

# A consideration of the nature and purpose of mental health social work

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## Abstract

**Purpose** – *This paper aims to provide an analysis of the mental health social work role, its contribution to social inclusion, and its ability to translate this into practice.*

**Design/methodology/approach** – *The paper considers national policy, research and theory to consider the nature of social work and the mental health system.*

**Findings** – *While social work is ideally placed to challenge the biomedical model and promote social inclusion, organisational and other failings would appear to seriously undermine its ability to do so.*

**Originality/value** – *The paper considers some important issues facing social work and mental health, and raises points for thought and discussion.*

**Keywords** *Social work, Social care, Mental health, Social inclusion, Personalisation, Recovery, Mental illness*

**Paper type** *Conceptual paper*

At a recent national mental health social work conference, we were asked to consider what the unique contribution of social work is to mental health services. As one might expect, there was a variety of passionately held opinions and much discussion of social inclusion, safeguarding, law, and values. A clear consensus was eventually reached, however, indicating the value of social work in working with families and social systems, and in working with people through situations of high complexity and risk.

I had cause to reflect on this at a recent university planning meeting, where I asked the programme leader for mental health nursing what he considered to be the unique contribution of mental health nurses: his reply, of course, was working with families and working with complexity and risk. I am fairly sure that if I was to ask the same question of any good psychologist, psychiatrist, occupational therapist or anyone else working in mental health, they would claim a somewhat similar answer.

This, of course, leads us to ask a number of questions, but the one which I intend to examine here is “so what exactly is social work’s contribution?” In answering this we will need to consider whether the social work contribution should be anything different to what it is, and also to examine the factors such as professional regulation, national policy, and commissioning arrangements which dictate what social workers are actually able to do. Within all this, we can only create meaningful considerations if we add in the question of what do service users actually need from social workers.

## What is social work?

Social workers work with a wide range of service users, including abused children, people with mental health problems, drug users, people with disabilities, asylum seekers, homeless people, sex workers, pregnant teenagers, vulnerable older people, anti-social families, and persistent criminals. What do all these people have in common? They are all people that

society would like to pretend did not exist, that will rarely be treated kindly or un-tokenistically in the media, that face barriers to their full participation in society: they are in other words, structurally oppressed and socially excluded. This social rejection has also affected the way in which social workers themselves are seen, resulting in negative depictions in the media and invisibility in soap operas. The main purpose of social workers working with these people is to somehow support or empower them to overcome the barriers that society has placed in their way so that they can play as full a part as they wish in society.

In its excellent *Social Work at Its Best* paper, the General Social Care Council (GSCC), (2008) provides an aspirational account of all aspects of social work, including the following description of mental health settings:

people with mental health problems want expert help at times of difficulty, freedom from abuse, stigma and discrimination, and support to recover, get jobs and homes of their own, and take their place in society. Social work at its best can help them overcome the barriers to living full lives in the community, challenge negative stereotyping and improve public understanding of mental health matters (GSCC, 2008).

This quote highlights the importance of understanding the impact of social factors, such as employment, housing, and stigma, to social work practice, and the impact that these can have on causing or preventing mental illness. This perspective is enshrined within social work's values, which are the defining characteristic of the profession, embodying structural explanations of disadvantage through human rights and social justice discourses, translating these into practice shaped by a person centred, anti-oppressive, and empowerment based focus.

### The "social perspective"

While perhaps not particularly central to the emancipatory objectives of the mental health social work role outlined above, the role of Approved Mental Health Professional (AMHP) is at least clear, well defined and potentially powerful. While this role is now open to people from a number of professions, it is still a social work role in terms of the theory, perspectives and values on which it is based (Gilbert, 2003). Paragraph 4.51 of the Mental Health Act Code of Practice states that an AMHP's role is "to provide an independent decision about whether or not there are alternatives to detention under the act, *bringing a social perspective to bear on their decision*" (Department of Health (DH), 2008, p. 36; my emphasis).

Defining a "social perspective" is more problematic. The bio-medical perspective on mental illness, despite all its faults, does provide a clear, coherent perspective that is easy to understand: mental illness is the result of a physical dysfunction somewhere inside a person that can be treated through physical interventions, such as medication. A psychological perspective provides for an almost equally explainable model: mental illness is the result of dysfunctional thoughts, often as a result of bad things that have happened to someone, that can be treated through psychotherapy. When it comes to trying to explain the social perspective in this way we start to struggle; we know that mental illness can be caused by people's social environment, the things going on around them and the way they are treated by society, but, lacking a ready answer such as pills or therapy, the social model offers few realistic alternatives to "a radical redistribution of wealth and power in society". This is, of course, because in reality there are no easy answers, and those offered by the drug companies and their apologists are based on decidedly poor evidence (Kirsch, 2009).

What the social perspective does offer, however, is the beginnings of an evidence-based understanding of what mental illness really is. In conjunction with a psychological model, with which it shares much common ground, there is theory and evidence that is more than capable of providing a viable alternative model to the biomedical perspective. While the bio-medical perspective is dominant within our mental health services, with its tenets widely accepted by professionals, service users, and public, there has been very little challenge to concepts such as hereditary mental illnesses, influence of neurotransmitters such as dopamine or serotonin, or the division of conditions into "diagnoses", which are based not on evidence, but on ideology. The main danger of the biomedical model is that while we

pretend that madness can be cured with pills, we can conveniently ignore all the massive social problems within our communities which directly impact upon mental wellbeing.	115
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Research has shown very clear links between social factors, such as housing, employment, education, social networks, debt, and stigma, not just in exacerbating pre-existing conditions, but in causing mental illness (Tew, 2011; Reininghaus <i>et al.</i> , 2008). While we tend to concentrate on negative factors such as bad housing and lack of employment, these same social factors in their positive form have been shown to be protective factors, i.e. a person with positive social networks and a good job is less at risk from being diagnosed with a mental illness (Social Exclusion Unit, 2004). The problem with our biomedically-influenced mental health services is that too often our only treatment options are medication and hospital, the side effects of which generally have a markedly negative effect on such factors. Once a person is taken into a psychiatric hospital, treated with drugs that cause sedation or weight gain, or even just labelled as mentally ill, then these protective factors are undermined. A report by the Shaw Trust revealed that over half of employers would not employ someone who had had a mental illness (Shaw Trust, 2010).	117
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A social approach would be based around working with the person to preserve these protective factors, an approach which is intended in more modern service models, such as Early Intervention in Psychosis and Crisis Resolution Teams. Such approaches are undermined, however, when the culture of the organisations providing the services still view mental illness as a fault situated within the person which requires fixing by experts. As such, people are removed from their social context for problems to be fixed which can only really be understood when the social context is considered as part of the treatment plan. Additionally when hospitalisation, medication and stigmatisation undermine the protective social factors and exacerbate the negative social factors which have caused the problem in the first place, the absurdity of our system is clear.	131
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<b>What about the biopsychosocial model?</b>	143
A lot of discussion of mental health centres on an understanding of multiple contributing factors and a general acceptance of a “biopsychosocial” model. In reality, however, such a model generally steers clear of arguments about cause of mental illness, with a tacit understanding that a biological predisposition exists and is later triggered by psychosocial factors such as trauma or poverty. Such assumptions are carried forward into variations of this model such as Zubin and Spring’s (1977) stress vulnerability model. While such models are a clear improvement on a pure biomedical model, the lack of challenge to the medical assumptions and the potential damage they can do, leaves these a long way short of meeting service user’s needs. As the psychologist John Read states:	144
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Since the 1970s, the illusion of a balance, of an integration of models, has been created by the so-called “bio-psycho-social” approach. . . . This is not an integration of models, it is a colonization of the psychological and social by the biological (Read, 2004, p. 4).	154
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One of the differences between the medical and social approaches to mental illness (or to disability) is that while the former views the person as having a problem to be solved, the latter views the problem as existing within the person’s relationship with society and that it is aspects of this interaction which need to change, not necessarily the person.	157
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<b>Are social work and social inclusion the same thing?</b>	163
So, if social workers work with marginalised people in a values-based approach using a social perspective which sees mental illness caused by social factors, is not what they are doing the same thing as what we call social inclusion? According to Community Care, “Social Work was practising social inclusion before it has even been invented” (quoted in Godden <i>et al.</i> , 2010, p. 9), and given the theory and perspectives behind social work, this is a viewpoint that is hard to dispute. Social inclusion, however, like social work, social care and many similar terms, is not easy to define, although the concepts we have discussed above, such as the influence of housing, education, employment, etc. on mental health,	164
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and the marginalisation of people diagnosed with mental health from mainstream society, fit naturally with the main discourse of social inclusion which is derived from *les exclus*, those people excluded from society by virtue of a “rupture of the social bond” that is the main part of the social contract between state and people (Morgan *et al.*, 2007).

### What about the recovery model?

Like social inclusion and psycho-social interventions, the recovery model is another social worker sounding concept which has crept into the mainstream in recent years. In all these areas, however, social work has failed to push its obvious expertise to the fore, instead of championing these new developments to promote what it holds as important, it has let other professions steal its clothes and promote socially orientated perspectives in watered-down versions. The recovery model is “Social Work Lite” in that while it acknowledges the role of social factors and the imbalance of power between client and clinician, it stops short of the more challenging and progressive ideas that social work has been championing for over 40 years. The term “recovery” itself implies an individual with a problem to be fixed, incapable of moving on until they have “recovered”, and while this does not reflect the ethos of the model, that word will hold the model back because it nullifies any challenge to the individualistic nature of the biomedical illness model. As a service user, Sally Clay, is quoted as saying:

Jacob named the place of his struggle Peniel, which means “face of God”. I too have seen God face to face and I want to remember my Peniel. I really do not want to be recovered. From the experience of madness I received a wound that changed my life. It enabled me to help others and to know myself. I am proud that I have struggled with God and with the mental health system. I have not recovered. I have overcome (Clay, 1999, p. 15).

### Is personalisation the new social work?

Personalisation is the new context in which mental health social care is meant to be delivered. This arose out of a number of political strands, such as the Darzi review of the NHS, and the “Our Health, Our Care, Our Say” white paper produced by the previous labour government, and is influenced by moves towards a more service user focussed, socially inclusive way of understanding social care needs in general, such as those already discussed. The ethos of personalisation is a shift in the power balance between service provider and service user, with “individually tailored” care packages being based on what the service user needs rather than what the service is set up to provide (DH, 2010). While the objectives behind personalisation are ones of cultural shifts and system-wide transformation, what it has generally come to represent is the more prosaic outcome of a different process for funding care.

The development of personalisation has the potential to be a defining moment in the history of social work. Despite a very slow process of gradually increasing influence on the way mental health services are actually delivered (five years in and still only a minority of service users receiving a personal budget), personalisation forces services to ask what service users want. It is a big step away from the paternalistic “doctor knows best” culture, towards the self-determinism of service users dictating which services work best for them.

Whether this potential will ever be realised, however, is a different story. The visible effects of personalisation are still functional changes, such as direct payments, rather than the far more difficult cultural changes such as shifts in power and realisation of genuine choices. The power base of psychiatry is still very strong, and the desire to diagnose, manage risk and medicate clashes with many of the objectives of personalised service provision.

### Do commissioning arrangements allow social workers to do social work?

So far in this paper, we have considered the nature of social work, in being grounded in social values, social perspectives and social inclusion, and suggested that, as a profession, it is best placed to be leading the challenge to the biomedical approach to mental illness.

We have also looked at how personalisation may be a key factor in this process. It is time, however, to take a step back and consider how this picture translates into real life social work practice.	229 230 231 232
One of the biggest practical changes to mental health social work has been a long, ongoing move from generic social work teams to integrated mental health teams (Godden <i>et al.</i> , 2010). This has meant that a generic social worker in the 1980s would have been working with any number of different social issues, including mental health, based with other social workers but separated from health professionals who may also be working with the same service users. An equivalent social worker in 2012 may be directly employed by the NHS, based in a team of health professionals, in which they may be the only social worker. Obviously the modern situation allows for more specialist knowledge of mental health, while the older generic model allows the social worker to see a wider spectrum of social issues covering the whole life span. However, the move to health settings has had a number of significant impacts on the way in which social workers are able to carry out their role.	233 234 235 236 237 238 239 240 241 242 243
It is easy to see how a narrow focus as a mental health specialist and isolation within predominantly health-based settings can make it hard for social workers to maintain the values and perspectives which are at such odds with the mainstream view (although it is highly questionable whether social work's lofty aims have ever been successfully translated into practice). A number of commentators (Godden <i>et al.</i> , 2010) have talked about the need for social workers to maintain their unique focus and skills within an integrated setting, and this requires not only the more obvious things that need to happen at a worker/team level, such as effective supervision, management, leadership, training, case allocation, etc. but also at an organisational level where there needs to be respect, equality and transparency between partners, and a culture of valuing different perspectives and professions within the organisation. Allen (2010) described the difference between "soup" and "salad" models of integration, where in the former professions are merged into a gray amorphous mess, while in the latter professions retain their integrity and purpose and both staff and service users understand the differences between them.	244 245 246 247 248 249 250 251 252 253 254 255 256 257 258
With increasingly complex partnership agreements dictating the deployment of social workers, the specific commissioning arrangements are becoming hugely important in understanding what it is that social workers are supposed to do. However, as the economic situation has resulted in massive cuts across public services, such arrangements are stripped down to the bare bones of legislative duties, with little time for much else. As a result, most mental health social workers, hosted by, seconded to, or working for an NHS trust will have a very clear specification of exactly what the local authority is paying the NHS Trust for the social worker to do – generally, community care assessments, setting up personal budgets, and some element of safeguarding, AMHP and BIA duties – anything else that the social worker wishes to do, social inclusion for example, is not paid for and will therefore not happen.	259 260 261 262 263 264 265 266 267 268 269 270
<b>What is the future?</b>	271
It is hard to view this situation with much optimism for social work. Where services have taken on socially minded initiatives these have been lead by other professions; where social work had specific and unique independent roles, such as AMHP, these have now been taken on by other professions; where personalisation should be empowering the social work role, commissioning arrangements have reduced that role to the purely functional. Payment by results will have a huge impact on how the NHS funded side of mental health is delivered, potentially creating a competing system of assessment and intervention to that delivered by social care (Godden <i>et al.</i> , 2010). By putting a clear income tag on different interventions, payment by results will certainly focus health providers' minds on the relative profitability, or otherwise, of health and social care interventions.	272 273 274 275 276 277 278 279 280 281 282
The good news, however, is the increasing rumble of the challenge to the biomedical approach. Psycho-social and alternative views are gaining credibility and evidence, whether in terms of the causal role of social exclusion, the difference in outcomes for ethnic	283 284 285

minorities, the increase in real power and choice for service users, or the role of childhood trauma in causing psychosis, the rumble is set to become deafening over the next ten years. The biggest challenge to psychiatry, may however be a financial one, with the unprecedented cuts to the NHS, the £1 billion that is spent on psychiatrists will start to be questioned for value for money (Goemans, 2011). Social work may be best placed to challenge psychiatrists, to champion social inclusion, and to promote service users' interests, but even if in 50 years time mental health social work no longer exists, I would not mind so long as service users are receiving services that understand and address the fact that their needs are psychosocially produced and not the function of a faulty brain. Social work, however, has an opportunity, possibly a last chance, to finally put its rhetoric into practice, working with service users to address the social factors which can have such an impact on their lives, and influencing other practitioners to do the same. Whether this will happen in the NHS or in local authorities; in statutory services, the voluntary sector, social enterprises or social work practices; and whether this will be because of or in spite of personalisation, are questions that will have to be asked. If commissioners, managers and social workers do not ask themselves some hard questions we may all lose out.

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