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South East Coast

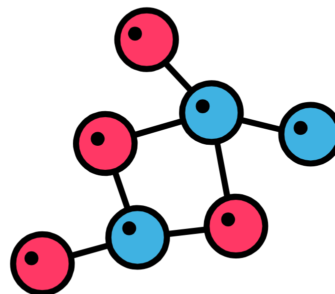
Models of Chaplaincy

Mental Healthcare

Dr Stuart Johnson – South Downs NHS Trust

Frameworks

- Models



- Maps

- Metaphors

An Integrated Service Model

- Staffing and Staff Management
- Education and Training
- Information Systems
- Service User
- Risk Management
- Clinical Audit
- Clinical Effectiveness

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Model Definition 1

- **Definition:** *An approach to chaplaincy service provision which integrates the chaplaincy team **within Trust structures** and enables chaplaincy to work alongside other professions in enhancing the overall quality of service user care provision.*
- **Characteristics**
  - Where in the structure
  - Who and how represented
  - How the task is addressed
  - What are the channels by which it is made known
- **Comparative**
  - Wilson's Primary Task Model (1971)
  - Woodward's Service Model (2002)

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3 ‘R’ Chaplaincy Practice Model (a)

- **FIRST LEVEL MODELS**
  - 1. Disease(biological)model
  - 2. Behavioural model
  - 3 Cognitive model
  - 4 Psychodynamic model
  - 5 Social model

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3 ‘R’ Chaplaincy Practice Model (c)

- **The 3 ‘R’ Practice Model:**

Reflective	***Referral***	***Recovery***
Background & training of the chaplain	Source of referral	Contract agreement with the service user
Location – in-patient; residential; home; clinic;	Levels of distress	Support provided in context of other team members
Expectations of the trust	Expectation of refer	Issues of confidentiality & sharing of information
Models in operation	Expectations of service user	Reflecting the trust focus of attention
Diversity of population	Method & methodology guiding support programme	Philosophy underpinning care programme and CPA

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Model Definition 2

- ***Definition:*** *An approach to direct patient care which specifically focuses on the religious and spiritual needs of service users/carers and locates this aspect of care* ***within multi-disciplinary team approaches*** *to care provision.*
- **Characteristics** a ***Practice Model*** can be a means of indicating to trust colleagues, service users/carers, church authorities and the public how the religious and spiritual dimension to care provision is addressed ***within the context of the mental health service provision***:-
  - Availability of chaplaincy
  - The criteria for an nature of the service provided
  - The Channels for sharing information
  - The processes by which services provided can be audited and outcomes assessed
- **Comparative**
  - Faber's Conversational Model (1971)
  - Wilson's Primary Task Model (1971) – practice aspects

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Three Types of Framework

- **Explanatory Framework**
  - Endeavours to show how something happened
- **Ideal-type Framework**
  - Defining characteristics - phenomenon
- **Normative Framework**
  - Set out conditions or arrangements for goals

Comparative Models

- Disease Model- E. Kraepelin, 1893
- Psychodynamic Model – S Freud, 1933
- Behavioural Model – B.F. Skinner, 1950s
- Cognitive Model – Beck, 1952
- Social Model – Durkeim, 1897

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Hierarchy of Models (a)

- Disease Model
- Behavioural Model
- Cognative Model
- Psychodynamic Model
- Social Model

Treatment Matched to Models (b)

- **Disease model**
  - Antidepressants and/or ECT to treat manifested psychotic symptoms
- **Behavioural model**
  - Reward outgoing social behaviour
- **Cognitive model**
  - Encourage rational thinking
- **Psychodynamic model**
  - Facilitate expression of feelings and promote adjustment
- **Social model**
  - Offer/provide support following the bereavement.

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Levels of Distress (c)

- **Level five: DISINTEGRATION**
  - Normal functioning, even though possibly limited at earlier phases, is now impossible.
- **level four: CHANGED BEHAVIOUR**
  - Prolonged experience of symptoms leads to behaviour changes
- **Level three: IRRATIONAL THINKING**
  - Enduring conflicts in danger of producing distorted thinking.
- **Level two: SYMPTOMS**
  - Earlier phase continues and consequent emotional conflict becomes focuses on mental & physical complaints
- **Level one; DISTRESS**
  - Awareness of uncomfortable feeling such as sadness, nervousness, tension, puzzlement, irritability and anger. Feeling may be universal in face of stress and disappear when the pressure is removed.

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3 ‘R’ Chaplaincy Practice Model (b)

- I see my own practice as a **second level** contribution.
- The ***criteria*** for referral to me are that:
  - * the service users is willing to be referred;
  - * the service user has indicated religious, spiritual or personal beliefs are in some way implicated in the experience of mental dis-order;
  - * my support is essentially directed to that aspect of the mental disorder but if other support may be more appropriate (art or music therapy etc) I will refer on or back.
- The ***assessment tool*** in operation, to help staff identify RSPB needs is the “**HOPES**’ assessment tool.

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Integrative Model

- **General Tenets of a General Integrative Model**
  - Each have several levels of functioning.
  - Mental disorder can affect one or more levels.
  - Dysfunction may change in time.
  - Each psychiatric model links to one level of function.
  - Successful treatment mean matching the level of disturbance to appropriate model and philosophy of management.
- **Central Tenets of a Chaplaincy Integrative Practice Model**
  - Accepting a referral: Source will indicate level at which religious/ spiritual/ personal belief needs are apparent, thus indicating at which level assessment is required
  - Religious, spiritual or personal belief issues raised as an aspect of mental disorder indicate more than one level of functioning is affected.
  - Communication between and with sources of profession care is important
  - Utilization of the chaplaincy model will involve sensitivity to behavioural, cognitive and social functions linked with aspects of religious, spiritual or personal beliefs.
  - An audit programme is required to take account of positive outcomes that arise from the service provision