People-Centred Organization of Psychiatric Services

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37.1 Introduction

The provision of mental health services remains highly inadequate in most parts of the world. Treatment gap is sometimes as high as 90 % and more pronounced in low and middle-income countries [19]. Even when the services are available the potential beneficiaries are not gaining full access to them due to several reasons. The main roadblock seems to be related to the organizational aspects of mental health care delivery [18].

The traditional organization of mental health care is centred around hospitals which are specialized for treating mental illness. This hospital centred system has the advantage of operational feasibility from the point of view of health administrators. The fact that this system is very efficient in providing services for serious mental disorders in acute stage need to be acknowledged. But looking from the consumer side this system is unfriendly and insufficient in several ways. Unfriendly in the sense that it is not very sensitive to the user needs and insufficient in the sense that it does not capture the broad range of mental health problems nor provide adequate attention to health promotion. There is a neglect of the needs of real people [14]. Similarly, neither does it address the promotional aspects of mental health nor it prioritizes prevention. These proven deficiencies in the conventional hospital-based system clearly call for a more person-centred and broad system of

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psychiatric services. Needless to say that the services within the hospital should be reorganized to be more people-centred. Collaborative extension of person-centred approach to general medicine [11], and integrating mental health in general health and public health may be a useful step in filling up the deficiencies in health care delivery systems and making it more person-centred [7, 13].

Greater participation by patients in healthcare decision-making has been the trend in high-income countries which are facing the problems of ageing of population and a shift in focus from acute care to chronic care [17]. This stems from the notions that citizens as responsible consumers must become co-producers of their care and less dependent on paternalistic models of health care [15]. The concept of person-centred practice which evolved in general primary care is expected to become influential in mental health care delivery in primary and specialist settings in the near future [18].

37.2 The Person-Centred Approach in Psychiatry

Recent movements emphasizing recovery and resilience place patients as active participants in the treatment process. The fundamental assumption of the recovery movement in mental health is the principle of "people first" and this places person-centred care planning for individuals with serious mental illness at its core [3].

In the field of mental health care 'person-centeredness' is generally understood as a holistic approach with an attitude of respect for the individual and his or her unique experience and needs [5]. The World Psychiatric Association Institutional Program on Psychiatry for the Persons (IPPP) affirms the whole person of the patient in context as the centre and goal of clinical care [10]. IPPP emphasizes the person's involvement as user and citizen in creating policy, plan and delivery of services.

Person-centred care has recently been emphasized in psychiatric rehabilitation as well [2]. This new approach in rehabilitation of the chronic mentally ill opens up hopes of moving beyond the rhetoric of recovery to concrete practices. Partnership in decision-making in person-centred approach may reorient rehabilitation from patienthood to personhood. Similarly, the family's role in person-centred care has been analyzed in a focussed manner [1].

37.3 Models and Guidelines

Models based on person-centred approaches have started to emerge. Recovery-oriented behavioural health care and community health of Yale University School of Medicine is one such model. This model focuses on culturally responsive person-centred care for psychosis in urban mental health system. Illness management and recovery, facilitated person-centred planning and community inclusion programmes are the components of this programme [16].

Recently, the influential mental health care provider organization, NICE, has given recommendations on "improving the experience of people who use adult NHS mental health services" [12]. NICE guideline makes some quality statements with hopes that people using mental health services, and their carers feel optimistic that care will be effective and they are treated with empathy, dignity and respect. Quality statements also hope for easy accessibility to mental health services when people need it. Care from a single, multidisciplinary community team, familiar to patients and with whom they have a continuous relationship is expected. Patients are actively involved in shared decision-making and supported in self-management. The views of service users are used to monitor performance of services. Patients are informed about the assessment process, their diagnosis and treatments options, and receive emotional support for any sensitive issues. People using mental health services jointly develop a care plan with mental health and social care professionals. Those who may be at risk of crisis are offered a crisis support and a comprehensive assessment, undertaken by a professional competent in crisis working. People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to the service user and regularly see other members of the multidisciplinary mental healthcare team. People receiving in-patient care can access meaningful and culturally appropriate activities 7 days a week, not restricted to the convenience of day duty staff in the regular working hours. Control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force. People using mental health services feel less stigmatized in the community and health service system, including within mental health services.

The spirit of people centeredness in the delivery of psychiatric services is reflected in the quality statements in the guidelines. The guidelines aim to promote person-centred care that takes into account service users' needs, preferences and strengths. It is expected that by practising these guidelines people who use mental health services get the opportunity to make informed decisions about their care and treatment, in partnership with their health and social care practitioners.

However, the person-centred approach in psychiatric care is not without reservations. Practitioners might have apprehensions whether allowing people with mental illness to make their own decisions increases the liability of the care giving professional. Its applicability in acute settings, labour intensive and time-consuming nature, not having sufficient evidence base, conflicts between patients choice and clinical wisdom are some of the other concerns [16].

The NICE Guidelines suggests that people-centred approach in organization of psychiatric services should ensure the following:

1. Care and support across all points on the care pathway.
2. Access to care.
3. Comprehensive assessment.
4. Community care.
5. Access to interventions in crisis.

6. Hospital care.
7. Discharge and transfer of care.
8. Assessment and treatment under legal provisions.

37.4 Organizing Services Based on the Person-Centred Approach

The above models of care are based on the situation in the western world. Though they are very well based on the principles of person-centred approach, their feasibility in the less-developed and resource-limited settings may be limited. So each country needs to evolve its own model of person-centred delivery of mental health care services.

In middle and low-income countries, several hurdles like lack of human resources, low priority of mental health in health policy and budgeting, limitations of infrastructure, poor awareness about mental disorders and stigma and discrimination are to be tackled in organization of person-centred care for persons with psychiatric disorders. These issues need to be kept in mind when the western models are adapted to middle- and low-income countries.

The services for the mentally ill should be organized with "person first" principle at every point in the pathway of care starting from assessment to rehabilitation.

1. Person-Centredness in Assessment.
2. Person-Centredness in Hospital Care.
3. Person-Centredness in Family and Community Care.
4. Person-Centredness in Rehabilitation.

37.5 Person-Centred Assessment

When people are referred to mental health services a face-to-face appointment with a professional within the shortest time should be ensured. Patient's preference regarding the place and choice of services should be given due consideration. Transparency should be ensured by providing the name and professional designation of the person who will assess them. The process of assessment should be explained using plain language.

The assessment should take place in a warm, empathic, dignified and professional manner. The patient has to be explained that the assessment will cover all aspects of their experiences and life and the basic approach is that of shared decision-making. Although they can be accompanied by a family member or carer, it is preferable to see the person alone for some of the assessment. They should be told that they can refuse permission for any other member of staff, such as a student, to be present. Limitations of confidentiality should be disclosed.

When carrying out an assessment ensure there is enough time for the patient to describe and discuss their problems. Explain the use and meaning of any clinical terms used. Give information about different treatment options, including drug and psychological treatments, and their side effects, to promote discussion and shared understanding.

If the patient is unhappy about the assessment and diagnosis, give them time to discuss this and offer them the opportunity for a second opinion. Waiting periods should be minimized. Ensure that waiting rooms are comfortable and have areas of privacy.

37.6 Person-Centred Hospital Care

In the event of admission to a hospital, the person should be received in an atmosphere of hope and optimism. Ensure that he feels safe and address any concerns about safety. Give adequate information to the patients, and their families or carers about the hospital and the ward in which they will stay, treatments, activities and services available, rules of the ward (including substance misuse policy), service users' rights, responsibilities and freedom to move around the ward and outside and visiting arrangements. Undertake shared decision-making whenever possible. Service users in hospital should be offered daily one-to-one sessions with a healthcare professional known to the service user and regular one-to-one sessions with their consultant.

The overall coordination and management of care should ideally take place at a regular multidisciplinary meeting led by the consultant and team manager with full access to the service user's treatment records. The advocates of those who are treated under legal provisions should be encouraged to be in contact with the treatment team through the manager.

Health and social care providers should ensure that service users in hospital have access to the pharmacological, psychological and psychosocial treatments recommended in standard guidelines provided by competent health or social care professionals. Control and restraint, and compulsory treatment including rapid tranquillisation, should be used as a last resort, only after all means of negotiation and persuasion have been tried, and only by healthcare professionals trained and competent to do this. Document the reasons for such actions.

When a patient is subject to control and restraint, or receives compulsory treatment including rapid tranquillisation use minimum force, make sure the service user is physically safe, try to involve healthcare professionals whom the service user trusts and explain reasons for the episode of compulsory treatment to the patient and involved family members or carers. Offer to discuss episodes of compulsory treatment with there at the time of discharge and do so in a calm and simple manner.

Psychological and psychosocial treatments may be provided by health and social care professionals who work with the service user in the community. Those receiving community care before hospital admission should be routinely visited

while in hospital by the health and social care professionals responsible for their community care.

Ensure that service users in hospital have access to a wide range of meaningful and culturally appropriate occupations and activities. Patients should be permitted to access Internet and telephone during their stay in hospital.

Discharge should be discussed and planned carefully beforehand with the patient and care giver in family. Assess the service user's financial and home situation, including housing, before they are discharged from in-patient care. Agree discharge plans with the patient and include contingency plans in the event of problems arising after discharge. Ensure that a 24-h helpline is available to service users so that they can discuss any problems arising after discharge. Give service users clear information about all possible support options available to them after discharge or transfer of care.

37.7 Person-Centred Care in Family and Community

37.7.1 Involving Families

As a general principle, the involvement of family should be encouraged. However, providers should discuss with the person using mental health services if and how they want their family or carers to be involved in their care. As the involvement of families and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with families and carers, and also in managing issues relating to information sharing and confidentiality. Service users may be ambivalent or negative towards their family for many different reasons, including as a result of the mental health problem or as a result of prior experience of violence or abuse. The more tolerant and stable family system in less-developed countries are potential assets for ensuring person-centred care.

37.7.2 Avoiding Stigma and Promoting Social Inclusion

The professionals caring for the patient should be respectful of and sensitive to his gender, sexual orientation, socioeconomic status, age, cultural, ethnic and religious backgrounds. They should have competence in assessment skills and using explanatory models of illness for people from different cultural, ethnic, religious or other diverse backgrounds. They should work with local authorities and all other local organizations with an interest in mental health (including social services, other hospitals, voluntary, organizations, local press and media groups, and local employer organizations) to develop a strategy to combat the stigma in the community and even inside the health care system. The success of involvement of community gate keepers in community-based programmes like suicide prevention gives optimism for the effectiveness of such interventions in other aspects of mental health [8].

37.8 Person-Centred Rehabilitation

The principle of "*nothing about us, without us*" accepted in the planning and management of physical disabilities should be adapted in mental health care as well. Develop rehabilitation plans jointly with the recovering patient, and include activities that promote social inclusion such as education, employment, volunteering and leisure activities. Health and social care providers should consider employing service users to be involved in training teams of health and social care professionals and supporting staff (such as receptionists, administrators, secretaries and housekeeping staff) in 'person-centred care'. Recovering patients themselves should be provided with training and supervision to undertake this role. Support service users to develop strategies, including risk- and self-management plans, to promote and maintain independence and self-efficacy, wherever possible. Incorporate these strategies into the care plan.

For people who may be at risk of crisis, a crisis plan should be developed by the service user and their care coordinator, which should be respected and implemented, and incorporated into the care plan.

37.9 Challenges Ahead

There are many foreseeable hurdles for the implementation of these changes in reorganizing psychiatric services [4, 6]. These include

1. Resistance to change from the existing system itself: The existing organization of mental health care delivery is designed to suit the convenience of the providers. Feasibility issues may come up as roadblocks if sufficient planning and preparations are not undertaken. It is very important to impart training programmes for the professionals in the service with an objective to reorient them to a person-centred approach. Person-centred approach should be incorporated into the curricula of mental health professionals.
2. Difficulties of service users and families to adapt to a system which requires more active involvement from their part: The service utilizers and their family members (especially in the non-western world) are used to the paternalistic care being provided by the existing system. Changing over from this passive recipient mode to the actively involved and responsible mode is likely to create difficulties.
3. Limitations of resources and funding: The changeover to the person-centred services may require employment of more manpower and development of more infrastructures. This calls for more investment and budget allocation for mental health services. This factor can be an important hurdle which needs to be tackled especially in resource limited countries.

37.10 Conclusions

Psychiatry has slowly started embracing a person-centred approach which is a holistic approach with an attitude of respect for the individual and his or her unique experience and needs as a patient. Mental health care delivery needs to be reorganized in a way which is sensitive to the needs of the users. Integrating mental health in primary care and general health care can make mental health care more affordable and feasible in most parts of the world. Models like the NICE guidelines [12] have essentially captured the spirit of person-centeredness in the organization of mental health services. Though these guidelines are drawn upon the system in a western world setting, other countries including the low- and middle-income countries can adapt this model for initiating effective person-centred organization of mental health services. This may serve as a model upon which innovations can be tried keeping with resource limitations. A simple model of person-centeredness at four levels—assessment, hospital care, family and community care, and rehabilitation is introduced and briefly described. Associations of mental health professionals may contribute to and catalyze the organization of person-centred mental health services in each country in a manner that suits its social, cultural and economic realities. They should be incorporated into the national health policy of each nation.

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