Policy implications of a psychological model of mental disorder

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Abstract
Background: Mental health care in the United Kingdom is rapidly changing, but many commentators, particularly sociologists and psychologists, view systems as remaining wedded to a medical model and not “fit for purpose”. If services are to improve, the way that mental health problems are understood by the services providing care needs to change radically.
Aims: To illustrate how a psychological model of mental disorder – the “mediating psychological processes model” – could assist mental health service policy development and implementation.
Method: A review of selected literature and policy documents was conducted.
Results: A “manifesto” for mental health service policy is presented, based on psychological principles.
Conclusions: Psychological models, at least in addition to medical approaches, could better inform policy and service design.

Keywords: Psychological model, mental disorder, mental health policy, biopsychosocial model, psychiatry

Introduction
Mental disorder is common (Office of National Statistics, 2001), impacts hugely on individuals (World Health Organization, 2003) and imposes extremely high costs on the economy (Layard, 2005; World Health Organization, 2003). Despite this, in the UK, only a small minority of people with identified mental health problems receive appropriate treatment (Office of National Statistics, 2001), and existing mental health care provision is frequently non-therapeutic (Mind, 2004; Sainsbury Centre for Mental Health, 2005a). Mental health care appears to fail its clients. Meaningful recovery in terms of social, psychological, or occupational functioning is influenced as much by social class, opportunities for employment and economic and social policy as by “successful” treatment of psychiatric symptoms (Warner, 1994). Mental health services appear to be targeted at “mental illness” rather than “mental health”, and traditional mental health care may often fail to achieve even that limited symptomatic outcome (Whitaker, 2002). Mental disorders are implicitly assumed to be biological disorders requiring treatment with variants on the traditional medical care systems, and proposals for service redesign (see, for example,
Boardman & Parsonage, 2007; Sainsbury Centre for Mental Health, 2005b) rarely challenge these fundamental assumptions. Psychological approaches offer coherent alternatives (Bentall, 2003; Kinderman, 2005; Read et al., 2004). If service design or re-design is based on these available alternative frameworks of understanding, fundamental service improvement may result.

The “Mediating Psychological Processes” model of mental disorder

The mediating psychological processes model of mental disorder (Kinderman, 2005) suggests that disruptions or dysfunctions in psychological processes constitute a final common pathway in the development of mental disorder. These include, but are not limited to, cognitive processes. Instead of assuming either that social and psychological factors mediate the effects of biological processes, or that biological, social and psychological factors are co-equal partners in the aetiology of mental disorder (the most common interpretations of the biopsychosocial model; Pilgrim, 2002), this approach proposes that distal causative agents; biological abnormalities or physical insults, social factors such as poverty and social deprivation, and circumstantial factors or life events such as childhood sexual, emotional or physical abuse; lead to mental disorder because those factors adversely affect psychological processes. The model is presented graphically in Figure 1.

Kinderman and Tai (2007) discussed the possible clinical implications of this model for the individual therapist. They proposed that psychological formulations rather than diagnoses should predominate clinical planning; and that these formulations should detail the social, biological and circumstantial factors hypothesized to lead to the disruption of psychological processes or mechanisms and on the functional consequences of this. Such a process is likely to be more person-centred and normalizing than a diagnostic approach (British Psychological Society Division of Clinical Psychology, 2000; Tarrier & Calam, 2002), and is compatible with both the “recovery” model of mental health care and service user preferences (National Institute for Mental Health in England, 2004a; 2005).

Kinderman and Tai (2007) suggested that medical, social and even psychological interventions are most likely to be effective if they are designed on the basis of their predicted beneficial impact on underlying psychological mechanisms. Medication could better be targeted at problems and processes rather than putative “illnesses” and should be more cautiously deployed than at present (Moncrieff & Kirsch, 2005). Evaluating the clinical effectiveness of medications could examine not only their potential for symptomatic relief, but also their effect on functional outcome, acting in partnership with cognitive, behavioural, social, occupational and practical interventions. Such an approach is common in general practice where, for instance, pain may be managed on a symptomatic basis once it is

![Figure 1. The mediating psychological processes model.](image-url)
clear that obvious risk factors have been addressed. A possible consequence of this would be
greater use of supplementary prescribing by nurses and pharmacists. Such developments are
already part of NHS policy (Department of Health, 2005). Psychological models are
consistent with recent developments in service design, workforce planning, and professional
training. An explicit focus on such models may, however, further improve the delivery of
frontline services.

**Implications of the model for service design**

Adopting a psychological approach such as this to service provision would imply that:
(i) services would be planned on the basis of need and functional outcome rather than
diagnostic categories. Where residential care is necessary, a concept of “hospital” care
would be unnecessary, (ii) the current emphasis on specialist teams would continue, but the
focus of these teams would be based on underlying psychological principles, (iii) services
would fully embrace the recovery approach, (iv) services could facilitate genuine service user
involvement, (v) improvement could be made in relation to accessing psychological
therapies based on individual case formulations and driven by recovery models, (vi) nurses
could develop increasing competencies in psychosocial interventions; occupational
therapists and social workers should see their roles develop, (vii) psychologists should be
prepared to offer consultation and clinical leadership, and (viii) psychiatry would remain a
key profession, but emphasis placed on a return to the key principles of applying medical
expertise as it assists a multidisciplinary team in the understanding and treatment of mental
disorder.

**Health care, social care or psychological care?**

At present, within the UK, mental health services are seen as a specialist form of health
provision. But psychological approaches (Bentall, 2003; Kinderman, 2005; Read et al.,
2004) do not characterize mental disorder as an illness. It follows that an appropriate policy
framework would place care within a social, not medical, framework. Within the current UK
Government structure, this may not mean a move from the Department of Health (since this
Department of State is responsible for a wide range of social care), but it may have
implications for the internal organization of that Department.

A number of Government initiatives have supported psychosocial approaches; emphasiz-
ing patient-centred services (Department of Health, 2000; 2004a; 2004b), recovery
(National Institute for Mental Health in England, 2005a) and improving access to
psychological therapies (Department of Health, 2004c; Department of Health Press Release,
2006; Layard, 2006) and envisaging changes in mental health legislation (Department of
Health, 2004d; Kinderman, 2006). Several cross-Departmental initiatives such as the focus
on psychological therapies in helping people on disability benefits return to work
(Department for Work and Pensions, Department of Health & Health and Safety Executive,
2006; Layard, 2006), psychological approaches to crime reduction (Audit Commission,
2004; McGuire, 1995) and social inclusion (Cabinet Office, 2006) all suggest models for
future working. Nevertheless, a policy concentrating on personal distress, psychological
dysfunction, social circumstances and (perhaps only lastly) medical approaches for
understanding and intervening in mental disorder may lead to profound changes. It is
possible to imagine, for example, community psychosocial well-being centres (hopefully
with a more engaging name!) funded by a Department for Social Care, integrated care plans
for socially disadvantaged or excluded persons, multidisciplinary approaches to childcare,
children’s health and education, policies that more appropriately link mental health with the benefits system as well as with the police, prison and probation services... and so on. Many people would applaud the call for mental health services to link “more closely with grassroots voluntary agencies and self-help groups, including offering helping-the-helpers support, or taking responsibility ourselves for training and supervising community members” (Haunstein Swan, 2005, p9). Some child and adolescent mental health services have already led the way in this respect (Belsky et al., 2006). But such integrated, community-based services do not follow naturally from a disease model of mental health and it may be useful to consider how our theoretical frameworks help, or hinder, such developments.

The high levels of prejudice and stigma experienced by people in receipt of mental health care has been well documented (see Bhugra, 1989). Traditionally, attempts to reduce this stigma have employed campaigns that essentially make the case that “mental illness is an illness like any other” (see Read et al., 2006). But these have been of limited success; with negative attitudes toward people with mental health problems either remaining stable over time or even deteriorating (Read et al., 2006). People experience stigma with many physical illnesses such as cancer, AIDS and leprosy (Link & Phelan, 2006). It simply does not follow that to be seen as ill protects from stigma. Indeed, the apotheosis of biological explanations – genetic abnormality – is quintessentially stigmatising (individuals experience difficulties because their heritable genetic blueprint, their DNA, is faulty). Although it is entirely possible for psychological models to be stigmatizing (Moloney, 2006), biological explanatory models are generally associated with greater discrimination (Mehta & Farina, 1997; Read & Harre, 2001). A non-medical approach to understanding and intervening in mental disorder is likely to be de-stigmatizing.

A psychological basis to mental health services could change existing services from the top down. The mediating psychological processes model places psychological considerations at the heart of services. This implies that the Department of Health (or Department for Social Care) should consider employing a “Chief Psychological Officer”, as it does a Chief Medical Officer and a Chief Nursing Officer. It would further imply that all NHS mental health Trusts should have Directors of Psychological Therapies or Clinical Directors on their Boards.

Access to and provision of services

Decisions about the provision of mental healthcare could better be based on individuals’ distress and their personal and social functioning, rather than diagnosis of illness. There are good arguments for a substantial increase in funding for mental health care (World Health Organization, 2003), but difficult decisions have to be made about to whom and in what circumstances services should be made available. Any diagnostic distinction between “real illnesses” and “normal reactions” is alien to psychological models of mental disorder (Bentall, 2003; Kinderman, 2005; Read et al., 2004). If prioritization is required, it is sensible to base this on the severity of, consequences of, and risk posed by a person’s problems.

This may seem to some to be a loose and vague arrangement in comparison with diagnostic approaches. Indeed most available research evidence for clinical effectiveness is necessarily based on diagnostic information. This reflects current practices for describing sampling and research populations, rather than acceptance of a particular theoretical framework for understanding mental disorder. The assessment of psychological difficulties can be conducted on alternative bases that are at least as reliable as diagnosis
(van Os et al., 1999), and have the major advantage of ecological validity (British Psychological Society, 2000; Kinderman & Tai, 2007). These changes have already started to be implemented with the ideas of stepped care (Bower & Gilbody, 2005) and the psychosocial flavour of many recent mental health policies noted above.

**Residential care**

Hospitals could be replaced with residential units designed and managed from a psychosocial perspective. In psychological approaches such as the mediating psychological processes model people are not “ill”. It is clear that many people in personal distress very frequently need access to a range of therapeutic services, may occasionally need a place of safety and care, may require crisis resolution and very occasionally need a place of containment. People receiving specialist medical care may well need continual support and monitoring, but it does not follow that a “hospital” is needed (Kinderman, 2006; Kinderman & Tai, 2007). Instead, people could better receive these forms of service from specialist residential social care units.

Mental health hospitals are frequently very non-therapeutic (Mind, 2004; Sainsbury Centre for Mental Health, 2005a) and often fail to provide people with appropriate care (Office of National Statistics, 2001). In other areas of social and personal care, “hospitals” are not seen as an appropriate model. People with learning disabilities frequently receive care from specialist units offering care (including medical care) in residential settings, while care for older adults (where a wide range of specialist services are offered in residential settings) and even hospices are very frequently designed and organized in deliberately non-medical ways. Government plans are to provide more opportunities for home-based and non-hospital care (Department of Health, 2006a). Innovative mental health and social services already operate residential crisis units. These are often away from traditional hospital sites and typically cater for people in acute distress and in need of immediate staffed support. Such residential units therefore rely upon the skills of nurses and the other traditional mental health care professions.

**Structure of services**

Current strategic developments in mental health services in the UK involve the establishment of specialist teams (Department of Health, 2004a), representing specialist subsets of skills, expertise and perspectives (Onyett, 1995) to complement multidisciplinary teams addressing the needs of a wide variety of service users (National Institute of Mental Health in England, 2004b). Different subsets of psychological processes will be compromised (for different reasons) for different people. The set of skills necessary to address some problems (e.g., offending behaviour) may not be the same as those relevant to others (e.g., early intervention in the development of psychotic phenomena). It follows that some people will require the services of a speciality team (i.e., a specialist psychological therapies team, an early intervention team or an assertive outreach team) comprising specialist focus, skills and assessment expertise. Others will have multiple needs and problems that may best be met by a multidisciplinary team applying its multiple perspectives and competencies. And, for many people, a mix of these approaches will be needed; care from a multidisciplinary generic team while also requiring specialist services. In the UK, the development of specialist teams is already part of health policy. However, adopting psychological principles for service delivery requires teams to operate on the basis of competencies and skills mix, targeting psychological mechanisms identified as clinically relevant, not on putative diagnoses of
disorders. Such an approach is entirely compatible with modern principles for multi-
disciplinary team working (Department of Health, 2002), in which services are a planned on
the basis of factors such as level of disability and risk to self or others, rather than being
dependent on diagnosis.

Service user involvement and the recovery model

Both the involvement of service users in care service planning and delivery and the adoption
of the recovery model are key parts of current policy (Department of Health, 2004a;
National Institute for Mental Health in England, 2005) and do not need to be justified here.
But they are also both entirely compatible with a psychological approach to mental health
care. People would not be “treated” for “illnesses”, but may be helped to recover a better
quality of life. It follows that the relationship between service users and professionals would
benefit from reconsideration, with “experts by experience” ideally placed to encourages the
giving of information and promoting hope and optimism.

Staffing

There is a parallel between the clinical application of psychological models and the approach
to workforce redesign currently adopted by the National Institute of Mental Health in
England. In simple terms, planning for a modern mental health workforce would involve:
(a) identifying the service needs of the population, (b) identifying the most appropriate
therapeutic response – based on appropriate primary and clinical evidence, (c) identifying
the appropriate competencies required to deliver these therapies, and (d) planning the
appropriate workforce development strategies, staffing models, role redesign and service
structures (National Institute of Mental Health in England, 2004b). There are important
consequences for most of the major professions in mental health care.

Psychiatry

Psychiatrists could better refocus their efforts on physical healthcare and on biomedical
perspectives of mental disorder, within multidisciplinary teams. It has been argued for many
years that traditional psychiatry has given a dominant position to biomedical approaches,
even within supposedly biopsychosocial models (Pilgrim, 2002), where social and
psychological factors are considered merely to be moderators of the direct causal role of
biological processes. This “primacy” of biomedical causation (Guze, 1989) has led to claims
of professional superiority (Rashkis, 1979), which unsurprisingly has been a source of
tension (Eisenberg, 1995). From a psychological perspective, a range of biological factors
impact on mental health through their influence on psychological processes. Therefore the
clinical effectiveness of medical treatments require examination not only of the potential for
symptomatic relief, but also the effect on functional outcome, acting in partnership with
cognitive, behavioural, social, occupational and practical interventions.

It is therefore essential that mental health services have competent medical professionals
to assess the possible contribution of biological causative factors to mental health and deliver
appropriate biological interventions. So psychiatrists and other medical staff are crucial but
there needs to be an emphasis on their return to the key principles of the application of
medical expertise as it assists a multidisciplinary team in the understanding and treatment
of mental disorder (Rosen, 2001). It may even be sensible to consider exploring other
ways of providing such a medical perspective.
Nursing

Mental health nurses could further develop competencies in psychosocial interventions (Lancashire et al., 1997). In many ways, the role of the mental health nurse can be seen already to have evolved in this direction; their skills and competencies are highly valuable and essential but there is a convincing argument for a substantial change in the nature and profile of the nursing role.

Mental Health Nurses form the backbone of the mental health services, acting as frontline carers, and commonly offer 24 hours a day, 7 days a week care. For the majority of such “out of hours” services, nurses are the only direct care providers. Their extended and close contact with service users often leads to a detailed knowledge of the individual and their carers and families. The numbers of staff involved (more than 45,000; Department of Health, 2006b), the fact that mental health nurses work in all areas of mental health services, the fact that mental health nurses frequently act as care coordinators, and the specialist competencies of many mental health nurses all demand respect.

A psychological model of service provision would support the development of the autonomy and independence of the Nurse Consultant, strongly support the development of nurses’ competencies in psychological aspects of care, and strongly support their development of competencies in psychological interventions. The Department of Health is currently in the process of reviewing the role of mental health nurses (Department of Health, 2006b). This review is likely to recommend the development of a range of new nursing roles, particularly emphasizing the further development of nurses’ skills in physical health promotion and the provision of evidence-based psychological interventions, supporting the “recovery model” (National Institute for Mental Health in England, 2004a; 2005), the “10 Essential Capabilities” (National Institute for Mental Health in England, 2004c) and the need to enhance social inclusion and the positive and holistic therapeutic relationships nurses develop with service users, their families and carers.

There are, however, tensions between traditional nursing roles and the implications of a psychological model. Mental health nurses provide care within a direct, personal relationship of the kind emphasized by Burkitt and colleagues (2001) and provide a range of social caring roles. The role of medical (that is pharmacological) treatments in mental health care would imply a considerable role for medically skilled professionals overseeing the use of medication. But there may be some rationale for seeing the bulk of care as essentially social or psychological in nature within a personal, therapeutic relationship. If these ideas are taken forward, nurses would be expected to remain as the providers of the bulk of care both in the community and in the residential psychosocial care units referred to above. Such responsibilities should be reflected in authority and autonomy in clinical decision-making.

Psychologists

Within the “New Ways of Working” programme (National Institute of Mental Health in England, 2004b) and the Government’s plans for reform of mental health legislation (Department of Health, 2004d; Kinderman, 2006), the roles of clinical and applied psychologists are receiving increasing attention. This does not necessarily mean that more psychologists — persons with specific qualifications in psychology — are required. Policies have rather advocated increased training and supervision of other professions in psychosocial approaches (National Institute of Mental Health in England, 2004b). Both the Department of Health and external commentators have advocated a substantial increase in
the provision for cognitive behavioural therapy (Layard, 2006). Most of the proposed additional therapists would not be psychologists.

As with medically trained staff, it makes sense for the team to possess a range of competencies, but for professionals individually to focus on their core skills. For psychologists, that means a focus on psychological formulations and consequent interventions. In addition to providing psychological interventions psychologists should be more involved in supervision and training of those other professions delivering psychological therapies, and could perform more consultancy work developing psychological formulations and consequent care plans, and then working indirectly with clients through other members of the team. Psychologists should assist in developing and ensuring the implementation of care plans that draw together identified needs of the service user. Psychological therapies per se may be better delivered by professional specialist staff other than psychologists or psychiatrists. Possessing competencies in the delivery of psychological therapies is different to being able to assess, formulate and develop a care plan which incorporates a number of therapeutic approaches. This is particularly salient for people with complex needs involving multiple agencies. The competency in clinical case formulation is seen as central to a clinical psychologist's distinctive contribution to mental health care (British Psychological Society Division of Clinical Psychology, 2001; National Institute for Mental Health in England, 2004b; Quality Assurance Agency for Higher Education, 2004).

Adams and colleagues (2000) suggest that psychological interventions can be seen on three levels: (i) support and education (e.g., psychoeducation), (ii) specific skills training (e.g., assertiveness, social skills etc.) and (iii) problem-focused interventions (ranging from basic interventions such as anxiety management to more complex and longer term individualised formulation based interventions). There is, therefore, a range of interventions suitable for a variety of problems and requiring a range of skills from the professionals delivering them. A formulation-based approach using these levels of intervention allows for clearer and more transparent stepped pathways of care.

**Social workers**

Social workers could take a more central role in mental health care, and perhaps could consider developing a “social pedagogue” role. A psychological perspective emphasizes how social factors such as poverty and social deprivation may induce disillusionment, hopelessness and learned helplessness, likely causal factors in mental disorder (Evans et al., 2001). Social factors should therefore be integrated with psychological and biological elements in clinical formulations and social interventions strongly supported. Recent discussions have highlighted social workers as currently the only mental health workers with specific and comprehensive social science education and training (Care Services Improvement Partnership/National Institute for Mental Health in England, 2006) which encompasses a wide range of theoretical perspectives and methods of intervention and strengthens the social worker's role in tackling social inclusion. There is clear support for the distinctive contribution offered by social workers; they have important roles in organising and even commissioning care packages beyond the NHS. While this is valuable, it may be worth considering the slightly more direct and therapeutic role offered by “social pedagogues” elsewhere in the EU (Asquith et al., 2005; Kornbeck, 2002).

**Occupational therapists**

Consideration of the role of occupational therapists covers similar issues. Work is known to be important in promoting recovery for those who have experienced mental health
problems (Boardman et al., 2003) but this group faces major challenges in the employment market problems (Huxley & Thornicroft, 2003; Office of the Deputy Prime Minister, 2004). Occupational therapy addresses “the nature, balance, pattern and context of occupations and activities in the lives of individuals, family groups and communities” (National Institute of Mental Health in England, 2004b) but, as with other professions, there is an aspiration to develop psychological interventions. Occupational therapy also retains a particular focus on issues of social inclusion within a social disability model of mental health (National Institute of Mental Health in England, 2004b). This occupational focus may presage greater links with occupational psychologists and return to work advisors.

Conclusions

In several different areas, psychological models of mental disorder have important implications for mental health service policy.

Services could better be planned and delivered on the basis of individuals’ functional needs rather than diagnostic categories, and should emphasize psychosocial therapies targeting underlying psychological processes. Residential care should be provided, when necessary, without medical characteristics. Multidisciplinary teams could also operate according to these principles – with nurses increasing their competencies in psychosocial interventions, the roles of occupational therapists and social workers developing and with a large-scale investment in psychological therapists. Psychologists should be prepared to offer clinical leadership, but psychiatry would remain a key profession, with increasing emphasis on the application of medical expertise as it assists a multidisciplinary team in the understanding and treatment of mental disorder.

Such an approach is evolutionary, rather than revolutionary. It reflects the best of current practice (National Institute for Mental Health in England, 2004b) and many academic and professional commentators will see this approach merely as reflecting common sense. It represents, nevertheless, a radical challenge for those who view mental healthcare as a natural branch of medicine (Guze, 1989; Kandel, 1998).

References


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