Workshop report

The Challenges of Mental Health for Social Science and Policy

King’s College London

June 2014
On 19th June 2014, a workshop on “The Challenges of Mental Health for Social Science and Policy” was held at King’s College London, Waterloo Campus. Supported by the King’s Interdisciplinary Social Science Doctoral Training Centre’s Science & Society initiative and organized by the Department of Social Science, Health and Medicine, in collaboration with Institute of Psychiatry and Social Care Workforce Research Unit, the workshop hosted a number of distinguished speakers and experts on mental health and involved postgraduate and early career researchers.

After a welcome and introduction by Prof. John Abraham (Department of Social Science, Health and Medicine), the workshop consisted of three sections, psychiatry, social policy and social science. The key theme of the workshop – the challenges of mental health – allowed for the accommodation of a wide spectrum of perspectives including psychiatry, psychology, global mental health, anthropology, gerontology and policy research. Participants had a chance to reflect on the contemporary significance, meaning and problematics of mental health as a field of research and clinical practice, while also evaluating the role that social science and policy is and can be playing in the advancement of knowledge and improvement of practice in mental health.

**Psychiatry session.**

Opening the psychiatry session, was Prof. Derek Bolton (Institute of Psychiatry) with his talk ‘Are mental disorders brain disorders? Tensions in current theory and method’. Bolton started with an observation that psychiatry is, significantly but not always recognisably, to large extent concerned with psychosocial phenomena. These are personal, inter-personal and social factors that inform and shape notions of mental incapacity and impairment. Diagnostic categories in DSM (Diagnostic and Statistical Manual of Mental Disorders), with their listing of symptoms, are based on criteria of functional human conduct in everyday life.

Currently, significant efforts are made to reconceptualise “mental disorders as disorders of brain circuits”. One of the most visible efforts is to find biomarkers for mental disorders, which has not yielded expected positive results. However, various levels of
causation have to be recognized, specifically psychological and social factors in conjunction with the acknowledgement that psychiatry as a medical field has strong corollaries with social values. The exclusive privilegization of “brain circuitry” in causation of mental illness, leaving psychosocial factors out, presents well-known reductionist pitfalls. On the other hand, difficulties in finding biomarkers – also sometimes seen as an attempt to boost psychiatry’s image as a scientifically-medical discipline worth of more funding and attention – might be not-so-bad news for those who argue for psychosocial frameworks in mental health treatment and research. And yet in a somewhat counter-intuitive manner, Bolton suggests that psychiatry might possibly be ahead, in clinical practice, of a certain curve in biomedicine, through its recognition of the importance of social determinants of health.

A recent departure of the National Institute of Mental Health in the US from the DSM paradigm in favour of the Research Domain Criteria (RDoC) research project has created tension but also holds the possibility of developing new diagnostic tools that would be more sensitive to the multi-faceted nature of mental disorders. Among the most promising areas to look at are genetics and social determinants of health. Such interconnected fields of mental health research hold the promise of necessary inclusive scope for mental health research and illness treatment strategies.

Dr. Mary DeSilva (London School of Hygiene and Tropical Medicine) presented the paper ‘An evidence-based response to critiques of global mental health’. In her talk, DeSilva gave a perspective of Global Mental Health (GMH) and addressed three major critiques of the movement. These comprise: 1) GMH tend to medicalize social suffering, 2) the size of the problem is overestimated, 3) the use of Western biomedical models. In her response to these critiques, DeSilva emphasised that there is, of course, truth to them but GMH specialists are committed to addressing these issues.

GMH promotes a biopsychosocial model and this includes a recognition of the social determinants of health. There is no ‘Big Pharma’ funding for GMH research and interventions. Almost all GMH interventions are psychosocial and only one trial has evaluated the effect of pharmaceutical interventions. And while depression, for instance, is
also social suffering, psychiatric treatment is still an appropriate and, often in low and middle income countries (LMIC’s), a difficult-to-provide response.

The size of the problem is a result of a miscalculated treatment gap. Current measurement conflates potential and actual mental health service coverage. Treatment gap measurements should be more precise – it is questionable for example whether people who do not want to receive any help for their mental health problems should be included in the denominator for the treatment gap. Importantly, the numerator of help received should include social interventions such as social support groups and self-help initiatives from which many people derive benefit, instead of conceptualising ‘receiving treatment’ as biomedical treatments only.

Regarding the use of Western models of mental illness in GMH, initiatives do use some of the evidence which is produced in the West. However, there is a need to start somewhere with so little evidence from low and middle income countries. The Mental Health Gap Action Programme (mhGAP) gives treatment guidelines not rules or a manual for how to implement those interventions within the health system. All interventions must be locally adapted and this is done by local experts and partners, supported by ministries of health who also often provide the funding, who have knowledge of the local health systems and culture.

The aim of GMH is to provide treatment and break the cycle of mental illness and poverty. Echoing a point made by Bolton, DeSilva emphasised that there are difficulties also in GMH to getting attention to prevention needs, which is crucial to tackling mental health problems.

GMH need better screening tools and there is a need to do research and develop more appropriate diagnostic tools. However, in order to scale up interventions, adaptation of existing evidence-based approaches is key. The latter strategy is opposed to long term development of locally based interventions which are much more difficult to apply outside their original context and, given limited funding, prove to be cost-ineffective. These are the
issues where social scientists can contribute – to monitor and improve performance, outcomes and training.

The discussion after the presentation raised more questions about the use of the evidence from Western psychiatry and the actual commitment of GMH specialists to engage with culturally sensitive approaches in mental health. DeSilva noted that there might be a difference between the public ‘face’ of the movement and the private discussions and debates they have, with the latter being more welcoming to culturally-focused perspectives. However, limited funding also has to be taken into account which is putting pressure on GMH to do the most possible in order to provide and support as effective treatment in LMIC’s.


Social Policy session.

The social policy session was opened by Dr. Martin Stevens (Social Care Workforce Research Unit) who presented on the ‘Ethical questions and processes – what helps to get a study approved’ as an overview of research ethics and moral responsibilities of the researcher when engaging with participants in a mental health-related study. Stevens suggested that the question of ethics in research can be described as threefold: are ethics objectively true? Relevant to the culture? Or subjective? The right answer would be ‘yes’ to all of the above. Research ethics broadly relate to philosophical theories of ethics which are: absolutist (deontological ethics), where ethics exist as a moral dictum, values in and of themselves; utilitarian, where actions are judged on the basis of the consequences these actions cause; virtue ethics, which are concerned with the moral character of the subject; and a value-based model. The role of intuition, emotion and reason in research is important for ethical awareness. It should be kept in mind that research is usually done in a ‘messy’ world with varying conceptions of individuals and society and therefore research without ethical awareness can cause harm.
Balance is needed between something that is good and necessary and its potentiality to cause harm. In history, there are a number of salient examples of ethically dubious and in retrospect strongly unethical studies, such as the Tuskegee syphilis study, the Milgram conformity study, the Stanford prison experiment and the Alder Hay body parts scandal. What these examples show is the importance of honesty and openness toward study participants. This leads to the next important aspect in research ethics, that of voluntariness and informed consent. As Stevens points out, it might be not easy to distinguish between encouragement to participate and pressure. Especially, this aspect is important in considering how to include particular social groups in research. Consent, Stevens suggests, is a state of mind and therefore can change. It also requires capacity to understand what a participant is consenting to, going back to the question of honesty and openness of the researcher.

A particularly important issue in mental health research is mental capacity. As such, mental capacity is key in obtaining consent from potential study participants. Thus, about a third of detained mental health patients have capacity to consent. But mental health conditions can make this a complex question due to the possibly fluctuating capacity of the participant to give consent and thus participate voluntarily. Therefore, researchers might need to gain consent on a continual basis. However, the issue of mental capacity has had more thought given to capacity to consent to treatment than in research.

Overall, research ethics is something which should always be kept in mind. It is the researcher’s responsibility to make sure that enough information, in an appropriate format and through an appropriate medium, is provided to study participants before they can make an informed and voluntary decision about participation in the study, with an option to withdraw at any time.

Prof. Jill Manthorpe (Social Care Workforce Research Unit) opened her presentation, entitled ‘Coming of age? The curious case of adult and older mental health research’, with an observation that the mental health of the older-age population is a relatively neglected field and usually research is related to the “burden thesis”. Older-age mental health is approached in broadly recognisable patterns, such as attention to the notion of loneliness.
and its development into depression. Nevertheless, the recent move from psychosocial to biopsychosocial frameworks have enlarged the space of research on old age.

One of the main research areas in older age mental health is concerned with dementia. Discovery of dementia can be seen as discovery of a research focus. This focus mobilizes various actors and social institutions, from politicians to media, to medical experts and advocacy groups. It is here that social science can contribute substantially by exploring the debates that surround the classification of age in politics and in the media, and the role of social class. As well, the search for a dementia cure has some of the trappings of the search for the Holy Grail and even a cause of national anxiety. The difference and division between actual dementia research and the need for it, and political rhetoric and language that surrounds it, have become essential to understand. The language employed is that of war, fighting, victims and soldiers. Social science has much to contribute through research on these metaphors’ influence in older age mental health research.

The leading public policy approach to older age population health and mental health is, in line with areas of contemporary life, focused in self-responsibilisation and financialisation. The creation of the “I” as a focal point of responsibility is similarly applied to evaluations in policy research and politics. A focus on the individual has become a leading approach in dementia research. However, the individual is also seen within a social network and responsibility is distributed amongst family members. This is evident in awareness campaign advertisements currently being shown on television. Another aspect of individualisation is expressed in popular conceptions of brain fitness, as evident in ideas about playing Sudoku and crosswords as a means to improve one’s mental health in older age.

This awareness, nevertheless, brings forth some important questions, such as – should people be screened for conditions for which there is no cure and do benefits outlie risks? The problem of false positives and false negatives becomes evident in this context. Should part of the money instead be directed into actual health and care for those with the condition and the avoidance of excess disability?
All this is evident, Manthorpe suggests, in the almost exclusive focus on dementia in older age mental health research. Conditions such as depression, with some exceptions, are rarely articulated in later life. For example, the question of suicide among older people is a very complex one and rarely addressed despite older people taking their own lives more often that it might be assumed. This highlights the question of assisted suicide where older people and others are making their own voices heard. Writer Terry Pratchett is a famous figure in this debate and he has expressed a wish to die when, having being diagnosed with dementia, he perhaps no may no longer consider life worth living. In Switzerland, the company “Exit” has added ‘suicide due to old age’ as a reason for suicide or assisted dying. In the UK, debate over death and its timing is ongoing with, for example, a recent well publicized case for the right to die being lost in the Supreme Court.

Moving beyond these debates, and organ and disease-based approaches, is possible by developing new conceptual frameworks for thinking about older age mental health. One of the concepts that allows that is ‘frailty’. Frailty provides a conceptual basis for a more integrative model of health and as such fits well the biopsychosocial generalism. From this perspective, it becomes clear that to focus not only on responsibilities but on psychology more broadly, such as coping mechanisms and self-efficacy in daily life, is key to ‘managing’ or at least understanding more of the experiences and impact of disabilities in later life.

Social Science session.

The social science session was opened by Prof. Nikolas Rose (Department of Social Science, Health and Medicine) with a talk on ‘What is diagnosis for?’ Rose noted that DSM, historically considered to be the main diagnostic tool for psychiatrists, today has a somewhat limited use in actual clinical practice, at least in Britain. On the other hand, DSM is widely used in RCTs and as a basis for epidemiological studies and psychiatric research. The latest DSM-5, published in 2013, has leaned towards the inclusion of not only new or updated psychiatric diagnoses but also of novel risk categories. These developments, in turn, suggest that diagnosis has various cultural and social functions.
Rose highlighted a number of functions that psychiatric diagnosis has today, such as a condition of eligibility for treatment and a legitimate reason for the absence from work, or a condition for access to welfare payments. For epidemiologists it is the very basis of calculation of incidence and prevalence; for planners of services, this information of incidence is needed to plan services; for research funders it is a basis for qualifying a problem to be investigated, and for insurance-based regimes it determines payment. Cultural aspects of diagnosis are such that it can legitimise ailment, organising symptoms into behavioural patterns that can be labelled. Diagnosis can reframe the past, shape the present and impact the future. It legitimises treatment and can generate or alleviate stigma. Also it can help people to better understand either their own or others’ behaviours. Diagnosis allows for a story to be developed of what the ailment is and how to deal with the condition. For a doctor, diagnosis can be a performative act and for the patient a transformative moment. Diagnosis can possibly reduce responsibility and the “moral weight” of the diagnosis can become a means to develop a “moral career”.

Use of diagnostic categories are attempts to demarcate clear conceptual and theoretical space to adequately research mental health and consequently treat mental health problems. However, Rose highlighted a recent move away from DSM diagnostic categories, notably by the NIMH RDoC program and the Human Brain Project, through their endeavours to find “brain signatures” for mental disorders of various forms. The main attempt consists in finding biopathology that underlies mental disorder – the ontological notion of disorder.

In the light of current developments and the state of diagnostic process in psychiatry, Rose distinguishes two alternatives: first, the locus of mental disorder is body and brain. The search for biomarkers is a salient example of this approach; second, a more holistic view of the disorder in its milieu, or a “disease as experience of the person” not merely a “disease entity”. In clinical practice, the latter might mean that there is indeed no need to work with diagnostic categories and thus to move away from listing of symptoms that people must have in order for the condition to apply. In psychiatric research, Rose suggested beginning with the understanding of the person in his/her milieu and working towards overcoming the distinction between biological and social, an area of research where social scientists have a
lot to contribute to help overcome reductionistic pitfalls. There is a need to focus on patterns, experiences and resilience. Drawing the boundaries between normal and pathological is a considerable and crucial problem for diagnosis and as such ought to be taken seriously.


The last speaker of the workshop in the social science session was Dr. Dominique Behague (Department of Social Science, Health and Medicine) with talk entitled ‘Researching the political and material life of diagnostic unravelling in Southern Brazilian psychiatry.’ Behague presented her work on adolescent psychiatry in Pelotas, Brazil. From a historical perspective, adolescence is a modern invention, closely related to formalization of education and development of capitalist economic systems. Today, this still makes adolescence a new formation in various localities. Behague pointed out, there is a discernible political production of certain kinds of adolescents and the “development is not a given”.

In the late 1990s researchers in Pelotas Southern Brazil began documenting what they considered to be unacceptably high rates of licensed psychotropic use among individuals of all ages, including youth. This came as a surprise, since the vast majority of psychiatrists in Pelotas draw on psychoanalytic theory and approach pharmaceutical use, especially for children and adolescents, in a consciously tempered way.

In her paper, Behague explored the social life of an “anti-biologizing” epistemological framework that Pelotense psychiatrists and researchers are using to pre-empt the kind of diagnostics-driven “biopsychiatrization” so prevalent in North America and to make sense of the situation they see unfolding before them. Drawing from a longitudinal ethnographic sub-study, part of a larger 1982 birth cohort study, she explored the circuitous trajectories of emergent pharma-patterns among “shantytown” youth over a ten-year period.
Behague provided analysis of the clinical and extra-clinical circumstances, such as class, age and gender, in which psychodynamic psychiatrists’ therapeutic intentions both succeed and crumble. She suggests that psychiatrists’ use of polarizing anti-pharma epistemologies ironically contributes to their failed attempts to “resist” pharmaceuticalization.