# Social work and a social model of madness and distress: Developing a viable role for the future

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*Abstract: This article explores the social model in relation to 'mental health' policy and practice generally and social work specifically. It highlights the continuing dominance of bio-medical approaches to and interpretations of 'mental health'; examines the development and nature of mainstream social approaches and considers mental health service users' own discussions of a social model of madness and distress. The article looks at the ramifications for social work which is based on a social model of madness and distress; what it might look like and what infrastructural supports it is likely to require to develop effectively.*

*Key words: social work, social model, madness and distress, disconnection, oppression, barriers*

## Introduction

The focus of this article is social work in relation to social models and 'mental health'. This raises big questions, which as yet have not been discussed over anything like as long a period, or as intensely, as those raised by the social model in relation to disability. Because discussion is less developed, very little can be taken for granted in trying to set out and take forward thinking and ideas in this field. Acceptance of this principle underpins this article and shapes its approach. The aim is to start from the beginning.

These are complex, ambiguous and uncertain times for social work. But the reality is that this has been true for most of social work's modern life. Writing in 2004, Lena Dominelli, one of the leading authors in conventional discussions about social work said:

> Social work is a troubled and troubling profession. Its role and place in the professional firmament of the twenty first century are hotly contested. Challenges to its current

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organizational structures and purpose are emanating from several sources (Dominelli, 2004, p.1).

Social work's role in relation to psychiatry and the mental health system is particularly uncertain. The role of 'approved social worker' has come in for particular question in government proposals for new mental health legislation. Social workers in mental health essentially operate within a medical/psychiatric model of 'mental illness/disorder' and as part of that system, have had powers to restrict people's rights through sectioning processes alongside medical professionals.

At the same time, social work uniquely among health and 'care' professionals is theoretically committed to a social orientation. Nonetheless, it has come in for the most intense questioning over its relevance to social approaches to social issues and problems. Yet among such professional disciplines, it can perhaps make the strongest claim to have responded to such concerns.

If we are to advance discussion about social work, social models and approaches and mental health issues, then it is likely that we will need to interrogate and examine each of these three constructs carefully. We cannot assume that there is any consensus or clarity over the meanings attached to any of them. We cannot take for granted that they have been adequately considered in relation to each other. Finally we may have to recognize that differentials of power and status between different stakeholders involved in these domains, for example, between service users, professionals and policy makers, may also impact on how they come to be understood and taken forward. The aim here is to try to explore these issues. While we may not come to any satisfactory conclusions, we may be able to cast some additional light, clarify meanings and offer some helpful ways forward.

## Social work

To make sense of social work generally and specifically in relation to social approaches to social problems, we have to acknowledge its uncertain position in society as a comparatively new profession, largely made up of women, with contentious roles and responsibilities, involving support, control and state intervention. In spite of, or perhaps because of this, in the 1970s and early 1980s, social work emerged as a radical force (Langan and Lee, 1989), following Marxist critiques of its regulatory potential (Corrigan and Leonard, 1978). It was the first profession seriously to address issues of difference and equality in both its process and goals and came under powerful attack as 'politically correct' because of this. However, by the 1990s, social work was again coming in for growing criticism for having an increasing role as a means of state control, reinforcing broader pressures to economic individualism and social division and for its weakening concern with social justice and equality

(Parton, 1994 and 1996; Williams, 1996; Jordan, 1997).

Bureaucratisation and managerialism have been identified as increasingly important forces in social work, undermining the progressive and liberatory aspirations of its advocates (Jordan, 1990: Clarke, J. and others, 1994; Lowndes, 1997; Gibbs, 2000). They have been associated with the recasting of professional social work in managerialist terms of 'care management' (Gorman and Postle, 2003). They have led to 'changes to the values, regimes and objectives of social work' (Gibbs, 2000, p.231). They are seen to have reinforced the gendered nature of social work and social services, reinforcing traditional male dominance in its hierarchy and ideology. They have been associated with a shift in power from professionals to managers and have been linked with constant organisational restructuring and the strengthening of central government control over social work's aims, activities and finances.

Social work's independent identity has also been weakened in recent years. Its organisations, like the National Institute for Social Work (NISW) and Central Council for Education and Training in Social Work (CCETSW) have been closed and replaced by organisations labelled in terms of 'social care', a new term that carries limited value and meaning publicly and politically. These new organisations themselves also seem to be insecure, with, for example, the key new inspection body, the Commission for Social Care Inspection, already scheduled for amalgamation with its health service equivalent , as well as some of its responsibilities being handed over to OFSTED. Like disability more generally, mental health issues have tended to have a relatively marginal place in social work. Dominelli's book devotes only a few pages to discussion of mental health issues (2004), although it has long been identified as a major factor in children being taken into state care – in which social work is centrally and contentiously involved.

In 2004 the Government announced that it aimed to develop a 'new vision for adult social care', to match the developments that have taken place in social care for children, embodied in the White Paper, 'Every Child Matters'. The Green Paper, 'Independence, Well-being And Choice' was published in 2005 (Department of Health, 2005). It has relatively little to say about social work generally or about social work practice specifically. It suggests a new social work role as 'navigator', linking people to the various services they may need. But this can also be interpreted as a restatement of the care management ideal of 15 years ago, reframed in the terminology of a later age. Service users, in contrast consulted over the future of social work and social care, as part of the development of the Green Paper, are emphatic that what is needed is better social work and social care practice; practice that is uniformly of good quality and better resourced. They see the route to this as valuing social workers more, providing them with better conditions of work and involving service users in their education, training, recruitment and promotion (Beresford et al, 2005; NCIL and Shaping Our Lives, 2005).

There can be no question that social work has generally received a bad press and been particularly associated with tragedies and scandals which have had an undue

influence on its development and public perceptions of it (Butler and Drakeford, 2003). At the same time, there are areas of social work which are highly valued and which have particular resonance for this discussion. One such is specialist palliative care social work. In a recent study of 'what service users want from specialist palliative care social work', participants were almost universally positive about their experience of practice. They had found it helpful and supportive, improving their quality of life and capacity to cope with the major difficulties and changes which they had been experiencing. It addressed their personal, social, material and spiritual needs in keeping with palliative care's emphasis on 'holistic' support (Croft et al, 2004).

This article looks at social approaches to mental health issues later. But it is important to note at this point, as has already been indicated, that social work has traditionally been associated with social models and understandings. Its historical connection with the social explains why early on the term attached to it was '*social* work'. Service users still comment positively on practitioners' appreciation of the social relations of their selves and situation when giving their views of social work. This traditional recognition of the social does not mean, of course, that social work was necessarily always liberatory or empowering in intent. The two are not necessarily synonymous. Strands of paternalism and social control have always been associated with social work.

However, it is important to recognise that there have recently been growing pressures for integration between health and social care which seem to have significant negative implications for the social understanding of social issues. The integration of health and social care offers the promise of reducing administrative barriers and divisions between the two and improving the support service users receive by making sure it is properly linked and coordinated. But both practitioners and service users express concern that social understandings which have been developed in social work and social care may be put at risk as social care is absorbed in the much bigger and more powerful world of health and health professionals, who still largely operate on the basis of a medical model.

Significantly, the Green Paper on social care is to be followed by a white paper which combines health and social care, rather than policy being developed through a specific social care white paper (Brody, 2005). Concerns are already being expressed about this. Thus the context for any discussion about social work, mental health and social models, seems to be a policy environment which is raising some serious worries that recent advances achieved through the development of social understandings in relation to social care service users, may be put at risk by a shift back to reliance on medicalised understandings as integration reinforces the dominance of health thinking.

## Mental health

Mental health is still primarily bio-medical model based. This is explicit in the term itself. The authors of a current text exploring other approaches refer to the 'enduring status and domination of a bio-medical understanding and delivery of mental health services' (Ramon and Williams, 2005, p.1). As the sociologist David Pilgrim has stated:

> The bio-medical paternalistic norm in the (psychiatric) profession still privileges the doctor's right to treat over the patient's right to freedom (Foreword, Ramon and Williams, 2005, p.xi).

This is not to say that other models have not been developed in this field, or exerted an influence over time, or that the bio-medical approach has not come under challenge, not least from within psychiatry itself. The point, however, remains that an individual medicalised model of mental health underpins current western policy, practice and legislation, as well as political and public understandings of madness and mental distress. For most mental health service users too (with some exceptions for black people and members of minority ethnic groups with other cultural backgrounds), this is the only frame of reference that they have had available, for interpreting their own experience, so powerfully has it permeated cultural consciousness and popular understandings.

It is important also to note that the psychiatrisation of experience and social problems has not only dominated the conceptualisation of madness and distress. The influence of psychiatry and psychiatric thinking has also had the effect of medicalising a much wider range of social and public issues and concerns, reframing them in diagnostic categories for 'treatment'. These range from the human effects of war, 'post traumatic stress disorder' (PTSD) to the non-conformist and non-cooperative behaviour of children and young people, 'attention deficit hyperactive disorder' (ADHD) (Newnes, 2005). The psychiatric system has also extended its administrative empire to include violent, criminal and dangerous behaviour through the use of an increasing range of labels like 'personality disorder', 'dangerous personality disorder' and 'narcissistic personality disorder'.

These labels are not necessarily associated with independent evidence of 'mental illness' or 'pathology' and in the case of 'dangerous personality disorder' are defined as 'untreatable' even though they are still included in the province of psychiatry. This has led to an increasing blurring of distinctions between 'mental illness', madness and distress, violence and criminal behaviour. This has diverted attention from the failure to provide adequate, appropriate and reliable support for mental health service users who are experiencing – and frequently reporting difficulties. Instead it has encouraged the further negative stereotyping of mental health service users; their association with dangerousness and negative risk and international pressure

for extending the controlling role of mental health legislation. As I write, the UK government is seeking to impose such legislation, in the face of unanimous opposition and after more than six years of determined efforts to get it on the statute book.

## Social models

There has recently been a rapidly increased interest in social models and approaches in mental health. This has been reflected in the establishment of the Social Perspectives Network and a crop of new publications (for example, Duggan et al, 2002; SPN, 2003; Ramon and Williams, 2005; Tew, 2005; Barnes et al, 2005). While these developments should not be taken to mean that there hasn't been a longstanding interest in social approaches to mental health thinking, policy and practice, it undoubtedly does signify an increased concern with this. The reasons for this are likely to be complex. There is no doubt that there has been some concern in the social care field that such social approaches are under challenge (see above) and need to be further secured. At the same time, there also seems to be a growing sense that they have a new importance at a time of change and conflict in mental health policy and thinking, with a new emphasis on rights, regulation, 'recovery' and 'public safety'. Thus there may now be new opportunities for social approaches in mental health.

This development has also coincided with the establishment of new organizations with an interest in social as well as more traditional treatment responses to health and social care service users, including the National Institute for Mental Health England and the Social Care Institute for Excellence, both of which have been involved in the development of the Social Perspectives Network. The publications and initiatives that have emerged have involved mainstream academics, researchers, policymakers and service users. They have established positive cooperations and the development of new thinking and supported its broader dissemination.

They have also begun to highlight some tensions in taking discussion about social models forward. These tensions seem to relate to the different, sometimes conflicting perspectives of service users and people more directly associated with the service system. Major questions are raised. For example, is the aim to develop a basis for mental health practice which is more inclusive of psychological and social perspectives, or is it to develop more fundamental critiques of the 'mental health' framework overall? Are we all actually agreed about what we seek and value in a social perspective on mental health? In putting together one joint publication recently, there were clear differences between service users and other researchers (happily later resolved), where initial efforts to impose a consensus by the latter met with objections from the former, who felt that there were clear differences of view, for example, over people's value base on research, subjectivity and validity.

It would be wrong to suggest that this mainstream debate is uniform in other

ways too. It has offered a rich range of insights and made it possible for different 'takes' to be made on social approaches to mental health. It has enabled comparison between different countries internationally, highlighted different approaches to social understandings, explored different models like 'recovery', self-help/mutual aid and explored different perspectives including those of women, lesbians and gay men and minority ethnic groups. Having said this though, a key distinction can still be drawn between this discourse and that which has begun to come specifically from mental health service users themselves.

Mainstream social approaches to mental health have frequently taken the concept of mental health for granted and have argued for the inclusion of a wider range of social, political and economic factors beyond the individual when analyzing and responding to people and their perceptions, emotions and behaviour. They have stressed the importance of 'nurture' as well as 'nature'; of people's environment as well as their bio-chemical make up. As two authors recently wrote:

> All social models in psychiatry have the same fundamental premise. They regard the wider influence of social forces as more important than other influences as causes or precipitants of mental illness (Tyrer and Steinberg, 2003, p.87).

In contrast, the approach developed by service users has typically challenged the overall framework of 'mental health'. It has tended to follow the social model of disability by highlighting issues of social oppression and discrimination in relation to madness and distress. Thus this is a discussion about a social model of madness and distress, which needs to be distinguished from broader professional discussion of social approaches to 'mental health'. To recapitulate, the social model of disability rejects the medicalised individual model which sees disability in terms of the deficiencies and incapacities related to personal physical, sensory and intellectual impairment. Instead it asserts that the capacities of people with (perceived) impairment(s) are constrained and prejudiced by the creation and perpetuation of disabling physical and attitudinal 'barriers by the non-disabled majority' (Thomas, 2002, p.38). The social model of disability thus draws a distinction between (perceived) individual *impairment* and societal responses to it, *disability*.

A lively critique of the social model of disability has developed among disabled writers and commentators over the years. Concerns were expressed that an undue emphasis was placed on disability, to the detriment of discussion about impairment as a reaction to traditional mainstream preoccupations with individual impairments (for example, Corker and Shakespeare, 2002). Concerns were raised that the negative impact of impairments (as well as disability) had been understated. Some theorists also argued that insufficient attention has sometimes been paid to the interrelations between individual impairment and societal reaction (for example, Crow, 1996; Thomas, 2002a and b). Thus the social model of disability needs to be understood

as a dynamic and developing construct, rather than a completed project.

Discussions from mental health service users and their organizations about a social model of madness and distress have tended to develop within the framework of the social model of disability, while at the same time seeking to extend and make it relevant to 'mental health issues'. Such discussions have really only developed over the last 10 or so years, but they are now commanding increasing interest and enthusiasm (Beresford et al, 1995; Beresford et al, 1995/6; Beresford et al, 1996; Beresford, 2000, 2002, 2003).

The history of social approaches in the fields of psychiatry and 'mental health' can be traced to the post-war social psychiatrists and perhaps most significantly, the 'anti-psychiatrists', like Thomas Szasz and notably R.D. Laing, David Cooper and others. These certainly sought to move from traditional medicalised understandings, to social approaches, which explored social issues, for example, the role of the nuclear family in mental distress (Laing, 1965; Coppick and Hopton, 2000). However, they did not parallel or prefigure the concern with discrimination, social oppression and civil rights embodied in the social model of disability. It is difficult to see the social approaches of the anti-psychiatrists prefiguring any equivalent of the social model of disability.

## Building on the social model of disability

There is no doubt that most if not all mental health service users/survivors are well aware of the discrimination and oppression which they face, for example, as parents, and in terms of negative stereotyping, their exclusion from employment and their compulsory 'treatment' and restriction of their rights within the psychiatric system. But this has not until recently led to any equivalent of the social model of disability playing a central role in their discussions or collective action. This has now begun to change. One reason for this has been the new focus on the human and civil rights of mental health service users that has developed as government has tried to extend restrictions on those rights.

The social model of disability provides an important framework for mental health service users' thinking and action by shifting the focus from their supposed individual pathology and deficiency to consideration of oppression and discrimination operating at individual and societal levels. It highlights the barriers thus created and their effects in segregating, excluding, subordinating and marginalising mental health service users. Two other issues also need to be highlighted as relevant to the development of a social model of madness and distress within the framework of the social model of disability. First, some mental health service users do not see themselves as having any kind of personal difficulty or problem. Thus they do not accept the idea of having an *impairment*. This does not, however, create a conceptual problem with the social

model, since many readings of it, see impairment as 'perceived' impairment, that is like disability itself, socially constructed.

However, this issue does highlight a potential difference between disability and 'mental health' discussions. Whatever interpretations are placed upon them, a missing limb and a spinal injury remain a missing limb and a spinal injury. But psychiatric diagnostic categories are notoriously unreliable and inconsistent and ultimately socially constructed. Service users may not only contest them as interpretations. They sometimes argue that they are arbitrarily imposed without any rational basis. A related issue emerges in relation to bioethical approaches to impairment and distress. A major debate is now taking place about suggestions that certain genetic conditions associated with physical and sensory impairment could and should be 'screened out'. Similar debates are taking place in relation to 'schizophrenia', but given the contested nature of the diagnostic category schizophrenia, it is difficult to see on what rational physiological basis it could rest.

Second, while mental health service users are increasingly highlighting the social and political relations of their identity, they pay no less attention to personal and psychological issues. The emphasis tends to be on a holistic approach to madness and distress which takes account of personal, spiritual, cultural and other wider issues and relations. As we have seen, some commentators have criticised the social model of disability for failing to integrate personal and political issues – although this has been heavily contested. However, a strong and developing discussion has emerged which has focused on these issues and which has sought to highlight the personal and experiential nature and consequences of both impairment and disability. The social model of disability has now been subjected to a wide range of critiques, including feminist, race equality, gay, lesbian and bi-sexual and postmodern critiques, as well as critiques from traditional medicalised individual perspectives.

## The implications of a social model of madness and distress

It is debatable how different social work practice based on current professional discussions of social approaches to mental health would actually look. As has been said, such discussions do not necessarily represent a challenge to conventional medicalised individualistic models of 'mental illness' and thus we might expect that social work might still essentially be based on these. However, the same is unlikely to be true of the impact of social model discussions current being developed by mental health service users. Basing social work, as they do, on a social model of madness and distress is likely to have fundamental implications for both social work policy and practice. A set of principles or values can be identified which follow from and are consistent with such a model. These include:

- Being rights based and anti-discriminatory, rather than focusing narrowly on the individual;
- Valuing self management and self support
- A commitment to anti-oppressive practice
- Supporting race equality and cultural diversity
- Prioritising advocacy and self-advocacy
- Minimising compulsion in the psychiatric services by prioritising prevention, rapid and appropriate support and advanced directives;
- Breaking the bad/mad link that continues to be a driver in mental health policy and provision;
- Prioritising participation in the development, management and running of policy and services;
- Equalising power relations between service providers and service users in services and support (Beresford, 2005, p.115).

A series of components for socially based services and support can also be identified:

- for further discussion and development. These include:
- Services and support based on self-defined needs and rights;
- Self run services;
- Valuing holistic and complementary approaches to support;
- Extended schemes for personal support;
- User-led training and education;
- Encouraging community development approaches in mental health;
- Developing new roles and approaches in mental health services and support (Beresford, 2005, p.116).

Almost all the occupational roles linked with mental health policy and practice have had their origins in medicalised individual approaches to treatment and understanding. If social work is to take serious account of a social model of madness and distress approach, this will need to change. New support roles and approaches will need to be explored and developed. The question for social work will be whether it can absorb these in a reconfigured version of itself, or whether they develop and expand separate from it. In this author's view, there is no reason why social work cannot develop to accommodate these changes, since they seem strongly consistent with its founding values of supporting self-determination, independence and social justice. There are a number of such roles and activities already emerging from user-led initiatives including

- Non-medicalised crisis and safe-house workers
- Peer advocates and counsellors
- Employment and employment support workers
- Non-medicalised support workers
- Advice workers
- Personal assistance workers

Such roles have also been based on the recruitment of people with direct experience of distress and disability. There are continuing structural obstacles which currently inhibit social work accessing people with such experience on equal terms and if such a shift to a social model approach is to be developed consistently, then these will need to be addressed (Beresford and Wilson, 2000).

A user led social model approach to practice with mental health service users will also have significant implications for the nature and process of practice. This becomes clear in each stage of practice. Thus:

## Assessment

Where the role of the social worker is explicitly to support (with information, advocacy and advice) the service user to undertake their own self-assessment. This will be based on a social model (what support is needed to enable the person to live as independently as possible), rather than the current medical model (what is the person unable to do so that support must be offered). Direct payments and personalised budget schemes should be on equal offer, with the back up of support schemes from local user controlled organisations to make them accessible to and viable options for as wide a range of service users as possible.

## Referral

Framed in terms of services which enable the individual to safeguard and develop their independence, rather than which reinforce their dependence. This will mean moving beyond conventional psychiatrically based provision to user-led, non-medicalised, complementary , therapy based and holistic provision in the community.

## Review

Review needs to be a regular process which the social worker supports service users to

lead, using a set of social model based criteria to ensure that support for independent living is being provided adequately, appropriately and reliably.

## Support

Social work's own role in providing support should be recognised. It should be framed in terms of support to foster independence, rather than 'care', 'cure', 'rehabilitation', 'recovery' or 'treatment', all of which originate with a medical model. Framing the role in terms of 'support' is also a helpful reminder that mental health service users, like other disabled people, may need ongoing support even when they are living independently (for example, being in education or employment) and that flexibility needs to be ensured to accommodate changes that can be expected in their situation. The social work role needs to focus both on acknowledging and challenging broader barriers as well as addressing the individual's situation in social systems that are inherently discriminatory against madness and distress.

# Infrastructural change and development

Developments in all the areas identified above have been taking place over the last 15-20 years, both in the UK and internationally. But they remain limited and patchy and dominant thinking, policy and practice continue to be based on the bio-medical model.

A key issue emerging in this discussion is that 'social model' understandings from professional social work perspectives tend to differ significantly from those arising from service users. It is not being suggested here that one is better than the other. But their differences need to be acknowledged. Crucially the former continue to be tied to 'mental illness' approaches to distress; the latter relate to the social model of disability. This is not to say that there aren't overlaps as well as tensions between different positions. For example, it is possible to come across a discussion of 'hearing voices' based on a non-medical model, which nonetheless talks of 'recovery' which has clear associations with a medical approach (James, 2005).

It is also important to recognise that this is a developing discussion and positions are not fixed. The development of joint discussion between service users and providers is likely to help challenge boundaries. At the same time, it is important to remember that the institutional relations of social work as a state-led activity may limit the extent to which it is able to adopt a user led social model of madness and distress systematically, even if some practitioners do make this move. We already know, for example, that service users and professionals can have quite different takes on the meaning of 'anti-oppressive practice', which relate to the ownership and substantive

purposes of social work (Beresford and Wilson, 2000).

There is unlikely to be major change towards a social based mental health system without wider changes in professional, public and political attitudes and priorities. Social work cannot be considered in isolation. To increase the likelihood of such change taking place, a number of broader developments also need to take place. These are likely to include:

- Developing more effective and inclusive service user involvement as a basis for policy and practice development
- Strengthening user controlled organisations
- More support for self-education and prevention
- A greater emphasis on societal education and prevention
- Valuing user experience in the workforce
- Continuity of support
- Supporting service user research and evaluation
- The more effective development of anti-discriminatory education as part of the national curriculum
- The improvement of quality based on developing user-defined standards
- More effective anti-discrimination legislation.

While these are likely to be essential for the longer term, social work and its proponents can also take a lead now by strengthening anti-oppression based social model elements in social work education and training at both qualification and post-qualification levels, ensuring the fuller and more systematic involvement of service users in the process as is required for the new social work qualifications.

Taken together, the elements identified in this discussion are likely to offer a framework for a social work for the future which is both consistent with a social model of madness and distress (located in the framework of the social model of disability), with traditional social work values and principles and which offers the prospect of a liberatory and rights based role for social work. This is the only basis on which it is likely to have a justifiable or realistic future.

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