially when everyone was being forced to work from home, as it caused some home networks to collapse. Necessary facilities and software are not always adequate or available to provide or receive care at a distance (Blandford et al., 2020; Postel et al., 201; Wentzel et al., 2016).

But perhaps the most visible and tangible difference is the changing physical presence of healthcare professionals, as it disappears when care at a distance is being provided. Van Hout et al. (2015) describe how care at a distance can result in the feeling of being either 'too distant' or 'too close'. The authors describe the physical presence of healthcare professionals in the patient's environment as an important as well as ambiguous tool. Healthcare professionals are accustomed to using their own body in order to pick up signals and sense the atmosphere. Using their bodies takes on a different form when this takes place behind a screen. The ability to sense the patient is lost and only part of the facial expressions and posture can be read and used. Physical presence of practitioners makes way for the physical presence of the aid, for example a personal computer or smartphone.

Because of the lack of physical closeness, non-verbal communication could be picked up insufficiently, which could lead to misunderstandings (Van Beek, 2020; Van der Vaart et al, 2014). Some healthcare professionals see this as a stumbling block due to the belief that these non-verbal aspects are essential for building trustworthy relationships with patients (Postel et al., 2013). However, the same authors also cite literature stating that a similar trusting relationship can be built without these nonverbal cues.

Whenever face-to-face contact is combined with telecare, it results in blended care. Several scholars describe blended care as an optimal way of using the advantages of both face-to-face contact and care at a distance. This implicates that blended care is a sum: however, as Aristotle once said, *the whole is greater than the sum of its parts*. Blended care thus changes care. The conversational topics of the face-to-face contacts takes on a different meaning when online elements are added. Roles and responsibilities will also shift: the patient will be able to take more control in his or her recovery process, which will also have an impact on the patient-nurse relationship.

The ideas of Postel et al. (2013) who state that *"converting a face-to-face treatment to a blended treatment is more than just adding a piece of technology to an existing treatment."* (p. 219), are therefore adopted. They describe that the aim of blended care is providing a mix of both types of contact, where face-to-face and online care complement each other. The face-to-face treatment components must therefore be aligned with the online treatment components. As a precondition, they stipulate that the content and methodology must be identical and that there will be a choice in how the treatment component is carried out. This makes it easier for protocol-based interventions to be offered in a blended way. Postel et al. (2013) even go as far as to state that only well-protocolised treatments are suitable for blended care: whether this statement holds is left to further research and professional practice.

Various contradictions or paradoxes can be found in literature, for example the aforementioned question of whether or not it is possible to build up a relationship of trust while missing non-verbal communication. These are perhaps directly indicative of this care practice, which is not surprising given its complexity. Care at a distance is not suitable for every patient, and not every intervention is suitable for telecare (Baumeister et al., 2020; Postel et al., 2013; Schuster et al., 2020; Van Hout et al., 2015; Van der Vaart et al., 2014; Wentzel et al., 2016).

In fact, no patient is similar, so this care practice should be approached with a certain nuance. Something that theoretically seems appropriate for care at a distance, looking at the condition, the 'patient profile' or the intended type of intervention, may not always work in practice.

Mello (2020) states that the relationship between patient and practitioner should be critically examined. It is not only about the condition and the problems, but also about the additional (life) goals and needs of the patient. It is not only about the illness but also about the patient's well-being. In addition, it is not only about the personal preferences of the patient: it is also about the personal preferences of the healthcare professional.

The studies described above illustrate how complex mental healthcare really is, and how each patient-practitioner relationship is different from another. For this reason, any overview of which conditions, types of conversations or types of interventions lend themselves for care at a distance will be inadequate. Hence, this study will stay away from attempts to form an assessment framework or decision tree-like implementations. The *Tool* will have to respond to or make use of the existing knowledge and experiences to leave the knowledge and choice with the healthcare professionals.

In this section, literature was used to describe the differences between face-to-face contact, telecare and blended care, to provide some practical context. In the following sections I will elaborate on the core concepts of the design challenge.

1.2 THE CHOICE BETWEEN THE DIFFERENT FORMS OF THERAPY

The advent of technology in healthcare practice offers new possibilities for shaping care. This offers possibilities for personalised care, as it allows care to be more tailored to the individual. The arrival of technology in care relationships also changes care itself. The theoretical concepts for the impact of 'the choice' are therefore twofold: on the one hand, it is approached from the perspective that the choice is extended and thus gives rise to new possibilities, and on the other hand from the perspective that the possibilities of the choice bring about changes in the content of care and the care relationship. To better understand this, I will elaborate on how scholars explain this partition.

TECHNOLOGY CHANGES CARE: ACTOR NETWORK THEORY

Because of the complexity of healthcare practice, blended treatment should be offered tailored to the patient since there is no fixed formula for blended care. The result (personalised care) is established in the relationship between the healthcare professional *and* patient, including the patient's environment (Van Hout et al., 2016; Ventegodt et al., 2016; Wentzel et al., 2016). The ongoing dialogue between the patient and the health care professional, but also the dialogue between professionals, contribute to the provision of good care (Van Hout et al., 2016; Wentzel et al., 2016). Care is not only about the patient, but also about everything and everyone that surrounds them, including spouses but also animals and plants. In this, we can see that humans as well as non-humans together shape a care practice (Van Hout et al. 2015). Van Hout et al. (2015) describe that these non-humans not only refer to the aforementioned plants and animals, but also all things material, such as the house itself or everyday objects. Questionnaires and webcams also influence care. Drawing from the work of scholars in science and technology studies (STS), we can learn that technology is not neutral and will therefore have an impact on social relations (Akrich & Latour, 1992; Latour, 1992): thus, it would have an impact on how care is shaped. According to the Actor Network Theory, objects, ideas, and processes are also part of social networks, and not only human beings who are creating social situations.

It is essential to take into account that when technology in the care relation is introduced, technology will also change care (Van Hout, et al., 2016). These changes cannot automatically be recognised and discussed by health care professionals. In the analysis of the role and impact of technology on mental health care practice, I want to pursue a similar approach as van Hout et al. (2015). In this work, the intertwinement of the human and non-human is acknowledged in order to better understand the roles of humans and non-humans in care. Trying to reveal obvious as well as more subtle changes that occur when introducing technology in the care relationship in order to support mental health care professionals to recognise, discuss, and consider the changing context when switching between the different ways of therapy and how this can positively contribute to the care process.

TECHNOLOGY RESULTS IN NEW (ACTION) POSSIBILITIES: AFFORDANCES

The human is inextricably linked to the environment, as we continuously interact with it. We have already seen that the arrival of technology in the care relationship changes care itself. It changes the environment, the context, physical closeness, etc. We have also seen that the arrival of technology results in new possibilities for shaping care. I see these possibilities as opportunities for action, which is a free translation of James Gibson's ideas on affordances (Goldstein, 1981). The theory of affordances can be summarised as: affordances are what the environment offers the animal (or individual) for guiding their behaviour (Goldstein, 1981). It is important to keep in mind that these affordances are relational and are influenced by the ability of the observer, his or her intentions and the suitability of the environment to the observer. The same object, with the same aspects, can mean something different for different people and therefore lead to different affordances. It could even lead to different affordances for the same individual at another point in time.

We as humans are set on finding these affordances. On one hand, we are focused on our goal and whether we can achieve this goal with the object, the affordance. On the other hand, we can see the importance of the learning aspect with respect to the understanding of the meaning of objects (Goldstein, 1981). However, Gibson, in his book *The Ecological Approach to Visual Perception*, does not pay much attention to this aspect (Goldstein, 1981). On the contrary: he even stated that an excessive amount of learning is not necessary. When we look at childhood development, a child will learn how to perceive an affordance for itself, but also what it means to someone else. We teach our children how to use objects by demonstrating how to use the object, and in doing so, we familiarise them with the conventional meaning of an object. Or in other words: we teach them affordances. Seeing someone do something helps people to do it too. In this sense, we can say that responding to affordances is, in a way, a learned behaviour. Can we then also say that in order to recognise technology as an affordance, healthcare professionals must also learn to respond to these possibilities? That they have to gain experience with the affordance in order to recognise it as an affordance?

If we analyse technology from this perspective, we see that the advent of technology results in new affordances. Technology affords us: freely translated, this means that it allows us to communicate with each other from a distance, to monitor the patient from a distance, to respond to the patient in between appointments or to put the patient at work remotely with assignments. In this sense, the arrival of technology results in new possibilities for action. These new possibilities for action impact the shaping of care. Looking at the theory, we could say that in order to recognise technology as an affordance, it has to be learnt that this affordance can support the achievement of the intended goal. You could even go as far as say that experience must be gained with the new affordance(s) in order to be able to recognise the affordance as an action possibility. I will elaborate on this during the explanation of the following core concept.

Apart from citing the theory of affordances as a theoretical concept for the explanation that technology results in new possibilities, I also want to extend the body of thought into the development of the *Tool*, in the sense that the *Tool* itself must become an invitation or affordance to contemplate, discuss and consider.

1.3 DRAWING UPON EXISTING KNOWLEDGE AND EXPERIENCE

If we look at how care professionals possess and gather knowledge, we see that great value is attached to gaining experiences and that care professionals tend to call on their situated and embodied knowledge. This section therefore looks at the learning curve that healthcare professionals go through and the impact of gaining experience. Additionally, the application of knowledge is discussed. The problem that this knowledge is difficult to put into words is considered.

LEARNING BY DOING: FROM NOVICE TO EXPERT

The complexity of healthcare practice and the responsibility that healthcare professionals have demands continuous learning and professional development. Benner (1982) therefore stressed the importance of looking at the differences between novice nurses and experienced nurses. She builds on the Dreyfus Model of Skill Acquisition, which describes the development of skills. The learning curve a person goes through can be described in five different stages: novice, advanced beginner, competent, proficient and expert. Benner has found that this model can be generalised for nursing practice, in which knowledge and professional development grow as experience is gained. Novice caregivers mainly base their decisions on learned and abstract principles and see situations proportionally, which makes it difficult to set priorities. (More) Experienced care providers act from previous experience and see the situation as a whole in which certain aspects play an important role.

The knowledge, skills and experience together constitute the 'repertoire' of care providers (Benner, 1982). Expanding the repertoire requires gaining new experiences in new contexts or using new forms of therapy. Van Hout (2019) states that care providers continually build on their repertoire in order to ensure good care, as best as possible. In her empirical research into the impact of telecare in two different care settings, it was demonstrated that care providers had gained more and more experience with the new technology over time. With experimentation and adaptation, the new technology could find a place in this healthcare practice and overcome earlier obstacles. This resulted in an expansion of their repertoire, which could then be applied in new care situations and eventually even result in new forms of care. Van Hout poses: *"As nurses enrich their repertoire, it leads to new care forms that are triggered by the possibilities that the use of technology offers"* (p. 116). The possibilities facilitated by the advent of technology have already been discussed in the explanation of the core concept of 'the choice' where the concept of affordances was introduced as the free translation of action possibilities. Technology was analysed as a means to make new forms of care possible. However, it remains unclear whether technology in itself sufficiently initiates new forms of care.

The expansion of the practitioner's repertoire, which requires a learning curve, combined with the importance of gaining experience and recognising affordances, leads me to believe that the mental healthcare professional, despite being an expert in the provision of mental healthcare, becomes a novice again the moment he or she starts providing mental healthcare at a distance. This would mean that, mental healthcare professionals will have to go through the learning curve again, albeit on a smaller scale: the knowledge is already known to practitioners, however, the situation is changing and requires translating the current knowledge to fit the new context. In the end, being able to offer effective telecare requires getting used to, trying out and adapting to the new situation. Thus, gaining experience and being confronted with new situations as well as learning to translate embodied knowledge into these new contexts can contribute to the process of becoming an expert care provider again, but then for the provision of mental health care at a distance.

KNOWING IN DOING: SITUATED & EMBODIED KNOWLEDGE

Regarding the knowledge that care providers possess and acquire, a difference can be observed between learning through theory (know-that) and learning by doing (know-how) (Benner, 1982; 1983), whereby know-that knowledge is associated with propositional knowledge and know-how knowledge relates to practical or tacit knowledge (Van Hout, 2019). The 'tricky' thing about tacit knowledge is that it is difficult to put into words. A well-known example is cycling. You know that you have to pedal in order to go forward, and that you can steer by bending your steering wheel to the left or right. Despite the fact that we know all the actions which we need to perform, it is difficult to put them into words. Tacit knowledge is about situated and embodied knowledge: these embodied and embedded skills are essential in nursing and other clinical practices (Van Hout, 2019). *"When nurses develop their skills, part of what they learn is integrated in what they do. They do not have to think about each step, but are able to respond to the situation at hand."* (Van Hout, 2019, p. 94).

Van Hout (2019) shows that putting this knowledge into words is a way of developing valuable knowledge for nursing practice. For the process of 'putting into words' she borrows the term 'articulation' from Donna Harraway (1991). Van Hout states that 'doing things differently', whereby she refers to learning to deal with new technology, is an important form of know-how knowledge. She therefore calls on researchers to help care providers articulate this tacit knowledge. This way, the knowledge can travel more easily in professional practice.

The concept of 'knowing in doing', which I borrow from van Hout (2019), in combination with 'articulation', will be applied to find out how mental health care professionals have dealt with the rapid implementation of technology in care at the emergence of COVID-19 and how this has changed their care. What they encountered, how they applied the technology, where care at a distance could be of added value and what was important in the decision making about the form of therapy: by studying this, I aim at contributing to the articulation of this knowledge, the stories of practice, and at supporting health care professionals to better articulate their knowledge.

1.4 BECOMING SENSITIVE FOR THE CHOICE

Sensitivity is a frequently used term in nursing literature (Sayers & de Vries, 2008). In this paper, the authors focus on the general nursing literature and do not elaborate on mental health care. 'Sensitivity' refers to the degree to which someone is sensitive. This is related to perception and feeling (Sayers & de Vries, 2008). Dictionary definitions focus on the presence of 'stimuli' and being open to receive them, by being aware and responsive to them, and by considering the impact of the 'stimulus'. The article by Sayers and de Vries (2008) focuses on how nurses define the act of being sensitive or insensitive towards others, combining both theoretical and qualitative research data. When we look at mental health care, we see health care professionals who focus specifically on being sensitive towards others, by responding to these stimuli and signals from patients and their environment. The knowledge of Sayers and de Vries (2008) will be applied to form an understanding of when someone is sensitive or insensitive to these stimuli. In addition, their research studied whether sensitivity can be stimulated and taught.

BEING SENSITIVE VERSUS BEING INSENSITIVE

Sayers and de Vries (2008) describe 'being sensitive' by means of two core features: 'being aware' and 'responding and reacting to needs'. Regarding the latter, active listening, observing, being open and transparent are effective contributors. With regard to 'being aware', we see that this is not only about awareness towards others but also about self-awareness. Mental healthcare professionals are extremely well equipped for awareness towards others, which requires attentiveness, alertness and intuition. Self-awareness on the other hand also requires the ability to oversee the impact of one's own actions. This may be an area for improvement, given that the changes that occur as a result of the advent of technology cannot automatically be recognised and discussed by mental health care professionals.

The counterpart of 'being sensitive' is 'being insensitive'. It is thus not surprising that the core features are also counterparts of each other: 'lack of awareness' and 'not responding or reacting to needs'. The lack of insight into the cultural, personal and informational needs of the patient as well as the personal unawareness of the care professionals their own limitations, exacerbate insensitivity (Sayers & de Vries, 2008). They argue that 'being insensitive' can ultimately lead to a poor patient-nurse relationship. In addition, they also emphasise that being extremely sensitive can result in 'oversensitivity', which can also negatively impact the patient-nurse relationship.

BECOMING SENSITIVE: SELF-AWARENESS AND REFLECTIVE THINKING

Sayers and de Vries (2008) describe that there are different degrees of being sensitive and being insensitive, which are influenced by motivation, innate characteristics, time, environment, culture and coping strategies. Their qualitative data showed that practitioners believed that the degree and depth of sensitivity was related to practitioners' motivation to learn through experience and observation. They cite an article by May (1992), who states that insensitive individuals can become more sensitive by paying more attention to overseeing the effect of one's own actions on somebody else's feelings and needs. In addition, Hooft (as cited by Sayers & de Vries, 2008) has emphasised the importance of developing self-awareness, among other things. It is therefore important for the design challenge to support care professionals in overseeing the impact of the chosen form of therapy on the provided care and the treatment relationship.

If we delve further into literature regarding self-awareness, it can be observed that it is closely related to self-assessment and self-reflection. Rasheed (2015) describes that self-awareness is frequently regarded as the most important and essential aspect of a healthcare professional, as it is important for a healthcare professional to have insight into their own attitudes, behaviours, norms and values. They constantly analyse their own actions and reactions to avoid that their assumptions and prejudices are projected onto others. In order to increase self-awareness and be open to changing current behaviour, literature shows that the willingness of the healthcare professional plays an important role (Rasheed, 2015). One of the most common methods in healthcare to increase self-awareness is to use self-reflection, which involves reflecting on experiences and learning from weaknesses.

With regard to self-reflection and reflective thinking in healthcare, we see that almost all studies refer to the ideas of Schön, posed in his book *The Reflective Practitioner* (1983). Schön introduced the term 'reflective practice', with which he emphasises the importance of practice for the development of professional knowledge. This is in line with the *From novice to expert* philosophy of Benner (1982). Schön explained that there are different forms of reflection in practice: reflection in action and reflection on action, whereby the former focuses on the reflection while doing an action. Reflection on action refers to the reflection after the events have taken place.

Teekman (2000) conducted a literature study on how 'reflective thinking' is applied in nursing literature. He frames reflective thinking in nursing literature in terms of learning, critical inquiry or a mixture of both. Reflective thinking for learning is used to get a grip on specific situations in practice, focusing first and foremost on the here and now and second on the learning aspect for the development of practical knowledge. Reflective thinking for critical inquiry on the other hand goes further than gaining an understanding of the current situation: it refers to gaining an understanding of how contexts influence care. It includes evaluating why certain choices were made and how they affected the provided care. It is precisely this understanding of the impact of the context and the choice (in my research, the choice of the form of therapy) that is relevant to stimulate, and thus requires more than just evaluating the current situation.

In addition to the theoretical section, Teekman (2000) adds from qualitative research an identification of three different successive levels that describe the nature and focus of reflective thinking: reflective thinking for action, for evaluation and for critical inquiry. Here, he splits reflective thinking for learning into action and evaluation. Teekman makes no distinction between reflection before, during or after the action as we know it from Schön. Teekman sees reflection for evaluation as second-level reflective thinking since it can only be applied after reflection for action. Respondents of his research considered whether they would have acted the same way in similar situations. However, in the context of my research, the question 'What could also have been possible?' would be more relevant than evaluating whether they would have acted the same. It is about alternatives that need to be considered, rather than an evaluation of the routine interventions.

I have already mentioned that reflective thinking for critical inquiry should be tapped into, given the importance of considering the impact of the choice. While the respondents had several self-questions in the previous two reflection levels, it seems difficult to tap into this third and final reflection level (Teekman, 2000). Despite the fact that self-questioning is an effective way of reflecting on the situation, Teekman makes it clear that it cannot compensate for or replace the dialogue with colleagues. Just as we saw earlier on, especially the ongoing dialogue between professionals among each other contributes to the provision of good care (Van Hout et al., 2016; Wentzel et al., 2016).

Self-questioning is currently primarily an automatic reaction to so-called 'situational gaps' that occur when an individual is confronted with unusual events. This happens partly consciously but also subconsciously (Teekman, 2000). However, conscious self-questioning for routine situations is of added value (Teekman, 2000). In conclusion, Teekman's study has shown that learning with the aid of reflective thinking is certainly not something that happens automatically. It requires active commitment on the part of the care provider and requires that the clinical environment is supportive of the learner's needs. However, a question that remains unanswered is what this environment can and should look like. The *Tool* should therefore fit the practitioner's daily working environment in order to stimulate self-awareness and reflective thinking, while keeping the ongoing interprofessional dialogue in mind.

METHODOLOGY

This chapter firstly describes the research and design approach and process. Secondly, I outline the methods used within the thesis, the analysis procedure and the number of respondents per research method. In order to support other researchers and designers in going through the same process. However, without the expectation that others would come to the same or a similar result, I hereby refer to the ideas of Research through Design.

02

2.1 RESEARCH THROUGH DESIGN APPROACH

Research through Design draws on design's strength as a reflective practice, in which the problematic situation is constantly reinterpreted and reframed through a process of making and critiquing artifacts that function as proposed solutions (Schön, 1983 as cited in Zimmerman & Forlizzi, 2014). This links to the design challenge, as this reflective attitude towards the impact of the different choices mental healthcare professionals have needs to be stimulated in me during my research. As well, ultimately, stimulating the reflective attitude in mental healthcare professionals towards the changing care practice and its impact by the means of the *Tool*. Zimmerman and Forlizzi (2014) describe that Research through Design requires exploring the desired future, probing on what the world could and should be.

Before I could envision what this desired future practice 'should' look like, I focused on mapping the current practice. In order to make mental health care professionals sensitive to the choice of form of therapy or contact, I mapped the current decision-making process: what plays a part in this decision-making, and what impact does this choice have on (shaping) care? In order to get a better grip on the topics that are at stake and the changes that occur, as well as to find out what my *Tool* and this desired future should and can respond to.

Due to the nature of the practice that has been researched, an exploratory and qualitative research approach was chosen to map the current practice. This research approach was chosen to do justice to the diversity and the story of the care practice. This study is practice-oriented, so the findings of the research and the development of the instrument will be applicable to the field.

In this study I have combined several qualitative research methods. Individually, the various methods helped me understand the Dutch mental health care practice and supported me in shaping my research and design process. The methods were used cyclically, insights from one method served as input for the next method. However, this approach also resulted in an iterative process, as new insights led to a sharpened focus for the (re)analysis of earlier methods. Bundled results, with the power of design, were used again in evaluation sessions and resulted in sharpening and adding finesse to 'the story' of the current mental health care, current practice scenarios, and what the desired future, desired future practice scenario, should be about. The desired future practice describes the design vision, resulting ultimately in designing the *Tool* in an iterative manner. This allowed for even more insight into the mental healthcare practice during the design, evaluation and validation phase.

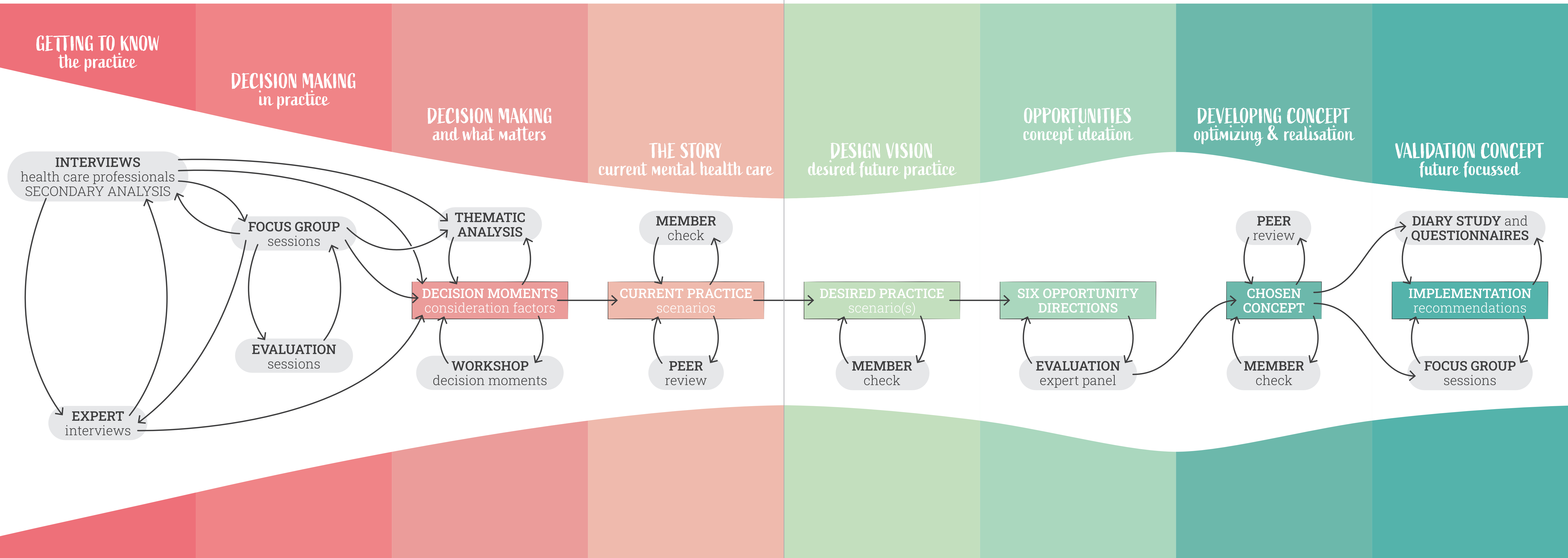
2.2 RESEARCH & DESIGN PROCESS

The process of this research and design project has been divided into eight phases, four phases for mapping the current practice as well as four phases for the desired future practice. Figure 1 shows which methods were used in which phase, each with their own method of data collection. The coloured boxes represent the 'intermediate results' and the arrows illustrate the iterative process, how the insights and outcomes influenced the design or (re)analysis of subsequent or earlier methods. The left side of Figure 1 describes the process of gaining insight into the **'Current practice'** and the right side represents the vision of the **'Desired future practice'**. From this desired future, my design vision, the final *Tool* was developed iteratively. Within the project, research and design were closely intertwined.

The mapping of the **'Current practice'** is divided into four phases: (1) Getting to know the practice, (2) Decision making in practice, (3) Decision making and what matters, (4) The story, current mental health care. In parallel to the qualitative research, literature reviews on important topics that emerged from the sessions were also conducted. The outcomes of the first three phases resulted in each time sharpening and adding finesse to 'the story'. As a result, the outcomes of the first three phases were of input for the fourth phase, 'the story' of current mental health care practice illustrated with current practice scenarios.

The **'Desired future practice'** is also divided into four phases: (1) Design vision: the desired future practice, (2) Opportunities: concept ideation, (3) Developing concept: optimizing & realization, (4) Validation concept: future focused. From the current practice scenarios and all insights from the previous phases, a few pillars emerged which have been incorporated into the desired future practice scenario. This scenario was used as a guideline throughout the development of the *Tool*: for the creation of the design guidelines, as inspiration for the concept development and for the inclusion of peers and members in my design vision. The thesis ends with the validation of the final concept with the target group from which recommendations are formulated for possible implementation, further development and follow-up research.

Figure 1: Research and design process



2.3 DATA COLLECTION, RESPONDENTS AND ANALYSIS

This section describes how the research material was collected. In the vast majority of cases, this was done using (reflective) interviews or focus group sessions with healthcare professionals and/or healthcare experts or peers. The overview also describes the number of respondents per research method and how the research material was analysed.

Before proceeding to the data collection, an overview of the respondents is presented (Figure 2). For the readability of the data collection overview, global insights have been included to provide insight into the relationships between the research methods. The detailed process description, insights and research and design choices are described in the subsequent chapters.

	CURRENT PRACTICE			DESIRED FUTURE PRACTICE		
HEALTH CARE PROFESSIONALS	FOCUS GROUP 1.1	FOCUS GROUP 1.2	FOCUS GROUP 2	FOCUS GROUP	DIARY STUDY	SURVEY
R1: SOCIAL WORKER	○	○	●	●	○	○
R2: PSYCHIATRIC NURSE	○	●	●	○	○	○
R3: PSYCHIATRIC NURSE	○	○	●	○	○	○
R4: PSYCHIATRIC NURSE	○	●	○	●	○	○
R5: PSYCHIATRIC NURSE	●	○	○	●	○	○
R6: PSYCHIATRIC NURSE	●	○	○	●	○	●
E1: PSYCHIATRIC NURSE	○	○	○	●	○	○
E4: NURSE PRACTIONER	○	○	○	○	○	●

HEALTH CARE EXPERTS, RESEARCHERS & PEERS	EXPERT INTERVIEWS	EVALUATION focus group sessions	WORKSHOP decision moments	MEMBER CHECK current scenarios	PEER REVIEW current scenarios	MEMBER CHECK desired scenarios	EVALUATION concepts	PEER REVIEW final concept	MEMBER CHECK final concept
E1: RESEARCHER KIEM, PSYCHIATRIC NURSE	●	●	●	●	○	○	○	○	○
E2: RESEARCHER KIEM, EXPERT BY EXPERIENCE	●	○	●	●	○	○	●	○	○
E3: RESEARCHER KIEM, MENTOR RESEARCH GROUP	●	○	●	○	○	●	●	○	●
E4: RESEARCHER KIEM, NURSE PRACTIONER	○	○	○	○	○	○	●	○	●
E5: PSYCHIATRIC NURSE	○	○	○	○	○	○	●	○	○
E6: HEALTHCARE PSYCHOLOGIST	○	○	○	○	●	○	○	○	○
E7: RESEARCHER RESEARCH GROUP	○	○	○	○	○	○	○	●	○
E8: CONTENT CREATOR	○	○	○	○	○	○	○	●	○
E9: DESIGNER	○	○	○	○	○	○	○	●	○

Figure 2: Overview participants

INTERVIEWS WITH HEALTHCARE PROFESSIONALS (N=17)

Secondary analysis of already obtained data from the KIEM project 'Blended Care in the GGZ: learning from best practices', which started on 1 January 2020 and ended on 31 December 2020. Researchers from different universities of applied sciences, including the Research Group I am conducting my research for, collected practical knowledge in collaboration with various mental healthcare institutions about the impact of technology in the care process. The use of technological applications to provide telecare to patients in the mental health sector was already increasing steadily, but due to the COVID-19 pandemic it suddenly accelerated. The ongoing research on best practices of Blended Care in the mental health sector was redirected to mapping the gains and obstacles of current mental health practice, in which care at a distance became the new normal. The data collection took place in the first COVID-19 wave, which made it possible to collect the opportunities and obstacles regarding care at a distance 'in the heat of the moment'. The KIEM project group used both qualitative and quantitative research methods. For my research, the qualitative research data was used to gain insight into the story of healthcare professionals, and to get a feel for 'the language' they speak.

The project group conducted interviews with 17 healthcare professionals. Respondents received an information letter prior to the interviews. The content of this letter was discussed in the online introductory interview (30-45 minutes), after which online consent was given. The initial interview was followed by another four to six weeks of weekly online interviews (15-30 minutes). The researchers used topic lists and interview protocols. The interviews were anonymously transcribed and coded. The recordings, transcripts, topic lists, and coding lists were used for orientation of the healthcare practice.

EXPERT INTERVIEWS (N=3)

During my master's thesis, I had a valuable network of researchers, healthcare experts and healthcare professionals. I was able to share and discuss my insights from the KIEM data and my concerns with three researchers involved in the KIEM project, two of whom are also healthcare professionals, in the form of semi-structured expert interviews or a brief exchange of ideas with each other. This way, I was able to add layers and nuance to the insights.

FOCUS GROUP SESSIONS (N=6)

A total of three focus group sessions took place in which six mental health professionals within the Optimal Living Assen (OLA) team participated. Of these, five were psychiatric nurses and one was a social worker. The OLA team is a multidisciplinary team from different care organizations that provides outpatient care to the EPA target group (severe psychiatric disorders) in four neighbourhoods in Assen.

The focus group sessions were facilitated by a co-researcher who was also working on the development of a tool as an extension of the KIEM project, in her case an intervision model. The purpose of the focus group sessions was therefore twofold, on the one hand my fellow researcher wanted to test the effectiveness of her intervision model. And on the other hand, I wanted to experience and understand what happens when healthcare professionals talk to each other about the changing healthcare practice(s).

The respondents were close colleagues of the co-researcher and recruited by her. The co-researcher sent an invitation to her team resulting in an attendance of four colleagues for the test sessions of the first version of her intervision model. The insights from the first test sessions led to a second prototype which was tested again with the target group (N=3). The focus group sessions took place through TEAMS as a result of the measures of the COVID-19 pandemic. Respondents participated in the study on a voluntary basis. Prior to the focus group sessions, permission was sought to record the sessions with both audio and video. Patient information was kept confidential during the sessions. The recordings were transcribed anonymously and therefore not traceable to individuals.

After transcription, the recordings were removed. For the analysis of the focus group sessions, the transcripts were used for a thematic analysis, in which relevant passages were highlighted and open coded. Subsequently, these codes were merged into overarching themes, axial coding.

EVALUATION SESSIONS (N=1)

After each session, my fellow researcher and I listened back to the entire recordings and shared our initial insights with each other. These insights led to the improved version of the intervision model and helped me understand and value the meaning of the outcomes.

SECONDARY THEMATIC ANALYSIS CLUSTER OF CONSIDERATIONS

Insights from the focus group sessions and expert interviews led to a refined analysis of the cluster 'Considerations' from the KIEM project group's coding list. This cluster was used for a secondary thematic analysis, where the quotes from the cluster were categorised further into specific consideration factors, open coding. Subsequently, these codes were merged into overarching themes, axial coding.

The codes from the thematic analysis of the focus group sessions in combination with the thematic analysis of the cluster 'Considerations' were subsequently used to create an Affinity Diagram to provide a visual representation of the factors that play a role into the decision making for the form of therapy.

WORKSHOP DECISION MOMENTS (N=3)

The insights from the earlier phases led to a glimpse into the complex and multi-layered practice of care, in which personalised care is the goal of mental health professionals. Factors that play a role in the decision for the form of therapy have been identified. In addition, we saw that events in the life of the patient can lead to relapse or recovery and therefore impact how care is shaped. This led to the insight that, time after time, this reconciliation is required, resulting in numerous decision moments. I have tried to map and illustrate these decision moments and the factors that are considered by mental health professionals. The illustrations were presented during a workshop, using MURAL and TEAMS, to three healthcare experts (two of whom were healthcare professionals).

The aim of the session was to creatively verify the bundled considerations and check whether any factors or decision moments were missing. Additionally, the aim was to find out if the illustrations appeal to the imagination by means of an immediate 'test' whether illustrations can be used in the final tool. Prior to the workshop, permission was sought to record the sessions with both audio and video. The transcriptions were anonymous and the recording was deleted after transcribing.

MEMBER CHECK (N=2)

The insights from the previous phases have led to the understanding that customised care requires new decision moments time after time, causing the way care is shaped around various factors (i.e., 'the story') to be different every time. I have tried to capture these stories within current practice scenarios, which have become exemplary not with the aim of being exhaustive, but with the aim of illustrating the layered complexity of care practice.

For this purpose, 'tension fields' were first formulated: consideration factors that are 'opposite' to each other and which are 'weighed' up. This list of tensions was discussed with two KIEM researchers, a psychiatric nurse and an expert by experience[1]. The input has led to enrichment of what has already been described, resulting in version one of the scenarios. These scenarios were presented to the psychiatric nurse using TEAMS. This feedback was then processed again, resulting in version two of the scenarios. This was again discussed, but this time with the expert by experience on TEAMS. This led to version three of the scenarios.

PEER REVIEW (N=1)

Since the scenarios are based on data obtained via the members, or data known to the members. A peer review was held with a GZ-psychologist in a personal capacity in order to test the recognizability of the scenarios with a complete outsider. The respondent received an information letter prior to the session after which online consent was given for participation in the study. The session was recorded with both audio and video and transcribed (transcriptions were again anonymous). After transcribing the recording was deleted.

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[1] Someone with experience as a patient in mental healthcare, who has transformed this experience into experiential knowledge and who is able to apply and transfer this knowledge to others professionally.

MEMBER CHECK (N=1)

From the current practice scenarios and all insights from the previous phases, three pillars strongly emerged which were processed into three possible desired future practice scenarios. Based on the insights and the theoretical framework, one desired future practice scenario was chosen for the design vision of the tool. The chosen desired future practice scenario was then discussed several times with my former mentor of the Research Group and fine-tuned together so that the direction of the desired future could be tuned.

EVALUATION SESSION (N=3)

Using the desired future practice scenario, design guidelines were created. Using these guidelines, six concepts were devised and presented to a mental healthcare expert panel consisting of two KIEM researchers and a psychiatric nurse. The concepts were provided with feedback and jointly assessed against the design guidelines using MURAL and TEAMS. The session was recorded with both audio and video and was transcribed (again anonymous), after transcribing the recording was deleted. The outcomes of the session led to the refinement of the evaluation criteria from which a final concept direction could ultimately be chosen.

MEMBER CHECK (N=2)

The final concept was further developed by me. For the substantive themes, I once again sparred with one of the experts from the evaluation session. The concept in its completeness was also provided with care content, design and language technical feedback by my former mentor of the Research Group.

PEER REVIEW (N=3)

The final concept was reviewed in its completeness by three peers. These consisted of a content creator, designer for visual and textual elaboration of the concept and a researcher from the Research Group with a healthcare background who went through the texts from the care-related perspective.

FOCUS GROUP SESSIONS (N=5)

The research has led to a rich and varied understanding of current care practice. How care at a distance can be of added value, how it can change care, but also what care professionals encounter during the deployment of care at a distance. What choices are available to care professionals and what impact does this have on care? These insights and experiences have been incorporated into a poster series. The goal was to inspire, inform and prompt mental health professionals to reconsider and discuss what different forms of therapy can bring to their care. Part of this series has been exhibited in a mental healthcare organization in Drenthe[2] and another part in Friesland[3]. This was spread over three weeks, where two subjects were exhibited per week. After these three weeks I visited one of the locations to collect the findings using a focus group session, the other location unfortunately could not be visited due to the COVID-19-measurements. Prior to the sessions, permission was sought for recording with both audio and video, and again, the sessions were transcribed (anonymous) and after transcribing the recordings were deleted. The sessions were of input to the recommendations and the implementation plan.

DIARY STUDY (N=0)

In addition to the posters, notebooks were left at the locations explaining the project and the poster series with the question if healthcare professionals wanted to write down what they thought of the topics and what it brought them. This was in preparation for the focus group sessions.

QUESTIONNAIRES (N=2)

Not all professionals could attend the focus group session and they could alternatively fill out a digital questionnaire for the evaluation of the poster series. Given the COVID-19 measures, the session in Leeuwarden was replaced with the completion of the questionnaire.

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[2] Optimal Living Assen (OLA team): The OLA team is a multidisciplinary team from different care organizations that provides outpatient care to the EPA target group (severe psychiatric disorders) in four districts in Assen.

[3] Early Intervention Psychosis Leeuwarden (VIP-team): A VIP-team aims to treat psychotic symptoms, especially in young people, as soon as possible after they occur in order to prevent aggravation.

03

CURRENT PRACTICE

This chapter describes the results of the first four phases of the Research through Design process, which resulted in insights into current mental health care practice where care at a distance became the way of contact in response to the COVID-19 pandemic. I will take the reader step-by-step through the various research and design methods and will show how they were intertwined and how the insights influenced the subsequent components. Herein, summary insights will be presented with reference to the appendices for the complete descriptions of setups and results.

3.1 GETTING TO KNOW THE PRACTICE

At the beginning of the project, I started writing a literature review and immersing myself in the already obtained data from the KIEM project 'Blended Care in the GGZ: learning from best practices' (2020). Researchers from different universities of applied sciences have been working together with various mental health care institutions to collect practical experiences on the impact of technology in the care process. Technology is playing an increasing role in healthcare, but not much is known about its impact on the quality of care. The application of technology in health care can result in both positive and negative effects. For healthcare professionals, it is important to avoid these negative effects and to purposefully apply the positive effects. The goal of the KIEM project was to collect data around current dilemmas in the implementation of blended treatment, but also to gain insight into new best practices.

And then came COVID-19, which took the project group and the mental health care institutions by surprise, like the whole world. The use of technological applications to provide care at a distance to patients in mental health care was already increasing steadily, but because of the COVID-19 pandemic, it suddenly went at a rapid pace. The ongoing research on best practices of Blended Care in mental health care was redirected to identify the gains and obstacles in current mental health care practice, in which telecare became the 'new normal'. The data collection took place in the first COVID-19 wave, which made it possible to collect the opportunities and obstacles with regard to care at a distance 'in the heat of the moment'.

This section first takes you through the brief insights from the KIEM data: how technology changed care, the technology's potential gains and the obstacles that were encountered. Subsequently, the insights from the KIEM data are held against what scholars from the field have described about what happened and changed in the field in response to the COVID-19 pandemic. I conclude with the insights from the expert interviews and KIEM project group members. This is necessary to ensure the correct interpretation of the insights and to be able to add nuance, as it soon became clear that I am dealing with a complex and layered healthcare practice.

INSIGHTS SECONDARY ANALYSIS KIEM DATA

The COVID-19 pandemic forced many mental healthcare professionals to rapidly switch to telecare. Care professionals who had already gained experience with this medium before the COVID-19 pandemic had a visible advantage over care professionals who had no experience with it. The interviews revealed that care professionals with no experience mainly focused on keeping in touch, whereas those with (some) experience were also able to successfully continue treatments.

Looking at the distinction between the purpose of the appointment ('maintaining contact' versus 'persistence of treatment'), we see that in the case of maintaining contact, a great deal of variation was applied in terms of the form of contact: calling, video calling and sending messages. In the case of treatment, online modules were used most often and combination modules with online group treatment were also tried out. Additionally, protocol-based interventions were translated into online mediums, such as EMDR.

Protocolled interventions seem easier to convert into online mediums because they are protocol-based and thus already defined. This is in line with what we have already seen in the theoretical framework, where Postel et al. (2013) even state that only well-protocolised interventions can be redirected to blended treatment. It seems that with protocolised treatments, the consequences and oversight of the steps to be taken are more understandable to healthcare professionals. This makes it easier to translate protocol-interventions to online platforms.

When the possibility arose to go back to face-to-face contacts, due to lifting of COVID-19 measures, many practitioners immediately switched back to 'business as usual'. This was done in spite of the positive experiences with care at a distance. This did not apply to everyone: especially the practitioners who already had experience with care at a distance did (partly) maintain this. From this we can learn that comfortable and effective use of care at a distance is also a matter of experience and habituation. Perhaps it thus also involves a learning curve, which I have already suggested as a possibility in **1. Theoretical framework.**

The easier persistence of telecare, by experienced mental healthcare professionals, could thus possibly be explained by that care providers indeed need to go through the learning curve again, on a smaller scale; this notion is based on Benner's skill acquisition model *From novice to expert* (1982), which emphasises the importance of gaining experience in order to learn skills.

Technology is changing care

The changing context in which the appointment takes place is changing the 'ritual' of therapy. Patients indicated that the drive to the therapist's office, sitting in the waiting room, the small talk and the drive home used to be parts of this 'ritual' as well. Now you switch on remotely and the conversation follows, resulting in new manners. How do you begin and end the conversation? The dynamics of a (video) call are different and can sometimes feel unnatural and business-like. Healthcare professionals talked about how it helped them by 'switching on and off' in a targeted 'light-hearted' way with for example small talk, which allowed the conversation to flow more 'naturally'.

Care professionals encountered unexpected situations. For example: nurses who saw patients appear before the webcam in a bathrobe or accompanied by a can of beer. These were situations they did not encounter in the treatment room, but now they suddenly had to deal with them on the spot. To what extent can healthcare professionals address this? After all, they are now entering the patient's home as well. The coordination in new situations between healthcare professionals and their patients is of great importance.

Where the office of the care professional was seen as a 'safe haven' by some of the patients, they are now asked to continue their appointments from the home or work setting. Not every patient feels comfortable having treatment sessions in this context, how open can the patient communicate when family members might also be able to hear the conversation? On the other hand, somebody else may find it easier to open up in their own familiar surroundings. It results in a certain (physical) distance and anonymity, which for some makes it easier to share their concerns.

The changed context also led to new topics of conversation, especially for nurses who previously only saw their patients in their treatment room. Being able to see the home environment of the patient resulted in a new layer in the treatment contact, with examples of patients proudly showing off their homemade furniture or chores they had completed. While the new context provides new topics for discussion, it also entails an invasion of the clinician's privacy as the patient now also sees some of the clinician's home situation. Some practitioners chose to make their backgrounds blurry or remove family photos from the wall. It presented the practitioners with the question: what aspects of your personal life do you want to share with your patient?

The home context can also act as a 'calming agent'. An example of this is a patient who met the practitioner online while their baby was present: this patient was now less likely to react angrily. Also, the 'delay on the line' that occurs due to the digital conversation resulted in decrease in angry outbursts. On the other hand, 'the little screen' also acts as a filter for the care professional. One care professional indicated that it made her less susceptible to the 'counter reflection'. The lack of physical contact can also act as a filter or calming agent, for example in couples therapy as partners tuned in remotely from different rooms. The participants in the conversation must be careful not to interrupt each other, which can also have a positive effect on the dynamics of the conversation.

Potential gains

Despite the sudden complete switch to care at a distance the healthcare professionals found it easier to provide telecare than expected in advance. Which they therefore shared with the researchers with some surprise. The obstacles turned out to be less significant than expected and there were even unexpected benefits. They also received many positive reactions from their patients about the care provided at a distance. It turned out to be a voyage of discovery for both the care professionals and their patients. As the weeks went by, they became more and more proficient in its use and combining applications was tried out. For example, one care professional indicated that the use of a good headset increased the naturalness of the interaction instead of the previously 'tinny' sound. Opportunities were discovered for updating medication while video calling through the use of both smartphone and laptop. Telecare thus results in more possibilities for shaping care, tailored to the individual, which could now be experienced by the care professionals.

Concretely, we can see that care at a distance results in easier involvement of relatives in the care process. Technology makes it easier to call in from a distance, and there is no need to plan a day (or part of a day) for this. It is also easier to have an available colleague or co-therapist join the conversation. This facilitates multidisciplinary contact, in which travel time and distance are no longer an issue because calls can be made from different locations.

This also offers opportunities for online group therapy, something that turned out to be quite possible online, to the astonishment of the care professionals. Despite the possibilities that video calling offers for group therapy, actually conducting group therapy online is more complex and difficult than doing it face-to-face. Face-to-face group therapy can already be challenging in itself. It can result in a dynamic that is sometimes more difficult for the care professional(s) to manage. After all, maintaining an overview and control in larger groups is a challenge in itself. The arrival of the screen in this dynamic makes it even clearer that maintaining an overview and control becomes more difficult in larger groups. Non-verbal coordination with colleagues is more complex online, as is the ability to respond to the nonverbal communication of the patients. It is therefore necessary to make good agreements with each other.

Practitioners have experienced that some patients are more open online: some patients experience telecare as even more accessible. Care at a distance is ideally suited for a 'quick check-up'. Online contact can result in possible time savings because the online conversations are often shorter than the regular face-to-face contacts. As a result, it can become easier to schedule a short 'in between' meeting. This can provide opportunities for more contact growth, through the use of more (short) contact moments.

Care at a distance has resulted in the possibility to maintain contact in times of the COVID-19 pandemic, something that was experienced as very pleasant. The common denominator of 'having to endure' COVID-19, and the unaccustomedness that went with it, was consciously used by various care professionals. Patients and care professionals were equal in this challenging and sometimes frightening situation, in contrast to their previous relationship.

The changed care practice also resulted in self-reflection among the care professionals, making them wonder whether face-to-face contact is always necessary or if interim (video) calling could also be applicable in some situations. This led to a more critical look at their own way of treating and maintaining contact, which may also have contributed to being able to see the added value of Blended Care. The nature of the weekly interviews added value in stimulating this reflection process, with the reflective and focused nature of the questions the researchers asked.

This gives rise to the question: could one say that the interviews stimulated the practitioner's self-questioning and in turn self-awareness?

Obstacles encountered

Providing care at a distance was an impactful as well as unexpected transition for many healthcare professionals in the mental health sector. Many care professionals were used to face-to-face contact, however, some of them already used online modules or (video) calls in between appointments. For them, the transition was less big and could be extended to even more online contact without major interventions. After all, Blended Care was already (partly) anchored in their care process. The care professionals with some experience were therefore less hesitant to act and the technical hurdles were not seen as insurmountable.

Nevertheless, for many the complete switch was a major challenge: processes had to be set in motion quickly. As a result, the focus was mainly on the practical matters. The appointments were mainly used for maintaining contact instead of continuing treatments. In the first COVID-19 wave, care at a distance was therefore mainly used to do 'quick check-ups' to keep in touch, rather than with the intended function of supplementing treatment.

The downside of care at a distance was also mentioned by care professionals: the lack of personal contact with patients makes it more difficult for care professionals to assess the situation because of the lack of contextual information. Care professionals do not only look at the face of the patient (which can also be seen with video calling), but also at the whole body language of the patient and the non-verbal communication. The 'atmosphere' is also more difficult to sense online: this can make it more difficult for the care professional to check whether the intervention is really 'hitting the spot'. Connecting with patients, specifically new patients, is also experienced as more difficult. It is therefore strongly preferred for intake interviews to be held face-to-face, in order to build a relationship of trust.

The possible time savings of shorter online meetings were experienced as an advantage. The downside is that the conversations are also instinctively more 'business-like' and 'goal-oriented' in nature, which can make the contact feel more superficial. The dynamic of a face-to-face conversation makes way for a question-and-answer structure. Especially at a time when you cannot sense how your patient is doing and whether your message is 'getting through'. The practitioner will have to ask more questions to find out what is going on.

With regard to the effect of the care provided, it was mentioned that care at a distance was perceived as less effective. The reason for this was that it was more difficult to check whether the intervention had the desired effect on the patient. In addition, not all treatments (especially visualization treatments) are currently suitable for telecare. The translation of protocol-based treatments to online mediums was quite possible, but it seemed to be difficult for mental health care professionals to translate non protocol-based treatments to online mediums. An example of this is whether it is possible to discuss traumatic events without physical closeness. The practitioner had to think about the possibility of the patient reliving a traumatic event and possibly losing touch with the patient during the session.

The switch from face-to-face contact to online contact is experienced by care professionals as more intensive. Physical complaints such as head and eye aches were mentioned. Where certain situations are more efficient, practical matters such as getting everyone into the online program takes more time. Care professionals were given the additional task of supporting patients in dealing with the video call software and the patient portals. Interfering factors such as poor internet connections and background noise sometimes resulted in patients being difficult to see or hear. The facilities offered by the organization were sometimes inadequate, and the stumbling block of the video-calling software not working on certain networks was experienced as disruptive. Therefore, some of the practitioners felt inadequate in the first COVID-19 wave. For them, the quality of the care delivered came into question.

HOW KIEM'S INSIGHTS RELATE TO SCHOLARS

The beginning of chapter **1. Theoretical framework** describes what is discussed in literature about the differences between face-to-face contact and telecare. Both opportunities and frictions of telecare and how Blended Care can add value to personalised care were studied. However, it seems that it remains difficult for healthcare professionals and patients to understand how care at a distance and Blended Care can add *concrete value*. It seems that the practical applicability in care practice is not sufficiently clear at this moment. Large-scale deployment of care at a distance and Blended Care have failed to materialise in recent years, despite several (small-scale) pilots that have published inspiring results.

Because of COVID-19, care professionals and patients had no choice; their wait-and-see approach towards care at a distance became a forced leap in the dark. In order to compare the insights of the KIEM with what others have written on the subject, this section focuses on what scholars in the field have published regarding the experience of the deployment of care at a distance at the emergence of the COVID-19 pandemic, given that the data from the KIEM was also collected in what we now call the first COVID-19 wave. Three articles are included in this comparison.

The first article that comments on the changes that telecare brings to the health care system is Blandford et al. (2020). The authors do not specifically address the changes for mental health care practice, but describe that COVID-19 resulted in having to overcome the barrier of changing work processes. Individuals had to redesign current care practices and look at what is possible and desirable in this rapidly changing world. The authors emphasise that telecare is not only about the technology but also about the change that occurs in work practices. Here, they mainly focus on the practical changes and the technological challenges involved. Blandford et al. (2020) formulate the encountered preconditions and argue that, in order to properly utilise the potential of telecare, care professionals and patients must be able to rely on digital systems. Their information should be secure and private. In addition, organizations will need to start collaborating to learn what worked well in which situations. They stress the importance of accessibility to a good internet connection and inclusion, which requires affordability of the necessary resources.

The KIEM data also shows that, in order to properly organise care at a distance, resources and systems are needed, as well as learning how to use them. This is in line with Blandford et al. (2020). However, the data of the KIEM goes further than just the preconditions, facilities and user-friendliness. The less tangible is most valuable: how technology is changing care, what these contextual changes mean for shaping care and how these changes can add value to the care offered. This builds on what is already discussed in the theoretical framework about the ideas of Actor Network Theory, that technology is not neutral and therefore will change care. Latour (1992) teaches us that not only human factors but also non-human factors such as technology have an impact on social situations.

Crowe et al. (2020) and Van Beek (2020) also pay attention to the changing healthcare practice, in addition to the technical challenges. They describe from their own experiences and those of their colleagues how telecare changed the healthcare practice at the emergence of COVID-19. Van Beek (2020) describes how the human contact between patient and care professional changed and for some even completely disappeared, and what uncertainty this brought. Therapists did not learn to conduct their therapy through this kind of medium, and did not know whether their methodologies were tested through the new medium. Despite the fact that much attention was paid to how contact was made, using which medium and the concrete changes this brought, Van Beek (2020) argues that we should instead be talking about the changing context of therapy. Continuing the current video calling policy on a large scale without nuance and overseeing the additional effects, and how this impacts the care that has been offered, serves no purpose (Crowe et al., 2020; Van Beek, 2020).

Both Crowe et al. (2020) and Van Beek (2020) address (some of) these contextual changes. They describe the arrival of therapy, not just the technology, in the patient's living environment. This was difficult for some and a relief for others. For some patients, the physical distance resulted in greater openness and less shame (Van Beek, 2020; KIEM data), whereas for others it was difficult to find a private place without being disturbed or overheard (Crowe et al., 2020; KIEM data). Crowe et al. (2020) describes that it is also important to dwell on 'entering into someone's personal space', in telecare this process of invitation is not always tangible. The ritual of therapy changes, such as coming to the treatment room and driving back home which was often a moment of reflection and contemplation (Crowe et al., 2020; KIEM data).

COVID-19 resulted in the obligation to stay away from each other, and in turn in an involuntary distance. This seems to clash with how the profession is viewed: now more than ever, it became clear that contact does not only exist for information exchange. But it is also about all sensory information, what needs to be sensed and the silences in between (Van Beek, 2020; KIEM data). Video calling on the other hand was never silent (Van Beek, 2020). This changed therapy and the contact between practitioner and patient.

Despite the fact that this resulted in the therapists' perception that the care provided was insufficient, limited research shows that patients disagree with that sentiment, and that online treatments can be effective or comparable (Van Beek, 2020). Despite the positive results, online treatment is hardly preferred by patients as a favoured medium in a general sense, in particular acceptance in advance is limited. Van Beek (2020) argues that this may be a result of the reflection of unfamiliarity and resistance among practitioners. He wonders if there are currently wrong assumptions about whether the usual face-to-face contact is really always necessary, which is also in line with what the KIEM has demonstrated.

He emphasises the remarkability of this situation. Why does one doubt their personal expertise when they are put behind a webcam but not at the moment when they have to work in another treatment room? The new context and the new means thus come with uncertainty. Van Beek (2020) wonders if this discomfort reflects the therapist's own fear of the COVID-19 period. Indeed, the therapist's life also changed drastically. Practitioners were looking for something to hold on to, as they could not fall back on the certainty of their learned skills in their regular environment. This uncertainty and feeling of incompetence was also strongly noticeable among the respondents to the KIEM study. Therefore, I don't find it surprising that healthcare professionals went back to 'business as usual' when they were allowed to, in order to regain a foothold in a world that was and still is uncertain.

However, it remains to be seen whether the perceived sense of incompetence reflects the discomfort of the COVID-19 pandemic. Both Crowe et al. (2020) and Van Beek (2020) cite literature that discusses the effectiveness of remote psychotherapy compared to face-to-face therapy. They refer to research findings which were collected before the COVID-19 pandemic. Van Beek (2020) refers to a study by Perle et al. (2012) that investigated the acceptance rate of online interventions in mental health care. Despite the fact that two-thirds of psychologists were open to computer-based interventions, the study showed that only 21% of healthcare professionals felt competent enough to conduct online treatment. This sense of incompetence is thus not new: I expect that it was therefore two types of insecurities that reinforced each other. First, the feeling of incompetence with new tools and methodologies; second, the uncertain period in which it had to be integrated in rapid succession. Perle et al. (2012) also shows that the acceptance rate increases when healthcare professionals and patients have used the new tools and methodologies before. The importance of gaining experience (which is in line with Benner (1982)) comes into play here as well.

INSIGHTS EXPERT INTERVIEWS

During the project I had a valuable network consisting of researchers, (care) experts and mental healthcare professionals. I was able to share and discuss my insights from the KIEM data and literature, as well as my reservations about them with three researchers of the KIEM project, two of whom are also healthcare professionals.

It has become clear to me that I was dealing with a very complex and layered healthcare practice. Semi-structured expert interviews, and more casual conversations, were used to add stratification and nuance to the insights. The focus at the beginning of our contact was on sharing and understanding the gained experiences with telecare during the COVID-19 pandemic of themselves or (interviewed) fellow healthcare professionals, as well as sparring about how these insights relate to previous or other research. As time went by, when I had a slightly better understanding of the current mental healthcare, I actively questioned them about noteworthy situations. During the conversations, I asked them how they would have acted if the situation had been slightly different. To gain a better understanding of how they weighed the factors that played a role in deciding how to act, what to prioritise and why.

At the same time, the media were full of articles about how the COVID-19 pandemic had 'finally' opened the door to telecare and that healthcare professionals could 'finally' put their cold feet aside (e.g. MedNet, 2020; EenVandaag, 2021). I see and saw it more as a forced leap into the dark, where there was no choice but to offer care at a distance. It was by no means always as beautiful and promising as it appeared in the media. Dramas played out on treatment facilities, crisis services, and in chronic psychiatry (Van Beek, 2020). There were harrowing stories of patients who became completely disturbed or out of touch, as well as confused and suspicious patients (Van Beek, 2020; Visser, 2020; KIEM data).

The COVID-19 pandemic had resulted in great new practices, but also demonstrated that telecare is not suited for every patient. The stratification, complexity and nuance within this healthcare practice became increasingly clear and both healthcare professionals in my network underlined the importance of personalised care. And that this personalised approach requires consultation with the patient, and continuous adjustments.

CONCLUSION

Care at a distance was used as an *alternative* to face-to-face contact, instead of the always intended *supporting* function of online treatment and online forms of contact in addition to face-to-face contact. I believe that, as long as we continue to see telecare as a counterpart to face-to-face contact, the preference would continue to be given to face-to-face contact. It seems that many practitioners view these two types as mutually exclusive, which causes the wrong assumptions about care at a distance to remain.

It appears to be difficult for therapists to see the concrete added value of care at a distance for themselves. Some practitioners assume that face-to-face contact is more popular among their patients, with the result that they sometimes do not even discuss care at a distance with their patients as an option. Benefits for patients have been observed, but it seems that there is no conscious use of the perceived benefits, as practitioners almost completely returned to 'business as usual' face-to-face contacts after the first peak of the pandemic. In addition to not consciously using the perceived benefits for the patient, it remains to be seen what the benefits really are for the practitioner.

The *'promised'* time savings of care at a distance or Blended Care, would be better to write off as *possible* time savings, and perhaps even in some cases as *no time* savings at all. After all, effective use of telecare also requires a time investment and follow-up from the practitioner, which therefore does not always result in this *'promised'* time gain. Especially during the implementation and embedding phase, there is a good chance that it actually costs more time than it saves. It should therefore not be about the possible time savings, but about how it can benefit the care and thus the recovery process of the patient.

The consideration of which treatment or contact options are used and discussed by the mental health professional seems to be influenced by many different factors. As also their personal preferences in this contact. In order to make mental health care professionals sensitive to the different choices they have for the form of therapy I will first focus on mapping these 'consideration factors' that play a role in the decision-making process. Additionally, the impact of these factors on the chosen form of therapy or contact and in turn on the care offered will be discussed.

3.2 DECISION MAKING IN PRACTICE

Parallel to the previously described **3.1 Getting to know the practice**, I have worked together with a post-HBO Health Innovation master student from NHL Stenden University of Applied Sciences. This collaboration gave me the opportunity to discover in practice what plays a part in the decision-making process for the form of therapy of mental health care professionals. My co-researcher is a mental health nurse and was developing a tool in line with the KIEM as well. When we first met, I was working on my contextual analysis which consisted of desk research and the secondary analysis of the data from the KIEM project. She had just completed her contextual interviews to better define her problem definition and was in the process of idea generation for her tool. Her problem statement read:

> *"Patients from the EPA target group (severe psychiatric disorders) depend on the personal preferences and attitude of caregivers towards digital care or possibilities of it are discussed with them, while it is important to discuss and weigh all the different treatment options together."*

This problem statement is based on the insight that mental healthcare professionals prefer to act based on their own repertoire, intuition, embodied knowledge and the familiarity with the forms of therapy. As a result, not all possibilities are discussed with patients: only those possibilities that are known or preferred by the care professionals are discussed. In the contextual interviews, her colleagues emphasised the importance of acting from shared decision-making, in which the personal preferences of the patient should also be considered more. The team already saw the added value of digital care, but it was not yet a regular part of their working routine.

Our first contact moments were devoted to sharing our insights and asking the mental health nurse about her personal experiences with care at a distance. While sharing practical experiences, I was triggered by the choices she had made and actively asked her how she would have acted if the situation had turned out slightly different. With the aim of stimulating reflective thinking, the questions prompted the mental health nurse to reflect more deeply on her own actions resulting in in-depth conversations. My questions often resulted in reactions like *"I hadn't thought about it that way myself"*.

The care professional told me about a patient who went into 're-living' during the video call. She 'lost' her patient, not only in a figurative sense, because the patient stared blankly ahead and stopped responding: also in a literal sense, because her patient eventually broke down the connection. This was an unusual situation, which required the care professional to act quickly. Fortunately, this patient lived under supervision and supervisors could be called to take care of the patient immediately. With this, the story was 'finished'.

Yet, this triggered me in different ways. I asked her what she would have done if this patient had lived alone somewhere in a small student room. "Yeah, then I would have gone there". But what does this mean for your other patients? "I build in some time between my patients, and fortunately all patients live close by". Okay, but if that had not been possible, would you have been able to reach someone else? "Yes I have the contact information of the mother of the patient, then I would have called the mother I think." Okay, but what does this mean for this mother? Can the mother leave immediately or do you then leave the mother in stress and worry? "Yeah, I had not actually thought of that..."

Personal communications with my co-researcher (A. Ytsma, April 19, 2020).

Considering one of the theoretical concepts (affordances), it seemed that the invitation to continually think critically on her own actions was missing. In that sense, the affordance for reflective thinking on her own actions is lacking. This is also related to what Teekman (2020) taught us: self-questioning is currently primarily an automatic response to unusual events rather than a response to routine situations.

However, the situation she described was unusual in character, as it was a remarkable situation she had to deal with on the spot during the beginning of the COVID-19 pandemic. Nevertheless, she had dealt with it and that seemed to be the end of it. She had not really thought about this situation anymore, nor did she look at other factors that could have influenced her decision-making, as I tried to do with the questions I asked.

The mental health nurse indicated that she enjoyed discussing and evaluating the situation with someone else. It became clear that the questions I asked were not really questions that she asked herself or that colleagues asked each other. Because of the current repertoire and acting in the rush of the day, based on intuition and routine, reflection seems to be absent. Mental healthcare professionals have a long to-do list which causes them to prioritise, resulting in things that are 'left open' (A. Ytsma, personal communications, April 19, 2020). For the discussed desire, as well the discovered importance for self-reflection or team reflection, there is unfortunately not enough time at the moment, or made available (Focus group sessions, 2020; KIEM, 2020).

FOCUS GROUP SESSIONS

In the conversations with my co-researcher the importance of reflective thinking became increasingly apparent. In combination with her previously described problem statement, this eventually led to an intervision model which was intended to:

> *"Learning mental healthcare professionals to become aware to explore new possibilities of digital care together with patients from the EPA target group by discussing unknown considerations with each other in order to learn from each other and to motivate each other to step out of their comfort zone."*

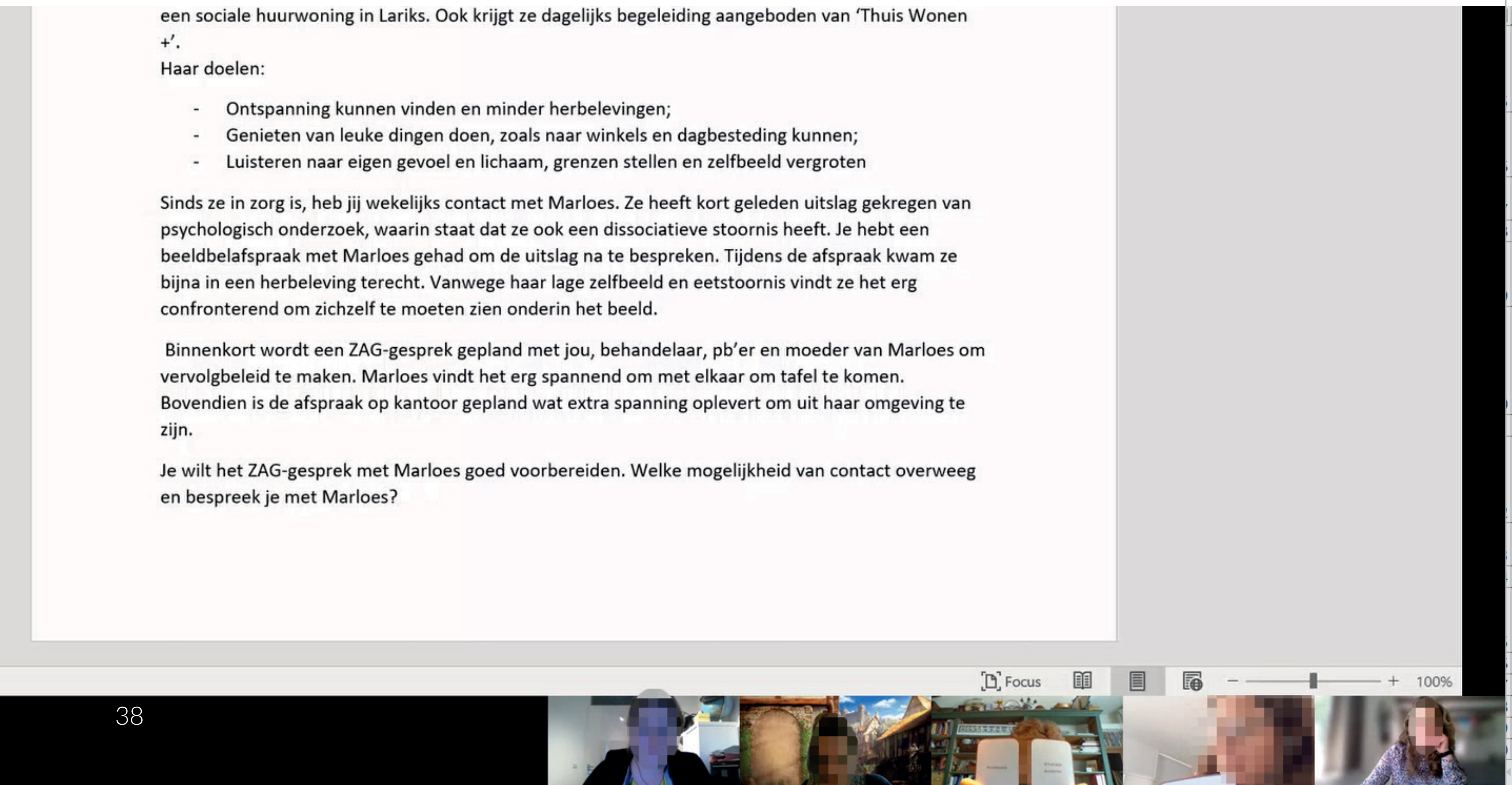
To test her intervision model, my fellow researcher facilitated three focus group sessions. In two of three sessions, I acted as second observer. With the help of the intervision model, we tried to invite the care professionals to reflect on their own actions and to become aware of the impact of their own repertoire on the care offered. Additionally, the model stimulated the consideration of alternative possibilities that could be used as well and what this would require from their skills and knowledge. The development of the intervision model was iterative. The first version was tested in two sessions and the optimised second version in one session (Figure 3). For the concrete setup and overview of the respondents of the focus group sessions, see Appendix 1.1.

The purpose of the focus group sessions was twofold. My fellow researcher was focused on testing the effectiveness of the intervision model. Personally, I had several goals. I had already seen in the KIEM data that how care is shaped, and which kind of therapy is used, seems to depend on all kinds of factors. During the interviews, I was therefore curious about (1) which consideration factors influence these mental healthcare professionals, in what proportion and to what extent. Moreover, I was curious about how their considerations would change when the care situation slightly changes. In addition, I was interested in (2) what happens when you offer alternative forms of therapy and ask mental healthcare professionals to actively discuss what this requires of their knowledge and skills. Lastly, I was curious (3) to learn to what extent talking about these consideration factors and alternative forms of therapy contributes to reflecting on one's own actions and creating awareness.

For the analysis of the focus group sessions, the transcripts were used for a thematic analysis, where relevant passages were highlighted and then open coded. This list of codes was then aggregated into overarching themes, axial coding (Figure 4). This resulted in eight themes: personalised care, changing care practices, consideration factors, safeguarding and follow-up, repertoire, necessity of gaining experiences, the importance of dialogue and awareness.

The themes reflect the considerations and factors that influence the decision-making of the interviewed mental health care professionals. What, according to them, would be the impact of alternative forms of therapy on the care they offer? What do they encounter in the implementation of Blended Care and what is important for them to 'steer' this in the right direction? Appendix 1.2 describes the meaning of the themes, supplemented with quotes from healthcare professionals. In the following pages, the outcomes regarding the three goals for the focus group sessions will be discussed.

Figure 3: Testing the intervision model, respondents were given a case study and could indicate their chosen form of therapy by using the cards



een sociale huurwoning in Lariks. Ook krijgt ze dagelijks begeleiding aangeboden van 'Thuis Wonen +'.
Haar doelen:

- Ontspanning kunnen vinden en minder herbelevingen;
- Genieten van leuke dingen doen, zoals naar winkels en dagbesteding kunnen;
- Luisteren naar eigen gevoel en lichaam, grenzen stellen en zelfbeeld vergroten

Sinds ze in zorg is, heb jij wekelijks contact met Marloes. Ze heeft kort geleden uitslag gekregen van psychologisch onderzoek, waarin staat dat ze ook een dissociatieve stoornis heeft. Je hebt een beeldbelafspraak met Marloes gehad om de uitslag na te bespreken. Tijdens de afspraak kwam ze bijna in een herbeleving terecht. Vanwege haar lage zelfbeeld en eetstoornis vindt ze het erg confronterend om zichzelf te moeten zien onderin het beeld.

Binnenkort wordt een ZAG-gesprek gepland met jou, behandelaar, pb'er en moeder van Marloes om vervolgbeleid te maken. Marloes vindt het erg spannend om met elkaar om tafel te komen. Bovendien is de afspraak op kantoor gepland wat extra spanning oplevert om uit haar omgeving te zijn.

Je wilt het ZAG-gesprek met Marloes goed voorbereiden. Welke mogelijkheid van contact overweeg en bespreek je met Marloes?

Figure 4: Part of the thematic analysis focus group sessions

A	B	C	D	E
	D1: Ja beiden, ja beiden, ja daar moet je erg transparant in zijn. Ook elkaar motiveren, maar ook cliënten bewegen, dat dit ook een hulpmiddel kan zijn. Ja niets moet, maar soms is het ook een eyeopener voor cliënten. Er zijn ook wel veel mensen die dit juist als uitdaging hebben, en ik denk dat ik ook zo zou zijn. Dat ik de hulpverlener zou zeggen, doe mij maar wat huiswerk, wat ik eerst eens kan doorlezen en dan hebben we het erover. Dat zou mijn methode ook zijn. En als je zo in elkaar zit, dan doen we mensen tekort bij wie we dit eigenlijk nalaten	1	1	
	D2: En voor mij niet alleen die tijdsplanning maar vooral die bewustwording, ik merkte daarstraks ook wel van oh dan komt er bij mij zelf ook van alles opborrelen, wat ik dan in de praktijk niet toepas, maar wat kennelijk wel ergens in mijn hoofd zit en dan helpt het wel om het met elkaar erover te hebben.	1	1	
	D1: Ja, zoals we nu bij elkaar zitten, en dan teambreed, dat zou ongetwijfeld ook stimulerend werken. D2: Ja, dan komen er vast nog zoveel meer ideeën en mogelijkheden ja met elkaar.	1	1	
17. Doen helpt bij link leggen naar andere cliënten	D2: Los van durven, je gaat er ook makkelijker aan denken. Dat merkte ik bij deze cliënt, las ik het dan in de rapportage terug van mijn voorganger, dat die het wilde inzetten, anders had ik het zelf ook niet bedacht, maar daardoor dacht ik bij een volgende cliënt weer van hé voor diegene zou die module wel geschikt zijn. Ik denk ook dat als je het eenmaal toepast dat je het dan ook makkelijker met elkaar aandenkt.	6	6	
	O2: En heb je ook weleens situaties waarbij je het prettiger vindt om het telefonisch te doen, koppel je het dan ook aan andere cliënten om het uit te proberen? D1: Ja, dat doe ik ook, klopt, want ik heb toch wel, ik voel me ook wel genoodzaakt om het echt praktisch te houden. We hebben ook soms wel veel reistijd, dus dan voel ik mij ook wel verantwoordelijk om dat te verminderen, dus als het net zoveel oplevert, ja zeker dan kies ik daarvoor. En bij sommige is dat zeker het geval.	6	6	
18. Borging binnen betrokkenen, continuïteit van de zorg	D1: Maar ik haak even in op hoe geven we vorm aan behandeling, ik vind wel dat duidelijkheid daarin erg belangrijk is. Vorige regiebehandelaar zette weleens huiswerkopdrachten in, maar dat vind ik wel een beetje apart dat ik daar dan niet vanaf weet, terwijl ik wel betrokken ben bij de cliënt. Ik vind dat wel belangrijk. Waar is deze cliënt mee aan het werk? Anders vind ik het niet zorgvuldig, dan kan ik ook niet signalen oppakken wat dat doet met iemand. Die continuïteit van de zorg, vind ik dan wel een punt.	10	3	
	D2: Ja ik kan mij inderdaad voorstellen dat het veel minder effectief is, als je het niet ook echt met elkaar opvolgt. Als je als team van elkaar weet die module is ingezet dan kan je ook daar adequaat op reageren.	10	3	
	D1: Zou ook terug moeten komen in het behandelplan, daar moet het in te vinden zijn. Of in een HOP. Het moet ergens te vinden zijn, zorgvuldig.	10	3	
	D2: Ik merk bij mijzelf ook wel een soort schroom om het zomaar toe te passen, ofzo, ik vind het dan wel belangrijk om dat dan of samen met de regiebehandelaar of teambreed eerst te bespreken. En ik vind het dan wel zonde als we in zo'n sessie ideeën hebben, en het daarna niet vastleggen en het dan verdwijnt.	10	3	
19. Voorkeur cliënt meenemen	D1: Ik zou in ieder geval aan haarzelf vragen waar voelt zij zich er beste bij.	9	2	
	D1: .... Dat zou allemaal ingezet kunnen worden bij deze cliënt, maar dat zou ik ook erg bij haar willen checken en voorbereiden.	9	2	
	D2: Vooral belangrijk van wat de cliënt zelf wil inzetten en aan wil werken.	9	2	
	D1: Dus ik zou het met haar bespreken.	9	2	

1) Impact of the consideration factors

The interviewed mental healthcare professionals stressed that shaping care is always an ongoing process of re-evaluation. This is in line with the data from the KIEM and expert interviews. Whether or not to 'intervene' or 'change course' is something they 'quickly weigh up in their heads', based on intuition, experience and routine. When there is a crisis or an unexpected event occurs and the patient comes into contact, they quickly decide whether or not to take immediate action. They look at the severity and seriousness of the situation, whether it is an exceptional situation for the patient and whether the patient is responding in line with expectations.

> *"It's always an assessment you make with all the factors that play a role. Something you weigh up in your head, very quickly: should I be worried or not, should action be taken, why or why not. If family members are worried, there's another component that comes into play, which you have to comply with. And that leads to other actions and considerations as well."*
> *Respondent 4, mental health nurse*

The sessions provided deeper meaning to the understanding that decision-making seems to depend on dozens of consideration factors, which was already observed in the secondary analysis of the KIEM data. We discussed the impact of personal preferences of both themselves and their patients. What factors play a role for them in the decision, as well as what they need from a preconditional point of view to be able to provide care at a distance was discussed. These topics correspond with the topics of the KIEM interviews.

In addition to this, the team has mentioned the 'recovery phases' as an important consideration factor, as the team is focused on recovery-oriented care. They therefore use the recovery phases that are known within the mental healthcare sector. Consisting of (1) being overwhelmed by the condition whereby the patient is in crisis, (2) struggling with the condition, (3) living with the condition and (4) living beyond the condition. For the healthcare professionals, the recovery phases are in line with the stability and state of mind of the patients.

The more progressed the patient is in his or her recovery, and the more insight there is into the condition, the more they believe that care at a distance is possible and could supplement regular treatment and contact. Transitioning to a different stage of recovery is something that is discussed with the patient, but at times like this, healthcare professionals do not yet consider and discuss whether this might mean something different in terms of how contact is established.

Besides that, it became clear that (unexpected) events in the life of the patient can result in recovery or in a relapse. During the recovery process of the patient, there are a lot of decision moments that are formed around these events and considerations, which can have an impact on each patient in a different form, at a different moment and in a different proportion.

2) Effect of talking about alternative forms of therapy

When we asked the care professionals to think about alternative forms of therapy, it quickly became clear that there is a sense of incompetence among the care professionals. This is in line with what we have seen in the literature, resulting in hesitation to act (Van Beek, 2020). The feeling of incompetence keeps care professionals from 'daring' and 'being able' to use care at a distance. On the one hand, they are not yet aware of what is possible or what tools there are to help them become familiar with it. This prevents them from being able to recognise the technology as new affordances. In this sense, you could say that the new possibilities are not recognised by the mental health professionals. On the other hand, they are familiar with the existence of the possibilities, but believe that they need to know the content of what they are offering. They want to be able to make an informed assessment of why for example an app or module might be suitable for their patient. Because of the unfamiliarity with the content, they cannot make this assessment (sensitively) sufficiently. Therefore, the new possibilities are not considered and discussed.

The repertoire of healthcare professionals influences how care is shaped. As stated before, expanding the repertoire of actions requires gaining new experiences in new contexts and/or using new forms of therapy (Benner, 1982). The need to gain experience with the new technological possibilities was therefore strongly emphasised in the interviews with the care professionals. The current repertoire, based on intuition, previous experience and knowledge, results in routine work. As a result, care professionals rarely gain new experiences with the new possibilities that technology offers.

The COVID-19 pandemic has resulted in being able to gain these new experiences with care at a distance. New best practices have emerged, which likely would not have been acquired without the COVID-19 pandemic. Experiencing the positive side of deploying new forms of therapy seems to make it easier to sustain the deployment. This has the side effect that the form of therapy is more likely to be identified as an option and to be discussed with other patients. This once again underlines the importance of gaining experience.

> *"Respondent 1 (social worker): I have a patient who has had years of trauma treatment, and is now stabilising again in the home situation, and eh yes, she talks just as easily on the phone as face-to-face. I actually do have the feeling that she talks more easily when we don't see each other than when we do. So it doesn't have to be that face-to-face is always the best way to go. And I notice with her that the conversation just goes smoothly. After an hour, I really have to tell her it's done now.*
> *Interviewer: And is that something you discovered with her during COVID-19? Or was that before that already?*
> *R1: Yes, that's a good question, during COVID-19.*
> *I: And is that something you're consciously maintaining now?*
> *R1: Yes, right*
> *I: Does this make you more likely to consider calling as a form of contact?*
> *R1: Yes, indeed, that is true!"*

The dialogue, like the ones we had during the focus group sessions, was perceived as very important. By scheduling a moment to reflect on the alternative possibilities, time was created to really dive into a case together. The exploratory atmosphere, the constant questioning, the visually offered treatment and contact possibilities with the help of the cards made it possible to go deeply into the effects of the form of therapy. This made it possible to weigh up why it would be suitable or not for the patient and what it would mean for their knowledge and skills if the alternative method would be chosen. It was of added value that this was a team affair so that they could discuss it with each other: this way, they could learn from each other and each other's experiences.

The care professionals also stressed the importance of carefully embedding new treatment and contact possibilities. Safeguarding within the team was therefore extensively discussed in the focus group sessions. When there is no communication among involved practitioners about the fact that new forms of therapy have been initiated, changes cannot be actively signalled.

The topic of Blended Care is not yet high on the team's priority list, even though the care professionals believe it is important that this becomes a team subject. They want to learn from each other and spread the 'investigative burden', since it became clear that they are currently reinventing the wheel individually and concerns are not being shared. Good ideas were discussed, such as the team-wide creation of an inspiration folder or including care at a distance structurally in the policy and team meetings. It was remarkable to hear that they did not even know from each other that they were facing the same obstacles.

> *"We never discussed it in the team like this before. It's not really an agenda item now. We are all dealing with the subject individually. Some have more affinity with it than others. I don't even know that about my colleagues."*
> *Respondent 4, mental health nurse*

3) Reflection on own actions

The sessions demonstrated that the care professionals were used to acting from their known repertoire. They sometimes ask themselves whether the chosen form of therapy still does justice to the intended goal. To determine this, they focus on what the purpose of the contact is and whether this goal is 'achieved' with the way care is shaped. However, according to literature, this form of self-reflection could be classified as reflection-in-action, since this reflection takes place in an implicit way while working, without explicitly taking the time for it (Den Boer & Hoeve, 2017). During the intervision moment, we did take this explicit time for reflection on everyone's own actions, which allowed the care professionals to gain insight into their own assumptions:

> *"Yes, that's actually how I usually do it. I think that's what someone would like the most, to see each other face-to-face. I prefer it myself, I assume that it is also more pleasant for the patient but I am not sure about that, it is just an assumption."*
> *Respondent 4, mental health nurse*

The intervision moment also allowed healthcare professionals to openly discuss what kind of care they would want to receive if they had been patients. They realised that they are currently failing their patients when they do not become more receptive to alternative forms of therapy.

> *"Yes you have to be very transparent in that. Motivating colleagues, but also moving patients, that this can also be a tool. Nothing has to be done, but sometimes it can be an eye-opener for patients as well. And I think I would be the same. That I would say to the healthcare professional, just give me some homework, which I can read through first and then we'll talk about that the next time. That would be my preferred approach as well. And if you're like that, then we're failing people with whom we're actually neglecting to do this." Respondent 1, social worker*

The effect of the intervision moment, and the awareness it resulted in, is quite visible among the respondents. The respondents afterwards turned to my fellow researcher to help them find out more about the digital possibilities that the organization offers them.

> *"Yes this motivates me to look it up again and start doing it again. I have been working on it for a while, but it didn't work out, so I left it as it was. But yes... Yes, I do think it's a very beautiful tool, and also see reasons for implementing it. Yes I will start over again. Yes, that's what I'm committing myself to now." Respondent 1, social worker*

CONCLUSION

One could say that, given the positive reactions and the increased awareness of the theme Blended Care and the expressed motivation to delve more deeply into it once again, the purpose of the intervision model has succeeded. However, the working principle behind the intervision method has already been delivered as an instrument by, among others, the Research Group IT Innovations in Health Care, my graduation place. In the project 'Beeldbellen in de GGZ' in 2017, an intervision tool was developed that was aimed at reflecting on one's own actions. The aim was that care professionals would gain insight into their own learning and thinking processes. They were prompted to think about what impact this has on the care offered to increase the effectiveness of their actions. Despite the different look and feel of the instruments delivered by the Research Group compared to the intervision model we tested, and the extra component regarding thinking about alternative forms of therapy that we have added, the working principle was the same.

However, the delivered instruments in 2017 are seldom or not used in practice. It is therefore questionable whether the intervision model will be adopted by the team in the long run. Instruments and tools are available to healthcare professionals, but they do not seem to be used. A logical explanation for this could be that there is simply no time for it, and that reflection-in-action is considered in the rush of the day, but that focused reflection-on-action is not sufficiently embedded in work practice. However, respondents are receptive to this and believe that it should become part of the practice and be supported team-wide.

Would a driving force for this be lacking in the team? Or the stimulus, the trigger, to make time for this reflection-on-action? On the other hand, the 'problem of articulation' probably plays a role in this as well, as we have seen in the theoretical framework that it is difficult to put know-how knowledge into words.

Several factors can and will play a role in the lack of reflection-on-action. These not only include the already discussed lack of time, lack of stimulation and the difficulty of sharing and obtaining best practices. The dynamics within a team, the increasing caseload, the growing waiting lists and the pressure on the mental health care system could also be possible factors that are part of this problem. Although I do not know what the holy grail would be, I do not believe that tools that require a lot of effort and time will find their way into the *current* work practice given that healthcare professionals should first be given more time for this.

Stimulating the awareness and triggering reflective thinking by means of a planned intervision moment led to powerful insights and discussions among the care professionals. The working principle seems to work, however, the implementation does not match the hectic working practice. It would therefore be interesting to look for an accessible trigger that could inspire reflective thinking of a healthcare professional or a team of care professionals in order to consider different forms of therapy and evaluate the consequences of the choice.

3.3 DECISION MAKING AND WHAT MATTERS

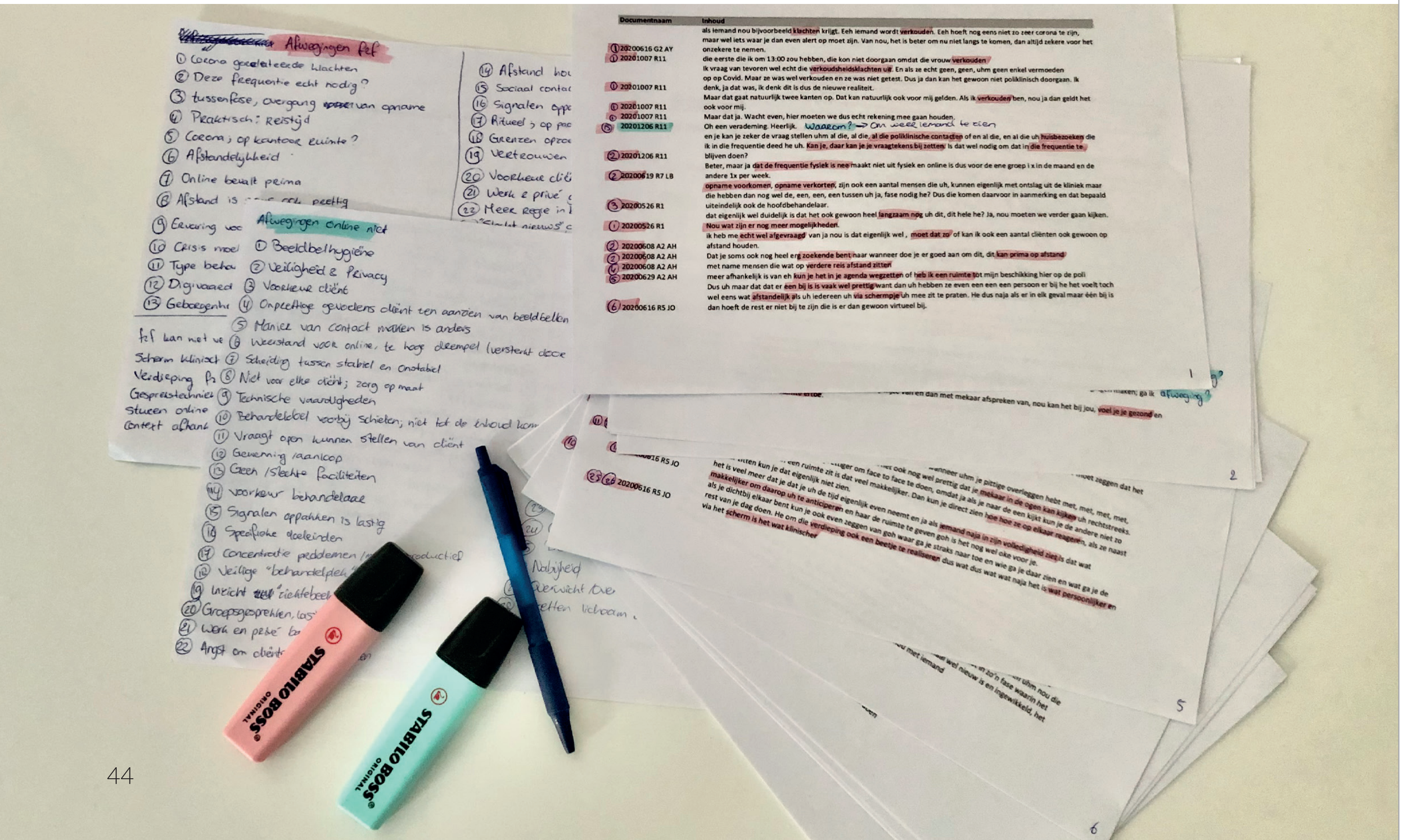
The insights from **3.1 Getting to know the practice** in combination with **3.2 Decision making in practice** resulted in a re-analysis of the coding list of the KIEM project group. The first analysis (3.1) focussed on how care has changed and had already revealed that dozens of factors seem to play a role in the decision-making process of the choice between different forms of therapy. The focus group sessions enriched this insight. In the literal sense by bringing up more consideration factors than had already been seen and in the figurative sense by enriching the meaning and importance of the consideration factors that had already been seen. Because of these additional insights, a targeted secondary thematic analysis of the cluster 'Considerations' of the coding list of the KIEM project group was done (Figure 5). The aim of this was to map these considerations in a more concrete manner. In order to do so, the cluster 'Considerations' was printed out and open coded. This resulted in a long list of consideration factors that play a role in decision-making.

AFFINITY DIAGRAM

This list of consideration factors was then used for an Affinity Diagram. Its goal was to classify the large amount of consideration factors into groups to structure the large set of data. This resulted in a visual representation of the mutual relationships (Figure 6, next page). This overview also includes the considerations that emerged from the focus group sessions. Consideration factors that originate from both the KIEM and the focus group sessions are shown in BLACK. The consideration factors that only arose from the KIEM are shown in PINK, and the consideration factors that only followed out of the focus group sessions are shown in BLUE.

In this, it is of added value to mention that the questions *"How do I establish contact? And what plays a part in this decision?"* were not necessarily embedded questions in the participating teams. Through the questions the KIEM members asked at the time, and the questions that I raised during my contact moments with care professionals, the care professionals were actively questioned on how the decision was made in specific situations. This strongly encourages reflection on one's own actions, allowing various consideration factors to surface, something that in daily practice is not consciously considered.

Figure 5: Thematic analysis consideration factors



PERSONAL PREFERENCES
from both patient and care professional

FREQUENCY
TIME
DATE
PHYSICAL DISTANCE versus PHYSICAL CLOSENESS
SECURE LOCATION (therapy room, home, elsewhere)
WORK-LIFE BALANCE

PURPOSE
of the conversation or treatment

(HAVE TO) BE ABLE TO ESTIMATE CONSEQUENCES
(HAVE TO) BE ABLE TO 'SENSE'
(HAVE TO) BE ABLE TO 'CHECK' THE MESSAGE
CONTENT OF THE CONVERSATION
DYNAMICS OF THE CONVERSATION
NEED FOR CLOSENESS
TENSION CURVE NEEDED

PRACTICAL BENEFITS

TIME SAVINGS
EASIER TO SCHEDULE
TRAVEL TIME
MULTIDISCIPLINARY CONTACT
EFFICIENT CONTACT
online contacts are often shorter

WILLINGNESS
from both patient and care professional

RESISTANCE
UNPLEASANT FEELINGS
EXPERIENCE/EXPERTISE
HABITUATION
ABILITY TO REVEAL ONSESELF ONLINE

STABILITY PATIENT

COMPLEXITY
URGENCY
SEVERITY
CRISIS versus STABLE
UNDERSTANDING OF THE DISEASE
RECOVERY-ENHANCING EVENTS
RECOVERY-HINDERING EVENTS

PRECONDITIONS

INTERNET CONNECTION / ACCESS
FACILITIES (PC or phone)
PRIVACY and SECURITY
ABILITY TO FOLLOW-UP
DIGITAL LITERACY
CONCENTRATION
AVAILABILITY OF WORKSPACE

(SELF) MANAGEMENT

patient	nurse
SDM (Shared Decision Making)	CONTROL OF THE CONVERSATION
UNDERSTANDING OF THE DISEASE	

PATIENT-NURSE RELATIONSHIP

ESTABLISHED RELATIONSHIP versus NON-ESTABLISHED RELATIONSHIP

BOTH KIEM
FOCUS GROUP

Figure 6: Affinity Diagram

CONSIDERATION FACTORS, EVENTS IN THE PATIENT'S LIFE AND NUMEROUS DECISION MOMENTS

The Affinity Diagram (Figure 6) has illustrated the identified consideration factors of the secondary analysis of the KIEM data supplemented by the expert interviews and focus group sessions. In addition to the consideration factors, we can learn from the focus group sessions that events in the life of the patient can lead to relapse or recovery and therefore have an impact on the decision-making process as well. Resulting in the insight that this alignment requires numerous decision moments time after time. The factors that play a role in the decision-making process can influence the provision of care for each patient in a different form, at a different time and in a different proportion. It adds another layer to this already complex care practice, consisting of new decision moments over and over again.

The insight regarding recovery-enhancing events and recovery-hindering events needed some deepening. I made a rough draft from what I had already heard and read. In addition to this, a member check was done with my co-researcher who was also present at the focus group sessions. From this conversation, example events were formulated to further explain the recovery-enhancing and recovery-hindering events. The following overview is meant purely illustrative, I am aware that it is not exhaustive or conclusive:

> *Recovery-hindering: moving, death, heartbreak, losing job, divorce, physical problems, not well-regulated medication, social isolation (COVID-19 pandemic) etc.*
>
> *Recovery-enhancing: moving, new relationship, new pet, new job, volunteer work, well-regulated medication, hobbies, sports and activities*

The events can have an impact on the stability and state of mind of the patient and can therefore change the patient's healthcare needs. This can result in the necessity to reshape care. In this, a different form or frequency of contact or treatment may be desirable. For (re)shaping or evaluating care it is therefore of added value to discuss *"How do we establish contact?"* as well as *"What does this form of therapy bring us?"*.

Verifying the factors and events

I wanted to verify the identified consideration factors, forms of therapy and a selection of the recovery-enhancing and recovery-hindering events with KIEM project members to find out if no 'big aspects' are missing in the already formulated overview. Instead of giving them a list of the inventoried factors, the choice was made to illustrate these factors, events in the life of the patient and the different forms of contact. For this, I relate to the ideas of Sinek (2009) who teaches us that *"Symbols help us make tangible that which is intangible"* (p. 160). As I am dealing with (large) intangible concepts, I tried to capture these in a more tangible way by illustrating the factors that seem to play a role in decision-making.

See Figure 7, next page, for the elaboration of these illustrations.

Reflection design process illustrations

It was remarkable during the design process of the illustrations that, although I have made icons and illustrations for graphic purposes in the past, these illustrations were more extensive and complex than initially thought. I had expected that, since I had been immersed in this health care practice for quite some time and I had a clear overview of the aspects I wanted to capture with the illustrations, it would be a natural and relatively easy design process. But nothing could be further from the truth. Over time, some concepts, especially those concerning the factors of consideration, proved difficult to capture in uniform images. While certain images naturally arose, I had to search for 'logical' associations or known uniform images for other concepts. To clarify, the illustrations for 'Control over the care process' of both the patient and the care professional are a relatively large and abstract concept in the practice of care. For this, an image of a care professional or patient who is 'taking over the wheel' has been used. During the design process, the thought *"Will my message get across?"* or *"Will they understand what I mean?"* often crossed my mind.

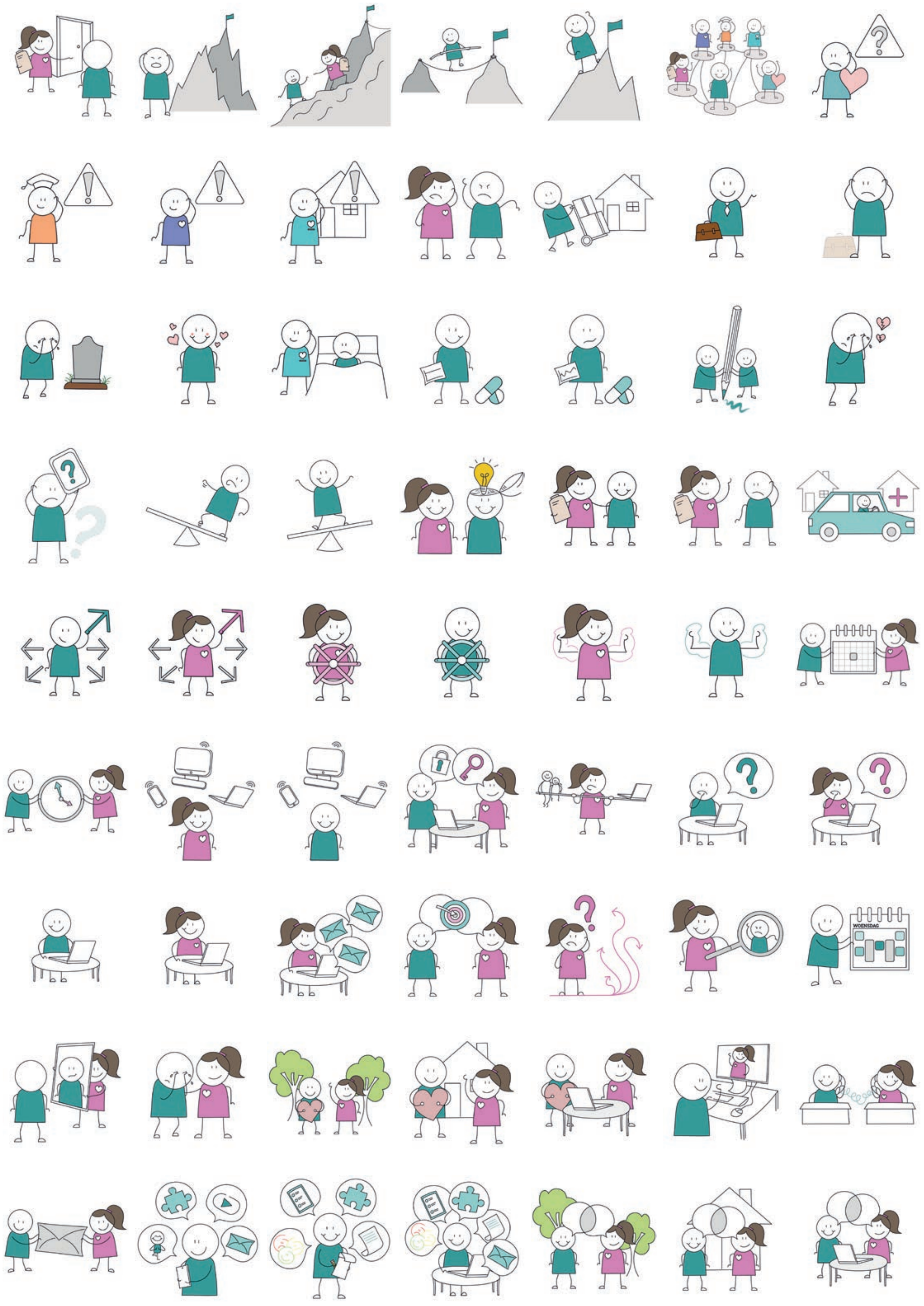


Figure 7: Illustrations of the consideration factors, forms of therapy and a selection of recovery hindering as well as recovery enhancing events

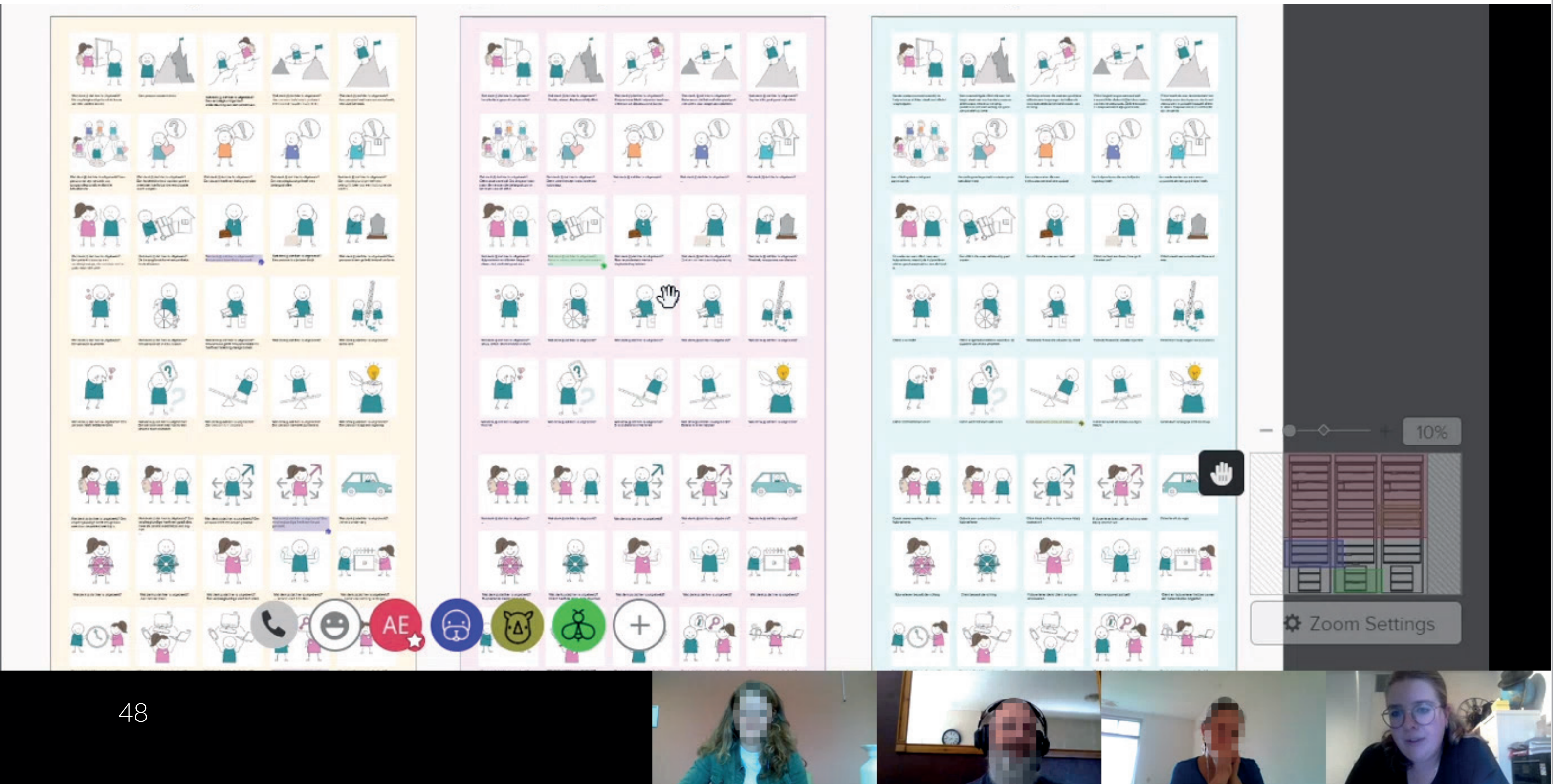
SETUP WORKSHOP DECISION MOMENTS

After the illustrations were designed, I presented them to the KIEM members. The creative way of data validation was twofold: first to test whether there were any major aspects missing in the overview; second to find out whether the illustrations about the intangible care concepts were made more tangible with the illustrations, and thus if the illustrations appealed to the imagination. This was carried out using a MURAL board in which all three respondents were shown the same illustrations with a text box under each illustration stating *"What do you think is depicted here?"* as a large fill-in-the-blank exercise (Figure 8). Individually from each other, they were given time to look at the illustrations and fill in what they thought was portrayed. Afterwards, the illustrations were discussed together.

In addition to this activity, a second MURAL board had been prepared in which the KIEM panel members were asked to create their own story around the theme *'Decision moments: consideration factors and events in the patient's life that impact how contact is established'*, using the illustrations. In this, the illustrations could be used in a larger whole to build a story. The goal was to create their own 'prompting boards', which could be used in the discussion afterwards. This assignment consisted of two goals: capture their story about what plays a part in decision-making according to them and find out whether such 'prompting boards' facilitate or support the conversation. The concrete setup of the workshop decision moments can be found in Appendix 2.

During the session, it soon became clear that the KIEM panel members needed more time than planned to review the illustrations and answer the question of what they thought was depicted. Therefore, the participants were given more time. As it was exactly the discussion about the illustrations that was so valuable to me, I decided to abandon activity two and focus on the deepening of activity one. This gave us plenty of time to discuss the differences and similarities and what this means and tells us about this healthcare practice.

Figure 8: Screenshot debrief workshop decision moments



INSIGHTS WORKSHOP DECISION MOMENTS

Even though not all participants had the time to go through all the illustrations, we were able to discuss all of them during the debriefing. In the discussion, it quickly became clear that there were similarities to some extent, especially the illustrations for the events in the patient's life and the different forms of therapy, between the three panel members as well with the 'intended' message of the illustration. However, many of the illustrations raised questions or resulted in different interpretations and associations. This discussion was very valuable to me: this was not about understanding all the illustrations 'correctly' or about how some illustrations could be optimised to trigger the intended associations. Instead, I was curious about those differences and how those differences in interpretation arose.

We have seen that for a part of the illustrations, there is a difference between the intended message and the final interpretation by the viewer(s). With that, the meaning attributed to the illustrations by the viewer(s) differs as well. We can explain this difference using the concept of *connotation*: interpretations are influenced by the viewer's own experiences and emotional meanings attached to both words and images. The meaning of the illustrations is therefore not found in the illustrations themselves, but in the meaning that is given to them by the viewer, which can therefore differ from one viewer to another.

When we look at the ideas of Ferdinand de Saussure, one of the founders of Semiotics who has looked at the role of signs as part of our social life (Hjelm, 2002), we can learn that signs are built from signifiers and the signified. When we consider the illustrations as such 'signs' we can see that they are composed of the visual presentation of the illustration or the physical form that the illustration takes (the signifier) combined with the concept that the sign represents (what is signified). However, we can learn that healthcare practice is not uniform in nature and therefore these concepts are not generally shared.

> *During the workshop we discussed the illustration that was meant for 'daytime activities', my association with this was social creative activities undertaken in a group and illustrated with two puppets drawing together. Neither of the panel members interpreted the illustration 'correctly'. When I revealed my intention, a fun discussion arose about how one person inextricably linked daytime activities to making birdhouses, while the other, with experience in elderly care, linked daytime activities to 'the van that picks you up'.*

Eggink (2011) describes that, based on the ideas of social semiotics, the intention of the creator (here: me) can only be correctly communicated if the creator would have the same association with the symbol(s) as the healthcare professionals have. These associations have to been learnt in the same social context, creating a common frame of reference for interpretation. Eggink combines this with the ideas of Adrian Forty: *"No design works unless it embodies ideas that are held in common by the people for whom the object is intended."* (Forty, 1995, as cited in Eggink, 2011, p.251).

However, as we have just seen, this social context is not shared among healthcare professionals, given the multidisciplinary nature and diverse specialties of mental healthcare practice. As a result, the ideas and concepts are not generally shared, leading to different interpretations and associations. The question arises of whether it is a bad thing that these different interpretations occur. After all, the discussion about the different interpretations was especially valuable and could therefore lead to interesting conversations among healthcare professionals.

The illustrations were a first attempt at making previously intangible concepts more tangible. However, the proportions of the number of correct interpretations and alternative interpretations leans towards the alternative interpretations. The alternative associations show that the illustrations are richer than the word but can also cause confusion as a result. This may need to be avoided if we want to talk about the deeper layer (how the concept influences the care process) instead of discussing the associative layer.

It is of added value to mention that the illustrations were presented separately and thus were not collectively making a unified story, therefore the context of the whole could not help the viewer in making sense of the meaning. I do expect that this contextual information can contribute positively to the understanding of the illustrations. In case something would be done with the illustrations in the final *Tool*, it would be valuable in future development to look at whether adding this contextual information positively contributes to sensemaking.

One final point, and perhaps the most important point in relation to the insight that the health care practice on its own is not uniform at all: the concepts are not only diverse within the various disciplines of mental healthcare practice, but they are also large in scope and therefore not easy to grasp. It is therefore debatable whether a uniform image can be formed at all, as the practice of mental healthcare is not uniform either.

I have focused on illustrating the separate components that play a role in the decision-making process. However, these components are currently about variables, the factors that come into play, that influences care. Nevertheless, the final *Tool* will have to be about the bigger picture, the way that components collectively contribute, the way 'the story' is formed, and the way the pieces jointly result in the changing healthcare practice. And most importantly about the way these pieces can be deliberately brought together so it benefits the patient's recovery process. Therefore, a higher level of abstraction than just simply discussing the individual components and events is needed.

3.4 THE STORY, CURRENT MENTAL HEALTHCARE PRACTICE

We have seen that we are dealing with a layered, complex and diverse care practice. All kinds of factors and events play a part in the decision-making, and the relationship between these factors per patient, event and phase of recovery can have different impact on how care is shaped. This results in numerous decision moments. 'The story' is different every time and consists of a combination of these different factors and events in the recovery process.

The decision moments workshop (3.3) has shown that capturing this care practice in unambiguous images, in my case tried with the 'images' for the separate components, turns out to be a difficult and maybe even an impossible task. The concepts are not shared within the care practice and therefore not uniform in themselves. I learnt that a higher level of abstraction and treating separate components as parts within a 'big picture' rather than individually can be beneficial. This 'big picture' is captured using current practice scenarios to illustrate the layered stories of healthcare practice.

REALISATION OF THE SCENARIOS

To be able to describe the current practice scenarios, the weighing factors from the Affinity Diagram were used to find 'fields of tension', by which I mean consideration factors that appear to be opposed to each other. For example: an established treatment relationship *versus* a new patient *or* a stable patient *versus* an unstable patient. Additionally, consideration factors that appear to be related were considered, such as: insight into the condition *versus* the possibilities of care at a distance *or* embedding care at a distance *versus* the changing role of the care professional.

An initial list of contrasting or related consideration factors was drawn up and presented in separate sessions to both a mental health nurse and an expert by experience[1]. In the discussion, more emphasis was put on the relationship between the consideration factors which were placed opposite each other, and how they themselves saw this reflected in their working practice. In the discussion, the importance of describing the 'grey' area instead of the 'black and white' sides of the axes became clear. This weighing happens in the head of the healthcare professionals and is therefore not articulated easily. From the discussions around the contrasting consideration factors, the final 'major' themes were identified, resulting in a selection of eight themes that illustrate decision-making in current healthcare practice:

1. Integrating telecare ***versus***
   The changing role of care professionals
2. Crisis situations ***versus***
   Requiring physical closeness
3. Being in touch ***versus***
   Having contact
4. Confrontive conversations ***versus***
   Estimating consequences
5. Insight in condition ***versus***
   The possibilities of telecare
6. Established treatment relationship ***versus***
   A new patient
7. Feeling secure: treatment room ***versus***
   Feeling secure: at home
8. Purpose of the contact ***versus***
   The 'need' for physical closeness

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[1] Someone with experience as a patient in mental healthcare, who has transformed this experience into experiential knowledge and who is able to apply and transfer this knowledge to others professionally.

These themes have been elaborated on from the perspective of the healthcare professional, describing the 'grey' area in which the 'black and white' sides are considered. The eight scenarios have become exemplary, based on the 'stories' from the KIEM, the focus group sessions, the expert interviews and the member checks. These were not meant to be exhaustive, but were meant to be illustrative of the stratification and complexity of this care practice.

Structure of the scenarios

The scenarios all consist of four paragraphs and almost all have a similar structure in the story, with the exception of the scenario about what different contexts can mean for the contact, as this scenario is built up from four different stories. For the other scenarios, paragraph one describes what the healthcare practice was like before the COVID-19 pandemic either a description of the event or the practice that would be covered. This is followed by two paragraphs about the changes that occurred and what consequences this had. The final paragraph may not quite fit the story of current mental healthcare practice, as it consists of reflecting on the tangible and intangible changes and the questions that I had or that were discussed with experts. This reflects my reflective attitude towards the changing healthcare practice.

Validation of scenarios

The eight scenarios were presented in their entirety as a member check with the same mental healthcare professionals with whom the tension fields were discussed, to be able to add finesse and nuance to the stories. First it was discussed with the mental health nurse. This feedback has been processed and resulted in version two of the scenarios. This version was then presented to the expert by experience. This feedback resulted in version three of the scenarios.

Since the scenarios were written based on stories from or known by the members, given their role in the KIEM project, an additional validation was held with the use of a peer review with a GZ-psychologist. The respondent received an information letter prior to the session (Appendix 3). The peer review was meant for testing the recognisability of the scenarios with a complete outsider.

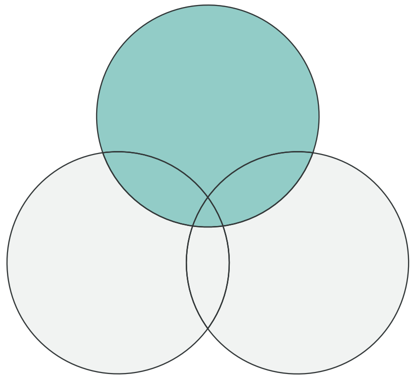
This input led to the realization that the themes and dilemmas were recognisable in the psychologist's own care practice or in that of colleagues. However, the psychologist noted that the scenarios were written from a 'guidance' rather than a 'treatment' perspective. With this, the psychologist referred to the difference between 'actively bringing about change' and 'stabilizing the patient'. From the psychologist's perspective, their work practice consists mainly of fostering these changes, whereas other therapists focus on the stabilizing and guiding side in the recovery process. In this sense, the 'tone of voice' of the scenarios did not always match the language of the clinical psychologist.

The difference between guidance and treatment, and thus the 'stabilizing' focus of the scenarios, can be explained in two ways. First, because I have relied on data collected at the emergence of the COVID-19 pandemic. During this period, healthcare professionals focused on stabilisation and maintaining contact, which meant that treatments were put (partly) on hold. As a result, the focus of the conversations was on how technology had changed contact and less about the effect on the treatments. Second, the fact that the members from the member checks have a 'stabilizing' role in the recovery process instead of this 'changing' role that also plays a part.

Even though the tone of voice did not always match the psychologist's language, the scenarios did prompt the GZ-psychologist to share similar experiences and situations with me. To me, it confirmed that the stories appeal to the imagination and that the themes are indeed recognisable. Regarding the 'tone of voice', we together concluded that it would probably not only be different with regard to the role of the professional in the recovery process, referring to the difference between guiding or treating, but also that it depends on your education, experiences and discipline. It is questionable, however, whether it matters that there are differences in this 'tone of voice': after all, it is about the larger concepts underlying these scenarios which could be discussed with the GZ-psychologist without any problem. We have seen that the story is different each time, so the scenarios are illustrative examples. I would like to add that, as a result of the peer review, apart from the fact that the story is different each time, it can also be told in a different way.

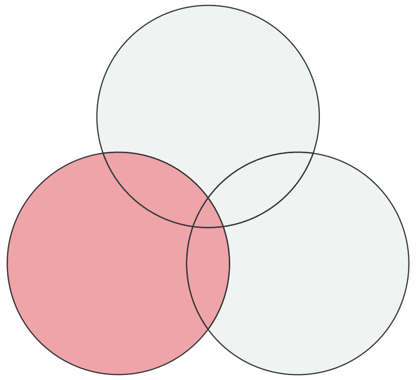
HOW THE SCENARIOS RELATE TO EACH OTHER

When we compare the current practice scenarios, we can see that three pillars strongly emerge, namely: technology changes care, personalised care and existing patterns. These are in line with what we have seen in the theoretical framework. In this sense, the scenarios confirm the theory with practical experiences. With this, I hope to have contributed to the articulation of the changes, the visible tangible changes but also the subtle, less tangible changes that occur when technology is used in this care practice. Before the eight scenarios and their relationship to these three pillars are presented, I would like to briefly revisit the underlying theory of these three pillars and how this relates to what we have seen before.



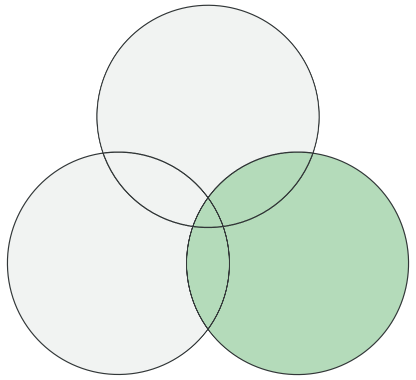
Technology changes care

The Actor Network Theory has taught us that technology is not neutral and has its impact on care. In the scenarios, we see that the advent of technology results in the change or disappearance of physical closeness, which directly or indirectly has consequences for the dynamics of the conversation. The context of the conversation changes, which makes it easier for some to open but causes others to be closed off. The arrival of technology in healthcare also results in new possibilities (affordances) which makes new forms of contact possible as well as allows working on treatment goals in between appointments. This increases the accessibility of care and creates a certain freedom in which travel time and distance no longer play a role.



Personalised care

We have seen that personalised care is established in the relationship between the healthcare professional *and* patient, including his environment. The ongoing dialogue between the patient and the healthcare professional, as well as the dialogue *among* professionals, contribute to the provision of good care. All kinds of factors play a role in shaping care, including events in the patient's life, additional goals and needs but also the personal preferences of both the patient and the care professional. Blended Care or care at a distance is not suitable for every patient. Shaping care is always an ongoing process of re-evaluation, resulting in numerous decision-making moments.



Existing patterns

The knowledge, skills and experience form the repertoire of healthcare professionals. Currently, choices seem to be made mainly based on intuition and routine. We have seen that when the COVID-19 measurements allowed face-to-face contact again, care professionals 'without realizing it' slipped back into 'the business as usual' and their familiar patterns. This routine keeps them from reflecting on their own actions. This may have hindered their sensitivity to the changes that occurred and their ability to see the added value of Blended Care and care at a distance. The structural deployment of technology (in parts) of care requires the expansion of the repertoire and thus requires breaking the routine to gain new experiences.

01

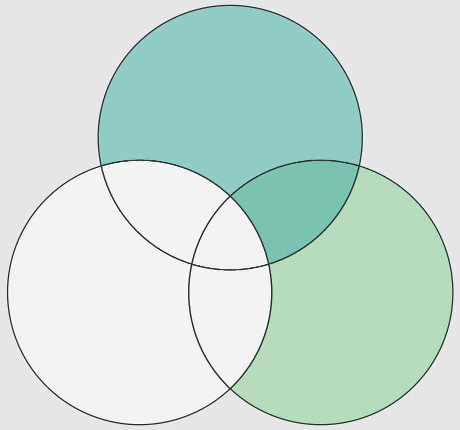
INTEGRATING TELECARE *versus* THE CHANGING ROLE OF CARE PROFESSIONALS

My work activities are very diverse, I am involved in diagnostics as well as treatments. In this, I do not only have to deal with my patients, but also with the people that stand around them. I frequently involve the network of my patients and therefore I have contact with a wide range of people.

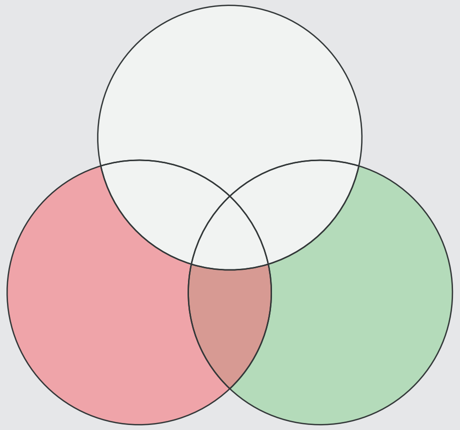
And then Corona came along... and suddenly, my work became even more diverse than it already was. We started making a lot of (video) calls, and that demanded a lot from me as a healthcare professional as well. Suddenly, I had to take all kinds of different software, privacy and security issues into account. Some patients or people who were involved in the process preferred to make video calls via WhatsApp, I simply did that as well because I had to do something. After all, it took us all by surprise. Of course WhatsApp is familiar to us, but it is not really safe.

I also realised that I got an additional role in the package of responsibilities: I was not only the therapist, but I also started to act as a coach on how to deal with the devices and software. I suddenly had to consider how to explain to my patients and their families how the video call software works, what to do if the connection suddenly breaks down, but also how to position ourselves so that we can still see each other sufficiently on the screen. For myself, it was a search for what works best as well. For example, I gradually found out that (video) calling with a headset provides a less 'tinny' sound which gave a more natural feel to the conversation.

Before you can use care at a distance it requires some preliminary work from you as a practitioner but also from the one you want to be in contact with. It is a search, together with your patient, to find out what works best for you. What facilities do you and your patients need? What do you agree on with each other? How can you support patients and their families in establishing a video call connection?



TECHNOLOGY CHANGES CARE
AND EXISTING PATTERNS



PERSONALISED CARE
AND EXISTING PATTERNS

02

CRISIS SITUATIONS versus REQUIRING PHYSICAL CLOSENESS

My patients do not live close by, so I have to deal with quite a bit of travel distance. A while ago, me and my colleagues received a call that we had to go to a patient immediately because there was a crisis. The patient is known for being unpredictable, and because of previous incidents, the police were also on their way to the patient's house. For our own safety, two of us went over to the house. Once we arrived at the patient's house, my colleague and I went inside; we kept the police at a distance, out of sight of the patient.

The atmosphere in the house was not too bad, especially considering the seriousness of the incoming alert and the patient's history. The young man is very damaged from his past and can be very violent because of this, however, at no time I felt unsafe. In fact, within half an hour, my colleague and I had been able to identify the problem, take the sting out of it, and leave the patient in peace. The police could leave without having had to intervene, and we could also return to our office.

In recent months, I have regularly thought about this and similar situations. It strikes me that when there is an absolute crisis, we start acting on the 'automatic pilot': we drop everything we are doing at that time and respond to the crisis. But honestly, I believe that in this situation we could have done just fine with a video call. Of course, in this case the travel distance played a role, and I can well imagine that if you are 5 minutes away from your patient it might be less of a consideration.

But I do wonder, is physical closeness always necessary in crisis situations? Or could a listening ear at a distance sometimes be sufficient as well?

03

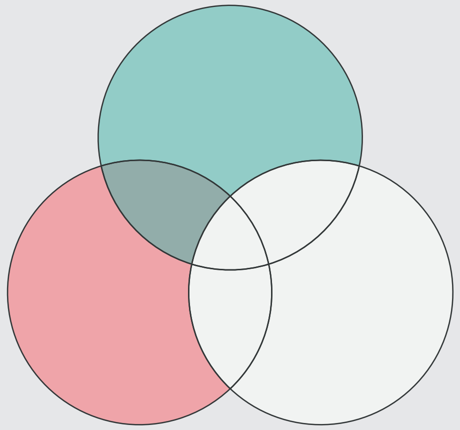
BEING IN TOUCH versus HAVING CONTACT

Before the COVID pandemic, I had actually rarely used digital means to support my treatments. Some patients contacted me by email or WhatsApp, but apart from that, I had no real experience with the use of digital tools in my care practice.

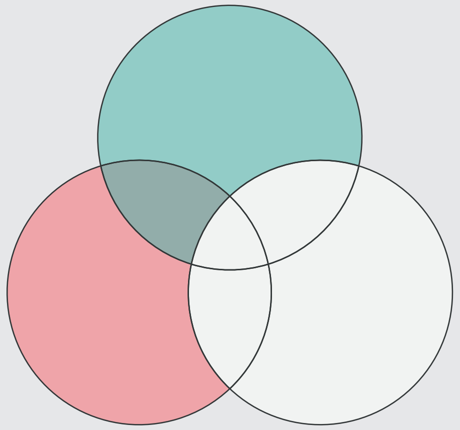
When we suddenly started to use video calling as an organization, it became clear how much things change for me as a therapist the moment the physical closeness disappears. Where I normally gathered about 80% of the information by means of sensing and observing my patient and his environment, I now had to work very hard to get this information to the surface. Instinctively, this also changed the dynamics of the conversation. The dynamics of face-to-face contact made place for much more of a questions-and-answer structure.

When the connection was successful, we immediately moved on to what needed to be discussed: the contact was efficient and purposeful. As a result, the conversations were shorter than they usually were here in my treatment room. The depth of the conversations decreased with the lack of physical presence. During the first weeks, it became increasingly clear that offering a cup of coffee, hanging up the coat of my patient and having some small talk is also part of the therapy and our relationship. When I became more conscious of this and started to actively 'check in and out the conversation' in a light-hearted way, the natural and dynamic aspect of our contact came (partly) back. It made the transition before and after the treatment contact smoother for both me and my patients.

Care at a distance requires a different way of picking up signals and sensing the atmosphere: we are used to being able to sense this from just being close to one another. It may not require new communication techniques, but perhaps it requires a more conscious use of these techniques? How can we translate our existing skills to achieve the desired effect from a distance as well?



TECHNOLOGY CHANGES CARE
AND PERSONALISED CARE



TECHNOLOGY CHANGES CARE
AND PERSONALISED CARE

04

CONFRONTIVE CONVERSATIONS versus ESTIMATING CONSEQUENCES

I regularly hold up the mirror to my patients during our conversations, which can sometimes be quite confronting. Each time the question remains of how my patient will react to it. Sometimes, this can result in reliving a traumatic situation accompanied by strong emotions. At such moments, I like to be able to really support my patient, with an arm around the shoulder for instance.

I notice in myself that I am a bit hesitant and tentative as to whether I can touch on these difficult subjects during a video call. Normally when we see each other face-to-face I can sense more easily how the patient is feeling and whether this is an appropriate moment or not, because: what do you do when your patient is reliving a traumatic experience without your physical presence? How can you still 'stay in contact' with each other? When that arm around the shoulder is no longer possible, how do you offer support and closeness without being physically present?

Most of the time it went fine, however it has also happened to me that my patient broke down the connection out of emotion, so what do you do then? Do you call back, step in the car, call someone else, or...? For me it was difficult to leave my patient alone while reliving a traumatic experience.

Are all subjects and treatment goals suitable for telecare? What can you discuss with each other at a distance, and wherefore do you want to see each other face-to-face? How do you know if you can bring up confronting topics during a (video) call? How do you estimate the consequences? And how do you know if you can provide sufficient support at a distance?

05

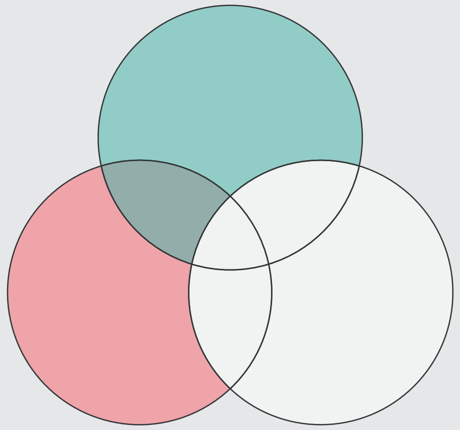
INSIGHT IN CONDITION versus THE POSSIBILITIES OF TELECARE

I often talk to my patients face-to-face, but I also regularly text or call them. Since COVID, video calling has been added to this, which I find a pleasant addition to my telephone contacts. It allows you to see each other even when you're not together. During my work, I was already accustomed to using online modules, and I continued to do so during the pandemic.

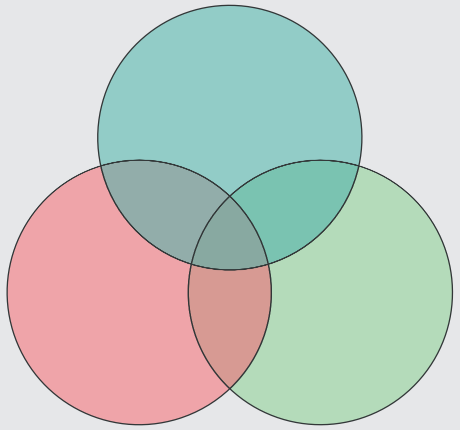
I have to say that this works quite well for some of my patients: it keeps them busy between the appointments. I check the assignments they have completed and we discuss them during our next appointment. This does require some preparation on my part and following up questions between appointments. Despite the promising results for some of my patients, I have also seen the other side of it, as it doesn't work equally well for every patient. Sometimes they start and gradually get stuck on something and then quickly give up. Then, they need a little more support I guess, but how can you offer someone sufficient guidance online?

I have noticed that the patient's insight into his or her condition is an important factor in this. It also depends on how far someone is in his or her recovery process. I have the feeling that the further someone is in their recovery process, the more is possible online. For me this is thus closely related to the stability of the patient.

Therefore, it is important for me to know where my patient stands. Is my patient able to work independently with online modules? Can my patient adequately express what is going on and what he or she is struggling with, even remotely?



TECHNOLOGY CHANGES CARE AND PERSONALISED CARE



TECHNOLOGY CHANGES CARE, EXISTING PATTERNS AND PERSONALISED CARE

06

ESTABLISHED TREATMENT RELATIONSHIP versus A NEW PATIENT

I see the use of digital tools to support regular therapy as something very personal, it doesn't work for everyone, and certainly not in the same proportion for everyone. I have become quite accustomed to online options such as video calling and the use of online modules. I certainly see online care as a supplement to regular therapy when it can be used in a well-tuned way.

Yet I notice that I never use online means from the very first contact. In the beginning, I focus on building a relationship of trust and getting to know each other, for which I deem physical closeness a necessity. I believe that, before I can make a good estimation of what may be possible online for supporting the patient, I must first know my patient really well. And I also think that my patient needs to feel familiar enough with me to be able to open up at a distance. After all, my treatment room and my physical closeness may feel comfortable enough to open up, but does he or she also feel comfortable enough at a distance?

During COVID, I also did intakes where the first contact was a (video) call appointment. This was quite uncomfortable for me at the beginning because I was so used to face-to-face intakes. However, I noticed that physical closeness was not always necessary, and some patients actually liked the fact that there was a certain amount of distance at the very beginning.

Can physical distance sometimes be more comfortable? Should I also offer the possibility of (video) calling for such a first contact? For me as a practitioner, physical closeness may feel necessary, but is my patient ready for it?

07

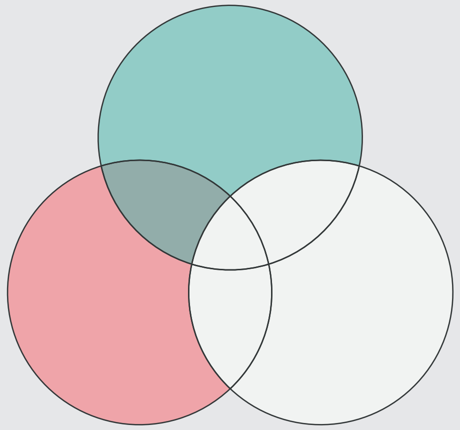
FEELING SECURE: TREATMENT ROOM versus FEELING SECURE: AT HOME

Normally, patients only visit me at the clinic. Sometimes we have telephone contact in between the appointments, but I have never made home visits. Because of this, I've never been able to take a look at my patients' homes. This changed when we started video calling during the pandemic: now we could see each other's home environments for the first time. This also made my private life visible for my patients, which was a little bit strange in the beginning. *Do I want my family photo to be visible in the background, do I remove it, or do I make my background blurry?*

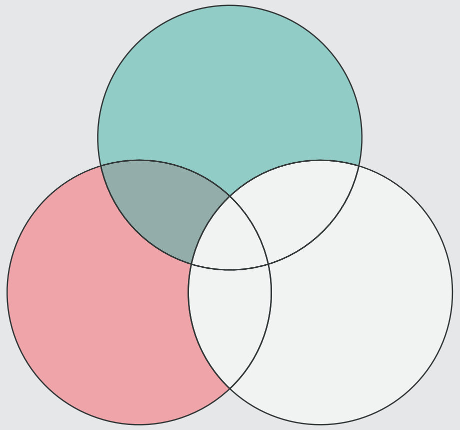
Not everyone dared to speak freely from home. The security that the four walls of my treatment room provided was important for some patients. Nobody was used to working from home on a structural basis, and therefore, they did not always have a suitable secluded space. People started video conferencing from their bedroom, or downstairs at the kitchen table with all kinds of possible distractions from pets or other housemates. *What can and will you share if your housemates can possibly hear you? Can you concentrate on the therapy with these new external stimuli?*

The structure and the 'ritual' of coming to the clinic and driving back home disappeared. It became clear that some of my patients really needed this structure. They had no reason to leave the house anymore, I regularly saw a patient calling in from his or her bed or while wearing a bathrobe. *How do I feel about patients appearing like this in front of the screen? Should you make agreements with each other about this? How can you remotely activate patients and help them maintain their daily structure?*

On the other hand, I also saw that a new, deeper layer was created in the contact between me and my patients. Instead of just talking about their home environment, patients could now show me concrete things. For example, one patient proudly showed me his homemade furniture, something we had never discussed before. *Telecare can provide new topics for discussion. Where can care at a distance add depth to the treatment relationship?*



TECHNOLOGY CHANGES CARE
AND PERSONALISED CARE



TECHNOLOGY CHANGES CARE
AND PERSONALISED CARE

08

PURPOSE OF THE CONTACT versus THE 'NEED' FOR PHYSICAL CLOSENESS

My patients almost always visit me at the polyclinic. Occasionally, I prefer to do a home visit, but only if I am concerned about the patient. Many of my patients are already well-advanced in their recovery process. Our conversations are about whether the medication is still properly regulated and how the patient is doing. Often these are conversations that don't require much follow-up unless something unexpected has happened that needs to be addressed.

When COVID came, my home visits and polyclinic conversations could obviously no longer take place. We quickly picked up where we left off by making (video) calls. And to be honest, it actually went quite well. We were able to get to the heart of the matter and work on the treatment goals from a distance. I have to say that the fact that I know my patients very well, since I have been counselling them for a long time, helps a lot.

Because of the sudden transition to care at a distance, I started to wonder to what extent the frequency of actually seeing each other is really necessary. I have quite a lot of patients with whom I only have some monitoring conversations, and that goes really well remotely. I must say that it was also nice to talk to my patient while they were busy with their hobby and I could just call in for a moment.

What kinds of conversations lend themselves to care at a distance? Where can I scale up telecare? And for what do I really want to see my patient anyway?

4.1 - 4.3
4.4 - 4.6

DESIRED FUTURE PRACTICE

The insights into the current practice have led to eight current practice scenarios (chapter 3) which illustrate the complex and layered nature of this care practice. In these stories, three pillars emerged: (1) Technology changes care, (2) Personalised care and (3) Existing patterns. Based on these pillars, this chapter describes approaches that can contribute to making health care professionals sensitive to the choice between face-to-face contact, telecare or blended care. These approaches were guiding in the realization of the desired future practice scenarios. With the help of the theoretical framework and the empirical insights, the preferred future practice direction was chosen, which also describes the design space. This resulted in design guidelines that informed the development of six design concepts. These concepts were presented to an expert panel. From the feedback on the concepts, a concept choice was made.

04

4.1 FROM EXISTING PRACTICE TO A DESIRABLE FUTURE

By now, we have a diverse picture of the complex and layered care practice, illustrated by the eight current practice scenarios. In chapter **3.4 The story, current mental health care**, these scenarios were related to three pillars: technology changes care, personalised care and existing patterns. The factors that influence the decision-making of the form of therapy are described, as well as the |changes that occur due to the introduction of technology in the care relationship. In addition, we have seen that we are dealing with entrenched views on the (desired) care and a sense of incompetence which most likely hinders trying (digital) alternatives.

The three pillars illustrated the relationship between the theoretical framework and the work practice, as the empirical evidence has confirmed these theoretical notions. Each of these three pillars will be used as a starting point for the development of possible desired future practices, resulting in three desired future practice scenarios, which will be further elaborated in **4.2 Desired future practice scenario(s).**

STARTING FROM ‘TECHNOLOGY CHANGES CARE’

We have seen that technology has an impact on healthcare, since technology is not neutral and has an impact on social networks. I have described these changes, both the major and more subtle ones, that occur as a result of the advent of technology. When we look at the desired future practice from this perspective, we would ideally like healthcare professionals to notice these subtle and not so tangible changes. They should be able to recognise how and when these changes occur, so that the resulting changes can be used as opportunities to benefit the patient’s recovery process. I believe that care professionals need to be supported in recognizing these changes: moreover, I believe that they should be supported in recognizing the concrete added value of various forms of therapy and contact for themselves and their patients. In this, I think it should not only be about how technology can contribute, after all, there are also possibilities in face-to-face contact that bring differences.

STARTING FROM ‘PERSONALISED CARE’

Personalised care is established in the relationship between the healthcare professional *and* the patient. We have seen that the ongoing dialogue between patient *and* healthcare professional, but also healthcare professionals *among themselves*, contribute to the provision of good care. However, **3.2 Decision making in practice** showed that healthcare professionals are (sub)consciously guided by their own assumptions and personal preferences in shaping their care. This can obstruct the conversation with the patient about the various options. It was also noted that care professionals did not talk much with other professionals about the (new) possibilities and the changes that these entail. Currently, they deal with the new possibilities individually, while there is a desire for a more shared approach. Since we have seen that it is precisely these conversations that support care professionals in considering the consequences of the alternatives (focus group sessions) and contribute to the delivery of good care (theoretical framework), it is of added value to facilitate this conversation.

STARTING FROM ‘EXISTING PATTERNS’

How care is provided depends on a variety of factors, such as on the attitude of healthcare professionals. Acting in the rush of the day, and thus acting from intuition and routine, does not encourage reflection on one’s own actions. However, in order to make healthcare professionals sensitive to changes, a reflective attitude is needed. Teekman (2000) shows us that reflective thinking is currently an automatic reaction to get a grip on ‘unusual events’. In his article, he emphasises the importance of reflecting on routine actions in order to be able to oversee the impact of choices and one’s own actions. It is therefore of added value to stimulate this reflective attitude among healthcare professionals so that they can recognise the impact of their own routine actions.

The use of (new) opportunities requires breaking through this routine and expanding the current repertoire. Benner (1982; 1983) showed that gaining new experiences contributes to increasing this repertoire. During the focus group sessions, healthcare professionals repeatedly expressed the need to gain new experiences in a safe context, so that they did not have to ‘fiddle around in front of patients’. It seems that they want to, but do not dare to. They would like to be able to oversee ‘all’ the consequences in order to prevent unexpected events, as well as to be able to guarantee the continuity and quality of care. Creating this safe and exploratory environment can therefore contribute to courage to experience.

4.2 DESIRED FUTURE PRACTICE SCENARIO(S)

Each pillar, with its associated insights and approaches, serves as a starting point for the formulation of a desired future practice, resulting in three desired future practice scenarios. Table 1 briefly describes what these desired future practices will look like and the starting point(s) on which they are based. The complete description of the scenarios can be found in Appendix 4.

Table 1: Desired future practice scenarios

The consideration, the added value and reflection Technology changes care & Existing patterns	The dialogue and team-wide approach Personalised care	Gaining experience in a safe context Existing patterns
A practice in which the consideration of "How do we establish contact?" is no longer made intuitively, but in which care professionals are sensitive to the changes that occur as a result of the different ways of making contact and how these can be used in a considerate way to enhance the recovery process. 1	A practice in which Blended Care is supported team-wide and the exploration is addressed together. In this, practicalities are left behind and there is time to discuss what these new ways of contact bring about. 2	A practice in which care professionals dare to explore new ways of contact and treatment, whether or not together with the patient. By learning step by step in a safe context, they can get a better sense of the new opportunities. 3

The three scenarios each have a different focus: (1) developing the reflective attitude and breaking through the routine, (2) the importance of jointly carrying the exploration within the team and (3) the importance of gaining experience, whether or not together with the patient. Although I believe that all three are equally relevant and can have a positive influence on the more informed use of different forms of therapy, the project can only prioritise one scenario. From my perspective, (2) facilitating the discussion indirectly affects all the scenarios and should therefore not be overlooked when considering the other scenarios. Scenario two would therefore not be chosen as the focus of the design space, although it would be included as a design guideline. This choice is supported by the theoretical notion of Teekman (2000) who taught us that the ongoing dialogue should not be neglected. As scenario two is excluded as the focal point, this presents me with the choice between (1) transferring knowledge and stimulating a reflective attitude versus (3) creating an environment in which experiences can be gained.

Research has shown that people go through different stages of change when changing their behaviour, in which the first step is often to create awareness of the current automatic behaviour and providing insight into the desired new behaviour before you acquire new knowledge and start experimenting with the new behaviour. For example, the Transtheoretical Model, also known as TTM, classifies behavioural change into six stages, from the intentional change to sustaining the changed behaviour (Prochaska et al., 1994). In the first stage, the *precontemplation stage*, the individual is unaware of the problem and the need to change their behaviour. In the second stage, the *contemplation stage*, awareness has increased, and the individual develops the intention to change their behaviour, weighing up pros and cons. In order to move from stage one onwards to stage two, Prochaska et al. (1994) describe that the individual needs to be helped to process information more clearly and to increase awareness.

Based on this philosophy, in combination with the body of thought of the *From Novice to Expert* model from Benner (1982), which describes skills acquisition in different stages, the first step will have to consist of creating awareness, transferring knowledge and stimulating the reflective attitude. For the desired future practice, this therefore results, as the first step for a more informed use of different forms of therapy, in stimulating the reflective attitude (1), in which I do not want to subordinate the need for experiences (3) in this: to me, this would be a logical, valuable and also necessary next step for future research and the development of tools.

Improvement desired future practice scenario

After a choice had been made between the three desired future practice scenarios, the final scenario was improved several times by me as well as by my former mentor from the Research group IT Innovations in Health Care. In the improvements that were made, a strong emphasis was on touching the right chord. This way, the final focus and direction of the design space could be coordinated together, as well as the finesse of the scenario's 'story'. The green 'box' below will present the chosen desired future practice scenario.

THE DESIRED FUTURE PRACTICE

"How do we establish contact?" is a consideration that has gained an increasingly prominent place in the care practice. Where previously contact moments consisted of face-to-face conversations at the office of care professionals or at the patient's home, this range has broadened to include not only telecare but also the consideration of more diverse locations to meet with patients.

These new possibilities of contact change care. For example, the context of the conversation and thus the dynamics of the conversation change. Whereas face-to-face feels more dynamic, a video call is often more functional and ideally suited for a quick check-up. With telecare, the physical closeness disappears, something that was a bit uncomfortable for care professionals and their patients at first. But experience has shown that this closeness is not always necessary. And sometimes the physical absence can actually be more pleasant for the patient. After all, some patients talk just as easily, if not more easily, at a distance. Coming to the office or receiving the care professional at home can sometimes be so tense for the patient that care at a distance feels more accessible.

The complexity of the care practice requires tailored solutions, where each time a good coordination with the patient is needed to come to the best possible care. For some patients, this means only providing care at the office. For others, it means a variation between at the office, at the patient's home and meeting somewhere else, like going for a walk. And yet another person would benefit from a good mix of physical contact moments, supplemented with telecare such as (video) calling or chatting. The ratio, composition and frequency of these possibilities differs for each patient.

This requires constant reassessment and re-adjustment whenever necessary. Not only when a new patient comes in for treatment, but also when there is progress or a relapse in the recovery process. Or when something (unexpected) happens in the life of the patient. The impact these events have on the stability and state of mind of the patient is taken into consideration when deciding how to establish contact, the frequency but also the intensity of the contact. Consideration factors of practical order but also the personal preference of the patient and the care professional play an important role in this.

In the past, the consideration "How do we establish contact" was made intuitively, but now care professionals have to consciously consider this question. After all, how contact is established has an impact on the care provided. And that question arises time and time again: does the agreed method of contact still provide the best possible balance for all concerned? And how can the changes that other forms of therapy entail be used to enhance the patient's recovery process?

4.3 DESIGN GUIDELINES

The chosen desired future practice describes the design space. The design space combined with the theoretical framework (chapter 1) and the insights and dilemmas gathered with empirical research (chapter 3) have led to the formulation of eight design guidelines:

1 THE DESIGN IS AN INVITATION TO HEALTHCARE PROFESSIONALS TO BECOME SENSITIVE TO THE CHOICE BETWEEN FACE-TO-FACE THERAPY, TELECARE OR A COMBINATION OF THESE, BLENDED CARE

In this first guideline, we see that the original design challenge is combined with the concept of Affordances, in the sense that the *Tool* itself should become an invitation or affordance to contemplate, discuss and consider the new affordances that arise as a result of the advent of technology.

2 THE DESIGN IS AN INVITATION TO REFLECT ON ONE'S OWN ACTIONS AND TO CONSIDER THE IMPACT OF THE CHOSEN FORM OF THERAPY

We have seen that sensitivity is related to self-awareness, and that this can be increased through self-reflection and self-questioning. However, self-questioning is currently mainly an automatic reaction when there are so-called 'situational gaps': when an individual is confronted with unusual events. However, it is of added value when this self-questioning is continuously stimulated, also for routine situations. The reflective attitude should extend beyond getting a grip on specific situations in the here and now (reflective thinking for learning). The reflection should actually focus on the understanding of how contexts influence care (reflective thinking for critical inquiry).

3 THE DESIGN ACTS AS A TRIGGER TO THINK ABOUT THE DIFFERENT FORMS OF THERAPY THAT EXIST

We have learnt from the philosophy of Affordances that the arrival of technology results in new possibilities for action. However, the focus group sessions also have shown that care professionals are not always aware of what is possible or that they are not used to looking outside their current repertoire. As a result, the new possibilities created by the advent of technology cannot always be recognised.

4 THE DESIGN IS SUPPORTIVE IN OVERSEEING THE IMPACT AND CONSEQUENCES OF THE CHOSEN FORM OF THERAPY

The Actor Network Theory teaches us that technology is not neutral and has an impact on care and the care relationship. However, we have also seen that these changes are difficult for healthcare professionals to recognise and discuss. It remains difficult for care professionals to understand how care at a distance and Blended Care can have *concrete added value*. At the moment, it seems that the practical applicability in care practice is insufficiently clear. It is therefore important to support care professionals in overseeing the impact of the chosen form of therapy on shaping care and the treatment relationship, in order to enable them to make well-founded choices.

5 THE DESIGN IS THOUGHT-PROVOKING TO MAKE CARE PROFESSIONALS THINK ABOUT PREVIOUSLY UNCONSCIOUSLY MADE CHOICES, TO THE EXTENT THAT THE CHOICES CAN BE MADE MORE CONSCIOUSLY AND TANGIBLY

We have seen that care professionals act from intuition, routine and their current repertoire in the rush of the day. As a result, considerations are made quickly and 'on the spot'. The result of this is that their considerations and the factors that play a part in their decision are not tangible, which makes the articulation and sharing of knowledge difficult. The design will therefore have to support care professionals in recognising and discussing the tacit knowledge.

6 THE DESIGN CAN BE USED INDIVIDUALLY AS WELL AS IN A TEAM CONTEXT

We have seen in the focus group sessions that Blended Care and telecare are not yet embedded themes in the interviewed team, while they do attach great value to being able to carry the load together and to learn from and with each other. We have also seen that there is a serious shortage of time in this care practice. Because of this lack of time, there is not much time to structurally plan moments to discuss the topic of technology in care practice and the changes that are occurring with each other. The *Tool* should therefore be designed for individual use, but it must also remain applicable to team matters.

7 THE DESIGN CAN SUPPORT OR FACILITATE THE CONVERSATION WITH EACH OTHER

We have seen that the ongoing dialogue between the patient and the healthcare professional, but also the professionals among each other, contribute to the provision of good care. The importance of talking to each other and the effect of these kind of conversations was clearly visible in the focus group sessions. By discussing the changes that occur and what this means for their working practice with each other for a planned period of time, they had explicit time to reflect on this topic with each other. The conversation among themselves led to being able to openly discuss and to jointly consider new possibilities, allowing experiences and dilemmas to be shared.

8 THE DESIGN IS HARMONIOUS WITH THE CONTEXT OF THE WORKSPACE OF MENTAL HEALTHCARE PROFESSIONALS OR, THE DESIGN CAN BE PLACED 'PROMINENTLY' IN THE WORKING ENVIRONMENT AS AN EXTERNAL TRIGGER

The study by Teekman (2000) has stressed the importance of reflective thinking and illustrates that the clinical environment must be supportive of the learner's needs. The changes that occur and the impact of one's own actions are difficult to notice, discuss and evaluate. In the hectic rush of the day, healthcare professionals do not simply stop to reflect on these issues. The *Tool* can therefore be used as an external trigger within the various contexts of the mental healthcare organisation, in order to repeatedly remind them of 'the choice' and its impact. Although I have not done a specific analysis of the settings of several care organisations, I would venture to say that every care organisation has at least a few common denominators: four walls, a table and a chair. Often there are also specific treatment rooms, office spaces and team rooms, but this does not apply to every care organisation. In some organisations, these spaces are the same due to lack of space, so the difference in context resides primarily in the nature of the encounter. The contexts that I will include in the concept development will be the following: the treatment or office space (where healthcare professional and patient meet), the hallway (which healthcare professionals and patients pass through), the team rooms (where healthcare professionals meet) and the coffee room (where healthcare professionals meet unplanned).

4.4 CONCEPTS

From the design space (desired future practice scenario) and the design guidelines, six concepts were developed. The following pages will present these six concepts, describing the rationale behind them as well as the context in which they can be placed or used in the mental health organizations. The style of the concepts is low in detail to emphasise the conceptual experience without going into the technical and content-related details. All concepts are attempts to support the transfer of knowledge, to facilitate the conversation or to trigger the reflective attitude. In this, the focus is on looking at how this knowledge transfer can be achieved from the working principle, and thus not yet specifically on what content the *Tool* should contain. Therefore, this will still have to be elaborated after the final choice of concept.

LINE ART FOR THE VARIOUS 'CONNECTION LINES'

WHICH 'LINE' DO YOU CHOOSE?

PROMINENT DESIGN GUIDELINES: 1, 3, 6 & 8

The line symbolises the connection between the patient and the healthcare professional, designed to prompt healthcare professionals to consider the various forms of therapy and means of contact available to them (Figure 9). The artistic form is intended to act as an external trigger that can be exhibited in the working environment of the healthcare professionals, in order to stimulate healthcare professionals to keep thinking about the different possibilities they have.

The context of the line art is not dependent on encounters or spaces and can therefore be placed in all possible areas within a healthcare organization (treatment rooms, coffee rooms, hallways or team rooms). The line art can serve as an individual trigger as well as a discussion topic for the whole team. The design itself does not actively invite to this conversation with the help of questions or information, however, the artistic form can stimulate a dialogue.

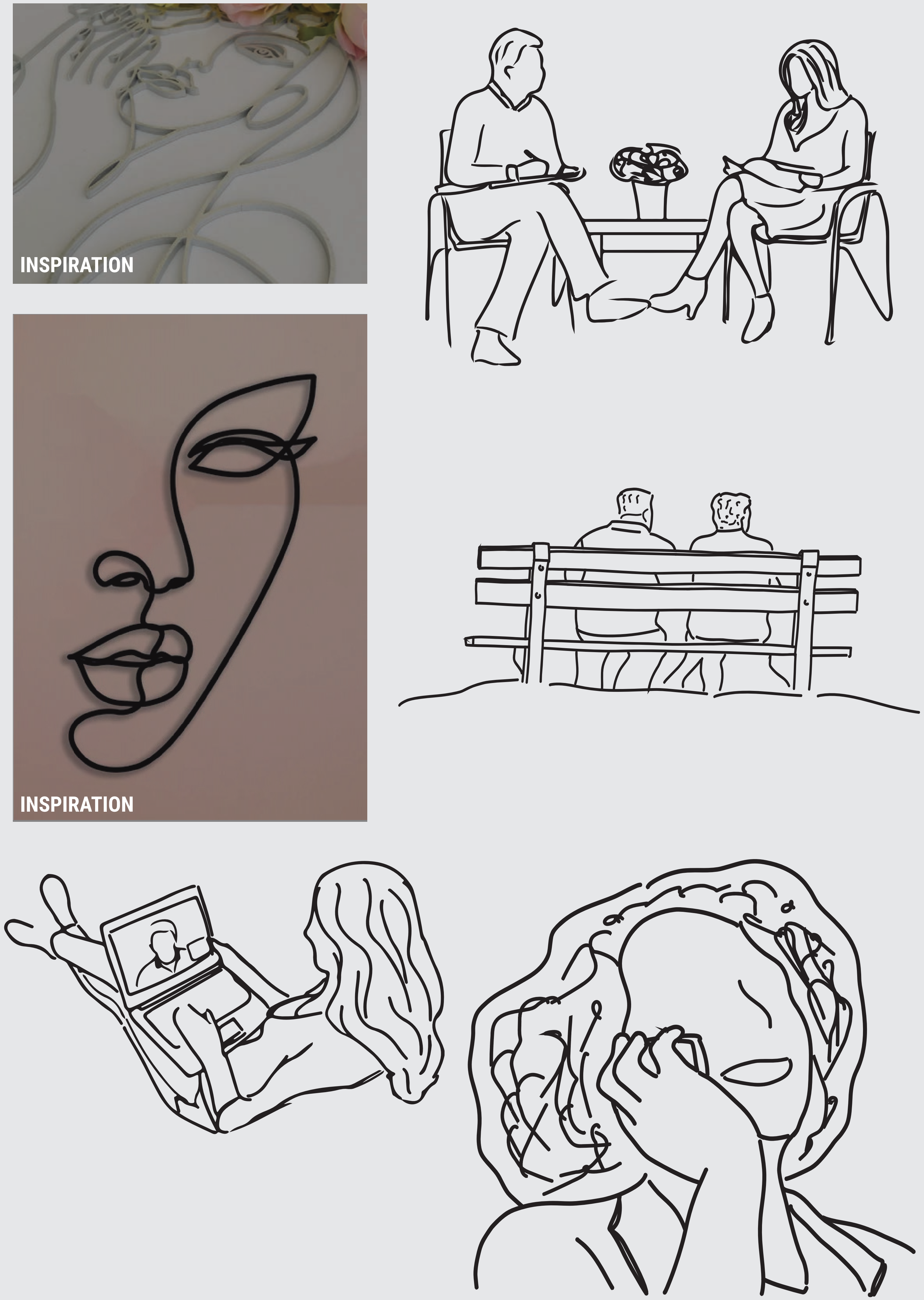


Figure 9: Concept board: line art

HAVE YOU ALSO THOUGHT ABOUT?

POSTER MATERIAL WITH PICTURES AND REFLECTIVE QUESTIONS

PROMINENT DESIGN GUIDELINES: 1, 2, 5, 6, 7 & 8

The questions posed to mental healthcare professionals during the interviews and sessions, resulted in stimulating a reflective attitude towards one's own actions and the current care practice. As a result, assumptions and routines could be noticed and subconscious considerations became more tangible. The poster series is intended as an external trigger that tries to stimulate the reflective attitude with the help of atmospheric images and reflective questions (Figure 10). Questions relating to the changes and implications; questions that they were not simply asking themselves. The context of the poster series is not dependent on encounters or spaces and can therefore be placed in all possible areas within a healthcare organization (treatment rooms, coffee rooms, hallways, team rooms). The poster series can serve as an individual trigger as well as a discussion topic for the whole team.

Figure 10: Concept board: poster series

HOW DO YOU ‘MAKE’ CONTACT?

THE 'PUZZLE' AND THE 'PIECES OF THE PUZZLE' THAT 'PLAY ALONG'

PROMINENT DESIGN GUIDELINES: 1, 2, 3, 4, 5, 6 & 7

The puzzle pieces illustrate the different ways of establishing contact, as well as the consideration factors that play a role in the decision-making process (Figure 11). The puzzle in its completeness represents how care is shaped and what plays a part in it, in which the connections and effects of forms of therapy, events and consideration factors can be linked. The aim of this is to make the previously unnoticed considerations more tangible.

The aim is to be able to discuss the impact of the composition of the puzzle pieces, as a symbol for the consequences of the factors that play a role in the choice. The idea is that the way in which care is shaped can be reconstructed over and over again. The puzzle can be used both individually and in a team, for example during intervision moments or casuistic meetings.

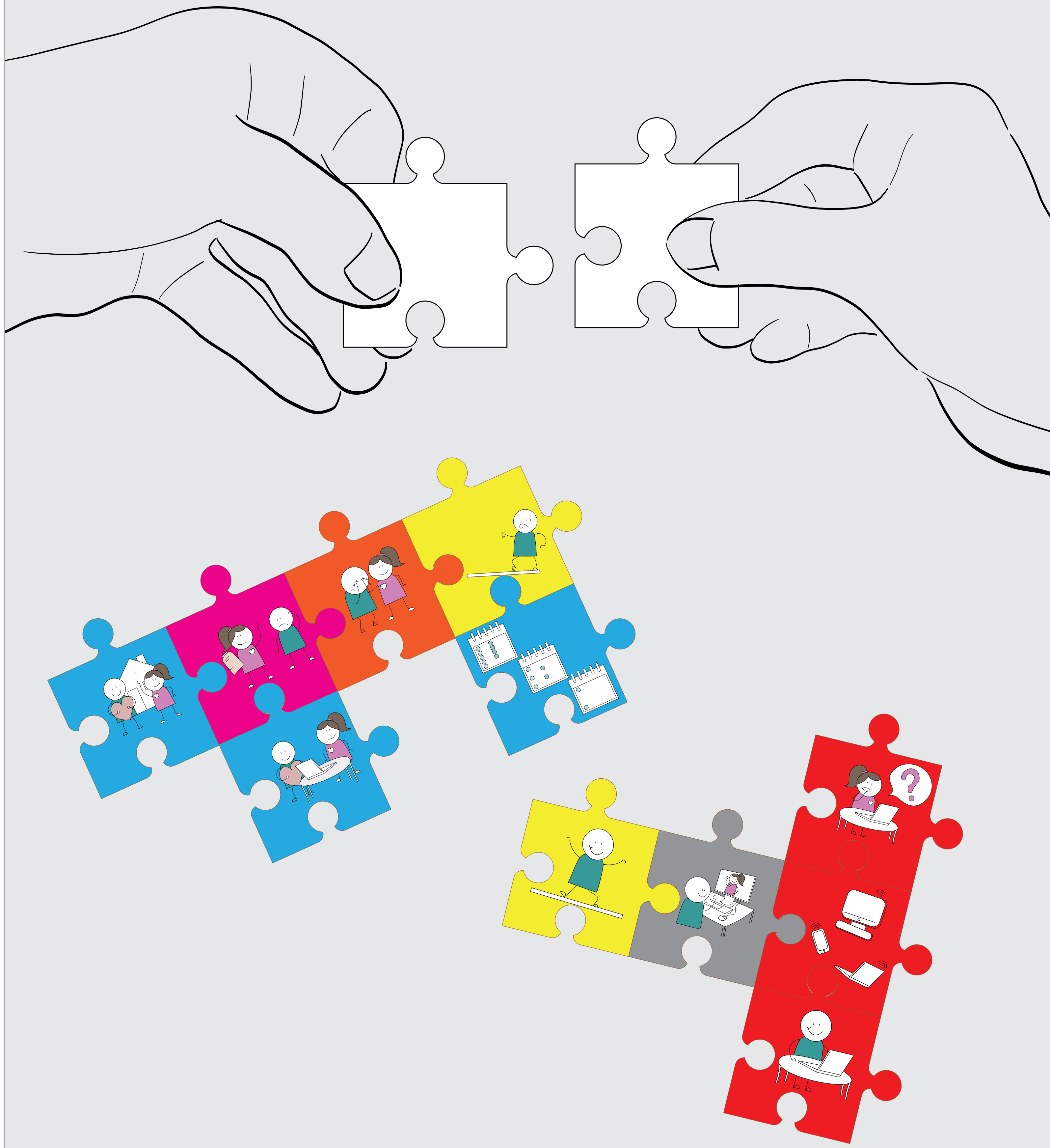


Figure 11: Concept board: puzzle

WHICH SIDE DO YOU CHOOSE?

THE DIFFERENT SIDES OF CONTACT

PROMINENT DESIGN GUIDELINES: 1, 2, 3, 4, 7 & 8

The cube has different sides, just as the work practice has different 'sides': different possibilities, each with a different impact depending on the patient, the situation and the factors involved (Figure 12). For some, this contact can be supportive, while for others it can be restrictive. The Conversation Chart gives depth to the chosen 'side', for example, with the help of casuistic, points of attention, reflective questions or tips for using this form of contact.

The cube can be placed on the desk of the mental health care professional, where it is in the view of the mental health care professional during contact moments with patients. This way, it as an external trigger to think about the different possibilities of making contact with their patient. The Conversation Chart can be used to elaborate on the chosen manner of contact for oneself or in the conversation with the patient.

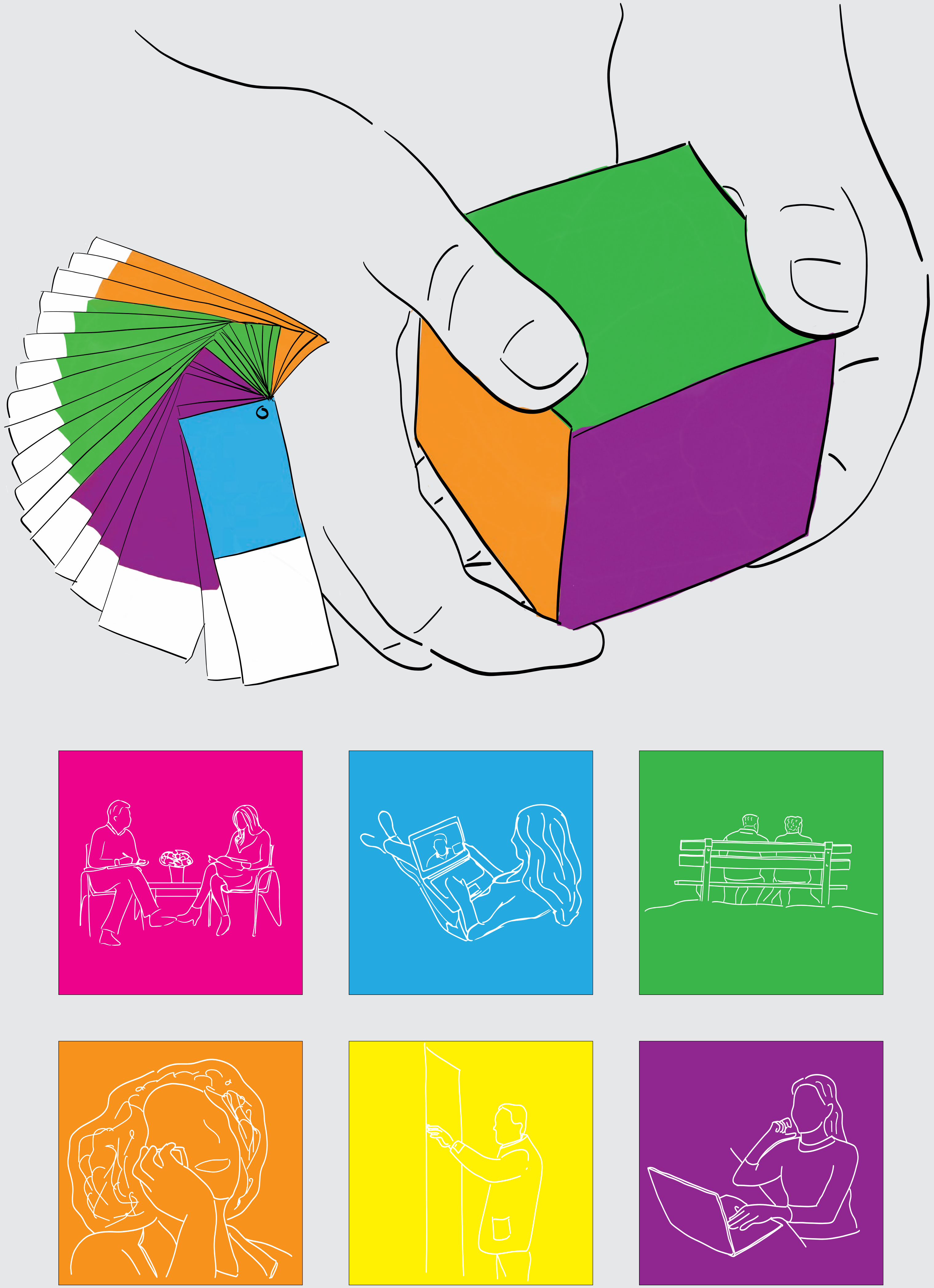


Figure 12: Concept board: cube

WHAT IS PLAYING A ROLE SUBCONSCIOUSLY?

THE INVISIBLE LAYER OF THE FULFILLMENT OF CARE

PROMINENT DESIGN GUIDELINES: 3, 5, 6, 7 & 8

A prompting board (Figure 13) in which an iceberg is used as a symbol for the visible (top) layer: the patient's recovery process is represented in this way, as well as and the chosen way of contact. And the invisible layer of the iceberg, below the surface; with factors and events that have an impact on the recovery process and the chosen way of contact. For this, the illustrations from the decision moments workshop were used and placed in context with the use of questions and textual explanations.

The prompting board and accompanying Conversation Chart can be used individually as well as in team settings. The board serves as an external trigger in the team room or coffee room. And the Conversation Chart can be used to delve deeper into the conversation about the elements that play a role in the choice of the form of therapy, for the healthcare professionals themselves as well as in their contact with patients.

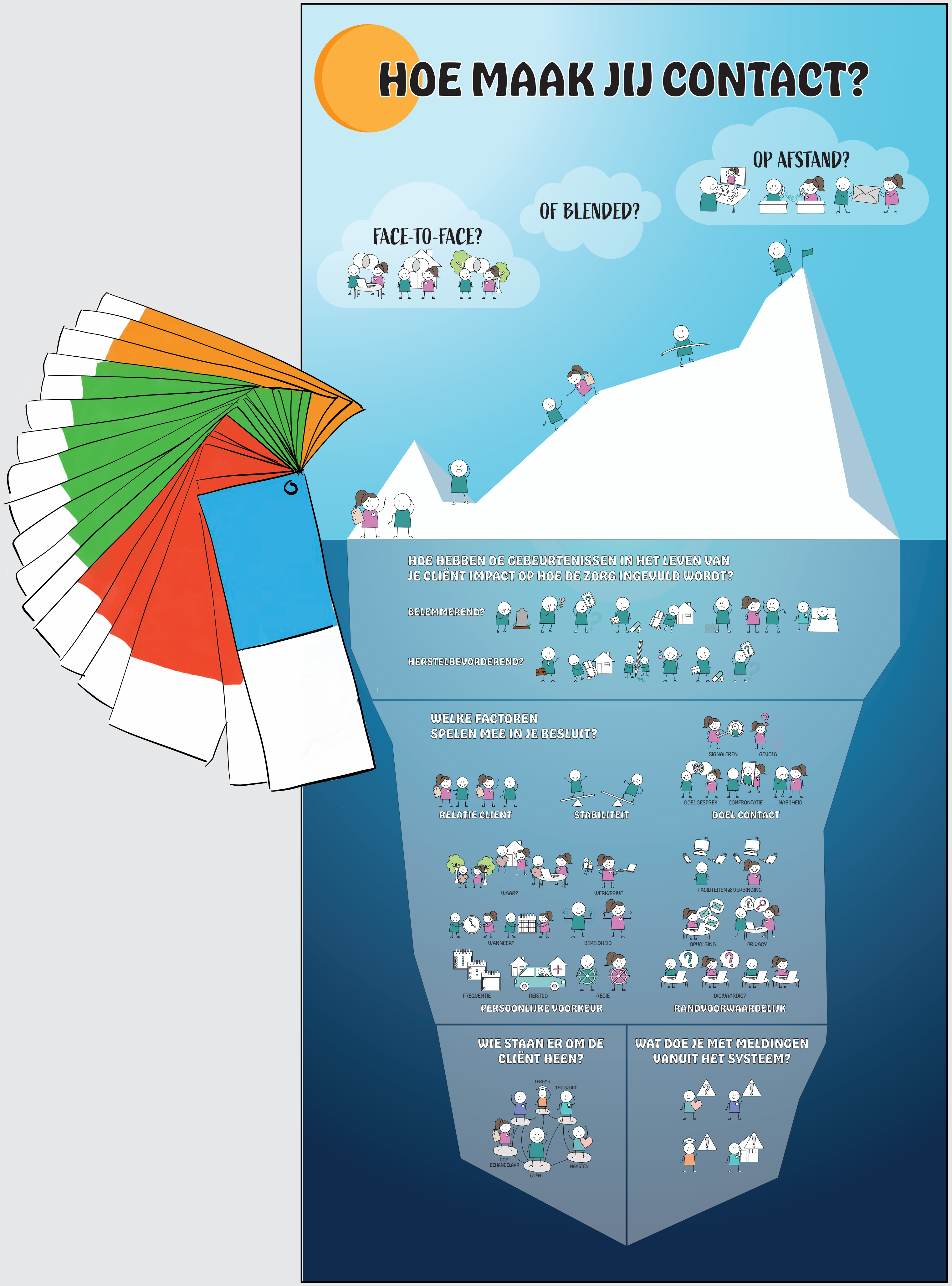


Figure 13: Concept board: Iceberg

THE JOURNEY AND WHAT YOU ENCOUNTER ALONG THE WAY

HOW THE "JOURNEY" IS DEFINED AND INFLUENCED

PROMINENT DESIGN GUIDELINES: 1, 2, 3, 5, 6, 7 & 8

The individual 'journey' of the patient, which is 'mapped out' over and over again, can have a different starting point each time: namely, the form of therapy that is chosen. What the care professional and patient encounter on their journey is represented as well: events or factors that alter the 'route'. The prompting board is supplemented with a magnetic board, where the 'treasure chest' consists of magnets that represent all the factors illustrated in the prompting board (Figure 14).

The prompting board with accompanying magnetic board can be placed in the common area of the healthcare professionals (team room or coffee room). That way, it can be easily used both individually and as a team. Because it is always present in the common room, it does not need to be grabbed independently.

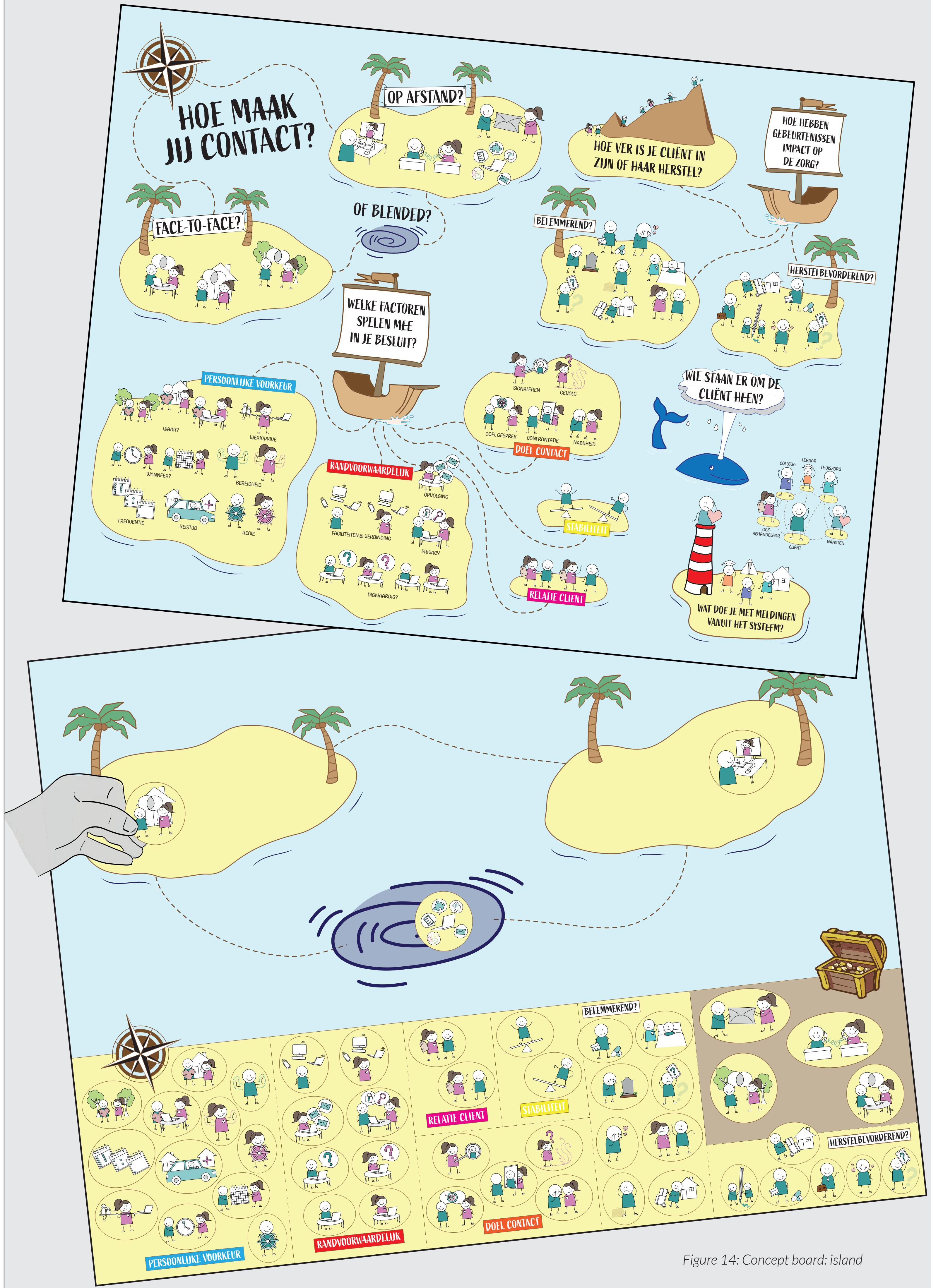


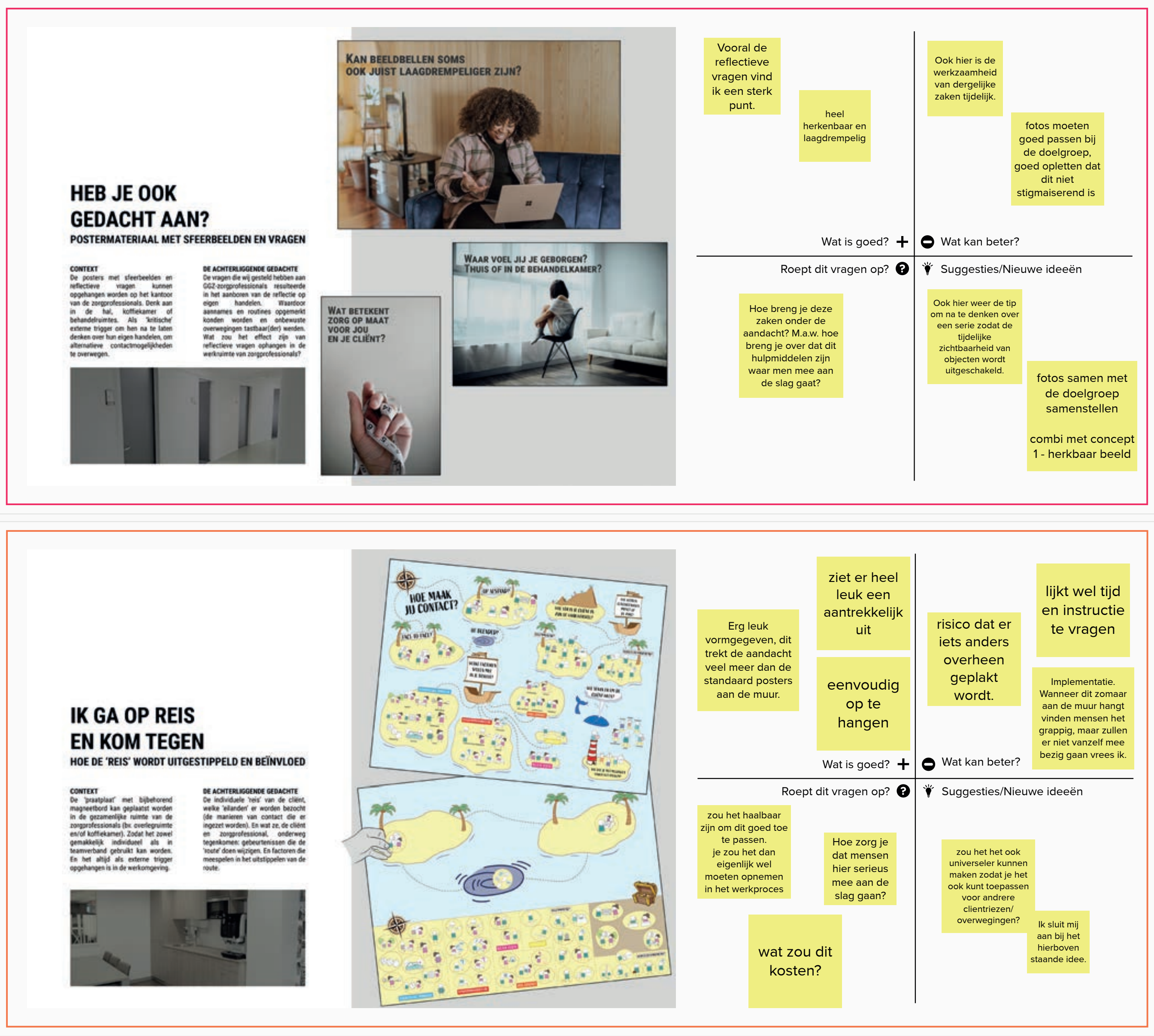
Figure 14: Concept board: island

4.5 EVALUATION OF CONCEPTS

The six concepts were presented to a care expert panel consisting of two KIEM researchers, an expert by experience and a health psychologist. In addition, out of personal interest, a mental health nurse joined the health psychologist. Given the prevailing COVID-19 measures, the session was held online using MURAL and TEAMS. For the concrete setup of the evaluation session, I refer the reader to Appendix 5. The approach and insights of the evaluation session will be discussed below.

In the evaluation session, the participants were first introduced to all six concepts by means of 'concept boards' of the visuals and textual explanation (Figure 15 shows two examples, see Appendix 6 for all the concept boards). They were asked to provide feedback on each concept, using a grid with four points: (1) what they liked about the concept, (2) what could be improved, (3) whether the concept raised any questions, and (4) whether they personally had any suggestions.

Figure 15: Example of two concept boards with feedback grid



HEB JE OOK GEDACHT AAN?

POSTERMATERIAAL MET SFEERBEELDEN EN VRAGEN

CONTEXT
De posters met sfeerbeelden en reflectieve vragen kunnen opgehangen worden op het kantoor van de zorgprofessionals. Denk aan in de hal, koffiekamer of behandelruimtes. Als 'kritische' externe trigger om hen na te laten denken over hun eigen handelen, om alternatieve contactmogelijkheden te overwegen.

DE ACHTERLIGGENDE GEDACHTE
De vragen die wij gesteld hebben aan GGZ-zorgprofessionals resulteerde in het aanboren van de reflectie op eigen handelen. Waardoor aannames en routines opgemerkt konden worden en onbewuste overwegingen tastbaar(der) werden. Wat zou het effect zijn van reflectieve vragen ophangen in de werkruimte van zorgprofessionals?

Wat is goed? +

Vooral de reflectieve vragen vind ik een sterk punt.

heel herkenbaar en laagdrempelig

Wat kan beter?

Ook hier is de werkzaamheid van dergelijke zaken tijdelijk.

fotos moeten goed passen bij de doelgroep, goed opletten dat dit niet stigmaiserend is

Roept dit vragen op?

Hoe breng je deze zaken onder de aandacht? M.a.w. hoe breng je over dat dit hulpmiddelen zijn waar men mee aan de slag gaat?

Suggesties/Nieuwe ideeën

Ook hier weer de tip om na te denken over een serie zodat de tijdelijke zichtbaarheid van objecten wordt uitgeschakeld.

fotos samen met de doelgroep samenstellen

combi met concept 1 - herkbaar beeld

IK GA OP REIS EN KOM TEGEN

HOE DE 'REIS' WORDT UITGESTIPPELD EN BEÏNVLOED

CONTEXT
De 'praatplaat' met bijbehorend magneetbord kan geplaatst worden in de gezamenlijke ruimte van de zorgprofessionals (bv. overlegruimte en/of koffiekamer). Zodat het zowel gemakkelijk individueel als in teamverband gebruikt kan worden. En het altijd als externe trigger opgehangen is in de werkomgeving.

DE ACHTERLIGGENDE GEDACHTE
De individuele 'reis' van de cliënt, welke 'eilanden' er worden bezocht (de manieren van contact die er ingezet worden). En wat ze, de cliënt en zorgprofessional, onderweg tegenkomen: gebeurtenissen die de 'route' doen wijzigen. En factoren die meespelen in het uitstippelen van de route.

Wat is goed? +

Erg leuk vormgegeven, dit trekt de aandacht veel meer dan de standaard posters aan de muur.

ziet er heel leuk een aantrekkelijk uit

eenvoudig op te hangen

Wat kan beter?

risico dat er iets anders overheen geplakt wordt.

lijkt wel tijd en instructie te vragen

Implementatie. Wanneer dit zomaar aan de muur hangt vinden mensen het grappig, maar zullen er niet vanzelf mee bezig gaan vrees ik.

Roept dit vragen op?

zou het haalbaar zijn om dit goed toe te passen.
je zou het dan eigenlijk wel moeten opnemen in het werkproces

Hoe zorg je dat mensen hier serieus mee aan de slag gaan?

wat zou dit kosten?

Suggesties/Nieuwe ideeën

zou het het ook universeler kunnen maken zodat je het ook kunt toepassen voor andrere clientriezen/ overwegingen?

Ik sluit mij aan bij het hierboven staande idee.

The concept boards were first presented to the three respondents, in which the health psychologist worked together with the mental health nurse since the mental health nurse physically joined unplanned the health psychologist.

After all the concepts had been reviewed and assessed, the concepts were discussed together. The participants first of all wanted to share their personal preferences. This was done by giving a top three. Remarkable in these rankings was that almost all concepts appeared in one of the rows, with exception of the 'Iceberg prompting board'. From these ranks however, there could not be drawn any clear conclusion yet, except that the 'Iceberg prompting board' was discarded. It was seen as an unsuitable image for the healthcare practice. The iceberg metaphor makes it seem as if the choices are only made by the healthcare professional (underwater) and the role of the patient in this journey was not sufficiently emphasised.

After this ranking exercise, we discussed the preferences in more detail, considering the question of how the participants' top three was formed. The expert by experience was especially charmed by the *Tools* that make healthcare professionals 'get to work' with the subject. His top three consisted of: the puzzle, islands magnetic board and the cube. He emphasised the positive element of the puzzle, that it can be used over and over again, whereby you can tangibly reorganise care each time. The other participants understood his preference, but noted that this is a time-consuming concept, and that it remains to be seen whether this will be used repeatedly by the care professionals or whether they will have understood the 'message' after one single use.

The puzzle has to be actively 'picked up from the shelf', either individually or collectively. However, as we have unfortunately seen before, such *Tools* are not easily picked up because of lack of time or because care professionals do not think about it. Therefore, the expectation is that this concept will not be used very often. During the discussion, the 'cube' was not really mentioned by the participants. The only remarked that it was questionable whether the cube really consists of six sides or whether it has more.

On the contrary, there was an extensive discussion about the island magnetic board. This concept already serves as an external trigger in the working environment of the healthcare professional, which means that they do not need to actively pick it up, as it is already on the wall. The concept offers possibilities with regard to the fact that it is adaptable, making it possible to personalise it according to the current situation. However, the participants noted that this concept is currently very specific, which created a desire to make the magnetic board more universal. In addition, the lack of time was once more emphasised, and that the hectic nature of the daily practice can be a potential problem. It is a time-consuming concept that also requires some instruction. The participants therefore warned me about the complexity of the concept and advised me to look at the approachability of the concepts.

The health psychologist and the mental health nurse were more charmed by the more accessible concepts, referring to the posters and the line art, which act as an external trigger to think about the subject or 'the reflective question'. These concepts do not require much effort from the healthcare professional and are therefore not complex in terms of instruction. They advised me to collect the themes and images together with the target group, since I currently based those on my own associations. They highlighted an additional advantage of the line art and the posters: when exhibited also in the patients' environment, it may positively influence shared decision-making. They found the poster's questions thought-provoking, as well as the metaphorical idea of the line art. They suggested looking for a combination between this line art and the posters in the development of the final *Tool*.

I considered this a valuable recommendation, also from the point of view that there is a difference between images and pictures, as I believe that using images ('art') can achieve a higher level of abstraction than using pictures. When I use pictures as 'the visual to attract attention', other associations or 'misplaced' atmospheres are at risk. In this sense, images can be used more uniformly than pictures, which is exactly what is needed in this complex and diverse care practice.

If I would decide to further develop the posters, whether or not in combination with the line art, they advised me that it is important to develop several subjects (a series) in order to be able to vary between care organisations. They feared that if a certain image would be displayed for over a year, it would no longer be noticed. Therefore, they saw the need for variety.

As a final activity the concepts were ranked collectively, based on the design guidelines (Figure 16). The islands magnetic board (orange) scored the best, followed by (listed in order of assessment): the posters (pink), the puzzle (blue), the cube (green), the iceberg (yellow) and the line art (purple).

It was remarkable that the line art scored so low, despite the attributed value of the low threshold of this concept. The main reason for this was that the line art in itself is not thought-provoking enough. The island concept emerges as a superior concept in the assessment based on the design guidelines, however, the insights from the evaluation session call for a revision of the evaluation criteria. The next section describes this revision process and which concept direction was chosen.

Figure 16: Evaluating the concepts against the design guidelines

Het ontwerp is een uitnodiging voor zorgprofessionals om sensitief te worden voor de keuze tussen face-to-face therapie, zorg op afstand of een combinatie hiervan blended care.

Het ontwerp is harmonieus met de context van de werkruimte/ kantoorruimte van GGZ-zorgprofessionals. Ofwel het ontwerp kan 'prominent' geplaatst worden in de werkomgeving van de GGZ-zorgprofessionals als externe trigger.

Het ontwerp is een uitnodiging voor het aanboren van reflectie op eigen handelen en het overdenken van de impact van de gekozen manier van contact.

Het ontwerp is triggerend om de zorgprofessionals na te laten denken over eerder onbewust genomen afwegingen, in die zin dat de afwegingen bewuster en tastbaarder genomen kunnen worden.

Het ontwerp fungeert als een trigger om na te denken over de vraag 'Hoe maak ik contact?' ofwel fungeert als een trigger om na te denken over de verschillende contactmogelijkheden die er zijn.

Het ontwerp kan zowel individueel gebruikt worden als ook in teamverband.

Het ontwerp is ondersteunend in het overzien van de impact en consequenties van de gekozen contactmogelijkheid.

Het ontwerp kan ondersteunend zijn voor het gesprek met elkaar, tussen de zorgprofessionals.

4.6 CONCEPT CHOICE

The concepts that have risen from the desired future practice concern the development of a reflective attitude towards the changing care practice to be able to use these changes in a well-considered way to enhance the recovery process of the patient. In this, routine actions will have to be interrupted in order to reflect on the impact of one's own actions. We have seen that care professionals currently find it difficult to recognise these changes and that they are searching for the concrete added value of various forms of therapy. The concepts are therefore, each in their own way, prompts for reflection on the choice and the consequences of the choice.

When we compare the concepts using the design guidelines, we see that the island concept emerges as the 'superior' concept. However, in the discussion of the evaluation session, it became clear that this concept would need some fine-tuning in order to work in practice. At the beginning of **4.4 Concepts**, I already described that the concepts are forms for stimulating the reflective attitude. However, in all concepts, the more detailed informative knowledge layer still needed to be thought through. However, the fine-tuning that the island concept requires from the care practice perspective is precisely the opposite: to make the concept more universal and accessible so that it requires less instruction and is also less time-consuming. This would mean that layers would have to be taken out of the concept instead of being added to it. Within this scope, and the accessibility demanded by the user context, the intended purpose of the island concept cannot be achieved. It is also questionable whether the desired abstraction and universality can be achieved within this concept, as we have seen that healthcare practice is diverse, multidisciplinary and complex in nature. Concepts are not generally shared: the board with the consideration factors would therefore be too specific.

Despite the fact that the island concept would be 'the way to go' according to the design guideline, a high value was given to keeping the *Tool* accessible in light of the hectic care practice. This presents an important criterion in the evaluation of the concepts, namely: low threshold, which is related to not being (too) time-consuming and requiring little instruction.

This criterion is however not new: in the discussion of **3.2 Decision making in practice**, I had already observed the need for an accessible *Tool*, since current (time-consuming) instruments are in practice rarely or not used. However, I had lost sight of this criterion in the formulation of the design guidelines, which mainly focused on what needs to be stimulated in order to make the complexity, the considerations and the changes that occur tangible. In the concept phase, there was a focus on the user context in terms of where and when the concept would be applied, but there was no major focus on practical applicability. The evaluation session therefore helped understand which concepts can actually be applied in the current care practice. In addition, the alternation and having a new trigger every time was mentioned, given the risk that the *Tool* would otherwise no longer be noticed after some time.

In view of the valuation of accessibility, combined with the recommendation of continually having a new trigger, it was decided to develop the poster concept further, as it was also judged to be second best from the design guidelines. In this, images are used instead of pictures, based on the idea of line art as a metaphor for the 'connection' between the patient and the healthcare professional. In this sense, a combination of the poster concept and line art is sought. This resulted in the choice for an accessible, abstract yet specific concept, in which in-depth information can be provided and which serves as a varied external trigger in the work environment to keep thinking about the theme.

CONCEPT DEVELOPMENT

This chapter describes the materialization of the chosen concept which is a combination between the line art and the poster series: the poster will be visually supported with line art. The concept development will focus on further elaborating on and determining the themes for the poster series. This will be done in collaboration with (mental) healthcare experts and a content creator, to ensure that the themes and the content are aligned with practitioners as well as written in a thought-provoking way. This materialization includes a series of twelve topics, images and a substantive explanation of these themes. This chapter contains parts of the series in order to describe the design process. After the poster series was materialised completely it was exhibited in two healthcare organizations for the validation of the concept (chapter 6). The complete elaboration of the poster series can be found in "Final Concept".

05

5.1 IDENTIFYING THE THEMES

In the evaluation session of the concepts, it became clear that I had to work together with practitioners in the substantive and visual elaboration of the concept to guarantee the alignment with the care practice. This is in line with the data collection of the current care practice, which had a practice-oriented focus and attention for the story of practitioners. In the development of the poster series, I have once again sought the connection with the professional practice to be able to visualise and describe the story and the insights in an appropriate manner.

In the evaluation session, it was mentioned that the form of the *Tool* (as a poster series and/or line art) has the additional positive effect that it can also be seen by patients, which in all likelihood contributes positively to shared decision-making according to the participants in the evaluation session. I wanted to use this additional advantage, which was not consciously conceived, and develop it further for the final *Tool*. This way, the *Tool* can be used from both perspectives: by both healthcare professional(s) and patients.

This is important because we have seen that healthcare professionals are sometimes influenced by assumptions about the desired contact, which means that the options are not always discussed with the patient. By displaying the poster (with the line art as an image) in areas that are also accessible to patients, such as the hallway or treatment rooms, the posters can not only function as a conversation trigger for healthcare professionals, but the patient can also take an active role in this when he or she feels the need.

The reason for this is that we have seen that care professionals currently have difficulty recognizing the changes that various forms of therapy entail and that they are searching for the concrete added value of various forms of therapy. In developing the *Tool*, I have looked at how the knowledge gained from the research can be articulated and transferred, so that care professionals can make a more tangible and substantiated choice between the forms of therapy, in which they can oversee the consequences of the form of therapy and can optimally use the changes that come along in the recovery process.

The required textual in-depthness, in combi-nation with the desire to make the poster series also visible to patients, led to the decision to develop a two-panel format: first, a poster for both the patient and the care professional, in the hallway or the treatment room, consisting of the image (line art) and the theme described in a question or statement (Figure 17). Second, a more in-depth poster for the team room of the healthcare professionals, containing the same image and theme, but also giving more in-depth knowledge (Figure 18).

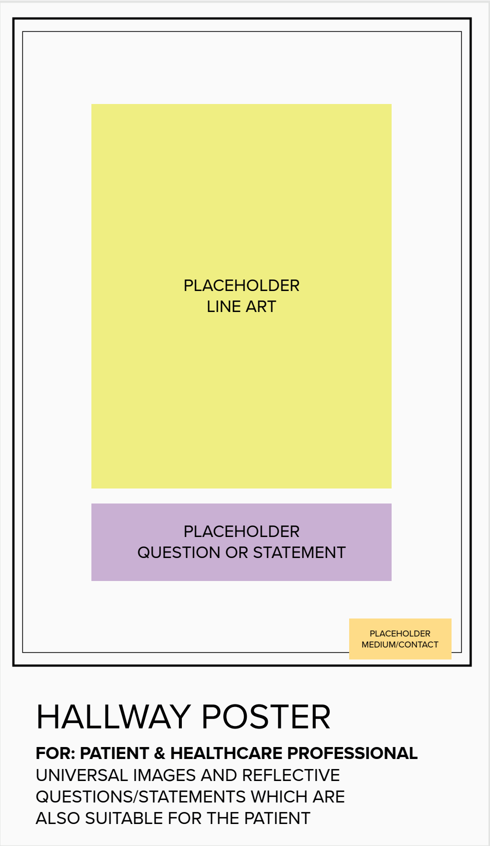


Figure 17: Grid hallway poster

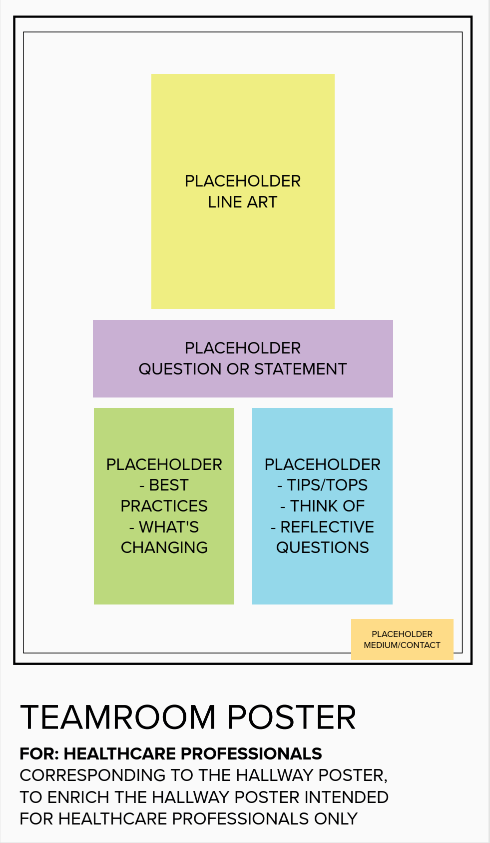


Figure 18: Grid team room poster

Regarding the content, I suggested devoting a column to the changes that occur when a specific form of therapy is chosen and what the experience has taught us about how this can be of added value to care. A second column could be devoted to dealing with points of attention regarding this form of therapy, which care professionals 'should' consider or which questions they can ask themselves when they choose this form of therapy. This setup, as well as the choice for a two-panel format, was tested by the health psychologist who also participated in the evaluation session. Once we had agreed on the intended components of the *Tool*, we could move on to the concrete content of the poster series.

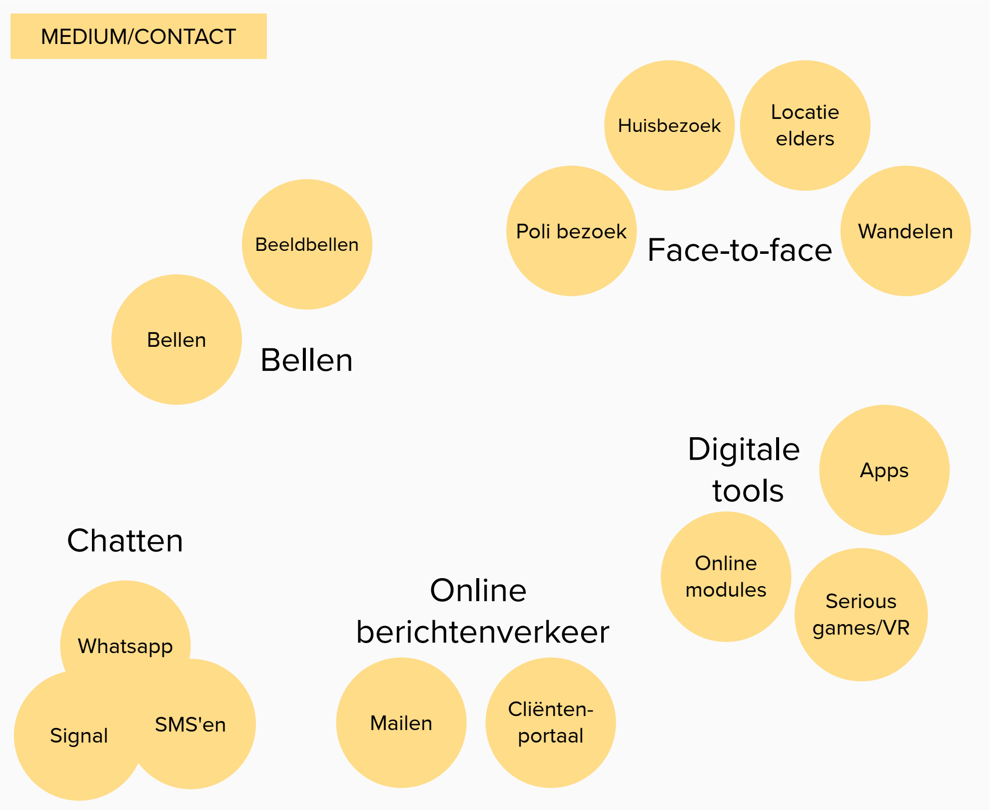
Based on the insights and stories from current health care practice, a first draft could be made of the possible forms of therapy, what concrete added value this therapy form can offer and what changes are associated with this therapy form. This resulted in an overview of topics and questions or statements for the development of the *Tool*, which was also presented to the health psychologist to verify the topics and themes.

THE FORMS OF THERAPY

First of all, we discussed the different forms of therapy with each other. For this, I had prepared a MURAL board (Figure 19). The health psychologist had added Serious games and Virtual Reality to the overview, after which we thematised the contact possibilities together. We formalised the different possibilities as: calling, chatting, online messaging, face-to-face contact and digital tools. For the further development of the *Tool*, I have categorised these forms of contact into 'medium' usage: telephone, smartphone/tablet, laptop and 'location'. I put medium between quotation marks because 'location' is perhaps the odd one out. However, I choose the word 'medium' as I see the medium as the connecting element, the element *through which* patient and healthcare professional can be in contact, or applied somewhat more freely, the connecting element *where* patient and healthcare professional are in contact, referring to the medium of location.

The context of where the conversation takes place (the location) has an impact on the contact. It can influence the topics that are discussed as well as the way in which they are discussed, relating to the dynamics of the conversation. In addition, it can also have an impact on how you feel during the contact, how safe and secure you feel in that environment and what your relationships are within this environment. The poster series is not meant to be about only dealing with the changes and differences in online contacts. After all, face-to-face contact has merits that are worth considering and discussing.

Figure 19: MURAL board contact possibilities/medium

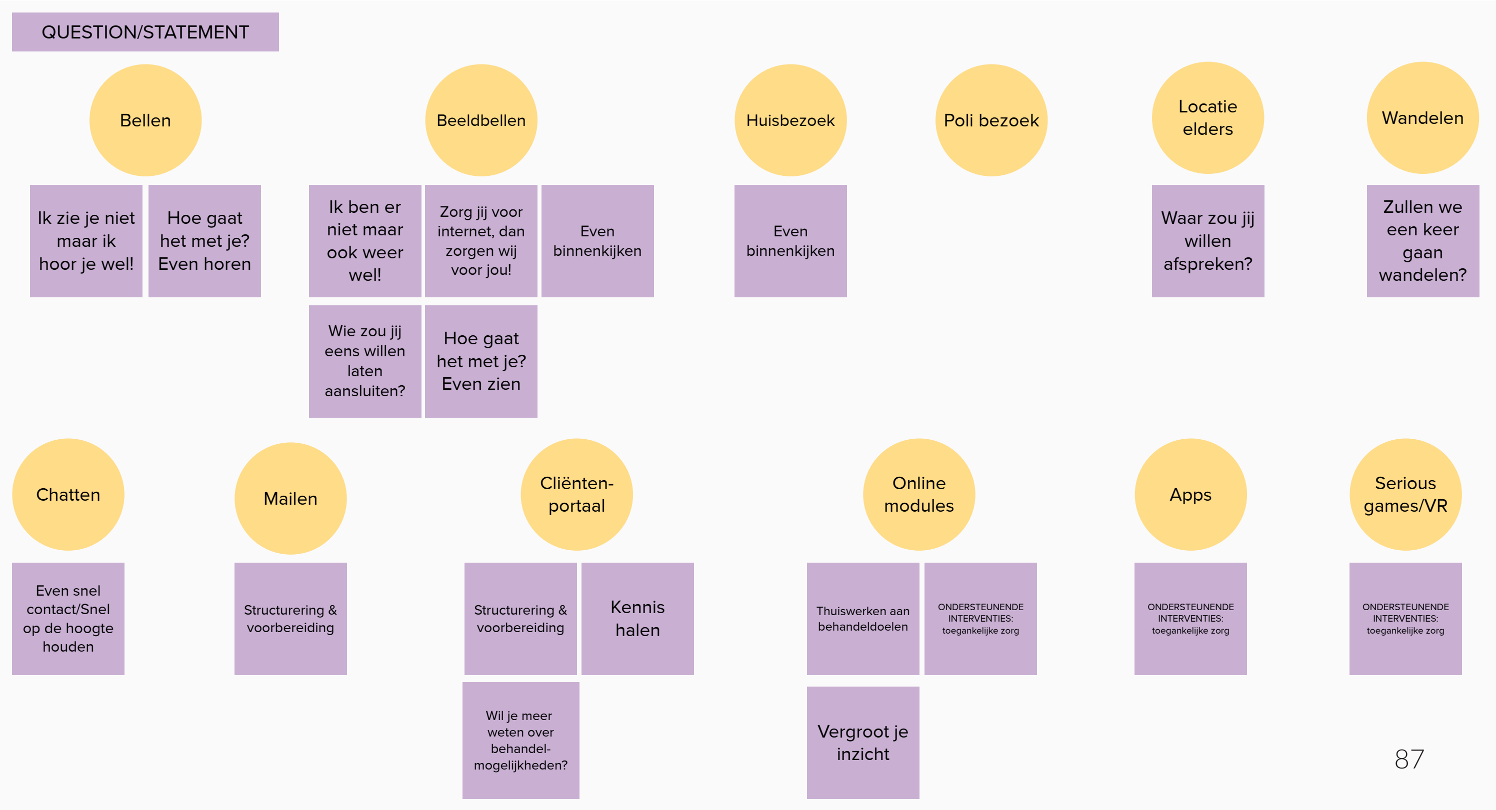


THEMES

For each of the different forms of therapy, we thought about what changes occur when this therapy form is used and how this can be of added value for care and thus the recovery process of the patient. A MURAL board was also prepared for identifying the themes (Figure 20). The orange spheres illustrate the various medium possibilities and the purple post-it's are possible themes supported by a statement or question. This formulation of themes was discussed with the health psychologist. Within the themes that had been formulated, I selected 12 topics from the idea; one theme each month in which I deliver content for a year within my project. In this selection, diversity between the themes was chosen so that different media uses could be addressed. This selection is therefore not a comprehensive overview of the themes at play. Section **5.2 Concept components** will further present and describe the elaborated themes.

We also discussed the added value and points of attention that deserve a place on the in-depth poster for the healthcare professionals. From this input, combined with literature research (chapter 1) and especially the insights into the current practice (chapter 3), I could start working on the textual development of the posters. After some time we sparred again in order to make the themes that were still partly open richer and more practical for the healthcare practice. Section **5.2 Concept components** will elaborate on the content and visual details of the poster series.

Figure 20: Themes poster series



5.2 CONCEPT COMPONENTS

This section describes the structure of the poster series, how the components were created and how they were verified. Afterwards, an overview of all the themes and images that are included in the poster series is presented (Figure 27). For the complete poster series, including the more in-depth posters, I would like to refer the reader to "Final Concept".

Both the hallway poster and treatment room poster (for patient and healthcare professional) (Figure 21) and the in-depth poster (for healthcare professionals) (Figure 22) consist of the tagline, the line art and the icon for the medium.

TAGLINE

All posters contain a tagline, some with a question and others with a statement. These taglines are meant as a textual trigger for the theme to get the conversation going. The taglines originate either from the change that occurs or from the added value of the therapy form.

LINE ART

The line art symbolizes the connection between the healthcare professional and the patient. They are my artistic translations of the theme. The images have been verified with fellow students (designers) as well as with my (former) mentor from the Research group IT Innovations in Health Care. Based on their feedback, the illustrations were redesigned and fine-tuned.

Figure 21: Hallway and treatment room poster

IK ZIE JE NIET,
MAAR IK HOOR JE WEL

Bij zorg op afstand verdwijnt de fysieke nabijheid. Iemand fysiek kunnen steunen op moeilijke momenten, door even een hand op zijn schouder te leggen, is door deze afstand niet mogelijk. Maar is fysieke nabijheid altijd nodig om je cliënt te kunnen steunen? Of is het kunnen bieden van een luisterend oor soms ook voldoende? Hoe bied je ondersteuning en nabijheid zonder fysiek aanwezig zijn?

ELKAAR ZIEN IS NIET ALTIJD NODIG EN DAT GEEFT OOK RUIMTE

De ervaring heeft geleerd dat deze nabijheid helemaal niet per se altijd nodig is. Soms kan het ook prettiger zijn voor de cliënt om juist die fysieke afstand te hebben. Sommige cliënten praten op afstand immers net zo makkelijk, al dan niet gemakkelijker. Het komen naar kantoor of het ontvangen van de zorgverlener thuis kan soms al zodanig spannend zijn voor de cliënt dat zorg op afstand juist laagdrempeliger voelt.

Zorg op afstand vraagt om een andere manier van signalen oppikken en sfeerproeven. We zijn gewend om dit letterlijk te kunnen voelen. Op het moment dat lichaamshouding en mimiek minder goed zichtbaar en voelbaar zijn, verandert ook de dynamiek van het gesprek. Daar waar je face-to-face minder woorden nodig hebt om te achterhalen hoe de cliënt erbij zit, kan bij bellen het boven tafel krijgen van deze woorden juist belangrijk zijn.

Hoe kun je achterhalen hoe de cliënt erbij zit zonder deze non-verbale communicatie? Het vraagt misschien niet eens zozeer om nieuwe gesprekstechnieken, maar wellicht juist wel het bewuster inzetten hiervan?

Bij beeldbellen kun je nog een deel van de non-verbale communicatie oppikken, maar voor sommige cliënten leidt het beeld juist te veel af en zou bellen geschikter zijn. Met wie bel je en met wie zou je liever beeldbellen?

Figure 22: In-depth poster

LEFT COLUMN

The textual column on the left addresses both the visible and the less tangible changes. Additionally, what experience has taught us about how these changes can benefit healthcare and the recovery process of the patient.

RIGHT COLUMN

The textual column on the right addresses what these changes require from healthcare professionals in terms of both practically and points of attention when establishing these forms of therapy. The reflective questions are intended to stimulate a reflective attitude to the changing practice of care. They are intended to act as conversational triggers.

Validation content

Several experts have contributed to the textual development of the poster series. First, a content creator and a fellow student went through the texts for grammatical flaws. Afterwards, a researcher from the Research group IT Innovations in Health Care, with a healthcare background, went through the texts from a healthcare perspective. To conclude the content validation, my former mentor from the Research Group assessed the poster series in its completeness, on language, graphics and the connection to the healthcare practice.

Figure 23: Icon telephone

MEDIUM: TELEPHONE

This medium refers to calling. It is purely about telephone contact, hearing each other and speaking to each other without seeing each other. In the use of icons, an 'old-fashioned' telephone has been used in order to distinguish between telephone and smartphone & tablet (Figure 23).

Figure 24: Icon smartphone & tablet

MEDIUM: SMARTPHONE & TABLET

This medium refers to the use of APPS, supporting APPS for relaxation or insight into the condition. But also communication APPS such as Whatsapp and Signal. Some patients also use their smartphone or tablet during video calls or while working on the patient portals (modules) (Figure 24).

Figure 25: Icon personal computer

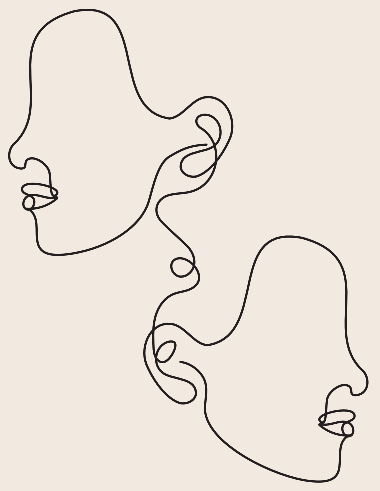
MEDIUM: PERSONAL COMPUTER

In addition to being able to use a smartphone & tablet, patients can also use a computer to consult self-help platforms, patient portals, videos etc. PCs are also used for making contact, such as video calls and e-mailing (Figure 25).

Figure 26: Icon location

MEDIUM: LOCATION

Besides the use of technological means as the connecting element, the location is also a connecting element: the place where health care professional and patient meet. This does not need to only consist of office visits or home visits: other locations can also be worth looking at, for example the forest or a terrace (Figure 26).

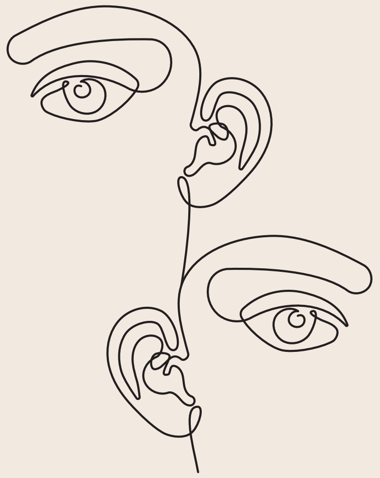


IK ZIE JE NIET,
MAAR IK HOOR JE WEL

☎

EVEN THOUGH I MAY NOT SEE YOU, I CAN HEAR YOU

With telecare, physical closeness disappears. When you opt for telephonic contact, you cannot see each other either, you are simply left to hearing and speaking. This requires a different way of signalling and 'checking' the patient. Does this require a more conscious use of conversation techniques?



HOE GAAT HET MET JE?
EVEN HOREN, EVEN ZIEN

📱 💻 ☎

HOW ARE YOU DOING? A MOMENT TO HEAR, A MOMENT TO SEE

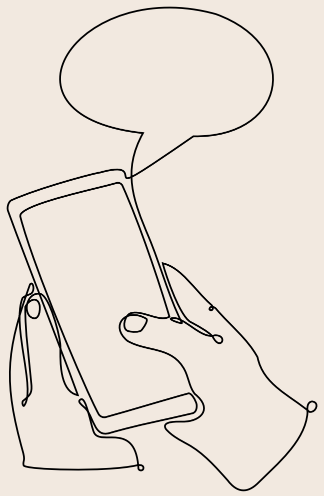
Care at a distance is often more functional in nature, resulting in short(er) contacts. This offers possibilities for scheduling and the frequency of contact. Would having more frequent, brief contact, add anything to your treatment relationship?

WIE ZOU JIJ EENS WILLEN
LATEN AANSLUITEN?

📱 💻

WHO WOULD YOU LIKE TO JOIN THE CONVERSATION?

Care at a distance offers opportunities for multidisciplinary contact; family members who live further away or an available colleague can join in more easily. Because several people are connected, managing the technology can sometimes be challenging.

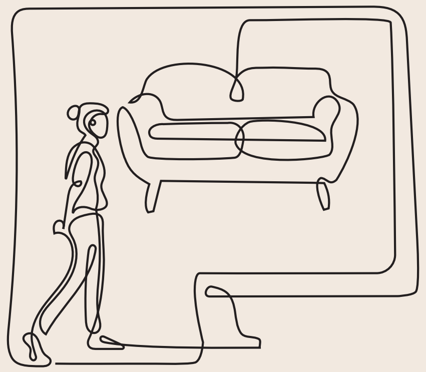


EVEN SNEL CONTACT?

📱

A QUICK WORD?

Communication applications offer a lowkey form of contact. You can briefly share or discuss something with each other. This in-between contact can influence the dynamics of the therapy. Chatting is practical and fast, but what do you agree on regarding your availability?



EVEN BINNENKIJKEN

📍 📱 💻

SNEAK A PEEK

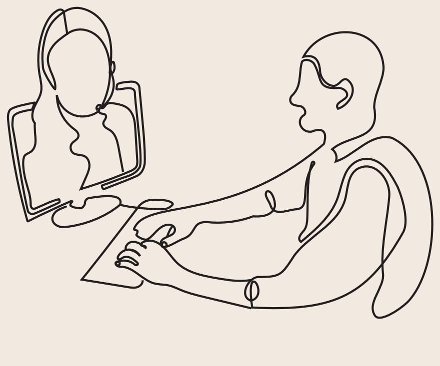
Seeing the patient's home environment provides healthcare professionals with a more complete picture of how the patient is doing. Being able to see the home environment can also result in new topics of conversation. What does a video call or home visit bring you?

WAAR ONTMOETEN WIJ
ELKAAR ONLINE?

📱 💻

WHERE DO WE MEET ONLINE?

Nowadays, all kinds of platforms are available to maintain contact with patients at a distance. Meeting each other digitally results in new unwritten rules and changes of "the ritual". What do you agree with each other?



IK BEN ER NIET,
MAAR OOK WEER WEL

📱 💻

I AM NOT THERE, BUT I'M WITH YOU

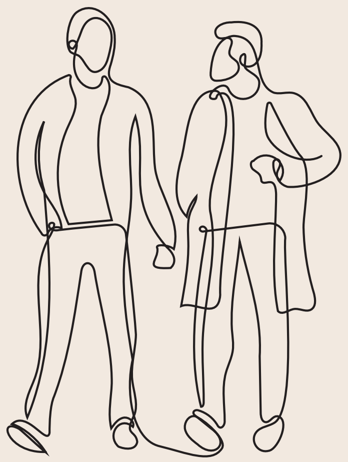
Being able to see each other, even if this is not physical, adds something. With video calls, some of the facial expressions and body postures can still be picked up, contrary to phoning. Video calls were a little uncomfortable at first; what makes it feel unnatural and how can you overcome this together?

WAAR ZOU JIJ
WILLEN AFSPREKEN?

📍

WHERE WOULD YOU LIKE TO MEET?

A different environment results in new topics of conversation. Although it is not always practically possible to visit the desired locations together, you can still discuss with each other what this location means to your patient.

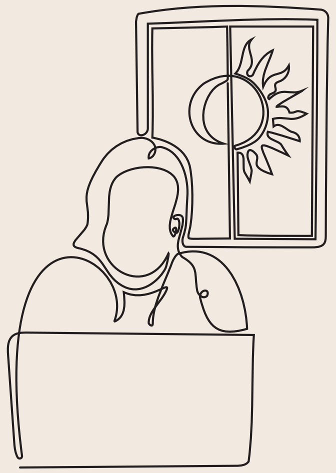


ZULLEN WE EEN
KEER GAAN WANDELEN?

📍

SHALL WE GO FOR A WALK?

Sometimes it can be pleasant not to sit face-to-face during the conversation. Walking can be easily combined with having a conversation: it additionally has a therapeutic effect. Your relationship to the environment is equal, which can contribute positively to the feeling with the conversation.

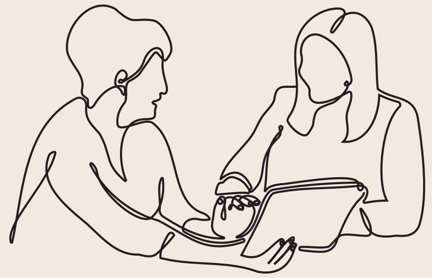


THUIS WERKEN
AAN BEHANDELDOELEN?

📱 💻

WORK ON TREATMENT GOALS AT HOME?

Technology increases the accessibility of care in between appointments. As an organisation, what options do you offer? How can you help patients get started with digital care?

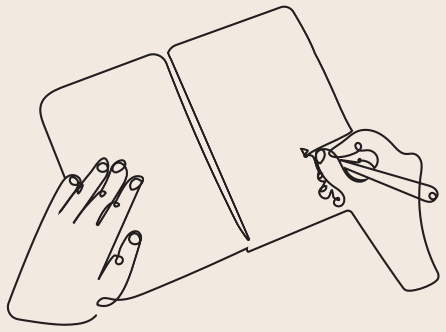


MEER WETEN OVER ONLINE
BEHANDELMOGELIJKHEDEN?

📱 💻

WANT TO KNOW MORE ABOUT TREATMENT OPTIONS?

Online treatment options can offer insight into the condition, progress and recovery. There are so many possibilities available, it is impossible to be familiar with everything. Can you also explore these possibilities together with your patient or colleagues?



WIL JE JE VERHAAL EENS
OPSCHRIJVEN EN DELEN?

📱 💻

WOULD YOU LIKE TO WRITE DOWN YOUR STORY AND SHARE IT?

Writing can help you process your experiences and emotions, and in this way structure your thoughts. Therefore, writing can also be supportive for patients in preparation for the therapy.

Figure 27: Overview of all the posters

CONCEPT VALIDATION

The research has led to a rich and varied insight into current care practice. How care at a distance can be of added value was studied, as well as how it can change care, what care professionals encounter when deploying care at a distance, what choices care professionals have and what impact this has on shaping care. These insights and experiences have been incorporated into a poster series with the intended purpose of supporting care professionals by making these changes and possibilities more tangible, so the choice for the form of therapy can be made more deliberately. The poster series has been exhibited in two different care organisations for the validation of the concept. This chapter describes how the validation was carried out and the insights it provided.

06

6.1 VALIDATION METHODS

The poster series has been exhibited in two different care organizations. Six topics have been displayed in a mental healthcare organization in Drenthe and the other six topics in a mental healthcare organization in Friesland. The pilot lasted three weeks and covered two subjects per week. After these three weeks, I would visit both locations to collect the findings by the means of a focus group session. Unfortunately, one of the appointments could not take place due to the tightened COVID-19 measures. Instead, some brief insights were shared by my contact person of the organisation. When bringing the poster series I also left a box of diaries for the healthcare professionals to carry with them throughout the weeks (Figure 28).

On the cover of the notebook I had pasted an information letter explaining my project, what the poster series is about and what I asked them to write down. This consisted of: what do you think of the topics? Did the posters lead to conversations with your colleagues and/or your patients? What were those conversations about and what did you gain from them?

Figure 28: 'Diary kits'

I also sent this information letter digitally to my contact persons within the organisations so the information letter could also be distributed digitally within the team. For the actual information letter I refer the reader to Appendix 7. Unfortunately, no diaries were filled in.

In preparation for the **focus group session**, I prepared a questionnaire. My questions were divided into general questions about the posters, questions about the content and implementation-oriented questions (Appendix 8). During the focus group session, it soon became clear that not all participants had read the information letter, which led to different expectations regarding the planned contact moment. The care professionals were under the assumption that I was visiting them to talk about my research rather than that it was meant to be an evaluation session about the posters. At that point, I switched to testing the effect of the poster series on the spot rather than asking them substantive questions about the various topics (Figure 29).

The healthcare professionals asked me to send them a **digital questionnaire**, as well as the posters, so that they could still evaluate the content of the series after the session (Appendix 9). This questionnaire was also sent to the team whose appointment had to be cancelled due to COVID-19. Unfortunately, I only received a response from one healthcare professional. This completed questionnaire was very similar to the insights I had already gained during the focus group session: therefore, I am not including a separate analysis section for this questionnaire. This feedback will be treated together with the insights from the focus group session in the next section. However, the insights of my contact person from the organisation I could not visit were in a different order. Therefore, a separate section is included in the analysis for these insights.

Figure 29: Validation poster series focus group session

6.2 VALIDATION INSIGHTS

The poster series has been exhibited in two different care organizations (Figure 30 & 31). I have already mentioned that the focus group session was structured differently than planned, as the care professionals had not received an information letter or had only read it briefly in their hectic days. As a result, there was no specific, conscious focus on looking at the poster series during the pilot weeks. Unfortunately, this meant that I was unable to go in depth during the focus group session regarding the themes and the care-related content of the in-depth poster.

However, this did give me the opportunity to find out what it was that made the posters not stand out enough and what this means for possible future implementation. In addition, we discussed one of the posters together: during the discussion that the healthcare professionals were having among themselves about the poster series, I was able to observe 'on the spot' whether the posters served as a conversation trigger or not. For the analysis of the session, the recording of the focus group session was anonymously transcribed and used for a thematic analysis. I will discuss the insights based on three themes: the added value of the posters, the obstacles (during the pilot) and implementation advice.

Added value

At one time during the session, one of the care professionals took the lead and read out loud the text of the in-depth poster so that the people who joined from home could also join the discussion. During this part of the session, I took on the role of observer and let the care professionals lead the discussion. What stood out was that, after the care professional had read the text, the people at home responded immediately with their own experiences with the medium and what they thought of the points of attention.

After sharing the personal experiences of the care professionals, I specifically asked them if they expected that the posters could have been topics of discussion if they had planned time for this together, since we could now conclude that in the 'casualness' it did not get enough (joint) attention. All healthcare professionals confirmed this: they expected that if attention had been paid to it collectively it would have become more alive in the team. They also believe that the posters in the treatment rooms would have been used more often and would have been noticed more, when a joint introduction has taken place. My contact person from this organisation had used the posters in two contact moments with patients.

The care professionals felt that they should have these conversations more often and asked me if they could keep the posters. They hoped that after the session they would be able to discuss them with greater focus. They also asked me if I could send them the remaining topics digitally.

Figure 30: Exhibited poster series at two different mental healthcare organisations

Obstacles (during the pilot)

During the pilot, we had to deal with some practical problems which resulted in insufficient attention for the posters. The team had just switched to a different patient-portal, which required their focus. In addition, the care professionals were rarely on location. There were several reasons for this: the autumn holiday fell within the pilot and there was a lack of physical space at the location, which meant that many care professionals had to do did home visits or video calls and were therefore mainly on the road or at home.

Despite the aforementioned practical problems, of which I believe they were certainly a part, I expect that the biggest problem was that there is no time for a moment of reflection in the hectic of the day. Where the accessibility was mentioned during the evaluation session of the concept boards, it appears that despite the low threshold character there was still no time or space for it. With 'space', I mean the ability to be open to reflecting on the subject, by reading it in the rush of the day, this level of reflection will not be achieved. It is therefore questionable whether the low threshold character of the posters has resulted in too much casualness or whether there really is no time in this care practice.

Implementation advice

Yet it seems that a lack of time is a very big stumbling block for healthcare professionals. In the conversation about what would be needed for the implementation of the poster series, I was told: *"TIME, TIME, TIME"*. They want, and need, to work on the subject, but are not given the necessary space and time to do so. No structural moments are planned, while they have such a great need for this topic to be carried team-wide, learning from and discussing it with each other.

In addition, they wanted to add that attention should be paid to making it a focal point, a theme for a certain period, which is also actively introduced together at the beginning so that in the following period, specific use can be made of the posters.

Figure 31: Exhibited poster in a treatment room

Figure 32: An in-depth poster which was also visible for patients

Feedback contact person from cancelled session

As already indicated, one of the focus group sessions could unfortunately not take place due to the COVID-19 measures. Despite the fact that the session could not take place, I did receive some feedback from my contact person at the organisation. She shared with me that the healthcare professionals were uncertain about what to do with the posters, resulting in repeated explanations by my contact person. Despite the fact that care professionals were unsure of what they could do with the posters, she did indicate that the healthcare professionals were visually impressed by the poster series. However, the 'large' number of words on the textual posters were not easily read in the rush of the day. The team discussed the content of the poster series together at various times, as well as with their patients. They indicated that the posters functioned well as a topic for discussion and that the posters made them talk about alternative forms of therapy more than they previously did.

Their temporary location does not have a team room, so the in-depth textual posters were also visible to their patients (Figure 32). For some topics, they questioned whether they could and would offer this form of therapy as a team or organisation. At times, this led to uncomfortable conversations with their patients. Along the lines of *"But if this is not possible, why is it on the poster?"* In the development of the poster series, the textual poster has been designed purely with the healthcare professionals in mind: in the eventual further development, it may be necessary to examine whether the content of the posters should also be made accessible to patients, although the team has not made any concrete recommendations in this regard.

Lastly, the team thought about the possibility of offering the topics as a 'menu' in which they could preselect which topics they would like to receive. I understand their reasoning, also given some uncomfortable conversations with their patients. However, I believe it is important that this selection should not only include what they are willing and able to offer, but that it should also include topics for which solutions or alternatives can be sought. Otherwise, the decision-making for the chosen forms of therapy will still be determined by the personal preferences of healthcare professionals and what falls within their repertoire, instead of additionally considering the preferences of their patients. A subject that is not applicable within the capabilities of the organisation might still be a subject for discussion, in the sense that someone else, for example a family member, might be able to offer it.

6.3 CONCLUSION

The intended purpose of the validation was to test the textual alignment of the poster series with healthcare practice and to find out if the posters function as conversational triggers. In preparation for the validation session the healthcare professionals received little booklets including an information letter as well as a digital information letter by e-mail. Unfortunately, in the hectic rush of the day, the health care professionals did not find time to fill in the booklets, in addition the information letter did not stick sufficiently in the mind of the healthcare professionals. Because of this lack of time no specific theme and content-related feedback could be provided. It seems that it remains difficult for them to understand what they could and 'should' do with the information, as well as how to translate this knowledge into their practice.

Nevertheless, the validation results did provide insight into the influence of the poster series as a conversational trigger both among mental healthcare professionals and in conversations with their patients. In which mental healthcare professionals confirmed that they discussed alternative forms of treatment more than they did intuitively before. This indicates an increased sensitivity to the various choices that mental healthcare professionals have. However, whether this has also led to an increased use of alternative forms is unclear. The interprofessional dialogue has once again proven to be a valuable tool, but I expect that besides this, more and also other tools are needed to support the implementation of alternative forms of therapy.

07

CONCLUSION

This chapter firstly reflects on the approach of the research and design project as well as the limitations of the research in the discussion section. Secondly, the conclusion will elaborate on to what extent the poster series is an answer to the design challenge. Concluding my thesis with recommendations for implementation, further development and follow-up research.

7.1 DISCUSSION

This study explored a complex, layered, and diverse healthcare practice. This practice is complex and layered in the sense that all kinds of factors and events in the patient's life play a role in the decision-making process for the form of therapy. We have seen that each time the story is different, resulting in numerous decision moments. The practice is also diverse due to the multidisciplinary nature of the healthcare practice, which means that there are also different ways to tell the story aiming at differing perspectives and approaches.

We are dealing with a care practice that is under extreme pressure: the waiting lists, as well as the to-do lists, are long. The mental healthcare professionals must balance their time daily and decide which tasks to prioritize. This work pressure was also noticeable among the care professionals and care experts who participated in my research: several appointments had to be rescheduled or cancelled (due to COVID-19), fewer healthcare professionals were able to join than planned, and many professionals were unable to fill out the diaries or the survey for the evaluation of the poster series. Despite their best intentions, their interest in this research and the perceived need to immerse themselves in this topic, in practice little time remained to actually engage with the *Tool* (the poster series). This lack of time affected the evaluation of the poster series, so no specific thematic and content-related feedback could be obtained, although the effectiveness of the poster series as a conversational trigger could be experienced.

Nevertheless, valuable sessions for the purpose of gaining insight into the current practice could be held. In addition, I could rely on a great variety of insights gained by the KIEM researchers which I could subsequently discuss and interpret with some of them. This iterative process of constantly reinterpreting, enriching, and adding finesse to the story of the current care practice has led to a thorough description of this practice. The description of current healthcare practice, by means of current practice scenarios, has contributed to the articulation of knowledge, putting into words the stories of practice.

Regarding the materialisation of the poster series, several experts and peers were involved. This contributed to the selection of the topics and the quality of the content of the poster series Their involvement guaranteed that the representation of the current healthcare practice is reliable and thorough. However, due to the described time pressure, the evaluation of the poster series among healthcare professionals in practice could unfortunately only focus on global aspects such as the visual representation and the chosen themes rather than on the in-depth content of these themes. As a result, few conclusions can be drawn regarding the textual alignment of the poster series with healthcare practice.

Besides the lack of time, the short duration of the pilot and the 'large' amount of topics within this timeframe possibly had an effect on the evaluation of the poster series as well. In the development of the poster series, I covered a new theme 'every month'. Within this project, I provided content for a year (12 themes). Given the duration of my project, the healthcare professionals in the pilot received six topics in three weeks: two topics per week. Due to the large amount of content in a short period of time, the topic may not have landed sufficiently, which may have hindered discussing the content of the topics as well.

The healthcare professionals expressed retrospectively that there was limited time for reading the "large amount" of text on the posters, therefore they advised me to include less text. However, all posters contained approximately 300 words, which would equate to a reading time of about two minutes. Of course, more time will be required to get a thorough understanding of the posters in terms of reflection on the subject. But nevertheless, I wonder whether it really was the large number of words or rather the lack of time that was problematic. The richness of the poster series lies precisely in the textual elaboration which articulates the changes and the impact of the changes. It is remarkable that, although a very low-threshold concept has been chosen, this concept does not even appear to be low-threshold enough. I therefore wonder for what type of *Tool* there would be (enough) time anyway.

Mental healthcare professionals experience a ‘pressure’ to immerse themselves in digital care, mastering new forms of care requires learning to deal with the technology as well as discovering the pros and cons, do's and don'ts. However, this discovery process cannot yet be prioritized as other matters demand urgency. Therefore, care professionals stressed over and over again that they require time from the organisation to be able to immerse themselves in this subject, especially by means of structurally scheduled (collective) time. The care experts involved in the evaluation session of the different concepts are not all (full-time) practicing professionals (anymore), therefore I do wonder whether the prioritisation and ranking of the concepts would have been different if this evaluation session had been conducted with full-time practicing professionals. Also, a low-threshold concept was chosen, given the experienced workload in the practice, yet I wonder if the concept has not been too low-key now and whether a (slightly) more interactive tool might have increased sensitivity and immersion to a greater extent.

After noticing the effect of the poster series as a conversational trigger, and the more frequent discussion about alternative forms of therapy, we can state that the tool has indeed contributed to an increase in sensitivity. However, I believe that this is far from the end of the story: with the help of the theory of “Affordances”, the technology in this work practice was analysed as a means to enable new forms of care. The notion of affordances has also been used as a starting point for ideation, whereby the tool itself should become an invitation to increase sensitivity. Despite the fact that the posters were an invitation for an interprofessional conversation, it seems that the posters have not yet sufficiently functioned as an invitation to make more conscious use of the changes and benefits. Given the infrequent use of technology in this healthcare practice in recent years, and the limited persistence of telecare when relaxations were possible in consideration of the COVID-19 pandemic, I have reservations about whether technology in itself sufficiently initiates new forms of care. Additionally, I doubt whether the posters sufficiently initiate more conscious consideration of the possible new forms of care.

For the development of the poster series, the approach of Research through Design has been applied, in which different qualitative research methods have been used. This approach has its consequences: on the one hand, when using qualitative research methods, it is not meaningful to state how often a statement or topic was discussed, as each conversation took its own course. Each statement was therefore treated as equally important and valuable, which sometimes led to contradictions in the results. After all, there is no uniform experience with the use of technology in healthcare, since it involves different approaches and experiences. On the other hand, the choice of the various research methods still has its consequences. The multi-method approach, with a large focus on researching the current changing healthcare practice, has influenced the course of the project. As a result, a large part of this project focused on the articulation of the current practice, whereas a lesser extent was devoted to the development of the tool. This leaves me with the idea that there is still a lot to gain in optimizing or developing a different design (of the tool). For instance, I would have liked to explore what the impact of the poster series would have been if the topic had been introduced beforehand in a joint session.

During my research, I simultaneously applied literature reviews, the secondary analysis of the KIEM data, and expert interviews, as well as that I participated in the focus group sessions of my co-researcher. The iterative use of the different research methods impacted the course and focus of the conversations with healthcare professionals and experts. For example, a major focus arose on tapping into a reflective attitude towards the changing healthcare practice: if this focus had been less present in the interviews, the tool would probably also have had a different focal point. Despite the fact that this was not an 'incorrect' focus point, it seems that the translation of the transferred knowledge from the poster series into the work practice, the practical applicability, is still difficult for the healthcare professionals. Perhaps a tool that was more focused on the practical applicability would have been more easily embraced.

In underpinning the chosen desired future practice scenario, the body of thought from "Design for behaviour change" was briefly introduced. This approach has similarities with the ideas of Benner's *From Novice to Expert* model, which was included beforehand. However, if this body of thought had been involved earlier or to a greater extent it would most likely have changed the design guidelines and thus the final outcome. We have seen that, in order to expand the current repertoire, routine practices need to be interrupted, therefore the research question turned out to be perhaps more of a design for behaviour change problem than had been anticipated.

7.2 CONCLUSION

In my research I have explored how mental healthcare professionals have dealt with the rapid implementation of technology in their care practice and how this has changed their care. The design challenge was defined as: *“How can we invite mental health care professionals to become sensitive for the choice between face-to-face, telecare or blended care, by drawing upon their existing knowledge and experience.”* To become aware of when which form of therapy can be of added value to the treatment. In order to think about the changing context when switching between the different forms of therapy and how this can positively contribute to the recovery process of patients. This way blended care can be used more considered, well-balanced and personalised for the patient *and* professional.

Insights into the current mental health care practice and experiences regarding the implementation of technology in the care relationship have been incorporated into a poster series with the intended purpose of supporting care professionals by making these changes and possibilities more explicit, so the choice for the form of therapy can be made more deliberately. The poster series has been exhibited in two different care organisations for the validation of the concept.

The validation results provided insight into the influence of the poster series as a conversational trigger both among mental healthcare professionals and in conversations with their patients. In which mental healthcare professionals confirmed that they discussed alternative forms of treatment more than they did intuitively before. This indicates an increased sensitivity to the various choices that mental healthcare professionals have. However, whether this has also led to an increased use of alternative forms is unclear. This study therefore only contributes to the articulation of the changing healthcare practice and the impact of the choices that mental healthcare professionals have in shaping care. The *Tool* that has been developed, the poster series, has nevertheless made a positive contribution to the discussion about this topic, and can in this way contribute to increasing the sensitivity of mental healthcare professionals for the changing practice.

7.3 RECOMMENDATIONS FOR IMPLEMENTATION

The textual content and themes of the developed *Tool* are the result of thorough research: design choices and insights were continuously validated by a group of experts from within the field. In spite of that, I would still recommend the first implementation step to be to validate the care content with healthcare professionals. Because we were unable to reach this level of validation during the focus group sessions, I cannot draw thorough conclusions about the textual alignment with healthcare practice.

Part of the implementation advice, given by the healthcare professionals in the evaluation focus group session, corresponds to my intended vision in which each theme should become a focal point for a certain period of time. Apart from making it a focus point for a certain period of time, this period should also be 'introduced' together in the team. Care professionals indicated that fixed moments should be planned in order to discuss the topic with each other, since in the rush of the day, the in-depth textual posters were not given much attention. Care professionals therefore suggested that, in addition to making it a periodic theme, a joint introduction and discussion of the new theme is also necessary. By planning a moment together to discuss the theme and what they think about it personally as well as an organisation, the subject can become more alive. Within this context, they also find it of added value that hallway and treatment room posters are displayed as a trigger for discussion of the theme with patients. Currently, they have seen the posters hanging in the treatment rooms, but they could not sufficiently incorporate them into the conversations with their patients because they had not yet read or seen the in-depth poster. Given that most organisations have one team room and several treatment rooms, it may therefore be of added value to offer several treatment room posters so that a poster can be displayed in each treatment room.

When implementing the poster series, my advice would be to indeed have a certain period of time dedicated to the theme, with a joint introduction of the theme at the beginning of this period. However, the frequency of new content is guesswork, as we were not able to test it. I would start with a monthly theme in order to provide sufficient time for the theme to settle in, whereby the introduction of the theme could also be linked to monthly methodological discussions. I expect that a period shorter than a month will not give practitioners enough time to introduce, use and discuss the theme. A period longer than one month will probably cause the posters to no longer stand out. However, these are assumptions since this frequency has not been tested yet.

We have seen that the posters can function as a topic of conversation. In that sense, the joint introduction does not require much instruction apart from making time to talk about it with each other. The care professionals indicated that managers should make time available for these kinds of initiatives, in order to structurally embed it rather than relying solely on the personal responsibility of the care professionals.

Additionally, we have seen that the posters could function as conversational triggers with their patients. In the development of the poster series the textual posters have been designed purely with the healthcare professionals in mind, since the treatment room poster only consists of the theme and the visual. One of the locations does not have an enclosed team room so the in-depth posters were also visible to their patients, which led to meaningful but sometimes uncomfortable conversations with their patients as not everything that was mentioned on the posters could be offered to the patients by the organisation. In the eventual further development, it may be meaningful to examine whether the content of the posters should also be made accessible to patients which would require rewriting the posters to make them more fitting for the patient's perspective as well.

7.4 RECOMMENDATIONS FOR FUTURE RESEARCH

The aim of the poster series is to stimulate a reflective attitude towards the changing healthcare practice, how to make use of the changes that come along with the arrival of technology in mental healthcare practice and what the impact of the choice for different forms of therapy has on shaping care. This focus has been chosen out of three different desired future practice scenarios. In which, first of all, the focus was on increasing awareness and sensitivity instead of focusing on gaining experience. This prioritization derives both from the body of thought of the *From Novice to Expert model* from Benner (1982), which describes skills acquisition in different stages, as well as from that of design for behaviour change which first of all aims to create awareness before the new behaviour can be mastered.

With this the other opportunity direction, gaining experiences in a safe context, was left open for future research and design. I first of all focused on making the changes that come along with introducing technology in the care relationship tangible and on transferring the concrete added value of different forms of therapy.

Even though the articulated knowledge led to topics for discussion and reflection, which is extremely valuable for understanding the changes and possibilities in care practice, I still believe that the next step, being able to gain experience, is necessary and perhaps even more important than just being able to reflect on the choice. This is supported by the fact that my contact person from one of the evaluation locations recognised my concern regarding *"How can the knowledge be further applied in practice?"*. Containing our shared concern regarding the difficulty for healthcare professionals to be able to translate this knowledge into their daily work practices.

I believe that experiencing the added value contributes more than just discussing it, although this does not take away from the fact that the poster series may have increased the sensitivity for the choice. Nevertheless, in order to become an expert, gaining experience is necessary. In my opinion, this is where follow-up research and design should focus on.

I would find it relevant for follow-up research to look at the relationship between the *From novice to expert model* and the type(s) of support that care professionals need in mastering care at a distance. I still feel that there is perhaps some truth to my earlier hypothesis regarding the possibility that, in order to become an expert in care at a distance, you have to go through the various stages of the *From Novice to Expert model* all over again, albeit on a smaller scale. In which it could possibly be the case that healthcare professionals need different types of tools or information depending on the stage they are in.

To conclude, I would like to mention that currently efforts are already being made to look further into how mental healthcare professionals can be supported in gaining experiences in a safe context. The Research Group IT Innovations in Health Care already started September 2021 a new project for two healthcare students and three ICT students. Their project is focussing on developing a fictious video call tool that supports mental healthcare professionals to try out telecare in a safe context, without involving real patients. The tool provides them with tips and tricks and prompts them to become sensitive to changes in the patient's digital environment and body posture. During my graduation I have guided the healthcare students in multiple sessions, in which I have shared my insights into the current practice and the changes that healthcare professionals are facing and need to become sensitive to. The gathered stories and insights from this research have been used as inspiration for the elaboration of the fictitious case study and the learning aspects of the fictitious video calling tool.

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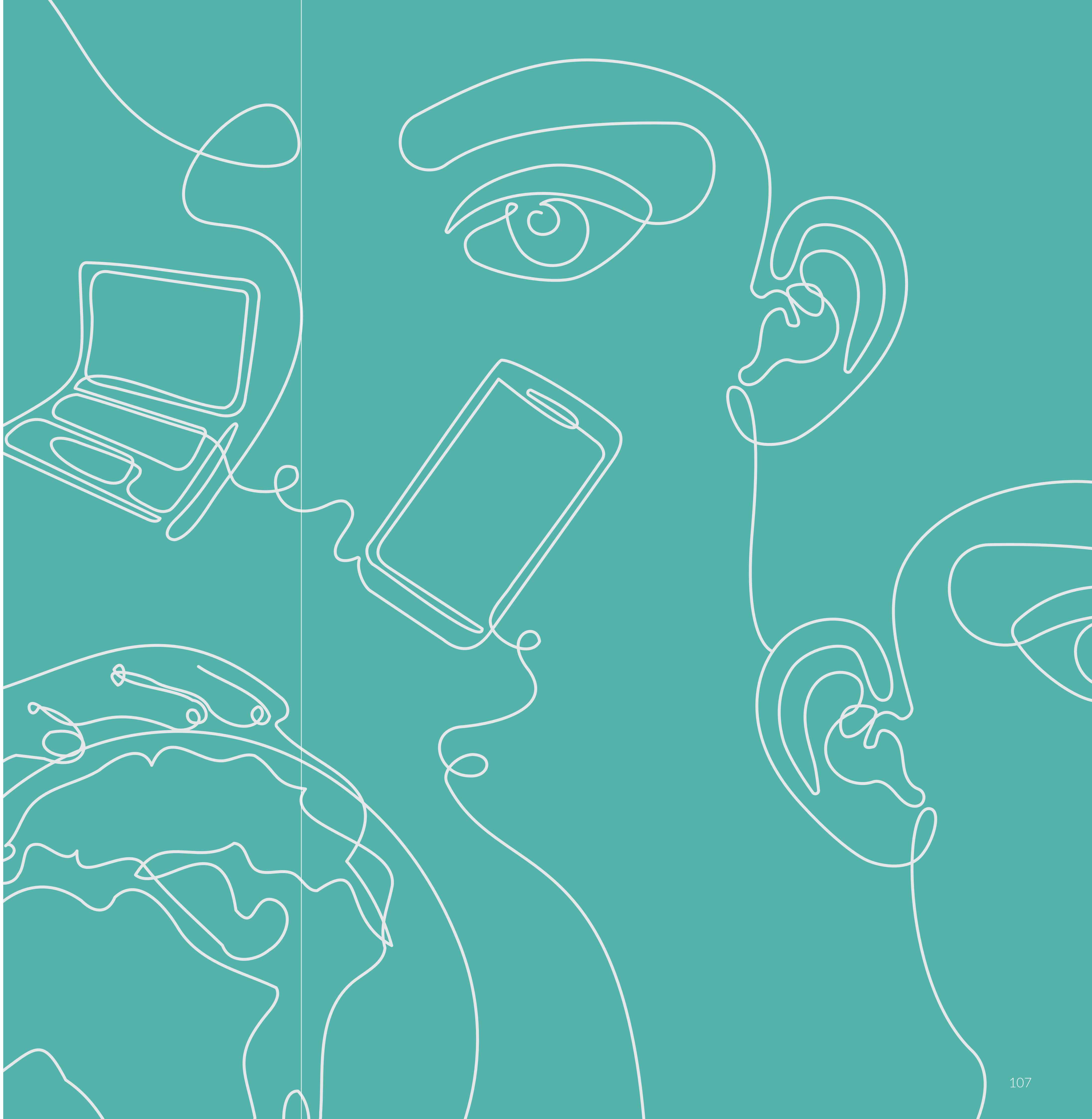
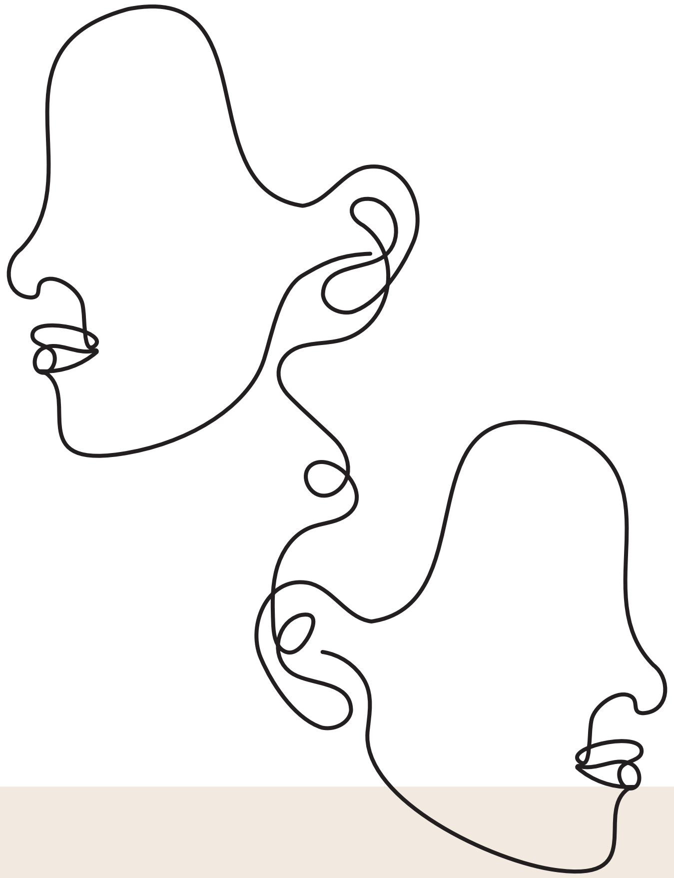
FINAL CONCEPT

Insights into the current mental healthcare practice and experiences regarding the implementation of technology in the care relationship have been incorporated into a poster series with the intended purpose of supporting care professionals by making these changes and possibilities more explicit, so the choice for the form of therapy can be made more deliberately.



IK ZIE JE NIET, MAAR IK HOOR JE WEL



IK ZIE JE NIET, MAAR IK HOOR JE WEL

Bij zorg op afstand verdwijnt de fysieke nabijheid. Iemand fysiek kunnen steunen op moeilijke momenten, door even een hand op zijn schouder te leggen, is door deze afstand niet mogelijk. Maar is fysieke nabijheid altijd nodig om je cliënt te kunnen steunen? Of is het kunnen bieden van een luisterend oor soms ook voldoende? Hoe bied je ondersteuning en nabijheid zonder fysiek aanwezig zijn?

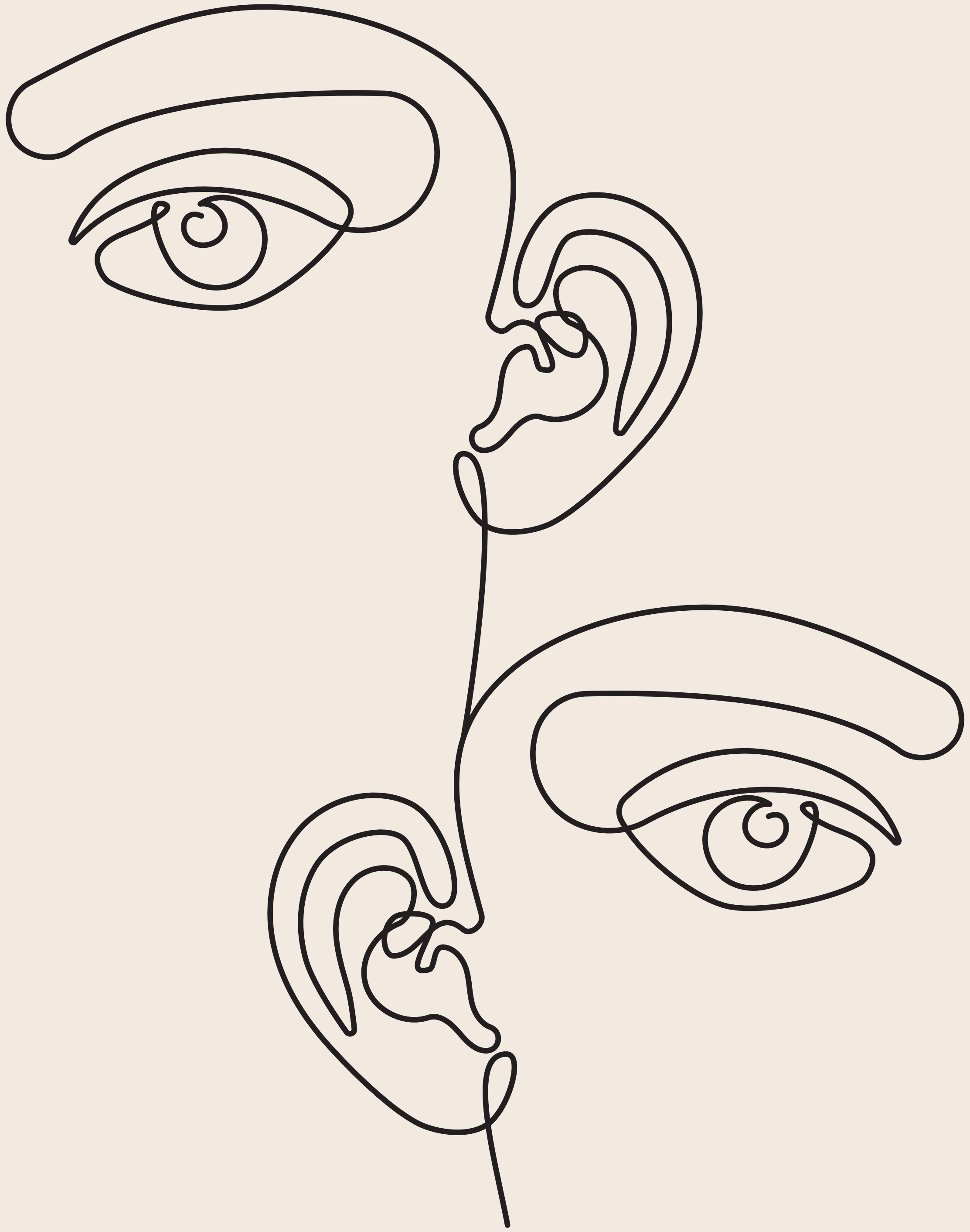
ELKAAR ZIEN IS NIET ALTIJD NODIG EN DAT GEEFT OOK RUIMTE

De ervaring heeft geleerd dat deze nabijheid helemaal niet per se altijd nodig is. Soms kan het ook prettiger zijn voor de cliënt om juist die fysieke afstand te hebben. Sommige cliënten praten op afstand immers net zo makkelijk, al dan niet gemakkelijker. Het komen naar kantoor of het ontvangen van de zorgverlener thuis kan soms al zodanig spannend zijn voor de cliënt dat zorg op afstand juist laagdrempeliger voelt.

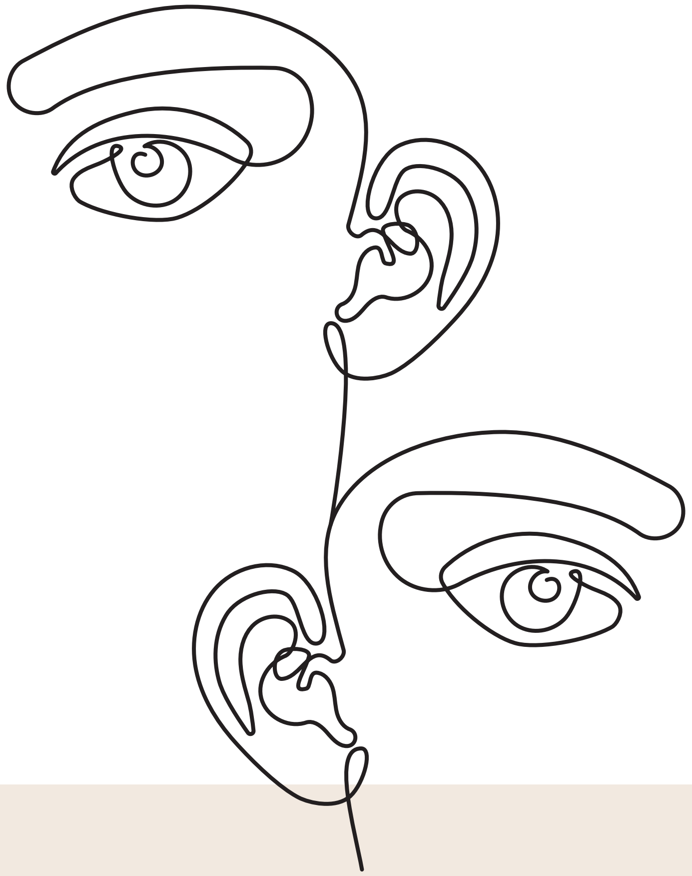
Zorg op afstand vraagt om een andere manier van signalen oppikken en sfeerproeven. We zijn gewend om dit letterlijk te kunnen voelen. Op het moment dat lichaamshouding en mimiek minder goed zichtbaar en voelbaar zijn, verandert ook de dynamiek van het gesprek. Daar waar je face-to-face minder woorden nodig hebt om te achterhalen hoe de cliënt erbij zit, kan bij bellen het boven tafel krijgen van deze woorden juist belangrijk zijn.

Hoe kun je achterhalen hoe de cliënt erbij zit zonder deze non-verbale communicatie? Het vraagt misschien niet eens zozeer om nieuwe gesprekstechnieken, maar wellicht juist wel het bewuster inzetten hiervan?

Bij beeldbellen kun je nog een deel van de non-verbale communicatie oppikken, maar voor sommige cliënten leidt het beeld juist te veel af en zou bellen geschikter zijn. Met wie bel je en met wie zou je liever beeldbellen?



HOE GAAT HET MET JE? EVEN HOREN, EVEN ZIEN



HOE GAAT HET MET JE? EVEN HOREN, EVEN ZIEN

Daar waar face-to-face dynamischer voelt, is een (beeld)belgesprek vaak functioneler van aard en bij uitstek geschikt voor kort even een vinger aan de pols. Door de snelle en toegankelijke aard van een (beeld)belgesprek is dit gemakkelijker in te passen in de dagelijkse gang van zaken. Reistijden vervallen en hiermee ook het komen naar kantoor of 'verplicht' thuisblijven voor de afspraak. Even inbellen vanuit een andere locatie behoort hierdoor ook tot de mogelijkheden.

(BEELD)BELLEN RESULTEERT IN MOGELIJKE TIJDSWINST EN PRAKTISCHE RUIMTE

Het inbedden van zorg op afstand vraagt om een tijdsinvestering van zowel zorgverleners als haar cliënten. De ervaring heeft geleerd dat als het eenmaal loopt, dit ook tijdswinst op kan leveren en dat het komen tot de inhoud via (beeld)bellen ook zeer goed mogelijk is, met name voor cliënten die al vergevorderd zijn in hun herstel.

De kortere duur van (beeld)belgesprekken ten opzichte van face-to-face contact levert niet alleen mogelijke tijdswinst op. Het biedt ook nieuwe mogelijkheden. Meer contactgroei kan optreden door meer (korte) contactmogelijkheden. Voegt het hebben van frequenter, even kort, contact iets toe aan je behandelcontact? Is het dan nog wel tijdswinst?

In de afweging tussen face-to-face contact of even (beeld)bellen speelt vooral het doel van het contact een belangrijke rol. Zijn alle onderwerpen en behandeldoelen geschikt voor zorg op afstand? Wat kun je op afstand bespreken met elkaar en waarvoor wil je elkaar toch écht zien? Kan mijn cliënt voldoende onder woorden brengen wat er speelt en waar hij of zij tegenaan loopt, ook op afstand?

WIE ZOU JIJ EENS WILLEN LATEN AANSLUITEN?

WIE ZOU JIJ EENS WILLEN LATEN AANSLUITEN?

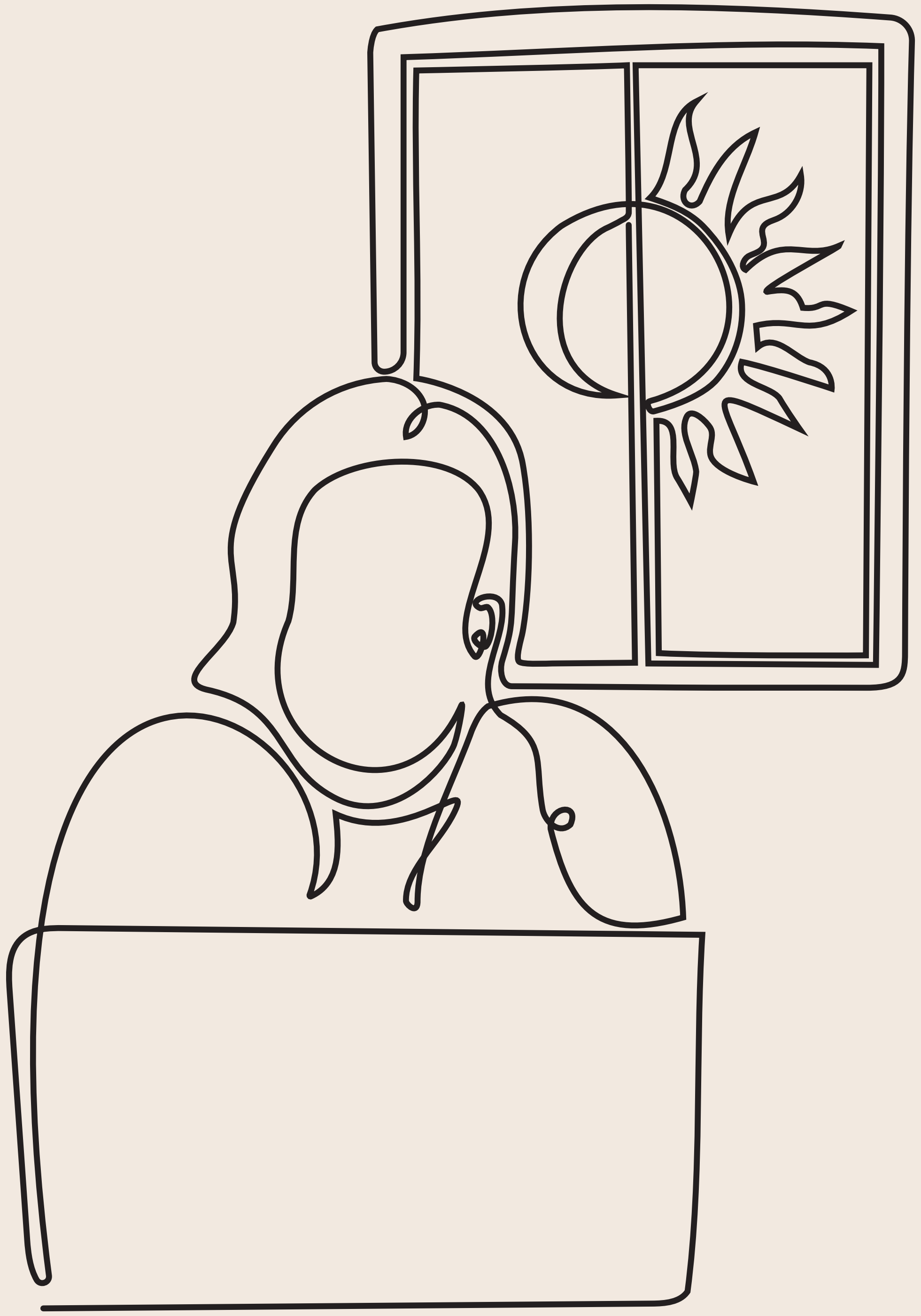
Beeldbellen bespaart reistijd. Niet alleen voor de cliënt en de zorgverlener, maar ook voor de omgeving van de cliënt en medebehandelaars doordat er gemakkelijk vanuit verschillende locaties ingebeld kan worden. Betrokkenen kunnen hierdoor gemakkelijker aansluiten bij de behandeling. Ouders of familieleden die verder weg wonen, kunnen ingeschakeld worden zonder dat hiervoor een dag(deel) vrij gepland hoeft te worden en een beschikbare collega kan gemakkelijker even geraadpleegd worden.

BEELDBELLEN MAAKT MULTIDISCIPLINAIR CONTACT MOGELIJK

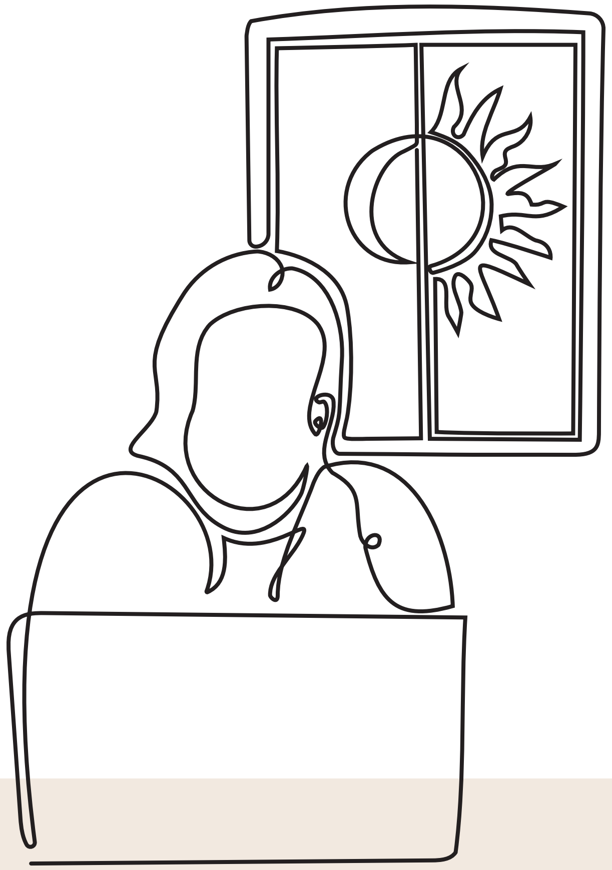
Dit biedt mogelijkheden voor het vormgeven van de afspraak. Is het van toegevoegde waarde om een keer een extra persoon uit te nodigen? De cliënt zou hier ook regie in kunnen nemen. Wie zou hij eens willen uitnodigen?

Beeldbellen biedt ook mogelijkheden voor groepstherapie doordat je gemakkelijk meerdere mensen samen kunt brengen. Ondanks de mogelijkheden is het daadwerkelijk houden van groepstherapie online toch complexer dan wanneer deze face-to-face wordt uitgevoerd. Groepstherapie is soms sowieso al uitdagend. De dynamiek verandert en overzicht houden in een grote(re) groep is al een uitdaging op zich. Bij groepstherapie via beeldbellen is het helemaal van belang om goede afspraken van tevoren te maken. Onderling non-verbaal afstemmen met behandelaren of het inspelen op de non-verbale communicatie van de cliënten is toch complexer online.

Ook vraagt beeldbellen om rekening te houden met de techniek en eventuele technische uitdagingen. Met name als je met een grote groep gaat beeldbellen. Hoe pak je dit aan?



THUIS WERKEN
AAN BEHANDELDOELEN?



THUIS WERKEN AAN BEHANDELDOELEN?

Technologie biedt cliënten de mogelijkheid om online en dus altijd en overal tussen de afspraken door te werken aan behandeldoelen of informatie te raadplegen op een moment dat het hen uitkomt. Denk bijvoorbeeld aan modules met opdrachten of psycho-educatie via videomateriaal. De inzet van modules blended toepassen, heeft een ondersteunend effect op de contactmomenten.

DIGITALE ZORG VERGROOT DE TOEGANKELIJKHEID VAN DE ZORG TUSSEN DE AFSPRAKEN DOOR

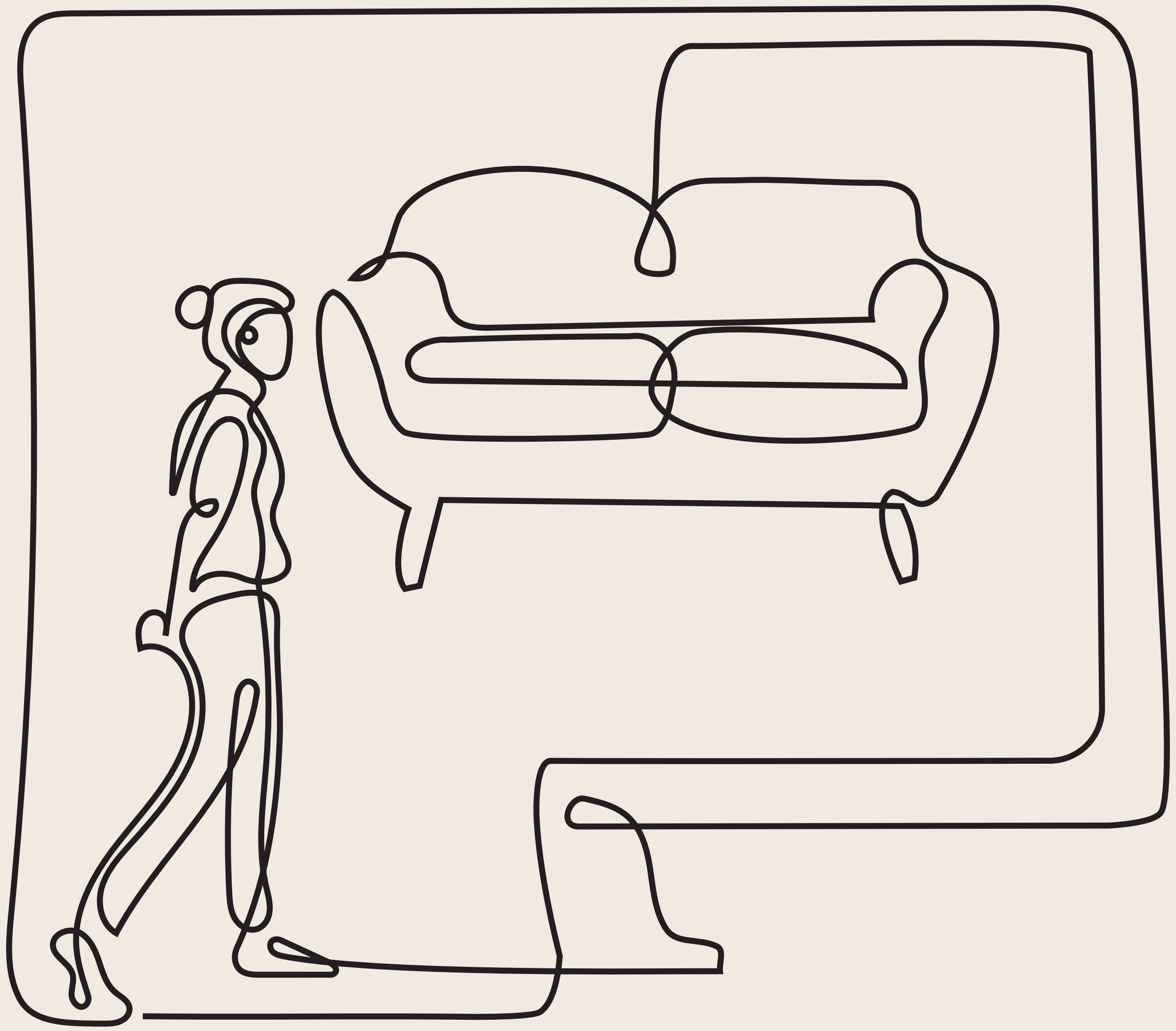
Het gebruik van modules en specifieke apps kan eigen regie en verantwoordelijkheid over de behandeling stimuleren bij cliënten. De inhoud van het behandelcontact verandert doordat er tijdens het gesprek dieper ingegaan kan worden op hetgeen waaraan gewerkt is.

Tegenwoordig is er een groot aanbod aan modules en ondersteunende apps beschikbaar. Welke modules bieden jullie als organisatie aan? Welke apps adviseren jullie? Wat zijn jouw ervaringen en die van je collega's?

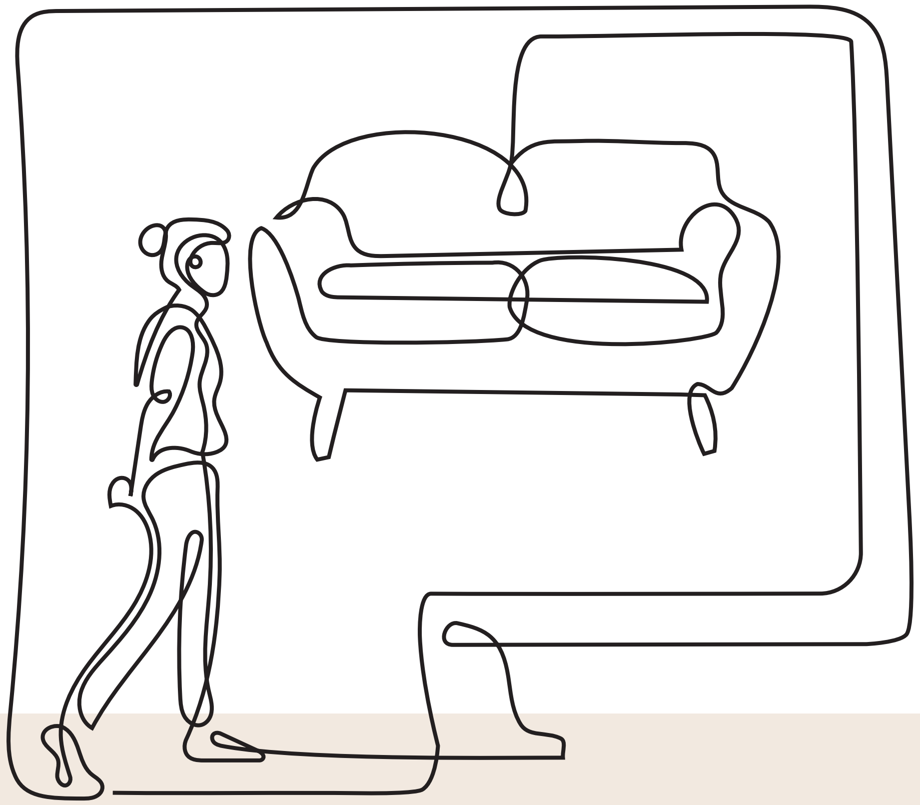
Het volgen van modules vraagt om inzet en motivatie van de cliënt, maar niet iedere cliënt staat hiervoor open. Waar wil je cliënt aan werken? Biedt de organisatie hiervoor een passende module? Zou je cliënt openstaan voor het proberen van een module? Hoe ga je het gesprek hierover aan met je cliënt?

Het kunnen starten met modules vraagt ook wat aandacht. Heeft je cliënt al toegang tot jullie portaal? Kan je cliënt direct van start of is gezamenlijk opstarten gewenst?

De inzet van modules vraagt niet alleen om inzet van de cliënt maar ook om opvolging vanuit de zorgverlener. Wat spreek je met elkaar hierover af? Wat vraagt dit van jouw planning?



EVEN BINNENKIJKEN



EVEN BINNENKIJKEN

Het kunnen zien van de thuisomgeving van de cliënt voegt iets toe, zo kan de staat van het huishouden een externe informatiebron zijn over de gemoedstoestand van de cliënt. Sommige zorgverleners zijn al gewend aan een afwisseling tussen huisbezoeken en afspraken op kantoor. Alleen niet voor iedereen is het houden van huisbezoeken in te passen in de dagelijkse praktijk. Beeldbellen zou hier een uitkomst kunnen bieden.

INZICHT IN DE THUISOMGEVING KAN OOK LEIDEN TOT NIEUWE GESPREKSONDERWERPEN

Met name voor zorgverleners die hun cliënten voorheen alleen op kantoor zagen, resulteerde het zien van de thuisomgeving door het beeldbellen tot een nieuwe laag in het behandelcontact. Met voorbeelden van cliënten die trots zelfgemaakte meubels of uitgevoerde klusjes konden laten zien.

Een huisbezoek geeft meer informatie, maar is het altijd noodzakelijk om fysiek een kijkje te nemen? Het houden van huisbezoeken is praktisch en organisatorisch gezien niet altijd mogelijk. De ene zorgverlener houdt structurele huisbezoeken, terwijl de andere zorgverlener haar cliënten alleen op kantoor ziet. Waar zou een structureel huisbezoek ook vervangen kunnen worden met een beeldbelgesprek? Wanneer is het van toegevoegde waarde om een kantoorbezoek te vervangen met een beeldbelafspraak?

Wanneer je het huis van de cliënt binnenloopt, voel je de sfeer en let je automatisch op kleine veranderingen. Bij beeldbellen zie je maar een klein gedeelte van het huis op de achtergrond. Hoe kun je cliënten stimuleren, tijdens een beeldbelgesprek, om eens wat van hun woonomgeving aan je te laten zien?

WAAR ONTMOETEN WIJ ELKAAR ONLINE?

WAAR ONTMOETEN WIJ ELKAAR ONLINE?

Tegenwoordig zijn er veel platformen die het mogelijk maken om te beeldbellen met je cliënt. Voordat je een beeldbelverbinding tot stand kan brengen, is het belangrijk om stil te staan bij wat hiervoor nodig is. Hoe kun je ervoor zorgen dat je elkaar goed kunt verstaan en zien? Wat spreek je hierin met elkaar af?

ONLINE-GESPREKKEN RESULTEREN IN NIEUWE ONGESCHREVEN REGELS EN OMGANGSVORMEN

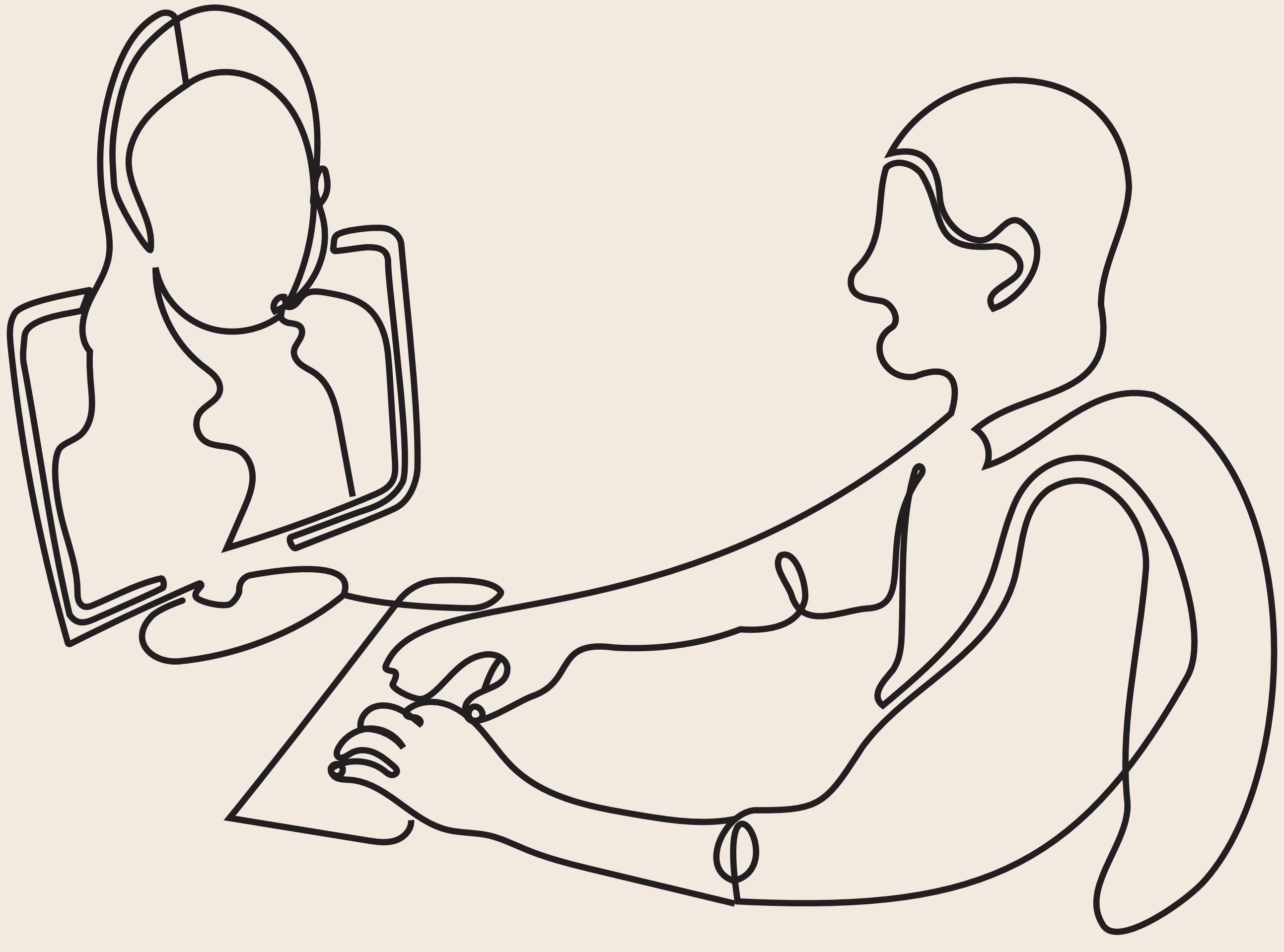
De veranderende context waarin de afspraak zich afspeelt verandert het 'ritueel' van de therapie. De rit van en naar kantoor of het binnenkomstgesprekje waren voorheen ook onderdeel van dit 'ritueel'. Nu schakel je in en volgt het gesprek. Hoe begin je het gesprek en hoe rond je deze af? Wat verwacht je van je cliënt ten aanzien van hoe ze voor de dag, het scherm, komen?

Voordat je kunt beeldbellen met je cliënt is het belangrijk om met elkaar in gesprek te gaan over de beschikbaarheid van de benodigde faciliteiten, de digivaardigheid van de cliënt en jullie persoonlijke voorkeuren in dit contact. Beschikt je cliënt over een laptop, smartphone of tablet en heeft je cliënt toegang tot het internet?

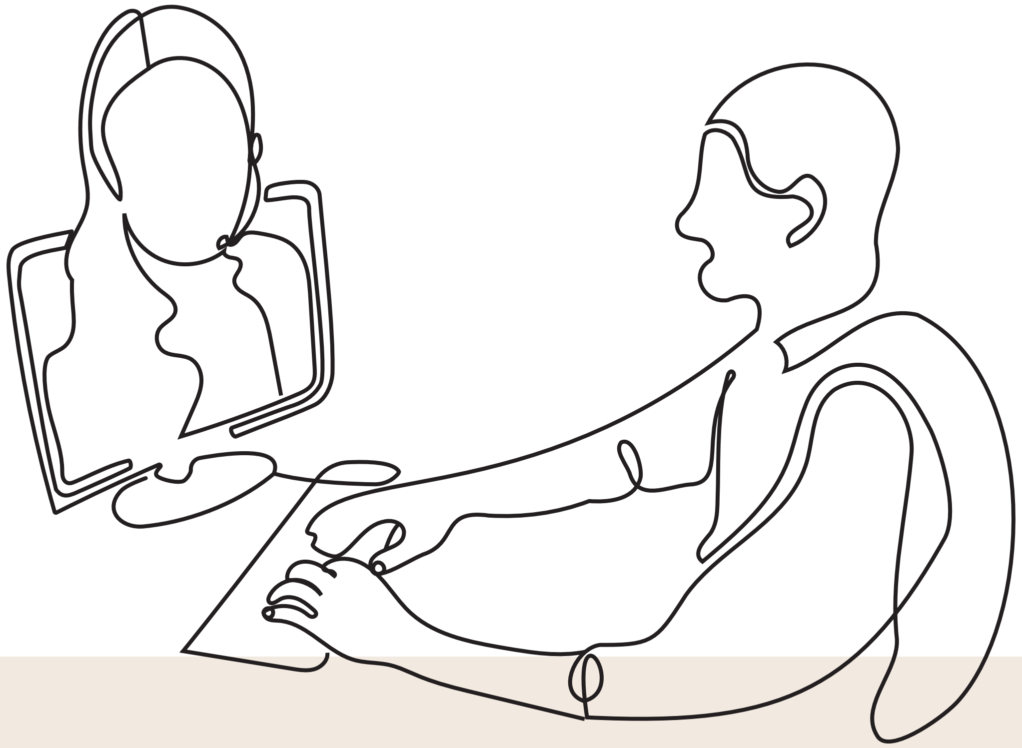
Uit alle mogelijke platformen, wat zijn jullie persoonlijke voorkeuren hierin? Wat betekent dit voor de privacy en veiligheid?

WhatsApp-beeldbellen is erg toegankelijk, maar dit is geen beveiligde verbinding. Wat biedt de organisatie aan als beeldbeltool en heeft je cliënt hiertoe al toegang?

Wat spreken jullie af als de verbinding ineens verbroken wordt? Kun je elkaar dan alsnog op een alternatieve manier bereiken?



IK BEN ER NIET, MAAR OOK WEER WEL



IK BEN ER NIET, MAAR OOK WEER WEL

De non-verbale communicatie is lastig(er) op te pikken bij zorg op afstand en ook het kunnen aanvoelen van de sfeer in de ruimte verandert. Daar waar het kunnen zien van de cliënt en diens omgeving vaak al veel informatie verschaft over de gemoedstoestand van de cliënt, kost het meer moeite om dit naar boven te halen met zorg op afstand.

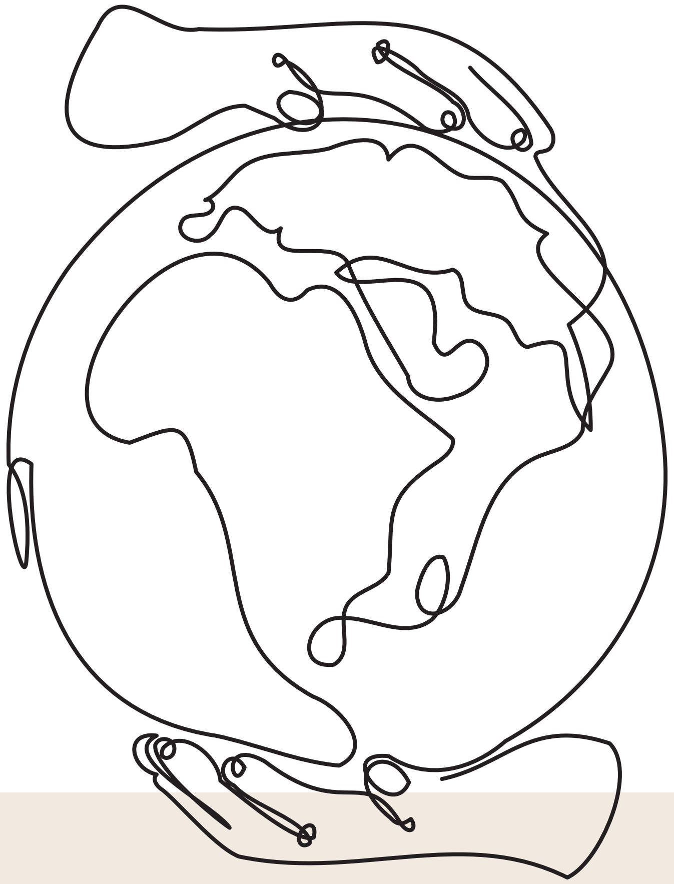
ELKAAR KUNNEN ZIEN, OOK AL IS DIT NIET FYSIEK, VOEGT IETS TOE

De mogelijkheid van elkaar kunnen zien, ook al ben je er niet fysiek, met behulp van beeldbellen voegt iets toe. Bij bellen verdwijnt het kunnen zien van de mimiek en lichaamshouding volledig. Beeldbellen maakt het mogelijk om toch een deel van deze mimiek en lichaamshouding op te kunnen vangen. Levert het iets op om je cliënt te vragen verder van de webcam af te gaan zitten?

Soms kan het praktisch gezien voor de cliënt ook fijn zijn om niet naar kantoor te hoeven komen. Beeldbellen maakt het mogelijk om elkaar deels te zien, ook al ben je fysiek niet bij elkaar. Bij beeldbellen valt er desondanks ook een deel weg, je mist informatie over de gehele context en de sfeer is lastiger aan te voelen. Wat kan online en wat moet fysiek?

Soms voelen die eerste contacten op afstand wat onwennig. Zo zie je bijvoorbeeld bij beeldbellen niet alleen de ander, maar ook jezelf. Dit kan soms best confronterend zijn of afleidend werken. Zorg op afstand passend maken, vraagt soms om creativiteit van de cliënt en de zorgverlener. Ga hierover met elkaar in gesprek, waardoor voelt het nu misschien nog onprettig en onwennig? Is het gezamenlijk komen tot oplossingen mogelijk? In plaats van het direct ‘afschrijven’ van zorg op afstand als ongeschikt. Helpt het bijvoorbeeld om jezelf onderin het beeld af te plakken?

WAAR ZOU JIJ WILLEN AFSPREKEN?



WAAR ZOU JIJ WILLEN AFSPREKEN?

De locatie waar je afspreekt en de omgevingsfactoren van die locatie kunnen van invloed zijn op hoe je je voelt en hoe vrij je je voelt om dingen te delen. Soms kan het ook fijn zijn om op een andere plek af te spreken, een plek die voor jou belangrijk is. Een plek die past bij het levensverhaal, een plek die veel betekent of een plek waar je cliënt veel te vinden is. Het biedt de mogelijkheid om een betere inkijk te krijgen in de wereld en omgeving van je cliënt.

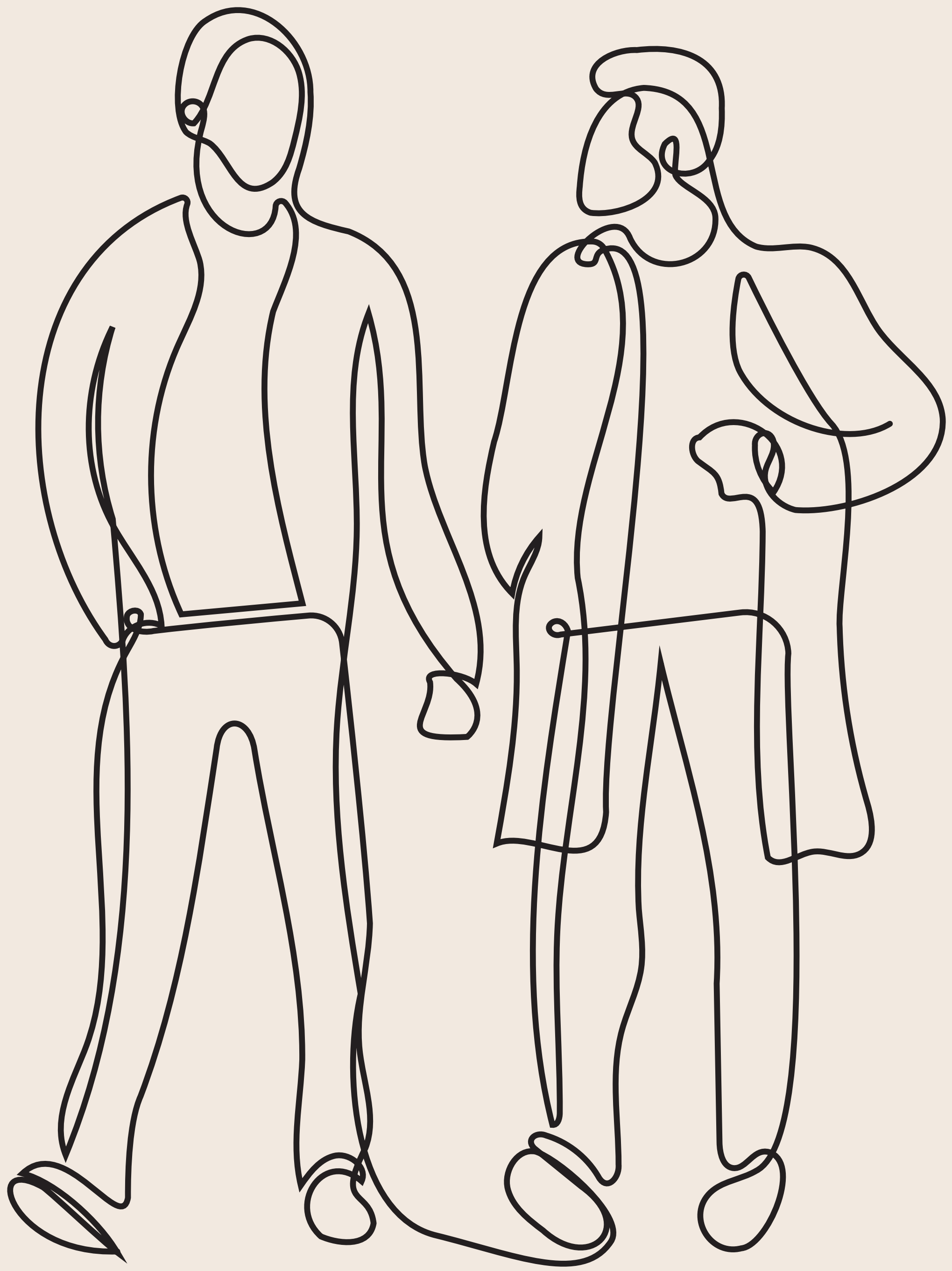
EEN ANDERE OMGEVING RESULTEERT IN NIEUWE GESPREKSONDERWERPEN

Door af te spreken op een plek die belangrijk is voor de cliënt, kun je in gesprek gaan over wat deze locatie betekent voor de cliënt. De locatie kan tot comfort of discomfort leiden voor de cliënt. Waardoor ontstaan deze gevoelens?

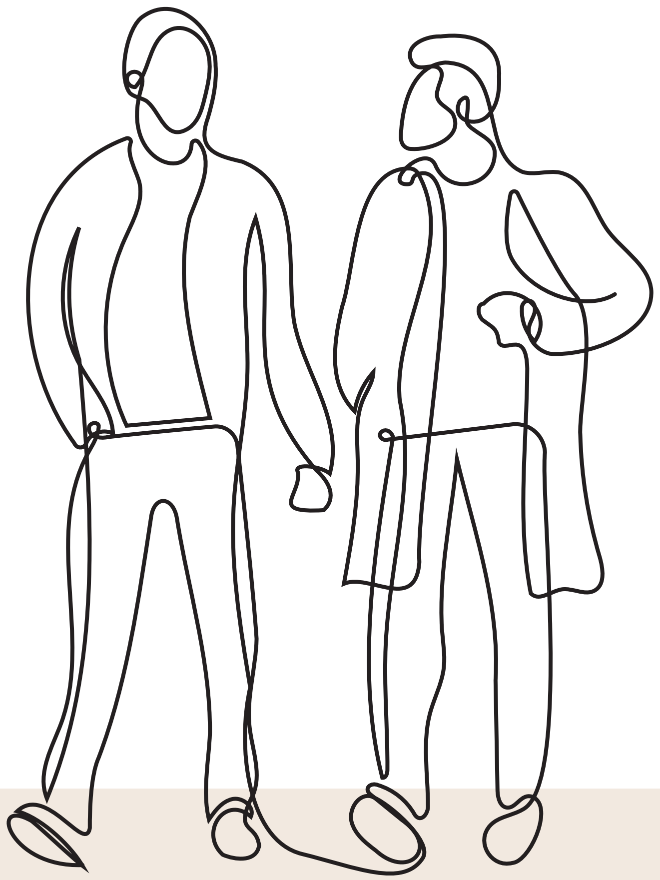
Een andere locatie kan tot verdieping leiden in het behandelcontact. Door in gesprek te gaan over wat specifieke plekken voor de cliënt betekenen, kun je beter aansluiten bij de wereld van je cliënt. Door deze locatie eens met elkaar te bezoeken, kan de inhoud van je gesprek veranderen. Wat zijn plekken die veel voor je cliënt betekenen en waarom?

Praktisch en organisatorisch gezien is het niet altijd mogelijk deze locaties samen op te zoeken. Wat zijn kenmerken van locaties die belangrijk zijn voor de cliënt? De rust en ruimte van de natuur? Misschien is er een natuurgebied in de buurt die gemakkelijker in te plannen is om te bezoeken.

Afhankelijk van het onderwerp en de inhoud van het gesprek, is het ook belangrijk om stil te staan bij de vraag of de omgeving en locatie ook matchen met het doel van het gesprek. Kun je vrij genoeg spreken? Hoe druk is de omgeving?



ZULLEN WE EEN KEER GAAN WANDELEN?



ZULLEN WE EEN KEER GAAN WANDELEN?

Het kan soms ook fijn zijn om in gesprek te zijn zonder voor elkaar te zitten. Wandelen is een activiteit die je goed zou kunnen combineren met in gesprek gaan. Wandelen heeft daarnaast ook een therapeutisch effect: de beweging en omgeving bieden je rust, terwijl je je gedachten op een rijtje kan zetten. Ook is gebleken dat wandelen het probleemoplossende vermogen kan stimuleren en hierdoor verrassende inzichten kunnen ontstaan.

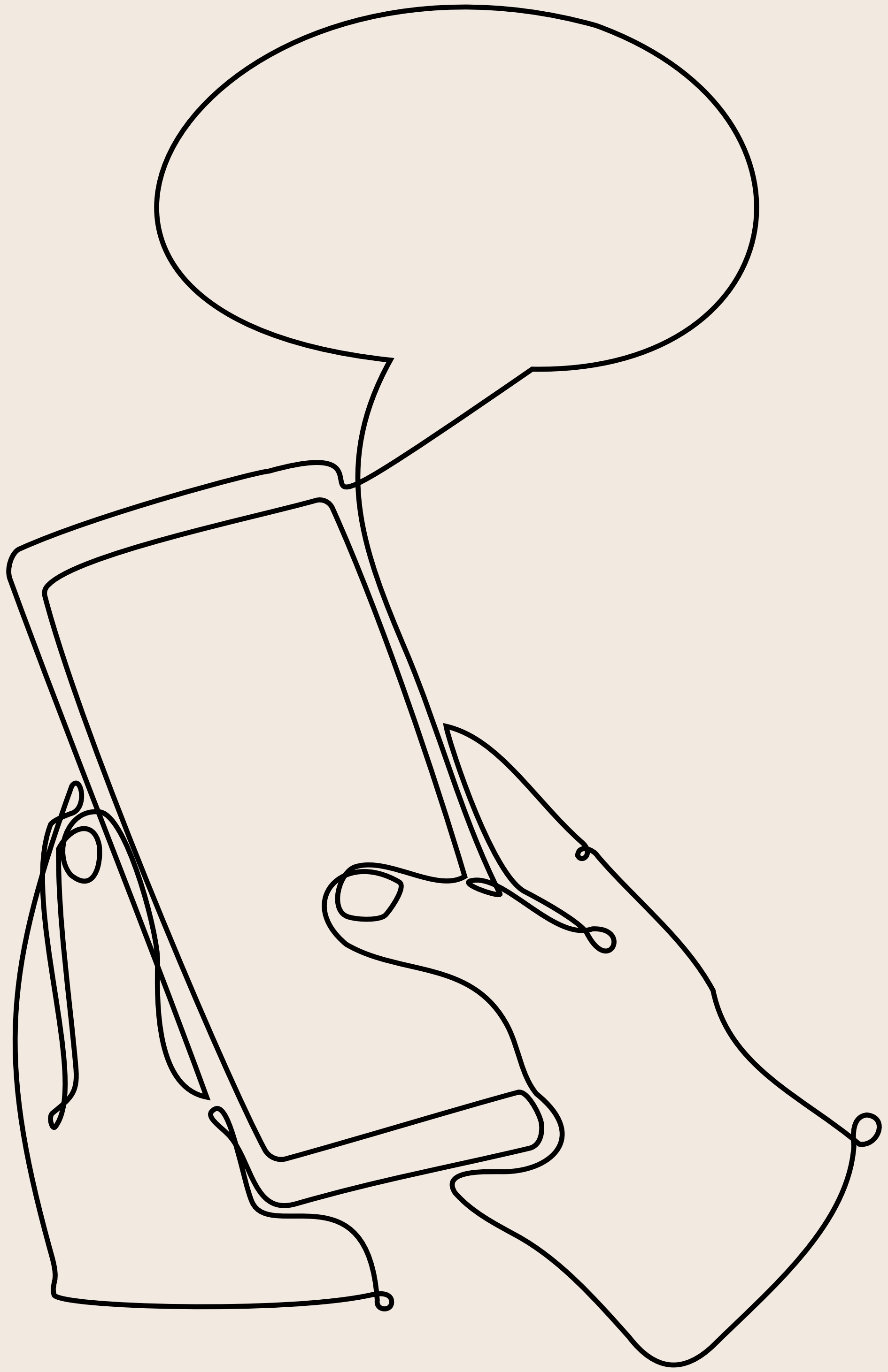
ALS JE WANDELT HEB JE TIJD OM STIL TE STAAN

Terwijl jij je fysieke gezondheid bevordert, werk je ook aan je mentale gezondheid. De gedeelde onbekende omgeving kan voor zowel de zorgverlener als cliënt resulteren in een meer gelijkwaardig gevoel. Doordat je een gelijkwaardige bent in deze omgeving. Dit kan positief bijdragen aan het algehele gevoel bij het contact.

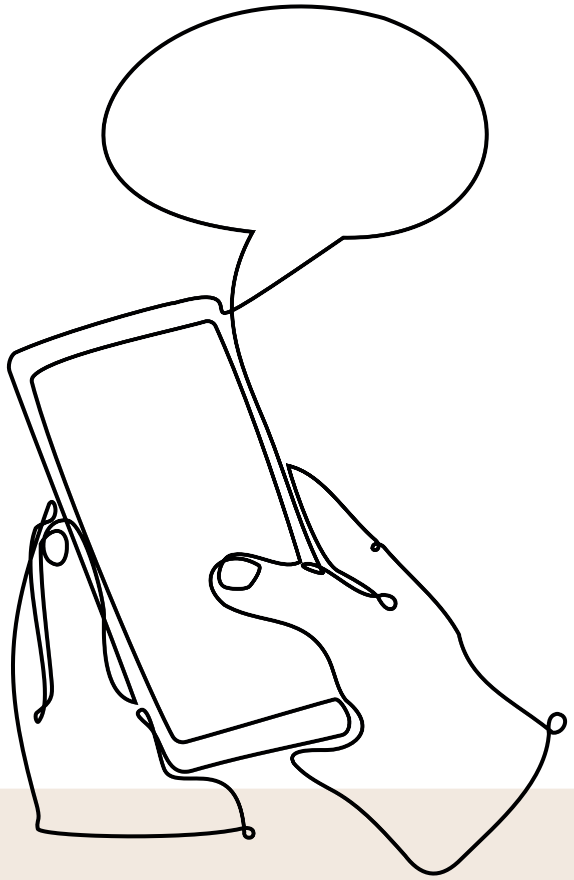
De omgeving waar je gaat wandelen heeft impact op het gesprek. Een stadspark zal waarschijnlijk meer bezocht worden dan een natuurgebied. Waar in de buurt hebben jullie een rustige en natuurlijke omgeving waar je vrijuit kan spreken?

Hoe goed is je cliënt ter been? Is er een bankje beschikbaar waar je tussendoor even rust kan pakken? Wat spreken jullie af als het slecht weer wordt?

Praktisch gezien is het niet altijd mogelijk om een wandeling met je cliënt te maken. Als je cliënt toch behoefte heeft aan samen wandelen is het goed om hierover in gesprek te gaan. Wat kan jij de cliënt bieden? Wie zou dit samen met de cliënt kunnen oppakken?



EVEN SNEL CONTACT?



EVEN SNEL CONTACT?

Onlinecommunicatie, ‘even appen’, is tegenwoordig niet meer weg te denken. Er zijn een hoop communicatie applicaties beschikbaar, zoals WhatsApp of Signal. Deze laagdrempelige vorm van communicatie maakt het gemakkelijk om even snel contact te hebben met elkaar. Ondanks dat dit een geschikte manier is om snel onderling wat af te stemmen of voor het versturen van een korte update, is deze vorm van communicatie minder geschikt voor het delen van inhoudelijke informatie.

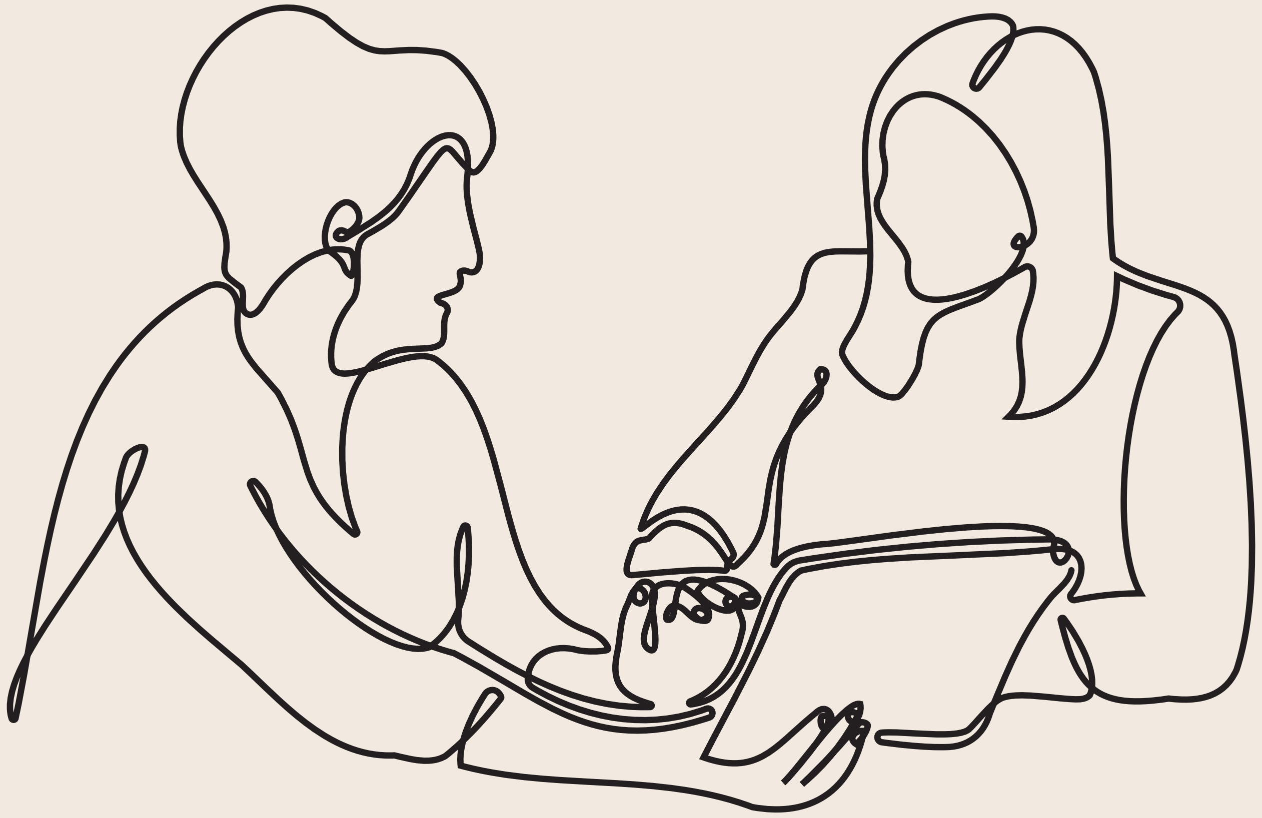
TUSSENTIJDS CHATCONTACT KAN DE DYNAMIEK VAN DE BEHANDELING BEÏNVLOEDEN

Heb je dit medium ook wel eens ingezet voor het delen van informatie? Bijvoorbeeld door je cliënt te wijzen op een passend artikel of filmpje? Deze laagdrempelige input tussen de afspraken door kan de inhoud van de behandelcontacten beïnvloeden.

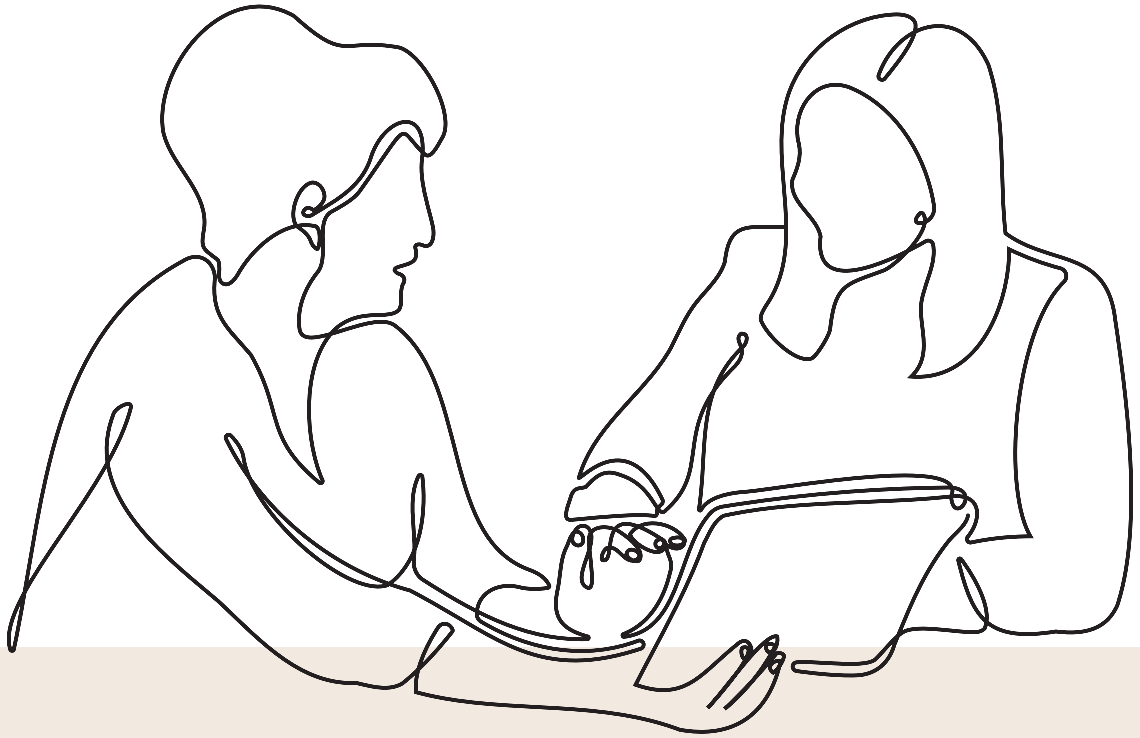
Even chatten is een laagdrempelige vorm van contact waar bijna iedereen wel ervaring mee heeft. Het vraagt dan ook niet veel instructie. Belangrijk hierin is wel of jij openstaat voor tussentijds chatcontact met je cliënten.

Het vraagt vanuit jou ook enige vorm van opvolging. Wat voor afspraken maak je hierover met je cliënten? Waarvoor mag je cliënt deze vorm van communicatie gebruiken? Wanneer ben je beschikbaar en wanneer afwezig? Wat kunnen cliënten verwachten ten aanzien van deze opvolging?

Wanneer je kiest voor chatcontact heb je de keuze tussen verschillende communicatie-applicaties. Welke heeft jullie voorkeur? Wat betekent dit voor de privacy en veiligheid? WhatsApp is erg toegankelijk, maar dit is geen beveiligde verbinding. Wanneer je cliënt niet over een smartphone beschikt, behoort sms'en misschien wel tot de mogelijkheden?



MEER WETEN OVER ONLINE BEHANDELMOGELIJKHEDEN?



MEER WETEN OVER ONLINE BEHANDELMOGELIJKHEDEN?

Tegenwoordig is er van alles digitaal mogelijk en beschikbaar. Elke organisatie heeft zijn eigen cliëntenportaal met informatie, zelfhulpmodules en blended modules. Daarnaast zijn er ook zelfhulp platforms en ook tal van YouTube-filmpjes die ter ondersteuning van herstel kunnen dienen. Thuiswerken aan behandeldoelen kan eigen regie bevorderen bij cliënten.

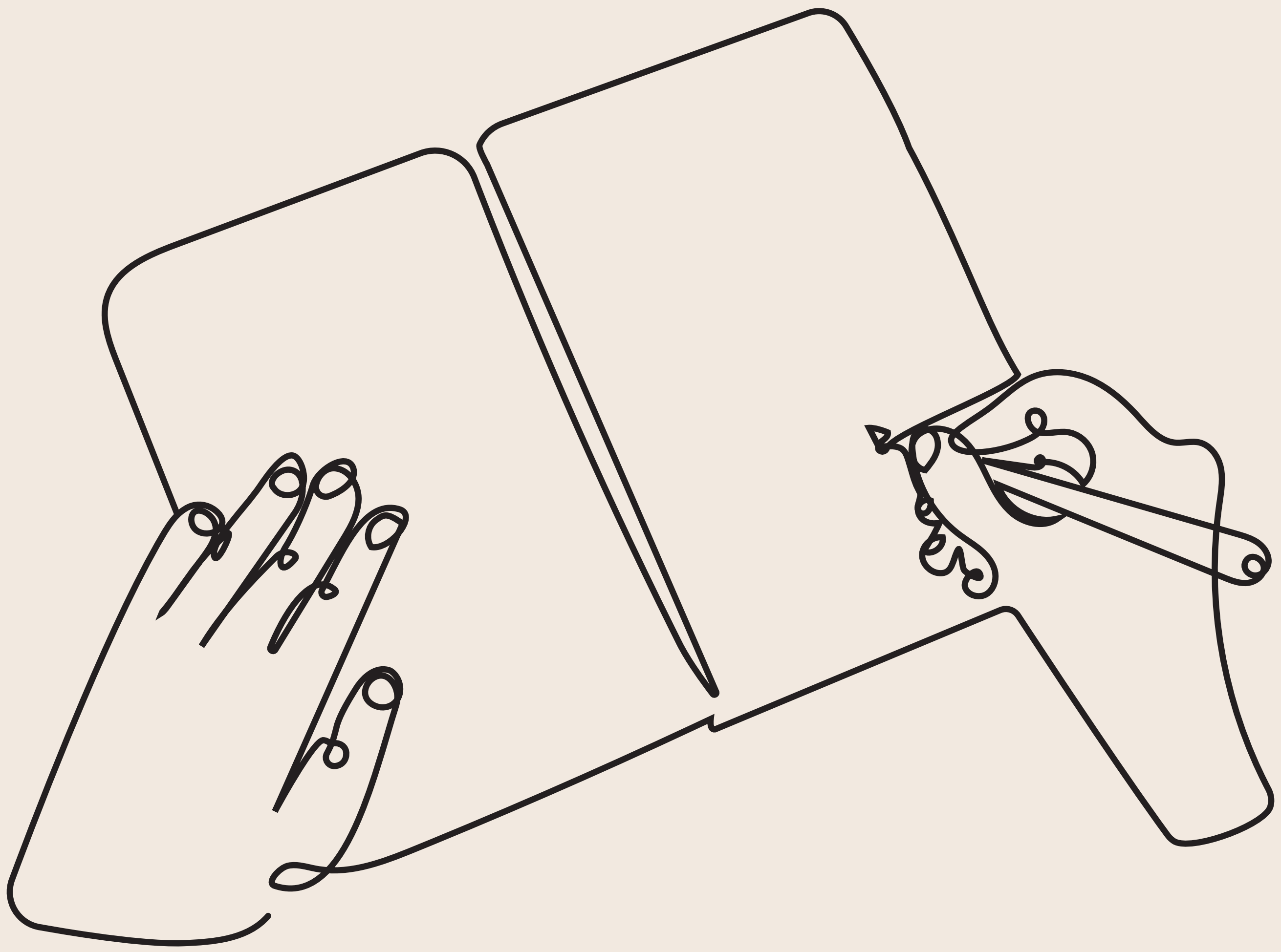
ONLINE BEHANDELMOGELIJKHEDEN KUNNEN ONDERSTEUNEND ZIJN VOOR INZICHT KRIJGEN IN HET ZIEKTEBEELD, VOORTGANG EN HERSTEL

Het grote aanbod dat tegenwoordig beschikbaar is, kan soms afschrikken en het gevoel geven dat je door de bomen het bos niet meer kan zien. Hoe weet je of een module geschikt is voor je cliënt? Moet je dit altijd van tevoren kunnen overzien of kun je dit ook samen ontdekken?

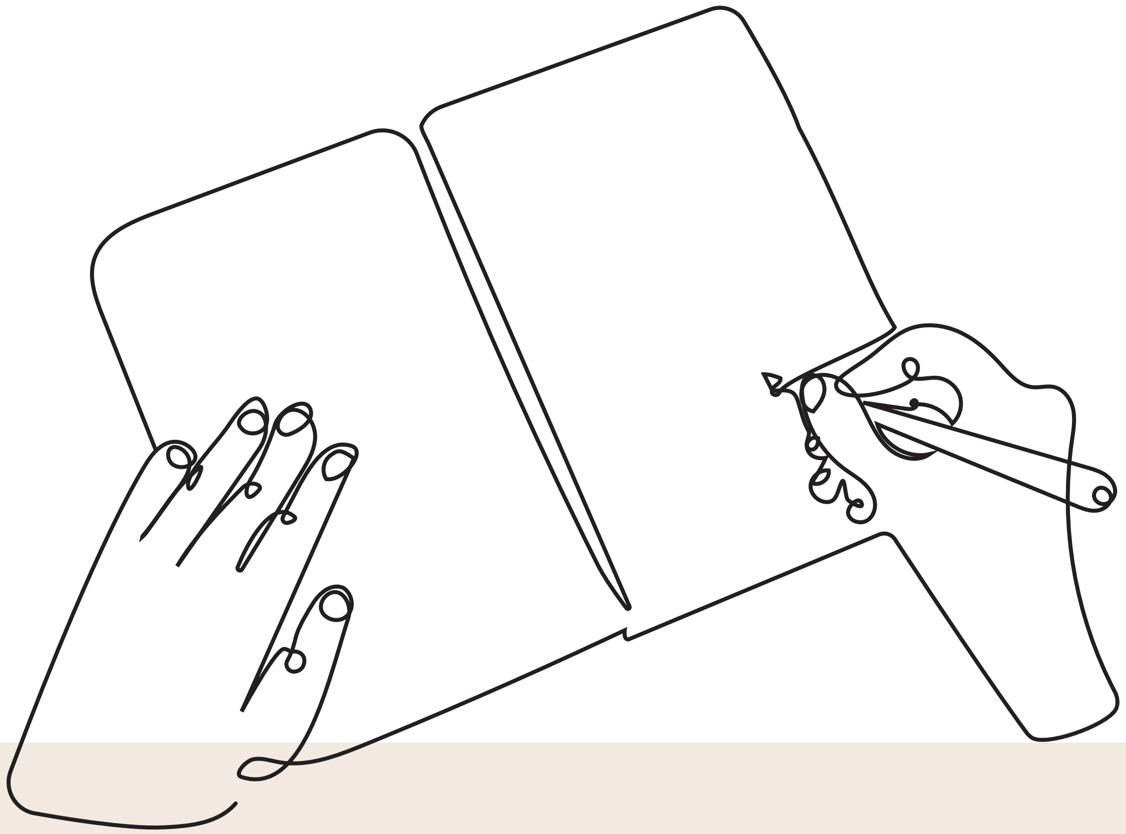
Veel zorgverleners hebben wel eens een module ingezet of positieve verhalen hierover gehoord van hun collega's. Er is ontzettend veel beschikbaar en hiervan is vaak nog maar een klein deel zelf ingezet. Wat zijn de ervaringen van je collega's met specifieke modules? Kun je met elkaar een overzicht maken van deze ervaringen, bevindingen en voor welke behandeldoelen een bepaalde module geschikt zou kunnen zijn?

Het is praktisch gezien eigenlijk onmogelijk om inhoudelijke kennis te hebben opgedaan van alles dat beschikbaar is. Het aanbod is simpelweg te groot. Kun je deze ontdekkingstocht ook samen met je collega's oppakken?

Moet je de inhoud van een module kennen voordat je deze kan klaarzetten voor je cliënten? Is open zijn over dat je de module zelf nog niet kent maar dat de cliënt deze mag uitproberen ook een optie? Ga samen met je cliënt eens verkennen welke modules er beschikbaar zijn!



WIL JE JE VERHAAL EENS OPSCHRIJVEN EN DELEN?



WIL JE JE VERHAAL EENS OPSCHRIJVEN EN DELEN?

Schrijven kan helpen bij het verwerken van ervaringen en emoties. Door je gedachten te beschrijven is het gemakkelijker om structuur en overzicht te krijgen in hetgeen wat er in je omgaat. Tijdens het beschrijven en ordenen van deze ervaringen en gedachten, worden hersenfuncties gestimuleerd die een stabiliserende werking hebben.

PAK EEN MOMENT VOOR JEZELF. GEEF JE GEDACHTEN DE RUIMTE OM ER TE ZIJN, CREËER RUST DOOR ZE TE BESCHRIJVEN

Cliënten die graag schrijven of heel erg in hun hoofd zitten, kunnen hierbij gebaat zijn. Schrijfopdrachten kunnen ook ondersteunend zijn voor je cliënt ter voorbereiding op het behandelcontact. Door de structurering en ordening, wat ontstaat tijdens het schrijven, is het voor hen misschien gemakkelijker om onder woorden te brengen wat er speelt.

Het opschrijven van ervaringen, emoties en gedachten is met name iets wat de cliënt voor zichzelf doet. Hoe kun je je cliënten stimuleren om hun verhaal op papier te zetten? Kun je schrijfopdrachten, thema's of vragen aanreiken waar je cliënt zijn of haar gedachten op los kan laten?

Buiten dat het de cliënt helpt in de structurering en verwerking van de gedachten, kan het ook ondersteunend zijn ter voorbereiding op het behandelcontact. Misschien wil je cliënt een keer iets delen en meenemen of dat opsturen naar jou ter voorbereiding op de afspraak?

Sommige cliënten kunnen hun gedachten beter beschrijven dan verwoorden. Bij tussentijds chat contact is het lastiger om de verdieping op te zoeken. Mailen kan geschikt zijn voor het komen tot deze verdieping. Is mailcontact soms prettiger dan een gesprek? Wat vraagt dit van jou, qua opvolging en planning?

APPENDIX

1. Setup and insights focus group sessions
2. Setup workshop decision moments
3. Informed consent peer review
4. Other desired future practice scenarios
5. Setup evaluation session concepts
6. Concept boards with feedback
7. Information letter diary study
8. Setup evaluation session final concept
9. Questionnaire evaluation final concept

A.

A.1 SETUP AND INSIGHTS FOCUS GROUP SESSIONS

This section describes the setup and the number of participants of the focus group sessions. For the analysis of the focus group sessions the transcripts were used for a thematic analysis, the thematic analysis resulted in eight themes. The meaning of these themes are supplemented with quotes from healthcare professionals in this section.

The purpose of the focus group sessions was twofold. My co-researcher was focused on testing the effectiveness of the intervision model. Personally, I had several goals. I had already seen in the KIEM data that how care is shaped, and which kind of therapy is used, seems to depend on all kinds of factors. During the interviews, I was therefore curious about (1) which consideration factors influence these mental healthcare professionals, in what proportion and to what extent. Moreover, I was curious about how their considerations would change when the care situation slightly changes. In addition, I was interested in (2) what happens when you offer alternative forms of therapy and ask mental healthcare professionals to actively discuss what this requires of their knowledge and skills. Lastly, I was curious (3) to learn to what extent talking about these consideration factors and alternative forms of therapy contributes to reflecting on one's own actions and creating awareness.

Respondents

A total of three focus group sessions took place in which six mental healthcare professionals within the Optimal Living Assen (OLA) team participated. Of these, five were psychiatric nurses and one was a social worker (Table 2). The OLA team is a multidisciplinary team from different care organizations that provides outpatient care to the EPA target group (severe psychiatric disorders) in four neighbourhoods in Assen. The participants are close colleagues of the co-researcher and recruited by her. The respondents were close colleagues of the co-researcher and recruited by her. The co-researcher sent an invitation to her team resulting in an attendance of four colleagues for the test sessions of the first version of her intervision model.

Due to organizational reasons this session was split up in two moments, of which I could not be present at the first session. The data of this session has been shared with me and has been included in the analysis of the sessions. The insights from the first test sessions led to a second prototype which was tested again with the target group (N=3). Table 2 shows which respondents were present at which session and what their function is within the team. In this table we could also see that R2 could attend both sessions, this respondent was therefore asked as well to reflect on the differences between prototype 1 and 2.

The focus group sessions were facilitated by my co-researcher and took place through TEAMS given the measures of the COVID-19 pandemic. Prior to the focus group sessions, permission was sought to record the sessions with both audio and video. Patient information was kept confidential during the sessions. The recordings were transcribed anonymously and therefore cannot be traced back to individuals. The recordings were immediately deleted after transcribing.

Table 2: Total overview respondents focus group sessions

		Prototype 1 Not involved	Prototype 1 Involved	Prototype 2 Involved
R1	Social Worker			X
R2	Nurse Level 5		X	X
R3	Nurse Level 5			X
R4	Nurse Level 5		X	
R5	Nurse Level 5	X		
R6	Nurse Level 5	X		

Focus group sessions prototype 1

We had scheduled an hour and a half for the first prototype test sessions. The session was led by my co-researcher, at first there was a moment to introduce ourselves to each other. In this introduction the care professionals told something about their background and function within the team. Then the co-researcher took over and introduced her research and the purpose of the session.

The session was meant for testing the first version of the intervision model, for which my co-researcher had prepared a Prezi. The model consisted of fictitious case studies in which various situations were described and in which the healthcare professionals had to make a choice in how they would contact the fictitious patient. The healthcare professionals were asked to think out loud, also known as concurrent thinking aloud. To describe what considerations, they make and why. To discuss what would be the most appropriate treatment or contact option for the patient from their perspective.

The first sheet introduced the fictitious patient Gijs Dijkstra (Figure 33), with five different dilemmas on the right: request for help, goals, incident, follow-up, accessibility. Each dilemma was introduced with a short situation sketch ending with questions for the healthcare professionals (Figure 34). These questions were intended to stimulate the discussion among the healthcare professionals. On the right side of the dilemma sheets two more options are listed. We have deliberately chosen to include these options as option 1 and option 2. In a previous version these options already contained contact or treatment suggestions, for example 'Video Calling', 'Home visit', 'Modules', I expected that the labels could be perceived as too directive. Which is not in line with the aim of the session since we wanted to prompt the healthcare professionals to think about the possibilities by themselves. Providing them with fitting options could possibly steer them, the titles have therefore been replaced by 'Option 1', 'Option 2' etc.

The options were only presented as possible suggestions after the 'think aloud' part, so the healthcare professionals could first think of possibilities by themselves. The suggestions sheets consisted of Gijs' reservations about the option (Figure 35). This was followed by a discussion with each other about what the suggested method would require from their skills. For some of the options there was also a fictitious colleague who gave tips for using the suggested method (Figure 36).


Gijs Dijkstra

- 28 jaar
- Schizofrenie, paranoide type
- Achterdocht & sociale angst
- In het verleden drugsgebruik

- Woonachtig bij ouders
- Geen werk of dagbesteding
- ICT-opleiding niet af kunnen maken
- Weinig sociale contacten

Hulpvraag
Doelen
Incident
Vervolg
Bereikbaarheid

Prezi

Figure 33: Introduction fictitious patient


Doelen

Inmiddels hebben jullie nu een paar weken contact en zijn jullie bezig met het opstellen van een herstelondersteuningsplan.

Doelen zijn:
- Dagbesteding zoeken wat bij Gijs past; hij weet niet zo goed wat hij wil of wat hij leuk vindt en wil dit onderzoeken.
- Minder last van negatieve gedachtes en achterdocht; over straat heeft Gijs het gevoel dat er over hem gepraat wordt.

Hoe help jij Gijs om aan zijn doelen te werken?

Optie 1
Optie 2

Prezi

Figure 34: Situation sketch of dilemma


Collega

Online module

Gijs:
"Een online module lijkt mij wel wat. Het is alleen zoveel lezen. Ik weet nu al dit gaat veel van mij vragen. Daarom is het nog wel een drempel om te beginnen."

Prezi

Figure 35: Patient's response to the suggestion


Collega Erwin

In het Karify programma zoek ik naar passende modules voor mijn cliënten.

In een afspraak help ik ze altijd even in het begin. De start doen we dan ook vaak samen.

In mijn agenda plan ik ruimte om het vervolg te zien en feedback te kunnen geven. In gesprek met mijn cliënten bespreken we ook vaak de module nog na.

Soms slaat het aan en soms ook niet, maar dat is gewoon uitproberen en onderzoeken.

Prezi

Figure 36: Tip from a colleague

For me, the goal of this session was to identify the reasons why they would or would not use a specific form of therapy in a specific situation. My role in this session was to observe, in which I was given the freedom to ask questions about the topics that I found relevant for my own research. After the care professionals expressed their choices and their reasoning, I asked them what they would do if the situation was slightly different, to find out whether a change in factors would also change their decision. In addition, we could test whether such a tool, an intervision model, would help to start the conversation about how care changes when you choose another treatment or contact option. And whether such a method could also result in more awareness about the theme: Blended Care.

Focus group session prototype 2

During the testing of prototype 1, we noticed that the in-depth layer of their reasoning was not yet tapped into during the focus group session(s). We tried to stimulate this by asking a lot of questions, but the mental healthcare professionals rightly pointed out that their choices were dependent on various factors and that the fictitious case studies sometimes did not contain enough information to give specific answers.

> *"I want to know what he has already tried.*
> *What has been used before, whether that has helped, whether there are things that can be picked up again. If not, maybe day care could be a solution. But regarding his negative thoughts... yeah it all depends on what he wants to use and what help has already been offered. It depends on the starting situation..."*
> *Respondent 2, mental health nurse*

By preparing more detailed fictitious case studies and asking the healthcare professionals to prepare a case study from themselves to bring into the renewed intervision session, we hoped to be able to achieve this more in-depth layer of reflective thinking.

To make the intervision model reusable, we had made an overview of the contact and treatment possibilities within this specific team. We made cards of this overview which we handed out to the respondents before the session started (Figure 37). The purpose of these cards was to raise the awareness of the care professionals, to help them think of alternatives more quickly, instead of the standard 'popping up' methods they were familiar with. We deliberately added blank cards to invite care professionals to think about other contact or treatment options as well. The cards can be used repeatedly and are independent of the case studies that are brought in.

Figure 37: Contact and treatment options cards.

As a final optimization, to stimulate reflective thinking and also for the reproducibility of the intervision model, we had formulated a set of reflective questions. The aim of these questions was to stimulate the discussion and reflection on one's own actions. The reflective questions consisted of:

- Which form of therapy would you choose in the case study and why?
- What knowledge, attitude and skills do you need for this?
- What are alternative forms of therapy you could use and why?
- What made this alternative not to be your first choice?
- How would the alternative change the contact with your patient?
- If you would use the alternative, what would that require of your knowledge, skills and attitude?
- What do you need to be able to use the alternative in your work?

For this session, two hours were planned. We started with a brief summary of the insights from the first test sessions. This was followed by an introduction of what we were going during this session. Unfortunately, none of the respondents had prepared a case to bring on the table, therefore the new fictitious case studies were used instead. Because we wanted to reach an in-depth layer of reflection, we decided to only discuss two of the three prepared case studies with each other. By asking the reflective questions we stimulated the respondents to think outside their comfort zone. The mutual conversation also contributed to the exploratory atmosphere of the session.

To conclude the session, we planned a debrief discussion which we have structured around a behavioural change model consisting of three phases (Figure 38). We were curious about to what extent the respondents were aware of their existing patterns and whether they already considered themselves capable of using the alternatives. The model describes that behavioural change initially requires raising awareness, with the underlying idea that you are often not aware that you are automatically exhibiting a certain behaviour. In the discussion afterwards, we therefore actively asked whether they had become aware of their automatic pilot, and to what extent they considered themselves capable of stepping outside their comfort zone. The second phase of the model is the ability or learning phase, in which you acquire new knowledge and start experimenting with the new behaviour. Ultimately arriving at the third phase, automation, in which you can recognize when the new behaviour complements the old behaviour.

By discussing which quadrant they would classify themselves in before and after the session we were able to find out what the session had meant to them. During the discussion it soon became clear that the session had resulted in (more) awareness about the 'necessity' for daring to look at alternatives. One of the respondents was not yet aware of the impact of her automatic behaviour, the other two respondents had already participated in other sessions or interviews of the study of my co-researcher, and they were therefore already (more) aware of the fact that they often acted on their automatic pilot. However, the quadrant of conscious incapacity had been expanded for them because of the session, in the sense that their awareness of the range of alternatives had been broadened.

Figure 38: Four phases in the acquisition of new knowledge, model Maslow

NLP voor Professionals: *Leerfasen van Maslow*

1.1 ANALYSIS OF FOCUS GROUP SESSIONS

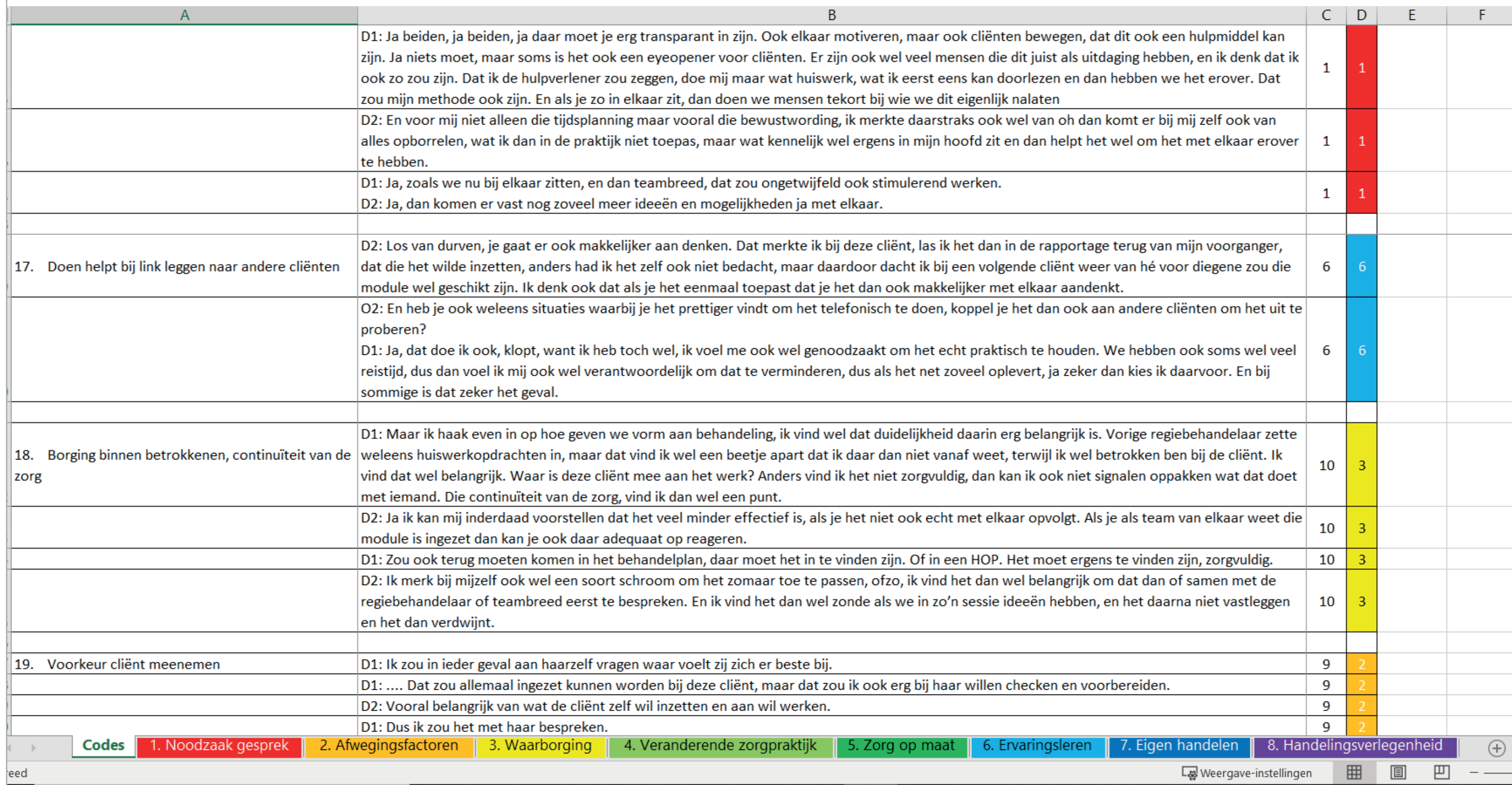
The focus group sessions resulted in a large set of raw data consisting of evaluation forms, field notes and recordings of the sessions. After each session, my co-researcher and I listened to the recording individually and shared our initial insights with each other. These insights led to the improved version of the intervision model.

In order to be able to analyse the focus group sessions in a more structured and detailed way, I transcribed sessions two and three, in which not all stutterings and 'uh's were included. This was done to do justice to the respondents' word choice and to avoid misinterpretation of 'crooked' sentences. For this reason, language errors were also not corrected in the transcripts.

For the analysis of the focus group sessions, the transcripts were used for a thematic analysis, where relevant passages were highlighted and then open coded. This list of codes was then aggregated into overarching themes, axial coding (Figure 39). This resulted in eight themes: personalised care, changing care practices, consideration factors, safeguarding and follow-up, repertoire, necessity of gaining experiences, the importance of dialogue and awareness.

Unfortunately, no recording of the first test session was available; instead, I received the field notes of my co-researcher. These notes have been used to enrich my analysis but have not been leading in the creation of the codes or themes, since the notes were not a literal elaboration of what was said possibly leading to misinterpretations.

Figure 39: Part of the thematic analysis focus group sessions



A	B	C	D	E	F
	D1: Ja beiden, ja beiden, ja daar moet je erg transparant in zijn. Ook elkaar motiveren, maar ook cliënten bewegen, dat dit ook een hulpmiddel kan zijn. Ja niets moet, maar soms is het ook een eyeopener voor cliënten. Er zijn ook wel veel mensen die dit juist als uitdaging hebben, en ik denk dat ik ook zo zou zijn. Dat ik de hulpverlener zou zeggen, doe mij maar wat huiswerk, wat ik eerst eens kan doorlezen en dan hebben we het erover. Dat zou mijn methode ook zijn. En als je zo in elkaar zit, dan doen we mensen tekort bij wie we dit eigenlijk nalaten	1	1		
	D2: En voor mij niet alleen die tijdsplanning maar vooral die bewustwording, ik merkte daarstraks ook wel van oh dan komt er bij mij zelf ook van alles opborrelen, wat ik dan in de praktijk niet toepas, maar wat kennelijk wel ergens in mijn hoofd zit en dan helpt het wel om het met elkaar erover te hebben.	1	1		
	D1: Ja, zoals we nu bij elkaar zitten, en dan teambreed, dat zou ongetwijfeld ook stimulerend werken. D2: Ja, dan komen er vast nog zoveel meer ideeën en mogelijkheden ja met elkaar.	1	1		
17. Doen helpt bij link leggen naar andere cliënten	D2: Los van durven, je gaat er ook makkelijker aan denken. Dat merkte ik bij deze cliënt, las ik het dan in de rapportage terug van mijn voorganger, dat die het wilde inzetten, anders had ik het zelf ook niet bedacht, maar daardoor dacht ik bij een volgende cliënt weer van hé voor diegene zou die module wel geschikt zijn. Ik denk ook dat als je het eenmaal toepast dat je het dan ook makkelijker met elkaar aandenkt.	6	6		
	O2: En heb je ook weleens situaties waarbij je het prettiger vindt om het telefonisch te doen, koppel je het dan ook aan andere cliënten om het uit te proberen? D1: Ja, dat doe ik ook, klopt, want ik heb toch wel, ik voel me ook wel genoodzaakt om het echt praktisch te houden. We hebben ook soms wel veel reistijd, dus dan voel ik mij ook wel verantwoordelijk om dat te verminderen, dus als het net zoveel oplevert, ja zeker dan kies ik daarvoor. En bij sommige is dat zeker het geval.	6	6		
18. Borging binnen betrokkenen, continuïteit van de zorg	D1: Maar ik haak even in op hoe geven we vorm aan behandeling, ik vind wel dat duidelijkheid daarin erg belangrijk is. Vorige regiebehandelaar zette weleens huiswerkopdrachten in, maar dat vind ik wel een beetje apart dat ik daar dan niet vanaf weet, terwijl ik wel betrokken ben bij de cliënt. Ik vind dat wel belangrijk. Waar is deze cliënt mee aan het werk? Anders vind ik het niet zorgvuldig, dan kan ik ook niet signalen oppakken wat dat doet met iemand. Die continuïteit van de zorg, vind ik dan wel een punt.	10	3		
	D2: Ja ik kan mij inderdaad voorstellen dat het veel minder effectief is, als je het niet ook echt met elkaar opvolgt. Als je als team van elkaar weet die module is ingezet dan kan je ook daar adequaat op reageren.	10	3		
	D1: Zou ook terug moeten komen in het behandelplan, daar moet het in te vinden zijn. Of in een HOP. Het moet ergens te vinden zijn, zorgvuldig.	10	3		
	D2: Ik merk bij mijzelf ook wel een soort schroom om het zomaar toe te passen, ofzo, ik vind het dan wel belangrijk om dat dan of samen met de regiebehandelaar of teambreed eerst te bespreken. En ik vind het dan wel zonde als we in zo'n sessie ideeën hebben, en het daarna niet vastleggen en het dan verdwijnt.	10	3		
19. Voorkeur cliënt meenemen	D1: Ik zou in ieder geval aan haarzelf vragen waar voelt zij zich er beste bij.	9	2		
	D1: .... Dat zou allemaal ingezet kunnen worden bij deze cliënt, maar dat zou ik ook erg bij haar willen checken en voorbereiden.	9	2		
	D2: Vooral belangrijk van wat de cliënt zelf wil inzetten en aan wil werken.	9	2		
	D1: Dus ik zou het met haar bespreken.	9	2		

1.2 THEMES

The thematic analysis resulted in eight themes, which also consists of sub-themes. The themes describe the considerations and factors that influence the decision-making process for the form of therapy of the mental healthcare professionals that are interviewed. What alternative forms of therapy would mean for their care practice. What they encounter in the implementation of Blended Care and what is important for them in managing and embedding this. This section describes the meaning of the themes, supplemented with quotes from the care professionals.

PERSONALISED CARE

The aim of every healthcare professional is to provide good care. The complexity of the healthcare practice requires personalised care. Not every intervention or form of therapy is suitable for every patient; some patients benefit from home visits, others from office visits and yet others from telecare. The COVID-19 pandemic made the team realise that telecare can be of added value for some patients. Additionally, they also experienced the downside of not being allowed to physically meet their patients. Now the measures have been relaxed and they are allowed to meet their patients face to face again, the question arises more than ever whether the purpose of their contact moments is suitable for care at a distance.

Added value for patients

Through COVID-19, the mental healthcare professionals were able to experience how the recovery process of their patients could benefit from digital means. During the sessions, the respondents realised that digital care could encourage patients to take control and responsibility for their own treatment. In the discussions about the online modules, they indicated that the modules result in more control for the patient and greater accessibility of care between appointments.

> *“It’s a great idea if patients are open to this. Then you (the patient) also have control, even at home. Nice tool to apply for the patient.”*
>
> *Respondent 2, Mental health nurse*

> *“It’s a nice tool, it gives the treatment more direction. You’re more evenly matched with the information. The patient doesn’t have to hear it all from me.”*
>
> *Respondent 5, Mental health nurse*

Due to the nature of the focus group sessions, one of the respondents realised that if she had been a patient herself, she would also prefer to be able to do assignments at home so topics and concerns could be discussed more in depth during the contact moments. She realised that they were currently failing their patients if they are not going to use digital care (more often).

> *“Respondent 1: That does motivate me, the part of control and responsibility of patients. It’s very stimulating to discuss the importance of that with each other.*
>
> *Interviewer: Do you mean with each other the team, or with the patients?*
>
> *R1: Yes you have to be very transparent in that. Motivating colleagues, but also moving patients, that this can also be a tool. Nothing has to be done, but sometimes it can be an eye-opener for patients as well. And I think I would be the same. That I would say to the healthcare professional, just give me some homework, which I can read through first and then we’ll talk about that the next time. That would be my preferred approach as well. And if you’re like that, then we’re failing people with whom we’re actually neglecting to do this.”*

Not suitable for everyone

Care at a distance is not suitable for everyone, the care professionals experienced that with some patients it is very difficult ‘to get in touch’ when you do not see each other physically. For other patients, this was not an issue at all, and they talked just as easily at a distance as when they did meet each other. The motivation, willingness and stability of the patient play a major role in this. For example, following modules requires commitment from the patient, and not every patient wants this. The caseload of the team consists of patients with severe psychiatric disorders, some patients are suspicious and have many questions about the privacy and security of digital care, sometimes there is ‘no talking to’.

> *“Respondent 1: But well not everyone wants this, some are also suspicious about computers, that neighbours are watching for example, well then it stops.*
>
> *Interviewer: Is that something you think, I’ll leave it at that. Or is that also something you can substantiate to patients that it is a secure system?*
>
> *R1: Well, the patient that I have in mind right now I can’t explain this at, he really thinks that his neighbours are watching him constantly. But sometimes he can use the computer of the organisation, he trusts that. But then he can’t do his homework alone, so he doesn’t want that either. So, we just do it on paper, he feels most comfortable with that.”*

> *“That also varies so much, I have patients for whom it (modules) is totally not suitable, because they are totally not motivated, but I also have patients who are very keen to get started with all kinds of things.”*
>
> *Respondent 2, mental health nurse*

Making care suitable at a distance sometimes requires creativity on the part of the patient and the care provider. By discussing this with each other, even though it may still feel unpleasant and uncomfortable, solutions can be found together instead of writing care at a distance off as unsuitable.

> *“Yes, I have used that (video calls) last year, when really everything was via video calling, during the first COVID-19 wave. That was a similar target group, and it worked, well it is not that it didn’t work at all. I had a patient who covered her own face with some tape or a post-it as seeing herself was apparently very unpleasant. Also, I do video calls with Karify[1], and at first, I didn’t install a photo of myself, so when the connection would suddenly break down, they saw an avatar, some sort of man’s picture, say, an anonymous picture, and that would sometimes cause them to feel uncomfortable, so I have changed that afterwards. So, yeah, anything is possible when you discuss it.”*
>
> *Respondent 2, mental health nurse*

Focus on the purpose

What is the purpose of the appointment and is it suitable for care at a distance? Despite face-to-face contact is possible again, the care professionals sometimes consciously choose to keep (video) calling, given the good experiences they have had. The purpose of the contact in particular plays an important role for the care professionals in this decision, and if this ‘can be done’ via care at a distance they sometimes consciously choose to do so in view of the practical advantages (video) calling offers them and the patient.

> *“If it can also be done via video conferencing, then I think we should look into that practically because it takes much less time, and you do get everyone together more quickly.”*
>
> *Respondent 1, social worker*

> *“But sometimes people just need time, to build up a relationship, to trust, but then that’s the goal. Then I need to think about what we are doing right now, well, that’s it for now, and then we take time for that and that’s it.”*
>
> *Respondent 1, social worker*

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[1] Patient portal, eHealth platform.

CHANGING CARE PRACTICES

In the theoretical framework it has already been discussed that technology is not neutral and has an impact on the care offered and the care relationship. The conversation changes by missing the physical closeness. Communicating at a distance, by the means of a 'tool' such as a telephone or computer, changes the dynamics of the conversation. The care professionals recognised and acknowledged this; it was uncomfortable for both the patients and the healthcare professionals to suddenly have to switch to video calling. They were used to being able to see their patients at the office or in the patient's home environment, especially the 'state' of the households were external sources of information about their patient's state of mind. The comforting and supporting function of putting a hand on someone's shoulder disappeared. Non-verbal communication was difficult to pick up; it requires a different use of knowledge and skills to 'bring out' the playing topics of the patient.

Care is changing with the advent of technology

The dynamics and content of the conversation changes with the advent of the 'screen' in the care relationship. It requires a different way of concentration, and it can be uncomfortable to see yourself on the screen.

> *"Well, I think video calling is really awful, I really recognise what patients say. I am constantly distracted by seeing myself on the screen, haha, so I prefer to look in a different direction now, you know, if I'm looking at the screen I'm going to communicate differently or something. Luckily my patients felt the same, they also preferred to just call, so that fitted in nicely. Video calling, yes, I find it difficult, also when I use it privately with friends or something like that."*
>
> *Respondent 2, mental health nurse*

The changing healthcare practice is asking for translating your skills to a new medium

Non-verbal communication is more difficult to pick up with telecare, the ability to sense the atmosphere in the room is lost. Whereas being able to see the patient and his surroundings often already provided a lot of information about the patient's state of mind, it is more difficult to recognise how your patient is doing with the use of telecare. A more conscious and focused use of interview techniques is required, as well as asking explicit questions.

> *"Respondent 1: What I said, when I see her, I also look to respond to the non-verbal signs. And I can't do that when I just call her. So preferably I would like to see her.*
>
> *Interviewer: If you cannot pick up the non-verbal signs, would you use other techniques, would you engage differently to ensure the quality of care?*
>
> *Respondent 1: That would be my second choice, but then maybe I would ask her more specifically. How do you feel about it? What does it do to you? I would ask her more or ask her in a different way.*
>
> *Respondent 3: Maybe also more conscious or something.*
>
> *Respondent 2: Yes, I have also noticed during my telephone conversations, when you mention certain emotions, that I ask more questions, Is that true? So, I check it a bit more."*

CONSIDERATION FACTORS

The secondary thematic analysis of the KIEM data has already shown that all kinds of factors play a role in the decision-making process as to whether telecare would be an option for the patient. This also emerged strongly in the focus group sessions. It is always an assessment that is been made. To avoid repeating what has already been discussed in the secondary analysis of the KIEM data, I have chosen to include only the most important consideration factors in the interpretation of this theme.

> *"It's always an assessment you make. With all the factors that play a role. Something you weigh up in your head very quickly: should I be worried or not, should action be taken, why or why not. If family members are worried, there's another component that comes into play, which you have to comply with. And that leads to other actions and considerations as well...".*
>
> *Respondent 4, mental health nurse*

Recovery phases

The team has mentioned the 'recovery phases' as an important consideration factor, as the team is focused on recovery-oriented care. They therefore use the recovery phases that are known within the mental healthcare sector. Consisting of (1) being overwhelmed by the condition whereby the patient is in crisis, (2) struggling with the condition, (3) living with the condition and (4) living beyond the condition. For the healthcare professionals, the recovery phases are in line with the stability and state of mind of the patients. The more progressed the patient is in his or her recovery, and the more insight there is into the condition, the more they believe that care at a distance is possible and could supplement regular treatment and contact. At the start, care professionals focus on building up a relationship of trust; to this end, they consider face-to-face contact as a must.

We had an interesting discussion about the impact of recovery or relapse regarding responsibilities. Whether certain responsibilities and control can be transferred to the patient, or whether certain responsibilities should be transferred back to the healthcare professional in case of relapse. In response to this, a healthcare professional indicated that it is customary to discuss the transition to another phase with the patient. However, this is not yet an explicit moment to look at which responsibilities can be transferred to the patient, or whether contact can be maintained in a different way.

> *"Respondent 1: We have agreed within the team, that the recovery phases are discussed with patients, so yes, we discuss that. So phase 1 is crisis, and if they move on to another phase, then they are no longer discussed among us every morning, and that is always explicitly discussed with the patient as well. And that overview of recovery phases, whereby you can discuss with the patient in which phase they place themselves, and how they move on to the next phase, is also something we discuss.*
>
> *Interviewer: Is this also a moment to reflect on the responsibilities? For example, I can imagine that during the first phase the healthcare professional takes on a lot of control, and that the patient gradually takes on more control. But are these responsibilities something you consider at each stage?*
>
> *R1: I think I am aware of that, but I also believe it could be discussed more explicitly. In my opinion."*

Unexpected situations

If there is an unexpected event or a crisis situation, it is important to switch quickly and weigh up whether immediate action is required or not. Here they look at the severity and seriousness of the situation, and whether it is an exceptional situation for the patient and whether the patient reacts as expected.

> *"Respondent 4: Maybe give him a call if he doesn't respond to the app. Also depends on the history. It's all part of the equation. Some people drop something via the app and then lose it, others don't. Depends on the person.*
>
> *Interviewer: If you know more about someone, how they react and act, you can also better anticipate how you make contact, and how someone responds.*
>
> *Respondent 2: Yes definitely. Whether it's exceptional or not for someone."*

Time management

The proper embedding of care at a distance requires an investment of time from both the care professional and the patients. Through COVID-19 they have experienced that once it is up and running, it can also save time, especially for a quick check-up or when you need to get several people together at short notice. Keeping things running smoothly also takes time, for example for the follow-up and safeguarding in the team. These follow-ups and the safeguarding in the team has become a separate theme given the big importance of this topic within the discussions, this will therefore be discussed in more detail in the next theme.

> *"Video calling is more productive; it can be used functionally."*
>
> *Respondent 5, mental health nurse*

> *"If it can also be done via video conferencing, then I think we should look into that practically because it takes much less time, and you do get everyone together more quickly."*
>
> *Respondent 1, social worker*

Personal preference of the patient

The patient's preference in terms of the form of therapy is also an important consideration in the decision-making about how care is organized. One of the healthcare professionals described how she had taken over a patient from a former colleague and that her former colleague had promised to select some modules for the patient. The healthcare professional wanted to comply with the patient's wishes and therefore decided to investigate the modules at a short notice.

> *"I am the case manager of a patient who was last seen by the former case manager in October and the patient has been transferred to me. If the patient still wants to work on modules, I realise it is six months later now of course, and the request for help may be different now, but if the patient still wants it, then I should know how it works and what it's all about."*
>
> *Respondent 2, mental health nurse*

Not only the patient's preference plays a role, but also the willingness and digital literacy of the patient. Patients must be willing to install the video call software and be skilled enough to use the digital patient portal. At the start of the COVID-19 pandemic, the healthcare professionals used WhatsApp for their video calls, even though this is not a protected connection, because for many patients this is a familiar app so they could easily switch over to it. The team still uses WhatsApp video calls sometimes, but only after it is clarified that this is not a secure system and that it is the patient's choice.

Personal preference of the healthcare professional

From the focus group sessions, we can learn that the personal preference of the healthcare professional also plays an important role in the decision-making process. One of the fictious case studies concerned a patient who was referred to the OLA team after two admissions for a psychosis. When we asked the care professionals how they would make the first contact with this fictious patient, a unanimous personal preference emerged for a face-to-face meeting since the patient had not yet built up a relationship of trust.

In this a large proportion of the care professionals were also attentive to the personal preferences of the patient and would actively ask about the patient's wishes whether the patient also preferred a face-to-face meeting.

> *"Respondent 2: Now, when building up the caseload, the first contact moment will be by phone, to see how things are going, and to pay attention to the current distrust, and then discussing how and where to meet. Also, what someone likes, where to meet.*
>
> *Interviewer: Is that now, that you discuss this with each other because of Corona? Or has that always been a topic of conversation?*
>
> *R2: I still prefer physical interaction. Certainly, in cases of distrust, it is difficult to assess how things are going on a screen, to establish contact… you cannot understand the natural and non-verbal communication as well as when you sit in front of each other."*

> *"What is important is that you have freedom of choice for the patient. What do you want, at the office or at home? If there are signs that all sorts of things are going on in the home situation, it would be interesting to see if there is a possibility for a home visit. I believe that it very much depends on the reaction of the patient, what kind of contact is established, and the signals from the environment."*
>
> *Respondent 2, mental health nurse*

Interestingly, during the focus group sessions, one of the care professionals realised, in response to the questions we posed, that it was actually an assumption on his part that what he preferred would also be the patient's preferred form of therapy. The respondent assumed that the patient would indicate if he did not want a face-to-face conversation.

> *"Yes, that's actually how I usually do it. I think that's what someone would like the most, to see each other face-to-face. I prefer it myself, I assume that it is also more pleasant for the patient but I am not sure about that, it is just an assumption."*
>
> *Respondent 4, mental health nurse*

> *"Interviewer: Suppose no preliminary information, and no preferences are expressed, how would you handle?*
>
> *Respondent 4: Then I would first make a suggestion for doing a home visit, to get to know each other, but it would have to come from the patient, 'I'd rather not do that, for this reason'.*
>
> *I: Not based on an open discussion?*
>
> *R4: Yes, and of course that also says something about the patient's situation. I wouldn't know how else, yes, I would have to approach it very openly then, with the options. Could leave the choice with the patient... yeah, that could be a possibility as well…".*

SAFEGUARDING & FOLLOW-UP

Care at a distance requires an investment of time and effort from both care professionals and the patient. The use of modules, for example, 'serves no purpose' if the healthcare professional does not subsequently respond or return to them. This requires an investment of time by the care professional and the active planning of this follow-up.

> *"Respondent 4: I will still have to take care of the direction of the treatment and the processing of reactions myself. If assignments are made, I must be the one who adequately does something with them. Preferably, I should have some experience with it myself, so that I can tell the patient what to expect.*
>
> *Respondent 2: When I hear Respondent 4, if a patient starts to work on modules, we should indeed also make time to react on it. If you say A, you also must say B. You also have to be able to answer questions."*

The care professionals also stressed the importance of carefully embedding new forms of therapy. Safeguarding within the team was therefore also discussed extensively in the focus group sessions. As soon as there is no reporting or transmission to other involved care professionals there cannot be actively signalled on changes.

> *"I'm going to look at how we shape care, in this I think that clarity is very important. The previous case manager sometimes gave homework assignments to patients, but I find it a bit odd that I don't know about these assignments, while I am still involved with the patient. I think that it is important, that everyone is informed. What is this patient working on? Otherwise, I don't think care is shaped very careful, because then I can't pick up signals about what that's doing to someone. The continuity of care is important for me."*
>
> *Respondent 1, social worker*

The topic of care at a distance is not yet 'lived' or 'felt' enough within the team. However, the care professionals belief it is important that this becomes a team subject, so that they are not reinventing the wheel individually. Good ideas were discussed, such as the team-wide creation of an inspiration folder or including care at a distance in the policy and team meetings.

> *"Of course, it all starts with yourself, but I belief it would help when we discuss it in the team from time to time as well. For example, discussing if a case is suited for online or blended treatment. That would be supportive though."*
>
> *Respondent 1, social worker*

It was remarkable to hear that they did not even know about each other's stumbling blocks.

> *"We never discussed it in the team like this before. It's not really an agenda item now. We are all dealing with the subject individually. Some have more affinity with it than others. I don't even know that about my colleagues."*
>
> *Respondent 4, mental health nurse*

NECESSITY OF GAINING EXPERIENCES

The feeling of lack of expertise hinders care professionals from 'daring' and 'being able' to use care at a distance. On the one hand, they are not yet aware of what is possible, or of the tools that are available to make it their own. As a result, they cannot recognise it as a new possibility at all.

> *"Well nice to hear that that exists, a webinar, about Karify. I did not know that."*
>
> *Respondent 2, mental health nurse*

> *"I don't know those apps, so I don't advise them at my patients."*
>
> *Respondent 4, mental health nurse*

On the other hand, they are aware of the possibilities but feel they need to know the content of what they are offering. They want to be able to make an informed assessment of why an app or module might be suitable for their patient. Because they are unfamiliar with the content, they feel they cannot make this assessment adequately and it is therefore not taken into consideration.

> *"Interviewer: What you just said, I don't feel qualified enough to use this. Do you think that this also has an impact, that you do not consider it as an option because of this?*
>
> *Respondent 4: Yes, I think so, certainly, I don't have any experiences at the moment with the use of modules, otherwise I suppose you could start lobbying more. I don't know what a module like that looks like.*

> *"When the patient has a question about it, I want to be able to answer that question properly. If you don't have any knowledge of it personally, then it is questionable whether you can answer the patient's question properly."*
>
> *Respondent 3, mental health nurse*

They also want to be well prepared for possible questions from patients. And whether the tone of voice of a module fits in with the vision of the organisation and the scope of the information provided by the healthcare professional. They are afraid of 'creating confusion' if these are not in line with one another.

> *"In the healthcare organisation I worked before, we noticed that the Karify modules had a different vision than what we wanted to communicate to our patients. And it was nice to discover that in advance, so we were able to decide 'Oh, do we want to do something with this as a team?' Otherwise, I think it's just trying things out."*
>
> *Respondent 2, mental health nurse*

> *"That you can take a good look at the module yourself at first. How do they explain things? You can explain the same subject from different perspectives, I believe."*
>
> *Respondent 2, mental health nurse*

They want to gain experience in a safe context, they do not want to 'mess around' with patients. However, not daring to use care at a distance due to a feeling of incompetence prevents them from gaining experience with the new tool. This leads to a vicious circle for the care professional.

> *"Respondent 1: Yes, I still don't understand it. I can follow 3 more webinars before I can do something with it, but maybe that's also very much up to me. I think.*
>
> *Interviewer: So, what would be information in a webinar that you miss so far?*
>
> *R1: Practicing how I get it all done and seeing how patients, who don't understand it as well either, get it done.*
>
> *I: If I have understood correctly, gaining experience in a safe context?*
>
> *R1: Yes, because I wouldn't want to mess around just along with patients..."*

REPERTOIRE

The repertoire of healthcare professionals influences how care is shaped. Expanding the repertoire of actions requires gaining new experiences in new contexts and/or using new forms of therapy (Benner, 1982). The need to gain experience with the new technological possibilities was therefore strongly emphasised in the interviews with the care professionals. The current repertoire, based on intuition, previous experience and knowledge, results in routine work. As a result, care professionals rarely gain new experiences with the new possibilities that technology offers.

Need for experience

The aforementioned theme 'Necessity of gaining experiences' has already shown that there is a feeling of incompetence among mental healthcare professionals. And they have a strong preference for knowing the content of what they are offering. Benner (1982) has shown that in order to develop skills experiences are needed. The COVID-19 pandemic has resulted in being able to gain these new experiences with care at a distance. New best practices have emerged, which likely would not have been acquired without the COVID-19 pandemic. Experiencing the positive side of deploying new forms of therapy seems to make it easier to sustain the deployment. This has the side effect that the form of therapy is more likely to be identified as an option and to be discussed with other patients. This once again underlines the importance of gaining experience.

> *"Respondent 1: I have a patient who has had years of trauma treatment, and is now stabilising again in the home situation, and eh yes, she talks just as easily on the phone as face-to-face. I actually do have the feeling that she talks more easily when we don't see each other than when we do. So it doesn't have to be that face-to-face is always the best way to go. And I notice with her that the conversation just goes smoothly. After an hour, I really have to tell her it's done now.*
> *Interviewer: And is that something you discovered with her during COVID? Or was that before that already?*
> *R1: Yes, that's a good question, during COVID.*
> *I: And is that something you're consciously maintaining now, given your pleasant experience?*
> *R1: Yes, right*
> *I: Does this make you more likely to consider calling as a form of contact for different patients as well?*
> *R1: Yes, indeed, that is true!"*

Routine

The data from the focus group sessions showed that by acting on the basis of their repertoire, care professionals 'without realising it' slip into their familiar patterns, resulting in routine work. Blended Care, however, requires an expansion of their current repertoire and therefore a change in this routine.

> *"Yes, yes, that it occurred to me to do it, this way. I'm also inclined to, well, just fly back into the normal, so to speak, the normal activities, in the rush of the day, and then this requires a different approach. And you just have to do it, I know, it seems very simple, hmm but you know, old patterns haha...".*
>
> *Respondent 1, social worker*

Respondents emphasised that trying out new forms of therapy requires a different approach, because it is not yet in your system. Making new forms of therapy a regular part of your work routine, requires repetition and frequently practicing with the new form.

> *"Last year I worked a lot with mijnGGZ[2], where people made their own signalling plans at home or adapted them. And I think we should do that more often, so that it becomes part of our system. But now the time in between is so long, that it sinks in, so to speak, at least in my case."*
> *Respondent 2, mental health nurse*

> *"Apart from daring, it is also easier to think about it. I noticed that with this patient, I read in the report of the former case manager that he wanted to make use of modules. When I didn't read it in the report I wouldn't have thought about it myself, but now with the next patient I thought, hey, this module would be maybe also suitable for that person. I also think that once you apply it, it becomes easier to apply it again, and think about it more easily."*
>
> *Respondent 2, mental health nurse*

If you don't or rarely use the non-standard forms of therapy for a while, it is difficult to recall what this form of therapy requires in terms of, for example, administrative tasks.

> *"Then I immediately think, how do they get into mijnGGZ when they have no access to it yet, they have to go to the secretariat to get a personal invitation, so I have to think about those kind of stuff again."*
>
> *Respondent 2, mental health nurse*

THE IMPORTANCE OF THE DIALOGUE

Talking to each other about the impact of routine actions on the care provided led to valuable discussions. The care professionals were not yet aware of the impact of acting on the basis of their repertoire, or only partially aware. The discussion made them realise that they sometimes base their decisions on assumptions, and that by not being open for alternative forms of therapy they sometimes fail their patients. Care at a distance, or Blended Care, is not yet a major theme within the team. The need to talk about this topic with each other, as we did during the focus group sessions, therefore emerged strongly. By scheduling a moment to reflect on the possibilities that could be used, time was created to really dive into a case study. The exploratory atmosphere, the constant questioning, and the visually presented forms of therapy (the cards) made it possible to go deeply into the effects of the discussed form of therapy. This made it possible to weigh up why the form of therapy would be suitable or not, and what it would mean for their knowledge and skills if they decided to use it.

> *"What I need, actually, these kinds of moments, what we are doing right now, that you can look at such a case in all peace by taking all the time you need. And I notice that all kinds of things pop up in my head. Whereas if you just go on with your daily routine, then I'm tempted to work on an automatic pilot, well not automatic pilot, but what you also indicated at the beginning, that you often use what you've already familiarised yourself with, and then don't think much about other new possibilities. I notice that the exchange of ideas is very nice to become aware of the possibilities."*
>
> *Respondent 2, mental health nurse*

By paying attention together to the topic of care at a distance and blended care, the care professionals expected the topic to become more prominent within the team. And that this would result in an increased use of care at a distance, as a supplement to regular face-to-face contacts. They consider sharing positive experiences of telecare with one another to be an inspiring activity. And also conducive for maintaining awareness. For this reason, they would like to have someone within the team that keeps drawing attention to the topic.

> *"Respondent 4: Someone in our team.*
>
> *Respondent 2: That brings the topic on the table, to the attention, putting it on the agenda.*
>
> *Respondent 4: Actually, it's always like that with innovations."*

The healthcare professionals consider my co-researcher to be one of the most digitally skilled of the team. The one with the most experience with modules and video calling. They therefore regularly use her as a source of information when they have problems with the patient portal. It is important for them to have someone they can approach if they have questions or problems.

> *"Respondent 3: I think I would first do some research on my own, and then afterwards I will come to you (co-researcher) since you are my contact person, so that's also a task for you, haha.*
>
> *Respondent 2: Haha, yes I have to say that I also often think I can ask (co-researcher) about online matters, haha."*

It is not only important to talk to each other, but also to talk with the patient when you want to use alternative methods.

> *"Respondent 2: Yes, with the patient too, there are several subjects we could return to, go into more detail about, but what do you think is important, where do you want to work on?*
>
> *Respondent 1: Indeed, starting that conversation requires another layer within yourself."*

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[2] Patient portal.

AWARENESS

The intervision model has created awareness around the topic 'blended treatment' and that acting from their repertoire and preferences has an impact on how care is shaped. The intervision also led to the care professionals reflecting critically on their own actions, in which they were able to discuss considerations with each other. The scheduled time of the focus group sessions gave them time to discuss the topic and to think more extensively about it than they would normally do in the rush of the day.

> *"And for me it's not just the time planning but especially the awareness, I noticed a moment ago that all sorts of things pop up, which I don't put into practice, but which are obviously somewhere in my head, and then it helps to talk about it together."*
>
> *Respondent 2, mental health nurse*

The visual representation of the therapy possibilities, the cards, led to greater awareness of what is actually possible. The respondents therefore found the cards to be of added value for the session.

> *"I bundled the cards in groups, of what I think is fitting. And, well in the groups I saw that actually 5 possibilities are with the use of Karify, and that surprised me though, and I still need some information about the possibilities to start applying it myself."*
>
> *Respondent 3, mental health nurse*

> *"And I really like the cards, or like, well, it works for me or something, that well, because of it things pop up."*
>
> *Respondent 2, mental health nurse*

The session also served as a stimulus to take a closer look at the different forms of therapy that are available. The care professionals were particularly motivated to take another look at what their eHealth platform, Karify, could offer them. In addition, it is nice to mention that this has actually been followed up within the team and that my co-researcher has planned moments at the request of her colleagues to guide them along the way.

> *"Yes this motivates me to look it up again and start doing it again. I have been working on it for a while, but it didn't work out, so I left it as it was. But yes... Yes, I do think it's a very beautiful tool, and also see reasons for implementing it. Yes I will start over again. Yes, that's what I'm committing myself to now."*
>
> *Respondent 1, social worker*

A.2 SETUP WORKSHOP DECISION MOMENTS

This section describes the setup of the workshop decision moments with three healthcare experts. The session consists of two activities: (1) checking the illustrations and (2) making a prompting board. During the session I have decided to skip activity two, since the respondents interpreted the illustrations in very different ways I wanted to have time for discussing these differences thorough.

Datum: 24-06-2021
Duur: 1 uur 30 minuten
Methode: Digitale creatieve sessie, Mural
Deelnemers: E1, E2, E3

DOEL:

- Checken of de illustraties tot de verbeelding spreken.
- Checken of er nog beslismomenten, afwegingsfactoren of manieren van contact nog niet opgenomen zijn.
- Input voor de verschijningsvorm van de ‘praatplaat’: “Beslismomenten en afwegingsfactoren die impact hebben op de wijze van contact maken”.

VOORBEREIDING:

- Illustraties maken van de beslismomenten, afwegingsfactoren en manieren van contact.
- Mural bord 1: Invulopdracht illustraties.

https://app.mural.co/t/blendedcare4602/m/blendedcare4602/1624520504276/6245d1bb456679940275dc4b0e190c9fbf0b47c6?sender=u3a26fc02bc7f68f29ca66854

- Mural bord 2: ‘Maak jouw verhaal’.

https://app.mural.co/t/blendedcare4602/m/blendedcare4602/1624526691300/34a4c12ec1a592fcb022352c439cb4006629239b?sender=u3a26fc02bc7f68f29ca66854

WE HEBBEN 2 ACTIVITEITEN OP DE PLANNING:

- ‘Wat denk jij dat hier is uitgebeeld?’, waarbij ik jullie wil vragen om in te vullen wat jullie denken dat ik heb geprobeerd uit te beelden.
- ‘Wat is jouw verhaal?’, de illustraties van activiteit 1 zullen als input dienen voor een praatplaat die ik jullie als tweede activiteit van deze sessie wil gaan laten maken.

Tijdsduur	Acties	Doel	Benodigdheden
10 minuten 15:00-15:10	**Iedereen welkom heten & introductie van de sessie** - Vragen hoe iedereen er bij zit, en toestemming vragen voor opname.	- Opname kunnen starten. - Deelnemers zijn verwelkomt. - Deelnemers weten wat er van hen verwacht wordt.	- Laptop met Teams verbinding. (Opname)
20 minuten 15:10-15:30	**ACTIVITEIT 1: ‘Spreekt het tot de verbeelding?’** - Deelnemers vragen om voor alle illustraties de vraag ‘Wat denk jij dat hier wordt uitgebeeld?’ te beantwoorden.	- Checken of de illustraties tot de verbeelding spreken.	- Laptop met Teams verbinding. (Opname) - Mural bord 1.
10 minuten 15:30-15:40	**Nabespreking activiteit 1** - Zijn er illustraties waarvan je niet wist wat er werd uitgebeeld? - Mis je hierin nog beslismomenten, afwegingsfactoren of manieren van contact?	- Deelnemers de niet tot de verbeelding sprekende illustraties uitleggen. - Achterhalen waarom illustraties niet tot de verbeelding spreken. - Achterhalen of er nog illustraties missen.	- Laptop met Teams verbinding. (Opname) - Mural bord 1.
5 minuten 15:40-15:45	PAUZE		
25 minuten* 15:45-16:10	**ACTIVITEIT 2: Maak jouw verhaal** - “Beslismomenten en afwegingsfactoren die impact hebben op de wijze van contact maken”. - Zelf zie ik in ieder geval ook losse platen en onderwerpen voor me, zoals: 1. Het traject die de cliënt doorloopt, herstelfase technisch gezien, en dat er verschillende gebeurtenissen hierin ook impact kunnen hebben enerzijds herstel bevorderend anderzijds ook juist kunnen resulteren in een terugval. 2. De verschillende manieren van contact waaruit gekozen kan worden, en dat deze manieren worden beïnvloed door verschillende afwegingsfactoren. Ik ben benieuwd naar jullie verhaal, laat je inspireren door de voorbeelden die ik net gegeven heb, combineer ze, of bedenk juist een compleet andere verhaallijn rondom het thema hoe maak ik contact, en wat is hierop van invloed. Voel je niet verplicht om alle illustraties te gebruiken, maak gebruik van hetgeen wat past bij jouw verhaal. Combineer de gemaakte illustraties met tekst, vormen, lijnen, en maak jouw eigen praatplaat. Hierna zal ik iedereen 5 minuten de ruimte geven om zijn of haar plaat aan ons te presenteren, ik ben benieuwd!	- Maken van een praatplaat met de illustraties.	- Laptop met Teams verbinding. (Opname) - Mural bord 2.
15 minuten* 16:10-16:25	**Presenteer jouw verhaal** - Iedere deelnemer krijgt 5 minuten om zijn of haar praatplaat te presenteren en uit te leggen wat zijn of haar ‘verhaal’ is.	- Presenteren van de praatplaat.	- Laptop met Teams verbinding. (Opname) - Mural bord 2.
5 minuten 16:25-16:30	**Afronding** - Wat vonden jullie van deze sessie? Nog tips of tops om mee te geven? Dank voor jullie deelname.	- Achterhalen wat de deelnemers van de sessie vonden.	- Laptop met Teams verbinding. (Opname)

* Tijdens de sessie bleek dat veel aandacht benodigd was voor het achterhalen van de verschillen in de interpretaties van de illustraties, wegens tijdgebrek kon activiteit 2 dan ook niet doorgaan.

A.3 INFORMED CONSENT PEER REVIEW

This section presents the Dutch information letter and informed consent for the purpose of the peer review in which a GZ-psychologist was involved in a personal capacity.

INFORMATIEBLAD VOOR ONDERZOEK ‘BLENDED CARE IN DE GGZ’

Doel van het onderzoek

Het doel van dit onderzoek is om te onderzoeken hoe we GGZ-zorgprofessionals kunnen ondersteunen bij het sensitief worden voor de veranderende zorgpraktijk. Het gaat dan in het bijzonder om de keuze tussen face-to-face contacten en online contacten, of een combinatie hiervan Blended Care. Beoogd resultaat van dit onderzoek zal een tool zijn die de GGZ-zorgprofessional ondersteunt bij het sensitief worden voor deze veranderende zorgpraktijk.

Dit onderzoek wordt geleid door Astrid Emmink. Master studente aan de opleiding Industrial Design Engineering, track Human Technology Interactions van de universiteit Twente.

De onderzoeksgegevens zullen worden gebruikt ten behoeve van de eindscriptie en conceptontwikkeling.

Hoe gaan we te werk?

Voor dit deelonderzoek is de huidige zorgpraktijk geïllustreerd met behulp van beschrijvende ‘scenario’s’ welke zijn voortgevloeid uit expertinterviews en een secundaire analyse van onderzoeksdata uit het KIEM-project “Blended care in de GGZ: leren van best practices”.
Deze ‘scenario’s’ zijn exemplarische voorbeelden geworden.

Tijdens het interview, welke circa anderhalf uur zou duren, zou ik u de in kaart gebrachte ‘scenario’s’ voorleggen. Het interview zal via een veilige digitale verbinding plaatsvinden via MS Teams. Tijdens het interview zal uw reactie worden opgenomen met behulp van een audio- en video-opname. Naderhand zal een geanonimiseerd transcript worden uitgewerkt van het interview.

Waarvoor wordt de data gebruikt?

De onderzoeksgegevens zullen worden gebruikt voor een peerreview, om de herkenbaarheid en kwaliteit van de ‘scenario’s’ te kunnen toetsen en waarborgen.

Potentiële risico's en ongemakken

Tijdens uw deelname aan deze studie kunnen u vragen worden gesteld die u als (zeer) persoonlijk kunt ervaren, vanwege de gevoelige aard van de zorgpraktijk. Ik stel deze vragen enkel en alleen in het belang van het onderzoek. U hoeft echter geen vragen te beantwoorden die u niet wilt beantwoorden.

Vergoeding

U ontvangt voor deelname aan dit onderzoek geen vergoeding .

Vertrouwelijkheid van gegevens

Ik doe er alles aan uw privacy zo goed mogelijk te beschermen. Er wordt op geen enkele wijze vertrouwelijke informatie of persoonsgegevens van of over u naar buiten gebracht, waardoor iemand u zal kunnen herkennen.
In een publicatie zullen anonieme gegevens of pseudoniemen worden gebruikt. U wordt bevraagd op persoonlijke titel, de organisatie voor wie u werkzaam bent zal dan dus ook niet kenbaar worden gemaakt.

De opname zal worden verwijderd nadat deze volledig geanonimiseerd getranscribeerd is. Het transcript zal bewaard blijven tijdens de looptijd van het project, het project loopt tot begin 2022. Uiterlijk na het verstrijken van deze termijn zullen de gegevens worden verwijderd. Tenzij u toestemming geeft dat uw geanonimiseerde data bewaard mag blijven voor toekomstig onderzoek, zie hiervoor het toestemmingsformulier.

De onderzoeksgegevens worden indien nodig (bijvoorbeeld voor een controle op wetenschappelijke integriteit) en alleen in anonieme vorm ter beschikking gesteld aan personen buiten de onderzoeksgroep.

Vrijwilligheid

Deelname aan dit onderzoek is geheel vrijwillig. U kunt als deelnemer uw medewerking aan het onderzoek te allen tijde stoppen, of weigeren dat uw gegevens voor het onderzoek mogen worden gebruikt, zonder opgaaf van redenen. Het stopzetten van deelname heeft geen nadelige gevolgen voor u. Als u tijdens het onderzoek besluit om uw medewerking te staken, zullen de gegevens die u reeds hebt verstrekt worden verwijderd.

Wilt u stoppen met het onderzoek, of heeft u vragen?
Neem dan contact op met Astrid Emmink.

Astrid Emmink
emmink.astrid@gmail.com
06-10717605

Tot slot heeft u het recht een verzoek tot inzage, wijziging, verwijdering of aanpassing van uw gegevens te doen bij de Onderzoeksleider.

A.3 INFORMED CONSENT PEER REVIEW

This section presents the Dutch information letter and informed consent for the purpose of the peer review in which a GZ-psychologist was involved in a personal capacity.

Door dit toestemmingsformulier te ondertekenen erken ik het volgende:
1. Ik ben voldoende geïnformeerd over het onderzoek door middel van een separaat informatieblad. Ik heb het informatieblad gelezen en heb daarna de mogelijkheid gehad vragen te kunnen stellen. Deze vragen zijn voldoende beantwoord.

2. Ik neem vrijwillig deel aan dit onderzoek. Er is geen expliciete of impliciete dwang voor mij om aan dit onderzoek deel te nemen. Het is mij duidelijk dat ik deelname aan het onderzoek op elk moment, zonder opgaaf van reden, kan beëindigen. Ik hoef een vraag niet te beantwoorden als ik dat niet wil.

Naast het bovenstaande is het hieronder mogelijk voor verschillende onderdelen van het onderzoek specifiek toestemming te geven. U kunt er per onderdeel voor kiezen wel of geen toestemming te geven. Indien u voor alles toestemming wil geven, is dat mogelijk via de aanvinkbox onderaan de stellingen.

	JA	NEE
3. Ik geef toestemming om de gegevens die gedurende het onderzoek bij mij worden verzameld te verwerken zoals is opgenomen in het bijgevoegde informatieblad.	☐	☐
4. Ik geef toestemming om tijdens het interview opnames (geluid en beeld) te maken en mijn antwoorden uit te werken in een geanonimiseerd transcript.	☐	☐
5. Ik geef toestemming om mijn antwoorden te gebruiken voor geanonimiseerde quotes in de eindscriptie en/of onderzoekspublicaties.	☐	☐
6. Ik geef toestemming om de bij mij verzamelde onderzoeksdata te bewaren en te gebruiken voor toekomstig onderzoek en voor onderwijsdoeleinden.	☐	☐
Ik geef toestemming voor alles dat hierboven beschreven staat.	☐	

Naam Deelnemer:

Handtekening:

Datum:

Naam Deelnemer:

Handtekening:

Datum:

A.4 OTHER DESIRED FUTURE PRACTICE SCENARIOS

Chapter 4.2 has presented the chosen desired future practice scenario. This section presents the two desired future practice scenarios which are left out of scope for this project.

THE DIALOGUE AND TEAM-WIDE APPROACH

Healthcare organisations all faced the same obstacles when they suddenly had to switch to care at a distance at the emergence of the COVID-19 pandemic. Preconditions and useful tips and tricks were shared with care providers. But due to the chaos that COVID-19 entailed, care providers were not always able to give the provided tips and tricks the careful attention it deserved and needed. Healthcare professionals discussed the problems that arose with each other, solutions were shared and colleagues helped each other to find their way around with the (new) software.

However, the discussion about how care at a distance actually changed the conversations, the content and the care relationship never took place. Telecare was used as an alternative, in order to stay in contact with their patients when they were not allowed to meet their patients physically.

In the months that followed, it became clear that there was an increasing interest among colleagues for new forms of therapy. However, due to lack of time and not knowing where to start, the individual exploration of new forms of therapy was pushed further and further away. As this became apparent, it became clear that the healthcare professionals were individually dealing with the same challenges.

Now the topic of care at a distance is higher on the priority lists of mental healthcare teams. As a result, the investigative burden could be shared with each other and telecare became a recurring part in team meetings, allowing care professionals to learn from each other. The use of telecare, and making it discussable, has now become more common. The care professionals can move beyond the practical matters, leaving room to discuss what the new forms of therapy entail.

BASED ON THE INSIGHT

The introduction of technology in the care relationship results in all kinds of frictions and dilemmas for care professionals. In a practical sense they face for example technical preconditions, but in terms of shaping care they do not know yet how telecare is influencing the content of the therapy. This challenge and exploration is picked up individually and is therefore not a shared challenge within teams. Bearing the investigative burden is therefore not distributed among colleagues.

A joint approach and safeguarding telecare within the organisation, and thus putting telecare on the priority list, could possibly help health care professionals to think more often about telecare as a possibility while shaping care. Talking to each other and sharing experiences has been proven to be very valuable, care professionals have also indicated that they are looking for this mutual conversation.

The dialogue
and team-wide approach
Personalised care

A practice in which Blended Care is supported team-wide and the exploration is addressed together.

In this, practicalities are left behind and there is time to discuss what these new ways of contact bring about.

2

GAINING EXPERIENCE IN A SAFE CONTEXT

It was all very uncomfortable at first, offering telecare, suddenly everyone had to sit in front of a screen, if you could establish and maintain a connection at all. It was quite a challenge to explain to all the patients how they could install the video calling software. And all kinds of new "unwritten" rules arose: Which agreements do you make with each other, when can you discuss something and what do you 'tolerate'?

Gradually, over the months, healthcare professionals and their patients learned how to deal with this. Learning by 'just doing' seemed to be a good approach after all. Care professionals were able to experience that a short (video) call can sometimes be much more pleasant and effective for patients compared to physically meeting each other. The fact that they have been able to gain some hands-on experience makes it easier for them to consider these new forms of contact for other patients.

Still, it remained quite a challenge to translate existing face-to-face interventions to online alternatives. This was a quest, and required healthcare professionals to become more open to different possibilities, as well as their patients. Some healthcare professionals chose to undertake this exploration together with their patients. Particularly when patients are at an advanced stage of recovery, and a good treatment relationship has been established, it became easier for healthcare professionals to suggest and try out new forms of therapy with them. This was sometimes quite challenging, since you are dealing with patients and you don't know how they are going to react to it. And it didn't always work out, so it was important to keep talking with each other.

Trying out new possibilities, step by step and in a safe way, helped to grow the expertise in the field of telecare.

BASED ON THE INSIGHT

There is a reluctance to use digital interventions that stems from a sense of incompetence. Because of this uncertainty, implementation is postponed, resulting in too little experiences being gained. While in fact the repertoire of the healthcare professional is formed and expanded by gaining experiences, which creates a vicious circle.

Benner (1982) showed the importance of gaining experiences in order to learn skills. Respondents from the focus group sessions indicated that they were looking for the possibility of gaining experiences in a 'safe' way or context, so they do not have to 'fiddle around in front of patients'.

The advent of technology in the care relationship results in new affordances, however recognizing these affordances also requires gaining experience with this affordance in order to be able to consider it as an affordance, or in other words, as an action possibility.

Gaining experience
in a safe context
Existing patterns

A practice in which care professionals dare to explore new ways of contact and treatment, whether or not together with the patient. By learning step by step in a safe context, they can get a better sense of the new opportunities.

3

A.5 SETUP EVALUATION SESSION CONCEPTS

This section describes the setup of the evaluation session of the concepts, in this session three healthcare professionals were involved. The session consists of two activities: (1) getting to know the concepts and giving feedback on them (2) comparing the concepts with each other on the basis of the design guidelines.

Datum: 16-09-2021
Duur: 2 uur
Methode: Digitale creatieve sessie, Mural
Deelnemers: E2, E4, E5

DOEL:

- Concepten voorleggen en feedback vragen per concept.
- Concepten met elkaar beoordelen aan de hand van de design richtlijnen.
- Achterhalen voorkeur van deelnemers.

VOORBEREIDING:

- Toekomstscenario met design richtlijnen.
- Presentatie van de inzichten en het vertrekpunt voor de ideegeneratie.
- Concepten presenteerbaar maken met behulp van conceptborden.
- Mural bord

https://app.mural.co/t/conceptenvoorleggen3873/m/conceptenvoorleggen3873/1631783127495/143505731f90a626f085dd25e3ec44f442918bf8?sender=u83a9cf7170f43968ea7b4612

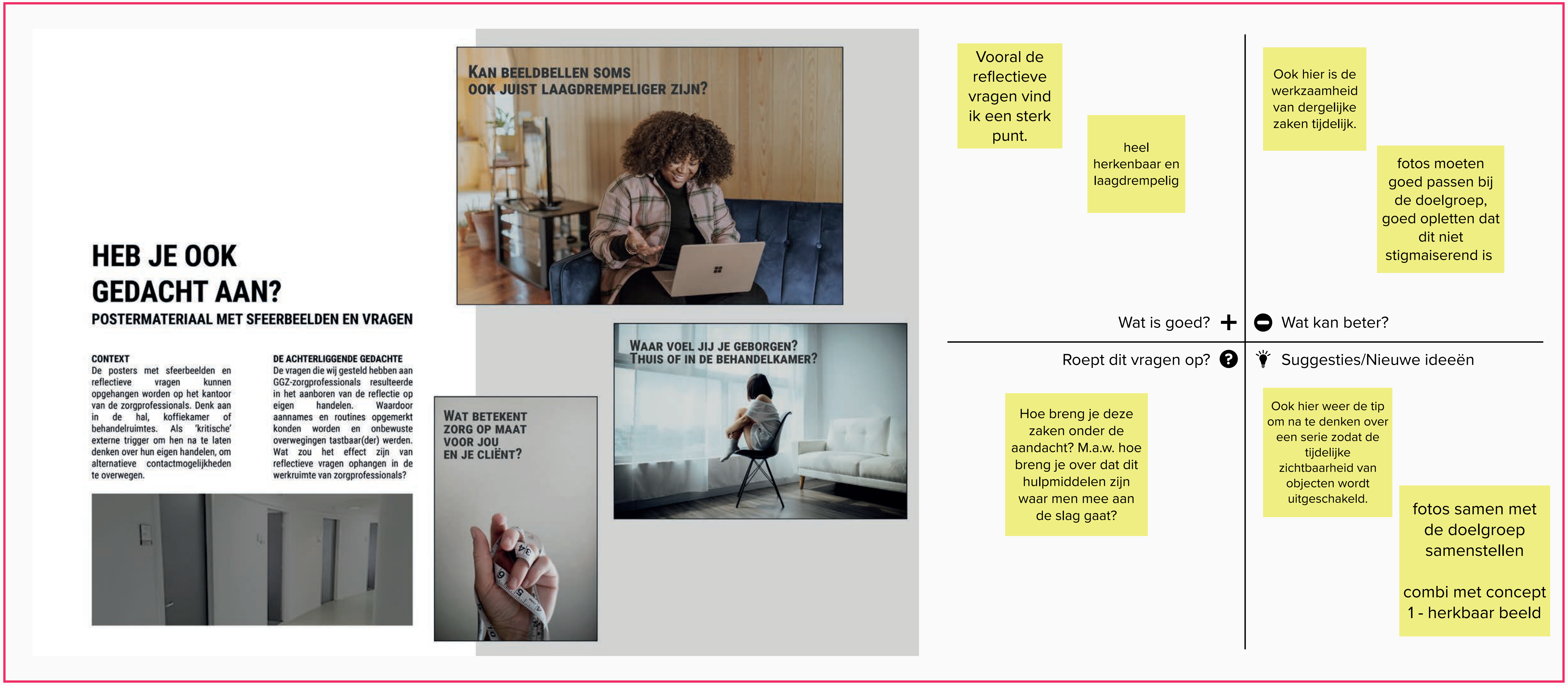
WE HEBBEN 2 ACTIVITEITEN OP DE PLANNING:

- De concepten leren kennen en individueel feedback geven op de concepten.
- De concepten vergelijken met elkaar aan de hand van de design richtlijnen.

Tijdsduur	Acties	Doel	Benodigdheden
10 minuten 13:00-13:10	**Iedereen welkom heten & introductie van de sessie** - Vragen hoe iedereen er bij zit, en toestemming vragen voor opname.	- Opname kunnen starten. - Deelnemers zijn verwelkomt.	- Laptop met Teams verbinding. (Opname)
20 minuten 13:10-13:30	INTRODUCTIE - Inzichten van de afgelopen periode presenteren. - Gewenst toekomstscenario presenteren. - Design richtlijnen presenteren. - Vragen of dit ideeën bij de deelnemers oproept. - Uitleg geven over de 2 onderdelen: 1. De concepten individueel leren kennen en feedback geven op de concepten. 2. De concepten vergelijken met elkaar aan de hand van de design richtlijnen.	- Delen van inzichten tot nu toe, vertrekpunt van de ideegeneratie helder maken. - Kennis laten maken met gewenst toekomstscenario. - Kennis laten maken met de design richtlijnen. - Deelnemers weten wat er van hen verwacht wordt tijdens de sessie.	- Laptop met Teams verbinding. (Opname) - Presentatie.
45 minuten 13:30-14:15	**ACTIVITEIT 1: Concepten leren kennen en feedback geven op de concepten** Als het goed is kunnen jullie rechts een outline zien, met 6 stappen, corresponderend met de 6 concepten. Ik zou jullie willen vragen om de komende 35 minuten de concepten te beoordelen door het grid in te vullen met de vragen 'Wat is goed aan dit concept?, 'Wat zou beter kunnen, wees vooral heerlijk kritisch', 'Welke vragen roept dit op, zijn er dingen die ik misschien nog niet goed genoeg doordacht heb? Iets wat nog niet duidelijk genoeg is uitgewerkt?, en 'Roept dit nog ideeën op?'. Of dit jullie triggert voor andere oplossingen of eventuele aanvullingen op de concepten.	- Deelnemers kennis laten maken met de concepten. - Feedback krijgen op de concepten.	- Laptop met Teams verbinding. (Opname) - Mural deel 1.
5 minuten 14:15-14:20	PAUZE		
30 minuten 14:20-14:50	**ACTIVITEIT 2: Concepten beoordelen met de design richtlijnen** - Allereerst even een eerste reactie op de concepten. - Beoordelen van de concepten aan de hand van de design richtlijnen. Door de post-its aan de linkerzijde van de boxen te verplaatsen binnen de boxen van de design richtlijnen. Waarbij de linkerzijde van de box het minst aansluitend betreft en de rechterzijde het meest aansluitend bij de design richtlijn. Meerdere concepten kunnen uiteraard op dezelfde hoogte staan.	- Eerste reactie/persoonlijke voorkeur van de deelnemers inzichtelijk maken. - Met elkaar de concepten beoordelen aan de hand van de design richtlijnen.	- Laptop met Teams verbinding. (Opname) - Mural deel 2.
10 minuten 14:50-15:00	**Afronding** - Wat vonden jullie van deze sessie? Nog tips of tops om mee te geven? Dank voor jullie deelname.	- Achterhalen wat de deelnemers van de sessie vonden.	- Laptop met Teams verbinding. (Opname)

A.6 CONCEPT BOARDS WITH FEEDBACK

This section presents the concept boards with the filled in grids of the evaluation session of the concepts.



KAN BEELDBELLEN SOMS OOK JUIST LAAGDREMPELIGER ZIJN?

HEB JE OOK GEDACHT AAN?

POSTERMATERIAAL MET SFEERBEELDEN EN VRAGEN

CONTEXT
De posters met sfeerbeelden en reflectieve vragen kunnen opgehangen worden op het kantoor van de zorgprofessionals. Denk aan in de hal, koffiekamer of behandelruimtes. Als 'kritische' externe trigger om hen na te laten denken over hun eigen handelen, om alternatieve contactmogelijkheden te overwegen.

DE ACHTERLIGGENDE GEDACHTE
De vragen die wij gesteld hebben aan GGZ-zorgprofessionals resulteerde in het aanboren van de reflectie op eigen handelen. Waardoor aannames en routines opgemerkt konden worden en onbewuste overwegingen tastbaar(der) werden. Wat zou het effect zijn van reflectieve vragen ophangen in de werkruimte van zorgprofessionals?

WAAR VOEL JIJ JE GEBORGEN? THUIS OF IN DE BEHANDELKAMER?

WAT BETEKENT ZORG OP MAAT VOOR JOU EN JE CLIËNT?

Wat is goed? +

Vooral de reflectieve vragen vind ik een sterk punt.

heel herkenbaar en laagdrempelig

− Wat kan beter?

Ook hier is de werkzaamheid van dergelijke zaken tijdelijk.

fotos moeten goed passen bij de doelgroep, goed opletten dat dit niet stigmaiserend is

Roept dit vragen op? ?

Hoe breng je deze zaken onder de aandacht? M.a.w. hoe breng je over dat dit hulpmiddelen zijn waar men mee aan de slag gaat?

Suggesties/Nieuwe ideeën

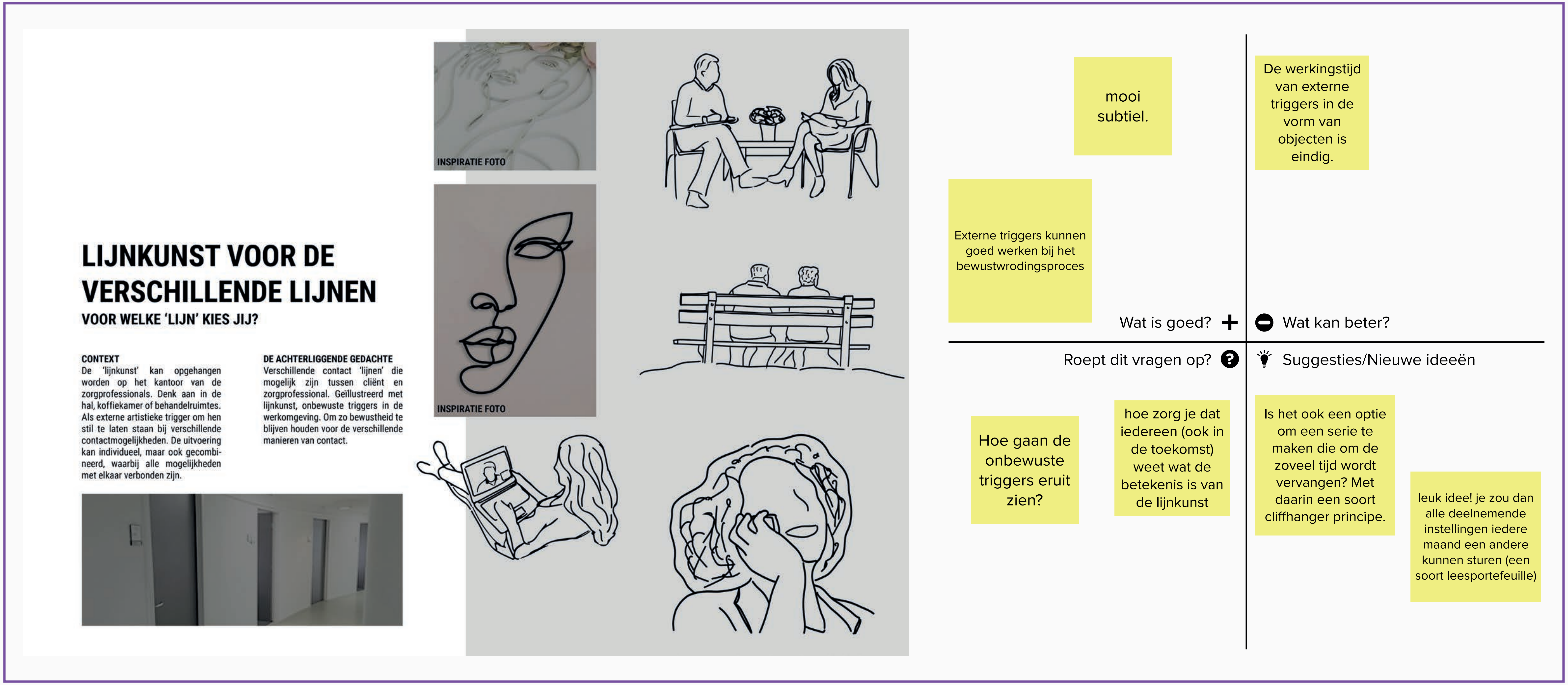
Ook hier weer de tip om na te denken over een serie zodat de tijdelijke zichtbaarheid van objecten wordt uitgeschakeld.

fotos samen met de doelgroep samenstellen

combi met concept 1 - herkbaar beeld

A.6 CONCEPT BOARDS WITH FEEDBACK

This section presents the concept boards with the filled in grids of the evaluation session of the concepts.



LIJNKUNST VOOR DE VERSCHILLENDE LIJNEN

VOOR WELKE 'LIJN' KIES JIJ?

CONTEXT
De 'lijnkunst' kan opgehangen worden op het kantoor van de zorgprofessionals. Denk aan in de hal, koffiekamer of behandelruimtes. Als externe artistieke trigger om hen stil te laten staan bij verschillende contactmogelijkheden. De uitvoering kan individueel, maar ook gecombineerd, waarbij alle mogelijkheden met elkaar verbonden zijn.

DE ACHTERLIGGENDE GEDACHTE
Verschillende contact 'lijnen' die mogelijk zijn tussen cliënt en zorgprofessional. Geïllustreerd met lijnkunst, onbewuste triggers in de werkomgeving. Om zo bewustheid te blijven houden voor de verschillende manieren van contact.

INSPIRATIE FOTO

INSPIRATIE FOTO

Wat is goed? +

mooi subtiel.

Externe triggers kunnen goed werken bij het bewustwrodingsproces

Wat kan beter? −

De werkingstijd van externe triggers in de vorm van objecten is eindig.

Roept dit vragen op? ?

Hoe gaan de onbewuste triggers eruit zien?

hoe zorg je dat iedereen (ook in de toekomst) weet wat de betekenis is van de lijnkunst

Suggesties/Nieuwe ideeën

Is het ook een optie om een serie te maken die om de zoveel tijd wordt vervangen? Met daarin een soort cliffhanger principe.

leuk idee! je zou dan alle deelnemende instellingen iedere maand een andere kunnen sturen (een soort leesportefeuille)

A.6 CONCEPT BOARDS WITH FEEDBACK

This section presents the concept boards with the filled in grids of the evaluation session of the concepts.

HOE 'LEG' JIJ HET CONTACT?

DE 'PUZZEL' EN DE 'PUZZELSTUKKEN' DIE 'MEESPELEN'

CONTEXT
De puzzelstukken kunnen worden gebruikt in team overleggen, om interactief casuïstiek met elkaar te bespreken. Met het doel om de verbanden tussen gebeurtenissen, factoren, en contactmogelijkheden te achterhalen. En wat voor een impact dit heeft op de aangeboden zorg.

DE ACHTERLIGGENDE GEDACHTE
De puzzelstukken illustreren de manieren van contact, als ook de factoren die meespelen in het besluitvormingsproces. De gelegde puzzel als metafoor voor de zorginvulling. Contactmogelijkheden en factoren kunnen op deze manier gekoppeld en gelinkt worden.

Wat is goed? +

- Leuke werkvorm. Spreekt tot de verbeelding en zou goed passen in een intervisie.
- teamverband ervaringen delen

Wat kan beter?

- Het zou mooi zijn wanneer er voor ieder teamlid een puzzel aanwezig is zodat zij deze allemaal kunnen leggen en vervolgens vergelijken.
- puzzel kan kinderachtig ervaren worden

Roept dit vragen op? ?

- de focus ligt op besluitvormingsproces, ik vraag me af of dat voldoende is.
- ik be heel benieuwd wat er dan in de puzzel komt te staan en hoe je dit uitdagend genoeg houdt.
- Geen toevoeging op de al aanwezige vragen.

Suggesties/Nieuwe ideeën

- je zou het kunnen kopelen aan intervisie
- zorg dat er voldoende uitdaging in blijft zitten
- ik zou ook aandacht besteden aan successen
- Intervisie tip staat al bij wat is goed. Maar daar lijkt het mij geschikter voor dan een casuïstiekbespreking

A.6 CONCEPT BOARDS WITH FEEDBACK

This section presents the concept boards with the filled in grids of the evaluation session of the concepts.

VOOR WELKE ZIJDE KIES JIJ?

DE VERSCHILLENDE 'ZIJDES' VAN HET CONTACT

CONTEXT
Het 'blokje' kan geplaatst worden op het bureau van de GGZ-zorgprofessional. Met het doel om in de werkomgeving en hiermee in zijn of haar gezichtsveld te zijn. Als externe trigger om na te denken over dat er verschillende mogelijkheden zijn voor het maken van contact met hun cliënt. De gesprekswaaier kan erbij gepakt worden ter verdieping.

DE ACHTERLIGGENDE GEDACHTE
Het blokje, de kubus, kent verschillende zijdes, net zoals de werkpraktijk verschillende 'zijdes' kent: de verschillende zijdes van het maken en of onderhouden van contact. De gesprekswaaier geeft verdieping aan de gekozen 'zijde'. Met behulp van bv. casuïstiek, reflectieve vragen of tips bij het inzetten van deze contactvorm.

Wat is goed? +

Valt op, mensen zullen hier naartoe getrokken worden denk ik.

iets wa tin het gezichtsveld is lijkt me goed aansluiten. zet professionals aan het denken

Wat kan beter?

het zijn 2 tools, een kubus en een waaier

Schiet mij zo niets te binnen.

Roept dit vragen op? ?

zijn er zes variaties?

kun je ook kiezen welk medium je gebruikt?

hoe ga je om met welke mogelijkheden en wensen heeft de client tav de vorm van het contact?

Waarom niet standaard de kleur en de waaier tegelijk gebruiken, zodat het een tool wordt?

Suggesties/Nieuwe ideeën

Is hier ook een cliëntvariant voor te maken of is deze al inzetbaar in de samenwerking met cliënten?

A.6 CONCEPT BOARDS WITH FEEDBACK

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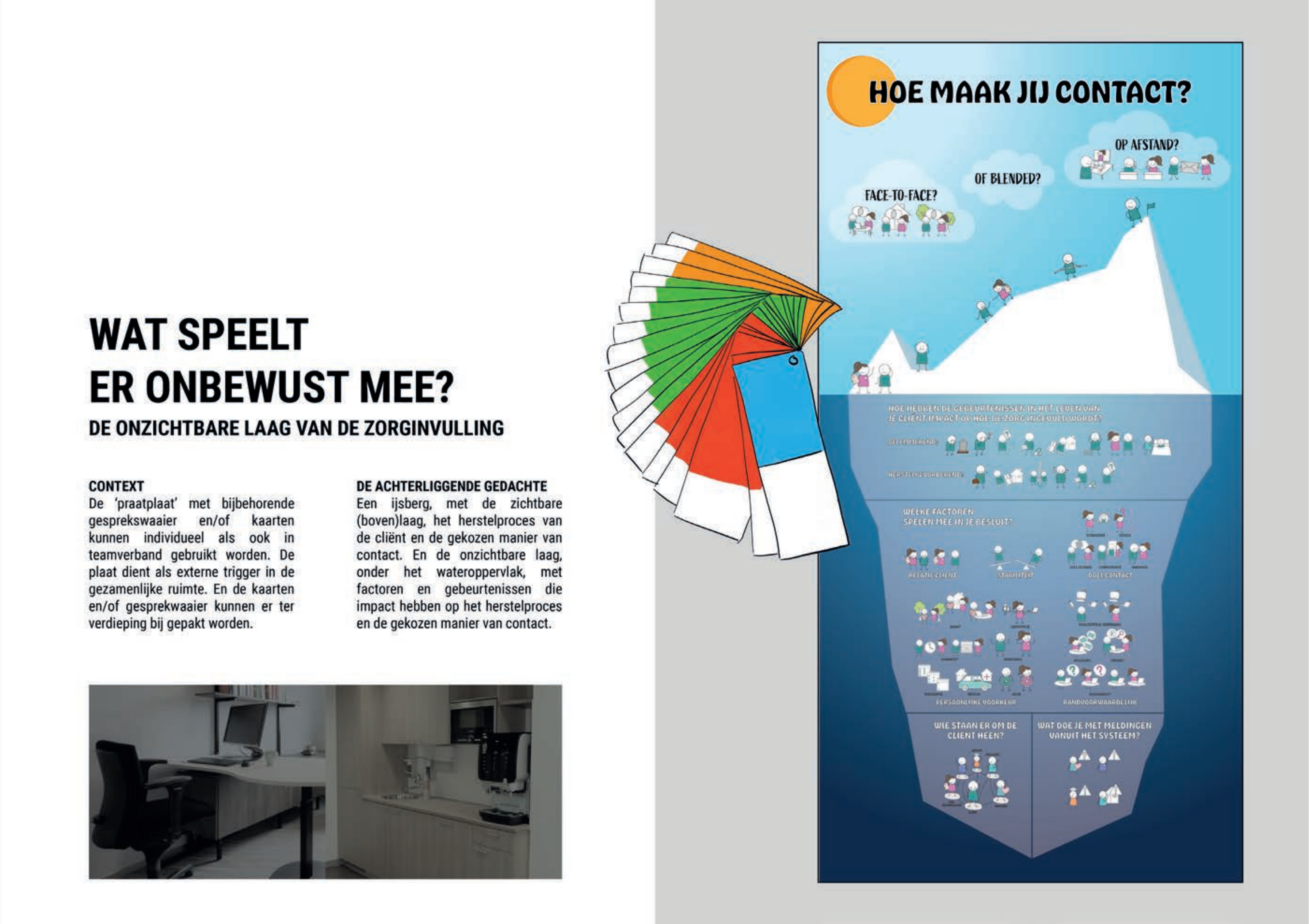


WAT SPEELT ER ONBEWUST MEE?

DE ONZICHTBARE LAAG VAN DE ZORGINVULLING

CONTEXT
De 'praatplaat' met bijbehorende gesprekswaaier en/of kaarten kunnen individueel als ook in teamverband gebruikt worden. De plaat dient als externe trigger in de gezamenlijke ruimte. En de kaarten en/of gesprekwaaier kunnen er ter verdieping bij gepakt worden.

DE ACHTERLIGGENDE GEDACHTE
Een ijsberg, met de zichtbare (boven)laag, het herstelproces van de cliënt en de gekozen manier van contact. En de onzichtbare laag, onder het wateroppervlak, met factoren en gebeurtenissen die impact hebben op het herstelproces en de gekozen manier van contact.

Wat is goed? +

Mooie vormgeving en voldoende informatie onder water om tot een reflectie te komen

het ziet er heel erg mooi uit. je kunt zo goed tot focus van hoofd en bijzaken komen - meer zicht op wat van invloed is

Wat kan beter?

omdat op afstand rechtsboven staat lijkt het "lonely at the top"

Niet alle onder water staande informatie hoort daar in mijn ogen thuis. Het lijkt nu alsof de cliënt zelf niets weet over zijn/haar herstelproces omdat dit allemaal onder water staat.

Roept dit vragen op? ?

metafoor past iets minder goed voor mijn gevoel. bewustwording is niet allemaal "onder water"

Waarom inderdaad gekozen voor een ijsberg? De praatplaat is een mooi idee, maar kan met een andere metafoor beter tot de verbeelding spreken en recht doen aan de ervaringskennis en inzichten van de cliënt.

Suggesties/Nieuwe ideeën

je zou nog meer factoren kunnen toevoegen, naast ftf, blended en online gaa thet ook om de plek van contact. (huisbezoek, poli, elders,)

Zie mijn vraag hier links. Het aandeel van de cliënt in het herstelproces meer waarde geven door een andere metafoor/ vormgeving.

A.6 CONCEPT BOARDS WITH FEEDBACK

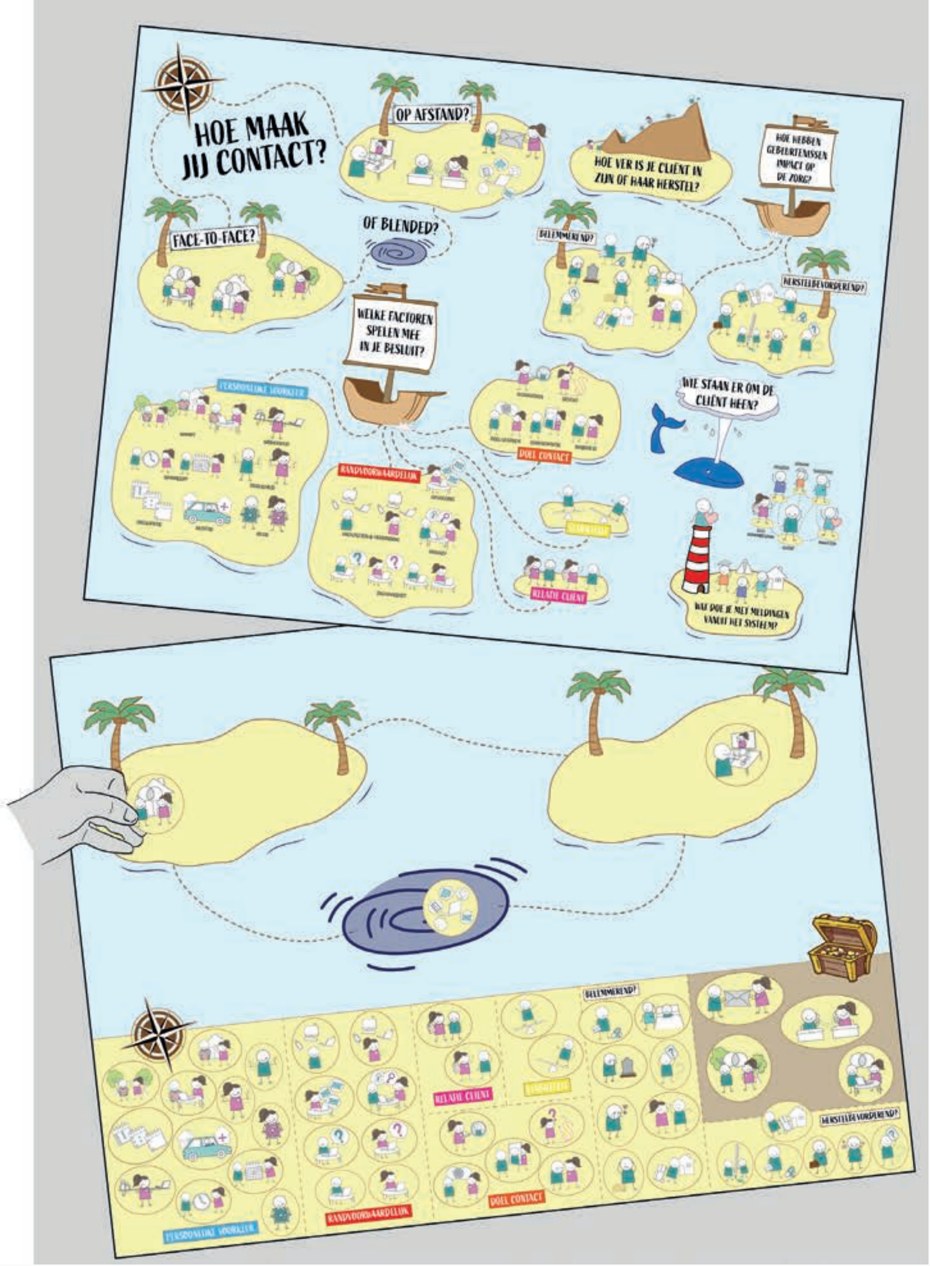
This section presents the concept boards with the filled in grids of the evaluation session of the concepts.

IK GA OP REIS EN KOM TEGEN

HOE DE 'REIS' WORDT UITGESTIPPELD EN BEÏNVLOED

CONTEXT
De 'praatplaat' met bijbehorend magneetbord kan geplaatst worden in de gezamenlijke ruimte van de zorgprofessionals (bv. overlegruimte en/of koffiekamer). Zodat het zowel gemakkelijk individueel als in teamverband gebruikt kan worden. En het altijd als externe trigger opgehangen is in de werkomgeving.

DE ACHTERLIGGENDE GEDACHTE
De individuele 'reis' van de cliënt, welke 'eilanden' er worden bezocht (de manieren van contact die er ingezet worden). En wat ze, de cliënt en zorgprofessional, onderweg tegenkomen: gebeurtenissen die de 'route' doen wijzigen. En factoren die meespelen in het uitstippelen van de route.



Wat is goed? +

Erg leuk vormgegeven, dit trekt de aandacht veel meer dan de standaard posters aan de muur.

ziet er heel leuk een aantrekkelijk uit

eenvoudig op te hangen

Wat kan beter?

risico dat er iets anders overheen geplakt wordt.

lijkt wel tijd en instructie te vragen

Implementatie. Wanneer dit zomaar aan de muur hangt vinden mensen het grappig, maar zullen er niet vanzelf mee bezig gaan vrees ik.

Roept dit vragen op? ?

zou het haalbaar zijn om dit goed toe te passen. je zou het dan eigenlijk wel moeten opnemen in het werkproces

Hoe zorg je dat mensen hier serieus mee aan de slag gaan?

wat zou dit kosten?

Suggesties/Nieuwe ideeën

zou het het ook universeler kunnen maken zodat je het ook kunt toepassen voor andrere clientriezen/ overwegingen?

Ik sluit mij aan bij het hierboven staande idee.

A.7 INFORMATION LETTER DIARY STUDY

In this section, the Dutch information letter for the diary study booklets is presented; fourteen booklets were distributed in preparation for the validation session of the poster series.

Mijn naam is Astrid Emmink, tweedejaars masterstudente aan de opleiding Industrial Design Engineering aan de Universiteit Twente. Ik onderzoek hoe we zorgprofessionals in de GGZ uit kunnen nodigen om sensitief te worden voor de veranderde zorgpraktijk. Het gaat dan in het bijzonder om de keuze tussen face-to-face contacten en online contacten, of een combinatie hiervan: Blended Care.

Mijn onderzoek heeft geleid tot een rijk en gevarieerd inzicht van de huidige zorgpraktijk. Hoe zorg op afstand van meerwaarde kan zijn, hoe het de zorg kan veranderen, maar ook waar zorgprofessionals tegen aanlopen tijdens het inzetten van zorg op afstand. Deze inzichten en ervaringen zijn verwerkt in een posterreeks. Het betreft een tweeluik, één poster in de hal voor zowel jullie als de cliënten en één ter verdieping van het onderwerp voor jullie. Een deel van deze reeks wordt de komende drie weken, twee onderwerpen per week, tentoongesteld bij jullie op locatie.

Ik wil je vragen om de komende weken in dit schriftje jouw bevindingen op te schrijven. Wat je vindt van het onderwerp en of het tot gesprekken heeft geleid met je collega's en/of je cliënten. Waar die gesprekken over gingen. Wat het jullie heeft opgeleverd.

Begin november kom ik langs om jullie bevindingen op te halen, leggen jullie de schriftjes voor me klaar?

Ik ga ook graag met jullie in gesprek over de bevindingen.
CONTACTPERSOON heeft jullie hiervoor al een uitnodiging gestuurd:
DATUM, TIJD. Zie ik jullie dan?

Mocht je vragen hebben of liever je bevindingen met mij delen door even te mailen/bellen/appen dan kan dat natuurlijk ook! Ik ben te bereiken op: 06-10717605, emmink.astrid@gmail.com.

Alvast bedankt voor je medewerking!

A.8 SETUP EVALUATION SESSION FINAL CONCEPT

This section describes the prepared questions of the focus group session for the validation of the poster series. Three different types of questions are asked: (1) general questions, (2) content related questions and (3) implementation questions.

Datum: 01-11-2021
Duur: 1 uur
Methode: Focusgroep sessie
Locatie: Op locatie en gedeeltelijk online
Deelnemers: Team Assen

Doel & vragen:

1. Achterhalen van de bevindingen met de posterreeks algemeen.
   - a. Wat vonden jullie van de posterreeks?
   - Wat vonden jullie van de onderwerpen van de posterreeks?
   - b. Hebben de posters geleid tot gesprekken onderling met je collega's?
     - i. Waar gingen die gesprekken over?
   - c. Hebben de posters geleid tot gesprekken met je cliënten?
     - i. Waar gingen die gesprekken over?
   - d. Hebben de posters jullie iets opgeleverd?
   - e. Hebben de vragen en de aandachtspunten jullie aangezet om verder over het onderwerp na te denken?

2. Wat de zorgprofessionals vonden van de posters inhoudelijk gezien.
   - a. Wat vonden jullie van het tweeluik?
     - i. Was de verdiepende poster een aanvulling op alleen 'het beeld'?
     - ii. Was alleen het beeld een verrijking op de verdiepende poster?
   - b. Wat vonden jullie van de tone of voice?
   - c. Is de verdiepende poster ook iets wat je gezamenlijk met je cliënt zou kunnen en willen doorlopen?

3. Implementatie van de posterreeks/toekomst van de posterreeks
   - a. Is dit iets wat je blijvend/tijdelijk langer zou willen laten hangen? Voegt het iets toe?
   - b. Met wat voor frequentie zou je nieuwe onderwerpen willen ontvangen?
     - i. Zijn de reflectieve vragen en de aandachtspunten iets wat je blijvend zou willen kunnen raadplegen?
     - ii. Heb je nog iets extra's nodig?
     - iii. Zou je mij nog iets mee willen geven in de uitwerking ofwel aanbevelingen?

A.9 QUESTIONNAIRE EVALUATION FINAL CONCEPT

This section presents the Dutch questions of the survey for the validation of the poster series. Three different types of questions are asked: (1) general questions, (2) content related questions and (3) questions regarding the implementation advice.

Mijn naam is Astrid Emmink, tweedejaars masterstudente aan de opleiding Industrial Design Engineering aan de Universiteit Twente. Ik onderzoek hoe we zorgprofessionals in de GGZ uit kunnen nodigen om sensitief te worden voor de veranderde zorgpraktijk. Het gaat dan in het bijzonder om de keuze tussen face-to-face contacten en online contacten, of een combinatie hiervan: Blended Care.

Mijn onderzoek heeft geleid tot een rijk en gevarieerd inzicht van de huidige zorgpraktijk. Hoe zorg op afstand van meerwaarde kan zijn, hoe het de zorg kan veranderen, maar ook waar zorgprofessionals tegen aanlopen tijdens het inzetten van zorg op afstand. Ook heb ik gezien dat er niet alleen verschillen zitten in online contacten maar ook face-to-face contacten. Deze inzichten en ervaringen zijn verwerkt in een posterreeks. Het betreft een tweeluik, één poster met het ‘beeld’ en één poster ter verdieping van het onderwerp.

Een deel van deze reeks is de afgelopen drie weken, twee onderwerpen per week, tentoongesteld bij jullie op locatie. Helaas was niet iedereen in de gelegenheid om op locatie de posters te kunnen bekijken. Of zijn de posters in de waan van de dag onvoldoende opgevallen. De wens is ontstaan om alsnog de posters ook digitaal te verspreiden binnen het team.

Mocht je tijd en ruimte zien om de posterreeks te bekijken en wat vragen te willen beantwoorden dan stel ik dat zeer op prijs! Mocht je liever je bevindingen met mij delen door even te bellen of ‘Teamsen’ dan kan dat natuurlijk ook! Ik ben te bereiken op: 06-10717605, emmink.astrid@gmail.com.

Alvast bedankt voor je medewerking!

VRAGEN:

Algemene vragen

- Wat vind je van de posterreeks?
- Wat vind je van de onderwerpen van de posterreeks?
- Hebben de posters geleid tot gesprekken onderling met je collega’s? Waar gingen die gesprekken over?
- Hebben de posters geleid tot gesprekken met je cliënten? Waar gingen die gesprekken over?
- Hebben de posters jullie als team en/of jou iets opgeleverd?
- Hebben de vragen en de aandachtspunten je aangezet om verder over het onderwerp na te denken?

Inhoudelijke vragen

- Wat vind je van het tweeluik (zowel het beeld los alsook het beeld met de verdieping)?
- Was de verdiepende poster een aanvulling op alleen ‘het beeld’?
- Was alleen het beeld een verrijking op de verdiepende poster?
- Wat vonden jullie van de tone of voice?
- Is de verdiepende poster ook iets wat je gezamenlijk met je cliënt zou kunnen en willen doorlopen?

Implementatie & toekomst posterreeks

- Is dit iets wat je blijvend/tijdelijk langer zou willen laten hangen? Wat voegt het voor jou toe?
- Je hebt nu alle onderwerpen in 1x ontvangen. De posterreeks is ontwikkeld met het gedachtengoed dat een bepaalde periode in het teken staat van dat onderwerp/thema. En dat de posters gefaseerd opgehangen zouden worden. Met wat voor frequentie zou je nieuwe onderwerpen willen ontvangen?
- Zijn de reflectieve vragen en de aandachtspunten iets wat je blijvend zou willen kunnen raadplegen?
- Heb je nog iets extra’s nodig?
- Zou je mij nog iets mee willen geven in de uitwerking ofwel aanbevelingen?

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