Social Perspectives Network

SPN

for Modern Mental Health

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What is the knowledge base and where does it come from?

Thoughts from the SPN study day 1 May 2002

Principal paper by Maria Duggan

SPN paper 2

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About SPN

The Social Perspectives Network for Modern Mental Health (SPN) uses knowledge-based practice to:

- articulate and promote the value of modern social models in mental health services
- provide a focus for the sharing of best practice in social interventions in modern mental health services
- engage with and influence key policy makers to support the integration of social models in modern mental health services.

Publisher's note to reprint of April 2003

The Social Perspectives Network for Modern Mental Health (SPN) has been hosted since its launch in February 2002 by Topss England, the strategic body for workforce development in social care. This is the second SPN paper to be published under those auspices. However, as this paper is being prepared for reprint in 2003, work is also underway to transfer the hosting of SPN to the Social Care Institute for Excellence (SCIE). Topss England is very pleased to be associated with SPN, and is confident that a close relationship will continue as work on developing the mental health workforce proceeds, and as the partnership between SCIE and Topss England leads to an increasingly mature relationship between research and workforce development.

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Purpose

This paper summarises the discussion at the first study day organised by the **Social Perspectives Network for Modern Mental Health** (SPN) following its launch in February 2002. The study day brought together a wide range of participants from a variety of backgrounds to consider the questions*: What is the knowledge base and where does it come from?* An important dimension of the day was the encounter of a number of mental health professionals at various levels of seniority with a number of people with 'lived experience' of mental ill health, and the consequent recognition of the shared internal and external landscapes which are inhabited by those who use services and those who work in them. One of the key characteristics of the modern social perspective, as expressed by the SPN at its inauguration, suggests that *'the modern social model emphasises shared knowledge and shared territory with a range of disciplines and services users and the general public'.* [1] The experience and the outputs of the study day are a reflection of this characteristic in action. Notes from the study day and additional comments from a number of participants have shaped this paper (see annex).

These points of shared knowledge and territory, which are discussed below, form the base upon which future thinking about 'the social' as both end and means in the delivery of modern mental health services will be developed. This paper outlines these briefly and goes on to indicate a future developmental agenda, for the SPN itself and for national and local agencies charged with developing and delivering mental health and other necessary services.

The evidence base

The dominance of biomedical approaches

The focus of the study day discussion required participants to grapple with the relative limitations of the current evidence base in relation to social approaches, the lack of visibility of that evidence which does exist and its relatively low status in a service and policy context, which privileges biomedical perspectives and research. The persistent 'medicalisation' of mental health service models and research priorities appears to relate very little to an accompanying evidence base which indicates that advances in pharmacology and other medical treatments have resulted in little consistent improvement in recovery rates.[2] We cannot say that the medical model, on its own, is a sufficient basis to underpin policy and practice in mental health. Other evidence suggests that variables such as cultural setting, levels of social support, employment and poverty appear to have much greater impact. There is, additionally, some evidence that such socially orientated services have greater recovery rates.[3]

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[1] Topss England. SPN Network. *The Key Characteristics of Modern Social Models in Mental Health.* February 2002. Topss England

[2] Tew. Jerry (2002) *Reconstructing a Social Model of Mental Distress*. Presentation to the Critical Psychiatry Network Conference.

[3] See for example Second Report of the Health Select Committee. Par. 115-116 cited in *Modernising the Social Model In Mental Health: An SPN discussion paper*. Topss England, Feb 2002

This tantalising paradox, it was forcefully pointed out during the study day, obliges us to rigorously examine how our knowledge is created and, more importantly, how certain kinds of knowledge are valued more highly than others. Numerous alternative strands of social thinking are currently in the shadow of the medical model and need to be brought together into a coherent model or set of models in their own right. However, exhortations to this synthesis miss the point if they fail to address the reasons why it has not already happened, or the likely fate of such a synthesis if it were undertaken. The fact is, as acknowledged at the SPN study day, that our current ways of seeing the world, our political system and the focus of our collective investment in the mental health system, including the training system, are medicalised. This is hardly surprising as much of the research is funded by the pharmaceutical industry, which perpetuates its own self-interest as a fundamental principle. However, the contours of this ideological domination are much more entrenched and subtle than this. The discussion at the SPN study day began, albeit tentatively, to address the highly ideological nature of both theory and practice in mental health, within the far broader context in which the production and distribution of knowledge itself is seen as highly culturally and politically determined. This important discussion, which can broadly be termed **the political economy of mental health,** suggests one important strand of future activity for SPN.

What works?

The incorporation of service user perspectives as a fundamental principle of effective mental health policy is the keystone of the social model. This is not to say that user perspectives should be uncritically regarded and accepted as fact, but that any credible research agenda, committed to demonstrating the effectiveness or otherwise of mental health interventions must include responses from service users as to their impact. Reclaiming the evidence base with and for service users must be a starting point. The identification of and development of a **service user driven research agenda** is another vital strand of future SNP activity. The following are among the elements of this research agenda.

An emphasis on relationship

Close personal relationships are a source of important and valued social support. Social support – or the lack of it – is implicated in both causing and recovering from mental ill health. Effective responses to mental distress involve helping people to deal with relationship problems and to help people in distress to develop and sustain social networks. This is particularly important when mental illness inevitably stresses relationships. In a mental health crisis, existing interactions may be damaged and it becomes harder to maintain relationships. In some situations the usual roles are reversed, for example when children become carers, or when lovers become estranged and hostile.

The stigma associated with mental illness may render relationships fragile and almost invariably limits the possibilities of extending these networks

Increasingly complex, modern societies may enable more networks but may also create alienation, loneliness and stress.

- ***How can mental health professionals assist service users and their social networks to accommodate each other better?***
- ***What capabilities are required of mental health professionals to work effectively with service users and their social networks?***
- ***How should services address the needs of people with mental ill health who are socially excluded and denied full participation as citizens?***

The importance of trust

Mental health professionals must be prepared to adapt their practice to meet the needs of the service user. When necessary, inter-professional boundaries need to be blurred. One clear potential benefit of a multi-disciplinary, team-based approach to support is that many different individuals may be available, within a coherent framework of intervention, to work closely with the service users and their social networks.

This requires the development of a practice based on a willingness to step outside of a prescribed professional role. *If the service user feels better about the social worker administering the drugs, or the psychiatrist organising the package of care -what's the problem if it works?*

This suggests that mental health professionals need to understand that there is a set of values that relate to long term commitment to, and engagement with, service users and their social networks. This kind of commitment enables trust to grow and facilitates the development of a therapeutic relationship. Mental health professionals need to be 'mindful', self aware, willing to blur their boundaries and able to subdue their own needs and interests (while being aware of these and able to take them into account) in the interests of the service user. The modern mental health agenda requires the development of 'new' approaches, new specialisms drawing on the integrated skills of a variety of professionals which need to be reflected upon and rigorously evaluated. **The development of integrated service models and influencing the training of mental health staff** is another important strand of activity to be taken forward by the SPN.

- ***How should mental health professionals be trained to enable them to sustain a values-driven and evidence-based practice?***
- ***What is the evidence for multi-disciplinary, team-based practice compared with traditional, uni-disciplinary approaches?***
- ***What organisational and service contexts are required to effectively deliver an integrated model of mental health provision?***
- ***What kind of leadership is required to drive through and support a user-orientated integrated service model?***

User empowerment

In the current health policy climate there is a discerned need to provide better support and advice to people in a range of life circumstances. In this new policy climate, the centrality of the user perspective is increasingly viewed as an integral and essential element of the health care system itself. In England, for example, the Secretary of

State for Health, Alan Milburn[4], and a past Minister for Health, John Denham[5], have described 'self care' or patient autonomy as the first level of health care. This shifting emphasis is driven in part by the Government's determination, as a central plank of the modernisation endeavour reiterated in range of national policies, to challenge and transform the nature of relations between professionals and the general public. It is also driven by the need to ensure value for money in health and social care by optimising health outcomes.

The necessity of achieving a significant shift in the direction of a preventative health care system is underpinned by the global burden of disease. Theses indicate that, by 2020, the disease burden attributable to non-communicable diseases is expected to rise sharply, driven largely by an ageing population and by a seemingly inexorable rise in mental ill health.[6] Assisting people to manage their own health more effectively should help make formal resources more adequately available at other levels. Whether the argument is that of social justice or value for money, it is both contradictory and profoundly discriminatory to deny this 'self care' to people with mental ill heath. Ensuring *empowerment, not compliance* needs to be the goal of mental health services as well as other areas of health care delivery.

While acknowledging that in certain situations, in order to protect individuals in great mental distress and, very rarely, their carers and the general public, control and autonomy need to be taken away, policy and services should not be driven by these situations. Frequently, admissions to acute units are extremely anti-therapeutic and reflect responses dictated by traditional service formations and by the needs and interests of staff, rather than by individual need.

A new approach to legitimising creativity and responsiveness to local individual and population needs is required in modern mental health services. However, efforts to influence and modify national policy are hampered by the current lack of detailed evidence.

Linked to this, the concept of recovery itself needs to be subjected to critical evaluation. **Establishing and publishing the evidence for a sustained social approach to meeting the needs of individuals who are in severe mental distress** is a primary objective for the SPN.

The discussion at the SPN study day, however, asserted that the task of factoring in the user perspective is much broader than this. Annexing service user input to a biomedical and profit-driven agenda is not the only or indeed the main task. As important is the exploration of concepts of citizenship, equity and human rights and the

[4] Milburn A. (2000). A *New Programme of Modernisation for the NHS.* Address delivered at the King's Fund, 2 February 2000.

[5] Denham J. (2000). *Presentation to the All Party Group on Primary Care and Public Health*, 15 March 2000

[6] WHO (1996) *The Global Burden of Disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Harvard University Press.

incorporation of these concepts into models of practice and service delivery. These indicate the need for mental health services to incorporate population- and community-focused approaches, as well as traditional individual casework methodologies. Mental health services need to develop partnerships with a wide range of other agencies, including the corporate structures of the local authority, community regeneration initiatives, local voluntary agencies, faith communities and the community justice sector. As one participant on the day pointed out:

> *If services were geared up differently, they would see that the Care Programme Approach provides a powerful opportunity to galvanise a proper, co-ordinated response to meet the user's needs in negotiation with the user. But everyone thinks in silos and opportunities to really make a difference are missed. Mental health services need to look to the wider environment. They stay within their own comfort zone as a way controlling the world.*

- ***What evidence do we currently have about the outcomes for those who are treated compulsorily, compared with those who are offered sustained supportive contact as citizens?***
- ***What service models currently exist to demonstrate the efficacy of sustained social support and intervention?***
- ***How do we define positive outcomes and who defines these?***
- ***What would user-defined recovery outcomes look like and how could these be reconciled with the professional agenda?***
- ***What are the implications of a citizenship perspective for service models and interventions***
- ***What might a strengths perspective look like when applied to a local population?***
- ***What policy opportunities exist to develop a more holistic approach to preventing and treating mental ill health and how can these be translated into viable options for reformed mental health services?***
- ***What indictors might be developed to evaluate such developments?***

Power and hierarchy

We may have common sense knowledge of who – and what – has the ideological and political power to deliver the modern mental health agenda but, in recent years, a critical analysis of power and hierarchy has been marginal in the formation of national policy and in the ethos and structure of services. Traditional interest groups and approaches remain entrenched in the structure and organisation of mental health service delivery. The practical manifestation of this is seen in three main ways within mental health services.

Firstly, in the consistent undervaluing of users' models – or ways of seeing the world – as hooks on which to hang disturbing or confusing experiences and feelings and the consequent 'shoehorning' of users into a variety of preconceived frameworks. In this regard all established interventions from psychoanalysis to pharmacological therapies are equally guilty.

Secondly, in the lack of attention that is paid to the diversity and complexity of perspectives which inform the experience of mental distress and which lend themselves to a similar diversity within the theoretical underpinnings of service delivery.

This rich repository of knowledge and lived experience challenges our current templates which are, as discussed above, the creations of a particular set of cultural and political arrangements. We need to remember that users are not homogeneous but are drawn from across the totality of our increasingly complex and varied societies. There is a vital need for a framework that enables all those interested in mental health to make sense of differing perspectives, whether these are from black and minority ethnic communities, from gay men or lesbians, from older people or from children or those whom war and famine have displaced and relocated in the uncaring and frequently hostile environment of our cities and towns.

Thirdly, we see the entrenchment of traditional approaches in the relative lack of value accorded to the provision of support for the practical problems of daily living, including the basic human needs of housing, money and access to essential services. These are often compromised in the panoply of interventions delivered by mental health services. Equivalent low status is attached to the staff who deliver these interventions.

The development of a framework that incorporates multiple perspectives and raising the status and morale of social care staff are both important future strands of activity for the SPN.

- ***What are the workforce implications of re-engineering mental health services to ensure that service users' definitions of their own needs and priorities are accorded equal value with the definitions given by biomedical professional groups?***
- ***What realistic measures can be taken to reform the roles of mental health staff and to raise their status within the multi-disciplinary mental health context?***

Conclusions

The following conclusions arise from this analysis of the discussion at the SPN study day.

1. There is a need for a new framework for the determination of what works in delivering services to people with mental distress which focuses on:
    - the quality of relationships
    - needs rather than diagnoses
    - clear and explicit values regarding the rights and dignity of people who use services
    - addressing the needs of populations as well as of individuals
    - taking account of the diversity of perspectives
    - enabling responsiveness to local needs and legitimising appropriate risk taking
    - encouraging role blurring
    - valuing social and practical support equally with biomedical interventions.

2. The development of this framework would establish a proactive research and policy development agenda for all those interested in social perspectives in mental health, categorised by the following headings:
    - the political economy of mental health
    - the priorities for a service user driven research agenda
    - the development of integrated models of service delivery
    - defining a user-orientated training agenda for mental health care staff
    - establishing and publishing the evidence for a sustained social approach to meeting the needs of individuals who are in severe mental distress
    - the development of a framework that incorporates multiple perspectives and raising the status and morale of social care staff.

Next steps

This is a large and challenging agenda, which cannot be taken forward in isolation by a loose, informal network such as the SPN. There is, however, a critical need to decide which parts of this agenda can be progressed by the SPN as an independent network with limited resources and which should be taken forward by others, particularly by bodies such as the Social Care Institute for Excellence (SCIE) and National Institute for Mental Health in England (NIMHE). The credibility of SPN will largely determine its influence in the future. Developing this credibility will be dependent, in its turn,on the quality of its outputs, whether these are publications or anything else.

Short term actions

The following short-term actions for SPN were suggested by study day participants:

- dissemination of the SPN's Key Characteristics and first discussion paper (*Modernising the Social Model of Mental Health*) through the Topss England website
- identification of a list of key resources, suggested by SPN members, to be posted on the website
- hosting an autumn study day on the diversity of perspectives which inform the social model and the drafting of a further discussion paper.

Longer-term actions

In the longer term, there is a need for prioritisation of effort and activity, and the development of a business plan. This should address the:

- identification of priorities for research and policy development, and a timetable for research activity
- identification of potential funders, taking into account the values of SPN and the need to retain its independence
- targeting of organisations and structures to influence and develop through the production of specific guidance and research
- identification of alliances with other networks and organisations to ensure that future SPN activities and publications reflect the diversity of perspectives which are integral to the social model

- distinction to be made between any campaigning focus for the Network and its development as a hub of social perspectives research, policy development and information sharing
- effectiveness of remaining hosted within Topss England or another national body, or becoming a 'stand-alone' organisation, and the feasibility of achieving this status.

A robust infrastructure

Whatever the ultimate decision about the future shape and activity of the SPN, there is an urgent need to provide dedicated co-ordinated administration for the Network, to update the website and to take a proactive approach to progressing actions outlined in the business plan.

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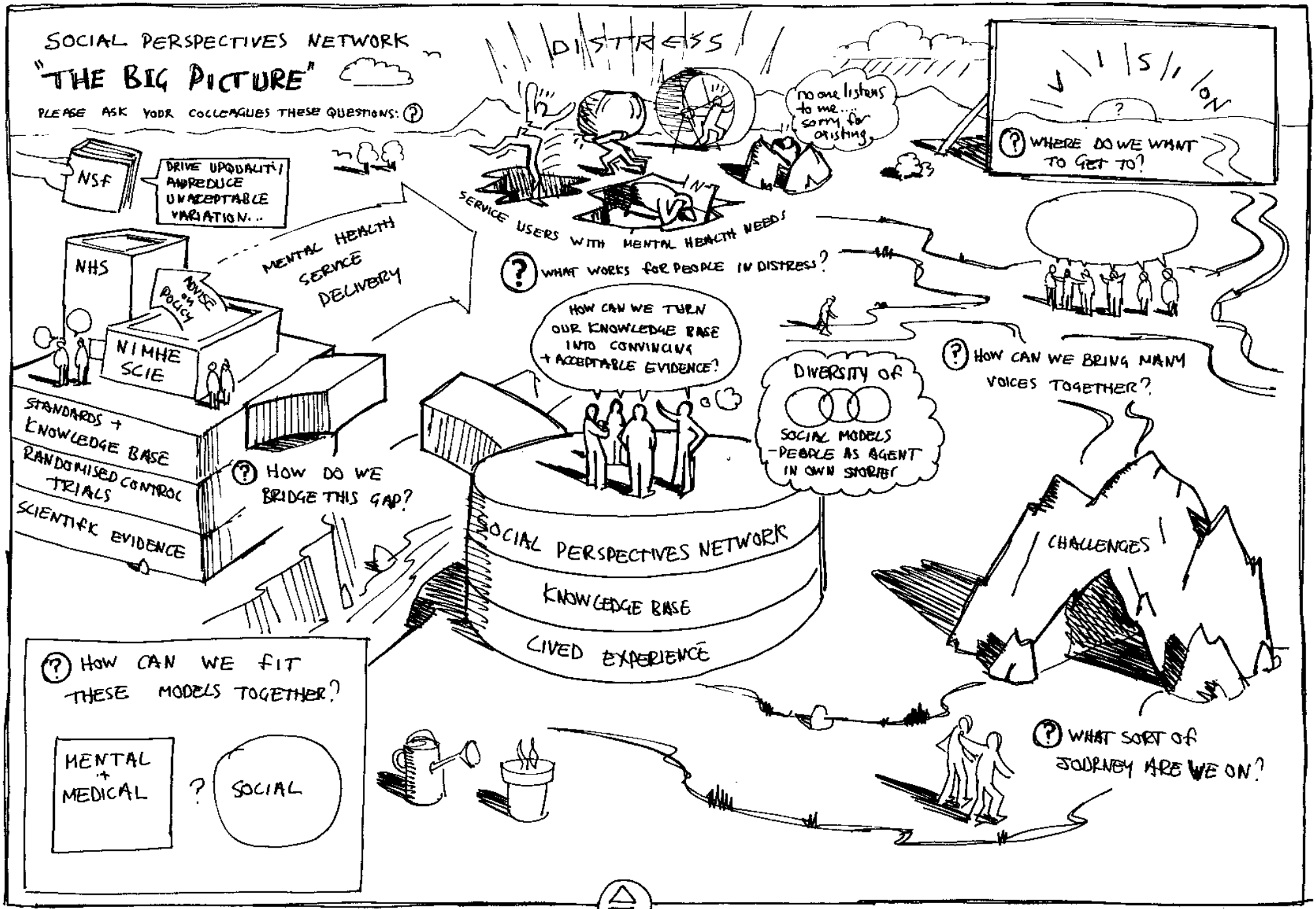

Annex 1. SPN study day 1 May 2002

What works for people in mental distress: summary of work in small groups

Values

- Hope – things can change
- Choice
- Being seen as a person – holistic perspective
- Having own understanding and experience believed / respected / validated – including spiritual beliefs
- Reciprocity – relationships of giving as well as receiving
- Acceptance of
    - 'dark side' of experience
    - Spiritual issues
    - Difference (culture, sexuality…)
    - Diversity of experience and expression (e.g. hearing voices, self-harming…)
- Accept that people will make mistakes – do not punish failure
- Finding meaning
- Reclaiming sense of value and self-worth
- 'Having a life'
- Empowerment not compliance – people have to have a sense of control over their lives
- Collaboration

Resources

- Information – of services, treatments, alternatives, different perspectives… and how to access them
- Opportunities to be involved in mainstream community life
- Support / talking to others who are in same situation
- Appropriate medication and support in self management
- Access to
    - employment / occupation – and lack of stigmatisation and harassment from employers
    - childcare
    - housing
    - benefits
    - leisure

    - education
- Opportunities to achieve a good quality of life and a sense of belonging – basic rights of citizenship
- Knowing that support and understanding is there
- Involving / creative activities
- Social networks – not losing old ones and developing new ones
- Getting people together – groups can be more powerful than individuals
- Intimate relationships
- Holidays
- Exercise

Professional input

- Focus on the helping relationship
    - awareness of professional power and how it is used
    - relationship skills - how to be with people in distress
    - offering continuity, consistency and reliability
    - building trust
- Dealing with the root social causes of why people become unwell
- Good planning
- Working towards user-defined outcomes
- Solving practical problems
- Workers being open about their own experiences of distress – potentially acting as 'survivor' role models
- Knowing when not to intervene, and how to let go – not building dependency
- Listening – giving time and space
- Validating the person - offering acceptance
- Engaging in dialogue - learning from user's experience
- Practical *and* emotional support – recognising emotional distress
- Support *and* challenge
- Finding out and working with people's aspirations
- Focus on strengths
- Permission for risk-taking
- Identifying indicators and factors that may lead to relapse
- Giving people ownership of their 'therapeutic process'
- Cognitive therapy

- Normalisation
- Democratic therapeutic community

Service / policy issues

- Needs-led approach
- Paying attention to physical health
- Service user involvement in all professional training
- Involving service users in design of services
- Training for service users in how to become involved in education and the delivery of services
- Overcoming stereotypes and low expectations from service providers
- Role blurring between professions – are professions necessary?
- Integration and coherence between services, and between services and the communities they serve
- Policy taking account of need for long term involvement
- Empowering, valuing and caring for staff - and helping them stay engaged with situations of acute distress
- Expectation of / facilitation of reflective practice

Outstanding issues / questions for the panel

- What do we mean by 'what works' or 'recovery'?
    - Whose agenda / outcomes are we working towards – e.g. 'cure' vs. quality of life / social participation / empowerment?
    - Do we need to prove that user empowerment has benefits or is it a goal in itself?
- What constitutes evidence of oppression?
- What do we know about what aids empowerment in practice?
- How can those people whose experience is researched see the benefit of this?
- How to challenge the bias towards evidence that is based on RCT approaches that treat people as passive objects who take no active part in their recovery or solving their own problems
- Need for pro-active approach to evidence based practice – not to stifle people with always having to follow existing validated protocols based on past research, but encouraging an ongoing process of innovation and evaluation
- Need to move from 'medical treatment' discourse to one of citizenship and democratic involvement
- Need to address root social causes of people's distress
- Tension between aspirations for non-hierarchical ways of being a professional and need to be seen as 'experts' on social perspectives.

Annex 2. SPN study day 1 May 2002

Hope

It could be argued that mental health services across the UK reached the start of the new 21st century with generally low levels of hope and expectations. These low levels may have been the end product of various forces and interactions.

The new century/millennium has seen a small yet significant rebirth of hope and raising of expectations.

Julie Repper (see *Adjusting the focus of mental health nursing: incorporating service users' experiences of recovery.* Journal of Mental Health 2000; 9, 6: 575-587) argues that recovery is about nurturing the spark of **hope** and helping people to develop coping strategies.

Much of the research into hope and its relation to mental health has been carried out in the USA and Canada.*

Some findings have been that:

- Hope is infectious and catching – hopeful mental health workers infect each other – similarly workers who have no hope (hope-less workers) infect each other.
- Hope is a key ingredient in successful treatment outcomes and the recovery of service users.
- Service user successes have a positive impact on worker's hopefulness.

It is not difficult to see from such findings that a mental health service that both establishes and maintains an overall atmosphere and ambiance of hope is likely to work better for both the providers and users of the service.

* for examples see:
Landeen J et al (1996) *Factors influencing staff hopefulness in working with people with schizophrenia.* Issues in Mental Health Nursing, 17:457-467.
Littrell K et al (1996) *The Experience of hope in adults with schizophrenia.* Psychiatric Rehabilitation Journal, vol 19, no 4: 60-65.

See also **Perkins R** (2001) *The You'll Nevers* Openmind 107, Jan/Feb

Annex 3. SPN study day 1 May 2002

Evidence (not alibis), *compiled by Thurstine Basset*

My top five evidence-based publications are:

Faulkner A, Layzell S (2000) *Strategies for Living – a report of user-led research into people's strategies for living with mental distress* London: Mental Health Foundation……. www.mentalhealth.org.uk

Davis A, Hill P (2001) *Poverty, Social Exclusion and Mental Health – a resource pack* London: Mental Health Foundation and Focus…….. www.mentalhealth.org.uk

Wallcraft J (1998) Healing Minds – a report on current research, policy and practice concerning the use of complementary and alternative therapies for a wide range of mental health problems London: Mental Health Foundation…. www.mentalhealth.org.uk

Seebohm P, Grove B, Secker J (2002) Working Towards Recovery – putting employment at the heart of refocused mental health services London: Kings College……020 7848 3740

British Psychological Society (2000*) Understanding mental illness: recent advances in understanding mental illness and psychotic experiences* Leicester:British Psychological Society…….available from publications@mind.org.uk and BPS website www.understandingpsychosis.com

Finally, not so much evidence as knowing more about our colleagues, essential reading is:
Royal College of Psychiatrists (2000) *Good Psychiatric Practice 2000 – council report CR83* London:Royal College of Psychiatrists, tel 020 7235 2351.

Useful References, February 2002.

Ann Davis and Phil Hill (2001) *Poverty, Social Exclusion and Mental Health: A Resource Pack*. Available from the Mental Health Foundation £10 – free to users and unwaged. Telephone: 020 7802 0300.

Ratna Dutt and Peter Ferns (1998) *Letting through the Light: a training pack on black people and mental health*. Was available free of charge from DH Distribution Centre, PO Box 410, Wetherby LS23 7LN ref C1 (98) 13. SPN is asking to have it scanned on to the web.

Shula Ramon (2000) *A Stakeholder's Approach to Innovation in Mental Health Services*. Pavilion Publishing.

Shula Ramon (2001) *Post ASW: future scenarios for mental health social work*. Available from the author at S.Ramon@anglia.ac.uk

Jerry Tew *Going Social: championing a holistic model of mental distress within professional education*, Social Work Education Volume 21 Number 2, April 2002.

Forthcoming articles by Andrew Cooper and Cathy Aymer on therapeutic social work and mental health in Journal of Social Work Practice Volume 16 2002 Number 1 (May).

Below: scenes from the study day.

Inset right: at the launch of SPN, February 2002 at the Topss England conference.