A Quantitative and Qualitative analysis of Spiritual needs in Integrated Care Planning.

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Introduction

The integration of Religion into Psychiatric practice has been a much debated and at time controversial topic[1]. Religiosity has been much studied as a determinant of Mental Health, with results that are generally positive but not uniformly[2]. Thus many authors have promoted the integration of religious and spiritual aspects into general psychiatric care[3].

Despite this controversy the Mental Health Commission have mandated specific regulations for providers of services in relation to Religion for residents of admission units[4]. These regulations place responsibility for mental health services to provide "residents with spiritual care and support" and well as providing "multi-faith chaplains" [4].

However, these regulations as well as conflating religion with spirituality, do not define what is considered a religion, which faiths are to be included or make reference to any of specific position paper or document regarding how Spirituality/Religion should be approached in Psychiatry.

In addition Integrated Care Planning (ICP) is a mandatory requirement of acute psychiatric admission units (approved centres) [5]. The guidance from the Mental Health Commission in relation to this states that ICPs need to make "reference to social recreational and spiritual needs.." [5]. Following this guidance many units have incorporated "Spiritual Needs" as an explicit part of their ICP process.

Our aim in this study was to explore how teams in practice complied with the inclusion of Spiritual Needs in the ICP process. In addition we were looking to ascertain attitudes of staff to the inclusion of Spiritual Needs into the ICP process both from a practical and training perspective.

Methods

Our study was conducted in an Acute Psychiatric Admission Unit based in an urban area. Ethics approval was received from the Hospital Ethics review board. The study was based on 50 consecutive admissions to the unit the previous year. Basic demographic details were recorded for each patient as well as any religious affiliation.

The study consisted of a retrospective chart review of 50 consecutive admissions to the acute admission unit. Patient's Integrated Care Plans included a direct prompt in relation to Spiritual Needs with an accompanying space to record the assessment. We reviewed whether this section had been completed; rated whether this entry had demonstrated a meaningful engagement with the patient in the area of Spirituality and if there was any follow up on subsequent care plans.

In addition medical staff (both currently and recently employed) working in the unit were invited to participate in an online survey in regards to their own spirituality; their experience of assessing Spiritual Needs; Their views on the inclusion of Spiritual Needs as well as their experience of training in the area of Spirituality.

Results

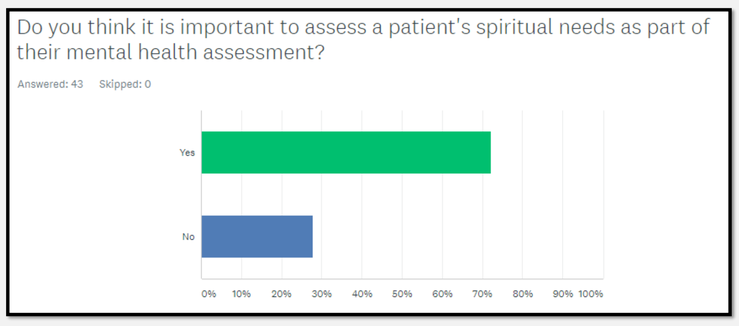
Retrospective Chart Review

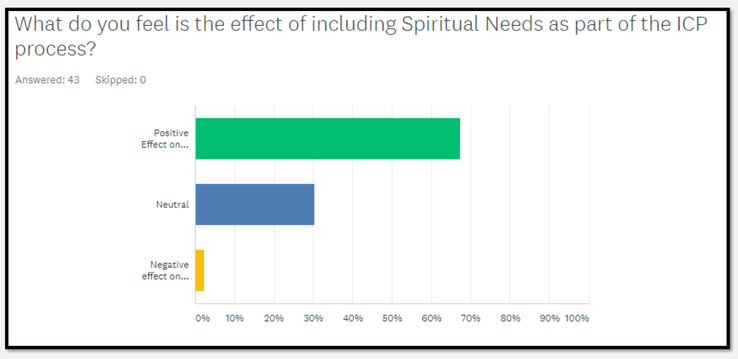
Table 1: Demographics		
Gender N(%)	Male	32 (64%)
	Female	18 (36%)
Age	Range	20-81
	Median	46
Religion	Roman Catholic	31 (62%)
	Islam	2 (4%)
	Orthodox Christian	2 (4%)
	Jehovah Witness	1 (2%)
	No Religion	12 (24%)
	N/A	2 (4%)

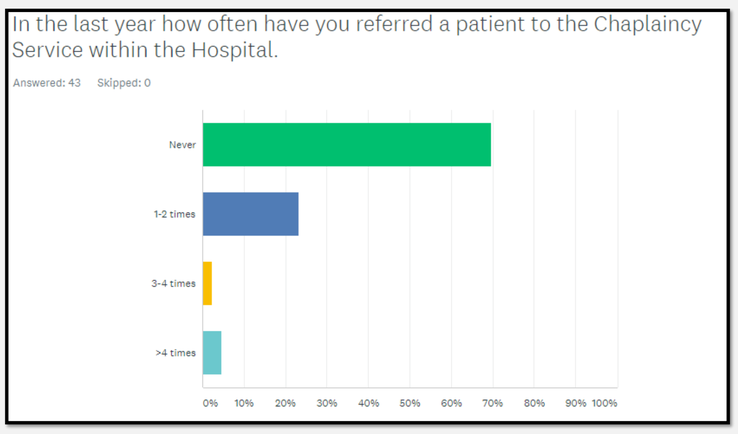
Table 2: Review of Care Plans.	
Number of charts reviewed	50
Number of Care Plans	46 (92%)
Number with an entry in Spiritual Needs	33 (66%)
Number with Meaningful entry in Spiritual Needs section	7 (14%)
Number with reference to Spiritual Needs in follow-up care plans.	1 (2%)

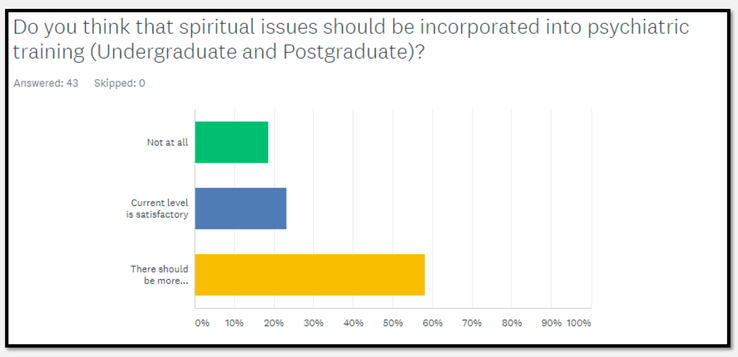
On-line Staff Survey

Table 3: Results of On-Line Survey on Care Planning	
Number of Respondents	43
Pre-membership NCHDs	23 (53%)
Post-membership NCHDs	12 (28%)
Consultants	7 (16%)
Prefer not to say	1 (2%)









Discussion

The results of our study has shown the ongoing contradiction in relation to Spirituality and Religion in Psychiatry. Our retrospective chart review showed that while two thirds of the ICPs reviewed showed an engagement with Spiritual Needs the majority of this was of a non-meaningful nature ("Nil significant"; "Nil"). Of the 7 ICPs that did have meaningful engagement only 1 had a follow up in subsequent ICP meetings.

However, the results of the on-line survey showed that the majority of medical staff felt that spiritual needs were important (72%); appropriate (65%) & Beneficial (67%). Despite this the majority of doctors did not feel that Chaplaincy should be included in Multi-Disciplinary Teams (MDTs) (63%) and patients were only rarely referred to chaplaincy (as shown).

Doctors did express that they did not feel competent in the assessment of Spiritual Needs (70%) and the majority felt that there should be more training in this area (as shown).

Our study displayed the changing nature of religious demography in Ireland over the last fifty years where over 90% of citizens identified as Catholic to the most recent survey where this proportion was 78%[6]. This has coincided with both an increase in other religious groups as well as a strong growth in those not identifying as non-religious[6].

Conclusions

We feel that our study highlights an important and neglected area of psychiatric practice. Our results show that while doctors had a positive view of the role of spirituality within psychiatric practice there was evidence of poor engagement with spiritual needs in practice.

One reason for this discrepancy is that doctors do not feel sufficiently equipped to engage in this area with a high number expressing a feeling of a lack of competence and a wish for more training. This finding we feel should inform future curricula of training programmes.

Our study also showed a high number of patients expressing no religious affiliation, which is in keeping with the baseline demographic factors. This emphasizes the needs for future regulations to separate religion from Spirituality.

This study we feel identifies a need for significant further research. Specifically focused on service users views on the involvement of Spirituality in care.

References

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