

1

UNDERSTANDING MENTAL HEALTH AND MENTAL DISTRESS

This chapter can be used to support the development of knowledge and skills in professional social work as follows:

National Occupational Standards for Social Work

Key Role 1: Prepare for and work with individuals, families, carers, groups and communities to assess their needs and circumstances

- Prepare for social work contact and involvement.

Key Role 3: Support individuals to represent their needs, views and circumstances

- Advocate with and on behalf of, individuals, families, carers, groups and communities.

Key Role 6: Demonstrate professional competence in social work practice

- Managing complex ethical issues, dilemmas and conflicts.

(TOPPS England, 2002)

Academic Standards for Social Work

Honours graduates in social work:

4.4 should be equipped to understand, and to work within, the context of contested debate about the nature, scope and purpose of social work, and be enabled to analyse, adapt to, manage and eventually to lead the processes of change.

4.6 must learn to:

- recognise and work with the powerful links between intrapersonal and interpersonal factors and the wider social, legal, economic, political and cultural context of people's lives
- understand the impact of injustice, social inequalities and oppressive social relations
- challenge constructively individual, institutional and structural discrimination.

6 Understanding Social Work Practice in Mental Health

4.7 should learn to become accountable, reflective, critical and evaluative which involves learning to:

- think critically about the complex social, political and cultural contexts in which social work is located.

5.1 should acquire, critically evaluate, apply and integrate knowledge and understanding in relation to:

5.1.1 *Social work services, service users and carers*

- the social processes (associated with, for example, poverty, migration, unemployment, poor health, disablement, lack of education and other sources of disadvantage) that lead to marginalisation, isolation and exclusion and their impact on the demand for social work services
- explanations of the links between definitional processes contributing to social differences (for example, social class, gender, ethnic differences, age, sexuality and religious belief) to the problems of inequality and differential need faced by service users
- the nature and validity of different definitions of, and explanations for, the characteristics and circumstances of service users and the services required by them, drawing on knowledge from research, practice experience, and from service users and carers.

5.1.4 *Social work theory*

- research-based concepts and critical explanations from social work theory and other disciplines that contribute to the knowledge base of social work, including their distinctive epistemological status and application to practice
- the relevance of sociological perspectives to understanding societal and structural influences on human behaviour at individual, group and community levels
- the relevance of psychological and physiological perspectives to understanding individual and social development and functioning
- models and methods of assessment, including factors underpinning the selection and testing of relevant information, the nature of professional judgement and the processes of risk assessment and decision-making.

5.5.3 should be able to analyse and synthesise information gathered for problem solving purposes to:

- assess the merits of contrasting theories, explanations, research, policies and procedures
- critically analyse and take account of the impact of inequality and discrimination in work with people in particular contexts and problem situations.

(QAA, 2008)

Key themes in this chapter

- The scope and definitions of mental health and mental distress
- Examining personal attitudes towards mental distress
- The power of language, images and representations of mental health and mental distress
- Theorizing mental health – medical and social models
- Becoming a user of mental health services
- Developing an holistic, user-centred approach to mental health assessment.

INTRODUCTION

This chapter introduces the different terminology, concepts and theories used to describe and understand mental health and mental distress. This is an important starting point as it is vital that practitioners appreciate the diverse, often antagonistic, nature of the language, ideas and explanations that have evolved in this area over time. Pilgrim and Rogers (2005) and Parker et al. (1995) explain that what we know about mental health and mental distress has been influenced in two ways; first through popular culture (everyday language, popular fiction, painting, photography, songs, news and entertainment media) and secondly through professional discourses (psychiatry, psychology, social work and the law). These interact in complex ways producing a powerful fusion of common-sense and ‘scientific’ knowledge that can be difficult to unravel. Therefore this chapter also involves a critical analysis of the relationship between lay and professional knowledge in this field in order to understand the basis of contemporary mental health practice. The process of becoming a user of mental health services is subjected to critical examination, and in particular the process of mental health assessment. As you engage with the materials and exercises you will learn to appreciate that the knowledge base of mental health social work is far from straightforward. Social work practice in this field is inherently complicated, with assessments and interventions often fraught with controversy, tension and contradiction.

DEFINITIONS AND TERMINOLOGY

It is often argued that lay attitudes towards people in mental distress reflect a lack of understanding and knowledge (MIND, 2007a; Thornicroft et al., 2007). For example, surveys of the general public consistently show confusion about what mental distress actually is (DH, 2003a). However, this is not really surprising since there is significant disagreement amongst academics and professionals on this. Ways of understanding and defining mental health and mental distress are constantly

changing in what is essentially a contested and dynamic arena. Finding a unified definition of what constitutes mental 'health' and mental 'illness' can be a frustrating exercise and something of a holy grail. For example, mental health can be defined either negatively, as 'the absence of objectively diagnosable disease' (WHO, 1946), or positively, as 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community' (WHO, 2001a). The Mental Health Act 2007 introduced a single definition of 'mental disorder' as 'any disorder or disability of the mind'.

The confusion and controversy surrounding mental distress is also clearly reflected in the diverse terminology used in the field – mental health; mental illness; mental disorder; mental health problem; mental distress. Although these terms are often used interchangeably, they actually derive from quite different philosophical, theoretical and ideological perspectives. That is, the terminology used to describe a person's mental health status is grounded in the particular approach to understanding mental health subscribed to by the particular individual, group or organization using the term. So for example, broadly speaking, traditional mainstream psychological or psychiatric literature will opt for the terms mental illness and/or mental disorder in keeping with a *psycho-medical* paradigm, while critical social scientific or user-centred literature tends towards the terms mental health problem or mental distress reflecting a *psycho-social* paradigm. These contrasting models of mental health are discussed later in this chapter.

In this book we have shown a conscious preference for the term 'mental distress', as this most closely reflects both our value position in relation to people who use mental health services and our critical social scientific approach to the subject. Occasionally we use the terms mental illness and/or mental disorder where we feel it is important to remain consistent with the original context in which the term is used (for example, when discussing official definitions used in mental health law or policy), but when doing so we indicate the contested nature of that term through the use of single inverted commas – as in 'mental illness'.

EXAMINING OUR ATTITUDES TO MENTAL DISTRESS

From the outset it is important to acknowledge and reflect on our own *individual* feelings, attitudes and understanding of mental health and mental distress. Neil Thompson (2006) explains how practitioners need to be aware that they do not practise in a moral and political vacuum. His 'PCS' model (Figure 1.1) is an extremely useful tool in assisting practitioners to develop their understanding of the relationship between wider society, popular culture and individual attitudes.

Thompson (2006) reminds us that the way we come to understand and behave towards the world around us, and the people within it, is primarily shaped by the culture in which we live. As essentially subjective beings, health and social care professionals are no less immune to the influence of prejudicial ideas, attitudes and behaviours. Acknowledging this fact is an important first step towards becoming a

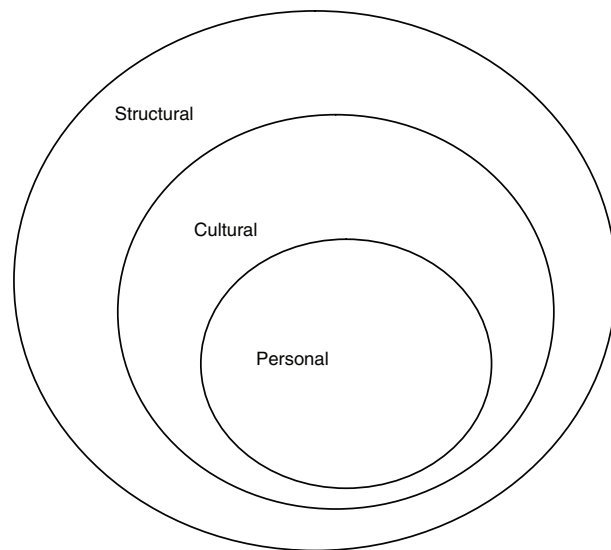


Figure 1.1 Thompson's (2006) PCS Model

critically self-aware practitioner, capable of identifying and then redressing any personal discriminatory beliefs and practices. We will return to Thompson's model and discuss its application to anti-oppressive social work practice in mental health more fully in Chapter 6.

Reflection exercise

How do *you* feel about people in mental distress? Write down as many words as you can to describe your feelings. Be honest with yourself!

It is highly likely that somewhere on your list the words 'fear' and 'sympathy' will have appeared, or at least words that convey similar meanings. These are extremely common emotional reactions that people have to those in mental distress. The diverse, complex and extraordinary ways in which mental distress is manifest in human beings can be disturbing, at times frightening, for those experiencing it, those close to them and those working with them. The UK Department of Health has conducted regular surveys of people's attitudes to mental distress since 1993 and these two themes have featured prominently and consistently in people's responses. Moreover, although fear and sympathy might initially appear to reflect quite different value positions, people often express sympathy and concern for the mentally distressed while simultaneously expressing support for actions that effectively stigmatize

and exclude them from the rest of society. This reveals how attitudes towards people with mental health problems are extremely complex and often contradictory.

Reflection exercise

How do you feel about *your own* mental health? Reflecting on your own life experiences, write down some words or phrases to describe your mental health at significant times. Again, be honest with yourself!

Official statistics indicate that one in six people might experience a mental health problem during their lifetime (Singleton et al., 2001). However, in research conducted by the Department of Health (DH, 2003a), 49 per cent of people reported knowing someone who had experienced mental distress, while only seven per cent admitted that they had experienced mental distress themselves. Similarly, in a MORI survey in 1995, 23 per cent of respondents said that if they were receiving psychiatric treatment they would be reluctant or unwilling to admit this to their friends:

It often seems a good idea to keep quiet about my mental distress. Yet when I am asked why I don't drink or why I took a year out from university, it would be nice to say, 'I was ill with schizophrenia' or 'I take medication for schizophrenia' without fear of a negative reaction. (service user, cited in MIND, 2007a)

This suggests that although mental distress is statistically a common experience and part of everyday human existence, we have a tendency to want to distance ourselves from it – to see it as something far removed from us. Furthermore, this seems to confirm the existence of a deep-seated fear of, or taboo around, mental distress in our society: 'I found that people do one of two things. They look at you in one of two ways. Some look ashamed and furtive because ... I suppose everyone talks, and everyone is afraid of madness'. (Nicola Pagett, from *Diamonds Behind My Eyes*, cited in MIND, 2003a).

There is plenty of historical and cross-cultural evidence to show how the mentally distressed have been feared and excluded from mainstream society. In *Madness and Civilisation* Foucault tells us how:

Suddenly, in a few years in the middle of the eighteenth century, a fear arose – a fear formulated in medical terms but animated, basically, by a moral myth ... the fear of madness grew at the same time as the dread of unreason: and thereby the two forms of obsession, leaning upon each other, continued to reinforce each other. (1967: 192–200)

Denise Jodelet's (1991) longitudinal research in rural France illustrates the persistence of alienating and exclusionary practices towards the mentally distressed despite their deinstitutionalization and official integration into the community. The rhetorical acceptance of these people into the community was not matched by the

reality of their status within it – their ‘otherness’ dictated that they only had a token place in the real world. Similar evidence has emerged from research into the social networks of mentally distressed people discharged into the community in the UK (Repper et al., 1997; Taylor 1994/95) and Ireland (Prior, 1993).

Recent evidence suggests that public attitudes may actually be worsening. In 2007, the Department of Health’s *Attitudes to Mental Illness* survey found an increase in prejudice across a wide variety of indicators, including: not wanting to live next door to someone diagnosed with mental distress; not believing that the mentally distressed have the same right to a job as anyone else; and believing that they are prone to violence (TNS, 2007). This suggests that very powerful ideological forces are present and that these are in tension with, if not resistant to, progressive social and political developments aimed at improving the lives of the mentally distressed in society. Therefore, our reluctance to admit to experiencing mental health problems in contemporary society is not simply to do with the existential fear of ‘otherness’ – it is as much to do with the *material* consequences of ‘exposure’ in the form of inequality, discrimination and oppression (Mental Health Media, 2008). As Sayce observes, ‘increasing social inequality ... impacts on people with mental health problems both because social exclusion itself creates distress and because those who are disadvantaged by the social status of the ‘mental patient’ become caught up in punitive, excluding policies and public moods’ (2000: 41). We discuss the relationship between mental distress, inequality, discrimination and oppression more fully in Chapter 6.

IMAGES AND REPRESENTATIONS OF MENTAL DISTRESS

Research has pointed to the important role played by the news and entertainment media in constructing negative attitudes towards people in mental distress (Clarke, 2004; CSIP/Shift, 2006; Philo, 1996).

Group reflection exercise

Spend a week analysing the content of newspapers, magazines, radio, television and film, collecting examples of the use of imagery and language relating to mental health/mental distress. Share your findings with a small group of fellow students and discuss the following questions:

How do you think such images/language affect people in mental distress? How can mental health practitioners contribute to promoting a positive image of users of mental health services?

It is highly likely that your examples will include stereotypical images of the mentally distressed as violent, unpredictable and dangerous. Research demonstrates that these

12 Understanding Social Work Practice in Mental Health

are particularly dominant themes, often wildly exaggerated (Clarke, 2004; CSIP/Shift, 2006; Laurence, 2003; Philo, 1996). Such representations are in stark contrast to the research evidence that demonstrates how people with mental health problems are more likely to be victims than perpetrators of violence (Monahan, 1992; Taylor and Gunn, 1999). People in mental distress are three times more likely to experience harassment (ranging from verbal abuse to violent attacks) in their local community than the general population (Berzins et al., 2003; National Schizophrenia Fellowship Scotland, 2001). A participant in the MIND survey *Creating Accepting Communities* (Dunn, 1999) reported that he had been abused in the street; his house broken into twelve times and a knife put through the door. He wryly observed how, according to the media, he is supposed to be nasty and violent.

Philo (1996) explains that media representations are a very powerful influence on beliefs about the nature of mental distress and this often overrides people's personal experience – something which is very unusual in media research: 'A friend of many years, responding to media reports of killings by ex-psychiatric patients, said that psychiatric patients should all be locked up' (service user, cited in MIND, 2003a).

The examples you have noted are also likely to include the use of pejorative terminology associated with mental health such as 'psycho', 'schizo', 'loony' and 'nutter'. These terms are often used in conversations not directly relating to a person or persons with mental health problems – perhaps being used as a form of interpersonal abuse, insult or joke. This indicates how such pejorative terminology is deeply embedded in our vocabularies and how negative images of people in mental distress are partly constructed through the ordinary everyday language we use to talk about mental health. Some argue that there is no harm in such language and that to make a fuss about it is simply political correctness. However, many researchers, mental health professionals, service users and carers have written about the power of language in stigmatizing mental health patients (see for example Read and Baker, 1996). Pejorative language is oppressive because it dehumanizes the person: 'Mentioning the name of my illness makes people feel as though you're Norman Bates' (service user, cited in MIND, 2003a).

The MIND survey *Counting the Cost* (Baker and MacPherson, 2000) analysed the effects of media portrayals on the lives of people with mental distress. Half of those who took part in the survey said that media coverage had a negative effect on their mental health:

- 34 per cent reported feeling more anxious or depressed
- 24 per cent had experienced hostility from their neighbours as a result of media reports
- 33 per cent felt reluctant to apply for jobs or to volunteer
- 37 per cent said their families or friends reacted differently to them because of recent media coverage.

One of the obvious consequences of negative stereotyping is that people avoid seeking help for their mental distress for fear of the stigma that follows (Read and Baker, 1996). Negative images and stereotypes are so pervasive and damaging that national and international campaigns and programmes have been developed to

reduce the stigma associated with mental distress. Some of these include the Care Services Improvement Partnership (CSIP) five-year initiative, *Shift* (2004–09) (www.shift.org.uk); the Mental Health Media, MIND, Rethink and Institute of Psychiatry campaign, *Time to Change* (previously *Moving People*) (2007–12) www.time-to-change.org.uk); the campaign by an alliance of five Scottish mental health organizations, *See Me* (2002–ongoing) (www.seemescotland.org.uk); the World Psychiatric Association campaign, *Open the Doors* (1996–ongoing) (www.wpanet.org/programs/opendoors-schizo.shtml); the Department of Health campaign, *Mind Out for Mental Health* (2001–04); the Royal College of Psychiatrists campaign, *Changing Minds* (1998–2003) and the MIND campaign, *Creating Accepting Communities* (1998–99). In the Moving People (2008) survey, *Stigma Shout*, 87 per cent of service users reported actual or anticipated stigma and/or discrimination.

Sartorius informs us that ‘the stigma attached to mental illness, and to the people who have it, is a major obstacle to better care and to the improvement of the quality of their lives’ (2002: 1470). Therefore it is essential that mental health practitioners and policy-makers challenge negative, damaging language, representations and attitudes in order to develop non-stigmatizing, accessible mental health care. Ironically, however, there is evidence to suggest that mental health professionals and mental health services may actually contribute to the stigmatization of people in mental distress – both through the diagnostic labelling process and in the way that treatments and services have traditionally been provided (Angermeyer and Matschinger, 2003; Sartorius, 2002). Sartorius (2002) illustrates how diagnostic labels can be an obvious source of stigmatization. While they might be useful in general medicine as a means of shorthand communication about a person’s physical condition, their relevance and/or appropriateness in the mental health field has been questioned. Moreover, mistakes in psychiatric diagnosis can have devastating consequences – for example, the case of Kay Sheldon (cited in Double, 2001) who was forced to make a claim for medical negligence against her Health Authority after being misdiagnosed and treated for schizophrenia. The critical psychiatrist Pat Bracken highlights another downside to diagnosis and the medical framing of distress:

It can cover up as well as illuminate the reasons for our pain and suffering. It is often presented to patients as ‘the truth’ of their condition and serves to silence other possibilities. Psychiatric diagnosis is often little more than a simplification of a complex reality and by formulating an individual’s experiences in terms of pathology it can be profoundly disempowering and stigmatising. (2002: 27)

It seems astonishing that in the round table discussions on mental health during the 54th World Health Assembly it had to be conceded that ‘most importantly, stigmatization, by all health professionals including mental health workers needed to be overcome’ (WHO, 2001b). In the UK context, a Mental Health Foundation survey (2000) found that 44 per cent of respondents had experienced discrimination from their GPs, while 32 per cent had experienced discrimination from health care professionals other than GPs. Prominent among them were:

- nurses and other hospital staff on both general and psychiatric wards
- psychiatrists and consultants
- emergency staff, particularly in A&E departments in response to self-harm
- community and social services, such as CPNs and social workers.

Similarly, in research by Thornicroft (2006) two-thirds of service users identified the attitudes and behaviours of GPs and other health professionals as stigmatizing. Incidents reported included being deliberately punished by staff or treated with a lack of respect. Other first-hand accounts of people who use mental health services reveal a disturbing picture of stigmatizing and oppressive treatment as illustrated in the following quotations:

Many mental health staff seem to embody the same stigma and discrimination that we might meet anywhere in society. Some staff treat us as if we are bad rather than mad, or talk to us as if we are naughty children.

I have observed or experienced so many occasions where staff are clearly making a situation worse by shouting at people, or threatening people ... it only leads to further humiliation and shame for us. How hard is it to maintain any kind of self-esteem in the face of this?

For over 12 years I have been a service user and have encountered an enormous amount of prejudice and total disregard for my feelings and intellect by the medical profession. I am a real life person with thoughts and feelings.

What most frustrates me is being treated like a dangerous animal ... The only violence in my 14 years of contact has been perpetrated by staff on me: once as I came down a flight of stairs I was jumped, my arms pinned behind my back, and my head and chest over the banister and then being 'restrained', prone on the floor with four nurses pinning me down and two deliberately inflicting pain because I dared to want to sit in the garden.

(selection of service user accounts, cited in *The Guardian*, 18 October 2006)

Chaplin (2000) draws attention to other aspects of psychiatric practice that maintain the stigma of mental distress – for example, the highly visible presence of medical, social work and police services in compulsory Mental Health Act assessments, and the overt physical side-effects of medications prescribed by psychiatrists (such as drooling and involuntary movements) that can make individuals appear socially undesirable. Similarly, McKay notes the stigmatizing effects of advertisements for psychiatric drugs that appear in medical journals:

How can we expect the general public to have a rational and informed approach to people with schizophrenia when learned journals accept advertisements that promote a product through negative stereotyping? Perhaps our willingness to allow this to happen is in accord with work in the field, which suggests that health professionals may have even more negative attitudes to mental disorder than the general public. (2000: 467)

THEORIZING MENTAL HEALTH – MEDICAL AND SOCIAL MODELS

In Western societies mental distress is almost universally understood as a belief that there is a disturbance in one or more areas of human functioning – thoughts, feelings and behaviours. Nevertheless, explanations for mental distress are a fiercely contested and debated area. Theories about the causes of mental distress vary between, and to some extent within, the various disciplines concerned with the field of mental health, though most conform to what is termed the medical or disease model. The medical model emerged from the mid-nineteenth century onwards, shifting earlier moral or religious frameworks of explanation for mental distress towards an illness framework. Psychiatry consolidated itself in the twentieth century through its assimilation with medicine, and the concept of ‘mental illness’ evolved as a generic term embracing a diversity of behaviours and phenomena. The modern day language and practice of mental health mimics that of the medical sciences in so far as it involves: the *observation* of human emotions and behaviour; the *identification* of pathological ‘symptoms’; the *diagnosis* of ‘disorders’ or ‘illnesses’ and the prescription of appropriate *treatment* for these.

The medical model approach is underpinned by the belief that mental health diagnosis simply involves the accurate naming of an objective disease process (Bracken and Thomas, 2000). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (2000), is the system used most often by psychiatrists in diagnosing mental disorders. The *International Statistical Classification of Diseases and Related Problems* (ICD) is a less widely used system published by the World Health Organization (1992). Both systems assume medical concepts and terminology and outline categorical disorders that can be diagnosed by set lists of criteria. The DSM has been revised five times since its inception in 1952. It was initially developed to create a standardized taxonomy that would enhance effective communication between psychiatrists to facilitate mental health research, diagnosis and treatment. The most recent version of the DSM is the DSM-IV-TR published in 2000.

Ostensibly, through the development of these formal diagnostic and classification systems, the medical model appears to provide practitioners with answers and certainties, but this can be a misleading assumption. Although they are modelled on the scientific paradigm, research has demonstrated that classification and diagnostic systems in the mental health field do not necessarily produce objective professional judgements. The process relies heavily on the interpretation of human emotions and behaviour, with diagnosis clearly capable of being influenced by subjective attitudes and beliefs (Double, 2002; Kirk and Kutchins, 1999). Double reminds us that ‘psychiatrists do not want to admit the uncertainty that there is around diagnosis. One only needs to attend a psychiatric case conference to realise that diagnosis is not an exact science. Many different opinions will be expressed’ (2001: 42).

The experience of learning to diagnose ‘mental illness’ is also influenced by the social, cultural and political contexts in which psychiatric training takes place, with a distinctly patriarchal, Western world-view dominating contemporary theory and practice

(Fernando, 2002; Loring and Powell, 1988). Similarly psychiatric knowledge itself is constantly under negotiation and changes over time. The contents of the DSM are determined through a process of periodic review and consultation by a panel of 'expert' psychiatrists. The number of classified disorders has grown significantly since the first edition (DSM-I) was published in 1952. From an initial list of some 128 disorders, the list had grown to 227 by the time DSM-III was published in 1980 and now stands at 374 in DSM-IV-TR (American Psychiatric Association, 2000). Some disorders have 'disappeared' altogether (most notably the de-classification of homosexuality as a mental disorder by a vote of the American Psychiatric Association in 1973 after a concerted campaign by gay activists) while new ones have apparently been 'discovered' (for example the introduction of 'religious or spiritual problem' in DSM-IV in 1994).

It is this uncertainty that has exposed psychiatry and the medical model in particular, to challenges to its authority. Throughout its history psychiatry has experienced dissent from within and outside the profession from those who contest the validity of the medical model of mental distress. Sociologists and dissident clinicians have argued that the emotions and behaviours that psychiatrists call 'symptoms' and 'illnesses' should not be considered pathological medical phenomena but meaningful 'problems of living' – manifestations of the social and political forces that shape the lives of human beings (see Foucault, 1967; Laing, 1959; Scheff, 1966; Szasz, 1961). The process by which people are categorized and labelled as 'mentally ill' is understood here as essentially *social* rather than medical – a means of pathologizing emotions and behaviours that society has deemed unacceptable. It is suggested that while the experience of mental distress is *real*, mental health problems are not, in fact, entities. It is misleading that the medical model speaks of them as though they are.

Furthermore, critics argue that formal psychiatric classification and diagnostic systems are subject to the limitations of the methods used to create them. 'psychiatric diagnosis is not dissimilar to astrology: both systems attempt to tell us something about people and to predict what will happen to them in the future, and both fail miserably' (Bentall, 2004: 21).

In practice, patients frequently fail to 'fit' into a particular category or, conversely, may fall into several. The categorical 'present or absent' approach to diagnosis encourages a polarized understanding of mental health rather than one which recognizes human experience as richly diverse and fluid, and better represented as a continuum. More significant, perhaps, is the criticism that rigid adherence to formal classification and diagnostic systems 'encourages unthinking practice and an impersonal approach' (Double, 2001: 43). Diagnosis, when used as a form of measurement, can easily overlook the uniqueness of individuals and important information can be lost that might otherwise help practitioners to fully understand the reason for the person's mental distress. As Poole acknowledges:

Psychiatric diagnosis is like a map reference. It tells you the general type of psychological terrain the patient is in; it tells you how this patient's disorder relates to other disorders, physical and mental. It conveys some limited predictive information, and a general indication of the types of intervention that might be helpful. However, just as a map reference cannot tell you the appearance of the landscape, similarly a psychiatric diagnosis

does not tell you what the person is like, how s/he will behave and the nature of any risks s/he faces. These matters have to be assessed individually on the basis of knowledge of the person. (2006: 134)

By contrast, the social model of mental distress privileges explanations that focus on independent life events that trigger breakdown (such as isolation, violence, bereavement and loss) and on social forces linked to: class (poverty and unemployment); race and ethnicity (racism); gender and sexuality (sexism and homophobia); age (ageism); and disability (disablism) that precipitate mental distress, recognizing that mental distress can be linked to issues of powerlessness, inequality and oppression (these issues are discussed more fully in Chapter 6).

In a national survey undertaken by MIND in 1990 mental health service users reported what it felt like to be on the receiving end of services (Rogers et al., 1993). Most saw their difficulties as rooted in the context of their life experiences rather than as symptoms of an illness. The responses of mental health professionals in primary and specialist settings were experienced as far too narrow and failed to engage with the priorities of service users. By contrast, the services that were valued were those that were in harmony with people's normal living arrangements, as well as services that engaged with issues related to housing, income, employment, isolation, relationships and meaningful occupation. The researchers concluded that mental health service users' needs are best framed broadly in personal and social rather than medical terms.

Advocates of the social model would argue that the medical model, on its own, is not sufficient to underpin policy and practice in mental health. The social model expands our understanding of mental distress beyond the narrow approach of just treating symptoms and provides frameworks that may be useful in giving meaning to the experiences of people in mental distress and in enabling and supporting their recovery (Tew, 2003). This does not necessarily imply an anti-psychiatry or anti-medication approach. Rather it is a model that refuses to privilege the medical model and pushes for the endorsement of a range of different perspectives on mental health (Bracken and Smyth, 2006). The next section explores further some of the essential differences between the medical and social models of mental distress with specific reference to the process of mental health assessment.

BECOMING A USER OF MENTAL HEALTH SERVICES: THE ASSESSMENT PROCESS

All assessments of mental health depend on theories about what constitute 'normal' thoughts, feelings and behaviours and how these can be distinguished from 'disordered' thoughts, feelings and behaviours. Nevertheless, as we have already established, the process of becoming a mental health service user begins well in advance of any direct contact with mental health professionals and is not solely influenced by formal professional judgements of what constitutes 'normality' and 'abnormality'. Other people (partners, parents and friends) will have already formed lay judgements

about the person's mental state prior to any formal examination by a psychiatrist. Indeed, often what triggers contact with mental health services in the first instance is a third party's observation and/or concern that the person's mood or behaviour has changed, becoming 'odd' or 'out of character' (as in the case study of Brian below).

De Swaan (1990) explains that the medical model of mental health is so firmly established in Western culture that we have all become 'proto-patients' and 'proto-professionals' – constantly monitoring and interpreting our own emotional and behavioural states, and those of others, in distinctly medical terms. Similarly, Pilgrim and Rogers (2005) talk around a cultural consensus between professionals and the general public around the conceptualization and management of mental distress. Sociologists (Goffman, 1961; Scheff, 1966) have argued that lay diagnosis is the first step in establishing the person in mental distress as 'other' or 'outsider'. Subsequently, through formal psychiatric diagnosis, that person then acquires the identity of 'mental patient'.

The mental state examination is the first formal stage in the process of psychiatric assessment and diagnosis. This is undertaken by a medical doctor (who is usually also a psychiatrist) using the standardized 'tools' available to her/him. This process is accompanied by a multidisciplinary investigation of the person's psychiatric and social history drawn from discussions with the individual, and his or her family and friends. Two points need to be noted here. First, while mental health practitioners do have very specific duties, powers and responsibilities under the Mental Health Act 1983 (amended by the Mental Health Act 2007) to assess a person for whom compulsory admission to hospital may be required, mental health assessments are not restricted to the compulsory context. (A full discussion of the process of compulsory assessment under mental health legislation is provided in Chapter 4). Compulsory assessments make up only a small part of the work of community mental health teams. Routine multi-disciplinary mental health assessments occur in a variety of other circumstances, most frequently in the context of needs-led assessments under the provisions of The NHS and Community Care Act 1990. Secondly, it is important to note that carers of those in mental distress also have the statutory right to an assessment of *their* needs alongside the assessment of those of the mental health service user, under the provisions of The Carers (Recognition and Services) Act 1995.

Case study

Brian Smith, aged 19, lives at home with his parents. He has suddenly become very reluctant to get up in the morning to go to University. He has become less talkative in recent weeks and spends most of his time in his bedroom, preferring his own company. Brian socializes less than he used to, refusing invitations to go out with friends. He shows little care for his appearance or personal hygiene. Brian's behaviour is now causing his parents serious concern and they have sought help from their family GP. The GP has asked the local mental health support team to visit the family home.

What steps need to be taken to ensure a thorough and accurate assessment of Brian's situation?

Explore the various theoretical models available to the team that might help them to (i) understand Brian's behaviour and (ii) assess Brian's situation.

Discussion: Case Study

As Bracken and Smyth point out, ‘for professionals who are trained to see the world through “medical model” spectacles ... questions to do with meanings, relationships and values ... are understood to be secondary concerns’ (*Irish Times*, 29 December 2006). If the practitioners in the team approach Brian’s case from the perspective of the medical model of mental health their attention is likely to focus heavily on Brian himself. However in this context a focus at the level of the individual does not equate with being ‘user-centred’. Quite the contrary, it relates to the assumption that ‘the problem’ primarily lies *within* the individual. Therefore the assessment process is heavily oriented towards the *form* of the distress rather than the *content* and *context* of the distressing experience. This can lead to the subordination or even denial of the individual’s account and the privileging of ‘expert’ knowledge or explanations that focus on individual (invariably biological) pathology and which inevitably lead to individualized (usually pharmacological) treatment responses.

Furthermore, an overly medicalized model of assessment in mental health practice can reinforce assumptions about the risks posed *by* the mentally distressed – either to themselves or others – simply by virtue of their ‘illness’ or ‘disorder’. Such an approach detracts from a full understanding of other dimensions of risk including social factors such as unemployment, poverty and domestic abuse and particularly the risks posed by the mental health system *to* the mentally distressed (Pilgrim and Rogers, 1996).

The social model approach to mental health assessment is informed by an understanding that ‘making a judgement and assessment about another person inevitably involves values as well as facts’ (Double, 2001: 42). This compels the practitioner to look beyond the level of the individual, to the wider context within which the individual, his/her immediate family/friends and the practitioner/mental health service are located. The need for a holistic approach to assessment is reflected in the *National Service Framework for Mental Health* (DH, 1999a).

Using Thompson’s PCS model (see Figure 1.1 above), we understand that Brian, his family and the mental health team do not exist in a ‘bubble’ – the social, political, economic and cultural forces that surround them influence both Brian’s ‘personhood’ and how his family and mental health practitioners ‘see’ and make sense of his situation. Tew explains how social models ‘explore the ways in which mental distress may be understood as, in part, a response to problematic life experiences’ (2005: 20). In this context, Brian’s mental distress may be understood as ‘the internalisation or acting out of stressful experiences’ or the development of ‘a coping or survival strategy’ rather than some internal ‘illness’ or ‘disorder’ (2005: 20). Therefore a full understanding of Brian’s thoughts, emotions and behaviour will require an integration of *all* dimensions of his lived experience. As Double argues, ‘what matters in assessment ... is an understanding of the patient as a person’ (2001: 43).

A holistic approach to mental health assessment also requires critical self-awareness on the part of all those practitioners involved, acknowledging power differentials and how personal and agency values and perspectives influence the assessment process. A social model approach to mental health assessment acknowledges the validity of Brian’s own account of his distress – as an ‘expert by experience’. The need

for people who use mental health services and their carers to be listened to and have their views taken seriously is a consistent theme in research literature (Beresford, 2007a; Rogers et al., 1993; Sayce, 2000).

This implies the need for a *partnership* approach to assessment – such an approach is consistent with a genuinely user-centred, empowering practice. A holistic approach to mental health assessment moves practitioners beyond the inherently stigmatizing medical model that imposes distinctions between ‘normal’ people and those suffering distress, or that tends to define the totality of a person in terms of their ‘pathology’ (Tew, 2002). As Tew argues, ‘there is no room for “us” and “them” thinking that can divide service users from carers or practitioners’ (cited in SPN, 2003a: 2).

Social workers are ideally situated to promote the social model approach to mental health assessment:

Social work brings something distinctive to mental health. Articulating it is more difficult. It is a constellation of values, commitment to social justice and partnership with users and carers. Social workers practised social inclusion before the term had been invented. Above all in mental health, it challenges the traditional medical model which does not fully acknowledge the patient or client as best informed about their needs. (Bamford, 2006)

The distinctive contribution of social work to interdisciplinary working in mental health

Social work perspectives and knowledge base

Social work is about change. Social workers try to improve the circumstances of people who are vulnerable or face social exclusion both by building on their personal strengths and by changing the social circumstances which have contributed to their mental distress. This means that they take a community as well as an individual perspective. They are committed to principles of self-determination and of helping people to overcome discrimination and other barriers to achieving their potential.

The social work knowledge base brings together a range of social science perspectives, linked to an understanding of law and social policy as it affects users of social care services and their families or informal carers. Seeing the person in their social context, practitioners apply social models of mental health, with an emphasis on how personal and family relationships, cultural needs, housing, work and social networks may be integral to recovery.

Social work has particular expertise in relation to the social and environmental factors that contribute to mental distress through the life course. This includes the impact of abuse and stigma on personal development.

The profession is characterised by a strong tradition of critical questioning, reflection and challenge within a multi-disciplinary context.

Essential shared capabilities

Social work has long provided a key and integral contribution to mental health services. Social work values, skills and knowledge are closely aligned with the 'Ten Essential Shared Capabilities' Framework for mental health practice and emphasise empowerment, challenging inequalities and working in partnership with service users and carers to support recovery.

Distinctive practice capabilities of social workers

- Assessing complex situations, taking account of an individual's strengths, aspirations, and vulnerabilities within a context of their personal and family relationships, cultural needs, social and environmental stressors and connections within the community.
- Working alongside service users to promote their social inclusion – mobilizing a range of community resources, networks, and statutory and voluntary services.
- Balancing legal and human rights and issues of risk and safety – achieving the least restrictive alternative within statutory roles and responsibilities, while offering protection to those who may be at risk of exploitation or harm.
- Working with family and informal carers to support an individual's journey to recovery
- Identifying and working with the personal and social consequences of discrimination, stigma and abuse
- Seeking changes in the social and environmental context which will promote recovery.

(NWW4SW Sub Group, in SWAP/MHHE, 2007: 10)

The Social Perspectives Network for Modern Mental Health (SPN, 2003b) identifies a number of barriers to achieving user-centred practice including:

- the consistent undervaluing of users' perspectives
- the failure to acknowledge diversity
- the lack of attention to the complexity of people's experiences of mental distress
- the entrenchment of the narrow medical model.

Conversely, there are some key principles for achieving user-centred practice including:

- *Empowerment* – working with service users, not doing things to them; avoiding paternalism
- *Partnership* – seeing service users as 'experts by experience' – accepting the right of service users to define their own experience and to find their own solutions – not a 'professionals know best' attitude
- *Empathic approach* – a willingness to look at situations through the eyes of service users
- *Genuine involvement* – of service users and carers in the design and delivery of services.

These are central principles for practice that will feature prominently throughout this book.

CHAPTER SUMMARY

In this first chapter we have begun to unravel the different terminology, images and representations, concepts and theories used in the field of mental health. A critical examination of the complex relationship between lay and professional ways of describing, assessing and explaining mental distress has revealed how stigmatizing processes dominate both professional discourse and practice and popular culture, and clearly have a negative impact on the lives of the mentally distressed. The over-reliance on the medical model of mental health in contemporary mental health practice has been exposed as heavily problematic and a case has been presented for the more widespread use of the social model of mental health – a model that is more closely aligned to the core values and principles of social work.



Further reading/resources

Foster, J.L.H. (2007) *Journeys Through Mental Illness: Clients' Experiences and Understandings of Mental Distress*. Basingstoke: Palgrave Macmillan.

Laurence, J. (2003) *Pure Madness: How Fear Drives the Mental Health System*. London: Routledge.

Tew, J. (ed.) (2005) *Social Perspectives in Mental Health*. London: Jessica Kingsley Publishers.
www.critpsynet.freeuk.com – the Critical Psychiatry Network.

www.spn.org.uk – the Social Perspectives Network for Modern Mental Health.

www.time-to-change.org.uk – national campaign to end mental health discrimination.