

Social Perspectives in Mental Health

Building alliances for change

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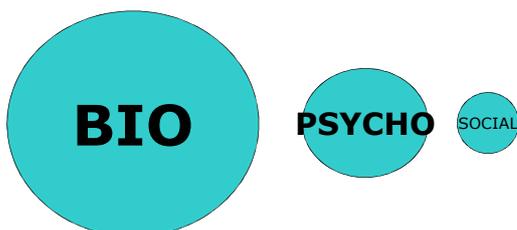


UNIVERSITY OF BIRMINGHAM

Social Perspectives Network
for modern mental health

HOW DO WE TEND TO THINK ABOUT AND RESPOND TO MENTAL DISTRESS?

THE BIOPSYCHOSOCIAL MODEL



'A bolt out of the blue'

A person is hit by a biochemical event that impacts on how they think, feel and behave and has implications for their family life, employment, housing needs...

'A bolt out of the blue' cont.

So, if we treat the illness, the rest will sort itself out (with some help and support)

Or, they have a chronic illness and will require ongoing treatment, care and surveillance

Some implications of 'A bolt out of the blue'

- Experiences of mental distress have no meaning or connection with social experience
 - just symptoms of an illness
- People are powerless to do much about mental distress – except for accepting medical treatments

Culture of compliance

Emerging critiques (and alliances)

- "For 150 years, psychiatry has fanned the flames of public hope and expectation, holding out promises of 'cure' and treatment for an ever-wider range of complex human and social problems. But these promises have failed to materialise... We believe that psychiatry should start a 'decolonisation', a phased withdrawal from the domains that it has laid claim to, including psychosis, depression and PTSD, by admitting the limited nature of its knowledge" (Bracken and Thomas, 2001)

Opening up the discursive space: psychiatry and psychology

- 'Psychiatry beyond the current paradigm' (Pat Bracken et al, 2012)
- 'The future of academic psychiatry may be social' (Stephan Priebe, Tom Burns and Tom Craig, 2013)
- 'Position Statement on the Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses: Time for a Paradigm Shift' (Division of Clinical Psychology, BPS, 2013)

A BIT OF HISTORY

- 1970s & early 1980s: Social / civil rights / feminist perspectives and higher profile for Social Psychiatry
- 'Decade of the brain' – neuroscience in the 1990s
- NSF for Mental Health 1999, especially
 - **Standard 1**
 - working with individuals and communities to combat discrimination and promote their social inclusion
 - **Standard 6**
 - Caring about carers – carers' assessments

A BIT OF HISTORY (cont)

- JSWEC 2001 and the birth of the **Social Perspectives Network** as an alliance for change
 - 1st SPN Study Day - 2002
 - DH funding / link to SCIE
- **PD No longer a diagnosis for exclusion** - 2003
- ODPM **Mental Health and Social Exclusion** report - 2004
- **A Common Purpose**: recovery in future mental health services – RCPsych/SCIE/DH (CSIP) 2007
- **New Horizons**: a shared vision for mental health 2009

A BIT OF HISTORY (cont)

- 'New Horizons confirms that people with mental health problems are able to run their own lives, participate in the life of their families and communities, and work productively to earn their living and contribute to the economy'

AND INTO THE PRESENT

- **No Health Without Mental Health**: A cross-government mental health outcomes strategy for people of all ages - 2011
- Implementation Framework - 2012

Public services improve equality and tackle inequality

- Services actively promote equality and are accessible, acceptable, and culturally appropriate to all.
- Services consider the particular needs of the most vulnerable groups.

A footnote....

- In addition to the groups defined by protected characteristics, groups with particular mental health needs include homeless people (including single homeless people and rough sleepers as well as the statutory homeless), offenders, certain BME groups, veterans, looked after children and young people, transgender people, gypsies and travellers, vulnerable migrants, victims of violence (including domestic and sexual violence), people approaching the end of life, bereaved people, people with dual diagnosis or complex needs, people with learning disabilities, people with personality disorders and people detained under the Mental Health Act.

Public services intervene early

- Children and their parents receive evidence-based mental health promotion from birth.
- Schools and colleges promote good mental health for all children and young people, alongside targeted support for those at risk of mental health problems.
- Public services recognise people, of all ages, at risk of mental health problems, and take appropriate, timely action, including using innovative service models.
- Health services intervene in the early stages of psychosis or crisis, to stop more serious problems developing.

Public services work together around people's needs and aspirations

- People receive faster, higher-quality care when they are in crisis.
- Health and care services focus on recovery, rehabilitation and personalisation.
- All services are underpinned by humanity, dignity and respect.
- Public services recognise the wider determinants of mental health and wellbeing, including how these differ for specific groups, and address them accordingly.
- Services work together to support people with mental health problems to maintain, or return to, employment

THEORY AND EVIDENCE

Publication of *Social Perspectives in Mental Health* – 2005

Publication of *Social Approaches to Mental Distress* – 2011

The future of academic psychiatry may be social - *Priebe et al, 2013*

Most of this builds on ways of understanding that have come from service users, survivors and their allies – and most of the best social research has been done by psychiatrists

Evidence base

- Social factors contribute to mental distress – e.g. abuse, systematic discrimination, family dynamics (*Read et al, 2004; Tew, 2011*)
- The most important factor in recovery would seem to be social opportunities – e.g. reclaiming valued social roles / identities; personal relationships of giving and receiving (*Warner, 2004; Schon et al, 2009; Tew et al, 2012*)

How important are social factors?

When all other factors are taken account of, incidence of psychosis can be:

- 9x higher for people of African Caribbean descent living in England (*Fearon et al, 2006*)
- 7x higher for people brought up in deprived economic backgrounds as children (*Harrison et al, 2001*)
- 5x higher for people brought up in stressful family environments (compared to 1.5x increase in incidence for genetic factors alone) (*Tienari et al, 2004*)

What happens when you have socially inclusive mental health services?

Long term evaluation of Open Dialogue in Finland (*Seikkula et al, 2011*):

- 81% of patients did not have any residual psychotic symptoms
- 84% had returned to full time employment or studies.
- Only 33% had used neuroleptic medication

Starting points for theory: What is mental distress?

- A biological illness where social factors may influence the course of the illness (stress-vulnerability model)

OR, EVEN BETTER,

- A potentially meaningful and understandable reaction to social circumstances (past and present) which may become embedded physiologically as well as socially and psychologically

The *biological* and the *social* connect

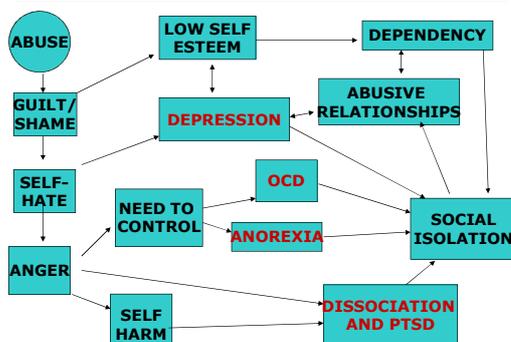
– but we may need to conceptualise this in a different way (*Tew, 2011*)

Evidence from brain scanning shows that

- Early childhood experiences of trauma or deprivation can become reflected in the 'hard wiring' of neural pathways in the brain
- Brains remain 'plastic' and positive life (and therapeutic) experiences may lead to positive 're-wiring' in later life

SOCIAL / TRAUMA MODEL

(based on Plumb, 2005)



The recovery movement

Recovery involves resolving personal and social issues and 'getting a life' rather than just 'taking the pills'

- Connecting with others
- Hope for the future
- Finding positive personal and social Identities
- Meaning and purpose
- Empowerment (*Leamy et al, 2011*)

Resources for recovery: recovery capitals *(Tew, 2012)*

- Personal
- Relationship
- Identity
- Social
- Economic

Social responses to mental distress: disability and stigma perspectives

What may be experienced as most disabling is not people's impairment, but societal responses to it.

These responses may be framed by a construction of 'normality' that puts down, patronises or excludes those who fall outside its definition.

What is so threatening about mental distress?

'Hysterical' societal reaction:

- Demonisation of mentally distressed as "a menace to the proper workings of an orderly, efficient, progressive, rational society" – *Roy Porter*
- Commitment to rationality and self-disciplining as price to be paid for citizenship in modern society – *Foucault*

The triple whammy

1. The experience of mental distress (which may connect with experiences of discrimination and abuse)
2. 'Othering', stigmatising or excluding responses from friends, family, professionals and society at large
3. Responses can make mental distress worse

PRACTICE: GETTING BEYOND THE STATUTORY 'TRAP'

- There is wide recognition across the sector that social workers have the skills and capabilities to do more than AMHP / DoLS roles

'In speaking to Chief Executives of Mental Health NHS Trusts, AMHP and mental health social work leads, the Chief Social Worker for Adults, the Mental Health Faculty of the College of Social Work, and mental health social workers, I have found widespread support for these roles. However, achieving them all is proving elusive...' (Webber, 2014)

TCSW areas of practice

- **A:** *Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority*
- **B:** *Promoting recovery and social inclusion with individuals and families*
- **C:** *Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity*
- **D:** *Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship*
- **E:** *Leading the Approved Mental Health Professional workforce*

PRACTICE: WHERE SOCIAL WORK SHOULD BE AT THE HEART OF CHANGE

Inclusive ways of working

- Whole family (not just carer) approaches
 - E.g. Open Dialogue, Family Group Conferencing
- Whole systems approaches to recovery
 - Community action / community development
 - Social engagement, education, employment

Prevention and (very) early intervention

- Join up with children's services
 - Targeted support for vulnerable groups
- Wellbeing / public mental health
- Crisis resolution *NOT* home treatment

PRACTICE: WHERE SOCIAL WORK SHOULD BE AT THE HEART OF CHANGE

Co-productive and asset/strengths-based ways of working

- Working with people to (re)build the forms of capital that may be necessary to underpin recovery:
 - Personal, Relationship, Identity, Social and Economic
 - Intentional Peer Support, Recovery Colleges
- Personalised action (not care) and personal (health) budgets that enable people to take charge of their lives

ALLIANCES FOR CHANGE - POLICY

- Alliance with Clinical Commissioning Groups and Public (mental) Health
 - Commissioning for prevention and early intervention
 - e.g. 0-25 commissioning - Forward Thinking
 - Health and Wellbeing Boards
 - Local implementation of No Health without Mental Health

ALLIANCES FOR CHANGE - POLICY

Implementing the Care Act 2014 – opportunities for collaboration around

- Promoting individual **wellbeing**
- **Preventing** people's care and support needs from becoming more serious
- **Young people in transition** to adult care and support
- **Personal budgets**

Personal health budgets from 2015

ALLIANCES FOR CHANGE - PRACTICE

What are the organisational contexts that would allow social workers to flourish in TCSW 'B, C and D' roles?

- Local Authorities
- NHS organisations (inc primary care)
- Co-operatives / voluntary sector (c.f. Social Work Practice Pioneer sites; Family Recovery Projects)

Linking with socially oriented developments in health service / public health provision

- Open Dialogue
- Recovery Colleges
- Preventative work with young people – e.g. in schools

ALLIANCES FOR CHANGE – MAKING IT HAPPEN

Effective **local** social care leadership - especially in integrated organisational structures

- Principal social workers / Board level representation
- Consultant social workers
- CPD learning that is not just AMHP training

New training initiatives – e.g. Think Ahead

ALLIANCES FOR CHANGE – THEORY AND EVIDENCE

- Building understanding collaboratively with service users, carers and practitioners
 - e.g. NSUN, Hearing Voices Network, BASW
- Influencing the agenda for the School for Social Care Research
 - E.g. Social work roles in prevention, wellbeing
- Interdisciplinary evaluation of socially focussed models of practice
 - E.g. Open Dialogue, Personal budgets, Intentional Peer Support

ALLIANCES FOR CHANGE – POLITICAL

- All party social work group committed to review of mental health social work after election
- Opportunity for BASW and SPN to lobby new junior ministers

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