Any meaningful challenge to the biomedical model must be supported by appropriate training in knowledge, beliefs and skills

Redressing the biochemical imbalance

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The government's national service framework for mental health and its agenda to modernise mental health services gives a direction to mental health policy. So far impetus has been given to the development of assertive outreach, crisis resolution and early intervention in psychosis. These initiatives are to be welcomed; yet many staff working in mental health services are demoralised, under pressure and exhausted by their workload and by constant change.

Training has an important role in the personal development of the workforce and can help to counteract such disillusionment by stimulating new thinking and new ways of working. The question is: which ways? Mental health practice and training are currently dominated by approaches that emphasise medical diagnosis and the use of physical treatments. My argument is that we should instead be encouraging what I call the biopsychosocial approach: that is, a more complete assessment of people's mental health problems and more recognition of the social and psychological aspects of those problems in the treatments we offer.

This is a prime moment for such a refocusing. The national service framework agenda has huge training implications. The new teams will be undertaking very demanding work requiring skilful interventions. If people are not properly trained the new services may actually make things worse for service users rather than better. Changing ways of working requires a proper training infrastructure and resources for team building. Otherwise the pressures on staff are simply increased, making them even more confused and demoralised. The Department of Health has also recently published its guidelines on acute inpatient units, with specific guidance on education and training of staff to be issued later this year. It is clear that training has to underpin any change to make wards more therapeutic. We need to relearn the advantages of the therapeutic community approach, which was so important in helping to open up the locked asylums. There needs, for example, to be more training on the importance of relationships and social context, for inpatient units and for community teams alike.

All in the brain

So what might inform this approach that distinguishes it from the medical model? There are three key initiatives. First is the report '*Recent Advances in Understanding Mental Illness and Psychotic Experiences*'[1] published by the British Psychological Society in June 2000. Written by the BPS division of clinical psychology, the report adopts a refreshingly individual and holistic approach to psychosis. Essentially it argues that the term 'mental illness' should be used as a psychological concept, not a medical one. Too often we assume that mental health problems are explained by an abnormal brain, with huge implications for the way we treat people. But this is only a hypothesis.

The report points out that psychiatric diagnoses are simply labels that describe certain types of behaviour so they can be assigned to various categories. They do not tell us anything about the nature or causes of the experiences. They do not offer an explanation for unusual experiences; they are merely a shorthand

description of these experiences. The report also suggests there is good reason to believe that mental health and 'mental illness' shade into each other and are not separate categories. This contrasts with the common medical view that draws a boundary between the 'normal' and the 'sick'. As to the causes of mental illness, there is no pretence that the biological solution to mental health problems is just round the corner and merely requires more research. In fact the report points out that for the majority of conditions research into genetics, brain chemistry, the physical environment and brain structure has not led to definite conclusions about physical causes. Indeed it points out that every single thought any of us have involves chemical changes in the brain, not just psychotic experiences. On assessment of mental health problems the report emphasises the importance of understanding the person's perspective and helping them come to an understanding of the problem and to decide what they think is likely to help. As far as medication is concerned, the report takes the view that it can alleviate symptoms but it is not a 'cure' and does not help everyone.

Adolf Meyer, the foremost American psychiatrist in the first half of the last century, was fond of calling the biological hypothesis a 'neurologising tautology'. What he meant was that postulating a biological abnormality does not help personal understanding of mental illness. His views have been largely eclipsed in the last 50 years; it's time they were revived as part of a critical psychiatry renaissance. The problem with the biomedical model is that it takes us away from understanding the patient as a person. A single word diagnosis does not do justice to the complexities of understanding a person's problems. It reduces the person to a brain that needs its biology cured. This is not to suggest that mental health problems are purely psychological. Rather they are biopsychological: a term I use to imply recognition of brain-mind integration. Just because the mind and the brain are talked about in different terms does not mean they are actually distinct. Of course there is a biological component to mental illness, as there is in all behaviour, whether 'normal' or 'abnormal'. The point is that the kinds of processes that underlie mental illness at the biological level may be no different from those that produce 'normal' thoughts, feelings and behaviour among people without a diagnosed mental health problem. That's a very different working hypothesis than mainstream psychiatry's reductionism and has implications for mental health practice.

Social models

The second key initiative is the potential revitalisation of mental health social work, in the form of the Social Perspectives Network for Modern Mental Health. The network was formally launched in February this year at the TOPSS England conference in Sheffield 'Achieving a Quality Workforce'. The Social Perspectives Network has been formed to promote the value of social models in today's mental health services. Although it could be seen as promoting social work, it is not an exclusively professional organisation. It encourages all stakeholders to recognise the value of the social perspective in mental health. As an umbrella organisation, the network aims to bring together users, carers, generic workers and members of the different professions to explore a wide variety of approaches to mental health care.

The network's opening discussion paper, 'Modernising the Social Model in Mental Health' by Maria Duggan with Andrew Cooper and Judy Foster,[2] concludes by noting the implications for training. As it says: '…[The] integration of approaches based on the social model carry with them radical implications for the education and training of mental health practitioners – and for the ethos of service and performance management frameworks.' The paper goes on to describe the key characteristics of the modern social model (see box).[2]

The modern social model[2]

- is based on an understanding of complexity of human health and well-being
- emphasises the interaction of social factors with those of biology and microbiology in the construction of health and disease

- addresses the inner and the outer worlds of individuals, groups and communities
- embraces the experiences and supports the social networks of people who are vulnerable and frail
- understands and works collaboratively within the institutions of civil society to promote and protect the interests of individuals and communities
- emphasises shared knowledge and shared territory with other disciplines and with service users and the general public
- emphasises empowerment and capacity building at individual and community level and therefore tolerates and celebrates difference
- places equal value on the expertise of service users, carers and the general public but will challenge attitudes and practices that are oppressive, judgmental and destructive
- applies a critical understanding of the nature of power and hierarchy in the creation of health inequalities and social exclusion
- is committed to the development of theory and practice and to the critical evaluation of process and outcome.

The social model is meant to imply more than just the practical issues that may impact on a person's life such as benefits and housing. Historically the social work perspective has offered a holistic approach to mental health practice. Contexts – social, political and cultural – are central to the understanding of mental health problems.

Part of the motivation for the Social Perspectives Network has been the move to integrate health and social services within care trusts. The fear is that some of the skills, knowledge and attitudes of social work will be submerged in the ethos of health services. The reform of the Mental Health Act proposes to share among a wider range of professionals the role of the approved social worker (ASW), currently undertaken by social workers alone. Fears have been expressed that the extension of the role to other 'approved mental health professionals' (AMHPs) will result in further diminution of the social model within mental health care. Equally, however, there's a case for arguing that such a move could free social workers from the bureaucracy and officialdom of the ASW role to use their knowledge and skills more broadly in working with users and their families, allowing them to return to their traditional emphasis on the social model.

A renewal of social work would create a revitalised focus on the social model. What will also be needed is training to create the knowledge, skill and attitudes to deliver the social model and study days have already been organised to take these issues forward. A central theme of the first such study day, 'What is the knowledge base and where does it come from?,' was the prominence of biomedical evidence, despite evidence of the impact of cultural variables and bias in interpreting the effectiveness of physical treatments.

Recovery

The third and last influence is the concept of recovery, which has recently begun to be recognised in the UK. Part of the explanation for the traditional pessimistic view of mental illness dates back to Emil Kraepelin and his description of schizophrenia, or dementia praecox as he originally called it. Kraepelin used the term 'dementia' to signify a deterioration of personality. Although personality deterioration can occur with some people diagnosed with schizophrenia, it is not an inevitable consequence. Meyer criticised Kraepelin's concept of dementia praecox for implying a biological causation. Meyer instead looked for the causes of mental health problems in the person's life situation, both current and in the past. Meyer's approach was thus more positive because he saw the potential for improvement in the person's circumstances; Kraepelin's view tended to suggest an inevitable worsening of the condition over time because of the biological inevitability of the disorder.

Thus the biomedical model encourages a tendency to believe that people are powerless to do anything about

their condition. In contrast, the recovery concept is a way of giving people hope. It comes from the accounts of people with personal experience of recovery from mental health problems and is seen as counter to traditional psychiatric views of mental illness as a chronic illness. Recovery is seen as dependent on finding a way of understanding and giving meaning to their experience that enables the person to reclaim control of what is going on for them. It does not necessarily mean becoming 'symptom-free'. Recovery is about reclaiming a socially valued lifestyle and social empowerment. It means a person becoming in control of the decisions he or she takes.

Interestingly, the Department of Health has recently taken up the concept recovery. It has even published a document entitled *The Journey to Recovery.*[3]

To quote from the report: 'Historically, people with mental illness were often not expected to recover. For example, people with schizophrenia were generally perceived as having a poor outlook, having to live their life in a uniformly downward spiral of persistent symptoms. This perception has influenced the public view of people diagnosed as having mental illness, as being ultimately unable to take control of their lives and to recover. Services of the future will talk as much about recovery as they do about symptoms and illness.

'We need to create an optimistic, positive approach to all people who use mental health services. The vast majority have real prospects of recovery – if they are supported by appropriate services, driven by the right values and attitudes.

'The mental health system must support people in settings of their own choosing, enable access to community resources including housing, education, work, friendships – or whatever *they* think is critical to their own recovery.'

In theory such official recognition should mean that we move to an emphasis on recovery programmes rather than care programmes – with considerable implications for training of mental health professionals in how we assess people's mental health problems. What a relief it would be to move away from the current overemphasis on risk assessment in the negative sense to regarding risk-taking as an opportunity. But will this shift take place? There are conflicting signals in government policy. For example, it is pushing ahead with its policy of introducing community treatment orders in the proposed new Mental Health Act. The primary motivation of such changes is safety: that of the general public rather than people with mental health problems. We also have to be wary of co-option by officialdom. The concept of recovery is inherently critical of the biomedical model; its full impact would be nullified if interpreted in a biomedical context.

Conclusion

Mental health professionals do not have to justify what we do by postulating brain pathology as the basis for mental illness. Rather we need a renaissance of the biopsychosocial understanding of mental illness and its treatment that looks at the whole person, their life and circumstances, and not simply into their brain. A national training programme in the skills, knowledge and understanding implied and promoted by the three initiatives discussed above would help to raise the profile of such an alternative approach and create more balance in current perspectives on mental health that tend to be dominated by biomedical thinking. It may also help to counteract some of the current demoralisation among staff, providing a renewal and freshness of approach in their work.

1 Kinderman P, Cooke A (eds). Recent advances in understanding mental illness and psychotic experiences. London: British Psychological Society, 2000 (www.bps.org.uk/docdownload/docdownload3.cfm?category_ID=19&document_ID=159)

2 Duggan M, Cooper A, Foster J. Modernising the social model in mental health: a discussion paper. London: Social Perspectives Network for Modern Mental Health/TOPSS England, 2002 (www.topss.org.uk/uk_eng/news/modsoc_model.pdf)

3 Department of Health. The journey to recovery: the government's vision for mental health care. London: the Stationery Office, 2001 (www.doh.gov.uk/mentalhealth/journey.htm)

The Critical Psychiatry Network can be found at www.criticalpsychiatry.co.uk