Review Article

Person-Centredness in Mental Health Care, a Contextual Framework for Nursing Aimed at Promoting Shared Decision Making and Self-Management

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Introduction

In this article we will reflect on challenges for nurse pratitioners facing changes in modern health care, especially in mental health care. We will formulate some critical questions concerning the competences that nurse practitioners must develop in order to cope with patient needs. There are demographic developments that cause an increase of chronic diseases and more comorbidity. Our ideas about health and how to realize good health are changing. The focus is now much more upon living with chronic diseases, accepting that total cure can not always be realized, and trying to have a good quality of life. At the same time policymakers recognize that the rising cost of health care threatens to become uncontrollable, so they instigate policy measures aimed at more efficiency, for instance by promoting stepped care, that is cheap light forms of care where possible and more expensive high care, often in hospitals, where necessary. In our opinion the problem of aging, rising prevalence of chronic diseases, of health-care consumption, of rising health-care costs, and changing needs of health-care consumers are not only restricted to the Netherlands but form a global problem. In the Netherlands this provides new opportunities for nurse practitioners. In 2015 the Dutch Committee on 'Innovation in Healthcare Professions' (commissioned by the Ministry of Health) has issued an opinion on the organization of affordable and accessible health-care in 2030 (Zorginstituut, 2015). This commission assumes: 1) according with Huber et. al. (2011), that health is the ability to adapt and self-manage social, physical and emotional challenges and that health is not a 'state of complete well-being', as the current WHO definition of health assumes , 2) not everything which is possible, should be done, and 3) in first instance, patients should be guided and supported by generalists and not by specialists. According to this committee, nurse practitioners can play a central role in these developments as they are familiar with a lot of healthcare professionals and they focus on the patient. In line with the Dutch Committee on 'Innovation in Healthcare Professions', we assume that shared decision making, co-creation, and self-management will be important concepts of the next decade within the healthcare system. To realize shared decision making and self-management in practice, collaboration is necessary, i.e. collaboration between the healthcare professional and the patient, between the healthcare professional and the family and informal networks around the patient, between healthcare professionals with various backgrounds, and between institutes.

The underlying new concept on Health is to see health as 'positive health' (see definition below). We do not any longer follow the concept of health as a state of complete physical, mental and social well-being as this concept (formulated by the WHO in 1948) implicated that many people must be classified as ill even where they coped with their disease very well and they themselves would not describe themselves as ill.

"Health is the capacity of people to adapt and direct their coping with adversities of life against the background of physical, emotional and social challenges. Being healthy means to be able to adapt to disruptions, show resilience and maintain a balance of refind this balance physically, mentally and socially "(Huber et al, 2011).

Coping with symptoms of an disease and being able to adapt to disruptions, showing resilience and maintaining a balance or refinding this balance physically, mentally and socially means that health professionals must facilitate this. The role of nurses to support this process becomes more and more important as we move into an era of personalized health care with treatment 'tailored' to the specific individual needs of the patient. These specific individual needs will often depend on where the patient stands in the transition stage from health to illness and vice versa and the incurring consequences this can have for daily life. Transition moments as defined by Tomlinson (1996) are "a movement' from one state to another that is accompanied by change in roles, relationships, or patterns of behavior" (in: Marineau, 2005). Transition moments concern turning points in the life course or in the career as a patient with a necessity to reorient oneself on one's past, the present situation and the future still to come. Meaning must be found in a new situation, losses must be integrated in one's life, a new balance (re-) established and a new identity may even be wanted. According to Meleis (2000) it is the task of nurses to support patients during transition moments and pay attention to essential aspects inherent to the experience of transition: awareness, engagement, time span, the relevance of critical points and events and how these are experienced. Dealing with these aspects in a good way is what positive health is all about and may contribute to vigour (vitality) and the strength to move on to a new phase in life. Patient resilience and capacity for self management will be strengthened ánd quality of life will improve (Huber &

Staps, 2016). In mental health care the taking of one's life in own hands again, (re)finding a positive identity and start living according one's values, is often called: recovery.

The question now is how nurses in mental health care can deal with all the demands that are made on their competences, from the perspective outlined as above. We think the answer can be found with person-centredness.

Person-Centredness

What is person-centredness? McCormack, one of the leading theorists for person-centredness stated: "Person-centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development." Other authors talk about patient-centredness and Patient-Centred Care (PCC), but 'person-centredness' is more accurate in its emphasis on personhood and the essential view that the person is more than a patient alone and should be approached as such. This is very much in line with holistic and humanistic nursing (Peplau, Travelbee, Watson and others).

How do these dimensions fit into a framework that encompasses care as a organizational model? McCormack and McCance adopted a system-oriented approach to develop a person-centred framework (Figure: 1). There are 'prerequisites' on the level of the individual carer: person-centred care can only be given when the nurse is professionally competent, has developed interpersonal skills, is committed to the job, shows clarity of beliefs and values and has introspective skills. This is the level of competency. Nurses apply this competency in a care environment that in itself can be more or less contributive to person-centred care, depending on critical attributes. Shared decision-making for instance is conditional on how power is shared within multi-disciplinary teams. There is a synergistic relationship between caring and person-centedness, that expresses itself on the organizational level in a learning environment offering nurses also the prospect of professional growth, mutuality and collegiality. The healthcare organization should be 'human-centred' not just patient-centred, "where all stakeholders, including healthcare managers and other frontline staff, are engaged in creating effective and responsive systems of care" (Shaller, 2007, quoted by Pelzang, 2010). This has an emancipatory and transformational impact.

Within the environment of person-centered processes the following activities are deployed: working with patient's /families beliefs and values; engagement; having sympathetic presence; sharing decision making; providing holistic care. Shared decision making and recognizing the patient as a person are considered the two main factors (Dwamene et al, 2012; De Boer, 2013). The person-centred processes must lead to outcomes (most inner circle in the figure). These are twofold: subjective ones and objective health related ones. There is satisfaction with care (experience of good care); being involved with care; feeling of well-being. There are the more objective results as: health behavior and health status (see the Cochrane review by Dwamena et al, 2012 for the effects of training providers in PCC).
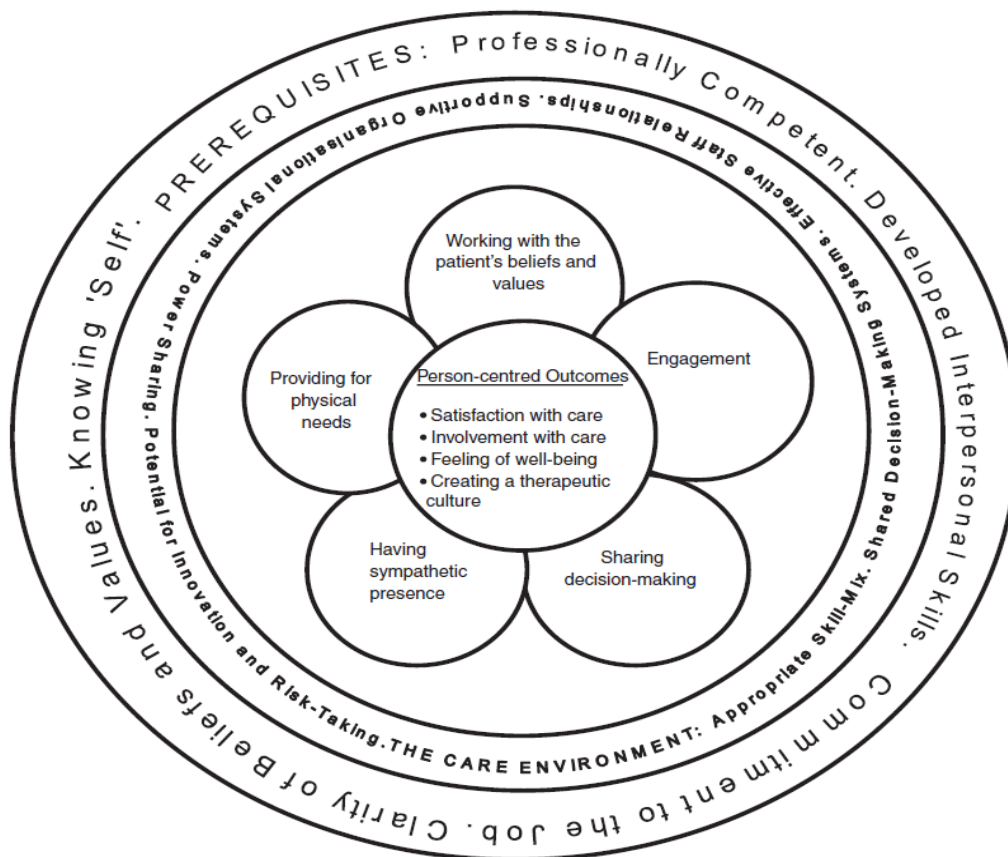
B. McCormack and T.V. McCance

Figure 2 The person-centred nursing framework.

Figure 1: The person-centered nursing framework (copied from McCormack & McCance, 2006)

Holistic care can be 'evasive', so the challenge is to close the gap between rhetoric and reality. This asks for an operationalization of nurses' competences. From a range of studies we arrived at the following competences (Hudson et al, 2012).

1. The nurse involves the patient in decision-making and provides information to that end.
2. Exploring both the diseases and the illness experience.
3. Consideration of the patient's beliefs and values.
4. Engagement.
5. Having a sympathetic presence.
6. Finding common ground.
7. Incorporating prevention and health promotion.
8. legitimizing the illness experience, acknowledging patient experience, offering hope and providing advocacy.

We consider 4 and 5 as conditional for 6 finding common ground and 1 shared decision-making. We would therefore not focus on attentiveness, empathy, responsiveness or even presencing (all aspects of 4 and 5 and which have been dwelt on in Sitvast, 2016; 2017). These can be considered as generic and basic competences while we search for competences on master level.

Applying Competences To Shared Decision Making And Self-Management

When applying these competences to our core themes, shared decision making and self-management, then we may formulate the following critical questions:

Recovery And Social Inclusion: How can nurses help patients explore the meaning of the disease and illness experience and take into account (consider) their beliefs and values as prerequisite for dialogue, finding common ground and shared-decision making in the context of recovery and social inclusion?

('How' meaning: what must nurses on master level know, be able to do (skills) and what values must they be aware of and adopt?)

Mental Health Promotion And Prevention: How can the articulation of the patient perspective be facilitated by the care professional to promote an intrinsic motivation for self-management of health behavior and a healthy lifestyle (and integrate this in their patterns of daily life)?

Family And Carers: Expanding the critical questions mentioned above to include family and other carers, we arrive at: How can nurses involve family and other carers in this process of finding common ground (see above) and engage their point of view and perspective to realize a balanced triadic shared-decision making in matters of treatment and support?

('balanced' meaning that the weight of professional responsibility, the patient perspective and the view of family/other carers in the decision making can vary from one case to another, depending on contextual factors).

We postulated elsewhere (Sitvast, 2018) that central issues in promoting self-management are: awareness and goal readiness and that professionals could contribute to them by:

• Keen understanding of what awareness and goal readiness takes
• Person-centred approach
• Narrative-orientation
• Being relation-oriented
• Assessing needs and risks

• Coaching skills (how to cope with a disease)

We have expanded on these points in our earlier work and in a monograph that will be published shortly (Sitvast, in press). One example of nurses assisting patients in creating awareness and goal readiness will be described here and that is using photography as a therapeutic medium. Patients will make photographs supported by assignments. Patients will then be invited to reflect on these photographs and make them part of a visual narrative. The focus will be on how to live a valued life with an illness or disorder and what this means for illness management, lifestyle decisions, spirituality, etc. The photo-instrument, developed by the author (Sitvast, 2008; 2013) is one intervention that has been researched for how it inspires patients to goal setting in the context of self-management and shared decision making. It has been tested for mental health illness and cancer(2013; 2016a; 2017a). It can be implemented and pilot tested again to fit local context and specific target populations. The aim of the intervention in this context is to generate an inventory of values and strengths (the so called "values compass") –made visible in photographs and storied in narrative-that serves the patient to make better choices for his individual self-management or recovery trajectory (Sitvast, 2019). The emphasis on making one's own photographs and narrating what they mean to the maker guarantes a certain equivalence in the relationship with the professional (the nurse directing the photogroup) which is a condition for shared decision making.

Discussion and Conclusion

The aim of this article is to describe the scope of research that the author has been involved in and which to his opinion is contingent on changes in modern health care and society. The three critical questions may be useful to guide future research and the training/education of nurse practitioners in mental health care. We have not touched on the complex coherence of aspects of self-management and shared decision making and how they relate to professional competencies. We believe that this should be the subject of further nursing research.

References

1. De Boer D, Delnoyy D, Rademakers J. The importance of patient-centred care for various groups. Patient education and Counselling. 2013;90:405-410.
2. Dwamena F, Holmes-Rovner M, Gauldan CM, Jorgenson S, Sadigh G, Sikorskii A, et al. Interventions for providers to promote a patieny-centred approach in clinical consultations (Review). The Cochrane library. 2012;12;CD003267.
3. Huber M, Knottnerus JA, Green L, Horst HV, Jadad AR, et al. How should we define health? BMJ. 2011;343:d4163.
4. Huber M, Staps S. Self-management for health and environment: Time for a new approach-position paper. Louis Bolk Instituut en Institute for Positive Health White Paper. 2016.
5. Hudson C, Fortin M, Haggerty J, Loignon C, Lambert M & Poitras ME. Patient-centred care in chronic disease management: a Thematic analysis of the literature in family medicine. Patient Edcation and Counselling. 2012;88:170-176.
6. Marineau M. Health/illness transition and telehealth: A concept analysis using the evolutionary method. Nurs Forum. 2005;40:96-106.
7. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the literature. Social Science & medicine. 2000;51:1087-1110.
8. Mcormack B, McCance TV. Development of a framework for person-centred nursing. Nursing Theory and Concept de-

velopment or Analysis. 2006;472-479.

9. Mcormack B, Dewing J, McCance T. Developing person-Cented Care: Addressing Contextual Challenges Through Practice Development. Journal of Issues in Nursing. 2011;11.

10. McCormack B, McCance T. Person-centred Nursing. Theory and Practice. Oxford: Wiley-Blackwell. 2010.

11. Meleis AI, Sawyer L, Im EO, Messias DK, Schumacher K . Experiencing transitions: An emerging middle-range theory. Adv Nurs Sci. 2000;23:12-28.

12. Pelzang R. Time to learn: understanding patient-centred care. British Journal of Nursing. 2010;19:912-917.

13. Sitvast J, Abma TA, Lendemeijer HHGM, Widdershoven GAM. Photo stories, Ricoeur, and Experiences from Practice: a Hermeneutic Dialogue. Advances in Nursing Science. 2008;31:268-279.

14. Sitvast J. Self-management and Representation of Reality in Photo-Stories. Advances in Nursing Science (ANS). 2013;36:1-15.

15. Sitvast J. The Engagement Model, Transition Processes and a New Definition of Health. J Clin Res. 2016;7:2155-9627.

16. Sitvast J. A Case Study "A Life with and beyond Cancer".

Journal of Palliative Care & Medicine. 2016;6:3.

17. Sitvast J. Importance of Patient's Narrative and Dialogue in Healthcare. International Journal of Emergency Mental Health and Human Resilience. 2017;19:2.

18. Sitvast J. Commentary (to 'A Case Study "A life with and beyond Cancer". Mol Oncol Res. 2017;1:928-930.

19. Sitvast J. Photography as a Means to Overcome Health Anxiety and Increase Vitality, A Local Group Intervention in an Ailing City District. SF Nurs Heal J. 2017;1.

20. Sitvast J, Van Zalk B, Klarenbeek L. Transition in Health Care and Clinical Leadership. Journal of Nursing and Health Studies. 2018;3:2-6.

21. Sitvast J. Research Proposal Self-Management and Commitment for Cancer Patients. Nov Appro in Can Study. 2019;4.

22. Sitvast J. How Nurses can Facilitate Meaning-making and Dialogue: Reflections on Narrative and Photo Stories. Cambridge Scholars Publications.

23. Tomlinson P. Martial relationship change in the transition to parenthood: A reexamination as interpreted through transition theory. J Fam Nurs. 1996; 2:286-305.

24. Zorginstituut. Naar nieuwe zorg en zorgberoepen: De contouren. 2015.