Mental health social work

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Mental health social work: the dog that hasn't barked

Introduction

Some sixty years have now passed since the publication in the USA of *The Sane Society* by Marxist psychoanalyst Erich Fromm (1955/2001). Fromm's main argument in the book was that in promoting the idea that the road to happiness and fulfillment lay in consumerism, in persuading people to conform to a very narrow conception of 'the good life', and in encouraging people to deny their real needs and feelings, American society in the 1950s was actually creating mental ill-health. Far from being a 'sane society', it was in fact an 'insane society'. Consumer capitalism, Fromm argued, was making people ill.

The book struck a massive chord and within weeks of its publication was fifth in the New York Times best-seller list. Since that time, it has sold more than three million copies.

Following Fromm, the central argument of this chapter will be that the world in which we live today– the world of neoliberal global capitalism – is similarly creating mental ill-health on an industrial scale. Three examples will illustrate the point. Firstly, according to the World Health Organisation, depression now affects 350 million people worldwide and by 2020 will be the leading cause of disability in the world (WHO, 2014). As George Brown and Tirrill Harris argued some forty years ago in their classic study of depression in women, while sadness, unhappiness and grief are inevitable in all societies, the same is not true of clinical depression (Brown and Harris, 1978). Rather, depression on this scale tells us something about the nature of the society we live in.

Then there is the current epidemic of loneliness. Neoliberalism, the ideology that preaches individualism and claims that 'there is no such thing as society', has contributed to a situation where loneliness and social isolation are having a devastating effect on the lives and health of both young people and old people. According to research conducted by Age UK in 2014, for example, more than 80,000 people aged 65 and over living in Scotland said they always or often felt lonely (Age, UK 2014). Across the UK the figure was more than a million. Loneliness in itself of course is not the same as mental ill-

health and there can be definite mental health benefits to solitude. However, chronic or persistent loneliness not only contributes to anxiety and paranoia but has been shown to have definite physical effects, equivalent to smoking fifteen cigarettes a day.

Finally, there is the impact on mental health of the current war on the poor, graphically portrayed in director Ken Loach's award-winning film *I, Daniel Blake*. Loach's film highlights the extreme pressure that so-called welfare reform, backed up by brutal sanctions, is placing on the physical and mental health of millions of poor and disabled people. It is scarcely surprising then that demand for mental health services in England has risen by a staggering 20 per cent over the last five years at a time when mental health service budgets were cut by 8 per cent in real terms (ref). Research has also shown that the introduction of fit-to-work tests for sick and disabled people have coincided with 590 "additional" suicides, 279,000 cases of mental illness and 725,000 more prescriptions for antidepressants (ref).

In this chapter, I want to suggest that these findings should have considerable implications for mental health social work. For if we choose to use the language of 'evidence-informed practice', there is now a huge body of evidence which shows that the causes of mental ill-health are overwhelmingly social, rather than biological or genetic. That does not mean that our brains do not react to changes in our material situation or to negative experiences, particularly of trauma - of course they do. Nor does it mean that some people may not be more predisposed to mental ill-health than others. But what is clear is that it is primarily the things that happen to us in our lives, rather than what happens in our genes or our brains, that underlies mental health or distress. As the leading neurologist Steven Rose has argued:

> Consider the world-wide epidemic of depression identified by the World Health Organisation (WHO) as *the* major health hazard of this century, in the moderation – though scarcely cure – of which vast tonnages of psychotropic drugs are manufactured and consumed each year. Prozac is the best known…Questions of why this dramatic rise in the diagnosis of depression is occurring are rarely asked - perhaps for fear it should reveal a malaise not in the individual but in the social and psychic order. Instead the emphasis is overwhelmingly on what is going on within a person's brain and body (Rose, 2005)

So if social rather than biomedical factors are the main causes of mental ill-health, one might assume that a profession called 'social work' – the clue is in the name - should be making an important contribution towards the alleviation of that distress. Sadly that is far from being the case. As Terry Bamford has observed in his recent history of the profession, social work has been marginalized in most areas of mental health work. The key strategy paper for England and Wales, for example, *No health without mental health*, published in 2011, contains not a single reference to social work, despite lots of references to the key role of social factors in causing mental ill-health. Nor does Scotland fare much better. The recently published ten-year mental health strategy contains two mentions of social work, one a reference in a footnote to the 1968 Social Work (Scotland Act) Act, the other a passing reference to the statutory work of Mental Health Officers (the Scottish equivalent of Approved Mental Health Practitioners).

Social work has not always been marginalised in this way At one time mental health social workers were perceived as making an important contribution to mental health services. The central part of this chapter will address some of the reasons for this marginalization of social work within mental health and the profession's relative silence in the face of the current crisis- why, in other words, like the dog in Conan Doyle's short story, the social work dog hasn't barked.

The final part of the chapter will pose the question 'what is to be done'? If social work as a profession still retains some potential to make a contribution both to the understanding of mental ill-health and also to relieving the emotional misery it frequently produces, then how can we begin to move from our present position of marginalization towards becoming a stronger voice within mental health policy debate and discussion?

On the margins: social work and mental health.

In answering the question of why social work isn't playing a more central role within mental health services, I want to suggest four main reasons.

Dominance of the biomedical model

The first is the continuing dominance of the biomedical model of mental ill-health. There are two main aspects to that dominance. Firstly, there is organisational dominance. In contrast to social work and social care, NHS psychiatric services are universal services and while that universalism has been severely undermined by neoliberal policies of austerity and privatization in recent years, they have in general been better protected than the mental health services provided by local authorities or the voluntary sector (which in reality are often funded by local authorities). That dominance is likely to be reinforced by the integration of health and social care services currently taking place both in Scotland and in England and Wales.

Secondly, there is the ideological/cultural dominance of the biomedical model. It is a model based on three main assumptions: Firstly, that mental illness can be described in terms of discrete categories; secondly, that mental illnesses, particularly conditions such as schizophrenia or bipolar illness, have an organic basis; thirdly, that these conditions are primarily amenable to medical interventions, particularly pharmacological interventions.

All three of these assumptions have been the object of a powerful critique in recent years coming mainly from a new critical psychology and psychiatry. Like the anti-psychiatry of the 1970s, this body of work challenges some of the basic tenets of biomedical psychiatry but on the basis primarily of empirical scientific research. Some flavour of this critique can be gained from the following quote from one of its leading proponents, Richard Bentall:

> A wide range of evidence suggests that our current system of diagnostic classification has led psychiatry down a path that is no more scientific than astrology. Like star signs psychiatric classifications are widely believed to tell us something about ourselves, to explain our behaviour and personality, and to predict what will happen to us in the future. Like star signs diagnoses fail on …all of these counts.[1]

The central contention of this discourse is that despite the millions that have been spent over decades searching for an organic basis for mental disorders, whether in the form of chemical imbalances or genetic markers for conditions such as schizophrenia or bipolar

[1] Bentall, 2004: 195

illness, we are no nearer finding any such evidence. The reason, in a nutshell, is that we are looking in the wrong place. As Read and Sanders argue:

> If there is a common message it is perhaps that we aren't born with the problems we have as adults, they aren't somehow inherently and inevitably built into our brains; they come from our interactions with other people, especially, but not exclusively, early on in life (Read and Sanders, 2010: 124).

Despite this body of evidence, however, the biomedical model shows no sign of disappearing. One reason is that it can be seem to make sense of people's experiences. Mental distress, whether its takes the form of frightening moods, suicidal thoughts, hearing voices or struggling with food, is precisely that: distress. We do not feel 'ourselves'. So despite the stigma that labels like schizophrenia can carry, seeing it as an illness with a name can sometimes seem helpful to the person experiencing it (and their families), both in terms of giving a sense of control and also as a passport to services.

More importantly, however, from the point of view of those who run society, seeing mental distress as an illness plays an important ideological function in individualizing the conditions and diverting attention from the social reasons why people become unwell. It's not surprising therefore that it's a model that tends to be supported by governments which want to obscure any connection between poverty and inequality and mental distress.

Thirdly, and very importantly, portraying mental distress as an illness is hugely profitable. The profits of the big drug companies are higher than any other sector of industry – including the banks – while nearly all psychiatric research is now pharmaceutically financed – more than 90% in the UK. That is one reason for the creation of hundreds of new categories of mental illness over the past four decades. To quote Stephen and Hilary Rose once more:

> This rise in the medicalization of everyday distress consequent on job loss, bereavement, divorce and the many other adversities of daily life has continued unabated [is]…a process facilitated by the close relationship between the American Psychiatric Association, health insurance and the pharmaceutical industry. The underlying practical and theoretical problem, which remains to the present day, though

> cheerfully ignored by psychopharmacologists and many biological psychiatrists, is how to relate the classifications of the DSM which are essentially phenomenological, based on listening to and observing the patient, to the assumed neurochemical causes. There were – and still are – no neurochemical markers to match against the DSM diagnoses. (Rose and Rose, 2016: 23-24).

So the first factor that has contributed to the marginalization of social work within mental health services is the continuing dominance of the biomedical model.

Neglect of social determinants literature

Next, there is the failure of the social work profession to make more creative use of research findings concerning the role of social factors in causing mental distress. Here, I will refer to three areas of findings which in principle could be more effectively deployed by social workers.

Firstly there is inequality. As Wilkinson and Pickett showed in the book *The Spirit Level*, levels of mental ill-health, as well as a whole range of other social problems such as violence, obesity, and how much people feel they can trust each other, are much worse in societies with bigger income differences between rich and poor. This is not just about the material effects. It has more to do with feelings of superiority and inferiority, feelings of being devalued, disrespected, looked down on, being at the bottom of the pile. The UK is the third most unequal country in Europe so perhaps it's not surprising we also see such high levels of mental ill-health.

Secondly, there is the impact of trauma on mental health. There is now substantial evidence demonstrating a link between different forms of child abuse and mental health problems in later life. A review of 59 studies of the most severely disturbed psychiatric patients found that 64% of the women and 59% of the men had been physically or sexually abused as children (Read and Sanders, 2010: 85). Other types of traumatic experience, whether in childhood or in later life, has also been shown to result in mental health problems with research showing links to bullying, rape and violence in adulthood, and war trauma (with the label 'post-traumatic stress disorder' having originated out of the experience of Vietnam War

veterans). In a study of homeless people in Glasgow who were labelled as having a personality disorder, one psychiatrist commented:

> I would go as far as to say that I can't think of any patients I've seen in the last two and a half years of the homeless population who described what you might call a normal upbringing. And I'm not exaggerating, I really can't think of anyone' (cited in Ferguson, et al, 2005).

Thirdly, there are the effects on mental health of different forms of oppression, such as racism and sexism. Research by University of Manchester academics, for example, has revealed for the first time how harmful repeated racial discrimination can be on mental and physical health, an especially relevant finding given current levels of Islamophobia across Europe and the US.

In respect of sexual oppression, the 2017 Adult Psychiatric Morbidity survey found that more women in the UK aged from 16 to 24 are experiencing mental health problems than ever before. "Young women have become a key high risk group," the report concluded. Psychological distress is now so common that one in four in that age group have harmed themselves at some point. One factor contributing to this is the impact of social media. According to journalist Rhiannon Lucy Coslett, girls and young women routinely alter the photos they post to make themselves look smoother and slimmer. Some phones, using their "beauty" settings, apparently can do it for you without asking . As George Monbiot has commented: 'Is it any wonder, in these lonely inner worlds, in which touching has been replaced by retouching, that young women are drowning in mental distress?

There is scope in each of these areas to imaginatively develop the kind of individual, group, community responses and political responses (as well as drawing on social pedagogy approaches) which were a feature of social work practice at different times and places in the past (and still are in some parts of the world). In reality, however, the shrinking of social work practice to assessment and care management in the UK following the implementation of the 1990 NHS and Community Care Act means that such responses have largely disappeared from the social work canon or have been contracted out to health promotion professionals or the voluntary

sector.

Neoliberalism and social work

The third factor contributing to the marginalization of social work within mental health provision is the deliberate transformation of social work resulting from the creation of what John Harris called 'the social work business' in the early 1990s. While it would be wrong to suggest that there was ever a 'golden age' of social work practice, the period of the late 1960s and the early 1970s did see an increased awareness amongst many social workers of the impact of poverty on the lives of their clients and the need for less, individualized, more collective, groupwork and community development approaches.

By contrast, as noted above the introduction of the market into social care in the early 1990s has meant that not only are social workers much less likely to draw on these approaches but there is also much less scope for the forms of therapeutic casework that had previously been common, especially in psychiatric social work. And the experience of social workers throughout the UK suggests that the current personalization agenda based on giving people individual budgets to buy their own care, far from opening up the great new era for social work which its advocates promised, means that adult care social workers are now more involved than ever in assessing risk and rationing services, based on tighter and tighter eligibility criteria, rather than working in preventative or creative ways.

Supporters of the purchaser/provider split argued it would lead to greater choice as a result of the increased role that would be played by the voluntary and private sector in the provision of services, including mental health services. And given the limitations of the NHS psychiatric services on offer, some of the new services that were developed in the 1990s did seem to offer more user-centred ways of responding to mental distress. Research into mental health service user involvement in Scotland in the mid-1990s, for example, found several examples of projects employing a social model of mental health, with service users playing a central role. My own perception as a social work tutor in this period was also that larger numbers of social work graduates were opting to work in voluntary sector organisations, often for lower pay, in the hope that there they could do 'real social work' there.

More than two decades on, however, the limitations of the market as a means of providing mental health services are increasingly obvious. Firstly, the voluntary sector has changed massively during this period. Many large national organisations which were previously active campaigning organization are now service providers, dependent on winning contracts from local or national government. Not surprisingly that means that few are now willing to speak out, let alone campaign against, government policy. The experience of the homelessness charity Shelter following the Grenfell Tower tragedy in London in 2017 highlights the point. According to reports, there was considerable disquiet amongst within the organization over its apparently muted response to the tragedy. One possible reason for that response became clear when it emerged that Shelter's chairman Sir Derek Myers was a former chief executive of Kensington and Chelsea council, which owns Grenfell Tower, while trustee Tony Rice was chairman of Xerxes Equity, the sole shareholder in Omnis Exteriors – the company that sold the cladding used in the tower, the flammable properties of which contributed to the deaths of over eighty tenants. Both resigned soon after.

Secondly, a key rationale for the introduction of mixed economy of care was precisely to drive down welfare costs. And as both academics and trade unions in the voluntary sector have argued, the past two decades in the voluntary sector have seen 'a race to the bottom' in terms of wages and conditions. In addition, following the election of the Coalition Government in 2010, however, and despite David Cameron's (now long-forgotten) Big Society rhetoric, the voluntary sector has been one of the biggest casualties of the cuts that have taken place since then. Figures.

Mental health under pressure: cuts and austerity

That brings to the fourth factor that has led to the marginalisation of mental health social work – namely cuts and the loss of resources, especially resources in the community since the implementation of austerity policies from 2010 onwards. When the role of Mental Health Officer was created by statute in the 1980s, the rationale for that role was that these would be the professionals who have a knowledge of what resources existed in the community and would be able to come up with alternatives to hospital care. The reality is, however, that not only did these roles quickly become overly legalistic and shaped by psychiatric perspectives but also the

disappearance in recent years of many community-based mental health resources means that such alternatives are now few and far between. Instead, Approved Mental Health Officers in England now find themselves chasing fewer and fewer hospital beds across the country (King's Fund) while the other face of reduced community support is an increase in the use of coercion in the form both of community treatment orders and ECT (Burns)

What is to be done?

How, then do we begin to challenge this marginalization of social work? Four possibilities suggest themselves. Firstly, in terms of the knowledge base, as noted above there is now a very considerable body of theory and research stretching from trauma theory to Wilkinson and Pickett's work on the impact of inequality on mental health which highlights the role of biographical and social factors in the production of mental distress. The two key concepts that emerge from this work and are particularly relevant to us as social workers are *context* and *life experiences.* Read and Saunders in *The Causes of Mental Health Problems* sum up the core finding of that body of knowledge as being:

> Problems in mental health are more often than not the result of complex events in the environments in which we live and our reactions to them. These reactions can also be influenced by our biology or the way we have learned to think and feel (Read and Sanders, 2010: x).

In other words, many of the thoughts, feelings and behaviours that people identify as mental illness are a response to difficult life experiences, whether that be past life experiences such as abuse or neglect, being bullied or feeling undervalued or a response to current contexts of racism, work-related stress, loneliness or the effects of inequality. That social model of mental health needs to be at the heart of every qualifying social work programmes' teaching on mental health – and not just for students whose placements are in mental health settings or practitioners who are training to become AMPHs. In a recent paper in the *British Journal of Social Work* McCusker and Jackson refer to 'the universality of mental distress'. As one of the students whom they interviewed about their practice placement experience commented:

> From my experience it [mental health] is one of the few areas of social work that is involved in all specialisms and affects people from every age group, background and ethnicity. Every placement I was on during the course involved mental health issues, although I did not have a mental health placement.

People do not live their lives in boxes with children in one corner, older people in another and people with mental health problems in another. Hence the limitations of qualifying programmes like the Think *Ahead* programme in England which treat mental health social work as a specialism. Instead, an understanding of mental health and of the impact of mental distress should be at the core of all generic practice.

Secondly, we need to be more assertive about the social work role in mental health. For all its current limitations, to a greater extent than other mental health professions social work is underpinned by an awareness of the impact of structural factors such as racism and sexism on people's mental health and quality of life as well as an understanding of the need to take service users experience seriously and involve them in decisions about their own lives. In their research, McCusker and Jackson found that what they call 'transformative social work practice' rested on three elements:

> [F]irst, a relationship-based approach, central to which was genuine interest in and drive to get to know the service user; second, a holistic approach to assessment that explored the potential impact of wider structural/situational factors on people's circumstances; third, persistence in the face of the many personal, cultural and organisational barriers encountered.

Thirdly, we need to develop new critical understandings of individualism and collectivism. The dominant policy agendas in mental health and in adult social care more generally such as personalisation and recovery approaches sound very progressive – all about people having more choice and control. In reality, however, unless supports in the form of good services are in place, then we are creating a false idea of independence which is setting people up to fail. There is a very dark side to a neoliberal model of independence which preaches that if you don't stand on your own two feet, you will be punished, whether that be through benefit sanctions, psycho-

compulsion in the form of CBT coaching or detention in the community. By contrast, the definition of independence proposed by the Independent Living Movement is clear that without good services and supports, real independence will remain an illusion:

> Independent living means all disabled people having the same freedom, choice, dignity and control as other citizens at home, a work and in the community. *It does not necessarily mean living by yourself or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life*.

Finally, we need to continue to develop the kind of radical campaigning activities and collective forums for discussion that the Social Work Action Network has tried to promote, with some success, in recent years. Central to that process is the dual task of building alliances with other radical mental health professionals such as Psychologists against Austerity and service user organisations such as Recovery in the Bin while at the same time carving out a clear and distinctive role for a new radical mental health social work. This is a challenging agenda but not an impossible one. Recent political developments in the UK and elsewhere suggest that the tide may finally be turning against the individualist neoliberal deluge which has done so much damage to society, to relationships and to our collective mental health over more than three decades. Social workers need to ensure that they are part of that hopeful movement for change.