(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 about 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 multidisciplinary 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 analysis (see Figure 1.1, p. 9), 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.

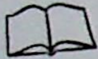
Conversely, there are some key principles for achieving user-centred practice including:

- *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 ar representations, concepts and theories used in the field of mental health. A critic examination of the complex relationship between lay and professional ways c describing, assessing and explaining mental distress has revealed how stigmatizin processes dominate both professional discourse and practice and popular cultur and clearly have a negative impact on the lives of the mentally distressed. The ove reliance on the medical model of mental health in contemporary mental health prac tice has been exposed as heavily problematic and a case has been presented for th more widespread use of the social model of mental health – a model that is mor 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.

2 THINKING THE PRESENT HISTORICALLY

The making of the modern mental health system

This chapter can be used to support the development of knowledge 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 6: Demonstrate professional competence in social work practice

- Research, analyse, evaluate, and use current knowledge of best social work practice.

(TOPPS England, 2002)

Academic Standards for Social Work

Honours graduates in social work:

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.