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Entering into, departing from and working within the psychiatric domain

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Abstract: This article is a Festschrift contribution which maps out the similarities in the career trajectories of Professor Peter Huxley and myself. It begins by exploring the key considerations of our common profession; social work, and its relationship with mental health. It then explores how a social orientation has enable us to reframe understandings of dual diagnosis. The second half of the article then explores the key lesson learnt from these interactions. The findings of the contribution are centred around the need for better understanding of the social detriments of mental health and substance use. In reaching these conclusions, the article summarises the importance of seeing individuals for the problems they encounter and working with them in partnership to arrive at more empowered responses.

Keywords: alcohol; drugs; dual digagnosis; mental health; older people; recovery

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Introduction

This article is a Festschrift contribution which maps out the similarities in the career trajectories of Professor Peter Huxley and myself. It initially outlines some important characteristics of our common profession, social work, and in particular its relationship with mental health. It then reframes our understandings of dual diagnosis through the social orientation lens. The paper explores the key lesson learnt from these interactions, with a strong emphasis on the need for a better understanding of the social detriments of mental health and substance use.

Peter and I first encountered each other as social workers in and amongst a range of social scientists at Bangor University [Wales], many of whom had criminological and sociological backgrounds. Perhaps for both of us this represented a receptive space as social workers, in contrast to some of the challenging environments of our formative past respective journeys. Peter's, as this special issue testifies, is characterised by being the first Professor of Psychiatric Social Work in the UK and the first social worker to be head of an academic department of Psychiatry in the UK. Mine is one of being an advocate for inclusive and social understandings of alcohol and drug use, where medical approaches and models are the dominant interpretation. In this, my contribution to Peter's honouring, I wish to explore what I have characterised as the entering into, departing from, and working with, the psychiatric world. I will do this through not only an integration of our own journeys and writing, but that of our profession, and with particular regard to a number of common interests including 'dual diagnosis', older people, recovery, social justice and well-being. Additionally, I offer a brief synthesis of much of the recent social model literature. It will hopefully become rapidly apparent that the common thread in all this is a claim for strong regard to be given to the social (detriments, inclusion, interventions and understanding) in the experiences of those living with complex alcohol, drug and mental health problems.

A Shared Profession

The starting place for these musings is social work, which itself has also stepped in, out and alongside the psychiatric domain. Social work can be characterised as one of the minor professions (Eraut, 1994). It is often inferred as playing catch up with the big players of the 19th century university, including medicine and psychiatry, with regards to claiming a legitimacy of evidence base and (academic) role. Social work moved from its own 19th century origins of philanthropic street work (e.g. Octavia Hill) through to an early 20th century embracing of the 'psy discourses' (Healy, 2005) of Kraepelin psychiatry, Freudian psychoanalytical

casework and cognitive behavioural approaches. For most of the profession the flirtation was a relatively brief, or at least not wholesale, one, with many happy to move with the deinstitutionalisation of, for example, Goffman and the person-centred approaches of Rogers. This psychological theoretical base was rapidly supplemented with that of the sociological, namely Bourdieu, Foucault, Giddens and Habermas (Gray and Webb, 2013). The 1970s then saw the departure, or return, to the street and through a range of radical- and social justice- (feminist, anti-racist or Marxist) led approaches to social work (Ferguson, 2008).

From here social work can be argued to have established its own models, theoretical approaches, international professional identity, academic journals and increasingly fused practice approaches. These adopted an empathetic regard to enabling individuals within an understanding of social injustice and family/community-based solutions, critically accepting the complexity of multiple considerations (Hood, 2018). The profession increasingly saw people for the (symptoms of) problems they experience, rather than inappropriate and maladapted coping mechanisms they manifest. Critically for this conversation (about mental health), we moved away from the sense of the professional as expert, or diagnostic and prognostic guru, and towards an approach of shared empowerment and partnership with a diverse range of colleagues and those with lived experience. Social work/ers sees it/themselves with clear professional identify and roles, in the worlds of multi-agency, integrated and co-production practice approaches. If this is the profession's journey and understanding, then in essence it captures much of ours.

Social Work and Mental Health

The predominant current social work approach to mental health does not seek to disregard the knowledge and evidence base of psychiatry, but rather articulates an argument for understanding of individual experiences or responses to distress in the context of relationships, identity, social capital and resources (Guthrie, 2018); one where individuals have more choice and control over their own narrative and the services they receive, and within which they are enabled to self-manage and co-produce solutions that work for them (Glasby and Tew, 2015). In adopting this position social workers often refer to this as an embracing of a social rather than medical model (Johnstone, 2022). Much of our careers, both academic and professional have been about how these broader sociological, social justice and inclusive social work understandings into the arena of experiences of mental health, alcohol and drug use are then applied, researched and written about. Indeed, as early as the 1980s, Peter was clearly articulating sociological and social considerations within acute and sub-acute mental health settings (Taylor and Huxley, 1984; Huxley and Fitzpatrick, 1985). Overtime we have argued that

those with complex experiences of alcohol, drugs and mental health are often amongst the most social excluded. Any successful response to their experiences requires a clear social justice approach (Huxley and Thornicroft, 2003; Livingston, 2009, 2022).

Social workers in these arenas not only have had to grapple with positionality and roles, but also language. Mental health, if not mental well-being, has like many contested language positions (Williams, 1983), become an increasingly preferred adopted expressions (position) by social work, as it seeks to establish recognition for a continuum of a diverse and vast set of experiences as opposed to the narrow definitions and service criteria of diagnosable mental illnesses (Goldberg and Huxley, 1992; Glasby and Tew, 2015; Livingston, 2020). This is not to suggest any outright rejection of the useful value of diagnosis, the stability provided by medication or the role of psychiatry in understanding experiences and supporting people (Gould, 2016). Indeed, for many years in the UK social workers have been the lead profession responsible for detaining individuals under the various Mental Health Acts. For social work, the considerations of inclusivity and broader models of explanation for experiences and potential interventions, require a language that moves beyond that which reflects an emphasis on pathologizing individual experience or the power of the expert. Similar discourses about avoiding the potentially discriminatory and stigmatising, and understandings of the continuum of experiences occur within social work's adoption of alcohol and other drug use as a preferred expression over say addiction or substance abuse (McCarthy, 2019; Livingston, 2020).

Dual Diagnosis

Often the two experiences of mental health and substance use are framed within discourses of dual diagnosis. This is a difficult concept to easily resonate with social work considerations of inclusivity, as by definition it excludes all but those fitting elements of two specific diagnostic manual criteria. The lived reality of here-and-now interwoven experiences is often indistinguishable from any original prior trajectory of casual behaviour and adapted coping mechanisms (Livingston, 2022). Dual diagnosis further invites narrow linguistic definitions of mental illness or addiction rather than broader formulations of mental health and alcohol or drug use. Whilst much of Peter's work has been undertaken within some of the dominant paradigms of the psychometric, psychiatric, and random control trial approaches to research, and at times with specific regard for 'mental disorders' or mental illness, it has had a focus on establishing and arguing for a broadening of these traditions to include parameters of the social determinants of mental health. Peter's huge contribution to the development of the Social

and Communities Opportunities Profile (SCOPE) (Huxley et al., 2008), and its emphasis for example on education, employment, family and housing, has furthered an articulation for seeing beyond the symptoms of distress. For many reaching the point of critical experiences, consistent with the need for acute treatment, the causes of malaise matter less than the way forward and have long been lost in the continued struggles of daily survival (Livingston, 2020).

Dual diagnosis, like mental illness, invites a polarised perspective of two distinct populations. However, experiences of mental health, and notably those that involve acute or extended difficulties of mental distress, are often accompanied by a range of other complex needs: i.e. those of aging, alcohol and drug use, and homelessness. Very often it can be argued that the specialist knowledge is that of social work, and effective working relationships, which fuses the multiple and complex needs rather than the individual specialism of any bespoke adult service provision (Livingston, 2021). Broadening conceptualisations, definitions and methodologies offers the opportunity for social work to be a critical friend within the psychiatric domains, a position that could be said to encapsulate much of Peter's career. Formulating the role of social care or social work in alcohol, drug and mental health research and practice is about establishing greater regard for social inclusion. The inequalities experienced affect the positions people find themselves in, adversely shape the quality of services available and reinforce experiences of discrimination (Gould, 2016).

Social Justice and Inclusion

Social inclusion is central to questions of recovery, and the move to recovery-oriented approaches for mental health and substance use has dominated much of the recent policy, practice and research responses (Davidson et al., 2016; Watson and Meddings, 2019; Livingston, 2022). Intrinsic to much of this positioning is the argument that, while treatment establishes a stability window, it is the being and doing with others in a refreshed healthier and less damaging perspective, that is key to long-term sustainable change. Thus, while diagnostic labels often open doors to specialist provision, and medication frequently affords periods of physical and psychological stability, it is the establishment of sustainable social networks and alternative lifestyles that help maintain mental well-being and better relationships with substances. Peer to peer service provision and support offers unique levels of equality, genuine respect, mutuality, non-intrusive collaboration, role modelling, and shared experience (Livingston et al., 2011). Peter has been a strong advocate, through numerous projects, for understanding the centrality that social attachment and networks provide for person centred recovery (Webber et al., 2011; Sweet et al., 2018). Such considerations include

specific regard for the meaningfulness in people's lives of activities, location and social inclusion (Livingston et al., 2011). Quite simply put, we have both articulated how the lack of social inclusion is a contributing factor to mental ill health and sustained substance use, as well as increasing social inclusion is key to successfully supporting improvements in well-being (Livingston, 2009, 2020; Chan et al., 2015; Santos et al., 2018)

There is one further overlapping thread between mental health, alcohol and other drugs that encapsulates the social orientation and is reflected in our collective writing. This concerns the critical call for action for greater levels of peer involvement, within policy formation, research practice and service provision, including mental health policy and practice (Stanford et al., 2017; Beresford, 2020). Peer involvement is intrinsic to the discussions about recovery. More broadly, the demand for greater epistemological justice has been led for many years by Beresford, who cites the need for more challenging of the ideological, knowledge and political status quo, in ensuring greater inclusivity of those with lived experience (Beresford, 2020). The calls for great levels of co-production and inclusivity in the research processes associated with mental health have become more insistent and urgent (Flegg and Stratford, 2017; Stanford et al., 2017; Beresford and Beresford, 2020).

In 2002, Peter was involved in a study that identified that the number one priority for service users with regards to mental health research was not a specific topic but rather the total inclusivity of peers within the research process. This formative shout for participant (action) research was one that I have also recently been involved in articulating with regards to alcohol and other drug research (Thornicroft et al., 2002; Livingston and Perkins, 2018). The pronunciations here are for a shift away from the (medical or research) perspective of the expert diagnosis, problem and solution, to a more social inclusive position of a shared partnership approach with those with lived experience in formulating and understanding of what is going on and what needs to be done. They also critically embrace discourses about the nature of language and power.

One of the really useful social modules co-produced by professionals and those with lived experience is the Power Threat Meaning Framework (Johnstone, 2018, 2022). It has five clear summary messages which can all be seen to resonate with much of the account told within this chapter. Firstly, that emotional distress and troubled or troubling behaviour are understandable in context of people's experiences, indeed a coping model of understanding suggests that alcohol and drug use is a logical response to the difficult circumstances people find themselves enduring (Livingston, 2009). Secondly, that experiences exist on a continuum rather necessarily the 'us and them' conversations that logically sit with defining people as 'mentally ill'. Further, that both narrative

and varying cultural experiences should be used in understanding the specificity of experiences. Finally, and perhaps most poignantly for this contribution, that distress is rooted in wider contexts of social inequality and injustice, quite simply put it has clear social detriments and outcomes are adversely affected by social opportunity (Huxley et al., 2021). Such arguments have recently been made in the context of challenging the re-emergence of a brain disease model for alcohol and drug use (Hogarth, 2022). The impact of inequality on the mental health well-being of all, and not just a specific population, is well articulated, and moves beyond subjectively locating ills within individuals on the basis of presumed psychopathology (Pickett and Wilkinson, 2009; Hill et al., 2016; Marmot, 2020).

In many ways, much of the considerations return to sit within some of the Goffman's critiques of the mainstream and Laing's rejection of the diagnosis, where existential and social interpretations help us understand that we all are actors contributing to and experiencing the combinations of social, self and (health) professional stigma. The argument for social construction of 'madness' has continued to be explored, and more recently been well articulated through the work of Bentall (2004, 2009) and Davies (2013, 2021). There have been distinct calls for (academic) psychiatry to take more account of social theory (Poole and Robinson, 2022). Davies' (2013, 2021) explorations extend into an understanding of the globalised and neo-liberal construction of the diagnostic manual and the maintenance of current 'big pharma' environments, something also echoed in the work of Alexendar (2010) with regards to alcohol and other drugs. Many of these messages sit within what some have considered as the resurgence of an anti-psychiatry movement, (if ever such existed), often led by those with lived experience and based on many years of negative system engagement (Love, 2020). More helpfully for social workers (practitioner and researcher) is to adopt these messages within a pragmatic critical psychiatry framework. One that: (i) promotes values of dignity and respect when working within and challenging the pressures of managerial and risk orientated environments (Cummins, 2017; Stanford et al., 2017); (ii) acknowledges the effectiveness of psychiatric care but without any undue pedestal for it, (iii) accepts the equal importance of diverse forms of evidence and knowledge creation (Livingston and Perkins, 2018; Poole and Robinson, 2023) and (iv) recognises the centrality of individual lived experience perspectives and social inclusion (Davidson et al., 2016). The reality is that social work has to work within and with such psychiatric settings. Peter and I have chosen and been compelled to do so, and much of our work reflects this kind of dalliance.

My interactions with Peter over the last decade have at one level felt like many across academia, serendipitous and sporadic. However, in writing this piece I have been able to reflect how they have also been built upon a commonality

of experiences, positionality and profession. We have both articulated the social (care) worker voice within dominions traditionally led by medical and psychiatric approaches. In our own way, and especially in the case of Peter's long and indelible markers, this has been a shout to see the person within the presentation and the social within the assessment. He has, and I hope to continue to, contribute to the provision of an alternative evidence base and explanation, where the presentation of and solution of individual distress is rooted in understandings of social determinants, inclusion and justice.

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