A Shared Approach to Mental Health – The Plymouth Three Lens Model

Aims

This model has been developed as a means:

a) of bringing together different ways of understanding mental health problems and their origins in order to provide coherence (rather than bewilderment) for community residents and practitioners in the face of multiple, at times competing, models and approaches, and

b) to agree practical ways forward to create a balance between the currently more dominant diagnosis-based model of practice and other important approaches including trauma-informed, strengths-based, and person-centred etc.

It has been developed by opinion leaders from VCSE, primary care and mental health care from the Plymouth and wider Devon system who have an interest in mental health. Next steps include wider consultation and testing the ideas with both communities and patients/service users and those with formal leadership roles.

Background

Diagnostic approaches to understanding distress and mental health problems (based on the broadly similar ICD and DSM approaches) have influenced the practice of assessment and treatment of mental health problems for half a century. They also influence the research which is done to test treatments and the ways services are configured. While their weaknesses (lack of objective tests, overlaps, changeability with time etc) have been acknowledged, a practical coherent alternative has not been developed. Instead, a range of other approaches to understanding and practice have been developed. These include strengths based (including Solution Focussed, Assets Based), Trauma Informed and other meaning-based, non-diagnostic approaches such as the Power Threat Meaning Framework, Open Dialogue, Narrative Therapy. In addition, a range of more generic ways of working have been developed which have the potential to bring these approaches together. These include the use of the 'psychological formulation' (developed by psychologists and psychiatrists to 'eclectically' bring in different approaches to create an individualised understanding of the person, the bio-psycho-social model, person centred (or personalised) care. Additionally, values-based approaches emphasise engagement in addressing inequalities and breaking down unhelpful power differences; and positive risk management approaches take a system approach to risk. These tend to overlap considerably but emphasise different aspects. Furthermore, there are links between these approaches and different means of treatment/support (such as the wide range of therapies, psychotropic medication and social prescribing).

Meanwhile our understanding of the brain, through the study of neuroscience, including genetics and epi-genetics, continues to highlight the lack of robustness of the diagnostic model. And also providing a scientific understanding of how trauma and loss can affect brain function, and of how current adversity can contribute to a range of psychological states mediated by brain function. In summary science and social science both point towards an as yet far from complete understanding of mental health; and that it is not just theoretically complex but also for each individual currently unknowable i.e. we can't be sure, for an individual, the extent to which trauma has caused symptoms, or about the extent to which a diagnosis based on specific criteria relates to specific underlying brain pathway problems. We propose it is important to be open and confident about these uncertainties.

Bringing strengths based, trauma informed and diagnostic approaches together

We have attempted to combine the most important features of three of the most distinct approaches (diagnostic, strengths based and trauma informed) into a coherent model by using principles from generic approaches (formulation, bio-psycho-social, person centred), neuroscience and values-based care:

Whole person bio-psycho-social mental health support will:

- *Recognise importance of past trauma, adversity and loss, current relationship challenges, social inequality and injustice and survival responses when developing an individual's shared understanding (therapists might call this a formulation) and in the plan for going forward. (i.e. the process is trauma-informed)*
- *Use the diagnostic tradition and our understanding of neuroscience to help an individual understand the different emotional and psychological experiences they have (traditionally called symptoms) and the types of self-help strategies, therapies and medications that might be helpful in the future (i.e. recognises value in diagnostic and biological knowledge of mental health).*
- *Identify personal, relational and community strengths (assets) which have contributed to skills already developed and progress to address adversity, and which could contribute to wellbeing going forward including addressing social adversity (i.e. is strengths based and socially oriented care)*

The components of the approach need to be built into the everyday lives of individuals engaged in 'self-care', the work of practitioners both in every contact and in formal therapy, and into the health system. It is work in progress; detail can be added; and there will continue to be differences of view.

Assumptions and Challenges

In order to promote this way of understanding mental health and its origins, and also to create what could be considered a more cohesive approach to organising services and support, and to being alongside and supporting individuals in distress, a set of assumptions and challenges are laid out.

1. *Language, approaches and experience of services.* While the language we use to describe different approaches and in our practice is important (having potential both to confuse and to help understanding), the organisation of support is also crucial and can lead to people feeling held and/or empowered, or bewildered, retraumatised and without agency. We need to use plain language to explain the different models and concepts and how they can be part of a coherent approach. This should both help practitioners work together in an integrated way, and also help residents in our communities understand how to get help when needed and how to contribute to the community's wellbeing. We also need to develop systems of care which reflect the coherent approach, and therefore in themselves support wellbeing and avoid harms (e.g. through being rejected, "processed", "passed around", having long indeterminate waits or discharged).
2. *Enormity of challenges but opportunities.* We recognise the significant challenges for shifting thinking and practice towards a more integrated model. Nationally there is no accepted or even proposed model for doing so coming from government, academics or professional bodies. We propose a combination of a) listening and discussion, b) development of a local plan, c) practical support.

Challenges:

- Perception that national policy requires diagnostic approach can lead to formal leaders objecting to change
- The idea of a diagnosis being an actual disease/disorder rather than a (not very robust) model has been taken up not just by non-specialist practitioners but by whole groups in the population. The benefits of diagnosis being seen as a means to mitigate blame and responsibility.
- Our models of mental health and illness pervade multiple spaces beyond health care – face book groups, the benefits system, schools

- The relatively small effect sizes of treatments are not widely recognised, and (low and higher income) communities may resist suggestions that after years of promoting the benefits of early diagnosis and treatment there needs to be shift in the other direction
- For young people in particular there is a shift to being supported by institutions (schools, universities, social care) to recognise themselves as ill and needing support from services leading to increased medicalisation
- Currently health and social care systems feel to providers at breaking point which means there is often no time allocated for reflection on what's happening or planning for changes.
- Inequalities with respect to income and protected characteristics may be worsening due to both changes in health care delivery (e.g. digital) and to promotion of need for diagnosis (e.g. requests for ASD diagnosis).

Opportunities:

- Individuals change over time – while both individual patients and practitioners may initially resist new ways of thinking about mental health, explaining but not pushing a complementary trauma informed and strengths-based model may support shift in thinking over time
- Leaders locally are engaged in discussions, understand the issues and together have the opportunity to encourage significant shifts in thinking and practice – most rules are not legal but norms and protocols developed by individuals locally so can be changed
- While not articulated explicitly the Community Mental Health Framework (CMHF) does encourage a broader approach (reporting framework is still diagnostic but outcomes framework is not)
- Trauma informed and meaning based practices, which provide an opportunity to move beyond the 'brain or blame' dichotomy has developed significant traction though community groups, practitioners and leaders, and while it can be set up in opposition to diagnostic models there is the potential for working alongside in a powerful coherent model
- The crisis in workload and workforce is an opportunity because system leaders need to recognise the need for an alternative to current practices; one which better resources and draws more heavily on strengths and opportunities in voluntary sector and communities.

Practical steps

1. **Model for practice (not discussed explicitly in meetings, this is a first go at bringing different approaches as it seems vital to find a way to do this in practice).**

The proposed model needs to work across different scenarios – supporting someone in self-care; everyday (universal service) clinical contacts; initial and ongoing contacts with specialist mental health services; formal therapy. We will describe application of the model to each scenario below. Here we describe a generic approach as three steps (not often consecutive).

A. Engagement (trust building) and past history

This important part of encounters draws on the fundamental and essential use of relational skills of relational skills tailored to the needs of the individual to build trust, and narrative approaches and person-centred approaches:

- Listening to current concerns and eliciting a narrative to gain a sense of the past and present – losses and past trauma may be brought up but before some trust is developed asking directly about these may create difficulties
- Understanding past mental health care input including diagnoses, therapies and medication (from past records and according to the individual)

- Gaining an understanding of current priorities (may be social, or emotional or physical) and goals.

B. Developing a shared understanding

This is the core of the work of bringing together trauma informed, strengths based and diagnostic approaches. Current strengths are set alongside seeing symptoms as survival strategies, and this understanding of the present can be understood as caused by past losses and traumas, as well as positive nurturing and genetic disposition:

1. Understanding symptoms (mental state) about the present (and contrasting to the past), as well as behaviours and function, might follow a system broadly aligned with psychological and psychiatric practices:
    a. Emotions: Dominance of low mood, anxiety, anger or elation? How mood is changing – with days and over time?
    b. Thinking: Clarity, attention; positive/negative re self; ability to imagine what others think, paranoia/worry about others' intentions (appropriate, exaggerated, delusional (fixed and illogical)); obsessive. etc
    c. Perceiving world around us: Feeling of being 'present' vs self/world unreal; flashbacks (as if back in a traumatic past event); voices or see things when no one present. etc
    d. Physical: Sleep, appetite, tiredness, pain
    e. Behaviours/actions (positive and negative): getting out/staying in; self-harm, looking after self; eating and substance use;
    f. Function: abilities to wash and self-care, get food etc; abilities to function in work, relationships.

2. Enquiring beyond symptoms, perhaps using the 3 Ps model, adapted to focus on positives too, provides the basis for linking current mental state causally to the past and present context:
    a. Predisposing: trauma, loss and family history, invalidating environments as well as positive, nurturing ones
    b. Precipitating: what led immediately to current situation if anything
    c. Perpetuating: ongoing stressors and social-political contexts (housing, relational, financial, (un)employment), as well as assets (friends, family, home, work)

    Note. Also acknowledging the significance of personal characteristics such as ethnicity, income, age, gender and sexuality

3. Bringing (some/all of) this together in a 'shared understanding'. Working together to examine obvious and possible causal links between what's come out in and 1 and 2 above (see figure as example of a tool to do this as a diagram if preferred):
    a. Asking 'what is your understanding of why you feel how you do?' (may see in terms of trauma, biomedical, diagnosis, spiritual etc) – important to understand individual's starting point
    b. Explaining range of ways that might be helpful (confidently, valuing each, but not pushing any as 'The Way'.
    c. Explaining (confidently, but with lack of certainty) how different aspects might link or contrast for the individual: – e.g. how certain experiences (symptoms) may indicate that a diagnostic approach could be helpful as well as emphasising how symptoms can be understood as survival strategies and how together with identified strengths we get a more rounded understanding, e.g. how repeated traumas can over time can lead to shifts in brain functioning leading unpredictably to different experiences.
    d. A (more or less comprehensive) shared understanding of the individual's situation can be agreed (or differences acknowledged) which might include an individual's

experiences and behaviours (symptoms) described primarily as a single or several diagnoses, and/or as a set of prioritised symptoms/problems, if possible with causal links between them (might be called a formulation). Resultant problems with function, key strengths and agreed goals, as well as historical causes and/or current stressors and assets, together provide a more whole person picture.

C. Developing a shared plan

This is the future oriented part. For some individuals it may be a plan that's discussed informally in lay situations, or for practitioners it can be an outline (and not comprehensive) plan written in health care records, or a more formal plan (Care Plan).

1. Bringing threads together:
    a. Plans may be in place already and need revising
    b. Planning can occur v early during interactions – with individuals bringing a plan as a request
    c. Goals identified or agreed earlier may provide basis for plans

2. Using the 'shared understanding' with prioritised problems (including diagnoses if made and social issues) and goals, to decide on plans may be assisted by different types of reasoning:
    a. An individual's intuitive or thought through ideas about what might help
    b. Practitioners' ideas from knowledge of evidence about what might help for each problem/goal/diagnosis
    c. Thinking together about the whole, as well as 'zooming in' on specifics, to consider conflicts or synergies between possible plans, and what to prioritise.

3. Agreeing and sharing the plan:
    a. Review potential plans to see how they cover biological, social and psychological domains, and how they fit with trauma informed and strengths-based principles (e.g peer support), as well as diagnostic approaches.
    b. Agree a set of specific immediate and future plans, potentially with named people, and if desired with target dates.
    c. Agree how and whether to share shared understanding and plan.

The description of the model may feel lacking in detail or too prescribed for experienced expert mental health practitioners; we hope it will encourage them to incorporate aspects of the model into their practice, and to use it to work across disciplinary boundaries in locality teams around the individual patient/service user.

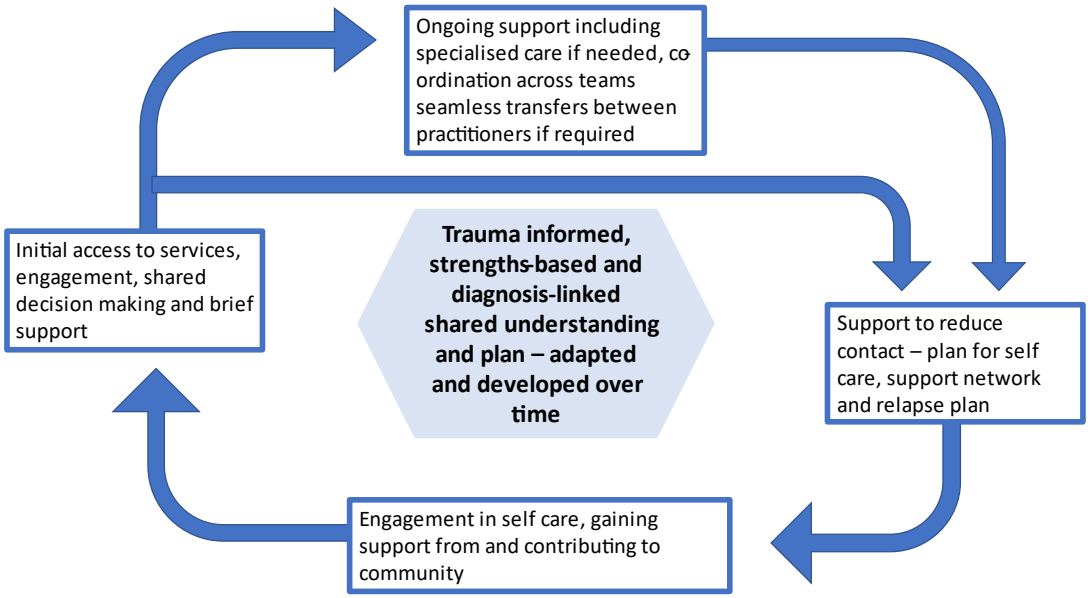
For less experienced or generalist practitioners, and individuals engaged in 'self-care' it may feel too ambitious; we hope that, with appropriate support, it will be possible for people to move away from overly simplistic or single-issue models.

While the model is focussed on language, how practices are carried out are informed by trauma informed and strengths and values-based approaches in particular. Practice should be flexible and personalised – going as slowly or quickly as needed, and trauma sensitive practices (such as only enquiring further with assent (permission) etc) are crucial. Kindness and support to build on personal strengths can be part of most contacts with services as well as in the community.

2. Different scenarios through an individual's journey – where to invest

The model described above is deliberately generic, but in order to provide cohesion for individuals and systems it needs to be relevant across a range of diverse scenarios - from individuals building their own personal plans for wellness and/or recovery to individuals requiring coordinated ongoing care. The figure depicts this range of scenarios both for those needing different intensities of support and over time for all individuals.

Self-Care. A supportive caring community, encouraging an ability to deal with distress and build coping strategies and a meaningful life is arguably the most important area for development. We have policies and now initial investment to support existing assets, and a buoyant Trauma Informed Network show signs of changing cultures in line with the proposed model. *Self-care and community supported care could be further enhanced by a comprehensive online guide to both local and national resources informed by the principle of the model, as well as by further investment in community connectors and peer support.*



Initial Access and brief support. The last five years has seen a step change in the capacity of services for mental health problems in Plymouth. The development of primary care based mental health teams funded through the community mental health framework and the development of voluntary sector services including specialist services for debt and employment as well as more social prescribers and community connectors is a very positive basis on which to build. *What is needed now is a programme of support and education for practitioners across primary care mental health and voluntary sector to understand each other's roles and perspectives. We proposed that the shared approach to mental health can provide a unifying framework for training and facilitation for better joint work. Additionally, and as a priority, a comprehensive guide to gaining access to mental health support alongside self-care which recognises the different roles of the range of services and incorporates trauma-informed, strengths based and diagnosis linked model should help overcome current confusion around access amongst communities and non-specialist practitioners.*

Ongoing support. Specialist services are under significant pressure, but there is an opportunity to reduce the use of high cost (in and out of area) in-patient care by developing a cohesive set of teams able together to provide care for those most in need and prioritise resource towards positive interventions over more risk averse practises of containment/observation. Developing such a culture-

change has already started through positive leadership. It is likely to require input from senior managers and integrated care system leaders to promote positive risk management. This will enable practitioners to work together to create a more balanced system including the strength-based principles, trauma- informed practices alongside traditional diagnosis-led care.

Supporting individuals to have less contact with specialist services. Politically this is perhaps the most difficult aspect as it is uncomfortable to tell people resources are limited. So, it will require prolonged community engagement and consultation. of creating a balanced system by ensuring practitioners are not feeling overwhelmed, are able to use their many skills as well as bring kindness into everyday care and support empowerment through using changes in language and testing a range of new interventions which are not led by the most specialist mental health practitioners in the system. This principle applies to those with high and low need. It will also be supported by the development of a comprehensive guide to services.