Ambulatory mental health professionals discussing spiritual care in a multidisciplinary meeting

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SUMMARY

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Background: Spirituality is an important dimension of health. Spiritual care is defined by Swinton as concerning “the issues of meaning, purpose, hope, value, connectedness in relationships, and for some people connection to faith and God”. Through spiritual care, patients can achieve more inner peace and their suffering can be reduced. Currently, mental health organizations focus on developing ambulatory care. It is unknown how mental health professionals can provide spiritual care to outpatients in their own environments.

Aim: To explore the ways in which mental health professionals of an ambulatory team discuss the spiritual care of psychiatric patients in a multidisciplinary care meeting and to explore the barriers and facilitators that appear from what mental health professionals report about the ways they discuss spiritual care.

Methods: Two teams of ambulatory mental health professionals who provide care to psychiatric outpatients are included. Qualitative data was retrieved from recordings of multidisciplinary meetings and focus groups. Data is analyzed using open coding.

Results: Themes from the data that concern spirituality included meaningful activities, contact with other people, overall life satisfaction, identity, and religion. Meaningful activities received the most attention in a meeting. Sometimes, the patient’s perspective was absent. Spiritual care receives less priority in a meeting due to preconditions such as the system of diagnosis-related groups reimbursement. Several preconditions stimulated discussing spiritual care such as focusing on recovery-oriented care.

Conclusions: Not all areas of spirituality were given equal attention. Preconditions in providing care could stimulate or impede the discussion of spiritual care.

Recommendations: It is important to educate professionals about the importance of spirituality and stimulate a vision of recovery-oriented care. Further research is necessary to explore the patients’ perspective in spiritual care.

Keywords: Spirituality, psychiatry, ambulatory care

SAMENVATTING

Het bespreken van zingeving in de geestelijke gezondheidszorg door ambulant werkende zorgverleners in een multidisciplinair overleg.

Achtergrond: Zingeving wordt gezien als één van de dimensies van gezondheid. Zingeving is gedefinieerd als aandacht geven aan problemen wat betreft betekenisgeving, doel van het leven, hoop, waarde van het leven, verbondenheid in relaties en voor sommigen een verbinding met geloof en God. Door zingeving kunnen patiënten met een psychiatrische stoornis meer innerlijke vrede ervaren en lijden kan worden verminderd. De geestelijke gezondheidszorg focust tegenwoordig meer op ambulante zorg. Onbekend is hoe ambulante hulpverleners zorg op het gebied van zingeving kunnen verlenen.

Doel: Het onderzoeken van manieren waarop ambulante zorgverleners in de geestelijke gezondheidszorg zingeving bespreken van psychiatrisch patiënten in een multidisciplinair overleg. Daarnaast wat belemmerende en bevorderende factoren zijn die blijken uit wat zorgverleners zeggen over hoe zij zingeving bespreken.

Methode: Twee teams van zorgverleners die ambulante zorg verlenen aan psychiatrisch patiënten zijn geïncludeerd. Kwalitatieve data zijn verkregen door opnemen van multidisciplinaire en focusgroepen. De data zijn geanalyseerd door open coderen.

Resultaten: Thema's voortkomend uit de data relaterend aan zingeving zijn zinvolle activiteiten, contact met naasten, voldoening in het leven, identiteit en religie. Zinvolle activiteiten krijgen de meeste aandacht in een overleg. Soms ontbreekt het perspectief van de patiënt. Zingeving krijgt minder prioriteit door randvoorwaarden van een behandeling die veel tijd kosten, bijvoorbeeld het Diagnose Behandel Combinatie-systeem. Andere randvoorwaarden stimuleren bespreken van zingeving zoals focussen op herstel ondersteunde zorg.

Conclusie: Niet alle gebieden van zingeving krijgen evenveel aandacht. Bepaalde randvoorwaarden kunnen stimulerend of belemmerend zijn in het bespreken van zingeving.

Aanbevelingen: Het is belangrijk om zorgverleners te scholen in het belang van zingeving en een visie van herstel ondersteunende zorg te stimuleren. Het is nodig om onderzoek te doen naar het perspectief van de patiënt.

Trefwoorden: Zingeving, psychiatrie, ambulante zorg

INTRODUCTION

Attention to the needs of patients has been valued more in recent decades.[1] Health care organizations are focused on developing patient-centered care.[2] A new “patient-centered” concept of health considers spirituality as one of the six dimensions that determine a person’s health.[3] In mental health care, recovery-oriented care is also an important movement for patient-centeredness.[4] Recovery-oriented care stimulates personal growth, self-direction, and change. Leamy et al. have developed a framework which includes five recovery processes: connectedness, hope, identity, meaning in life, and empowerment. These processes closely correspond to components of spirituality.[5]

Spirituality determines how patients understand and live their lives relative to their sense of meaning and value.[6] Patients may have questions about the meaning of life, illness, and death. For example, how to make sense of their lives when they have a mental illness and how to explain or cope with their illness.[7] Swinton, founder of Centre for Spirituality, Health, and Disability in Aberdeen, defines spiritual care for patients with mental disorders as, “paying attention to issues of meaning, purpose, hope, value, connectedness in relationships and for some people connection to faith and God”.[6-8]

Identifying and meeting spiritual needs has been identified as important in the recovery of mental disorders.[9] Patients frequently experience feelings such as anxiety, guilt, anger, and despair, which are often connected to spiritual issues.[10] By addressing spirituality in care, patients can achieve more inner peace, and suffering can be reduced.[11] A decrease in clinical symptoms, especially anxiety, is demonstrated when spiritual interventions are applied.[12] Qualitative research revealed that it is often the patient’s wish to talk about spirituality with mental health professionals.[13-14]

As a part of recovery-oriented care, mental health care organizations focus on developing care for patients with mental disorders in their own homes. In the Netherlands, spiritual care in clinical settings is more developed than in ambulant settings. Studies have explored spiritual care in intramural settings in mental health care.[11,15,16] However, there is a lack of research on how mental health professionals can provide spiritual care to outpatients in their own environments. Therefore, it is necessary to investigate the current state of spiritual care in ambulant settings before interventions are developed to support spiritual care.

A promising way to explore this is to investigate the ways in which spiritual care is addressed in multidisciplinary care meetings (MDMs). In these meetings, mental health professionals discuss and make decisions on the provisioning of care. Understanding the way in which care providers discuss spiritual care during MDMs can reveal in which way

attention is given to spiritual care when treatment is discussed. In addition, this research gives insight into the barriers and facilitators present when discussing spiritual care in order to know which aspects of spiritual care need to be improved in ambulant settings.

OBJECTIVES

The first aim is to explore the ways in which mental health professionals of ambulatory teams discuss the spiritual care of psychiatric outpatients in an MDM.

The second aim is to explore which barriers and facilitators can be concluded from what mental health professionals indicate about the ways in which they discuss spiritual care in an MDM.

METHODS

Design

This study utilizes a qualitative design which focuses on understanding and describing the experiences of mental health professionals while discussing spiritual care in an MDM.[17] A generic approach was used, aimed at a rich description of a thematic analysis.[18]
MDMs were recorded to explore the ways in which mental health professionals discuss spiritual care. Focus groups were organized to explore the barriers and facilitators of discussing spiritual care in an MDM.

Population and domain

The population of the study consisted of ambulant teams of mental health professionals who provide care to outpatients with severe psychiatric disorders and participate in MDMs. The researcher included teams that could provide the most information for the study, resulting in applying the purposeful sampling method.[19]
The study was conducted at Altrecht, a mental health organization in the province Utrecht in the Netherlands. Two teams of mental health professionals (hereafter referred to as professionals) were included. One team was located in the city of Utrecht and worked together as a team with an organization for “assisted living” named Lister. The other team in the rural city of Woerden was composed of Altrecht professionals only.

Data collection

MDMs

Care providers discuss patient cases each week in the MDMs. A number of MDMs were recorded by a voice recorder. The researcher did not attend the MDMs to avoid the potential bias of influencing the professionals to discuss spiritual care.

Focus groups

Focus groups were organized in each team after the MDMs were recorded and analyzed.[17] The team involved in an MDM was invited in the same composition for the focus groups. The researcher conducted the focus groups and was supported by a moderator. Three questions guided the conversation[20]:

- To what extent attention is given to the spiritual issues of the patients in an MDM?
- What impedes you to pay attention to spirituality in an MDM?
- What motivates you to discuss spiritual care in an MDM?

The researcher asked why professionals discussed spiritual care in the way they did in the MDM. The preparation of the focus group was supervised by a chaplain and supervisor. The focus group was recorded by a voice recorder. One extra MDM was used as a contrast case to determine the effect of the focus group on the team in discussing spiritual care and to check whether new themes linked to spirituality emerged.

Data analysis

Recordings of the MDMs and the focus groups were analyzed using open coding.[17] The program Atlas.ti (ATLAS.ti Scientific Software Development GmbH, Berlin) was used to process the data.[21] The supervisor and a chaplain supervised the coding process. A broad understanding of spirituality in the MDMs was used. Therefore, the researcher was able to code the data as openly as possible.[17] The text was coded as spiritual when it related to how a patient experienced meaning in life.[6] This could be associated with meaningful activity, relationships, religion, or identity.

Procedure

The chaplain, contact person for Altrecht for the study, approached the team managers of the multidisciplinary teams. The researcher then organized a meeting for the professionals to provide information about the research. Professionals signed an informed consent form before beginning recording the MDMs. Data was collected from February 2018 to May 2018. The study was conducted according to the principles of the Declaration of Helsinki. [22] The privacy of participants was protected by anonymizing the recordings. The Medical Ethics

Review Committee of UMC Utrecht evaluated the research protocol and confirmed that this study is not eligible under the Medical Research Involving Human Subjects Act (in Dutch: WMO). Ethical approval was obtained by the ethical review commission of Altrecht. The risks of the study for the participants were considered to be minimal.

RESULTS

Demographic characteristics

In the team of Utrecht all team members were present in the MDMs (N = 17). In the team in Woerden (N = 21), only the professionals involved in the case under discussion were present in the MDM. Both teams contained professionals of different disciplines. A large part of both teams had considerable work experience in an ambulant setting. Nearly all participants were older than 30 (Table 1).

(Insert Table 1)

MDMs

In each team, five MDMs were recorded with durations between 25 and 55 minutes. In the description of the MDMs, cases are summarized and no quotes are available.

The structure of an MDM begins with the introduction of a case or the reading of a treatment plan. Next, questions are raised about the treatment plan or course of treatment and are discussed. The different areas of the treatment plan, such as mental, social, and physical well-being and work and daytime activities, are then discussed. The professionals use an MDM to coordinate care, to discuss how to act, and to evaluate the treatment plan.
Themes derived from the data that pertain to spirituality included meaningful activities, contact with other people, satisfaction in life, identity, and religion.

Meaningful activities

In six MDMs, themes related to meaningful daytime activities for the patients were detected. The professionals discussed what kinds of activities were important to patients. This information is usually explained from the perspective of the patient. There were cases where professionals stated whether patients found satisfaction in their activities. These comprised of patients who undertook activities such as working, doing voluntary work, and having a hobby. Meaningful activities were discussed more than the other themes in the MDMs, described below, and related most to the use of interventions in spiritual care.

Contact with other people

Patients that had or missed connectedness with people was evident in three MDMs. One case described a patient who became more active in meeting friends. In another case, it was reported that a patient experienced that her children gave her meaning in life. A third case illustrated a grandfather who experienced no feelings when meeting his grandchildren. The conversation in this case was continued by discussing the psychiatric symptoms.

Satisfaction in life

Life satisfaction was discussed in three MDMs. In one MDM, a professional described the satisfaction experienced by a patient who had few personal belongings but, nevertheless, was pleased to live close to his family. In the same MDM, a patient was described who felt depressed and no longer experienced meaning in his life. The reasons for these patients' feelings were only minimally explained. Professionals also discussed the case of a young patient who worried about his future and what he wanted to achieve in his life.

Identity

Professionals discussed a subject linked to identity in two MDMs. One case described a patient who felt stigmatized as a result of receiving a governmental benefit. This case was described in only one sentence with no further explanation in the MDM. Another case mentioned a patient giving training to other people, which increased his self-esteem.

Religion

In three MDMs, there was a single comment or a small description with no further clarification mentioning the religion of the patient.

Focus groups

Defining spirituality

When a definition of spirituality was discussed with the participants, the understanding of spirituality differed by participant. [6] The participants viewed spirituality as something that pertains to all areas of life. Some participants found the description of the definition of spirituality provided by the researcher broad or heavy-handed. Moreover, the question was raised whether there should always be meaning in life or whether life sometimes does not make sense. Participants explained that spirituality in their view was linked to relationships, a feeling of belonging, determining personal identity, and discovering if it is possible to fulfill

one's role in life. It was observed that in conversations in the MDMs, the experience of the patient was sometimes missing.

During the focus groups, defining spirituality was regularly discussed. Substantial attention was also paid to the current position and the desired position of spiritual care in treatment and in MDMs. Several quotes linked to the text of the focus groups are depicted in Table 2.

(Insert Table 2)

Barriers

Several impeding factors in discussing spiritual care in an MDM were derived from the focus groups.

Clinical focus

Professionals are focused on medical treatment when a patient is in psychiatric distress (Table 2, Q1). A professional indicated that it could be a habit to think according to the medical model. If there are matters that have more priority, such as a patient accumulating debts or needing shelter, spirituality is not a priority. Team members stated that it depends on the patient whether spirituality is important.

Performance of psychiatric diagnostics is given higher priority than spiritual care. Professionals indicate that prioritizing diagnostics determines how a patient can be guided to lead a meaningful life.

In one of the teams, professionals stated that they were still finding out how the discussion could be done in an MDM. Team members used a 4-D model which focuses on the four dimensions of relational, social, mental, and physical well-being were the subjects of conversation in the MDM.

Spiritual care was not usually a separate topic in the treatment plan. Professionals indicated that they are not always aware of spirituality (Table 2, Q2). Implicitly spirituality is discussed in MDMs, but most of the time it is not explicitly called spirituality or spiritual care. Religion is integrated into the psychiatric examination, but spiritual care is not always requested or described in such an examination.

Time constraints

Time is limited in an MDM; there are about fifteen minutes available per patient. In a weekly meeting of one hour, four to five plans need to be discussed. Limited time can lead to lower quality in the discussion of cases. When time is short, professionals give more priority to medical issues instead of discussing spiritual topics (Table 1, Q3). Additionally, another factor is the full agendas of the professionals, which can lead to not addressing potential spiritual issues to avoid being asked to contribute to the treatment.

In one team, an MDM was generally perceived as going through a treatment plan in a short time. Barriers faced by professionals and activities with patients were discussed for a short time. Professionals often discussed a part of the content of a treatment plan outside the MDM because of limited time (Table 2, Q4). Participants did not find this way of working desirable, but they stated that it cannot be done differently.

Insurance system

Professionals were mainly focused on the medical aspect of treatment because the insurance requires making diagnoses and setting goals that can be justified. In Dutch health care organizations, the diagnosis, treatment, and costs are registered in so-called “diagnosis-related groups” (in Dutch; Diagnose Behandel Combinatie, DBC). In this system treatment aims at reducing psychiatric symptoms. It is asserted by professionals that there is a high administrative burden. A treatment plan must meet certain requirements to comply with the standard (Table 2, Q5). Prioritizing these requirements may leave less time to focus on aspects of treatment like spiritual care.

Disciplines

The person with primary responsibility for a particular patient’s care introduces that case in an MDM. Not every professional has this role, such as a peer support worker. Peer support workers are trained professionals with lived experience of a mental disorder.[23] A peer support worker can assess a patient differently. Otherwise, when a problem arises in the area of spirituality, spiritual care is seen as a domain belonging to a particular specialty, such as a peer support worker or a chaplain.

Relation with the patient

Participants stated that if a professional has not yet made sufficient acquaintance with the patient, this could be another reason why spiritual care is not discussed.

Facilitators

It can be concluded from what mental health professionals indicate that there are a few motivating factors in discussing spirituality in an MDM.

Changed focus

Participants explained that viewing from the perspective of recovery-oriented care help them be more concerned with who the patients are, who they want to be, and how patients can live meaningfully despite their illnesses (Table 2, Q6). Social and personal recovery have become important factors for the professionals in providing care.

Professionals asserted that there has been a shift in the extent to which spirituality is discussed over the years. One of the reasons is the development of Flexible Assertive Community Treatment (FACT) teams. A distinguishing part of working in a FACT team is the amount of attention paid to all areas of life (Table 2, Q7). One of the teams applies a 4-D model in which they discuss the mental, social, physical, and relational well-being of a patient. By discussing all areas of life, the topic of spirituality is broached more often.

Another motivating factor in discussing spiritual care in an MDM is that the definition of health has changed over time. In the focus group, it was stated that mental health is no longer just the absence of psychiatric illness. Participants mentioned that mental health and spirituality can no longer be considered separately (Table 2, Q8). The participants associated the shift in the definition with the concept of positive health that was developed by Machteld Huber.[3]

Some professionals stated that they did not stop themselves by meeting the requirements of the DBC system in discussing topics such as spirituality. Participants wished to take sufficient time in the MDM to discuss the content of a treatment plan properly. Professionals believed spirituality was valuable in treatment, and they added that providing care in the area of spirituality delivered satisfaction to them (Table 2, Q9). Guiding a patient with spiritual problems was regarded as a worthwhile task for professionals. Participants called spirituality the energy source from which patients could draw their recovery.

Multiple perspectives

Participants stressed that collaborating with different disciplines in a team helps to reinforce each other's treatment methods. The deployment of a peer support worker in a team is seen as contributing to the discussion of spirituality because this team member has a different view on the recovery process (Table 2, Q10).

Professionals stated that it would be desirable for the patient to be present at the MDM to ensure that the patient's experience is central in the conversation.

Spirituality in contact with the patient

Professionals declared that the quality of the relationship with the patient is an important factor in being able to talk about spirituality. Likewise, it is helpful to consider the course of the patient's life in discussing spirituality. The professionals also mentioned that it is necessary to have patience in certain situations.

Contrast case

In one specific MDM, spirituality was mentioned twice. A patient in the first case achieved a victory by reviving an old hobby after a significant time had passed. In the other case, a professional asked her colleague what the patient wanted to do if she no longer suffered from her illness. The colleague explained which activities the patient would like to undertake again. Both cases pertained to the category of meaningful activities.
If one MDM is any indicator, this MDM does not demonstrate that the way in which spirituality is discussed changed after the focus groups.

DISCUSSION

Themes in MDMs that pertain to spirituality included meaningful activities, contact with other people, satisfaction in life, identity, and religion. Meaningful activities were given the most attention. Other themes received less attention or the perspective of patients was lacking. Spiritual care receives less priority in a meeting due to several preconditions such as the clinical focus of a professional, time constraints, the insurance system, the role of various disciplines, and the lack of a relationship with a patient. Other preconditions stimulated discussing spiritual care, such as a change of focus for professionals, taking into account multiple perspectives, and the quality of a relationship with a patient.

It was obvious that the majority of attention to spiritual care in an MDM was related to the meaningful daytime activities of a patient. A study of understanding spirituality and its role in recovery in patients with schizophrenia found that professionals concentrate on relieving symptoms and increasing social acceptance when providing spiritual care.[24] This study concludes that professionals see spiritual care from a pathological perspective. Professionals in this study are mainly concerned with daytime activities; therefore, it could be that the first

tendency of a professional is to provide practical help and improve the current situation when a patient has spiritual problems.

Barriers were mainly related to the clinical focus of participants such as being focused on medical treatment, performing diagnoses, and being not aware of the presence of spirituality. Koslander et al. describes the shift from the concept of biomedical care to holistic care.[10] More attention in biomedicine is paid to the treatment of diseases. Professionals indicated in this research that solely concentrating on medical issue limited the time to give attention to spirituality, partially because of the requirements of the insurance system. Even so, a study of how clinicians cope with spirituality with patients suffering from chronic psychosis demonstrated that spirituality is not discussed because of insufficient time.[25] This study also found that clinicians had a lack of knowledge or awareness that spirituality is important to patients. This is not evident from the current study; professionals indicated in this study that it is important to pay attention to spirituality.

The changed focus of professionals is an important factor in facilitating discussion of spiritual care. The recent changes of focus in mental health and the changed definition of health also promotes discussion of spiritual care. In addition, a recovery-oriented care perspective leads professionals to pay more attention to spirituality. A study of Huguelet et al. reveals that a quarter of patients in the study reported that spirituality is important in their lives. [26] Moreover, spirituality is important in recovery-oriented care because spirituality is positively associated with social functioning, self-esteem, and social quality of life.

Strengths and limitations

A strength of this study is that professionals' opinions on the ways they discuss spiritual care and insight into actual practice is obtained through recording MDMs. This reflects clearly how spiritual care is discussed in reality compared to only conducting focus groups. Furthermore, two teams were chosen that differ from each other in several areas, revealing how spirituality is addressed in ambulatory multidisciplinary teams and increasing the generalizability of the results.

A limitation of this study is that concentrating on the MDMs is perhaps not representative of the extent to which spirituality is generally addressed. This study was conducted in teams in ambulatory health care in one mental health organization. Therefore, other organizations are organized in a different way. For this reason, the results can probably not be generalized to other ambulant and clinical settings. Another limitation is that probably no saturation has been achieved with regard to the number of recorded MDMs.

Conclusion

This research describes the ways in which professionals discuss spiritual care in an MDM setting in ambulatory care. The recordings of the MDMs suggested that professionals mainly concentrate on spiritual issues that affect short-term well-being such as meaningful daytime activities. Preconditions in providing care could stimulate or impede the discussion of spiritual care. Stimulating a recovery-oriented perspective can decrease the narrow focus on medical issues and contribute to discussing spiritual care. In addition, promoting the new definition of health, in which attention is given to all areas of life and the patient's ability is emphasized, can increase the amount of discussions of spirituality.[3]

Moreover, it is possible to ensure that professionals in ambulatory care gives more priority to spirituality because the importance of it is recognized Therefore, results of the current study are potential points of interest during professional training.

This study concentrates on the practice and perception of mental health professionals. Further research should be carried out to explore the experiences and needs of patients in terms of spiritual care.

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Table 1

Demographic characteristics of the participants		
Teams	2 (*n* = 17 and *n* = 21)	
Gender		
Male	14	36.8%
Female	24	63.2%
Discipline		
Community psychiatric nurse	2	
Case manager	15	
Psychiatrist	4	
Psychologist	4	
Nurse practitioner	2	
Peer support worker	4	
Route counselor	1	
Recovery coach	3	
Personal coach	2	
Team leader	1	
Work experience (Years)		
0 – 5	6	15.8%
6 – 10	7	18.4%
> 10	25	65.8%
Age		
20 – 30	3	7.9%
31 – 40	12	31.5%
41 – 50	8	21.1%
> 50	15	39.5%

Table 2

	Quotes
Q1	“You are already busy enough to keep someone on track.”
Q2	“We are not very conscious about it or that is more that you remind afterwards. Oh, that also gives hope, but it is not that you are talking about hope or something.”
Q3	“When everybody has very busy agendas, yes, you will also quickly think, well, I do not have to make a point of this right now.”
Q4	“Well, I do not think it is desirable, but now it cannot be different at the moment, but that is why the core of the good, substantive discussion of the MDMs takes place outside the MDM.”
Q5	“Over the years, and that’s what I really think is a development, more and more what we have to check off.”
Q6	“Nowadays, everybody wants to work recovery-oriented, and I think that is the main difference between looking at the disease and looking at what someone actually does with his or her life and how that person gets a meaningful life again.”
Q7	“Anyway, a big difference between, for example, a patient who is in the clinic or within a FACT[1] team. Of course we look much more at the FACT team in all areas of life.”
Q8	“I think it is really a problem to see these two things so separate from each other, mental health and meaning.”
Q9	“I think the knife cuts on two sides as well. Because it is nice for the therapist, I think that giving spirituality in that sense also gives satisfaction.”
Q10	“Because he also has a different view of someone and a recovery process and can sometimes also alert us to things.”

[1] *Flexible Assertive Community Treatment*