



Using a Structured Model to Promote Mental Health

Journal:	<i>Journal of Public Mental Health</i>
Manuscript ID	JPMH-12-2017-0040.R1
Manuscript Type:	Original Research Paper
Keywords:	Therapeutic relationship, Holistic approach, Creativity, Mental Health Promotion

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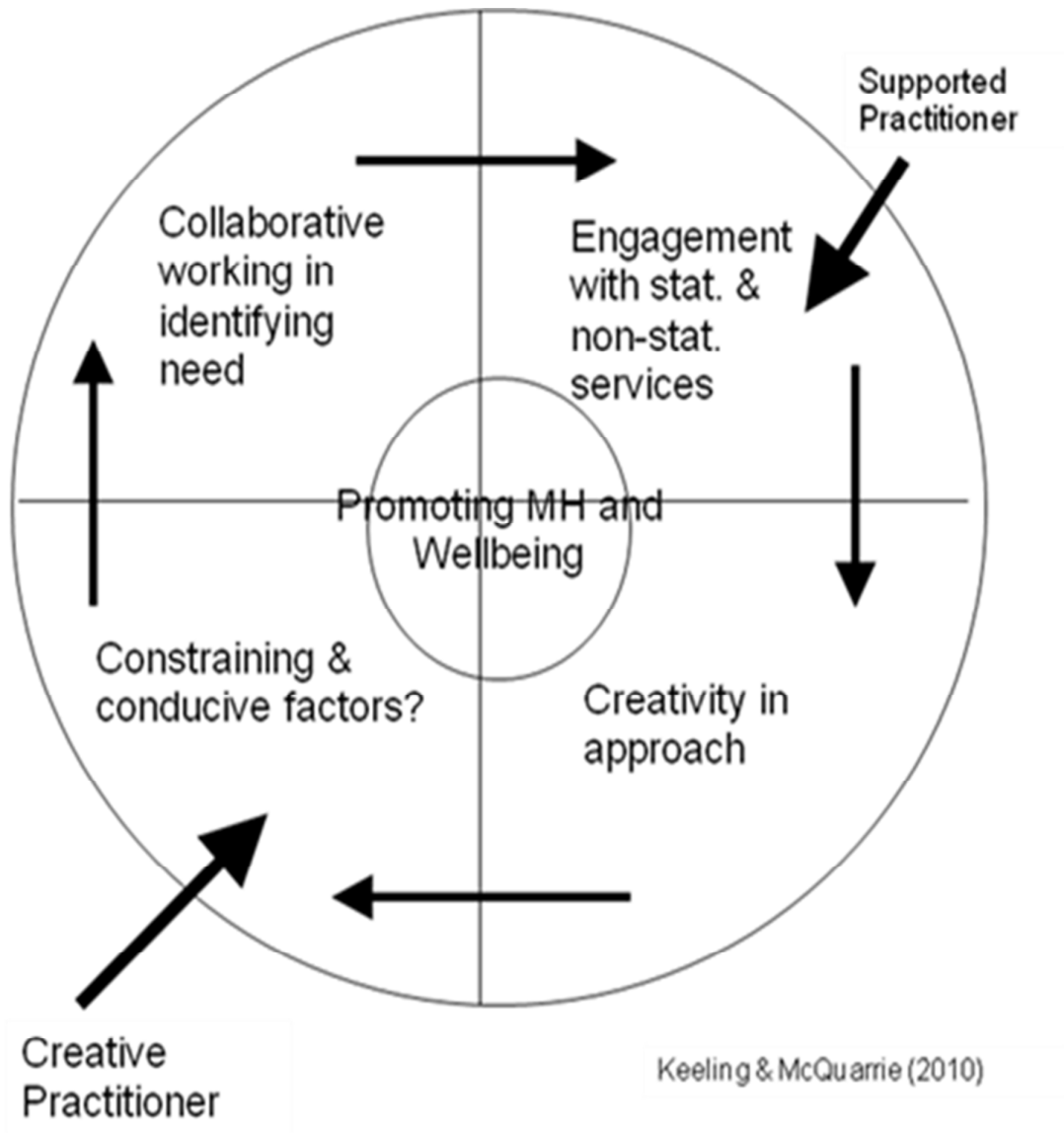


Figure 1.

Promoting Mental Health and Wellbeing in Practice – A Working Model.

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Figure ii.

Table of themes and illustrative data extracts from participants about using the model.

Theme	Illustrative data extracts
<i>Reconciling a non-traditional approach</i>	<p data-bbox="824 411 1349 506">"I think what makes it a little bit difficult is making sure they are working together and not relying on you completely"</p> <p data-bbox="824 541 1101 573">"they just want answers"</p> <p data-bbox="824 609 1344 674">"Sometimes it can be a little bit uncomfortable at first because they're not used to it"</p> <p data-bbox="824 709 1328 804">"It's uncomfortable at first..they expect to be fixed..because that's what everyone else has done with them"</p> <p data-bbox="824 840 1287 905">"We call people participants...because we participate in that journey"</p> <p data-bbox="824 940 1369 1073">"most of them (clients) are quite keen to say what is wrong. It is the moving forward with how they are going to tackle that that's more challenging for them"</p> <p data-bbox="824 1108 1344 1203">" I've had one person who when I wouldn't tell her what to do, she said right, I don't want the service anymore"</p> <p data-bbox="824 1239 1360 1333">"it was about making sure it's not our agenda, that we have to work...we don't have to get this person into work"</p> <p data-bbox="824 1369 1369 1434">"We don't have to make this person well...it's up to the individual to do it"</p>
<i>Promoting an holistic perspective</i>	<p data-bbox="824 1482 1360 1602">"Remembering important details like the names of children, so that's something that you can mention next time and that sort of sticks with the person"</p> <p data-bbox="824 1638 1344 1745">"you're not saying right you want to work...you're the smoker. It's the 'you're Julie who has three kids and a dog named Polly'"</p> <p data-bbox="824 1780 1369 1845">"you're looking at the person as a whole, not just their health conditions or just their problems"</p> <p data-bbox="824 1881 1360 1906">"at the end of the day they get to focus on what</p>

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	<p>matters to them”</p> <p>“you aren’t there to fix them or give them a pill....it’s about being there with them in that moment and just listening..”</p>
<p><i>Developing creativity and sense of empowerment to promote mental health and wellbeing</i></p>	<p>“I ask them what they want and together you come up with different ways to achieve it”</p> <p>“we can be flexible with the tools we use..so if it isn’t working then we just don’t do it”</p> <p>“Because we’re out in the community..that helps you be creative...we meet in a garden centre”</p> <p>“I think you can be more creative..as you’re learning more yourself”</p> <p>“because it’s not such a rigid structure..it allows you to be quite unique”</p>

Using a structured model to promote mental health.

Purpose

A Promoting Mental Health and Well-Being Working Model (Keeling and McQuarrie, 2014) was developed in response to recognition through teaching undergraduate nursing students, that interventions aimed at enhancing mental health and wellbeing are often hidden (Owens et al, 2010) or cloaked in traditional professional specific working interventions. The model was developed with the purpose of making the elements of mental health and well-being promotion visible and structuring them into a framework to aid working practice and personal development. The purpose of this paper is to evaluate the effectiveness from the participant perspective of using the model to enhance clients' mental health and well-being in community settings.

Design/methodology/approach

14 participants were interviewed within two focus groups. Five questions were posed to the participants structured around their experiences of using the model when working with clients in the community. The responses were recorded and transcribed and then categorised using a thematic analysis approach.

Findings

Three key themes were derived from the analysis in equal measure: "Reconciling a Non-traditional approach", "Promoting a holistic approach" and "Developing creativity and sense of empowerment to promote mental health and wellbeing". The findings suggest that using the model enabled participants to engage with clients in meaningful ways that in turn developed their self-confidence in helping clients develop creative strategies to promote their own mental health and wellbeing.

Originality/value

This paper shows that using a structured model to promote well-being and mental health has benefits in enhancing creativity, therapeutic relationships and knowledge base. Further research is needed in terms of the utility of the model from the client's perspective. .

Background

The model was initially presented at an International conference (Keeling and McQuarrie, 2010) and then used as a teaching tool to community workers in an attempt to bring together the elements of facilitating the promotion of mental health and wellbeing. Two focus groups were later used to elicit the experiences of those Participants (n=14) in using the model when working with people in community settings.

Mental health and well-being promotion have increasingly gained recognition as important aspects of any caring activity. However, literature is often focused on mental health and well-being promotion as an adjunct or secondary consideration of treatment and professional led “fixing” which can lead to a reactive and reductionist approach to care (Johansson *et al.* 2009; Kelsey, 2017; Shah and Mountain, 2007). In developing the model, it was considered how mental health and well-being promotion could become the focus of caring activity with the intention that increased self-efficacy and behavioural change would become the catalyst for more long term behaviour change and health benefits (Cornwall *et al.*, 2003). The model incorporates the concepts inherent within mental health and well-being promotion (Barry and Jenkins, 2007; Cattan and Tilford, 2006) but structures these concepts into a coherent framework for practitioners of any discipline to use (fig i). In enabling individuals to consider what is important to them and what they would like to change, it is argued that individuals can use initial success in these areas as a motivator to tackle other changes that may need to occur that initially may have been perceived as insurmountable. It is also acknowledged that mental health and well-being promotion may have very little obvious relationship to a diagnosis or presenting medical problem (Hermann, Saxena and Moodie, 2005). The model was designed on the initial premise that improved mental health and well-being may have a secondary effect of improving the presenting medical problem or health concern thus “flipping” the focus of caring activity to be person centred in its truest form (Cornwall *et al.*, 2003; Keeling and McQuarrie, 2014).

The model consists of four key aspects or considerations that the practitioner can use as a guide to working in enabling individuals to discover their own goals and ways to well-being whether this be physical or emotional. Stage one of the model is concerned *with collaborative working in identifying need*. an important factor here is that the practitioner is a facilitator rather than instructive or a solver of problems. Literature indicates that individuals who feel involved in their own care and listened to have better health outcomes than those who are prescribed interventions based on professional deciphering of what the individual must need or want (Laurance *et al.* 2014). A truly inclusive approach to need identification is a key aspect or foundation of mental health and well-being promotion and gives indication to an individual from the outset that the locus of control lies internally. Deciphering what an individual needs is a fundamental aspect of traditional caring roles but can be a passive process for the client due to concerns of workers regarding professional accountability and lack of training (Bee *et al.*, 2005). (. The use of motivational interviewing techniques (Miller and Rollnick, 2002) may go some way to encouraging the client to be active in ascertaining need

Stage two of the model considers *engagement with statutory and non-statutory services* and requires the practitioner to have knowledge of what may be available to support an individual in meeting self-specified goals or in addressing self-perceived need. With the advent of and now established tele-health sector, individuals may find the use of self-referral processes and online

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3 material and support useful as opposed to face to face engagement (Robin *et al.* 2013; Balatsoukas
4 et al. (2015) . However, this is itself requires consideration of the person's confidence and existing
5 skills in order to predict whether this avenue may be useful. This can be elicited through using stage
6 one of the model in getting to know the individual through a collaborative approach.
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8 Stage three of the model is concerned with *creativity in approach* and is aimed at harnessing the
9 pre-existing skills, interests and pastimes of an individual to best effect. Traditional interventions to
10 address need may be useful in the short term but a person may have already established coping
11 mechanisms that he uses to improve mental health and well-being when required (Cairns-Nagi and
12 Bamba, 2013). An example here would be physical activity; the use of physical exercise has well
13 known benefits to mental health and well-being: if an individual already engages in this activity
14 thinking about how it can be used in a creative approach to address his need seems logical. The key
15 aspect to this stage of the model is that the practitioner and individual are not constrained to using
16 traditional or prescribed interventions. Mere engagement in a hobby or pastime can have a
17 profound effect on mental health and well-being and can act as an excellent motivator for facing
18 future changes and challenges (Dickinson and Adams, 2014; Dieser and Christenson, 2016) . The
19 evidence base is growing for the use of many activities that have been traditionally viewed as
20 meaningless hobbies or pastimes, as useful interventions in addressing health needs and concerns.
21 Thus, the practitioner is required to develop skills in creativity in seeking out from the individual
22 alternative pathways to reaching a desired state of well-being.
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27 Stage four of the model prompts the practitioner and individual to consider *conducive and*
28 *constraining factors to implementation* as an important consideration before embarking upon any
29 individual's chosen strategy. An acknowledgement of what will help or hinder the potential progress
30 in addressing a specific self-deciphered need is important in predisposing critical points of potential
31 setback and perceived failure. Considering what is realistic and achievable in an individual's life is
32 crucial in terms of maintaining confidence and self-esteem throughout any journey to enhanced
33 well-being (Cox, 2011). Unrealistic expectations can be discussed and expectations managed if there
34 is consideration of practical issues such as finances, accessibility and required skills. In terms of
35 longevity of efficacy this is vital in ensuring that a person can be supported to pursue their goals
36 without falling at the first hurdle. A discussion of how any constraining factors may be overcome
37 and conducive factors enhanced can all aid in the planning process before activity is commenced.
38 The practitioner in enhancing his own development must facilitate a discussion that not only
39 identifies conducive and constraining factors to implementation, but has some suggestions in terms
40 of how these might be manipulated to gain the best outcome for the client and to ensure that the
41 service offered is meaningful (Cameron *et al.* 2018) .
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46 **Figure i**

47 **Study Objective and Sample**

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49 The purpose of the study was to evaluate the utility of the model in practice by eliciting the views of
50 participants using the model in working with people in community practice settings in inner-city and
51 suburban environments. The participants were placed within various community settings and
52 accepted referrals from a range of professionals in addition to self-referrals through a dedicated
53 Project website. All participants had undergone a training Programme structured around the
54 principles of the model (fig i) and had been working in the community for 12 months as "well-being
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3 coaches". None of the participants had pre-existing professional affiliations although some did have
4 experience working in health or social care previously in support roles.
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6 **Method**

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8 Two focus groups were held in order to elicit the views of the participants who had engaged in using
9 the model. The use of focus groups is well established in the public health arena (O'Toole et al 2004;
10 Hemingway et al, 2012) and are suited to collecting rich qualitative data from small groups who have
11 engaged with a service or intervention (Breakwell and Millward, 1995). Further, focus groups were
12 chosen as it enables participants to meet together, interact and share experiences regarding a
13 common theme (Webb and Kevern, 2001). As the participants were all employed in a unique and
14 new role, it was felt that a focus group would enhance the confidence of the participants in
15 expressing their views and would provide the opportunity to discuss challenges together. The focus
16 groups each lasted 60 minutes and comprised of the facilitator and seven Participants in each group.
17 The focus group facilitator was conducted by one of the researchers, although the researcher did not
18 provide any of the content of the training programme using the model. Written consent was gained
19 from all participants prior to the focus groups. The subsequent discussions were audiotaped and
20 then sent for independent transcribing prior to data analysis.
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24 *Data Analysis*

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26 The qualitative data emanating from the focus group discussions was transcribed and then analysed
27 using a conventional content analysis approach (Hsieh and Shannon, 2005). Transcribed text from
28 the focus groups was read several times by the two authors independently and coded according to
29 reoccurring keywords/phrases and then these were grouped in themes culminating in a broad
30 thematic analysis (Vaismoradi et al, 2013). Resultant broad themes deducted by the authors were
31 then compared to check for parity and refinement.
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34 **Key Findings**

35 *Figure ii*

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38 Participants identified the challenges of working with the model and the usefulness of using the
39 model in a collaborative and meaningful way both to themselves and the way they worked with
40 individuals. Through thematic analysis of the focus group participant data, it became evident that
41 using the model was initially challenging, but useful in enabling both the participant and the
42 individuals they were working with, to ascertain their own needs and discover meaningful realistic
43 routes to addressing them thus increasing self-efficacy.
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46 Participant responses to the questions posed regarding use of the model fell into 3 main themes
47 which were considered by the researchers as generally occurring with equal significance:
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50 *Reconciling a Non-traditional approach*

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52 Many comments made by participants focused on reconciling a non-traditional approach to need
53 identification. Participants voiced that working in a collaborative way required time and effort on
54 the practitioner part and was quite different from previous roles they may have been used to in the
55 health sector, "especially coming from a health training background where it was kind of prescriptive
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3 and advice giving". Participants reported that self-development was important in reducing
4 frustration and enabling the need to be discussed from the perspective of the client, "sit on your
5 hands a little bit more and realise it's their goals, it's their choice not ours". Participants commented
6 that "sometimes it can be a little bit uncomfortable at first because they are not used to it" in
7 relation to discussing clients' thoughts and feelings about what they perceived their need to be. One
8 participant commented, "I've had one person who when I wouldn't tell her what to do, she said
9 right, I don't want the service anymore" indicating that working in a collaborative way can be a
10 challenge to the traditional: not only confined to the practitioner but may also be experienced by
11 the client. One participant commented that, "most of them (clients) are quite keen to say what is
12 wrong. It is the moving forward with how they are going to tackle that that's more challenging for
13 them". Participants made many positive comments about collaborative working, "some people get
14 really motivated and enthused by it and run with it: the fact that they are setting their own goals"
15 but balanced this with the work involved in enabling clients to understand the different approach to
16 working, "I think what makes it a little bit difficult is making sure they are working together and not
17 relying on you completely", "they just want answers". Participants discussed the collaborative
18 approach and commented, "I think they take a little bit more responsibility", "I think once they
19 realise it is up to them they like it a lot more as well".
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24 Participants appeared to initially struggle with the concept of being an enabler or facilitator rather
25 than trying to identify a client's need and then attempt to fix it. This was compounded by the
26 expectation of the clients they were working with who appeared to have an expectation akin to this
27 as this may have been what they had experienced from health workers in the past.
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30 *Promoting a holistic approach*

31 Holism appeared to be a key theme derived from the participant comments. Participants voiced that
32 they felt able to work with clients in collaboration and get to know them as individuals and this
33 proved beneficial to identifying need. "Finding out what their interests are and developing a
34 relationship" led to a "more personalised" approach in eliciting a client's needs. "Remembering
35 important details like the names of children, so that's something that you can mention next time and
36 that sort of sticks with the person". Participants spoke of the model enabling them to consider the
37 wider determinants of health and well-being rather than just the presenting problem that the client
38 was referred for help with, "you're looking at the person as a whole, not just their health conditions
39 or just their problems". Participants spoke of how this way of working helped them to develop
40 relationships with people and changed the narratives of the sessions to be more meaningful.
41 Participants felt that this created a platform for negotiating creative ways for clients to start to work
42 on the areas of their lives that they felt they would like to change.
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47 *Developing creativity and sense of empowerment to promote mental health and wellbeing.*

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49 Participants spoke of a feeling of developing confidence through working in a collaborative way and
50 recognising that the client should take the lead in developing their own strategies for improving their
51 own health and wellbeing. This also enabled a creative and bespoke approach to goal setting and
52 action planning for attaining that goal. "I ask them what they want and together you come up with
53 different ways to achieve it"
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3 Participants felt using the model enabled them to consider the conducive and constraining factors of
4 different approaches and this developed their confidence to support clients on changing course if
5 plans weren't working "we can be flexible with the tools we use...so if it isn't working then we just
6 don't do it". Participants spoke of "creativity in approach" as extending beyond developing
7 strategies to meet needs but to the way in which they delivered the whole service from initial
8 meeting, "Because we're out in the community...that helps you be creative...we meet in a garden
9 centre"

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12 Participants spoke of moving from a place of being nervous around whether they would be effective
13 in their work with clients, to a place of feeling inspired and innovative in their approaches to
14 promoting mental health and wellbeing. "I think you can be more creative...as you're learning more
15 yourself". Participants reported that working with the model encouraged a bespoke response to
16 enabling clients to seek their own pathway to enhanced wellbeing "because it's not such a rigid
17 structure...it allows you to be quite unique".
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20 Discussion

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22 The findings from the focus groups demonstrate the underpinning philosophy of the model in
23 helping the participants develop strategies to engage people based on their individual needs and
24 desires in relation to reconnecting to their lives and wellbeing.
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27 There is hope that this choice of approach facilitates the development of creative thinking and thus
28 creative practitioners (Gillam, 2013). Practitioners working within traditional service delivery models
29 can be constrained in their ability to be creative. The philosophy of this model advocates a different
30 approach to care which is based on the premise that when people feel better about themselves and
31 fully involved in their care, outcomes will be more positive and longer lasting (Keyes, 2002; Prince et
32 al, 2007).
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35 The establishing of user led care and interventions can be a challenge for some practitioners, who
36 are already enmeshed in a culture of providing the 'expert' role and advice. Indeed, Benner's (1982)
37 model of development of nursing expertise could be applied to this scenario, when thinking about
38 novice to expert development, traditionally people who are new to caring roles can sometimes feel
39 less confident in their ability to 'let go' and let the client lead the care provided (Horsburgh and Ross,
40 2013). It is believed that this model can help facilitate the development of practitioners into
41 confident and engaged partners in care much sooner than traditional working methods. Initially the
42 participants reported needed a lot of support with insecurities due to being given a lot of leeway:
43 this was different to what they had been used to, working in more traditional services with set ways
44 of working.
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48 The model lends itself towards an empowerment based approach, utilising a client's own interest
49 and experiences to enrich the interaction between themselves and health providers. This moves
50 away from a traditional behaviour change model, which focuses on 'righting' the client and their
51 presenting problem/needs. Miller and Rollnick (2002) highlight this as a common, almost instinctive
52 response from health professionals. Indeed, one participant stated that a client had told them that
53 after many contacts with health services, 'this is the first time I feel that I've been listened to.'
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3 The participants highlighted that for some of them, being new to coming into this field was not an
4 obstacle to engaging clients with this model. The self-efficacy of the participants and their
5 development also followed a similar trajectory to their clients, creating a shared learning and
6 experience which levelled the playing field, creating a more equal partnership of care.
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8 The parallel training that was given to the participants in motivational interviewing techniques
9 complimented the underpinning philosophy of the model. Participants felt that the skills they
10 learned in encouraging clients to reflect and think about their own health needs enhanced their
11 understanding of the purpose of the model. Engaging clients in an empathic, non-directive manner
12 enabled the participants to be able to fully engage with the therapeutic process of promoting mental
13 health and wellbeing. The way that the service was developed in terms of looking at working with
14 people over a 12-month period helped facilitate the underpinning philosophy of the model – being
15 able to develop the relationship and collaborate with people in the true sense. This was reliant on
16 being able to focus on long term outcomes rather than quick solution focused short term outcomes.
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