Originalia

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Mental health professionals discussing spiritual care for psychiatric outpatients: a qualitative study of multidisciplinary meetings

Wie psychiatrische Gesundheitsfachkräfte Spiritual Care für ambulante Patienten diskutieren: eine qualitative Studie

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Abstract:

Background: Spirituality is an important aspect of health and so is spiritual care in healthcare. Mental health organizations reach out in the community through ambulatory care. It is unknown, however, how mental health professionals provide spiritual care to outpatients.

Aim: To explore how mental health professionals address spiritual care for outpatients in weekly multidisciplinary care meetings (MDM), and to explore the barriers and facilitators in the ways health professionals address spiritual care in those meetings.

Method: Two teams of mental health professionals providing care for psychiatric outpatients are included. Qualitative data were collected from audio recordings of multidisciplinary meetings and from focus-group interviews afterwards. Data were analysed using 'open coding'.

Results: Spiritual care was not frequently addressed mostly due to the requirements of the health insurance reimbursement system. Aspects of spirituality addressed in these meetings pertained mainly to meaningful daily activities. Addressing spiritual care was facilitated, on the other hand, by a holistic focus on health and recovery-oriented care.

Conclusion: In ambulatory mental healthcare spirituality is sparsely addressed and, when addressed, few aspects of spirituality come into view. Facilitating healthcare professionals' awareness of their clinical perspective is an essential step to improve spiritual care for psychiatric outpatients.

Key words: Spirituality, psychiatry, ambulatory care, mental health, spiritual care, outpatients

Zusammenfassung:

Hintergrund: Spiritualität ist ein wichtiger Aspekt in der Behandlung und Pflege von Krankheiten. Derzeit bemühen sich Institutionen der psychiatrischen Versorgung in den Niederlanden um eine Erweiterung der ambulanten Versorgung. Bisher unbekannt ist jedoch, wie diese Institutionen Spiritual Care in die professionelle Arbeit mit ihren ambulanten Klienten integrieren. Wenn die psychiatrische Versorgung um diesen wichtigen Aspekt ergänzt werden soll, muss mehr darüber bekannt sein, wie die zuständigen Teams die Aspekte von Spiritual Care diskutieren.

Ziele: Es soll untersucht werden, inwieweit sich Fachkräfte der ambulanten psychiatrischen Gesundheitsfürsorge in ihren wöchentlichen multidisziplinären Sitzungen mit Spiritual Care befassen. Ebenso sollen Faktoren identifiziert werden, die die Diskussion von Spiritual Care – Aspekten in diesen Besprechungen unterstützen oder behindern.

Methode: Inkludiert wurden zwei multidisziplinare Teams der ambulanten psychiatrischen Gesundheitsfürsorge. Aus den Audioaufnahmen der Besprechungen und nachfolgenden Fokusgruppe-interviews wurden unter Berücksichtigung von Freiwilligkeit und Anonymität qualitative Daten gewonnen und anhand von 'Open Coding' analysiert.

Ergebnisse: Aspekte von Spiritualität, die in diesen Sitzungen diskutiert wurden, betrafen hauptsächlich sinnstiftende tägliche Aktivitäten sowie bedeutungsvolle Beziehungen mit anderen, allgemeine Lebenszufrieden-

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heit, Identitätsfragen und religiöse Anbindung. Insgesamt wurden Spiritual Care – Aspekte nicht häufig diskutiert. Positiv wirkte sich aus, wenn das Team deutlichen Wert auf ganzheitliche und „recovery-orientierte" Versorgung legte.

Schlussfolgerung: Trotz des begrenzten Umfangs dieser qualitativen Exploration wurden erste Eindrücke und Erwartungen bestätigt. Wo Spiritual Care überhaupt diskutiert wurde, wurde nur wenigen Aspekten Aufmerksamkeit geschenkt. Wenn das Spiritual Care – Angebot für ambulante psychiatrische Patienten weiterentwickelt werden soll, muss ein Bewusstmachungsprozess in den Teams der psychiatrischen Gesundheitsfachkräfte angestoßen werden.

Schlüsselwörter: Spiritualität, Psychiatrie, ambulante Pflege, ambulante Patienten, Spiritual Care

Introduction

Background

There is an emerging literature pointing to the role of spirituality in physical and mental health (Ross 2010; Koenig, King & Carson 2012; Grabenweger & Paal 2020). To include spirituality in healthcare, therefore, healthcare organizations develop models for holistic, patient-centred care (Luxford et al. 2011). The "patient-centred" concept of "positive health", for instance, considers spirituality as one of the six dimensions that determine a person's health (Huber et al. 2016). In mental healthcare, especially, "recovery-oriented care" is an important development in patient-centred care which integrates spirituality (Storm & Edwards 2013). Leamy et al. (2011), lastly, developed a framework including five recovery processes – connectedness, hope, identity, meaning in life, and empowerment – which correspond closely to aspects of spirituality.

Swinton and Gibson define spiritual care for patients with mental disorders, then, as paying attention to issues of meaning, purpose, hope, value, connectedness in relationships and, for some, to faith and God (Swinton & Gibson 2017: 846). According to them, spirituality determines how patients understand and live their lives and their mortality in relation to their experience of meaning and value. For example, they may wonder how to make sense of life and death, or try to find the courage to carry on when they suffer from a chronic mental illness (Swinton 2011).

In clinical practice, assessing and meeting patients' spiritual needs has been identified as important in the recovery of mental disorders and the caring relationship in the context of mental health (Corrigan et al. 2003; van Nieuw-Amerongen et al. 2020; Baumann, Lee et al. 2021). Psychiatric patients frequently experience anxiety, guilt, anger, and despair which can be related to spiritual issues (Koslander et al. 2009). By supporting their spirituality in healthcare, patients can achieve more inner peace, while distress and relapse can be reduced (Greasley et al. 2001). A decrease in clinical symptoms, especially anxiety and depression, has been demonstrated after spiritual interventions are applied (Gonçalves et al. 2015). Research showed that psychiatric patients often have the need to talk about spirituality with mental health professionals (Koslander & Arvidsson 2007; Mohr & Huguelet 2014; Harris 2016). Mental health professionals, then, may be expected to address the need for support of the spiritual aspects of the patients' well-being, i. e., provide spiritual care.

Research question

As part of recovery-oriented care, nowadays, many mental healthcare organizations expand care for patients with mental disorders to their own homes. In most Western countries, mental health services have transformed from clinical, hospital-centred care to integrated, community-based services (Fakhoury & Priebe 2007). In the Netherlands, however, spiritual care in nursing is still more common in clinical settings than it is in ambulant settings. Studies have explored spiritual care in residential settings in mental healthcare before (Fakhoury & Priebe 2007). However, there is a knowledge gap concerning the way mental health professionals provide spiritual care to outpatients in their own home and/or community environments. Therefore, if spiritual care for outpatients by mental health professionals is important, what is the current practice of spiritual care by mental health professionals in ambulant settings?

An inroad to this practice is to explore the ways in which spiritual care is addressed by ambulant mental health professionals in their multidisciplinary care meetings (MDMs). In these meetings, mental health professionals such as psychiatric nurses and specialized social workers discuss patient cases and explore what is the best approach for an outpatient. Insight in the way in which professional care providers address spiritual care during their MDMs may reveal how they address spiritual care in ambulant settings. Furthermore, such exploration may provide insight in factors that hinder or foster the way spiritual care is discussed in practice, and suggest strategies to improve spiritual care for psychiatric patients in ambulant settings.

Objectives

- To explore the ways in which mental health professionals of ambulatory care teams address spiritual care for psychiatric outpatients in MDMs.
- To explore which barriers and facilitators can be found in the way in which mental health professionals discuss spiritual care in MDMs.

Method

Design

This study used a qualitative design exploring the understandings and views of mental health professionals when discussing spiritual care in MDMs (Boeije 2010). An open, generic approach was followed, aimed at a rich description of a thematic analysis of the recorded team discussions (Kahlke 2014). Focus-group interviews were conducted afterwards to explore factors forming barriers and facilitators of discussing spiritual care in MDMs. As a guideline for the steps of the study's design the COREQ was followed (Tong et al. 2017).

Population

The population includes mental health professionals who provide care to outpatients with psychiatric disorders (or recovering from them). Two teams of multidisciplinary ambulant carers were selected, one in an urban setting and one in a rural setting, applying the purposeful sampling method (Holloway et al. 2014).

The study was conducted by a spiritual care research institute in cooperation with a large mental health organization in the greater area of Utrecht, a central region in the Netherlands. One team is located in a larger city and works with professionals from a partner organization for sheltered and assisted living in mental health. The other team was located in a smaller town and consisted of professionals from the mental health organization only.

Procedure

As a liaison, the spiritual care advisor (formerly "chaplain") of the mental health organisation facilitated the researcher collecting the data to get permission from the relevant managers and chairs of the multidisciplinary teams to record the meetings for research purposes. The researcher collecting the data organized a meeting for the professionals to introduce the procedure of the study to them. To avoid bias, the general topic was mentioned, but no specific definitions or conceptual frameworks were given. Professionals signed an informed consent form before recording the MDMs.

The study was conducted according to the principles of the Declaration of Helsinki. The privacy of participants was protected by anonymizing the transcribed recordings and keeping all data in password secured storage. The Research Review Committee of University Medical Centre Utrecht (UMCU) decided that this study is not eligible under the Medical Research Involving Human Subjects Act (in Dutch: WMO), as no patients were involved and no patient-information would be disclosed. Ethical approval was also obtained from the ethical review committee of the mental health organization where the study took place.

Data collection

Mental health professionals discuss patient cases and care plans in the MDMs each week. MDMs were recorded by voice recorder. The researcher collecting the data did not attend the MDMs in person, so that the discussionv between the mental health professionals could follow their usual routine. After the MDMs were recorded and analysed, focus-groups were organized with both teams inviting the professionals to reflect explicitly on spiritual care (Boeije 2010). The researcher collecting the data introduced the concept in more detail than beforehand and moderated the focus-groups. The spiritual care advisor of the mental health organisation liaised with the relevant professionals to support the researcher's invitation and data collection.

Three questions structured the conversation (Morrison-Beedy et al. 2001):

- To what extent do you address spiritual aspects of outpatients' needs in MDMs?
- What factors make it difficult for you to pay attention to spirituality in MDMs?
- What factors help you to discuss spiritual care in MDMs?

The focus-group session was recorded by voice recorder. Afterwards, one additional MDM was recorded to follow up on possible effects of the focus-groups on the team in discussing spiritual care, serving as a contrast case to compare whether new aspects of spirituality emerged.

Data analysis

Audio recordings of the MDMs were transcribed verbatim and analysed following the procedure of "open coding" and "axial coding" (Boeije 2010). First, after breaking the sentences of the interviews up into meaningful fragments (deconstructing), the researcher collecting the data identified appropriate codes (constructs) to the fragments, as well as relationships between codes forming groups of related codes and a structure of related code groups (reconstructing). Thus, the researcher collecting the data was able to code the data as open-minded as possible (Boeije 2010). Next, the researcher collecting the data checked the first results using aspects of a broad definition of spirituality as meaning in life (Swinton & Gibson 2017) as sensitizing concepts in order to triangulate the results. Furthermore, these steps took place in an iterative process of supervision and approval by the senior researcher and the spiritual care advisor of the mental health organisation (Verhoeven 2007). Atlas.ti software was used to process the data throughout (Hwang 2007). Due to time constraints no member check of the analysis was possible.

Results

Demographics

Data were collected from February 2018 to May 2018. Of the team from the larger city all members were present in the MDMs (N = 17). Of the team from the smaller city, only those professionals involved in a case under discussion were present in the MDM (N = 21). Both teams included professionals from various disciplines, with a large majority of (mental health) nurses and social workers appointed as "case managers". A large majority of both teams had considerable work experience in an ambulant setting. Nearly all participants were older than 30 years of age (Table 1).

Table 1: Participants' demographics

Teams	n = 17 + 21	%
Gender		
Male	14	36.8 %
Female	24	63.2 %
Discipline		
(Mental health) Nurses	4	
Case manager	15	
Psychiatrist / psychologist	8	
Peer support worker	5	
(Personal) Recovery coach	5	
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 %

MDMs: aspects of spirituality

Of each team, five MDM meetings were recorded with a duration between 25 and 55 minutes. In the verbatim description of the MDMs, patients' cases were summarized; because of patient confidentiality no quotes are made available.

The MDMs usually began with the introduction of a patient case or a patient treatment plan. Next, questions are discussed about the treatment plan and options are discussed. The four dimensions of the treatment plan, namely mental well-being, social well-being, physical well-being, and jobs/daily activities, are then discussed. The professionals use the discussions in the MDMs to plan interventions, coordinate care, and evaluate the treatment plan. Compared to the working definition (Swinton & Gibson 2017), aspects of spirituality implicitely addressed in these meetings included meaningful daily activities, meaningful interaction with others, satisfaction in life, personal identity, and religious beliefs.

Meaningful activities

In six out of ten MDMs, spiritual aspects relating to meaningful daytime activities for the patients were discussed. This is usually explained from the perspective of the patient. There were cases where professionals stated that patients found satisfaction in their daily activities. These referred to patients who undertook activities such as working a job, doing voluntary work, and having a hobby. Noticeably, meaningful activities were discussed more than other aspects and more often led to interventions in spiritual care.

Meaningful interaction

Another aspect of spirituality evident in MDMs was whether patients experienced or did not experience connectedness with significant others. One case described a patient who became more active in meeting friends. In another case, a patient was discussed whose children gave her a sense of meaning in life. A third case illustrated a grandfather who could not feel emotions 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 happy to live close to his family. In the same MDM, a patient was discussed who felt depressed and no longer experienced a meaningful life. The background of these feelings was hardly explained. Professionals also discussed the case of a young patient who worried about his future and what he found important to achieve in his life.

Personal identity

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

Religious belief

In three MDMs, a brief comment was made or a brief description given concerning a patient's religious beliefs, without further clarification.

Focus-groups: barriers and facilitators for spiritual care

During the focus-group interviews, mental health professionals were asked to reflect explicitly on spiritual care for psychiatric outpatients and, especially, which factors influenced their discussion of spiritual care. Quotes from the focus-groups are shown in Table 2.

Concerning a definition of spirituality, the understanding of spirituality differed from participant to participant. Most participants viewed spirituality as something that pervades all areas of life. Some participants found Swinton and Gibson's definition of spirituality too broad or heavy-handed (Swinton & Gibson 2017). The question was also raised whether there must always be meaning in life or whether life sometimes simply does not make any sense. Some participants suggested that spirituality is linked to meaningful relationships, a feeling of belonging, developing one's personal identity, and finding and fulfilling one's role in life. It was observed by the participants that the voice of the patient was sometimes absent in the MDMs. Explicit mention was also made of the current place and the desired place of spiritual care in treatment and in MDMs.

In the analysis of the focus-groups, the following factors inhibiting or improving spiritual care were identified.

Table 2: Quotes from MDMs

Q1	'You are busy enough as it is to keep someone on track.'
Q2	'We are not very conscious about it or you remind yourself afterwards. Oh, that also gives hope, but it is not that you talk about hope.'
Q3	'When everybody has very full agendas, yes, you also quickly think, well, I do not have to make a point of this right now.'
Q4	'Well, I do think it is desirable, but now it cannot be done differently at the moment, that is why core discussions of the MDMs takes place outside the MDM.'
Q5	'Over the years, and that's what I really think is a development, it becomes more and more what we have to check.'
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 is able to live a meaningful life again.'
Q7	'Anyway, there is a big difference between, for example, a patient who is in the clinic or who is supported by a FACT team. Of course, in the FACT team we look much more at all areas of life.'
Q8	'I think it is really a problem to see these two things separately from each other, mental health and meaning.'
Q9	'I think the knife cuts on both sides, so to speak. Because it is nice for the therapist, I think that addressing spirituality in that sense also gives satisfaction.'
Q10	'Because he also has a different perspective on someone and a recovery process and so can sometimes also alert us to things.'

Clinical focus

When a patient is in psychiatric distress, professionals seem focused primarily on medical treatment (Table 2, Q1). When there are more pressing matters, say when a patient is accumulating financial debts or needs shelter, spirituality is not given priority. Team members stated that it depends on the patient whether spirituality is important. Usually, psychiatric diagnostics is given higher priority than spiritual care. According to the professionals, an adequate diagnosis is a condition for the support they can give a patient in leading a meaningful life.

In one of the teams, professionals stated that they were still working on ways to improve patient discussions in MDMs. Team discussions usually followed a model in which spiritual care is not included. Participants indicated that they themselves are not always aware of the importance of the patient's spirituality (Table 2, Q2). Implicitly, they reflected, 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 documentation, but spiritual care is not always requested or described on the basis of this.

Time constraints

Time is limited in MDMs, professionals say. In a weekly meeting of one hour, four to five care plans or treatment plans need to be discussed; there are about fifteen minutes available per patient case. Limited time can lead to less thoroughness in the discussion of cases or, at least, fewer topics. When time is short, as we saw, professionals give priority to medical issues instead of spiritual aspects (Table 1, Q3). Additionally, another factor is the work load of each individual professional, which can lead to not addressing potential spiritual issues.

In one team, the goal of MDMs was generally perceived as going through treatment plans in a short time. Professionals, consequently, often discussed parts of a treatment plan outside the MDMs (Table 2, Q4). Participants did not find this way of working desirable, but they stated that they didn't know how to do it in another way.

Health insurance system

Professionals were mainly focused on the medical aspect of treatment because health insurance requires reporting diagnoses and treatment goals that can be justified within the reimbursement system. In Dutch mental healthcare organizations, the diagnosis, interventions, and costs are recorded in pre-given "diagnosis-treatment combinations". In this system, medical treatment aims at reducing psychiatric symptoms. Not only do professionals mention that this system leads to a high administrative burden and thus to time constraints. Certain interventions in the care plan will meet the requirements for reimbursement while those not directly reducing symptoms will not (Table 2, Q5). Prioritizing these requirements does not stimulate the inclusion of other aspects like spiritual care in care plans.

Disciplines

A given patient case is introduced in the MDMs by the professional with an assigned responsibility for that patient (usually as "case manager"). Not every care provider has this professional role, however, such as peer support workers and spiritual care advisors. "Peer support workers" are trained care providers with first-hand experience of mental disorder (Jacobson et al. 2012). A peer support worker can relate to patients on a more personal level. Some professionals admit to see spirituality as an aspect of wellbeing outside their professional domain, and spiritual care as a role for peer support workers or chaplains.

Next to negative factors for spiritual care the following positive factors could be identified in the analysis of the focus-groups.

Holistic focus

Participants indicated that viewing from the holistic perspective of "recovery-oriented care" helps them to be more concerned with the patient as person, who they want to be, and how patients can live meaningfully with their illnesses (Table 2, Q6). They noted that there has been a shift in the attention given to spirituality over the years. One of the reasons is the development of Flexible Assertive Community Treatment (FACT) teams. A distinctive part of working in a FACT team is the broad focus on all areas of life (Table 2, Q7). By discussing all areas of life, the topic of spirituality is mentioned more often.

Another improvement is that the definition of health has changed over time. In the focus-groups, it was mentioned that mental health is no longer seen as 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 influential concept of "positive health" developed by Huber et al. (2016).

Some professionals stated that they did not see the "DBC system" as the end of the matter in discussing topics such as spirituality. Participants called spirituality the energy source from which patients draw on for their recovery and wish to take time in the MDM to discuss a treatment plan adequately. Professionals believe spirituality is valuable in treatment, and they added that providing care in the area of spirituality gave them satisfaction in their work (Table 2, Q9). Supporting a patient with spiritual problems was regarded as a worthwhile role for professionals.

Multiple perspectives

Participants stressed that collaborating with different disciplines in a team helps to reinforce each other's treatment methods. The appointment 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.

Contrast case

In the additional MDM, monitored after analysis of MDMs and focus-groups, spirituality was mentioned explicitly twice. One patient made great progress taking up an old meaningful hobby after significant time of impassivity. In another case, a professional asked her colleague what the patient would like to do if she no longer suffered from her illness. The colleague explained which activities the patient would like to undertake again. Both cases involved the category of meaningful activities and in that sense no new information was found.

Discussion

Strengths and limitations

This study provides insight in the ways ambulatory mental health professionals understand and address spiritual care for outpatients and reflect on their own practice. Analysis of MDMs shows more clearly how spiritual care is discussed in actual cases, whereas mere interviews might not. Furthermore, the choice to select two teams different from each other in several respects while yielding comparable results reveals how spirituality is addressed in multidisciplinary teams and increased the generalizability of the results to other ambulatory mental health settings.

Although steps were taken to influence the respondents as little as possible with input on spirituality prior to the recordings, it is hard to say in just how much information about the study and the mere presence of the spiritual care advisor had on the meeting. From the focus-groups and the concluding MDMN recording it can be inferred that insight in aspects of spirituality and in factors influencing spiritual care increased after the recording MDMs. This suggests that for the respondents the weekly MDMs felt like "business as usual" and researcher bias was indeed kept to a minimum.

A limitation of this study may be, however, that this type of MDMs is perhaps not representative of ambulatory mental health in other organizations, nor of their approach of outpatients' wellbeing and the way spirituality is addressed. Especially, on the basis of this study it cannot be said the results hold for clinical settings. Also, given the limited number of MDMs included in the study generalizations can be made only cautiously. Lastly, the possibility cannot be excluded that the participants gave socially desirable responses to some degree, as they knew their discussions and reflections would be recorded and analysed.

Theoretical and practical considerations

Aspects of spirituality in multidisciplinary ambulatory mental health meetings included meaningful activities, interaction with others, satisfaction in life, identity, and religion. This covers part of the working definition used by Swinton and Gibson (2017). Meaningful activities received the most attention by far, however. Other aspects received less attention, or the perspective of patients was absent altogether. According to our study, this seems due to limiting conditions like the clinical focus of the professional, time constraints, coupled with the demands of the insurance system. An earlier study of spirituality and its role in recovery in patients with schizophrenia confirms that professionals concentrate on relieving symptoms and increasing social acceptance when providing spiritual care (Ho et al. 2016). It confirms that professionals see patient care primarily from a medical perspective. Another reason why mental health professionals seem inclined to forgo spirituality in care plan meetings is offered by van Nieuw Amerongen et al. (2018). Her study suggests a "religio-

sity gap" between professionals and patient population, meaning that in a secular setting professionals themselves have a less religiosity and/or spirituality-oriented outlook on life than patients. Oxhandler (2017) adds that professionals who tend to recognize "the sacred" in themselves are also more inclined to recognize "the sacred" in others.

Koslander et al. (2019) confirm the shift in mental healthcare from the biomedical perspective care to holistic care. The biomedical perspective is focused primarily on treatment of diseases. Professionals in our study indicated that concentrating on medical issues limits the time to give attention to spirituality. Another study of how clinicians cope with spirituality with patients suffering from chronic psychosis confirms that spirituality is not discussed because of insufficient time (Borras et al. 2010). This study also found that clinicians had a lack of knowledge or awareness that spirituality is important to patients. This is not evident in our study; professionals indicated in this study that it is important to pay attention to spirituality, but sometimes saw little opportunity or professional language.

Other conditions stimulated discussing spiritual care, such as a changing perspective on health and care, taking into account multiple perspectives. The changed focus of professionals which Koslander et al. (2009) and Huber et al. (2016) describe, then, proved an important factor in facilitating discussion of spiritual care. In addition, a recovery-oriented care perspective leads professionals to pay more attention to spirituality. Huguelet et al. (2016) show that a quarter of patients in their study reported that spirituality is important in their lives, and positively associated with social activities, self-esteem, and quality of life. A holistic perspective on patient-centred care is recommended (van Nieuw Amerongen et al. 2019).

Conclusion

This study describes the ways in which some mental health carers discuss spiritual care in MDMs in ambulatory care. The analysis of the MDMs suggest that professionals mainly concentrate on spiritual issues in as far as they affect short-term well-being such as meaningful daytime activities and relationships. Several preconditions for providing spiritual care influence the discussion of spiritual care in MDMs. Facilitating a recovery-oriented perspective and other holistic, patient-centred approaches can widen the focus from primarily medical issues to discussing long-term well-being and spiritual care more broadly. As spiritual care partly proves to be a matter of awareness, knowledge and perspective, our study suggests points of interest for professional training. Lastly, this study concentrates on the practice and perception of mental health professionals. Further research should explore other factors in practice as well, not in the least the experiences and needs of patients in terms of spiritual care.

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