

Bhui , Susan Bailey , Edited in association with Daniel Maughan

Excerpt

[More Information](#)

Section 1

Schooling

Chapter

1

# Health and Society: Contributions to Improving Healthcare from the Social Sciences

Richard Williams

## Setting the Scene

This book's roots are in an impactful seminar series hosted by the Royal College of Psychiatrists in which practitioners and scientists from a wide array of disciplines came together in 2014 to explore the social influences on our health and recovery from ill health. This volume echoes the evocative conversations in that College and is intended to rehearse research of potentially great impact. It presents practitioners, researchers, policymakers and students of a wide array of disciplines and roles with the material to support them in better harnessing what we now know about the impact of social factors on health. Thereby, the editors hope to influence how practitioners and the responsible authorities work together with members of the public and communities to design and deliver services. Our aspiration is to contribute to creating better-targeted approaches to promoting health and mental health and more effective and integrated interventions for people who have health problems or disorders. Importantly, we set the task in the context of current world dilemmas.

While writing this book, there were and remain in the UK widespread and powerful concerns about funding services that promote health and deliver healthcare for people who are unwell that are able to keep pace with advances in science and practice and the expectations of the public. This evokes concerns about the values that underpin public services. The UK is by no means alone in experiencing these tensions. There are contemporary challenges in providing mental healthcare that meets the needs of populations in ways that match the provisions for physical healthcare in their funding, esteem and acceptability. Chapter 8 picks up this matter of parity of esteem for physical and mental healthcare services.

Worldwide, there are determined efforts to base policy, funding and practice on robust and rigorously gleaned evidence. Yet, there are also concerns about the balance of evidence employed to inform how services are designed and delivered to reflect the preferences of patients and the nature of their needs. Within evidence-based practice, there are also concerns about the sorts of evidence and scientific methods that we are ready to allow to influence policy and practice (see Chapter 26).

Progress over the last two decades in the brain sciences and, to a lesser extent, in developing healthcare delivery now points to promising lines of intervention within public health, public mental health and personalised healthcare with a view to developing and implementing evidence-based services. But, other considerations, such as those described by Heath (2016) and Abbasi (2016), indicate that, on their own, the contributions from the physical, genetic and neurosciences and study of service need and delivery by epidemiological means may not be sufficient. While what we are learning from research topics in the health sciences is of enormous importance, and they are shifting healthcare hugely, there are also highly relevant developments in the social sciences.

Bhui , Susan Bailey , Edited in association with Daniel Maughan

Excerpt

[More information](#)

## Section 1: Schooling

This book looks at the impacts on our health and healthcare services of the social worlds in which we live. The editors do not pretend that taking the social sciences into account will necessarily fill the gaps or answer the questions relating to values and funding public services. Also, we have had to limit the evidence that we can include from the social sciences in this single volume; in particular, we have focused on the social identity approach. Nonetheless, we hope that the contents of this book illustrate the importance of our including research from the social sciences in the evidence that we consider when we plan and deliver health and social care services and think about their patients and clients as human beings. They have many needs, preferences and expectations that interconnect with the physical and brain sciences, the nature of their problems, and their outcomes.

We generate thinking about novel approaches to problem-solving. While readers will find that this book particularly features wellbeing, mental health, mental ill health and mental healthcare in its pages, we also include in this endeavour people's physical health. We see all aspects of health and healthcare as intimately related rather than as representing separate matters. In other words, we stand away from the body–mind dualism on which so many practitioners were reared because we see that approach as having done more harm than good. As Smith and Bhui et al. remind us in Chapters 2 and 6, respectively, there is a tendency to associate the processes of social causation and social construction with mental health, but we see this as representing history rather than essential features. Indeed, these philosophical understandings can and, I think, should be applicable to health generally, and to all of healthcare.

Thus, readers will find in this book a focus on how people experience their health and needs. We see this as a defining part of the vital interface between assisting people to sustain their health and how they may best be advised and assisted when they are ill. We hope that readers will be stimulated to think broadly about how best to interact with people, how to work with them in coproductive relationships in which people and practitioners create a shared social identity, and, thus, how to better design services by taking a wider array of science and patients' and researchers' perspectives into account. Indeed, coproduction is a matter that recurs through this book. I hope that readers also find that the reflection that this book provokes may save scarce resources.

## Tensions in Health and Healthcare Services

### Equity and Equality in Health and Healthcare

The Chief Medical Officer (CMO) for England (Mehta, 2014) presents six strong arguments for choosing to focus her report for 2013 on population mental health. They include: the huge burden and costs of mental illness; the reduced real-term investment in mental health services; and the significant treatment gaps and unacceptably large premature mortality gap when comparing people who have mental ill health with those who do not. She defines public mental health as consisting of mental health promotion, mental illness prevention, and treatment and rehabilitation. The CMO points out that there is a wealth of robust evidence for public health approaches to mental illness prevention and mental health promotion. She identifies that mental illness is defined by the attributes or diagnosis of people whose problems meet ICD-10 (*International Statistical Classification of Diseases and Related Health Problems*, 10th Revision) or DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, published by the American Psychiatric Association) criteria

for mental disorders. This includes common mental disorders, which affect nearly one in four of the population, and severe mental illness, such as psychosis, which is less common, affecting 0.5–1 per cent of the population.

These findings alone would be sufficient motivation for writing this book, but there are wider considerations. We do not see healthcare and mental healthcare as separate: as we have said, Chapter 8 draws attention to endeavours to promote parity of esteem for mental health since the topic was passed into law in the UK, at a time when there is huge pressure on resources. But, importantly, most of the ideas that readers find in this volume are applicable to healthcare generally. Thus, we do not see public mental health as separated from public health.

The concept of the social determinants of health and mental health, and awareness of their huge impacts, have been established beyond doubt by, for example, the World Health Organization, based on the work of many researchers worldwide. There are powerful ways in which differences in our social relationships and resources influence our health.

First, they may influence our wellbeing and the nature and prevalence of the disorders that we may develop. A past US Surgeon General, Vice Admiral Vivek Murthy (Stone, 2017), has said,

When I began my tenure as surgeon general, I did not intend to focus on emotional well-being. But it became a priority after I travelled the country listening to people in small towns and big cities. I think of emotional well-being as a resource within each of us that allows us to do more and to perform better [and] to be resilient in the face of adversity . . . There are tools . . . They include sleep, physical activity, contemplative practices like gratitude and meditation, and social connection as well.

This book unpacks these themes and focuses on social connection.

Second, we recognise that distribution of services in response to people's healthcare needs is not driven in a linear manner by those needs but is impacted by people's social circumstances. Recognition of the significance of these circumstances to generating and sustaining people's problems and their access to effective services goes back well beyond the origins of the inverse care law that was first described by Julian Tudor Hart in 1971. In part, they drove creation of the National Health Services (NHS) in the UK. Tudor Hart (1971) said then that 'the availability of good medical care tends to vary inversely with the need for it in the population served'. In other words, despite continuing advances, both **inequity** (i.e. failure of health systems to adequately meet the needs of people in the populations they serve) and **inequality** (i.e. failure of health systems to treat people with similar needs in similar ways within and across communities) continue to strongly influence our societies. I draw attention to longitudinal population research on North–South disparities in English mortality from 1965 to 2015 (Buchan et al., 2017). The researchers found that:

England's northern excess mortality has been consistent among those aged <25 and 45+ for the past five decades but risen alarmingly among those aged 25–44 since the mid-90s, long before the Great Recession.

England has profound and persistent regional divides in economy, society and health [and] The extended period of austerity following the 2008–2009 recession has raised concerns about detrimental impacts on population health, particularly the health of disadvantaged socio-economic groups and more economically precarious regions. [They note

Bhui , Susan Bailey , Edited in association with Daniel Maughan

Excerpt

[More information](#)**Section 1: Schooling**

that, however]. . . the divergent trends in mortality we noted in the 1990s and early 2000s suggest that inequalities can increase rapidly during periods of sustained economic growth.

While the editors do not pretend that this book provides substantial ways forward in dealing with the enormity of these challenges, we show myriad examples of ways in which social science may be harnessed to improve our understanding of mechanisms that influence problems with equity and equality. We recognise, for example, research showing that low neighbourhood socioeconomic status (SES) predicts worse mental health outcomes and ‘... perceived neighbourhood quality was the means through which neighbourhood SES affected mental health’ (Fong et al., 2018). Also, we recognise vital matters relating to the social determinants of health and mental health that have attracted less attention than has the epidemiology of conditions or the neurosciences. They include drawing together:

- What is known about the power of social determinants of health;
- Evidence about the mechanisms by which the social determinants operate, for good or ill, within the dynamic array of factors that affect people’s states of health and their recovery from ill health; and
- Identifying constructive but practical mechanisms for harnessing the positive power of the social influences on good health and mental health.

The achievements of the physical sciences and neuroscience are many, and they are highly likely to have an enormous impact in the future. However, it is arguable that these achievements could be unnecessarily limited in their impacts if the opportunities provided by what we know of the social influences on health and mental health are not grasped at much the same time. Indeed, the science of epigenetics points to powerful ways in which genetics, cultures and social influences are drawn together within and across generations.

## Capability, Need, Expectations and Finance

There are many other tensions in health promotion and protection and healthcare. Nearly 15 years ago, Kerfoot, Warner and Williams illustrated one tension, that between the approaches based on public health and personal healthcare and, therefore, between directing existing and new resources towards health promotion or to relief of existing disease and disorder (Warner & Williams, 2005; Williams & Kerfoot, 2005). This debate continues worldwide.

Arguably, it has arisen once more in how the UK has been approaching responses to the healthcare needs of people who were affected by the series of disasters and terrorist events in the UK, from late 2016 to the middle of 2018. It seems to me that both policymakers and practitioners have found it more pressing to focus on how best to meet the needs of people who may go on to develop mental disorders. Less finance and energy has been expended on preventing people who are well from developing disorders or promoting their health. In part, but only in part, this approach is evidence-based and represents the extent of the research that has been conducted to date. But, in this regard, I think that there would be great advantage to policymakers, managers and practitioners in allocating scarce resources to treatments or to prevention and health promotion if there was greater awareness of the topics covered in this book.

### **Progressive Improvement in Capability, Changes in Need and Limitations of Resource**

Health policy and practice throughout the world must contend with the very rapid increases in capability and the ever-widening array of people who are able to influence the health and/

or otherwise of populations and persons. These developments compete for finance, training and staff, and they highlight the importance of better coordination between people, teams and agencies.

Ingenuity and research have driven spectacularly rapid improvements in the potential to deliver healthcare interventions. This has rapidly and substantially increased the financial costs of healthcare. In the UK, it has led to continuing debate about the role of the NHS and whether or not the principle of universality of availability of services in response to need can continue to underpin the roles and responsibilities of the state. Targets of healthcare cannot be static. While the risks of certain diseases have reduced substantially since the NHS was created, and there are now new possibilities for effective intervention with previously intractable conditions and undesirable circumstances, it is also the case that entirely new disorders, unknown in 1948, when the UK's NHS was created, have arisen while 'other' disorders have been defined and recognised.

Furthermore, democratisation of knowledge and rapid improvements in communications have played their part in accelerating public expectations of healthcare services. But, the affluence of societies and their willingness to give priority to health and healthcare have not expanded in parallel with the rise of potential capability. Thus, although increasing volumes of resource have been put into healthcare, the gap between the ability and/or willingness of the state to fund healthcare services and what could be done, if sufficient resources were available, continues to increase.

### Rationality versus Humanity

In 2016, Abbasi, executive editor of the *British Medical Journal (BMJ)*, looked at how the task of improving services in the current financial circumstances might be approached when he asked, 'Is it possible to improve health, improve care, and save money?' His opinion is, 'While we demand more evidence for changes to health services', which an endeavour to reduce the costs might require, there is a risk that 'our obsession with evidence may lessen our humanity' in clinical consultations.

In parallel, Abbasi (2016) observes a rift between evidence-based medicine, which guidelines and protocols ask us to deliver, and the humanity that patients seek in clinical encounters. Heath (2016) demands a new approach and calls on clinicians to bridge the rift between evidence and humanity, to deliver more coherence. Her view is '... evidence based medicine tempts us to try to describe people in terms of data from biomedical science: these are not, and will never be, enough. Such evidence is essential but always insufficient for the care of patients'. She continues, 'Each patient has unique values, aspirations, and context', and urges clinicians to '... see and hear each patient in the fullness of his or her humanity in order to minimise fear, to locate hope (however limited), to explain symptoms and diagnoses in language that makes sense to the particular patient, to witness courage and endurance, and to accompany suffering'. These opinions emphasise the position of values in research, in developing and conducting practice and in designing and delivering services.

Nolte (2017) says,

... political and policy declarations now widely acknowledge that the individuals should be at the heart of the health system. A person centred approach has been advocated on political, ethical, and instrumental grounds and is believed to benefit service users, health professionals, and the health system more broadly. The underlying premise is that people

Bhui , Susan Bailey , Edited in association with Daniel Maughan

Excerpt

[More Information](#) | Section 1: Schooling

requiring healthcare should be treated with respect and dignity, and that care should take into account their needs, wants, and preferences.

However, person-centred healthcare does not and should not imply taking an approach based on individualism. Rather it calls for each person to be seen and their needs to be construed in the context of the nexus of their relationships (see Chapter 14), including those with healthcare professionals, and the environments in which they live. Yet Nolte finds that,

Studies exploring understanding of self-management . . . have shown that many outcomes important to people receiving care are rarely mentioned by health professionals. These include maintaining independence and a desire that the health problem should not define people's lives ('being me').

Even where overlaps occur, outcomes are interpreted differently. For example, knowledge is regarded as important, but health professionals tend to view this as knowledge about the disease process ('knowing that'), whereas people receiving care emphasise knowledge that is personally relevant and tailored to their specific situation ('knowing how'). People place particular value on the quality of their relationship with their healthcare professional, but this understanding is not commonly expressed by providers.

Nolte's recommendation is that, 'This apparent disconnect between people's and health professionals' views and interpretations about what constitutes person centredness highlights a need to adapt the training of health and care professionals to enable them to engage in a true partnership with people receiving care'. She welcomes the person-centred care framework, published by Health Education England, Skills for Health, and Skills for Care (2017). It '... places communication and relationship building skills at the centre of all interactions, setting out the necessary underlying values and behaviours, describing desirable (what people receiving care and their carers want to see) and undesirable practices along with the expected learning outcomes from education and training for staff'. Importantly, Nolte says, '... the framework recognises that simply developing new skills and knowledge will not be enough to achieve fully person centred health systems. Professionals also need a supportive culture within organisations that encourages and fosters long term behaviour change'.

### Working in Healthcare Systems

The contents of this book reflect these values and speak to matters of the kind that I raise here. We consider, for example, the culture aspects for professionals in Chapters 26, 27 and 28. The contents also recognise the stress imposed on people who work in health systems that emerge from:

- Increasing potential capability of the system;
- Finite limitations of resource to fund what could be done; and
- Lack of social care to accompany healthcare and get the best for society from healthcare advances.

### Social Connectedness, Relationships, Health and Healthcare

Haslam et al. (2018) have published a paper reporting meta-analytic research indicating that social support and social integration are highly protective against mortality, and that their importance is comparable to, or exceeds, that of many established behavioural risks, such as smoking, high alcohol consumption, lack of exercise and obesity. Their findings suggest that people, generally, underestimate the importance of social factors for health.



Social connectedness and social support lie at the core of this book. They do have substantial impacts on our health, recovery from ill health and coping effectively with adversity, emergencies and other untoward events. Thus, for example, Saeri et al. (2018) report that social connectedness improves public mental health. Miller et al. (2017) report the reciprocal effects between multiple group identifications and mental health in adolescents. However, Saeri et al. also found that social connectedness was a stronger and more consistent predictor of mental health, year-on-year, than mental health was of social connectedness.

Recently, Professor Cath Haslam, a clinical psychologist who was involved in the Royal College of Psychiatrists' Seminars, and one of this book's editors, has developed the 'Five Ss' to encapsulate a programme for intervention. She has allowed us to use her approach to structure this book. Hence, the titles of this book and the five parts in it.

This first section, in which this chapter provides an introduction to the book, is titled Schooling. It introduces social scientific concepts that are central to, or building blocks of, the approach that this book takes. Steve Smith, a social philosopher, examines six dimensions of the human condition that recur through this book. The chapters that follow highlight important approaches to broadening our understanding of people's social connectedness and its importance to their health and meeting their needs.

Section 2, titled Scoping, covers the field in more detail. Its authors summarise an approach to health and healthcare that builds from recognising the social determinants of health through to meeting our core human social needs for belonging that impact on our health, resilience and endeavours to work together.

Section 3, called Sourcing, provides an overview of humans' experiences from a wide variety of perspectives, including crowd science. It examines topics and events that are rare for most people though we note that they are the kinds of matters on which national news bulletins focus daily. Our aspiration is to draw, or source, from these extreme circumstances lessons about how humans might approach more common events. Thus, we examine statistically uncommon, but all too frequent, events to seek evidence for social influences on societies. We consider disasters to show that people are unlikely to panic in the face of disaster and the importance of emergent relationships in these circumstances. We examine the behaviour of crowds to challenge the myth that groups are potentially dangerous.

Importantly, this book looks at the mental health of refugees. We know that psychosocial distress and loss are very common experiences and that a substantial percentage of refugees develop mild to moderate mental disorders (Weissbecker et al., 2019). Psychosocial support is vitally important to their care in humanitarian crisis settings. Also, I note that Morina et al. (2018) identify perceived self-efficacy (SE), which we might term 'agency' in this book, as an important factor that underlies wellbeing. They say that their research findings provide initial evidence that:

- Promoting SE in tortured refugees can assist with managing distress from trauma reminders and promoting greater distress tolerance; and
- Enhancing perceived SE in tortured refugees may increase their capacity to tolerate distress during therapy and may be a useful means to improve treatment response.

These findings recur in Chapter 18 in which Katona and Brady offer a commentary on the breadth of the programme of interventions that are required by people who have been through highly traumatic experiences, including torture.

We also examine radicalisation and how it might be that people are drawn to extreme movements. Thus, social connectedness and identity do not always have a positive valency and it is important to study the circumstances in which connectedness is a force for good

Bhui , Susan Bailey , Edited in association with Daniel Maughan

Excerpt

[More Information](#)**Section 1: Schooling**

rather than problems. This is a matter on which Reicher touches in Chapter 23. Chapter 21, in the final part of Section 3, examines the nature of the leadership that is required to help populations of people escape from intractable conflict.

In Section 4, we draw into a process, which we call social scaffolding, ideas from the preceding three parts with a view to synthesising a way forward and identifying approaches to solving persisting problems and, thereby, effect change. The messages have much wider resonance to promoting health and delivering effective health and social care more generally. Finally, in Section 5, we consider the challenges to the process of whole system change that is required, and how these approaches might be sustained.

Each section has been written on the back of the ones that precede it with a view to achieving a resonant, iterative approach. Thus, we have included a chapter at the end of each section in which we have invited several authors to draw together their personal accounts of the themes and ideas that stand out for them in the authors' contributions. In Section 4, that chapter describes a mythical town, which we are calling Smithtown, and links its many problems with the approaches we describe in Section 4. Thus, we see social scaffolding as applying to families, small groups of people, communities, towns and cities.

## Concluding Comments

This book is intended to develop and present an approach to advancing our understanding in these arenas that is based on selected contributions from social science. Much of the content focuses on people coming together in groups and the potential power of what happens in the space between people. Chapters in it examine these matters in a novel way.

Harford (2016) draws attention to 'the unexpected connection between creativity and mess'. He argues that 'we often succumb to the temptation of a tidy-minded approach when we would be better served by embracing a degree of mess' (p. 4). He provides many examples to show that, perhaps unexpectedly, '... creativity, excitement, and humanity lie in the messy parts of life' (p. 264) and others that help us to '... understand why unexpected changes of plans, unfamiliar people, and unforeseen events can help generate new ideas and opportunities even as they [make us] anxious and angry ...' (cover).

Put in a different language, I think that Harford is also talking about certain conditions that encourage our social connectedness and agency. Thus, he argues that good jobs, good buildings and good relationships are open and adaptable (p. 265).

These are powerful themes that run through this book on social scaffolding. All the contributions in it are built on the best of emerging science, hard-won experience and careful review. This book encourages openness to exploring new ideas, viewing established ones from new perspectives and expanding our adaptability in seeking solutions to some age-old, as well as new, and complicated, problems in promoting health and improving healthcare.

## References

Abbasi, K. (2016). We need more humanity as well as better evidence. *British Medical Journal*, 355: i5907; doi: 10.1136/bmj.i5907.

Buchan, I. E., Kontopantelis, E., Sperrin, M., Chandola, T. & Doran, T. (2017). North-

South disparities in English mortality 1965–2015: longitudinal population study. *Journal of Epidemiology and Community Health*; doi: 10.1136/jech-2017-209195. Published online 7 August 2017.

Fong, P., Cruwys, T., Haslam, C. et al. (2018). Neighbourhood identification and mental



health: how social identification moderates the relationship between socioeconomic disadvantage and health. *Journal of Environmental Psychology*; doi: org/10.1016/j.jenvp.2018.12.006.

Harford, T. (2016). *Messy: The Power of Disorder to Transform Our Lives*. New York, NY: Riverhead Books.

Haslam, S. A., McMahon, C., Cruwys, T. et al. (2018). Social cure, what social cure? The propensity to underestimate the importance of social factors for health. *Social Science and Medicine*, **198**, 14–21; <https://doi.org/10.1016/j.socscimed.2017.12.020>.

Health Education England, Skills for Health, and Skill for Care Person-Centred Approaches (2017). *Empowering People in their Lives and Communities to Enable an Upgrade in Prevention, Wellbeing, Health, Care and Support*. London: Health Education England, Skills for Health, and Skill for Care.

Heath, I. (2016). How medicine has exploited rationality at the expense of humanity. *British Medical Journal*, **355**: i5705; doi: 10.1136/bmj.i5705.

Mehta, N. (2014). *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence*. London: Department of Health for England.

Miller, K., Wakefield, J. R. H. & Sani, F. (2017). On the reciprocal effects between multiple group identifications and mental health: A longitudinal study of Scottish adolescents. *British Journal of Clinical Psychology*, **56**: 357–371; doi: 10.1111/bjc.12143.

Morina, N., Bryant, R. A., Doolan, E. L. et al. (2018). The impact of enhancing perceived self-efficacy in torture survivors. *Depression and Anxiety*, **35**: 58–64.

Nolte, E. (2017). Editorial: Implementing person centred approaches. *British Medical Journal*, **358**: j4126; doi: 10.1136/bmj.j4126.

Saeri, A. K., Cruwys, T., Barlow, F. K., Stronge, S. & Sibley, C. G. (2018). Social connectedness improves public mental health: Investigating bidirectional relationships in the New Zealand attitudes and values survey. *Australian & New Zealand Journal of Psychiatry*, **52**: 365–374; doi: 10.1177/0004867417723990.

Stone, D. (2017). 3 Questions – Vivek Murthy – former Surgeon General: I’m worried about America’s stress. *National Geographic*, September 2017: 8.

Tudor Hart, J. (1971). The inverse care law. *The Lancet*, **297**: 405–412.

Warner, M. & Williams, R. (2005). The nature of strategy and its application in statutory and non-statutory services. In Williams, R. & Kerfoot, M., editors, *Child and Adolescent Mental Health Services: Strategy, Planning, Delivery and Evaluation*. Oxford: Oxford University Press, pp. 39–62.

Weissbecker, I., Hanna, F., El Shazly, M., Gao, J. & Ventevogel, P. (2019). Integrative mental health and psychosocial support interventions for refugees in humanitarian crisis settings. In Wenzel, T. & Droždek, B., editors, *An Uncertain Safety: Integrative Health Care for the 21st Century Refugees*. Heidelberg: Springer, pp. 117–153.

Williams R. & Kerfoot, M. (2005). Setting the scene: Perspectives on the history of and policy for child and adolescent mental health services in the UK. In Williams, R. & Kerfoot, M., editors, *Child and Adolescent Mental Health Services: Strategy, Planning, Delivery and Evaluation*. Oxford: Oxford University Press, pp. 3–38.