Individualised Care in Mental Health and Psychiatric Care

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Abstract

Individualised care has been part of international discussion in mental health services and psychiatric care since 1990s. The discussion is originally based on a wide movement in psychiatry towards community care away from institutionalised and less human approaches in mental health services. However, a connotation of the concept of 'individualised care' varies in the literature. There is also a great variation on how the concept of individualised care has been used in different mental healthcare services or in psychiatric care regarding guidelines, strategies, research or educational purposes. In addition, different methods have been used to describe a realisation in individualised care in different target population. In this book chapter, we will first overview how individualised care in mental health and psychiatric care has been defined in different context. Second, we will list the measures and outcomes, which have been used to assess the realisation of individualised care in daily practices. Third, the interventions or programmes used to support individualised care in special target groups will be described. Fourth, the realisation and impact of individualised care will be described.

Keywords

Individualised care · Primary nursing · Psychiatric care · Mental health · Mental illness

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13.1 Introduction

Since 1990s, individualised care has been discussed in mental health services and psychiatric care. The discussion is originally based on a wide movement in psychiatry towards community care away from institutionalised and less human approaches in mental health services. However, a connotation of the concept of 'individualised care' may still be vague, and its meaning is unclear in the literature. There is also a great variation on how the concept of individualised care has been used in different mental healthcare services or in psychiatric care regarding guidelines, strategies, research or educational purposes. In addition, different methods have been used to describe a realisation in individualised care in different target population.

In this chapter, we will first overview how individualised care in mental health and psychiatric care has been defined in different context. Second, we will list the measures and outcomes, which have been used to assess the realisation of individualised care in daily practices. Third, the interventions or programmes used to support individualised care in special target groups will be overviewed. Fourth, the realisation and impact of individualised care will be described.

13.2 Definitions and Context of Individualised Care in Mental Health and Psychiatric Care

In the literature and empirical studies, a concept of individualised care has been described using a high number of different connotations and definitions. Already in early 1990s, Burchard and Clarke [1] used the concept of individualised care related to children who had severe maladjusted behaviour. The authors described individualised care from the point of view of the service environment and called it as 'a total system'. This means that the care is tailored to fit the needs of each individual child. For example, the services to be tailored are 'unconditional, flexible, child and family focused and interagency coordinated'. The services follow the child until he or she is adjusting in a normalised, mainstream environment. Based on the description, individualised care can be seen as a feature, which should be included in the healthcare services and the process of care. On the other hand, individualised care has also been used as a separate entity. In that case, 'individualised' is something to be developed and late to be integrated into an existing system of care [2].

Jones [3] explored perceptions of individualised care in mental health services. Jones's qualitative findings indicated two major themes in description individualised care: 'knowing the patient' and 'developing a relationship'. Indeed, a relationship between a patient and a nurse is a fundamental issue in psychiatric care [4]. On the other hand, pitfall of individualised care was recognised. Values of the professionals may have an influence to what kind of treatment is provided to a patient; a patient may be subjected to professionals' individual styles and decisions about what is important for the patient [3].

As manifestation of individualised care in mental health area, individualised care can be seen as a method of delivering nursing care or responsibilities of nurses, such

as ‘named nursing’ or ‘primary nursing.’ ‘Named nurse’ includes critical elements with specific concepts. First, a single nurse has responsibility over decision-making for a patient. Second, a single nurse is responsible of patients’ daily care. Third, a single nurse is responsible for direct communication to patient’s network. And fourth, a single nurse is responsible for the quality of patient care administered for a patient on 24-h basis. [5]. Primary nursing also means delivering patient-centred and individualised treatment for a patient and makes patient management less fragmented and aims to fulfil patient’s wishes and needs [6]. More recently, the emphasis of ‘named nurses’ has been moved towards multidisciplinary teams, which are comprised of staff who vary in their educational and professional experiences and bring together diverse perspectives, expertise and skills [7].

The studies have been conducted to find out different technical tools to support individualised care from the point of view of risk factors or predictors. Gowin et al. [8] used neuroimaging to predict patient relapses. The goal was to find out whether this advanced neuroimaging tool can use to make decisions about individualised treatment of substance use disorders. Zilcha-Mano et al. [9] also aimed to find out predictors for patient dropout to be used in individualised treatment recommendations. Further, Cannon et al. [10] used an individualised, web-based risk calculator tool to predict the risk for psychosis. They found based on the calculator that the 2-year probability of conversion to psychosis was 16%, which was predicted by higher levels of unusual thought content and suspiciousness, greater decline in social functioning, lower verbal learning and memory performance, slower speed of processing and younger age at baseline which contributed to individual risk for psychosis. Individualisation has also been used for diagnosis purposes for patients with schizophrenia and mood disorders [11].

13.3 The Measures and Outcomes Used to Assess the Realisation of Individualised Care in Daily Practices

Individualised care has been described to be something ‘mystical’ and specific in psychiatric care [3]. Some nurses has thought that it is impossible to make any structured assessment about patients’ status or outcome because each individual nurse can make their own judgement based on their experiences and intuition. Indeed, standardisation of care has been resisted due to this unique nature of psychiatric practice [3]. Different instruments have still been developed to measure individualised care, its process or outcomes in mental health and psychiatric nursing. The instrument has been used from patients’ and nurses’ viewpoints.

13.3.1 Instrument to Be Used by Patients

Pesola et al. [12] have developed Individualized Outcome Measure (IOM). The final version of IOM has two components: goal attainment (GA) and personalised primary outcome (PPO). For goal attainment, patients will identify first one relevant

goal for his or her treatment. The same goal will be rated again from the point of view of the goal attainment at follow-up. For personalised primary outcome (PPO), patient will choose an outcome domain related to their goal from a predefined list at baseline and complete a standardised questionnaire assessing the chosen outcome domain at baseline and follow-up. There are ten outcome domains from which a patient can choose from. All of these ten outcome domains are patient-rated, pre-existing measures. These include (1) the Empowerment Scale (ES) which has 28 items that are rated on a 4-point Likert scale [13], (2) the Herth Hope Index (HHI) which has 12 items that are rated on a 4-point Likert scale [14], (3) the Rosenberg Self-esteem Scale (RSES) which consists of 10 items that are rated on a 4-point Likert scale [15], (4) the Stigma Scale (SS) which has 28 items rated on a 5-point Likert scale [16], (5) the Meaning of Life Questionnaire (MLQ) which has 10 items rated on a 7-point Likert scale [17], (6) The MOS Social Support Survey (MOS) scale which consists of 21 items that are rated on a 5-point Likert scale [18], (7) the Community Integration Measure (CIM) which consists of 10 items rated on a 5-point Likert scale [19], (8) the Warwick–Edinburgh Mental Well-Being Scale (WEMWBS) which has 14 items rated on a 5-point Likert scale [20], (9) the Service User Perception of Functioning Scale (PPFS) which consists of 5 items that are rated on a 5-point Likert scale [21] and (10) the Manchester Short Assessment of Quality of Life (MANSA) which has 12 items rated on a 7-point Likert scale [22]. The authors recommend that the instrument can be used as a patient-specific outcome measure in RCTs of complex interventions, but further assessment of the psychometric properties of the instrument should be conducted. However, the PPO has been found to be feasible instrument approach? in ways that patients with mental illness are able to use the instrument properly.

The realisation of individualised care has been measured by assessing treatment outcomes: cognition level (The Brief Assessment of Cognition in Schizophrenia—Japanese version (BACS-J), [23]), psychiatric symptoms (Positive and Negative Syndrome Scale (PANSS), [23]) and physical health status [24]. Patients' individualised treatment as means of realisation of primary nursing in care has also been evaluated by asking patients' feedback with survey instrument whether patients were aware of a name of their primary nurse [25]. Further, realisation of individualised care has been assessed by identifying changes in care restrictions in primary nursing care by assessing the use of seclusion and restraints [25].

13.3.2 Instruments to Be Used by Nurses

The realisation of individualised care in psychiatric hospital has been measured by using Individualised Care Scale—Nurse—instrument [26]. This instrument is used to assess nurses' views about delivery of individualised care. The measurement scale guides nurses to rate in 5-point Likert-type scale how they support patients' individuality in clinical situations, in patients' personal life situation and in decisional control over care with a total of 34 items [26].

Impact of realisation of primary nursing care has been assessed by measuring work satisfaction [25] with the Index of Work Satisfaction Questionnaire (IWS, [27]). The instrument contains 44 items with six components: pay, autonomy, task requirements, professional status, interaction and organisational policies [28]. Further, the impact of primary nursing has been evaluated related to ward environment from nurses' perspectives [29] by using Ward Atmosphere Scale (WAS, [30]). This instrument with 100 statements has been used to capture various aspects of ward environment.

Moreover, as an outcome of providing more individualised care in primary nursing, nurses' burnout and job turnover have been measured [31]. As a burnout measure, the Maslach Burnout Inventory (MBI) has been used. The MBI contains 22 items that are assessed with 7-point Likert scale divided to dimensions of emotional exhaustion, depersonalisation and personal accomplishment subscales that are parts of the 22-item MBI [32].

13.4 Examples of the Interventions and Programmes to Support Individualised Care in Special Target Groups

A high variety of interventions and programmes have been developed to support individualised care. Burchard and Clarke [1] described two programmes for children. The Alaska Youth Initiative programme was established in which individualised care was used to return children from out-of-state, residential programmes. The other is Project Wraparound where it was used to prevent children from being removed from their families. Further, Curtis et al. [33] used a 12-week individualised intervention targeted to 14–25 years people with first-episode psychosis (FEP). The lifestyle and life skills intervention was delivered by specialist clinical staff (nurse, dietician and exercise physiologist) and youth peer wellness coaches. The importance of the intervention lies on the fact that antipsychotic medication frequently induces clinically significant weight gain.

Individualised care has been connected with a care pathway programme for mental health residential services. Care pathway programme emphasises individualised care for people with serious mental illnesses. In this programme, the strengths and individual goals of service users were assessed. Individual goals will be set together with healthcare professional, and these goals are written on a personal plan. Personal plan are used to decide what kinds of interventions are suitable to help the service user reach their goal [34].

Schneider et al. [35] planned to investigate the efficacy of an individualised metacognitive therapy programme (MCT+) for psychosis. The individualised version of the intervention was developed to allow for more detailed targeting of patient-specific problems, and therefore it should be used for individual persons only. Although the programme is highly structured and fully manualised, the therapist can select the therapy units that fit best to the patient's current difficulties and cognitive biases [35].

Further, Velligan et al. [36] examined the short-term efficacy of two treatments using environmental support to improve behaviours in individuals with schizophrenia. In this study, environmental support meant signs, alarms, pill containers or checklists. In the study, a group of patients participated in the treatment called 'cognitive adaptation training' (CAT). The training is a manual-driven set of environmental supports, which are customised based on individual's cognitive impairments and behaviours. They are further established and maintained in participants' homes on weekly visits. In the second group, 'Generic Environmental Supports' (GES) offered a generic set of supports given to patients at a routine clinic visit and replaced on a monthly basis. After 3 months, patients in both CAT and GES groups had better global function than those participants who continued in usual care. Further, patients in 'cognitive adaptation training' group were more likely to improve on, for example, orientation, hygiene and medication adherence.

Individual Placement and Support (IPS) is an approach used in the United States of America to improve employment rates for persons facing significant barriers. The IPS is an evidence-based programme, which includes a set of core principles, such as small caseloads, integrating treatment teams into vocational plans, no exclusion criteria, rapid job search and services provided in the community. The core components support the implementation of the principles: job exploration, individualised planning, job development and job carving, job coaching and natural supports. The programme has successfully used for persons with serious mental illness [37, 38]. More recently, IPS has been found to be more beneficial than a job club in working with individuals with severe mental illness who have legal convictions, misdemeanours or felonies [39].

13.5 Realisation and Impact of Individualised Care

It has been evaluated that patients with schizophrenia who have received individualised care interventions may have improvements in cognition and reduction in psychiatric symptoms [23] compared to treatment groups without individualised components. Health promotion of patients with severe mental illnesses seems also to benefit from individualised care planning: positive outcomes may be seen in actual physical health of individuals and in mental status as in patients' own satisfaction with their physical health [24]. In care of depression, realisation of individualised care has been showed to increased commitment to treatment and lead to reduced dropout from treatment [9].

In psychiatric inpatient settings, reduction in use of seclusion and restrains has been detected as a result of primary nursing care model. This has been estimated to be an outcome that nurses spend more time with patients and that nurses are able to recognise developing patient crisis earlier and they are more familiar how these crises would be managed when they know the patients in more individual level. Patients' has been also more aware who their primary nurse is after more individualised practices had been introduced [25].

Dechamps et al. [40] used the cognition-action (CA) intervention for severely deconditioned institutionalised old adults to reduce their behavioural disturbances. Patients received short bouts of 5–15 min and accumulated 50 min of interaction per week. Intervention included five standardised exercises as tools to enhance communication and social interactions between staff and old adults. The study showed that for institutionalised old adults, the combination of tailored guidance and simple standardised exercises can be an effective behavioural management approach for behavioural disturbances reduction and functional autonomy improvement.

For nurses, the introduction of primary nursing has had positive impact on nurses work satisfaction [25] and led to reduction in job turnover [31]. Mental health nurses, for example, have assessed how individualised care has realised in their daily practice. In generally, mental health nurses' assessments have been positive. They have perceived that nurses support well patients' individuality through nursing activities in clinical situations. For example, nurses talk with patients about their needs that require specific attention. Nurses also take into account the meaning of the illness to the patient personally [26].

On the other hand, opposite results have also been found when outcomes of primary nursing have been evaluated by asking nurses' thoughts about ward environment [29]. Like any other approach, individualised care may also include practical and ethical issues, which should be taken into collaboration in care environment. For example, the change towards more individualised care practices may cause resistance in psychiatric care, which was seen, for instance, when nurses assessed that ward atmosphere weakened as a result of introducing a working method, primary nursing, which they did not consider themselves as superior working style [29]. Individualised care of patients may also lead to incoherent treatment practices [3]. If 'individuality' means totally unstructured and invisible approaches, it cannot be measured or subjected to audit. For instance, it has been stated that nurses assess patients' needs and mental status in very different ways and using different concept areas [41]. This may result that professionals hide behind concept of 'individualised care' and are reluctant to open treatment practices to others or write them down [3].

13.6 Discussion

Individualised care in mental health and psychiatric services seems to be an integral element of care provision. Psychiatric care has traditionally been based on interaction between a professional and a patient [42], which provides a good starting point for creating individualised care. In its basic form, manifestation of individualised care in mental health area can be seen to lie on practice of primary nursing, where every patient is met as an individual with unique needs, problems and goals [6].

Besides nursing care practices, individualised care realises in different psychological and psychosocial interventions, which are structured, but able to be tailored based on individual needs. Instead of providing all patients the same therapy treatment, individual patients' preferences can be taken into account when there exist two or more treatment options which have been shown to be equally effective [43].

Besides, providing an opportunity to make individual care decisions has been evaluated to lead to higher patient satisfaction, increased treatment engagement and better treatment outcomes as well [9, 23, 24, 43], and individualised care for patients with mental illnesses is rewarding also to a professional [25]. As its best, it empowers professionals who know the patient best to coordinate the care based on individual needs and creates an environment where mental health professionals feel they make a difference [44].

However, there is still a lack of evidence-based and robust studies of individualised care in mental health area [45, 46]. For example, primary nursing care model has been launched decades ago, but still its realisation possesses challenges [25, 47]. There may also be doubts about the quality of care: patients may not have individualised treatment plans [47], or they are not aware who is responsible of planning, implementing and assessing their care based on their needs [48].

The future of individualised care in mental health and psychiatric care may lie on advances of personalised medicine. We may be able to predict disease vulnerability based on, for example, individuals' genetic information, other biomarkers and environmental exposures [49]. Thus, preventive mental health work could be targeted for individuals in risk of developing a mental illness. In future, especially pharmacology treatments could be optimised based on the individual patients' biological characteristics [49]. Although some promising results in this field have been achieved, personalised medicine is in its early development stages in psychiatric care [50]. While waiting for scientific breakthroughs in more enhanced prevention of mental illnesses and optimised drug therapies, clinical practice and mental health professionals need to ensure that each patient receives well-planned care of uniform quality with full respect, taking into account individual's needs and preferences.

Conclusions

A connotation of the concept of 'individualised care' may be vague, and its meaning is unclear in the literature. There is also a great variation how the concept of individualised care has been used in different mental healthcare and psychiatric services. In addition, different interventions and programmes have been developed and implemented to support a realisation in individualised care in different target populations. Although positive impacts have been described in patient and nurse population, the effectiveness of individualised care has not been evaluated with rigour and robust research methods.

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