Re-conceptualising Mental Health Social Work Education and Practice in Australia: Toward A Critical-Emancipatory Approach

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DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Anne Warnes Jarvis

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ABSTRACT

The study presented in this thesis consisted of an exploration of significant policy documents specific to mental health social work education and practice in Australia. The author's findings reveal that the origins of psychiatric social work, now known as "mental health social work", lie in the dominant discourse and practices of a bio-psychiatric, disease-saturated (illness) paradigm; a paradigm inherent in university-based education curriculum and the Australian Association of Social Workers *Practice Standards for Mental Health Social Workers*.

The author firmly believes that contemporary education and practice in mental health social work will benefit from knowledge and approaches that accord with social work's core values of respect for persons, professional integrity and social justice. Therefore, during the study, she reconceptualised psychiatric social work education and practice, re-newing it through her development of a critical-emancipatory approach to mental health social work, underpinned by critical realist philosophy, for incorporation in the Australian Association of Social Workers mental health social work curriculum for education and the *Practice Standards for Mental Health Social Workers*.

The findings from the author's five stage critical discourse analysis demonstrate that a critical-emancipatory approach can benefit mental health social work practice through reclaiming and re-constructing older, non-medical concepts grounded in socially just humanitarian ethics; concepts based in valuing relationships, human rights and a trauma-informed paradigm. The study's recommendations support this value-base and ethical stance.

Thus, this thesis extends the knowledge base for mental health social work education and practice, offering an approach that benefits new learners to social work as well as established practitioners; a critical-emancipatory paradigm for mental health social work practice embedded in social work's core values and ethics.

GLOSSARY OF ACRONYMS

AASW – Australian Association of Social Workers

ABS – Australian Bureau of Statistics

AIHW – Australian Institute of Health and Welfare

AMHSW – Accredited Mental Health Social Worker

ASWEAS – Australian Social Work Education and Accreditation Standards

CDA – Critical discourse analysis

CLTC – Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services

COAG – Coalition of Australian Governments

CR – Critical realism

CTO – Community Treatment Order

DSM – Diagnostic and Statistical Manual of Mental Disorders

ECMP – Ethics Complaints Management Process

HES – Human Experience Specialist

ICD-10 – International Classification of Diseases and Related Health Problems

IPV – Intimate Partner Violence

MHSW – mental health social work

MHSWP – mental health social work practice

MSW – Master Degree of Social Work

NGO – Non-Government Organisation

NMHC – National Mental Health Commission

NPM – New Public Management

NSMHWB – National Survey of Mental Health and Wellbeing

VT – Vicarious Trauma

WHO – World Health Organisation

READING GUIDE

Several terms and words referred to in this document are in common use in mental health social work (MHSW) language, such as “patient”, “mental illness”, “madness”, “insanity” and “lunacy”, as well as “assessment”, “treatment” and “intervention”. These terms are not placed within quotation marks or parentheses throughout the main body of the thesis (other than first usage or unless quoted directly) to facilitate smoother reading and to offer clarity regarding the language-use of the era or the situation. In the search for more humane and respectful language that pertains to people’s lived experience, the term “mental distress” is used in place of “illness” wherever possible. Mental distress is regarded as being on a continuum where the volume of distress is noted to vary in severity. For example, the emotional impact of hearing, and potentially responding to, voices often appears to be an intensely and sometimes enduring painful lived experience for the person; most often it is severe mental distress. However, there are many other distressing feelings and thoughts that do not bring people to act on them (e.g. responding to voices) but nonetheless impact people’s ability to cope with the stresses and strains of daily life.

Even where terms such as “distress”, “suffering”, “disturbance”, “condition” and “issue” are used, these do not always seem to provide a respectful or satisfactory language when considering the vastness of human emotions and the potential for suffering amid them, as well as society’s impact on the people experiencing them. In addition, it is recognised that the current terminology of the “lived experience” is most commonly used when referring to people’s experiences of mental distress. It is recognised that differing perspectives offer diverse opinion on terminology.

The term “social work educators” is used throughout to apply to any social work educators who teach MHSW curriculum or topics specific to MHSW. Two sets of social work practice standards are referred to in this thesis: the general social work *Practice Standards* (AASW, 2013), incorporating Standard 6 and Standard 7 specific to mental health social work practice (MHSWP); and the *Practice Standards for Mental Health Social Workers* (AASW, 2008a, 2014a). To avoid any confusion, both are written in full throughout.

PART 1

RUPTURING MENTAL HEALTH SOCIAL WORK EDUCATION

INTRODUCTION:
CONTEXTUALISING MENTAL HEALTH SOCIAL WORK EDUCATION, POLICY AND PRACTICE

Disentangling incidence, prevalence and language

> Throughout psychiatric history, institutions and procedures that appear reasonable responses to madness by most members of society in one era are often viewed as brutal and ineffective in the next because of the evolving mores and the democratization of the human experience over time (e.g., women becoming recognized as entitled to equal human rights as men). Our current arrangements are also likely to suffer in hindsight. (Kirk, Gomory, & Cohen, 2013, p. 12)

Kirk et al.'s (2013) insight captures the essence of this study. Although this piece invites consideration of broad notions in relation to the passage of time and the variety of establishments in which actions occur, it also signals the reality of assumptions about what is reasonable, right through to the point of ruthlessness. Kirk et al.'s recent *Mad Science: Psychiatric Coercion, Diagnosis and Drugs* (2013), while focused predominantly on the North American experience, can be seen as a compelling account of the current state of affairs in mental health and wellbeing across the globe (Hazelton, 2005; Pilgrim, 2015b).

The Australian scene compares with other Anglophone nations, especially in relation to data on mental distress that are almost always defined and described within the illness and disease, and/or the disorder paradigms. Statistical data are presented through national agencies such as the Australian Bureau of Statistics (ABS) (ABS, 2015), in Australian federal government policy documents, or within peer-reviewed publications and seminal texts that describe and discuss various viewpoints relating to the *whys and wherefores* of mental distress and disturbance. Less formal brochures, pamphlets and media interpretations (ABS, 2008; Armitage, 2016; Australian Government Department of Health, 2014; Fewster & McGregor, 2015; Merhab, 2016) propagated for public readership convey a tale of apparently real and reasonable prevalence rates of mental distress. Significantly, regardless of format, the language used is uniform and bleak. High proportions of populations are categorised as mentally ill, particularly in the Anglophone world, with related increases reported in third world countries (Pilgrim, 2015b). Extant data (ABS, 2015; AIHW, 2014; Andrews, Henderson, & Hall, 2001; COAG, 2009; Henderson, Andrews, & Hall, 2000) assert that approximately 1 in 5 Australians suffer from an apparent mental illness or disorder. A 2007 *Australian National Survey of Mental Health and Wellbeing (NSMHWB)* of adults aged 16-85 years demonstrates little change in the prevalence of mental distress over the previous decade (Slade et al., 2009). In addition, "Lifetime Prevalence Data" show that "(a)lmost half of the total population (45.5%) experienced a mental disorder at some point in their lifetime", while "…one in five (20%) Australians…experienced mental disorders in the previous 12 months…equivalent to almost 3.2 million Australians" (Slade et al., 2009, p. xii).

If Slade et al. (2009) are correct, this conclusion invites the question; How is this possible in a period of growth in knowledge about mental distress and of access to help (services) when the lived experience seems, at times, unendurable for the person?

It is stated from the outset of this thesis that although it contributes to, and re-conceptualises existing knowledge, centring predominantly on the mental health social work learner, what must remain implicit in any discussion about mental distress is the people we, as social workers, serve. These are people with a lived experience of mental distress; people for whom the system exists to respond to their need in times of unendurable pain.

The federal government is currently making efforts toward national reform within the mental health system in Australia. The following discussion provides further explanation regarding the nature of incidence and prevalence, and language-use for mental distress in the twenty-first century. Seven federal government policy documents as well as Australian Association of Social Workers (AASW; the professional body for Australian mental health social workers) documents reveal insights into current mental health social work (MHSW) education, policy and practice, and which can inform future policy. A strategically significant selection of these documents is the focus of the critical discourse analysis (CDA) in Chapter 4 of this thesis.

Setting the scene: mental distress in focus

The federal government, together with all the State and Territory governments, shares responsibility for national mental health policy in Australia, including policy that seeks reform. Although State and Territory governments initiate their own policies applicable to their populations' specific needs, they are guided by federal mental health policies, reports and reviews. This is also the case for the non-government (NGO) sector.

Representatives from each State and Territory government comprise the Coalition of Australian Governments (COAG), which is the federal government forum for reaching agreement regarding many national policies, including mental health. Two federal government organisations – the Australian Institute of Health and Welfare (AIHW) and the National Mental Health Commission (NMHC) – manage national mental health strategies and reforms. The AIHW has several functions, principally the collection, collation and analysis of data relating to Australians' mental health, thereby informing federal policy for mental health funding and service provision.

A number of other important organisations and interest groups represent Australians' mental health needs in a variety of ways, such as the Mental Health Council of Australia, Mental Health Australia, SANE, Mind Australia, Beyond Blue, GROW and the Black Dog Institute. These organisations are within the NGO sector and contribute significantly to the national scene. For example, they offer submissions toward reform and provide services to people with a lived experience, as well as to their significant others. Limiting this study's focus to public documents released at the federal government level for comparative purposes in this thesis is not meant to minimise these organisations' vital contributions in any way. The decision to focus on federal

government public documents was purely logistical.

The NMHC is a separate body the federal government commissioned in 2012 to review and report on mental health programs and services in all sectors across the nation for the express purpose of mental health reform (NMHC, 2012b). The NMHC maintains its independence despite its funding from the federal government. It comprises seven Commissioners, a Chief Executive Officer (CEO) and a Chairperson. The Chairperson, nominated for the position by the federal government, is a long-established advocate for reform in mental health policy and a carer for his daughter who has a lived experience of mental distress. The Chairperson is committed to supporting those with long-term mental health issues. The CEO, appointed two years after establishment of the NMHC, has a long career in senior health management roles in a variety of federal government departments. The seven Commissioners consist of one psychiatrist, three psychologists, two with careers in federal politics and two with a lived experience of mental distress. One of the psychologists identifies as an Aboriginal and Torres Strait Islander person and represents their interests in terms of social justice. The NMHC works with a number of other organisations on a variety of projects, the purpose being to change perceptions about mental health and improve service provision.

Thus, national agreement about federal policy for mental health service funding and provision begins with COAG. The AIHW and the NMHC guide the subsequent plans and strategies for mental health reform. These three bodies make a powerful contribution to national decisions and policy-making that relate to funding and service provision for mental health in Australia. Extant policy documents of significance, sourced from these bodies, were examined in this study and are critiqued in this thesis. The following discussion indicates some poignant points that highlight the current state of affairs in the mental health scene in Australia; a state of affairs that has important implications for MHSW education, policy and practice, all of which the author seeks to remedy.

An initial NMHC priority was the release of an annual *Report Card* (Lourey, Holland, & Green, 2012; Lourey, Plumb, & Mills, 2013; NMHC, 2014a) to inform the federal government about "how Australians are faring in their mental health and on the things that aid recovery and help make people better" (Lourey et al., 2012, p. 4). Since then there has been a change of federal government. The current government has requested the most recent review, released in 2014 and titled *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services* (*CLTC*) (NMHC, 2014b). This review examines system efficiencies and the cost effectiveness of programs and services that receive Commonwealth funds for mental health service provision. It also explores people's lived experiences of the mental health system in order to report on service provision, and reports on the strengths in the development of mental health reform since the early 1990s and a variety of issues across all of the aforementioned areas. All of the reported issues hold significance for MHSW education and mental health social work practice (MHSWP) because they relate to people's poor experiences of services and the lack of response from the existing mental health system that is supposed to serve them amid their lived

experience of mental distress.

Significantly, the *CLTC Executive Summary* includes a strong message about the current state of affairs in mental health service provision in Australia, stating plainly that "it is clear the mental health system has fundamental structural shortcomings … the same conclusion has been reached by numerous other independent and governmental reviews" (NMHC, 2014b, p. 3). In addition, the *CLTC* identifies apparent high financial investment, yet the level of any resultant improvement in people's mental distress is unknown:

> … almost $10 billion in Commonwealth spending on mental health every year, there are no agreed or consistent national measures of whether this is leading to effective outcomes or whether people's lives are being improved as a result. (NMHC, 2014b, p. 3)

The *CLTC* also calls for a "change within existing resources" and simultaneous change in several other areas while highlighting inconsistencies surrounding the seemingly large sums of money allocated for funding mental health services (NMHC, 2014b, p. 3). In late 2015, the federal government published the *Australian Government Response to Contributing lives, thriving communities Review of Mental Health Programmes and Services* (Commonwealth of Australia, 2015a) and released *A new blueprint for mental health service* (Commonwealth of Australia, 2015b), which sets the agenda for reform to be realised over the ensuing years to 2019. This response is incorporated in this study's CDA.

Referring back to Kirk et al.'s (2013, p. 12) words in the opening piece to this chapter – "our current arrangements are also likely to suffer in hindsight" – reminds me to refer here to the *Burdekin Report* (Burdekin et al., 1993)[1]. This prior national inquiry from twenty-three years ago, conducted by the Australian Human Rights and Equal Opportunity Commission, looked into the human rights of people with a mental illness. It revealed three main themes:

1. The human rights of people with mental health issues were "being ignored, eroded or seriously violated" (p. 3)
2. There is "widespread discrimination against people affected by mental illness" (p. 4)
3. Safeguards are lacking in the process of deinstitutionalisation, such as community-based support and accommodation.

Cross-referenced with the *CLTC*, which covers the same areas, it appears that hindsight is not assisting current arrangements, given that the *Burdekin Report* also signalled the need for change in mental health service provision because of people's poor experiences. Accordingly, the *CLTC* signifies that since the release of the *Burdekin Report* there have been a number of national mental health plans and reform strategies (ACSQHC, 2014; Australian Government, 2011; Commonwealth of Australia, 2015a,b,c; COAG, 2012, 2009, 2003, 1998, 1993; NMHC, 2014a,b;

[1] Full title: *Human rights and mental illness: Report of the National inquiry concerning the human rights of people with mental illness Volume 1 and 2*

Victorian Government, 2013), but changes in the provision of services remain urgent.

Seven extant federal documents consisting of policies, plans, reports and reviews (ACSQHC, 2014; COAG, 2012, 2009; Commonwealth of Australia, 2015a,c; NMHC, 2014b; Victorian Government, 2013), plus the *AASW Response to the National Mental Health Commission's Report on the National Review of Mental Health Programmes and Services* (AASW, 2015), which provide information relating to mental health service provision for the Australian population, are scrutinised in depth in Stage 2 of the CDA in Chapter 4. All of these extant documents place people at the centre of service provision and use the language of a "person-centred approach". While such an approach may signify a humanist stance for supporting people in distress, it has the capacity to centre practice only toward the individual while neglecting the need also to focus on the structural factors that impact service provision, as highlighted in the recent *CLTC* (NMHC, 2014b) and the earlier *Burdekin Report* (Burdekin et al.,1993). Practice that centres only on the individual person has the potential to "pathologise" them; and pathology sits amid the paradigm of a bio-psychiatric, disease-saturated (illness) approach, which is based in medicine because a medical degree precedes psychiatric training.

Medicine centres on pathology, which is located via exploration of the signs and symptoms with which people may present to any health service. Similarly, pathology for people who present to mental health services in a mentally distressed state they cannot explain is located by exploring the signs and symptoms of mental distress; it is a bio-psychiatric disease-saturated (illness) phenomenon, also known as "the medical model". Therefore, mental health service provision is based almost entirely on a medical model. The pathology with which people present in mental health or any other setting brings a level of ease for practice because, it is argued, familiarity with the bio-psychiatric, disease-saturated (illness) model offers the base from which practitioners operate, albeit with a genuine intent of wanting to "help" mentally distressed people trying to "fix" the "problem". This process also carries the requirement to meet certain criteria for ongoing funding of mental health service provision.

The language of pathology (signs and symptoms) guides practitioners in the decision-making process, which routinely requires assessment of "the problem" (a diagnosis) and some sort of "intervention" (fixing the problem). Indeed, some key extant documents make it clear that while there are appeals for people-centred mental health service provision, the diagnosing of pathology in individual people takes practitioners into a vicious cycle of diagnosing (and finding a label) for despair then searching for remedies that do not appear to benefit people. The lack of benefit is evident, particularly given that people with lived experiences of mental anguish continue to express their dissatisfaction with the mental health system. Yet this *is* the system, which ironically has a moral obligation to serve human beings with compassion and respect (NMHC, 2014b).

There is a further issue here. The vicious cycle of searching for remedies once a diagnosis is made tentatively or otherwise – a cycle of assessment and intervention – is a process that paves the way for coming to understand people's mental anguish and the subsequent distress as a

problem; in other words, the way that people's distress is problematised or represented. Bacchi (2009, p. vii), in her *What's the Problem Represented to Be (WPR)*? Approach, theorises the need "to shift the focus from 'problem' *solving* to 'problem' *questioning*". Although Bacchi's work focuses upon policy analysis, her WPR approach has credence for MHSW education and MHSWP because it offers possibilities for re-conceptualising the current focus on problems, problem identification, problem solving and the consequent problem-saturated milieu in mental health. The possibilities for re-conceptualising the current issues surrounding the problem-saturated milieu and the ensuing bio-psychiatric, disease-saturated (illness) paradigm, where mental distress comes to the attention of MHSW practitioners, is addressed in-depth in Part 2 of this thesis that explores re-newed knowledge for MHSWP and MHSW education.

Explaining mental distress through the lens of critical realism

This study applies the philosophical approach of critical realism (CR) to MHSW and MHSWP in the process of examining, exposing, interrogating and interpreting the bio-psychiatric, disease-saturated (illness) discourse that remains foundational to mental health service provision in Australia. Critical realism, coined by Roy Bhaskar for his doctoral thesis in the 1970s, is now an internationally recognised multi-disciplinary movement (Archer, Bhaskar, et al., 1998) offering a solid basis for critique in the social sciences. An in-depth explanation is provided in Chapter 2.

There are many layers amid the lived experience of mental distress and MHSWP has a moral obligation to ensure ethical service provision with people enduring anguish and distress. This thesis addresses these layers across three main areas: MHSW education; its associated pedagogical implications; and implications for policy and practice (MHSWP). Importantly, then, it turns toward this question: What is contemporary mental health social work in the twenty-first century, and what does this mean for MHSW education, policy and practice? Following on from this are the following questions:

- What differences are MHSW practitioners making amid people's experiences of mental health service provision?
- What might be the contribution of MHSW toward dialogue relating to policy, for example, the funding implications in maintaining high quality service provision?
- How can MHSW practitioners keep abreast of contemporary service provision in the practice environment?

These questions, as well as others associated with contemporary MHSWP, come from confident MHSW practitioners. There is a potential to ignite such confidence during MHSW education. This potential raises questions about the implications for contemporary MHSWP, with its roots in university-based professional education, later reinforced by practice-related legislation and policies (including those promulgated by the accrediting professional association). Social work is located across all health and human services, and the lived experience to the point of severe disturbance is seen among people within all these settings. Making education and practice

improvements across these settings requires answering the questions: What is the dominant paradigm? Where does this originate, and how has MHSW arrived at its current state? Seeking answers requires analysing the wider mental health industry and its potentially formative influences on the wider community and social work, particularly ways of knowing (epistemological leanings) and understanding human being (ontological notions); what it is to be human.

Starting from the three core values underpinning Australian social work – respect for persons, social justice and professional integrity – the author aimed to answer the questions: How can we gain a depth of understanding in MHSW that really makes a difference in people's lives? What are some ways forward in an emancipatory effort to do so?

Opening up: a critical-emancipatory approach to mental health social work

It is with this optimistic starting point based in clear values and a more sceptical stance which deconstructs the mental health industry that the author interrogates, exposes, interprets and discusses the impact of the bio-psychiatric, disease-saturated (illness) approach within the MHSW scene in Australia. How can this be changed? Drawing on critical social work theory and applying a critical realist discourse analysis, the author opens up three core foci applicable to MHSW; education, policy and practice. This opening up exposes opportunities and resources for re-conceptualising MHSW across the domains of education, policy and practice. It occurs as the author seeks to meet the study's two central aims, which she addresses in two parts. She aims firstly to expose the dominance of the bio-psychiatric, disease-saturated (illness) paradigm in the extant curriculum for MHSW education and the AASW *Practice Standards for Mental Health Social Workers* (AASW, 2014a), and secondly to re-conceptualise them in policy that supports a critical-emancipatory approach in education and practice. Thus, Part 1 problematises the bio-psychiatric, disease-saturated (illness) paradigm as the dominant ideology in the MHSW arena. In paving the way forward for a new era in MHSW, Part 2 re-conceptualises and resituates MHSW through relaying the foundations for education, policy and practice within some new constructions, including re-claiming and re-constructing older, non-medical concepts grounded in humanitarian ethics (Banks, 2012; Finn & Jacobsen, 2003; Gray & Webb, 2013).

This study is directed at learners in MHSW, both new and experienced practitioners alike, because, it is argued, there is a plethora of texts and courses related to working with clients, or patients. However, there is also the need to focus upon the professional in the context of the political nature of what mental health social workers do. Such a focus will ensure attention to the dominant bio-psychiatric, disease-saturated (illness) discourse that lies amid education and policy, and thus affect daily practice, and to the emancipatory potential of adopting a critical-emancipatory MHSW approach.

The following discussion introduces some beginning points for the redesign of education, policy and practice for MHSW.

Mental health social work education: pedagogy in focus

Extant curriculum, Standards, ethics and field education for mental health social work

It is important to consider redesigning the pedagogy for MHSW because of education's potential reproductive power. This section introduces the current curriculum for MHSW education, the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) and ethics that guide MHSWP, and the university-based field education requirements for social work learners as beginning practitioners. These documents are scrutinised in detail in Chapter 4, together with the aforementioned federal government and other documents pertinent to this study's CDA.

The Australian MHSW curriculum (AASW, 2012a, 2012b) invites critique of a variety of practice perspectives and approaches. The education curriculum facilitates a learning process that ensures demonstrated adherence to the standards and requirements set out in the AASW policy documents for education and practice, specifically:

1. *The Australian Social Work Education and Accreditation Standards V1.4* (*ASWEAS*) (AASW, 2012a)
2. *The ASWEAS Guideline 1:1: Guidance on essential core curriculum content* (ASWEAS, 2012b)
3. *The Practice Standards for Mental Health Social Workers* (AASW, 2008a, 2014a).

The following documents, which are applicable to generic social work, also bind MHSW practitioners:

1. *The Code of Ethics* (AASW, 2010)
2. *Practice Standards* (AASW, 2013), in particular Standard 6 and Standard 7 for MHSWP.

The *ASWEAS* is the national curriculum that guides tertiary social work education in Australia. It also provides the benchmark for accreditation processes in most schools of social work and the foundation for entry-level professional social work education. Social work educators are required to utilise this policy document, together with the supporting *Guideline 1:1: Guidance on essential core curriculum content* (AASW, 2012b), an addendum to the main document, to guide contemporary pedagogical approaches for learning. *Guideline 1:1* outlines some introductory points across four main areas of curriculum content relating to social work knowledge, skills and values. The mental health curriculum content is one of these four areas, in adherence with the requirement to educate new learners for MHSWP.

The *Guideline* policy document has a section on *Essential areas of knowledge* (AASW, 2012b, p. 5) for MHSWP and one on *desirable knowledge* about mental health. On reading these sections, the uniform bleak language and discourse surrounding assessment and intervention becomes immediately apparent, as established earlier. It is the language of a problem-saturated psychiatric paradigm. A further example is the criterion for *essential knowledge*, which is explicit regarding the requirement for a "basic grasp of a psychiatric diagnostic framework" (AASW, 2012b, p. 5). Nevertheless, in keeping with social work's core value of respect for persons and their

human rights, the *Attitudes and Values* section states clearly that people have a "right to refuse treatment" (2012b, p. 4). However, the statement following this implies the need to adhere to legislative requirements. It is easy to see the dilemma this creates for MHSWP. On one hand is a commitment to maintaining core social work practice values while on the other hand is adherence to legislative requirements.

The *Code of Ethics* (AASW, 2010), the generic document guiding all social workers in practice, including MHSWP, reinforces the dilemma created by the statements in *Guideline 1:1* (AASW, 2012b). Operating in conjunction with the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) and the generic *Practice Standards* (AASW, 2013), the *Code* outlines the core values of respect for persons, social justice and professional integrity, which underpin Australian social work. The *Code* suggests there is an "obligation" for social work to promote these values (AASW, 2010, p. 13). Importantly for MHSWP, the *Code* makes plain the obligation toward respect and social justice, taking account of those with exceptional needs and vulnerability, and the violation of human rights (AASW, 2010). How then, in MHSWP, do educators and practitioners reconcile the dilemmas associated with discourse that promotes problem-saturated frameworks and adherance to legislative requirements? What does all this mean for learners who are new to MHSW?

A core component of social work education is the requirement for social work learners to undertake a field education program to prepare them for practice in the workplace. As stipulated in *Guideline 1.2: Guidance on field education programs* (ASWEAS, 2012c, p. 3), social work learners are obliged to undertake "a minimum of 1000 hours in at least two field education subjects". However, MHSWP is not a specific requirement for field education, which is a university-directed process incorporating theory and field practice to assist learners' development toward ethical social work. Although some social work learners can undertake a field placement specifically in a mental health area, many variables impact upon this. Currently placement opportunitites are not abundant; a situation exacerbated by increasing numbers of social work learners now entering university. Nevertheless, as alluded to earlier, people experiencing mental distress can present in any practice setting, therefore social work learners are exposed to opportunites during field placements in diverse social work contexts to appreciate the layers of mental distress.

Social work degrees

The AASW accredits courses for Australian social work degrees, which are accessed through university-based education. The Bachelor Degree in Social Work (BSW) offers several combinations of degrees. The BSW can include a double degree, for example with an Arts degree, and there is a voluntary honours component dependent on the learner's progress through the initial BSW years. In addition, universities offer the qualifying post-graduate Master Degree in Social Work (MSW), which is a two-year full-time equivalent program accessible with a previous bachelor degree. There are differences among Australian universities in the programs they offer for many

reasons, such as population, remoteness, funding and fulfilling AASW criteria for staffing requirements in educating social work learners (AASW, 2012a,d). These variables may impact upon accreditation requirements for MHSW education. Their pedagogical implications must be considered. This study seeks to address pedagogy in MHSW education, not just as the means for expanding social work educators' and workers' current knowledge of program requirements for educating mental health social workers but rather to advance knowledge about the state of affairs in the mental health industry, and to embrace practice that focuses on social work's core values. Advancing this knowledge base requires a commitment to valuing a critical-emancipatory approach to MHSW while embracing practice from a respectful and socially just ethical stance.

Introducing social work learners

The author chose the word "learner" rather than "student" for this study because it opens up ongoing possibilities for learning from practice, initiated within field education and continuing into professional life. The *ASWEAS* (AASW, 2012a,b,c) curriculum content provides the components discussed in the previous section for entry level mental health social workers, with a focus entirely upon practice. However, the author argues that there also needs to be an emphasis on the MHSW learner. As stated out the outset, this study centres on the mental health social worker as a learner – a budding or an advanced practitioner – rather than only upon practice notions about "what to do" with the client/patient/consumer. The author posits that MHSW education provides an environment that has the potential to build and sustain social work learners' mental health and wellbeing, which mitigates against the possibility of Vicarious Trauma (VT) (Pearlman & Mac Ian, 1995) to some extent. Hence, there is a need for mindfulness of the impact of potentially confronting learning on new social work learners, especially considering there are circumstances in which people undertaking a MSW may not have an undergraduate degree in the human services area. In addition, some social work learners who have studied in the medical and social sciences are seeking further study because they feel they do not have enough depth of understanding about society and human interactions. Therefore, it is imperative to reflect on the possibilities for sustaining learner wellbeing as part of a critical-emancipatory approach in MHSW education and practice. These possibilities are discussed in Part 2 of this thesis.

Access to online technology is another area for consideration when focusing on MHSW learners. It can present challenges for the learning environment given that there is now a large contingent of people studying external to the university in their efforts to maintain a work/life balance. The established convention of face-to-face contact in the university setting is no longer the only option as universities cater to the needs of their learner populations. Online relationships with social work learners differ from those in the classroom, which can be a challenge for both the social work learner and the social work educator in situations where people struggle with their learning. Although there may be reasons for these struggles that are unrelated to the learning process, their impact upon people's capacity to learn must be considered. In the author's

experience, another challenge in the online environment is that these issues may be more likely to go unnoticed by social work educators than in a face-to-face contact environment, and therefore will be less likely to be addressed. This is not to say that such issues are always noticed in the face-to-face environment of the university setting, because struggles with learning occur for a myriad of reasons in either setting.

Consideration of MHSW learners' mental health experiences is also important. The current statistics for mental health-related issues in Australia indicate that approximately 1 in 5 Australians experience some mental illness (COAG, 2012; Hazelton, 2005), as discussed earlier. Therefore, it is inevitable that there are people coming to study social work who have a prior or current lived experience of mental distress. Regardless of the purported statistics, it may be reasonable to assume that there is a variety of lived experiences related to mental distress among the learner cohort. There may be learners who are trying to navigate their own mental distress or the mental distress of a family member; learners who are carers for their family member; learners who have witnessed varying levels of mental distress among their friendship groups at school or in their social lives, but have not been involved in this to any great extent; and learners who work in the human and social services industry who are well aware of the capriciousness that can occur with mental distress. However, this latter group's awareness tends to lie amid notions of assessment and intervention framed within the medical model. It comes as a shock when they begin to bear witness to curriculum offering theory and practice approaches that differ vastly from their prior knowledge and experiences. Finally, there may be learners with no lived experience of mental distress, either personally or as a witness to more severe mental disturbance among their family members and/or their friends.

The above discussion highlights the central importance of preserving learner wellbeing in the milieu of the learning process. Further to this is the need for a pedagogical approach that offers a rigorous, thought-provoking MHSW curriculum (Freire, 1996; Giroux, 2007, 2010; hooks, 1994; Nganga & Kambutu, 2013; Noddings, 2012; Parini, 2005). In addition, social work educators have an obligation to be mindful of the potential for the reproductive nature of MHSW education, its politics, and a critical pedagogical approach (McLaren & Kincheloe, 2007) that pays attention to critical social work theory and critical realist philosophy. Such an approach brings with it the potential to aid the learning journey.

Policy for mental health social work

Education has the potential to create new knowledge for practice, whereas the plethora of policies relating to MHSWP brings yet another dimension filled with challenges and opportunities. The policies referred to here relate to MHSW from within the AASW requirements for MHSWP, as well as federal government policies and reports that are applicable to setting the context for practice. This creates interesting pedagogical challenges and opportunities. The *first challenge* is the nonplussed response of new learners to social work, who, brimming with a level of anticipation and

hope for a career in the human services, find their eyes “glaze over” with the mere thought of policy. Experienced practitioners encounter this phenomenon. Questions of relevance to practice enter the conversation, perhaps because there is such a strong emphasis on working therapeutically with mentally ill individuals. Concern is voiced about: What difference does policy *really* make? Seen at its most simplistic, social work educators could argue in reply that policy has the potential to inform practice; not just in driving the *how* and *what* of practice, but in driving the ideology that lies within policy. This perplexed response produces the *second challenge*: How, pedagogically, to engage social work learners in embracing a beginning understanding about the relevance of policy to practice. This leads to the *third* and perhaps most pressing challenge: How can social work learners discover ways they can make a difference that advocates for an emancipatory approach?

The emancipatory intent of great (rather than merely good) MHSW requires at its base service provision that advocates for changes in policy or even involvement in writing new policy. Chapter 4 of this thesis provides an analysis of the discourse in mental health policies sourced from the AASW and the federal government, which relate particularly to service provision across the government sector. Chapter 5 re-constructs policy notions specific to MHSW in Australia, while Chapter 6 refocuses on the reproductive power of pedagogy by proposing news ways forward for MHSW education that commit to the “what” and “how” for the learner; a move away from MHSW being about individual pathology.

A brief outline of the content of all chapters after the next section concludes this chapter.

Practice in mental health social work

Typically, new learners to social work and those with practice experience most often are drawn to wanting to learn about *how* to practice, or practice differently. Again, this brings challenges for pedagogical approaches. First, there is the need to be mindful about the learners’ journey; about engaging them meaningfully with learning as they navigate the intricacies of part-time (or full-time) work, study and family commitments. Second, there is the obligation to engage learners in perspectives and approaches that stimulate discussion, beginning confidence and hope for their future practice in MHSW. The more practical orientation of social work as a vocational course means that at times the study and application of theory, and the subsequent concepts required in essays so that social work educators can assess learners’ capacity for practice, strike fear into the hearts of many learners.

Outline of chapters

This thesis has been written in two parts. **Part one (chapters 1-4)** establishes the presence of bio-psychiatric, disease-saturated (illness) discourse inherent in current MHSW policies, practices, settings and professional education, with a focus on what this means for contemporary approaches, especially in terms of limitations, misdirection and ethical compromise. A rigorous

CDA of a variety of policy, review and report documents relating to MHSW leads the author to advocate for a re-conceptualisation of MHSW. This stance is consistent with critical realist philosophy and humanist ethics that amplify the call for expansion of critical social work perspectives and approaches, which serve as socially just and ethical, and emancipatory practice. **Part 2 (chapters 5-6)**, which centralises humanitarian ethics at the heart of social work along with a growing body of evidence about alternatives, concludes the study with the author presenting emancipatory ways forward for education, policy and practice.

Chapter 1: Establishing a critical realist approach to mental health and mental health social work introduces the literature that influenced and guided this study. The author explores a variety of theoretical perspectives, appreciating that there are many ways of knowing, especially given the realities of MHSW practice. Influential theorists, located across several disciplines including critical psychiatry, sociology and social work offer scope and space for alternative understandings away from biological, determinist and reductionist accounts of mental distress. The work of some key Australian critical social work thinkers in MHSW provides local knowledge for re-conceptualising and repositioning MHSW education, policy and practice. The author reveals encouraging literature in social work that provides a framework for conceptualising the political nature of MHSW, and the moral courage to pursue new pathways that intertwine knowledge with ethical practice.

Chapter 2: The research approach: a critical discourse analysis and applying a critical realist approach in mental health social work explicates a critical realist approach to position it as a convincing methodology for deconstructing knowledge and language concepts utilised in the CDA. The author reviews literature regarding contemporary debates in mental health, illustrating the epistemic eclecticism within the field. These debates are not confined to the bio-medical, disease-saturated (illness) paradigm. Submerged alternative ways of knowing and understanding human being are identified that have the potential to impact MHSW education, policy and practice. Critical realism opens up a means to critique rationalist, reductionist accounts of mental distress, providing the platform for questioning extant knowledge about mental illness. Critical realists, questioning positivist knowledge claims about the world of mental distress and disturbance, describe this as the “epistemic fallacy” (Archer et al.,1998; Bhaskar, 2009; Bhaskar & Collier, 1998; Pilgrim, 2015). Such claims impact upon the capacity for mental health social workers to make a difference in the lives of the people they serve.

Chapter 3: Rupturing psychiatric social work demonstrates in detail how the bio-psychiatric, disease-saturated (illness) discourse is inherent in the course of the history of mental health in Australia, its impact upon contemporary mental health and what this means for MHSW. By illustrating the historical beginnings of psychiatry and the place of MHSW within them, the author demonstrates that the rear view of historical moments provides opportunities for clearer vision in driving reform for the future; that is, the way for not repeating the problems of history become clearer when historical moments are used as a guide. Conversely, historically apparent

themes can highlight the place of critical perspectives and approaches as a way forward. Thus, it would be naïve to assume that setting a new course that adheres to a critical paradigm will always be the future. Nonetheless, a critical conscience assists possibilities by remaining open-minded, always, about new ways forward.

Chapter 4: A critical discourse analysis with a critical realist stance: documents of significance to mental health social work education and practice interrogates exposes, interprets and discusses a selection of extant AASW and federal government policy documents relating to MHSW education and practice in Australia. The author utilised a five stage process for the CDA, sourced from the realm of linguistics and adapted specifically to meet the requirements for this analysis. Critical realism assisted and reinforced the critique of knowledge and language concepts revealed in the extant documents, thus laying the foundation for re-conceptualising and re-newing approaches for mental health social work education and practice.

Chapter 5: Re-conceptualising and re-newing mental health social work education discusses ways forward across the three core foci; education, policy and practice. The author theorises that there are a multitude of layers amid these foci, hence avoiding the potential for binary thinking in conceptualising critical perspectives and approaches. Adopting a critical-emancipatory approach, aided by CR, assists the questioning of the status quo that is inherent in the bio-psychiatric, disease-saturated (illness) approach. The dialectic of knowledge and care aims to address the epistemological underpinnings characteristic of critical-emancipatory efforts, together with the ontological leanings for critical-emancipatory approaches. The author deliberates a variety of approaches, emphasising a trauma-informed approach and positing that this can provide learners (including experienced practitioners) in MHSW and social workers with the capacity to be responsive and specific to those they serve in MHSWP. In other words, a trauma-informed approach serves future and current practitioners, and the citizens they serve.

Additionally, the author presents three broad concepts for facilitating new ways forward in education, policy and practice in MHSW. The core tenets of MHSW are relationship- and rights-based approaches, and social justice, which provide the basis for developing policy that enables learners and assists practitioners, and bring a critical-emancipatory approach to social work delivery.

Chapter 6: Re-conceptualising mental health social work: education, policy and practice revisits the relevance of this study for MHSW, offering some reflections for ways forward, demonstrated with examples. Reflections and examples extend across the three broad areas deliberated throughout the thesis; those of education, policy and practice. Additionally, the themes introduced in Chapter 5 – relationships, rights, reflective practice, trauma-informed perspectives and approaches, and social justice – provide the conceptual framework for re-constructing the current accepted decree that bio-psychiatric, disease-saturated (illness) terminology assumed in language-use and labelling impacts and influences MHSWP. Based on the discussion, the author proposes a new title for mental health social workers, with some introductory thoughts for this

providing another way forward for MHSW; this, too, having appeal for trauma-informed practice. The chapter ends with final comments relating to the study's limitations and areas for further research.

The **Epilogue** concludes the thesis with the author recommending that a critical-emancipatory approach, reinforced with critical realist philosophy, be included in the curriculum and the *Practice Standards for Mental Health Social Workers* (AASW, 2014a).

CHAPTER 1:
ESTABLISHING A CRITICAL REALIST APPROACH TO MENTAL HEALTH AND MENTAL HEALTH SOCIAL WORK

> Symptoms are interpersonal communications and are problematic to measure, for the very reason that they are negotiated inter-subjectively in a culturally context-bound situation in flux. For this reason, they ought to be treated tentatively as transitive phenomena at all times. Humble exploration, not authoritative declamation, is implied from those suffering some sort of plausible healing trade… And true signs may be identified post-mortem (it is current psychosocial (in) competence that tends to concern significant others and professionals). (Pilgrim, 2015b, pp. 5-6)

This critical realist account from Pilgrim (2015b) demonstrates the reification of symptomatology within a bio-psychiatric, disease-saturated (illness) paradigm, revealing concepts significant for understanding the value-base and context of mental health social work practice (MHSWP). This piece signifies caution about understanding the context in which people's lived experience occurs. The historical narrative describing the journey of mental health social work (MHSW) in Australia (exposed in Chapter 3) assists our understanding of the need for deliberation about critical social work theory as the basis for adopting a critical-emancipatory approach in MHSW.

Mental health social work in Australia originated from psychiatry's recognition that social workers could assist children and adults. Lawrence (1965, p. 94, citing Sebire, 1943) informs us that psychiatry viewed social work as "a valuable ally of the psychiatrist in child guidance and adult psychiatric clinics, and in mental hospitals". Thus, the foundations of psychiatric social work in Australia are located within the bio-medical psychiatric, disease-saturated (illness) paradigm. Psychiatric social work, now known as MHSW, has its own *Standards* for education (AASW, 2012a,b,c) and practice (AASW, 2008a, 2010, 2013, 2014a), first introduced only recently in 2008. The language has changed from that of psychiatric social work to that of MHSW policy guides, education and Standards for MHSW, inspiring a value-base (AASW, 2010) and humanist ethics (Banks, 2012) that encourage respect for human beings, and a commitment to social justice and maintaining professional integrity. However, tension is evident in the language of extant Australian Association of Social Workers (AASW) policies for MHSW, which echoes the accepted wisdom and practices of the long-established and inherent bio-psychiatric, disease-saturated (illness) paradigm. Therefore, the author argues that the extant policies for MHSW (AASW, 2012,a,b,c; 2014) prepare social work learners mainly for psychiatric social work.

This tension led the author to undertake the study reported in this thesis with the aim of re-conceptualising bio-medical, disease-saturated (illness) knowledge and approaches. She offers a conceptual framework that moves MHSW out of its psychiatric roots into a critical-emancipatory paradigm within a critical-emancipatory approach. A critical realist stance supports the critical-emancipatory approach, bringing possibilities for repositioning MHSW as the profession that

approaches MHSWP with “humble exploration”, while also ethically safeguarding against an authoritative presence.

The introduction outlining the context for this study emphasises that bio-psychiatric, disease-saturated (illness) discourse is the dominant paradigm in mental health services, and is inherent in MHSW. The discussion provides a conceptual understanding for MHSW amid the three core areas of education, policy and practice. This chapter contextualises the wider enquiry into social work pedagogy in mental health policy and practice by developing a conceptual framework that grounds a deeper and more nuanced, emergent understanding about the place of critical perspectives and approaches in facilitating new ways forward for MHSW. The author introduces a critical theoretical approach, which is strengthened by the philosophical concept of critical realism (CR), itself a central tenet of the interpretive stance amid the data analysis for this study. She addresses the importance of critical theory, and critical social work theory within this, for MHSW. Equally important is her illustration of critical realist philosophy, which provides the compass for navigating the critical realm in the mental health arena. The discussion of critical theory continues in Chapter 2 with the introduction and clarification of the study’s methodological underpinnings, suggesting that understanding the need to situate a MHSW approach within critical theoretical ideology strengthens the rigorous methodological approach. This, too, supports an emancipatory position.

A critical theoretical approach, buttressed with a critical realist stance, has the capacity to inform, and challenge, the current bio-psychiatric, disease-saturated (illness) orthodoxy in MHSW education, policy and practice. While the author notes that some of the following critical perspectives proposed in this chapter are currently utilised in social work education, she invites all mental health social workers to commit to the introduction of critical theoretical perspectives and approaches that inform MHSW not only in the area of pedagogy, but of policy and practice as well. While it is acknowledged that some critical social work theory is taught in social work schools in Australia, it is fragmented and inconsistent (Bainbridge, 1999; De Maria, 1992). Therefore, the author seeks from social work educators (of mental health topics) a commitment to, and consistency of, maintaining an approach that supports a critical-emancipatory knowledge base and thinking for practice. Further to this, on the basis of her findings in this study, she calls for the introduction of a critical realist stance to facilitate new understandings about perspectives and approaches that seek to challenge the current bio-psychiatric, disease-saturated (illness) paradigm inherent in MHSW education, policy and practice.

A rigorous approach to the literature offers possibilities for providing a sound conceptual framework in facilitating clarity of the theoretical foundations for MHSW education, policy and practice. Therefore, the process of researching, refining and critiquing the literature which begins in this chapter remains continuous throughout the entire study, with the aim of demonstrating that it is imperative for mental health social workers in any setting to remain abreast of contemporary debates. This process assists reflection upon the knowledge base together with the implications for

MHSW practice that move the paradigm of psychiatric social work to that of critical-emancipatory MHSW. This move provides the epistemological foundations for informed learners as well as experienced practitioners, and the ontological base for embracing MHSWP grounded in socially just, humanitarian approaches.

Opening up – epistemic eclecticism. Bio-psychiatric, disease-saturated (illness) knowledge grounded in psychiatric social work

The introduction to this thesis posits that multiple layers lie amid the anguish that occurs with mental distress seen among people within all settings, and given social work's key location within health and human services, invites questions related to the implications of these layers for contemporary MHSW university-based professional education and MHSWP. These questions, relating to the dominant paradigm, its origins and journey into the health and human services sectors, serve as the means to rupture the bio-psychiatric, disease-saturated (illness) paradigm as the distinguishing feature of psychiatric social work. These questions also invite analysis of the wider mental health industry and its potentially formative influences on the wider community and social work, particularly ways of knowing (epistemological leanings) and of understanding human being (ontological notions).

Psychiatry as medical power

Foucault (2006a) offers a critical historical perspective of the psychiatric enterprise and subsequent diagnosing of mental distress whereby he establishes various changes over the course of history from the Middle Age to the twentieth century. He illustrates the emergence of "madness" (his term) as relating to both social and cultural phenomena, and interrogates the practices and discourse surrounding the relationship of power and knowledge within the psychiatric enterprise. Pilgrim (2015b) maintains, as does Foucault (2006b), that psychiatry's authoritative position in the diagnosis and treatment of people experiencing mental distress is unlike the use of differential diagnosis in general medicine. Psychiatry takes the binary, and subjective, approach of defining whether it is madness or not (Foucault, 2006b; Pilgrim, 2015b). Foucault further hypothesises that psychiatry has built its domain of assumed knowledge about mental distress via "the act of seeing [or otherwise known as] the gaze" (1970, p. ix), rather than on what he refers to as "commentary" (1970, p. xvi-xvii). In *The Birth of the Clinic* (1973), Foucault indicates that commentary implies the need for conversation, or dialogue, between the patient and the psychiatrist; however, this does not occur because the psychiatrist's gaze surpasses that of people's lived experience. The discourse, therefore, remains within the medical gaze. The life of "the clinic" dictates the course of action; the treatment. Nevertheless, there is disagreement from within psychiatry regarding the ideology of madness, treatment regimens and the pharmaceutical industry's place in its ranks.

Critical psychiatry responding to the bio-psychiatric, disease-saturated (illness) paradigm

The early 1960s brought another dimension to psychiatry with the introduction of what is now termed "critical psychiatry", following Thomas Szasz' seminal publication, T*he Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961). This first of multiple publications for Szasz (publishing right up until his passing in 2012 at 91 years of age), holding a libertarian view, challenges the medically accepted wisdom of coercive practices in psychiatric care. Szasz' insights have brought intense criticism from the psychiatric community, earning him the label of an anti-psychiatrist; a term he repudiates. Laing (1985), also labelled an anti-psychiatrist, confirms the role of psychiatry in diagnosing and treating mental distress. However, he proposes that people's distress relates to the circumstances associated with their lives – dilemmas of existence, or existential angst – coming from the trials and tribulations of daily living (Laing, 1985). Laing's view regarding the function of psychiatry and meaning for his role as a psychiatrist during this part of the twentieth century is compelling:

> …society expects psychiatry to perform two very special functions. To lock certain people up; and to stop and, if possible, change certain states of mind and types of conduct in the name of curing mental illnesses (sic).
>
> Within two years of carrying out my duties as a clinical psychiatrist, I came to the very painful realization that I would not like to be treated the way my own patients had to be treated. I would not like to be locked up in a psychiatric ward under observation. I could not believe that the drugs, the comas, the electric shocks I was expected to prescribe and administer were the great recent advances in psychiatry I was trained to believe they were. (Laing, 1985, p. 9)

Although Laing describes his apprehension about his role as a psychiatrist, together with his surprise at the comfort of his peers in what they were doing, he nonetheless feels the pressure of the culture in which he is immersed, leading him to wonder if he had "got it all wrong" (1985, p. 9). This will be a familiar concern for mental health social workers, especially given that drugs and electric shocks remain within current protocols for "treatment". Therefore, it is essential to reflect on Laing's journey so that mental health social workers are mindful of the connotations of the lived experiences for people seeking help today. There are occasions when some people require solace. Reality, however, is admission to a psychiatric ward, being offered, strongly encouraged or forced to take medication, and electric shock therapy (known as ECT) as panaceas for treatment. Although the ward is in a general hospital, it is still a designated ward for those who are in mental distress and therefore regarded as ill.

Since the anti-psychiatry movement of the 1960s, '70s and '80s, the Critical Psychiatry Network (Double, 2002, 2006a) has come into being. Duncan Double, founding member and psychiatrist, clarifies the debates surrounding the original anti-psychiatry movement, suggesting that the early work of Szasz, Laing and others (Cooper, 1967) in critical thinking and perspectives

for psychiatry differed. Cooper's (1967) position, in the Marxist tradition, differed from Szasz, a libertarian, and Laing the existentialist (Double, 2006b; Pilgrim, 2007, 2015b). Although Szasz and Laing in particular dispute the anti-psychiatric label, it nonetheless remains as a testament to the power of labelling, which is addressed throughout this chapter. Double (2006b) and others (Breggin, 1993, 1999b, 2001; Moncrieff, 2003b, 2006b, 2009; Moncrieff & Crawford, 2001; Moncrieff et al., 1999; Pilgrim, 2015b; Whitaker, 2010) posit that critical psychiatry's contributions are a threat to conventional psychiatry because they are explicit in arguing fundamentally that, psychiatry serves to function as a mechanism of social control by safeguarding society from those who behave differently. Double's (2006b) critique further indicates that it is polarising to explore mental distress in this way, proposing that the nature of "mental illness has tended to be subsumed under either an *anti-psychiatric* or a *pro-psychiatric* position" (Double, 2006b, p. 39). Heaton (2006) differs slightly from Double, arguing that although psychiatry is "authoritarian and exclusive" (p. 42), debates about anti-psychiatry or otherwise detract from the social context in which psychiatry occurs: "psychiatrists these days are mostly servants of the state and are responsible for arranging places for disturbed people to stay" (p. 41). Psychologist David Ingleby (1980), possibly influenced by Foucault, introduces arguments about the politics behind mental health in *Critical Psychiatry: The Politics of Mental Health*. Ingleby (1980, 2006) reasons that the practice of psychiatry is a political one; that the arena of critical psychiatry is "at best a fuzzy set" (2006, p. 62). He surmises that it came out of academia in the late 1960s when there was a "wave of critical fervour [about] society [not being] a harmonious whole, but a power struggle [regarding] whose side [you] are on [and that] if you weren't part of the solution, you were part of the problem" (Ingleby, 2006, p. 63). In essence, Ingleby (2006) posits that the critical "movement" in the mental health arena needs to reaffirm the significance of social circumstances when appreciating people's distress. The movement also needs to reaffirm willingness for the sharing of power among professionals in what he calls "transcultural" mental health care; a perspective that would potentially be shared by many in the allied health professions, most especially MHSW.

Nevertheless, what is clear is that Szasz' work ignited debate contesting the space in which psychiatry operates and that contributors within the current critical psychiatry movement raise concern about psychiatric intervention in people's lives.

Psychiatry as gender power

A knowledge base for social work learners in MHSW education that accesses feminist literature offers the further depth and breadth required for applying knowledge in practice. For example, the interpretation of a variety of policies that relate to mental health service provision, including AASW MHSW policies, assists practitioners to gain at least a minimum awareness of the lived experiences for many women citizens (Ife, 2012). Some examples of women's lived experiences include having babies, which may bring the potential for isolation in the home, interrupted employment, balancing parenting and work responsibilities when nurturing and raising children,

and the issue of domestic violence perpetrated against them amid navigating the responsibilities of child rearing and full or part-time employment. Domestic and family violence in Australia are currently at high rates (Australian Institute of Criminology, 2015). The statistics suggest that in 2015, women were dying at the hands of their intimate partner (or ex-partner) at an average of more than one each week. In addition, a knowledge base that appreciates the implications of these experiences for some women raises consciousness about the possibilities for socially just and respectful practice.

Issues for women citizens seeking (or being forced to receive) services for mental distress are of paramount consideration, given that the analysis for this study focuses on the discourse within various policies related to MHSW education and practice. Faced with the above variety of issues women may face and the implications of their lived experiences of trauma where violence is perpetrated against them, it is inevitable that women will at times reach a point where they are struggling to cope. In addition, they may be either unemployed or underemployed, and may have experienced prior abuse. None of this is new, as exposed later in Chapter 3, which briefly signposts the historical trajectory of women's experiences from early colonial times and raises questions for MHSWP about their current plight. For example, how do MHSW practitioners pay attention to the severity of women's (mental) lived experience in situations where violence is perpetrated against them in what, arguably, should be the privacy and safety of their home? What does the current policy for MHSW education offer mental health social work learners regarding contemporary debates about the place of patriarchy and its resultant effects in our society? How can MHSWP contribute to conversations and decisions about policy within the AASW as well as in health and human services? What are the implications for MHSW in the context of practice in any setting where social workers are? Therefore, the analysis of the AASW policies relating to MHSW education, policy and practice in Chapter 4 aims to keep in firm view the plight of women whose lived experiences cause them emotional/mental distress and may point them toward social workers.

Further to this are key writings that have relevance for MHSW education, one dating back to 1887 (Bly, 1890, in Lutes, 2014). This is notwithstanding the relevance of many other accounts from earlier times, but the paucity of literature does not allow for more depth in the study. In the late nineteenth century, American journalist Nelly Bly approached a doctor with the intent of gaining admission to a female lunatic asylum. Bly's intention was to exhibit behaviours that would be diagnosed as madness to gain her a short stay in the asylum so she could report on life therein. Her account of this lived experience highlights Bly's remarkable spirit as a journalist in Victorian times. The negative experiences she encountered within the asylum spurred her pursuit of social justice. Bly's subsequent report earned her involvement in an investigation by a grand jury, resulting in million dollar funding for the care of people affected by mental health issues (Bly in Lutes, 2014). Indeed, Bly's moral compass is palpable and it is inspiring for MHSW in the twenty-first century to know that one person can make a difference.

Similar to Bly, there are writings from women who, although seeking help for their lived experience of mental distress, report negative outcomes (Boyle, 1990; findlay, 1975; Longden, 2013; O'Hagan, 1980, 2003, 2004, 2008, 2014). These women now hold prominent positions in professional life. Their writings, in the main, are accounts of the North American mental health system (Smith & David, 1975) and have important implications for women's experiences within the Australian mental health system, to which similar accounts from Australian writer Ann Tullgren attest (Bland, Renouf, & Tullgren, 2009, 2015). There are a number of other texts discussing the negative experiences of, and implications for, women seeking help from mental health services for various states of mental distress (Coppock & Dunn, 2010; findlay, 1975; Macfarlane, 2009; Morley & Macfarlane, 2011; Morley, Macfarlane, & Ablett, 2014; O'Hagan, 2008; Rosenfield & Pottick, 2005; Smith & David, 1975; Williams, 2005). These writings invite MHSW practitioners to be alert to the history and lived experiences of women's lived experience, and mindful of the possibilities based in humane and socially just practice.

Practice that is sensitive to the plight of women's distress owes much to mental health social work education that purports a feminist knowledge base for practice. Feminist Standpoint theory, informed by Harding (2008), as is a feminist approach to the sociology of knowledge by Smith (1987, 1990a, 1990c), and Smith and David (1975) assists social work educators develop such a knowledge base. Harding (2008) draws attention to the need for care in scrutinising women's lives for research purposes, while Smith (1990b) adeptly argues that biased patriarchal phenomena in mental health matters that affect women's lives heavily influence statistics. A feminist standpoint provides an understanding that although there is gender bias in the treatment of women in mental health services, there is also an oppressive culture within those services toward many people who access, or are forced to access, them. This oppressiveness is evident when reflecting upon the debates surrounding the *Diagnostic and Statistical Manual of Disorders* (*DSM)* (APA, 2013). Based on evidence from the literature and her own MHSWP, the author argues that feminist insight guides MHSWP in exploring the potential effects of the oppressive nature of *DSM* diagnoses, together with the apparent pharmaceutical remedies for these diagnoses.

The *Diagnostic and Statistical Manual of Disorders* – the psychiatric "Bible": categories and labels, guiding diagnoses and psychiatric intervention

The American Psychiatric Association (APA) publishes the *Diagnostic and Statistical Manual of Disorders* (referred to in clinical practice as the "Bible" or *DSM*), the first edition being published in 1952. The language-use within all versions of the *DSM* is the language of mental illness and disorder (APA, 1952, 1968, 1980, 1987, 1994, 2000, 2012, 2013). The APA also aims for consistency of the *DSM*, now in its fifth edition as *DSM-5*, with the World Health Organisation's (WHO) classification of mental disorders titled the *International Classification of Diseases for Mental and Behavioural Disorders Clinical Descriptions and Diagnostic Guidelines* tenth edition (*ICD-10*) (WHO, 2016). The WHO has a committee with many psychiatrists from across a variety

of countries with the aim of continuously developing and maintaining the guidelines for the classification of mental "illness" and "disorders" (APA, 2013; WHO, 2016).

The insurance and health industries in the United States of America and Australia consider the *DSM-5* and *ICD-10* diagnostic manuals as providing the basis for funding mental health services to individuals, using these classifications to fund individual's private health insurance claims. The health industry requires hospitals and mental health units to record these classifications to ascertain funding for mental health service provision in these institutions. Therefore, the *DSM-5* forms a key layer in the diagnostic process, not just for psychiatry but also for mental health services to secure ongoing funding. The layer of psychiatric diagnosis offered by *DSM-5* serves a dominant function in the categorisation of mental distress and of behaviour that is not acceptable (or causes discomfort) to the community. It is a labelling (Scheff, 1999) tool for mental distress; one that is encased in symptomatology. Therefore, the *DSM-5* is a powerful layer; it holds not just some of the cards in the mental health arena but the whole deck. This layer of the psychiatric enterprise, together with the pharmaceutical industry, is one that may well constitute a main obstacle to the move from psychiatric to critical-emancipatory MHSWP, as exposed (Fairclough, 2001a) and demonstrated in the CDA in Chapter 4.

Although the *DSM-5* and the *ICD-10* are the mainstays of psychiatric diagnosis and thereby the subsequent treatment interventions, this claim is contested territory even from within its own ranks. Significantly, Allen Frances, the Chairperson for the fourth version of the *DSM*, altered his position during the intervening years between the *DSM-IV* and the release of the *DSM-5* (APA, 2013; Frances, 2010, 2013; Frances & Dayle Jones, 2014). Frances argues that the categorising and descriptive nature of the *DSM*s is a mistake; narrow in its conceptualisation. He further asserts that the process is "flawed", thereby producing a "flawed product" (Frances, 2013, p. 1). Frances, contesting the *DSM* as a diagnostic guide, declared in an interview with Greenberg (2013, p. 23) that "there is no definition of a mental disorder…And it's bullshit…I mean you can't define it". Thus, Frances alerts mental health social workers to the serious concerns about the interpretation of "normality" and expresses his unease about the implications for society.

The inherent power of the diagnostic presence of the *DSM-5,* with its gendered perspective that imposes upon women's lives, adds to the aforementioned discussion about gendered notions of psychiatric power. The following illustrates the description for the category *Personality Disorder* (referred to in clinical practice as PD) or *Borderline Personality Disorder* (referred to in clinical practice as BPD). Notwithstanding that this category is also attributed to men, mainly in terms of their deviant (criminogenic or substance misuse) behaviour, the author, drawing on her practice experience, argues that the image of a "hysterical" woman is what comes to the majority of practitioners' minds when either the term BP or BPD is used. This may occur, for example, during team (or other professional) discussions about what might be an appropriate treatment intervention. This has implications for MHSWP beyond that of respectful and humane practice, to that of a moral obligation toward women as victims of traumatic events and situations, often

beyond their capacity to survive as human beings, not the least of which is the need for the preservation of dignity and humility.

The *DSM-5 Personality Disorder Fact Sheet* (APA, 2012) offers explanations for keeping some of the criteria from the previous DSM-IV (APA, 1994) as a result of feedback from the field, wherein practitioners requested less complexity in the diagnostic process. Thus, currently the *DSM-IV and DSM-5 Criteria for Personality Disorders* (APA, 2012) offer a comparison of the two criteria for diagnostic purpose. The following offers some excerpts from the *Fact Sheet* to demonstrate the descriptive nature surrounding these diagnoses. A PD is said to have "essential features [that] are impairments in personality … self and interpersonal … functioning and the presence of pathological personality traits. To diagnose Borderline Personality Disorder, the following criteria must be met" (APA, 2012, pp. 6-7):

> …[s]ignificant impairments in personality functioning manifest by…Impairments in self functioning (a or b)…(a) Identity: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress…(b) Self-direction: Instability in goals, aspirations, values, or career plans….AND… .

The description continues with a variety of other "impairments" (APA, 2012, p. 2) that encompass lack of empathy, issues with intimacy, lack of trust and then lists a variety of "Pathological **personality traits**" [that refer to] "mood changes", "anxiousness", "depressivity" and so on (APA, 2012, pp. 7-8, emphasis in original). Although this is a brief description of the extensive list (signs and symptoms) offered in the fact sheet, it reflects the negative terms used to express information throughout. The terms are negative in the judgement of human character, connoting women, for example, as deficient, weak, diseased, sick, insecure, unbalanced, and, it appears, under privileged ("impoverished"). This is not the language of optimism for the plight of human beings' lives, let alone for the predicaments and dilemmas that occur in women's lives. Taking the emotional effects of the perpetration of violence against women in what should otherwise be the privacy and safety of their home for example, the author, drawing from her prior practice experience, posits that these women will most likely be seen in health and mental health settings. This raises questions about the trauma of violence for women diagnosed with a PD, or a BPD in more recent years. They present to psychiatrists and allied health professionals, including mental health social workers, with apparent impairments in functioning and identity (self-esteem) as a result of ongoing fear, emotional (and physical) pain, mistrust and disassociation (APA, 2012) from the world when trying to cope amid horrid, and sometimes terrifying, circumstances.

Indeed, this perhaps raises more questions than answers proffered in this thesis. Nevertheless, a beginning question might be: How can MHSW education, policy and practice seek to have an open mind and professional curiosity in assessing the situations that occur in women's lives? The final chapters seek to address the critical-emancipatory possibilities for MHSW education, policy and practice; possibilities supported by asking questions from the approach of:

What's The Problem Represented to Be (WPR)?, offered by policy analyst Carol Bacchi (2009).

Further to the language, categories and labels (Scheff, 1999, 2009, 2010) in the aforementioned *DSM*s (APA, 2012, 2013) is the place of the pharmaceutical industry (also known as *Big Pharma*) in people's lived experience. The Critical Psychiatry Network (Breggin, 1991, 1993, 1997, 1999a, 2002, 2006, 2008, 2009, 2011, 2013; Cohen, 1990; Double, 2002; Kirsch, 2010; Kirsch & Moncrieff, 2007; Moncrieff, 2002, 2006b, 2007a,b, 2008b; Moncrieff & Cohen, 2005, 2009; Moncrieff & Crawford, 2001; Moncrieff & Timimi, 2010; Rapley, Moncrieff, & Dillon, 2011a,b; Tew, 2005; Whitaker, 2010) strongly contests this territory and its pervasiveness, while contemporary psychiatry embraces it with enthusiasm. Once again, this raises moral concern about the ethical dimensions of MHSWP.

The pharmaceutical industry's tentacles

Further to the opening discussion for this thesis regarding psychiatry's relationship with the very profitable *Big Pharma*, there are noteworthy critiques from a variety of sources (Breggin, 1993; Carlat, 2010; Cohen, 1990; Jureidini, 2012; Jureidini, Amsterdam, & McHenry, 2016; Kirk, Cohen, & Gomory, 2015; Kirk et al., 2013; Kirsch, 2010; Lacasse, 2014; Maisel, 2016; Moncrieff, 2008a,b, 2009; Moncrieff, Cohen, & Mason, 2009; Pilgrim, 2007, 2015b; Sheehan, 2012; Tew, 2005; Timimi et al., 2004; Whitaker, 2010). These critiques originate from within psychiatry, for example the Critical Psychiatry Network, and independent practitioners in psychiatry as well as those from other disciplines. The following discussion provides some examples from the extant literature that hold important implications for MHSW education, policy and practice, particularly keeping in firm view ethical and rights-based notions of care in MHSWP service provision.

Carlat (2010), a psychiatrist, discloses in his chapter titled *The Hired Guns* the quandary he found himself in with the pharmaceutical companies. He gained substantial financial benefits, allocated directly from drug companies, for touting the importance and efficacy of psychotropic drugs to his peers and allied health staff in a variety of medical settings. Carlat, delving into the research, discovered a lack of evidence for the efficacy of these drugs, together with a misrepresentation of the research data. Jureidini et al. (2016) and others (Breggin, 1991, 1993, 2009; Breggin & Breggin, 1994; Goldsmith & Moncrieff, 2011; Greenberg, 2010; Kirk et al., 2013; Moncrieff, 1999a,b, 2001, 2002, 2003a, 2006a,c, 2007a, 2009; Moncrieff & Cohen, 2006, 2009) echo Carlat's findings, and similarly Frances' (2010, 2013) concerns about the place of psychiatry's (over) prescription of medications, together with *Big Pharma*'s powerful presence and profit-making. Frances (2013, p. xv) writes:

> Psychiatric meds are now the star revenue producers for the drug companies – in 2011, over $18 billion for antipsychotics (an amazing 6 percent of all drug sales); $11 billion on antidepressants, and nearly $8 billion for ADHD drugs. Expediture on antipsychotics has tripled, and antidepressant use nearly quadripled from 1998 to 2008.

According to Frances, these figures are not only astounding but he also believes the "wrong

doctors are giving out the pills" (2013, p.xv). Frances notes that dispensing of these medications occurs predominantly in general practice; and general practitioners lack the expertise (of psychiatry), are pressed for time and therefore do not engage meaningfully.

Further to previous discussion, Carlat and others (Breggin, 2001, 2008, 2009; Jureidini et al., 2016; Kirk et al., 2013; Moncrieff, 2009) demonstrate their evident concerns about over prescription and *Big Pharma*'s profit-making, and psychiatry's relationship amid this. Frances, however, while agreeing that there is over prescription of psychotrophic medications, suggests this is because prescribing has predominantly left the domain of psychiatry. His intention, that psychiatry is very capable of "cure", of "compassion" and of assisting those "who are really sick" (2013, p. xix) seems at odds with his purporting that the *DSM-5* "will mislabel normal people, promote diagnostic inflation, and encourage inappropriate medication use" (2013, p. xviii). Assuming Frances' noble intent, there are others in psychiatry holding a different view.

American psychiatrist and clinical pharmacologist, Peter Breggin (1991, 1997, 1998, 2001, 2002, 2006, 2008, 2009, 2011, 2013; Breggin & Breggin, 1994) maintains a clear standpoint regarding the over prescription and wrongful use of psychotropic medications in psychiatry. His evidence is demonstrated in his representation of many American clients in the successful pursuit of legal action against various pharmaceutical companies and as an expert witness in court proceedings instigated by people experiencing chronic medical issues from the long-term use of psychotropic medications (Breggin, 1991, 2008). Breggin also gives evidence for coronial investigations into circumstances where families have lost a loved one from suicide as a direct result of the debilitating side effects of anti-depressant medications (Breggin, 1991, 2008). Breggin (1991, 2008) contends that not only are there unjust diagnoses of human beings' social and personal issues but there is also a lack of evidence to support the use of these medications as a panacea for these issues.

Alongside Breggin is social worker David Cohen, who vehemently asserts a critical stance regarding psychiatric coercion in the areas of diagnosis, medication and labelling (Breggin & Cohen, 2007). Cohen, together with critical thinkers in the psychiatric arena (Breggin & Cohen, 2007; Kirk et al., 2013; Moncrieff & Cohen, 2005, 2006, 2009; Timimi et al., 2004), challenges several areas relevant to MHSW. Principally, Cohen (1990) brings the social work voice to support Szasz' (1961, 1970, 1989, 2007, 2008, 2010a,b) and others' (Breggin, 1993; Jureidini, 2012; Moncrieff, 2009) contention that psychiatry is intimately connected with the introduction of the "therapeutic state". Cohen writes that the mental health industry "does not merely seek to eliminate or control *mental illness,* but to manage all aspects of social life with the aim of producing *mentally healthy citizens"* (1990, Preface). He asserts that the therapeutic state "constitutes one of the most encompassing projects in socio-political history, and its ideology – the medical model – now reigns supreme in the post-industrial world, explaining the innermost thoughts of individuals and shaping the social policies of nations" (Cohen, 1990, Preface). Cohen acknowledges there is similar opinion from other disciplines; that the methodical use "of the medical model…has produced and continues

to produce intellectual confusion, iatrogenic disorders, social enfeeblement and other difficulties" (1990, Preface). Additionally, he contests the orthodox bio-psychiatric, disease-saturated (illness) views regarding psychotropic drugs' safety and efficacy, and the wrongful diagnoses of children and adults 1 the emotional consequences of various distressing life events. Others share this view (Breggin, 1993; Jureidini, 2012; Jureidini et al., 2016; Kirk et al., 2013). Cohen advocates that coercive practices are not effective in working with any form of mental distress, arguing persuasively that mental health issues arise through socially constructed phenomena but that the psychiatric professions' persistence with social control and inhumane drug-treatment regimens continues to dominate thinking and practices. Thus, the dominant bio-psychiatric, disease-saturated (illness) paradigm, together with *Big Pharma*'s tentacles, holds a firm grip on the mental health industry. This indicates even more strongly the need for a critical-emancipatory approach in MHSW education, policy and practice, thus supporting the dialectic of knowledge and care.

The language of madness: the madness of language

Kirk, et al. (2013), in a recent review of historians of psychiatry (see, for example, their discussion in Chapter 2 on Scull, Porter, & Shorter), declare that there are many theories and implied reasons for considering people to be viewed (the gaze) as mad, and yet those reasons are not proven by science. Similar to Foucault and literature on deviance that discusses the use of labels (Becker, 1973; Curra, 2011; Scheff, 2010), Kirk et al. (2013, p. 39) propose that "madness…is a word first and foremost…its meaning being primarily determined by those responding to it". Accordingly, Kirk et al. (2013, p. 39) discuss the failure of defining what madness really is, informing that "(u)nusual or scary behaviours of our own or those of others that attract our attention and elicit powerful emotions typically challenge us to provide an explanation for their existence". Therefore, it is apparent that madness is a term that both transforms into, and constitutes, a language; a language that attributes meaning and therefore meaning that defines the parameters for its existence. Add to this the emotion, sometimes fear, in which there is the demand for a response, and you get a response that is justified with a term, a definition – a label for the behaviour.

This, too, is posited within the realm of deviance and of labelling theory proposed by Scheff since the 1960s (1967, 1975, 1984, 1999, 2006, 2009, 2010). Scheff's (2009) sociological approach emphasises that society has expectations about how people behave and are obliged to conform in particular ways. Scheff (2009), similar to Becker (1973), contends that where there are rule violations, this occurs on a continuum of behaviours from those that demonstrate a lack of manners through to those that are alarming, frightening or different from those viewed by society as the norm. In this spectrum of behaviours, psychiatry's gaze is directed at symptomatology, which focuses on the assumption of illness. Scheff (2009, p. 53, emphasis in original) purports that in psychiatry, "the medical metaphor *mental illness* suggests a determinate process that occurs within the individual: the unfolding and development of disease...the existence of this underlying illness is unproved". Hence, Scheff (2009, p. 53) continues, there is the necessity for discourse that

does “not involve the assumption of illness”. In psychiatry, behaviours that are not in keeping with social norms are not questioned as to their reasons but “taken as given” (Becker, 1973, p. 3) in practice, where the label, reinforced through the *gaze*, offers apparent explanation. Tew (2005, p. 84), acknowledging Foucault in terms of the power relations that form the discursive elements and the social order, posits that “modernity has required strategies for ‘correcting’ deviance and rehabilitating people as rational and docile subjects”.

Given the early insights of Foucault, Scheff and Becker, and others more recently (Curra, 2011; Kirk, 2005; Kirk et al., 2013; Tew, 2005), Pilgrim (2015b) contends a critical realist stance in a move away from language and labelling that sits also within the realm of deviance. He proposes that “some of us some of the time *really are* distressed or unintelligible or incorrigible … other people get upset about these forms of conduct, [hence] social consequences have to be dealt with [but] this messy reality needs fair exploration” (Pilgrim, 2015b, p. 1). Although “unintelligible” or “incorrigible” may arguably sit within the paradigm of deviance and the desire for an explanation of behaviour (conduct), alternative explanations (language) can be found in notions of shame (Brown, 2004, 2007, 2010, 2012, 2015; Scheff, 2009) and the impact of trauma on people’s lives (Bloom & Farragher; 2011; van der Kolk, 2014), all of which hold high importance for MHSWP.

Scheff agrees with Szasz in contesting bio-psychiatric, disease-saturated (illness) paradigm whereby psychiatry diagnoses “problems in living” as mental illnesses (Scheff, 2009, p. xiv, citing Szasz, 1961). However, Scheff advances Szasz’ argument in relation to problems in living in two main ways. First, Scheff utilises a sociological rather than a medical paradigm in the same way as Becker (1963) and Curra (2011) to contribute to identifying the trajectory toward mental distress and the consequences of doing so. Second, similar to Pilgrim (2015b), Scheff (2009) concludes that although problems in living are real in the emotional sense, this does not mean that they are an illness in and of themselves. Nevertheless, as alluded to earlier, both Scheff (2009) and Pilgrim (2015b) clarify that people present with some behaviours that violate social norms. What is at issue here is psychiatry’s judgement in determining the reasons for people’s behaviour and thus the responses to it. This has implications for MHSW in coming to a deeper understanding about what lies behind the variety and complexity of behaviours, emotions and conduct that people present with in practice settings.

Even though various types of behaviours may well be habitual in the extreme, objectionable and even inappropriate, it does not follow that a punitive response will make a difference. Equally, of importance here is that a MHSW assessment is essentially a judgement call. A critical-emancipatory approach offers the possibility for ascertaining a broader picture in an attempt to gain a deeper understanding of the stories people bring regarding their journey through often traumatic lives, otherwise known in MHSW as “contextual understanding”. People’s experiences (stories) constitute the language that provides opportunities for mental health social workers, and arguably all health professionals, to gain an insight beyond the language of labelling and descriptions in *DSM*s (APA, 2013) and *ICD*s (WHO, 2016).

The lived experience – patients, clients, consumers, service-users: language, identity and citizenship

People's mental distress is their lived experience of trauma and of the services they access (or are forced to receive) in their time of need, which goes beyond the effects of the language and labels used to define its parameters. As will be demonstrated throughout this thesis, the dominant bio-psychiatric, disease-saturated (illness) discourse of psychiatry has a powerful presence among nursing and allied health staff, including mental health social workers, which began within the context of the asylum. However, a return to community-based care occurred in the late twentieth century, and by the 1990s the consumer and Recovery movements (Anthony, 1993, 2007; Bland, Renouf, & Tullgren, 2009) had emerged in response to a call for fairer treatment. Gradually, the asylums have closed and the language of Recovery is now the contemporary theme in mental health care. Nevertheless, Goffman (1961) brings a dimension worthy of note with his research that maps the effects on the patient of institutional life in the asylum; effects of (mostly involuntarily) incarceration that place people at the mercy of decisions made by psychiatrists on their behalf. Goffman (1961) contends that people in asylums witnessed an environment that impacted their identity, their dignity and their capacity to regain any sense of citizenship. It is argued in the recent Australian National Mental Health Commission's (NMHC, 2014b) publication *Contributing lives, thriving communities Report of the Review of Mental Health Programmes and Services (CLTC)*, discussed early in the introductory chapter, that the effects of institutional(ised) thinking and practices are apparent in mental health services today. The author critiques this document in depth in the CDA in Chapter 4 of this thesis.

Identity, dignity and citizens' rights sit among the value-base of social work. An awareness of the institutional(ised) nature of dominant bio-psychiatric, disease-saturated (illness) discourse and its practices offers rich knowledge for MHSW education, and deep inquiry for MHSWP. Bacchi's (2009) *WPR* approach assists with the analysis of current mental health policies and policy documents, and for developing new policies that relate to MHSW social work education and practice. This applies also to analysing current legislative requirements that impact upon MHSWP in delivering socially just and ethical mental health care. Relatedly, critical-emancipatory MHSWP questions rather than uncritically accepting the foundations that currently have the medicalisation of mental distress set in stone.

A critical realist stance in MHSW offers an epistemological base with an ontological approach, which opens up possibilities for facilitating emancipatory intent for education, policy and practice. The following discussion begins with an exploration of the philosophical roots of CR because it offers the basis for MHSW to move from its psychiatric origins toward critical-emancipatory (epistemological) perspectives and approaches (ontological) for practice. The author discusses the ontological leanings for education, policy and practice in detail in Part 2 of this thesis.

Critical realism

The origins of CR lie within the philosophy of science, introduced by Roy Bhaskar in the 1970s. Given CR's philosophical completeness in offering a sound foundation for this study – it is complex and multifaceted – the author proposes a simplified explanation of some key concepts from CR for MHSW education, policy and practice through the following discussion.

Bhaskar (1975) delivered a critique of positivism and phenomenology with the aim of moving deliberations away from the science world's reductionist accounts of human social existence. Later, he developed the notion of "explanatory critique" (Bhaskar, 1986), an approach that assists the social sciences in aiming for emancipatory intent because it relates to human freedom (Archer et al., 1998). An explanatory critique provides the theoretical foundation for exposing various false beliefs in "which oppression and injustice are disguised, whether consciously or not, and perpetuated" (Bhaskar & Collier, 1998, p. 389). The explanatory critique is further deliberated in the research quest and approach in Chapter 2, particularly because it supports the Chapter 4 CDA in interrogating the policy and standards documents relating to MHSW.

The concept of "generative mechanisms" (Bhaskar, 1998) is additional to the explanatory critique offering the space to expose the nature of false beliefs (Archer et al., 1998). This concept has similarities to the accustomed social work notion of structural factors but generative mechanisms delve further by taking account of the conditions in which knowledge is generated. However, these are "explicitly distinguished from the conditions of being" (Bhaskar, 1998, p. 61), maintaining a pragmatic approach amid these phenomena. For example, in MHSW there is an exploration of the causal structures in mental distress but these are not reduced to only the biological or even sociological elements that may contribute to various forms of mental distress. Other mechanisms, such as political and environmental structures, also generate mental distress. These mechanisms are neither represented in, nor dependant on, science, or knowledge or human nature alone (Sayer, 2000). Thus, determinist, reductionist and biological accounts of human behaviour do not, and cannot, hold all the answers. This is the pragmatic edge of CR that has appeal for MHSW because it leaves epistemological space to generate knowledge ad infinitum and the ontological lean into ways of being in the daily reality of practice. Critical realism enters the sphere of "values and morality [within] the real world in which we all inhabit" (Bhaskar & Collier, 1998, p. 389). This also has meaning for MHSW because the core values – respect for persons, social justice and professional integrity – all relate to the critical realist sphere of values and morality. Additionally, MHSWP is located in the world of real work that all social workers inhabit.

Bhaskar (1998) presents the now familiar view that the human sciences are not neutral. He theorises further that "science is meaningless because it gives no answer to our question, the only question important to us, *what shall we do and how shall we live?*" (1998, p. 389, citing his 1986 works, emphasis in original), emphasising also that knowledge alone does not bring freedom. In other words, a critical realist stance asserts that knowledge is fallible, and that dichotomous

thinking about the place of facts and values runs the risk of entering the realms of *is/ought* and *either/or* thinking (Bhaskar, 1998; Bhaskar & Collier, 1998; Sayer, 2000). Consequently, Bhaskar (1975) names the fallibility of knowledge "the epistemic fallacy", which has significant implications for critical-emancipatory MHSW. It offers the opportunity for new possibilities in appreciating that knowledge (theory), for example mental illness, is fallible. Pilgrim (2015b) opens this space from a critical realist standpoint.

Bhaskar extends Kant's work in idealism through bringing (critical) realism to MHSW as a stance that addresses both epistemology and ontology (Archer et al., 1998). Ontology is a distinguishing feature of CR beyond the epistemological thread that it offers. Hence, there is acknowledgement of the probability that influences may be present that are not applied, therefore what occurs or is known to have occurred does not negate what may or did occur (Sayer, 2000). This means that realist ontology allows for possibilities that may not be considered otherwise. The connection here for MHSW is with an interpretation, and hence an awareness and an understanding, which goes beyond the confines of the bio-psychiatric, disease-saturated (illness) paradigm, for example in terms of the language (discourse) used to define people and their circumstances in imagining what may be possible. Critical realist ontology contains three domains of reality; the real, the actual and the empirical (Ayers, 2011, 2013). Sayer (2000, p. 12, emphasis in original) explains the three domains as follows:

> …the real…refers to the structures and powers of objects, the *actual* refers to what happens if and when those powers are activated, to what they do and what eventuates when they do [while] the empirical is defined as the domain of experience, and insofar as it refers successfully, it can do so with respect to either the real or the actual.

Sayer (2000) elaborates on these domains, suggesting that the phenomenological aspects relating to CR deliver extensive depth to the epistemological and ontological tenets of this philosophy. These domains hold particular relevance in the CDA utilised for this study because they invite exploration and the opening up of the structures and obstacles potentially impeding change in MHSW education, policy and practice.

Critical realism has gained prominence particularly since the 1990s. Social theorists (Archer et al., 1998; Archer, Sharp et al., 1999; Collier 1998; Gorski 2013; Hartwig 2007; Bhaskar & Hartwig, 2010; Sayer 2000, 2011) have developed it further, thereby advancing its momentum in the social sciences. Thus, there have been some early beginnings for CR in social work, namely through Houston (2001) and Oliver (2012), who both propose that CR offers considerable depth for social work inquiry. Therefore, it is envisaged that this study will encourage MHSW education to utilise all that this philosophical concept has to offer. Furthermore, a critical realist approach invites critical-emancipatory thinking about the context of mental distress (almost always resulting from trauma) (Bloom & Farragher, 2011, 2013; Hughes, 1998, 2008) and therefore opens more space for broader understandings about people's lived experiences. New possibilities emerge amid a critical realist stance, which reinforces them with the awareness that social work values, ethics and

social justice are critical-emancipatory pursuits in MHSWP.

David Pilgrim's (2015b) work in CR for mental distress complements the CDA undertaken in this study in Chapter 4. Pilgrim (2015b) provides some new foundations for the MHSW scene, inviting the need for humble questioning of long-held (and confidently so) beliefs about biology and human existence, positing that MHSW social workers have confused the two. Pilgrim's (2015b) most recent examination of the paradigm of mental health and the mental health industry titled *Understanding Mental Health: A critical realist exploration*, clarifies the place of the psychiatric enterprise in the polarisation of mental distress as that of illness and disease. He states that "so much of the presumptuousness about bio-determinism in psychiatric theories of aetiology has conflated biology with pathology, when this is illogical" (Pilgrim, 2015b, p. 44). Pilgrim (2015b) argues further that psychiatric positivism intervenes to maintain the social order (the paradigm of deviance) (Becker, 1973; Curra, 2011; Goffman, 1961; Kirk, 2005; Kirk et al., 2013; Scheff, 1984; Tew, 2005), serving to reinforce notions of the bad among the mad and the sad (Appignanesi, 2009). Pilgrim's (2015b, p. 8) critical realist standpoint draws attention to the deviance paradigm, suggesting that:

> …deviance emerges in society from a multi-factorial picture or permutation of generative mechanisms (biological, psychological, and social), but its identification as being problematic is always a social process.

Here, Pilgrim argues that many factors in the mechanisms generate the identification of issues, which nonetheless are the result of social processes. Likewise, Foucault (1998, p. 336) argues that people who do not conform within society's expected parameters are seen as "behav(ing) differently from others". The notion of the marginalised possibly originates here, given that Foucault describes those behaving differently from others as "marginal individuals*".* The CDA of these factors and their generative mechanisms refers to them as "layers", which are addressed in depth in the re-conceptualisation of MHSW in Part 2 of this thesis.

Additionally, Pilgrim (2015b) addresses the context of madness from a critical realist position, exploring the notion of "misery" and the psychiatric enterprise in this, saying that "misery and especially madness have become the existential states that the reputation and credibility of psychiatry rests upon" (p. 8). An example is his discussion regarding the paradigm of fear being a real and genuine human experience resulting from "some form of distress, worry, dread, or panic" (Pilgrim, 2015b, p. 20), yet this is reported in medical terms as "symptoms". Pilgrim argues compellingly that psychiatry, together with *Big Pharma* in the form of global "self-assured medical expansionism", reacts to the pressure of an apparent need for "something to be done in complex modern societies about misery, madness and incorrigibility [whereby this] provides an over-arching but rarely reflected upon rationale for the mental health industry" (Pilgrim, 2015b, pp. 4, 5).

Indeed, it is significant to note that psychiatrists train first in general medicine, which centres predominantly on biological markers in disease. This presents a preference for what is known from their early training rather than seeking alternative explanations (Pilgrim, 2015b); a

situation “shored up by drug company profit seeking…part of a web of real forces that maintained a medicalised understanding of madness (and do so to this day)” (Pilgrim, 2015b, p. 47). It is prudent to mention here that perhaps there may be some biological markers in madness. However, to date these have not been identified with certainty; no improvement has been seen in people’s states if this is so. Yet this is clearly identifiable when there are advancements in general medicine. Pilgrim (2015b, p. 47) asserts that there is an “unwarranted confidence in bio-reductionism about madness” and that the “generative mechanisms” to be explored begin with the eugenics movement originating in the United Kingdom. This movement later reached Nazi Germany. *Big Pharma* followed.

More forcefully, Pilgrim (2015b, p. 100) implicates all professionals, suggesting that psychiatric services, in which mental health social workers are situated, are “ineffective” and in fact, comparative studies of cross-national trends in these services advise they “actually damage the mental health of populations”. He warns that this relates to the “lowering of diagnostic thresholds and the iatrogenic impact of interventions as a consequence of being extended to larger numbers in the population” (Pilgrim, 2015b, p.100). What is missing here is the provision for the “articulation of alternatives” (Tew, 2005, p. 14), which also implicates notions of the representation of recovery rates. In fact, the figures are increasing, which equates with the rise in the prevalence data discussed in the opening lines of this study.

Critical realism: language and professional power

Pilgrim (2015b, p. 42) clearly states his critical realist position, and its place in language and the contextual understanding of madness, stating:

> … critical realism rejects the reductionist logic of the linguistic turn and its narrow preoccupation with epistemology, but it does not deny that language remains important. The way ordinary people and professionals understand madness does matter.

Although Pilgrim (2015b) acknowledges the need for professionals and society to recognise the importance of what madness means, he asserts that he does not support the term “mental distress” because it has the potential for further reduction of the reality that people become mad. While this conjecture about the potential for a reductionist approach to the language and lived experience of madness is accepted on the one hand, on the other it is purported that the intention behind using the term “distress” in this study has equal potential to encourage appreciation that even the most severe and frightening personal experiences are (extremely) distressing. Consequently, this means that people do not need to be defined in the realm of madness because this serves to reinforce the stigma (Corrigan, 2007) associated with any term used in the mental health industry. This paves the way for MHSW across the layers of education, policy and practice to theorise about the dimensions of language, which are re-conceptualised in Part 2.

Thus, as a philosophical framework for this study’s CDA and recommendations, CR affords depth for the interpretive and critical stance employed. Similarly, the aim of a critical realist stance

assists in identifying and exposing the power of the underlying structures and mechanisms that may constrain individual choices and actions for people either working in, or subjected to, the mental health arena. Fairclough (2010) supports Bhaskar's "explanatory critique" (1975), which provides the layer in the CDA that goes beyond fact/value statements to reflection on possibilities for action in MHSW education, policy and practice. This moves away from confusing medical notions of signs and symptoms toward cautious consideration of the meanings that lie in the cultural and social phenomena surrounding any given situation (Pilgrim, 2015b).

Epistemic eclecticism – the many ways of knowing. Theories that influence and inform mental health social work education, policy and practice

> Theory should be radical, probing, and immoderate. It is when we allow our thinking to be fearless, to encounter philosophical extremities, that we have the best chance of understanding the world at a deep level. (Chambon, Irving, & Epstein, 1999, p. xiv)

These introductory remarks from Chambon et al. (1999) summon confidence in the early career researcher to undertake a rigorous pedagogical approach in MHSW education, which invests in learning conversations that stretch the parameters for MHSW policy and practice. Chambon et al. (1999) "step back and reconsider the unexamined rationalities of our profession" (p. xviii), noting that a critically reflexive approach assists this process. Fook (2012) does the same. The author of this thesis contends that MHSW has unexamined rationalities that lie in the explicit acceptance of the positivist and reductionist notions evident within a bio-psychiatric, disease-saturated (illness) paradigm. Nonetheless, there is a need for caution to avoid dichotomous thinking about the many ways of knowing. Shakespeare (2014, p. 72), positing a critical realist stance to disability, makes the critical point that instead of "setting medical model versus social model…it is more fruitful to distinguish reductionist accounts and multi-factorial accounts", suggesting that "a plurality of approaches is beneficial in the analysis of disability". Given that mental health is situated within the realm of disability and that MHSWP is filled with complexity, ambiguity and the messy realities of life (Hallahan, 2012), analysis of the layers (many factors) of MHSWP brings depth to contemporary debates in the mental health scene. The author interrogates these notions in the CDA in Chapter 4 and re-conceptualises them in Part 2.

Critical perspectives amid many ways of knowing

The roots of critical social work theory date back to the Settlement Movement in the USA in the late nineteenth century with the Nobel Peace prize winning work of Jane Addams, a peace activist and community worker (Healy, 2012). Bailey and Brake (1975) introduce the notion of radical social work theory for practice in recognition of a need to respond to class- and identity-based forms of social oppression (Healy, 2012). Theoretical influences in social work come mainly from Marxist philosophy and critical social theory, and include work by the Frankfurt School's Habermas, Adorno

and Horkheimer, as well as Paulo Freire's (1996, 2005) consciousness raising efforts.

Critical social work theory, emerging with Bailey and Brake's "radical structural critiques" (1975, cited in Chambon et al., 1999, p. xv), Wakefield's (1988) concept of "distributive justice" and Manning's (1997) work regarding the professional as a "moral citizen" traverse the many ways of knowing for MHSW. Contemporary social work theorists focus on the connection with neo-liberalism and the politics of avoidance, and evidence-based notions of practice and of perceiving situations in a way that may misrepresent them (Bacchi, 2009; Bay, 2014; De Maria, 1992; Fook, 1996, 2002, 2012; Ife, 2012; Karban, 2003, 2011; Macfarlane, 2009; Morley, 2008, 2012, 2014; Nipperess, 2013; Pease, 2013; Pilgrim, 2015b). Some call for going beyond engaging only with the individual to engaging with the political. This, too, accords with an ethical stance. These debates are important for MHSW in keeping educators and practitioners informed about contemporary themes for practice. MHSW learners, in the main incline toward the binary understanding that knowledge of social work's political nature is either unnecessary or requires an aggressive stance. Bay (2014) maintains that thinking politically and acting ethically in social work – also part of a critically reflexive process – does not need to bring the usual fear of political action equating to a rendezvous with power in the negative sense. That is, engaging in political action is not just about being in opposition, or even oppositional, which most often comes with a vision of enforcement and engagement (Bay, 2014). Recognising this allows for moving away from thinking within the binary of an either/or perspective. Bay (2014, p. xix) states this fittingly:

> Politics narrowly understood as a power struggle potentially detracts from social workers reclaiming the political as a process that respects freedom and deliberation in a way that can inform ethical action and that can reinstate the unique voice of each person in learning to live with one another and in sharing a common world.

These remarks make the connection with ethical action, as does Foucault (cited in Bay, 2014) in calling for social workers to pay attention to, and challenge, our "taken-for-granted habits of thinking about people, problems and solutions" (Bay, 2014, p. 161). Arendt (2003) advances the possibilities for practice in proposing the need for awareness of the moral implications of our actions, offering powerful and thought provoking ideas about the potential for the lack of sound thinking and judgement in our actions, and of the dangerous possibilities that can transpire from this. Bay (2014) cites the powerful example of Arendt's attendance at the trial of Adolf Eichmann, one of the organisers of the Nazi German Holocaust in the Second World War. Arendt observed Eichmann's accounts of the atrocities he committed; he believed he was following orders and the law. Arendt's research demonstrates that Eichmann did not think for himself, nor did he appear to show any moral fortitude for his actions. The moral and political messages in Arendt's seminal works (2003, 1998) invite mental health social workers to embrace fundamental lessons for theory and practice. There are two distinct points here for MHSWP. First and most important, following psychiatrists' orders does not justify ethical grounds for practice. Second, just because a mental health act provides the statutory direction for mental health care decisions does not necessarily

make those decisions *right*, reasonable or respectful of human beings lived experience, possibly to a point of being advised (by psychiatry) to undertake electric-shock treatment, for example, which has no evidence to support its therapeutic value (Breggin, 1991, 1993, 1999a,b, 2008; Cohen, 1990; Kirk et al, 2013; Kirsch, 2010; Moncrieff, 2009; Pilgrim, 2007 2015a,b; Szasz, 1968, 1970, 1989, 2010a; Whitaker, 2010). Therefore, the author argues that social work practitioners must reflect on the effects of their practice habits, including the personal and professional intentions behind them, to engage in empathic responding to the people in their care, which sustains a commitment to social work values and ethics. Conceptual understanding that surrounds relationships, rights-based and socially just MHSWP is proposed and clarified in Part 2.

Foucault's addressing of the intersection of knowledge and power, with its resultant marginalisation, is also relevant for MHSWP in working with people experiencing the multiple effects of structural inequalities; the "generative mechanisms" (Bhaskar, 1998) associated with emotional distress. Foucault, heavily influenced by Nietzsche, questions modernist assumptions about truth, knowledge and power, and the institutional properties that surround them (Chambon et al., 1999); hence, his principled ideas about madness and reason suggest that notions of truth are subjective. A critical realist standpoint (Pilgrim, 2015b) advances this with the concept of the epistemic fallacy, which emphasises being mindful that concepts are just that; they are not necessarily facts.

The author had critical theory in her MHSW sights when tackling the intrinsic struggle within this study to not only find new meanings in moving forward, but also to attribute new meanings to understanding the inherent contradictions in socially just MHSW theory and practices. Core tenets of critical social work theory, such as those based within feminist, anti-oppressive and human-rights paradigms, bring the ontological edge to critical MHSWP (Allan, Briskman, & Pease, 2009; Bainbridge, 1999; De Maria, 1992; Dominelli, 2002; Dunk-West & Verity, 2013; Fook, 1996, 2002, 2012; Healy, 2012; Ife, 2012; McDonald, 2006; Nipperess, 2013; Payne, 2014). This enables MHSW learners access to language and reflection conducive to practices that are framed within socially just notions of social work based in social work's core values – respect for persons, social justice and professional integrity. These values also maintain an ethical stance.

In encouraging all social work educators and practitioners to follow her path, the author emphasises that it is equally critical to keep sight of the reflexivity process in appreciating the historical and cultural context in which meaning-making occurs. Examining and exploring meanings through the course of history, as well as in situating a new course for the future, requires an ever-present conscious awareness about unexamined rationalities in creating new ideology and practice while not being dogmatic and essentialist in doing so. The concept of multiple truths (Chambon et al., 1999) and Foucault's insights form part of the scaffolding surrounding the questioning of the bio-psychiatric, disease-saturated (illness) status quo for the CDA of extant policy documents in the Australian MHSW scene.

Chapter summary

This chapter has introduced the literature that influenced and guided this study. The author has explored a variety of theoretical perspectives, appreciating that there are many ways of knowing, especially given the messy realities of practice in MHSW. Influential theorists, located across several disciplines (critical psychiatry, sociology and social work), offer scope and space for alternative understandings to biological, determinist and reductionist accounts of mental distress. The presence of some key Australian critical social work thinkers in MHSW provides local knowledge for re-conceptualising and repositioning MHSW education, policy and practice. There is encouraging literature in social work that provides a framework for conceptualising the political nature of MHSW and summoning the moral courage to pursue new pathways that intertwine knowledge with ethical practice.

The author drew inspiration from a feminist approach to gain an understanding about the sociology of socially constructed phenomena in gender bias, and therefore the plight of women who have negative lived experiences of mental health services. Foucault illuminates the power of the psychiatric discourse, while the long-standing work of American social worker David Cohen, as well as others, highlights the dominance of *Big Pharma* in mental health service provision. Similarly, the philosophical approach of CR has been shown to assist the examination of unexplained rationalities in a rigorous determination to move toward critical-emancipatory, socially just efforts to find meaning among multiple truths by respecting people's lived experiences.

CHAPTER 2:
THE RESEARCH APPROACH: CRITICAL DISCOURSE ANALYSIS AND APPLYING A CRITICAL REALIST APPROACH IN MENTAL HEALTH SOCIAL WORK

Chapter 1 has established the foundations for a critical realist approach to mental health and mental health social work (MHSW). This chapter introduces MHSW education as the field of inquiry in this study. To date, the literature on this topic is sparse and directed mainly at generic social work education. A critical realist standpoint reinforces the research quest, the approach and the method because this standpoint is viewed as fundamental to critical-emancipatory MHSW education, policy and practice.

The justification for the chosen research approach, explained in this chapter, recognises and acknowledges that other methods could have been utilised for this study. This may be a limitation but the author argues there is scope for further research resulting from the study. She has adhered to ethical conventions and qualified these in the discussion, notwithstanding her situated perspective as the researcher, which is acknowledged.

The research journey toward critical-emancipatory mental health social work with a critical realist stance

Mental distress is seen in any setting that employs social workers. The author's desire to interrogate and expose the status quo of the apparent dominance of a bio-psychiatric, disease-saturated (illness) model in MHSW and mental health social work practice (MHSWP) motivated this study. Her experiences in excess of three decades in "the field" and the past nine years in a university setting, initially as a field education coordinator and currently as a social work educator, provide a solid base for the study. Witnessing the lived experience of people experiencing mental anguish in one way or another, firstly as a mental health nurse and then as a mental health social worker, brought more questions than satisfactory answers. These practice experiences in a variety of government mental health services and part-time private practice (satisfying the requirements of AASW mental health accreditation in the mid-1990s) revealed to the author that there is more to the lived experience than something that lies within the person. Ideas and practices surrounding pathology were not making sense with the narratives people shared about their lives. The author was sure "there had to be more to all of this".

Given that the research process occurred iteratively and was one of immersion, it became apparent to the author during the study that prior hunches about the dominance of the bio-psychiatric, disease-saturated (illness) paradigm were not just confirmed but extensively confronted. This paradigm appears to fit within the context of psychiatric social work rather than MHSW, which has implications for contemporary perspectives and approaches in MHSW education, policy and practice. This qualitative research process is also one of interrogation,

exposure, interpretation and integration, which contributes to the extension of the existing knowledge base, and therefore fresh approaches for MHSW education, policy and practice. Adopting an interpretive stance (Charmaz, 2014; Clarke, 2005) to the literature, policy documents and reports entices new insights for MHSW education, policy and practice, and the integration of critical realism (CR) as a philosophical basis amid these three core foci. Critical discourse analysis (CDA) guides the interrogation and interpretation (Denzin & Lincoln, 2011; Harvey, 1990; Ravitch & Riggan, 2012) of the policy documents and reports that hold relevance for MHSW (see Chapter 4).

Taking a critical realist stance supported by critical social work theory (Allan et al., 2009; Bainbridge, 1999; De Maria, 1992; Dominelli, 2002; Dunk-West & Verity, 2013; Fook, 1996, 2002, 2012; Healy, 2012; Ife, 2012; McDonald, 2006; Nipperess, 2013; Payne, 2014; Pease, 2013; Pease & Fook, 1999) and critical reflective social work praxis (Fook, 2012; Fook & Gardner, 2007; Morley, 2008; Morley & Macfarlane, 2011, 2010; Morley, MacFarlane, & Ablett, 2014) in the arena of MHSW demonstrates commitment to the modelling of critical-emancipatory social work across the three foci of education, policy and practice. Part 2 opens up and re-news possibilities in these areas. This qualitative research journey is perhaps best described using the words of Paul Klee, an early twentieth century Swiss-German painter: “A line is a dot that went for a walk” (cited in Denzin & Lincoln, 2011, p. 593).

The research field: mapping mental health social work education

As established in Chapter 1, the psychiatric enterprise is aligned with the pharmaceutical industry (*Big Pharma*), which possesses a powerful presence that is clearly palpable within the realm of MHSW education, policy and practice (Kirk et al., 2015; Lacasse, 2014; Macfarlane, 2009; Morley, 2008; Morley & Macfarlane, 2010; Pilgrim, 2015b; Tew, 2012, 2005). Contemporary notions of MHSW in Australia cannot be understood without reflection on its historical roots, beginning in the 1950s when it was inaugurated and recognised as “psychiatric social work”, the historical narrative of which is revealed in Chapter 3. Mapping the beginnings of psychiatric social work, with its endorsement by psychiatry, established the reason for the original research proposal for this study; that an exploration of the Recovery approach (Anthony, 1993, 2000, 2007; Davidson et al., 2005; Davidson et al., 2006) – the current dominant practice approach in mental health services – may reveal new insights for critical perspectives and approaches for contemporary MHSWP. The author reviewed the literature relating to the global and local mental health arena. She mapped (Clarke, 2005) sociological and feminist notions of mental distress (e.g. Becker, 1973; Harding, 2008; Morley & MacFarlane, 2008, 2011; Rogers & Pilgrim, 2014; Pilgrim, 2011; Scheff, 1984, 1990, 1999, 2009; Smith, 1987, 1990a,b,c); critical social work (e.g. Allan et al., 2003; Allan, Pease, & Briskman, 2009; Cohen, 1990; Healy, 2001; Kirk, 2005; MacFarlane, 2009; Mullaly, 2010; Nipperess & Briskman, 2009); and critical psychiatric discourses (e.g. Breggin, 1993; Jureidini, 2012; Kirsch, 2010; Maisel, 2016; Moncrieff, 2009; Szasz, 1961, 1970, 1989, 2007, 2008, 2010a,b, Whitaker, 2010. This process eventuated in the discovery of critical realist philosophy, which

informed the next phase of the research process and brought a change in the research direction; exploring the impact of the psychiatric enterprise, especially noting the fundamental influence of *Big Pharma* and what this means for MHSW education, policy and practice. Thus, the interrogation, exposure, interpretation and integration of the extant policy documents, outlined below, inform the CDA (Fairclough, 2001a).

In paying attention to MHSW education, the author reasons that the field of MHSW is not simply psychiatric social work; mental distress spans all areas of social work practice. The journey for MHSW learners begins with their university education, hence the suggestion that this brings with it the potential for the reproduction of powerful discourses, which are those associated with the psychiatric enterprise (Bainbridge, 1999; De Maria, 1992; Morley & Macfarlane, 2010). There is a paucity of literature specific to the domain of MHSW education, although inferences are drawn from research that appreciates critical perspectives and approaches for the Australian MHSW education scene. In the early 1990s, for example, De Maria (1992), offered a comparative analysis of the Australian, American, Canadian and United Kingdom social work education scenes, mapping the trajectory of "radical social work". This analysis evidenced concerns about the lack of a radical approach in the education of social workers (De Maria, 1992) and signified the long-held belief (O'Connor & Dalgleish, 1986 cited in De Maria, 1992) that there is an absence of "education for graduation" (De Maria, 1992, p. 234). Currently, learners express similar concerns in that many believe they are ill-equipped for practice. However, this concern is anecdotal.

De Maria (1992) highlights the need for theoretical sophistication, whereby he argues that this assists in raising possibilities for "radical consciousness" (De Maria, 1992, p. 231) as an ethical imperative for practice. De Maria (1992) acknowledges that the complexities of practice and the pedagogical implications for teaching sit amid the muddy waters of complexity, notwithstanding the place of hegemony within university education. Additionally, De Maria's (1992) insights also reveal the movement of language, originally known as "radical" but now viewed as "critical". Nonetheless, these insights highlight the need for exploring the complexities of social work for practice and remaining vigilant about affiliations between social work's core values and the pedagogical tensions regarding the hegemony that lies within. Thus, De Maria's work has important implications for MHSW education in the twenty-first century in Australia. Others who have contributed more recently to this discussion (Bainbridge, 1999; Morley & Macfarlane, 2010) illuminate the critical MHSW perspective.

The author of this thesis sought, through her study, to advance these contributions in calling for a critical-emancipatory approach to MHSW education, policy and practice. Bainbridge (1999) specifically addresses *Competing paradigms in mental health practice and education,* asserting that postmodernism assists in challenging binary thinking for education and practice. Bainbridge remarks upon the perils of dualism for MHSW, suggesting that "its associated discursive practices can lead to socially constructed distinctions between mental health and mental disorder, normal and criminal behaviour, and madness and civilisation [and that] these distinctions

always imply the existence of *the other* as a reference point" (Bainbridge, 1999, p. 181, emphasis in original). This also brings with it the meaning that the other is "primitive and inferior" (Bainbridge, 1999, p. 181). Therefore, it is argued that the construct of othering, with the potential for "us" and "them" thinking based in the individualist ideology of capitalism (Bainbridge, 1999), is a challenge to be embraced amid pedagogy in MHSW education. Bainbridge (1999) offers some practical points for MHSW education (see Part 2 of the thesis), which assist the re-conceptualisation of MHSW education, policy and practice in the twenty-first century.

More recently, Morley and Macfarlane (2010) argue for the place of the "critical" in MHSW education, policy and practice in their response to the AASW's policy changes that saw the introduction of mental health to the university curriculum in 2012 (AASW, 2012a,b,c, 2014) for qualifying social work programs in Australia. Notably, Morley and Macfarlane (2010) call for the *Repositioning of Social Work in Mental Health: Challenges and Opportunities for Critical Practice*, arguing that "a critical framework...for social work education…knowledge, skills and values associated with critical practice must be more than *desirable* in a social work approach to curriculum development in mental health" (AASW, 2008a, cited in Morley & Macfarlane, 2010, p. 53). In doing so, Morley and Macfarlane propose that MHSWP necessitates a commitment to "critical questioning around taken for granted assumptions" that lie within a dominant paradigm (2010, p. 53, citing Osborne & Gaebler, 1992). They claim that social work educators guide this questioning "as either agents of the state who perpetuate the status quo, or as agents of transformation who create contexts to question dominant practices" (Morley and Macfarlane, 2010, p. 53 citing Wehbi & Turcotte, 2007, p. 4). This attends to the political nature of MHSW, as discussed in Chapter 1 (Bay, 2014; Ife, 2012; Morley & Macfarlane, 2010; Pease, 2013), which is critical to the CDA in Chapter 4, and the implications for MHSW education, policy and practice addressed in depth in Part 2.

Mental health social work and mental health social work education: extant Australian Association of Social Workers policy documents in scope

The documents in scope for the CDA in Chapter 4 focus on the following AASW policy documents that are applicable to the three core areas of education, policy and practice in MHSW:

1. The *Practice Standards for Mental Health Social Workers* (AASW, 2014a)
2. The *Australian Social Work Education and Accreditation Standards V1.4* (*ASWEAS*) (AASW, 2012a) – the national curriculum that guides tertiary social work education in Australia and provides the benchmark for accreditation processes in many of the schools of social work
3. The *Australian Social Work Education and Accreditation Standards, Guideline 1:1*: *Guidance on essential core curriculum content – Section 1, Mental health curriculum content* (AASW, 2012b), containing:
    1.1.1. Attitudes and values
    1.1.2. Knowledge for social work practice
    1.1.3. Skills for social work practice
4. The *Code of Ethics* (AASW, 2010)

5. The *Practice Standards* (AASW, 2013)
6. *Standard 6*: *Communication and interpersonal skills*
7. *Standard 7: Information recording and sharing.*

The *Practice Standards* (AASW, 2013) document is noted as a compendium to the *Practice Standards for Mental Health Social Workers* (AASW, 2014a). This provides a comparative analysis, particularly given that Standard 6 (*Communication and interpersonal skills*) and Standard 7 (*Information recording and sharing*) in the generic standards policy (AASW, 2013, p. 3) are not included in the *Practice Standards for Mental Health Social Workers* (AASW, 2014a). The reasons for the exclusion of the aforementioned Standards 6 and 7 are not given, but the opening lines of the *Practice Standards* (AASW, 2013) intimate that MHSW practitioners are to access these two Standards via that policy document. Thus, it is suggested that both these Standards should be included in the *Practice Standards for Mental Health Social Workers* (AASW, 2014a), as will be addressed in the CDA.

In addition, the author posits that there is disjuncture among these policies, inviting the potential for confusion in MHSW education and practice. Although the *ASWEAS* policies (AASW, 2012a,b,c,d) guide social work educators in curriculum design and the AASW (2013) *Practice Standards* and AASW (2008a, 2014a) *Practice Standards for Mental Health Social Workers* policies guide MHSWP, the latter is more likely to be the policy taught explicitly in MHSW education. *The Code of Ethics* (AASW, 2010) is also a guiding policy, however, while there may be some explicit reference to it as part of the teaching nexus, again the focus is more upon the actual *Practice Standards for Mental Health Social Workers* (AASW, 2014a) document. Therefore, there is not necessarily a comprehensive approach to MHSW curriculum design and education (AASW, 2012a,b,c) .

In addition to the aforementioned policy documents, the extant federal government mental health policy documents outlined in the next section are in scope for the CDA. The discourses and discursive elements (Fairclough, 2001a; Fairclough, Jessop, & Sayer, 2004) contained within these policies also have relevance for MHSW education, policy and practice. Therefore, they are included in the data for the CDA and bring a robust approach through engaging with a historically, culturally and politically located interpretive stance (Denzin & Lincoln, 2011; Dickey, 1987; Garton, 1988; Harvey, 1990; Ravitch & Riggan, 2012). Therefore, the author posits that this approach addresses the multiple layers of MHSWP by questioning uncritical assumptions that are representative of the psychiatric paradigm located in a disease-saturated (illness) model of mental distress. The layers are re-conceptualised in Part 2 in the move toward a critical-emancipatory approach to MHSW education, policy and practice. The research method includes a five stage CDA process (Chapter 4) in which the concepts of interrogation, exposure, interpretation and integration are utilised to avoid a reductionist approach to the policy documents in scope.

Extant national mental health policy documents in scope for this study

1. *The Roadmap for National Mental Health Reform 2012-2022* (COAG, 2012). Compiled by the Council of Australian Governments
2. *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014* (COAG, 2009)
3. *Australian Mental Health Care Classification (AMHCC)* (Commonwealth of Australia, 2015c)
4. *National Practice Standards for the Mental Health Workforce* (Victorian Government, 2013)
5. *Scoping Study on the Implementation of National Standards in Mental Health Services* (ACSQHC, 2014)
6. *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services (CLTC)* (*NMHC,* 2014b). Conducted by the National Mental Health Council.
7. *Australian Government Response to Contributing lives, thriving communities Review of Mental Health Programmes and Services* (Commonwealth of Australia, 2015a).

The *AASW Response to the National Mental Health Commission's Report on the National Review of Mental Health Programmes and Services* (AASW, 2015) is included with these documents for critical analysis due to its contextual relevance. These policies and reports, chosen for their variety in scoping the Australian mental health landscape, focus on reform and plans for, and the review of, service provision and Standards of practice, including the classification of mental health care in critiquing what this means for an ethic of knowledge and care in MHSW and MHSWP. While recognising that the Australian non-government organisation (NGO) sector is large and offers a significant contribution to mental health service provision, the author notes that the enormous volume of policies, even as a representative sample, prevents scoping for this particular study. Nonetheless, federal mental health policies, reports and reviews guide the NGO sector for their services, and there is a minimum requirement to adhere to the *National Practice Standards for the Mental Health Workforce* (Victorian Government, 2013), meaning that MHSW education for MHSWP needs to address the links across the sectors.

Three bodies – the Coalition of Australian Governments (COAG), the Australian Institute of Health and Welfare (AIHW) and the National Mental Health Commission (NMHC) – are major players in national decisions about policy-making in regard to mental health service provision, thereby impacting upon, and influencing, the funding and service provision for mental health across the national mental health scene. Revisiting the place of national agreement about federal policies for mental health service funding and provision, this begins with COAG then the AIHW predominantly formulates, monitors and guides plans and strategies for mental health reform. Thus, reform plans, reports and reviews, and practice standards have the potential to reveal system inefficiencies; their aim is for more cost efficient programs and services, especially for those services receiving, or the NGOs tendering for, Commonwealth funds for mental health service provision. Furthermore, the abovementioned policies, reports, reviews and practice standards seek to address in various ways, people's experiences (in mental distress) of accessing mental health services; however, this is only directly addressed for practice through the *National*

Practice Standards for the Mental Health Workforce (Victorian Government, 2013*)* which aim for saturation across all services. As discussed previously, mental health social workers are situated in many of these services, which respond to a variety of states of mental distress regardless of whether these policies are in place or simply are not referred to as part of service provision. Drawing on her prior practice experience, the author suggests it is quite common for most practitioners (including mental health social workers) not to know the existing policies, let alone their content. Thus, there is limited awareness about the direction policy may provide for informed, ethical practice that offers potential occasions to question the status quo.

State and Territory mental health services provide psychiatric (medical) and allied health services, which have had an overarching focus on Recovery since the 1990s (Anthony, 1993, 2000, 2007; Davidson et al., 2005; Davidson et al., 2006), together with some rehabilitation programs that tend to come and go depending on continuation of funding. Nonetheless, the recent *Australian Government Response* (Commonwealth of Australia, 2015a) to the NMHC's (2014b) *CLTC* sheds some new light on policy reform that aims to realign current arrangements in government mental health services and assumes a flow-on effect to the NGO sector. While on the one hand policy reform suggests changes to service provision, on the other hand there are concerted efforts to align MHSWP with neo-liberalism in terms of funding efficiencies. Hence, a critical-emancipatory approach grounded in an ethic of care toward growth and change avails practice possibilities that are sustainable across the complexity of people's lived experiences of mental distress. This, too, is important for people experiencing more severe forms of mental distress over extended periods of time (chronicity), the forensic mental health area being one example. MHSW practitioners are located within this sector too, yet MHSW education tends not to be directed toward practice that appreciates the intricacies of navigating the complexities associated with "incorrigible" (Pilgrim, 2015b) behaviours.

Thus, the reports and reviews of the issues in service provision and areas for improvement in mental health reform since the early 1990s have significance for MHSW and MHSWP. The issues relate to people's poor experiences of services and the lack of response from the mental health system that is in place to serve them in their lived experience. Significantly, there remains a need for changes in mental health service provision in Australia (NMHC, 2014); a situation that is not new (Burdekin et al., 1993). Furthermore, the apparently high financial investment in contributing to the improvement of people's lived experience has led to minimal difference. This outcome can be attributed to a lack of agreed or consistent national measures about what constitutes effective mental health service provision. Given that MHSW education in its current configuration is grounded predominantly in a bio-psychiatric, disease-saturated (illness) paradigm, it is time for the CDA offered in this study.

The research quest

Logic will get you from A to B. Imagination will take you everywhere
(Albert Einstein, 1879-1955)

While the author assumes that MHSW education has some level of commitment to exploring critical social work theory and approaches, for example structural accounts relating to the impact of neo-liberalism on social work, others have developed the uncritical assumption that there is a consensus about ways forward in education, policy and practice (Bland et al., 2009, 2015; Harries, 1999, 2013; Healy, 2012; Karban, 2003, 2011). This study was prompted by the minimal Australian literature on offer, suggesting lack of consensus about ways forward for MHSW and MHSWP, given the earlier discussion (Bainbridge, 1999; De Maria, 1992; Morley & Macfarlane, 2010). This section indicates the author's situated perspective in this research journey to fulfil the need to state unambiguously how her position has shaped the study.

> *The journey, from what I originally embraced as a logical thinking nurse moving from A to B, is now one of embracing the imagination that social work offers, taking me everywhere, now too espousing hope as an early career researcher. I wrestle with and explore epistemological notions, serving as the foundation for a depth of understanding regarding prominent critical theorists and their relevance for critical-emancipatory MHSW theory and praxis. This transforms visions for social work education, policy and practice. Hence, in becoming more informed about the current bio-psychiatric, disease-saturated (illness) paradigm that remains inherent in MHSW, this study is driven by a body of theory that relates in one way or another to the world of MHSW; a world well known to me as both a practitioner and educator. I adopted an emergent approach to the literature, thus accepting the need to adapt the inquiry as my understanding deepened, inviting the pursuit of new paths of discovery.*
>
> *Denzin and Lincoln's (2011) seminal text, The SAGE Handbook of Qualitative Research, is a poignant primer to the "what" and "how" of my position as the researcher in this study. It provided me with a dynamic and valuable introduction to major theorists in the area of qualitative research. It also reinforced the diversity of methods and the fundamental place of a critical context, in that "a critical framework is central [in privileging] practice, politics, action, consequences, performances, discourses, methodologies of the heart, and pedagogies of hope, love, care, forgiveness, and healing" (Denzin & Lincoln, 2011, p. x, citing Pelias, 2011, and Dillard & Okpalaoka, 2011). My situated perspective, as a researcher, sits amid a passion, guided by an ethical stance, to support the liberation of people, many of whom are marginalised and stigmatised as a result of social and professional ignorance. This brings "the burn" to engage in asserting the many possibilities that lie among the realms of theory, pedagogy and practice. Similarly, my connection with a long established habit of a critically reflexive process (Fook, 2012; Fook & Gardner, 2007; Schön, 1995) from social work field practice aided my confidence to assert my presence as a researcher within this study.*

Equally important is the researcher's visibility in the research process. The work of Clarke (2005) and Charmaz (2007, 2014) influenced my approach to the study's methods. Clarke's (2005) situational analysis complements both the historical and contemporary lines of argument I have chosen, prompting mindfulness about the importance of people's lived experiences amid the place of history. Clarke, inspired by Wright Mills, also serves as a guide for the CDA in my research journey:

> … (w)e have come to see that the biographies of men and women, the kinds of individuals they variously become, cannot be understood without reference to the historical structures in which the milieux (sic) of their everyday life are organized. (Wright Mills, 1959, p. 158, cited in Clarke, 2005)

Acknowledging the place of people's lived experiences of emotional pain over the course of history requires, Clarke (2005, p. 13) suggests, "accountability by the researcher to be reflexive of one's own (privilege) prior knowledge and experiences". However, this must not be at the expense of "personal bias" (Strauss & Corbin, 1998 cited in Clarke, 2005, p. 13), in which the study becomes more about the researcher than those the study is intended to serve. Notwithstanding the fact that I bring prior experience, Clarke (2005, p. 13) notes that this is "valuable rather than hindering" because "we" cannot erase prior knowledge and experience. Judiciously infusing a little humour here, Clarke adds "there is something ludicrous about pretending to be a 'theoretical virgin'" (2005, p. 13 citing Loescher as quoted in Elkins, 2003, p. 31). In other words, the researcher is aware of the potential for bias and seeks to act with integrity by remaining reflexive throughout the research undertaking. Furthermore, Clarke (2005, p. 12) posits that in the "postmodern turn [it is indeed] unacceptable" for a researcher to stay quietly in the background because our "interpretive" presence is unavoidable. Here I note Clarke's poignancy in saying the researcher is "an actor, designer, interpreter, writer, co-constructor of data, ultimate arbiter of the accounts proffered, and…accountable for those accounts" (2005, p. 12). Therefore, in accepting this about myself as the researcher in this study, I am visible (Clarke, 2005) and interpretive, and therefore adhering to notions of reflexivity (Clarke, 2005; Dominelli, 2002; Fook, 2012; Fook & Gardner, 2007; Gould & Taylor, 1996; Payne, 2014; Pease & Fook, 1999; Yelloly & Henkel, 1995) and reflection. This accountability commits to an ethical stance, both for me as a researcher and for the research undertaken.

Reflexivity and reflection have become relatively well known to social work practice, mostly in the last ten years during which time Fook has written extensively in this area (Fook, 1996, 2012; Fook & Gardner, 2007). Arguably, there is probably greater awareness of reflection in terms of practice than of reflexivity. Elaborating on Clarke's (2005) notion of visibility, Fook (2012) discusses the context for social work research, suggesting that although reflexivity and reflection are interrelated, they are not one and the same. Reflexivity originates in social science research whereby it "refers more to a *stance* of being able to locate oneself in the picture, to appreciate how

one's own self influences the research act" (Fook, 1999b cited in Fook, 2012, p. 49, emphasis in original). This has the potential to be "more complex than being reflective" (Taylor & White, 2000 cited in Fook, 2012, p. 49). In contrast, "reflection" or "reflectivity" tends to be associated with practice, originating from Schön's (1995) work whereby the practitioner explores the influence of his/her assumptions, values and perspectives in the context of knowledge and practice.

While these are important distinctions in terms of my situated position and perspective in this study, the interrelationship of these two concepts provides for my ability to bring a "reflexive stance" to the research process as a researcher, while at the same time utilising reflective moments regarding my situated perspectives. Indeed, this reflexive process is influenced also by Harding's (2008, p. 291) standpoint theory, a "feminist critical theory of the relations between knowledge and power". In my case, this resulted in a standpoint that supports a critical-emancipatory approach to MHSW education, policy and practice; an approach incorporating socially just and humanitarian intent, whereby this study seeks to strengthen, reinforce and sustain the relationship between AASW mental health policies, education and practice. Furthering understanding of MHSW supports emancipatory intent through enacting knowledge and praxis to alleviate the conditions that impact upon people's emotional distress at the broader systems level. This forms the basis of the Part 2 discussion about re-conceptualising MHSW education, policy and practice.

Research influences

There is a multitude of influences impacting MHSW research. However, the greatest impacts are based in feminism and critical thinkers in sociology, psychiatry, psychology and social work. Woven amid critical perspectives is that of CR, together with the thread of Fairclough's linguistics (1989, 1992a,b, 1995, 2000, 2001a,b, 2003, 2006, 2010; Fairclough & Fairclough, 2012; Fairclough et al., 2002, 2004) and Bacchi's (2009) approach in *What's the problem represented to be? (WPR)*. This assists reflexion upon the politics of the representation of problems, issues, matters and the like, together with the language and thinking about the characteristically cruel terms used to describe people with a lived experience – madness, illness, lunacy, idiocy, insanity and so on.

Furthermore, navigating the waters of colonialism and the ripple effect on the Australian histiographical mental health scene directs the discerning researcher to social control theory (Garton, 1988) to consider alternative viewpoints about the journeys of the afflicted. This enables the scaling of heights in hovering over CR's potential to rupture and re-conceptualise the Australian *Practice Standards for Mental Health Social Workers* (AASW, 2014a). Importantly, trauma-informed theory shines the light on the ontological and emancipatory possibilities for MHSW learners, notwithstanding the potential for extending MHSW practitioners' practice wisdom (Samson, 2014). Equally important theories that inform and provide the basis for the critical-emancipatory, critical realist approach used in this study were discussed in-depth in Chapter 1.

Introducing critical realism in the critical discourse analysis for mental health social work

Further to the opening discussion in Chapter 1, CR is relatively new to the realm of social work and provides a philosophical perspective that assists in challenging the status quo of the psychiatric enterprise and within it the sprawling tentacles of *Big Pharma*. The influence of CR in social work stems from the work of Houston (2001) and Oliver (2012). Houston (2001) posits that social constructionism has limitations for social work, while more recently Oliver (2012) maintains that CR serves social work research well because it easily enables the bringing together of theory and practice; thus, it is immediately plausible. Additionally, Oliver (2012, p. 384) reveals the ravine between social work practice and research, emphasising the need to "support the development of practice cultures that value research". In concurring with Oliver's view about introducing the benefits of CR for social work research and practice, the author of this thesis seeks to contribute to narrowing the divide in the ravine between research and practice through MHSW education. Critical realism offers the grounds for questioning not just the epistemological notions that lie amid notions of mental health and distress, but also the ontological edge that is conducive to reflective, humane (ethical) practice. Consequently, this lays new foundations for re-imagining the possibilities for ways forward in MHSWP.

An important distinction to make here is that this is separate from re-imagining ways forward for the people served by mental health practice – the citizens of the State (Ife, 2012). Rather, this study's focus is aimed at myself and all my fellow MHSW professionals to make us reflect upon the theoretical and practice paradigms to which we are very often exposed automatically, as well as the policies and Standards that guide us in the practice we undertake, by choice, when serving people in distress. I contend that our automation as mental health social workers glides seamlessly to the current, dominant, bio-psychiatric, disease-saturated (illness) paradigm.

A critical realist interpretation, embedded in the five stage CDA (Fairclough, 2001a) for this study, assists in establishing the MHSW learner and/or practitioner at the centre of pedagogy and policy by locating them amid the layers that promote or constrain their capacity for decision-making in daily practice. The discussion in Part 2 addresses ways forward for conceptualising and re-conceptualising (for established practitioners) theory from a critical realist standpoint, and practice from a trauma-informed approach (Bloom, 2013a,b; Bloom & Farragher, 2011, 2013), all of which adhere to socially just notions of relationship- and rights-based MHSWP. Critical realist epistemology and ontology assists with bridging the gap between education, policy and practice through providing a realist approach that reaches across both ideology and practice.

Language and linguistics: associations and influences for mental health social work education

Scrutiny of the literature on linguistics (Chouliaraki, 2006; Chouliaraki & Fairclough, 1999; Fairclough, 1989, 1992a,b, 1995, 2001a,b, 2003, 2010; Fairclough et al., 2004; Wodak & Meyer,

2009) reveals the connections with the language of the world of mental distress. It also reveals what this means for educating MHSW learners. Language and semiosis (meaning) has a substantial impact on how the mental health industry interprets situations, together with the meanings that are placed upon people experiencing effects associated with prior, or current, trauma. The way a whole industry interprets the language of mental distress impacts and influences MHSW learners (for example, when they undertake their field placements), and established practitioners. This provides the basis for the author's decision to pay closer attention to words that equate to mental *distress*, rather than accepting the status quo of *illness*, notwithstanding the possible impact of the meaning of *health* in situations of mental stress or distress (Fawcett, 2012). All of this begs the question: So what is mental *health*? Is the word "health" a faithful and reasonable attribution when attempting to understand what is occurring in situations that impact upon people's state of mind, for example in situations of trauma. The author argues that mental health social workers equate health with some sort of *normal* state, which leads to binary thinking about people's stress. As discussed briefly earlier in this thesis, mental stress, to the point of extreme distress, occurs on a continuum varying from "stressed out", for example, where people can manage the level of stress (or distress), toward an extreme point where people may experience thoughts that impact upon their ability to cope with life's daily pressures. The way professionals, from whom the lay public seek opinions, define, discuss and describe these states of distress contributes to the status quo (Pilgrim, 2015b). Hence, there is a need to acknowledge that the MHSW language social workers use to define, describe and discuss people's emotional states currently sits within the bio-psychiatric, disease-saturated (illness) paradigm; this equates with a health/illness paradigm rather than a trauma-informed paradigm. This must change. Ways forward form the discussion and recommendations for MHSW education, policy and practice in Part 2 of this thesis.

The research method: critical discourse analysis

This qualitative study exposes, and analyses, a variety of policy documents and reports, sourced from publications by the Australian federal government and the AASW that underpin MHSW education, policy and practice in Australia. Therefore, this study is one of theoretical sampling, which exposes and examines the MHSW discourse within the texts of these policies and reports. Fairclough's (2001a) five stage analysis approach provides an analytical framework for the CDA, offering the basis for a close examination of the text in the policy documents and reports. Fairclough (2001a) posits that his five stage analysis is sympathetic to a critical methodology; a claim that assisted the author's decision to use it in establishing the analysis for the study. The document examination enabled the author to discern obvious and less obvious meanings, and to establish that the order of discourse (even subtly) influences both ideology and practice. Indeed, as Fairclough (2010, p. 56) demonstrates, there is a relationship between language and ideology. Ideology is in both "language structures" and "language events". He subsequently posits that it is

essential to take into account the potential for language to be "located" in ideology when considering "the wider framework of theories and analyses of power" (2010, p. 56). Fairclough (2010) also hails Gramsci's hegemony (Bates, 1975) as enriching for this process. Hence, this study is buttressed by the work of Fairclough, together with Gramsci's hegemonic tones, in determining that the dominant bio-psychiatric, disease-saturated (illness) ideology and its practices are deeply entrenched in MHSW. This is indicated further in the language contained in the policies on offer for MHSW education and practice via social work's professional body, the AASW.

The fifth stage of the CDA offered by Fairclough (2001a) incorporates CR as an essential feature within a CDA's interpretivist nature; another reason for choosing this method. Although the analysis fundamentally adopts Fairclough's five stage analysis, there is some adaptation. While Fairclough incorporates a critical realist interpretation as part of the critical reflection in the fifth stage, only in his later work (Fairclough, 2010) does he add the depth required to advance his argument in regard to ontology; an essential feature of a critical realist interpretation. Therefore, this study seeks to build on Fairclough's work by introducing the ontological edge the author believes is paramount for MHSW education and practice.

Thus, the main approach in this study is both theoretical and interpretive in nature (Altheide & Johnson, 2011). Accordingly, it is a theoretically constructed process (Fairclough, 2010) whereby exposure to rich sources of textual data extends interpretation to multiple perspectives. In addition, while the CDA of extant federal government and AASW documents utilises Fairclough's (2001a, 2010) analytical framework, it is imperative to note that this process is not chronological:

> … stages or steps in the methodology (may be identified) only on condition that these are not interpreted in a mechanical way: these are essential parts of the methodology (a matter of its 'theoretical order'), and while it does make partial sense to proceed from one to the next (a matter of the 'procedural order'), the relationship between them in doing research is not simply that of sequential order. (Fairclough, 2010, p. 234)

Therefore, although the methodological approach for this study contains some sense of order in its processes, there is a need for circularity in the progression of the analysis and its argument (Fairclough, 2010).

Explanatory critique: the critical realist edge in the critical discourse analysis

Fairclough's CDA framework is bolstered by Bhaskar's "explanatory critique" (Bhaskar, 1986 cited in Fairclough, 2010, p. 235), which is assisted through "the theory of explanatory critique [opening] up the exciting possibility that we may be able to discover *values*, where beliefs prove to be *incompatible* with their own true explanation" (Bhaskar & Collier, 1998, p. xviii). Oliver (2012) simplifies this in her clarification of explanatory critique, using the example that it "will illuminate the disjuncture between the belief that social workers burn out because they are 'bad workers' and the structural causes of burnout are in organisational factors like demand overload and inadequate support" (Maslach et al., 2001 cited in Oliver, 2012, p. 376). In other words, explanatory critique,

formed from the roots of CR, “goes beyond surface tinkering…to tackle the deeper roots of needs and false beliefs” (Oliver, 2012, p. 376).

In essence then, Fairclough (2001a, 2010) provides the framework for the CDA of the documents chosen for this study, while Bhaskar’s (1975) work closely equates with social work because of it being “complex and multi-layered” (Oliver, 2012, p. 374), and thus offering explanatory critique. The explanatory critique explores the mechanisms (Danermark et al., 2002) that contribute to the dominant psychiatric discourse, thereby laying the foundations for informing Part 2 of this study.

Five Stage Analysis – adapted from Fairclough

Stage 1: Focus upon a social problem that has a semiotic aspect

Although Fairclough (2001a, p. 236) uses the term “problem” in his first stage, the author of this thesis chooses to use the word “issue” in keeping a focus on the particularities of language and ensuring difference from the *WPR* approach for problematising (Bacchi, 2009). The author has made this change in support of Fairclough’s view, which invites reflection upon the language social workers use because it creates meaning that unfolds in the second stage. So often, the word problem brings with it the connotation that there is a problem, when sometimes there is not. Although Fairclough is framing a “social” problem in the broader sense, the author is mindful that the purpose of this study is to offer an opportunity for mental health social workers to reflect carefully about the connotations of the language they use to define, describe and discuss human beings’ plight at both the micro and macro levels. Nevertheless, Fairclough’s first stage offers the opportunity to focus upon a broad discourse-related issue, which this study seeks to do. The analysis exposes in detail the predominance of a bio-psychiatric, disease-saturated (illness) discourse in the text of a selection of extant federal government and AASW documents, all of which hold relevance for MHSW. Examination of the content and context of the discourse provides data for uncovering the possible implications of current practice while offering information for unveiling new ways forward in MHSW practice in addressing the ontological edge.

Fairclough (2001a) argues that discourse is representative of not just the language used in texts, as with the documents utilised for this study, but is also indicative of the ideology within. He explains that “also inherent to discourse is the dialectical relation of structure/event [in that] discourse is shaped by structures, but also contributes to shaping them and reshaping them, to reproducing and transforming them” (2010, p. 59). In addition, Fairclough (2010, p. 59) suggests that discourse occurs across three main areas; “social practice”, the manufacturing of text together with its dissemination, and how it is interpreted. This orders the place of ideology in a bio-psychiatric, disease-saturated (illness) paradigm. The manufacturing of MHSW text in all its forms draws on the influence of psychiatry, for example in policy-making, while a prominent example of the dissemination of discourse is via the psychiatric *DSM-5* (APA, 2013). The dialectical relation between the structures and events shapes individuals’ perceptions about how discourse is

received and understood, and its subsequent reproduction, for example, how mental health social workers interpret, represent and reproduce a bio-psychiatric, disease-saturated (illness) paradigm. While it is not just upon the individual per se, it is the combination of these factors that serve to reinforce the current bio-psychiatric, disease-saturated (illness) status quo in the mental health industry.

The analysis pays attention to these factors through the lens of interrogation, exposure, interpretation and integration of the data while taking heed to avoid a reductionist approach, all the while reflecting on the possibilities within the aim of re-conceptualising and re-newing perspectives and approaches appropriate to MHSW. Similarly, in Part 2, the author addresses these matters across the areas of education, policy and practice with the aim of integrating ways forward for MHSW.

Stage 2: Identify obstacles to the discourse-related issue being examined

The second stage analysis involves analysing the networks of practices in which the issue under examination is located, as well as the semiotic aspects of related obstacles (Fairclough, 2001a). Fairclough (2001a) provides a complex and informative account of semiosis, acknowledging the influence of Ferdinand Saussure's original work in this area. Assuming the complexity of semiosis, its depth extends beyond the scope of this thesis. However, a modest account of semiosis follows in order to explain its importance for the purposes of this study's CDA, and in respecting that it is vital to a critical realist approach.

In essence, semiosis is fundamental to "meaning-making" (Fairclough, 2010, p. 234), which comprises three elements – "visual images, body language and verbal language" – insofar as these assist "intersubjective" meaning. This does not mean that an interpretation of "reasons" for things (Fairclough, 2010, p. 234) should be oversimplified to cause and effect. Rather, it involves a complex and far-reaching network within "social life and social practices" (Fairclough, 2010, p. 234). For example, in the mental health industry it consists of the interspersing of social *life* and social *practices*. In other words, these concepts comprise the network of professionals associated with MHSW, their actions, words, behaviours, conversations and reflections, together with the textual elements (such as policy, speeches and meetings) that occur within it. Fairclough (2001a, 2010; Fairclough et al., 2004,) refers to these elements as "intersubjective" and "intertextual". The analysis for this study exposes these intersubjective and intertextual elements through an interpretive lens, with the author ever mindful and reflecting on the likelihood that it is neither possible nor realistic to be all encompassing.

Stage two flows from stage one in enabling the identification of hindrances that may lie in the network of practices and relationships (Fairclough, 2001a), and how these are embedded in the life and practices of mental health social workers, for example. The CDA of the various documents in this study examines the order of the bio-psychiatric, disease-saturated (illness) discourse, thereby exploring the context and the obstacles that may be preventing change. The

analysis includes an exploration of the representation of the bio-psychiatric, disease-saturated (illness) discourse, in and of itself, to highlight what this might be for the meaning-making that occurs in MHSW education, policy and practice.

Stage 3: What does the social order gain from the discourse-related issue?

Stage three offers the opportunity to contemplate what the social order gains from the discourse-related issue. The aim here is to question whose needs are being advanced in wanting to maintain the current order of discourse and, Fairclough (2001a) theorises, in whose interest is it to keep things the way they are? The CDA within this study identifies several explanations for the entrenched bio-psychiatric, disease-saturated (illness) perspective as the dominant ideology that impacts upon and implicates MHSW, beginning with the historical roots that potentially continue to blur the past with the future. It also locates *Big Pharma* as an entrenched business in contributing to madness, thereby creating the need to maintain the current social order and the "mystery" (Pilgrim, 2015b) that surrounds the variety of explanations for it. In rupturing the variety of notions that surround the social order and the hegemony within the mental health arena, several prominent critical thinkers in that arena strengthen and reinforce the CDA, as identified earlier in Chapter 1.

Stage 4: Identify the opportunities for possible ways forward in moving past the discourse-related issue

Stage four, in identifying the opportunities for possible ways forward in moving past the discourse-related issue, moves the gaze to the "contradictions that exist" (Fairclough, 2001a, p. 239), for example, in the way madness is understood. Hence, this encompasses the theories and practices that transpire in determining the associated meaning amid explanations about various states of mental distress and the resulting interventions. This stage differs from the other stages in that it entails a change in emphasis beyond the network of practices within which the dominant bio-psychiatric, disease-saturated (illness) discourse is embedded, to explore inconsistencies (Fairclough, 2001a). An example is the epistemic fallacy from CR (Archer et al., 1998), whereby Pilgrim (2015b, p. 42), in a chapter on *Madness in Context*, clearly notes the "narrow preoccupation with epistemology [while not] denying that language remains important". Equally, Pilgrim (2015b, p. 6) states that "psychiatrists confuse reality with what they call reality" [in] "reifying" signs and symptoms, thus constituting the epistemic fallacy. Further, it is important that this stage address the matters raised in Stage 2 to maintain clarity and consistency of the analysis, thereby assisting in "identify[ing] ways past the obstacles" (Fairclough, 2001a, p. 236).

Stage 5: Reflect critically on the analysis in the four prior stages

Stage five's critical reflection is essential for the following reasons. First, it is imperative to consider that the CDA meets the study's objective, which is to focus on what lies beneath the order of the discourse in identifying obstacles created for MHSW education, policy and practice by the dominant bio-psychiatric, disease-saturated (illness) discourse. This process exposes knowledge

of the realities of power relations held by psychiatry and *Big Pharma*, which are inherent in the organisational structures that support MHSW's processes and practices. Equally, this involves a critical realist interpretation of the policy documents to build new knowledge from a MHSW perspective.

Second, as the researcher in this process, it was imperative that I remained ever conscious of where I was situated in the analysis, as explained previously in the section titled "The research quest". I constantly reminded myself of my own biases within the MHSW arena, and my influence on the research process. Consequently, I made a commitment to transparency and an awareness of my own subjectivity from personal and professional experiences from which I aimed to contribute to, and consolidate, the analysis; an approach supported by Fook's work on critical reflexion in MHSW approaches (Fook, 2012; Fook & Gardner, 2007). "Critical curiosity" (Fook & Gardner, 2007, p. 163) pushes the social work researcher to go beyond "the adoption of a single epistemological and methodological position [in meeting] the demands of ethical and competent [research] practice" (Fook & Gardner, 2007, p. 163). Hence, I situated myself within Stage 5 of the CDA from a position of adopting and sustaining critical curiosity, which occurs through the process of questioning the status quo of the extant dominant psychiatric, disease-saturated (illness) discourse. This questioning leads to analysing power relations inherent in the discourse, exposing the potential for the creation of negative experiences occurring amid people's lived experience when seeking help. The implication here is that in not accepting current ways of knowing about people's lived experience uncritically (Fook, 2012) means moving away from binary thinking toward epistemological and ontological notions of "both/and" (Clarke, 2005), as well as "either/or".

Interrogating, exposing, interpreting and integrating: avoiding reductionism

The author makes a clear and conscious commitment to avoid a reductionist argument, favouring interrogation, exposure, interpretation and integration of the discourse. A critical realist approach provides the interpretive stance, with interrogation and exposure forming the method in the CDA. Integration is achieved through the whole research process, embracing the many threads that weave the study together, culminating in recommendations for alternative ways forward for MHSW to contribute to the continuing struggle toward the liberation of people affected by varying degrees of emotional pain. These are the threads of epistemology, the CDA and the re-conceptualising of the *Practice Standards for Mental Health Social Workers* (AASW, 2014a), and of the pedagogical, policy and ontological considerations within this.

Another essential point, emphasised by Charmaz (2014) in asserting a constructivist approach, is that there is reflection and regard for multiple definitions of reality while at the same time remaining open to all possible theoretical understandings that scaffold this study. Clarke's (2005) work in *Situational Analysis* complements Charmaz' (2014) approach in that Clarke (2005, p. 155) explicitly places the researcher in the foreground of the analysis in the research process,

stating: “what the researcher is choosing to feature, to attend to most, to write most about”. Thus, Clarke justifies the centrality of my presence in my positing of this study’s theoretical underpinnings and attributing meaning from the discourse analysis.

It is reasoned that the process of researching, refining and critiquing the literature remains continuous throughout the entire study. Integral to the requirement of keeping abreast of contemporary debates, the research process assists reflexion (Fook, 2012) upon the shaping and refining of the research, while bringing rigor to the investigation (Ravitch & Riggan, 2012). Likewise, rigorous research requires a sound conceptual framework offering clarity to the study’s methodological underpinnings, theoretical foundations and data analysis (the CDA).

Chapter summary

This chapter has identified the research field, the research quest, the approach and the method chosen for this study. The research field maps the key elements that impact MHSW education, while the research quest notes the contemporary assumption that there is consensus about ways forward for MHSW education, which has implications for MHSW policy and practice. Here, the researcher meets with the quest to make new links across these three core foci of education, policy and practice, thus locating the self-as-researcher in the research journey. The research approach introduces the place of CR in MHSW, buttressed with the five stages of CDA adapted from Fairclough (2001a) as the method chosen for scoping a variety of mental health policies and reports. In addition, CR’s explanatory critique (Bhaskar & Collier, 1998) advances understandings about the epistemic fallacy (Archer et al., 1998), which lies in the various knowledges implicit in bio-psychiatric, disease-saturated (illness) discourses that so often remain unquestioned. Therefore, this process seeks to rupture the bio-psychiatric, disease-saturated (illness) paradigm inherent in MHSW through problematising the psychiatric enterprise for rebuilding, thereby re-conceptualising an emancipatory commitment toward rigorous attention to pedagogy. This commitment includes a learner focus centred on relationships that are trauma-informed, rights-based and socially just.

CHAPTER 3:
RUPTURING PSYCHIATRIC SOCIAL WORK

> It is, of course, quite clear that to understand a slow-moving society, trapped for centuries in a cycle of poverty and tradition and disease and ignorance, requires that we study the historical ground, and the persistent historical mechanisms of its terrible entrapment in its own history. (Wright-Mills, 2000, p. 155)

Chapter 2 outlined the methodological approach used for this study, introducing the notion that an emergent approach to the literature affords the opportunity for new insights and understandings about mental health social work (MHSW) in Australia. This chapter explores a variety of narratives in some key histiographical literature toward deepening mental health social workers' insights regarding the journey toward the introduction of psychiatric work in Australia. The background to, and development of, institutions, legislation and services for people in mental distress – how the bio-psychiatric, disease-saturated (illness) discourse and practices have become enshrined in policy and service provision – are investigated. The connections and developments among policy, legislation and practices in Australia that relate to mental health are also explored, with these connections also taking account of the social context of the times in which these developments occur.

This discussion of the historical journey leading to the commencement of MHSW in Australia, utilising a critical realist stance, reveals through a social control perspective the introduction of the psychiatric enterprise, thus locating psychiatric social work. The socio-historical narrative situates the place of discourse, noting the language of the era and the place of fear in notions of othering, resulting in further marginalisation. Accounts spanning histiographical writings, administrative, legislative and medical views reveal how the presence of the bio-psychiatric, disease-saturated (illness) model in mental health has occurred in Australia. Importantly, the socio-histiographical narrative offers an alternative account to the powerful discourse that is inherent in numerous interpretations that surround a bio-psychiatric, disease-saturated (illness) perspective.

Ephemeral consideration is given to the Australian Association of Social Workers (AASW) policy documents, which provide the entry point of MHSW in Australia. The introduction of the concept of critical realism (CR) provides an ideological foundation in terms of assisting the explanation of the presence of the bio-psychiatric, disease-saturated (illness) paradigm in these documents, most particularly those for education and practice. These documents form the basis of the critical discourse analysis in Chapter 4.

The exploration demonstrates the emergence of the bio-psychiatric, disease-saturated (illness) paradigm within social work, utilising a critical realist stance for questioning what have now become contemporary assumptions about mental distress and disturbance. It also demonstrates the trajectory toward, and reveals reasons for, the influences of this dominant paradigm in MHSW

policy for education and practice. This exploration serves to deepen understanding, as Wright-Mills (2000) so ably informs, about the historical ground that lies at the base of the persistent historical mechanisms that reinforce the bio-psychiatric, disease-saturated (illness) status quo in contemporary MHSW education, policy and service provision.

Therefore, established in detail, are the roots of social work in Australia leading up to the introduction of psychiatric social work, the journey of the inauguration of policies for MHSW education and the *Practice Standards for Mental Health Social Workers* (AASW, 2008a, 2014a), and the place of ethics in MHSW practice. This assists historical appreciation of the situation and facilitates the process of determining new ways forward for education, policy and practice in MHSW.

Locating the historical journey of mental health social work in Australia: a critical realist approach

The historical and cultural context within which mental distress occurs influences MHSW education, policy and practice. Therefore, endorsing a critical realist approach in MHSW education, policy and practice in Australia requires the exploration of historical ideas and the cultural hegemony that contributes to extant beliefs and assumptions about mental distress. Documented accounts cannot be viewed in their entirety without considering the cultural and historical representations of their time (Clarke, 2005). Furthermore, an analysis of the various discourses would not be comprehensive without also paying attention to other attributions used over the course of time for describing mental distress; for example, the centrality of language in representations of mental distress. As stated previously in this thesis, the critical discourse analysis (CDA) in Chapter 4 exposes the place of language and power relations in mental health, and MHSW is subsequently re-conceptualised and re-newed across the three areas of education, policy and practice in Chapters 5 and 6.

This study is not a lineal historical account of the development of the tradition of psychiatry. Rather, it seeks to challenge traditional, long-held beliefs about madness. In doing so, it underpins one of the aims of this study; the place of CR in coming to new understandings about MHSW. The historical context is established through a historicist (Harvey, 1990) interpretation of the narrative of madness – its depictions, descriptions and meanings – woven together over time from the narrative threads of history, entwined with culture in seminal texts, policy documents and the scholarly literature. While an interpretive stance illuminates the exploration and evaluation of these threads (Gorski, 2013; Harvey, 1990), this stance needs further qualification. Despite the author's profound efforts to provide a distinguished, insightful and judicious interpretation of the textual accounts, it is neither possible nor wise to believe that all avenues have been exhausted (Gorski, 2013). Why? The complex and ambiguous nature of the social sciences, and the very nature of being human, means that things are ever-changing. In accepting this reasoning, having an optimistic view of the capacity for understanding and re-understanding the interpretation of

emerging themes and narratives offers endless possibilities. This means exploring the endless possibilities for the respectful consideration of people touched by mental distress while never losing sight of the emancipatory intent as a researcher and practitioner (Bhaskar, 1986, 2009; Gorski, 2013; Harvey, 1990; Houston, 2001; Oliver, 2012; Pilgrim, 2015b).

This study centres on MHSW within the Australian context, regarding its early beginnings and the inauguration of social work into the arena of mental health. Reference is made to the United States of America, Canada and the United Kingdom for comparative purposes, particularly given their early influences upon the Australian social work scene. The madness narrative cannot be anticipated, even in its humble incompleteness, without first prefacing it with Foucault in *The Archeaology of Knowledge* (2010, pp. 32-33), where he lays bare the powerful presence of the legal and medical professions, and the religious influence on knowledge and practice:

> The unity of discourses on madness would not be based upon the existence of the object 'madness', or the constitution of a single horizon of objectivity; it would be the interplay of the rules that make possible the appearance of objects during a given period of time: objects that are shaped by measures of discrimination and repression, objects that are differentiated in daily practice, in law, in religious casuistry, in medical diagnosis, objects that are manifested in pathological descriptions, objects that are circumscribed by medical codes, practices, treatment, and care.

Hence, it is with caution that one interprets not only the historical discourse of madness (Clarke, 2005) but also social work's place amid this; caution surrounding the interpretation of the constitution (Foucault, 2010) of the variety of discourses relating to madness in Australian ideology, policy and practice. Indeed, caution is needed regarding the relationships between ideology, policy and practice in the way they play out in the various health and legal professions. This must include social work. Furthermore, in "studying what is rejected and excluded" (Foucault, 1998, p. 335), there is recognition of a principled obligation to scrutinise disruptions. Therefore, the effect of such scrutiny furthers epistemological and ontological enquiry, and so the endless commitment toward emancipation of those who suffer the effects of mental distress lies at the heart of the disruptions. These disruptions lie within the realm of MHSW.

The early beginnings of social welfare in Australia – the forerunner to the introduction of the mental health scene

Various historical writings related to the responsibility for social welfare in Australia bring a variety of perspectives, and, in the main, include comparisons with the British system. This is particularly so because the arrival of the first fleet to Australia in 1788 from Britain saw the beginning of colonisation in this country. The Australian historical literature pertaining to social welfare appears to spread predominantly across three main realms; administrative (governmental) matters, the medical presence and the associated social implications since colonisation (Bostock, 1968; Cummins, 2003; Dickey, 1966, 1987, 1992; Garton, 1988; Geyer, 2009; Kimber, 2013).

This discussion outlines some of these significant events and struggles over the course of Australian history to date, relating to the passage of legislation, policy and practices that result in intervention into the lives of people experiencing mental distress. These events are explored in the context of the various accounts of administrative and legal decisions, the centrality of a medical presence in these, and the social implications for people who are either not permitted (e.g. convicts) or not able to care sufficiently enough for themselves. This provides the background for gaining an understanding about the introduction of psychiatric social work in Australia, and the fertile soil for the struggle toward further deliberations in regard to respectful policy and practice in the twenty-first century.

Colonisation: British instructions for the New South Wales colony mean survival of the fittest

The first fleet, led by Captain Arthur Phillip, arrived on Australian shores from Britain in 1788. King George III, in his *Draught Instructions for Governor Phillip* (Thompson, 2006)[2], granted Captain Phillip the powers to establish the first British colony in New South Wales, Australia and become the first Governor thereof. These instructions are a British document, and hence come with the ideology and practices of British Law and European notions of "land ownership and the political and social structures that would form the institutions and culture of modern Australia" (Thompson, 2006). There was an assumption that Australian land was *terra nullius* (owned by nobody), which underlay instructions for "managing the convicts, granting and cultivating land, and exploring the country" (Thompson, 2006).

The first settlers to New South Wales consisted of several hundred British convicts, soldiers and their wives. Known as the "penal colony", New South Wales consisted of a variety of British citizens originating from other nations as well as Anglo-Saxon Britons. Governor Phillip utilised all the settlers for their labour. British authorities regarded hard labour as the means of procuring the best opportunity to reform the convicts. The colonial government introduced free settlers from 1815 "to create an emancipist consumer economy and improve the moral tone of the colony" (Thompson, 2006), indicating early expectations that free settlers were more honourable than the convicts and would make some sort of "meaningful" contribution to the relatively new colony. Although the transportation of convicts from Britain to Australia ceased in 1852, the ravages of early life in the harsh Australian terrain (in comparison to Britain) took their toll on convicts and free settlers alike (Garton, 1988). A Colonial Medical Service, closely managed by Governor Phillip, was established to service the colony (Cummins, 2003). Early records are limited and do not mention mental health matters. Bostock (1968, p. 19) concludes that the "hard living conditions of frontier life … [meant that the] first objective was to live". Record keeping appeared to be of little importance compared to fighting for survival in such harsh conditions. Bostock (1968) postulates four probable possibilities that occurred with the existence of lunacy (as it was called at the time).

[22] Archivists have been unable to locate the original instructions

People either went into gaol or hospitals for convicts, or were responsive to care at home, although many would have died. Survival of the fittest was the hallmark of these harsh times (Bostock, 1968).

Parramatta Gaol: accommodation for lunatics

In the early colonial period, the Parramatta Gaol, built in 1796, was the only accommodation for convicts and prisoners at the time, including those labelled "lunatics". When lunatics were noted to be "a menace…a nuisance to the community at large" (Bostock, 1968, p. 20), they were segregated from society and placed in Parramatta Gaol. Overcrowding soon became an issue, drawing attention to the need for alternative accommodation and care for lunatics.

At the same time as colonisation in Australia, Britain had the Old Poor Laws, which provided relief to the poor through local parishes. As the British introduced the Poor Law of 1834, British settlements in Australia were increasing. However, Australia did not introduce *Poor Laws* (Cummins, 2003; Dickey, 1987; Garton, 1988; Kimber, 2013) for two main reasons. First, the convicts were under the auspices of Governor Phillip via the British Home Office, whereas in Britain the parishes were primarily responsible for the poor, unemployed, vagrants and lunatics (Dickey, 1992). Second, the new Australian colony wanted to appear a rich, vibrant community. It did not wish to be associated with the British class-consciousness inherent in the existence of paupers and poverty (Dickey, 1992). Nevertheless, despite there being no Poor Laws in Australia, there is abundant evidence of the harsh conditions many settlers endured, and workhouses became part of the Australian landscape (Bostock, 1968; Dickey, 1987; Garton 1988; Hendriksen et al., 2008; Kyle, 2007; Lawrence, 1965).

Convict women in the colony

Equally important in this history of settlement and lunacy is the place of convict women in the colony. Women were the minority group, and it is significant to note that they "were generally poor, young and unlikely to be important enough to be officially registered and recorded on any databases" (Kyle, 2007, p. 200). Kyle (2007, p. 202) elaborates on the difficulties of locating further information about conditions for women, partly due to name changes and a "lack of rigour" in record keeping. Lack of records rendered women essentially invisible both in the research process and as "part of a wider historical perspective which relegates women's lives, too often, to the invisibility of neglect and omission" (Kyle, 2007, p. 203). The significance of this point is that institutions were built to accommodate female convicts and orphans. The first of these was the "Factory above the Gaol" (Parramatta) in 1804, where female convicts lived in cramped conditions and worked on weaving looms. Next came a tiered class system in the "Parramatta Female Factory" in 1821, where women were classified either as "Merit Class" or "Crime Class", and duties were assigned appropriate to their status (Arts NSW, n.d.). In 1847, despite ongoing poor living conditions and poor state of the buildings, the Parramatta Female Factory became the "Parramatta

Lunatic Asylum" for lunatic and invalid convicts. On the one hand, it is apparent that these were harsh times for all, but on the other it is clear that there was not only class-related segregation but also gender-related segregation in Australia's early colonial times.

Madness, marginalisation and the 'other'

Indeed, Foucault's (1998) writings regarding industrialised societies provide a lens for considering madness, marginalisation and notions about the "other". In effect, the new Australian colony was growing at around the same time as the industrialisation of Europe. Foucault (1998, p. 336) proposes that four predominant areas of "human activity" occur in industrialised societies: "economic production"; "reproduction of society"; linguistics; and play. He further suggests that people who do not conform to the expected parameters of an industrialised society are seen as "behave(ing) differently from others"; he names them as "marginal individuals" (1998, p. 336). In fact, even Foucault (1998) does not appear to escape the ponderings about the marginalised other when citing an Australian example to demonstrate the marginalisation of individuals. He seems to allude to Aboriginal and Torres Strait Islander people as "a primitive tribe…the madman is regarded as an individual to be feared by the society, a man endowed with a supernatural force" (1998, p. 337). Remarkably, in offering this example, it exemplifies Foucault's reflections from afar – a culture that functions differently from the expectations of an industrialised economy comes within the realm of madness.

Aboriginal and Torres Strait Islander people, from colonisation to the current day, have been viewed as "different"; an attitude reminiscent of Foucault's work regarding the marginalisation of individuals who are regarded as different, and, shamefully, emphasising the devastating impact of colonisation on our Aboriginal and Torres Strait Islander peoples, and their culture of over forty thousand years. The severity of the impact of colonisation on their culture, health and identity remains abundantly clear in Australian society today (Dudgeon et al., 2010). The associated pain and lived experiences has caused, and continues to cause long-standing mental distress for their population. This is a critical contemporary issue for MHSW education, policy and practice.

The first asylums for lunatics

During the colonial era, medical doctors did not feature in the care of lunacy. This was the domain of the governors in the early colonial administration, while the police and the judicial process took over toward the later seventeenth and early eighteenth centuries.

Given that the original colony began in New South Wales, the first asylums were opened there. Castle Hill was the first asylum to open in 1811. Governor Macquarie commissioned "buildings on farm lands at Castle Hill specifically for an asylum" (Cummins, 2003, p. 34), even though care for lunatics was not a priority at that time. The original reason for building this asylum was a government response to the harsh conditions from overcrowding in Parramatta Goal; it was not to confine lunatics to a separate area. The overcrowded conditions brought abuse of people

who had “completed their sentences, or who had been pardoned or emancipated (and) remained in the Colony” (Cummins, 2003, p. 34). These people often lacked the capacity and/or the means to live independently after completing their sentences, especially given the minimal openings for them in a relatively new colony (Bostock, 1968; Cummins, 2003).

Similar to Cummins (2003) and Bostock (1968), Dickey (1987) argues there was a lack of attention paid to convicts who were showing signs of mental distress. Nevertheless, this situation generated an increasing unease in the community, whose members “feared the sufferers” (Dickey, 1987, p. 5). This appears to be the beginning of viewing people in the Australian colony as dangerous. Furthermore, despite Macquarie’s good intentions in commissioning land for the Castle Hill Asylum, it “was staffed by convicts” (Cummins, 2003, p. 34) and no attention was paid to their suitability for the job. Given this, it is probably not entirely unreasonable to assume that there may not have been an abundance of choice for staffing in these institutions during this era. Perhaps also, if thought were given to putting lunatics and convicts together in whatever capacity, this situation was viewed as satisfactory.

Cummins (2003) and Bostock (1968) suggest that living conditions were not much better in the asylums than in Parramatta Gaol. Additionally, their remoteness from Sydney prevented scrutiny and upkeep. Nonetheless, further asylums were opened with the intention of avoiding the “threat [to] harmony and even the security of the Colony” (Cummins, 2003, p. 34). The Liverpool Asylum opened in 1825 but by 1838 the population had increased quickly due to ongoing arrivals of convicts from Britain. Hence, the Tarban Creek Asylum, which later became the Gladesville Mental Hospital, replaced Liverpool (Cummins, 2003). Gladesville closed in 1997 with the consolidation of services at the Macquarie Hospital in North Ryde, Sydney (Cummins, 2003). At the time of writing this chapter, the Macquarie Hospital remains a mental health unit for adults with “a serious mental illness or disorder” (NSW Government, n.d.). This narration demonstrates that little has changed over the course of a long time in the language used to describe people with persistent and severe lived experience, most obviously in this unit; a concern this study exposes.

Many more asylums were built across Australia over the next one hundred years. Although the original purpose-built mental asylums are now closed, many psychiatric hospitals remained in existence until the late twentieth century. Currently, there are many smaller units providing mental health services in Australia, attached to general medical hospitals or in the community, and designed specifically for providing mental health services.

There appear to be similarities among some of the historical accounts, which claim the original purpose of the lunatic asylum in Australia was to provide a place of retreat and remedy (Bostock, 1968; Cummins 2003; Piddock, 2001). Conversely, Pilgrim (2015b, p. 91) notes that “the asylum system [in Australia] was not freestanding but an outcrop of prison life”. This indeed fits with previous points regarding the reasons for the opening of the early lunatic asylums. Pilgrim (2015b) further highlights the fact that during this period of history in Britain and Australia, the government was solely responsible for decisions relating to “madness” (Pilgrim, 2015b, p. 91). For

example, the penal colony in Port Arthur (Tasmania) built an asylum within its walls (Pilgrim, 2015b). Hence, the government was responsible for the states' lunatic asylums that housed both convicts and ex-convicts in overcrowded conditions, which no doubt had frustrations for their occupants. Although the paucity of early records does not highlight these frustrations, a later example from 1827 describes the women in the Parramatta Female Factory rioting over food rations (Piddock, 2001). Later, in the 1860s and 1870s, legislation and the medical fraternity brought another dimension to lunatic asylums with the introduction of the *New South Wales Lunacy Act* of 1878 (Cummins, 2003).

Other Australian states

As Bostock (1968) and others (Cummins, 2003; Dickey, 1987; Gaston, 1988; Piddock, 2001) note, the records for Australian States other than New South Wales are sparse. However, it is clear that similar to New South Wales, the accommodation of people with mental health was in prisons. Again, overcrowding and public fear paved the way for the building of more asylums as the solution. While South Australia varied slightly in that it had free settlers, the harsh conditions and lack of family and community support eventually took their toll on some people. It is probably reasonable to assume that there were people who retreated into a lifetime of mental distress, given the trajectory of their peers. Those with a lived experience, in whatever form it would manifest, were viewed as "public nuisances" (Dickey, 1987, p. 7). South Australia's first lunatic asylum opened in 1852.

Similarly, in Victoria, the Yarra Bend Asylum opened in 1848 and remained operational for the next eighty years (Bonwick, 1995). Somewhat later, in Western Australia, the Fremantle Lunatic Asylum opened in 1865, as did the Woogaroo Lunatic Asylum in Queensland. No asylums are known to have existed in either the Northern Territory or Australian Capital Territory.

In examining and exploring cultural representations of Australia's mental health history, Piddock (2001), an archaeologist, brings another perspective to the historical equation in regard to lunatic asylums. Her study focuses on the South Australian and Tasmanian asylums in relation to the impact of the "built environment" upon insanity (p. 84). Piddock makes comparisons between these two states, most particularly because one had free settlers (South Australia) while the other did not. Piddock (2001) emphasises French physician Phillipe Pinel's (1794 cited in Piddock, 2001, p. 84) notion of "moral management" occurring within the confines of the lunatic asylum; that the buildings themselves represent a "fundamental part of the treatment of the insane in the nineteenth century". It appears the colonies had reasonable purpose in building spaces for people in distress via the intent of "bring(ing) about a cure in the insane through the specific environment" (Piddock, 2001, p. 95). Notwithstanding the different purposes for housing the insane in South Australia and Tasmania, the issue of overcrowding occurred in both states, just as it had in New South Wales. Thus, overcrowding remained a central theme in the newer asylums despite apparent awareness of what had not worked well in New South Wales.

Many lunatic asylums continued to be purpose built to house people until the Community Mental Health and Recovery movement (Anthony, 2000, 2007) reforms of the 1980s and 1990s began, which gradually brought the closure of all lunatic asylums for people experiencing any form of mental distress.

Medical doctors enter the asylums

As mentioned previously, during the early colonial era medical doctors did not feature in the care of lunacy; this was the domain of the colonial governors, and later of the police and the judicial process. Medical personnel made sustained and concerted efforts to seek Governor Macquarie's support for the appointment of doctors at the Castle Hill Asylum (Cummins, 2003). As a result, Castle Hill was the first asylum in Australia to come under medical control, which occurred in 1819, eight years after it opened.

Cummins (2003), in his *History of Medical Administration in New South Wales 1788 – 1973,* traces the development of New South Wales' mental health services. Dr Frederick Norton Manning became the first Inspector General of Mental Hospitals in 1876. There were to be five more Inspectors General over the next eighty-five years. Significant contributors include Dr Eric Sinclair, noted for expanding the size and scope of mental hospitals. He altered asylums "from pseudo prisons in which the insane were incarcerated" to places for "active treatment" (Cummins, 2003, p. 102). In doing so, Sinclair brought about several changes regarding the treatment of lunatics, including the commencement of training for nurses and attendants, a voluntary system of care for those incarcerated and the establishment of the Chair of Psychiatry at Sydney University. Sinclair's efforts brought him a change in title in 1918, "from Inspector General of the Insane to Inspector General of Mental Hospitals" (Cummins, 2003, p. 102). He seemed intent on reform for people experiencing mental distress.

Bostock's (1968) *The Dawn of Australian Psychiatry* confirms many of Cummins' (2003) historical explanations regarding the early period of the management of madness in Australia, although his account differs in two main ways. First, it was written in the masculine form, this being the dominant language of the era. Bostock's narrative is replete with the writings of recollections of the men in charge, or seemingly wanting to be in charge. It was the 1960s, when the voices of feminist movements in America, Britain and Australia were shouting loudly for recognition. Bostock (1968) cites the case notes of Dr F. Campbell, pre-empting them with his own interpretations of madness. While it is plausible that during Campbell's time (1848-1850), his writings, littered with opinions of women's hysteria and apparent irrationality, represented the medical opinions of that era, it can be argued that Bostock's citing of them exposes his own opinion; out of time in the context of the feminist movement. For example, Bostock (1968, p. 178) observes "every mental hospital has its chronic manic…Tarban Creek…Margaret Coleman, aged 34…". His reasons for these opinions are not clear. Nevertheless, it is difficult not to ponder upon the sense of superiority in them.

Second, the flavour of Bostock's (1968) interpretation appears laced with his distaste for bureaucracy; hence, this historical narrative potentially brings with it a political interpretation that denounces the efforts of state participation in citizen's wellbeing. However, Bostock (1968, p. 5) makes it clear in his *Preface* that he "endeavour(s) to make distinction between facts and opinions", inviting the reader to ignore his opinions if they choose.

Bostock's (1968) writings about the harsh Australian conditions together with isolation from the convicts' home country, Britain, add further interest He suggests that the consumption of rum assisted the retreat from reality, hinting at the potential for further social issues. Dickey (1987) shares Bostock's opinion on this, writing about the Rum Rebellion and stating that in an effort to raise much needed funds for the General Hospital (Macquarie Street, Sydney), Governor Macquarie "granted D'Arcy Wentworth and his associates a monopoly of the import of spirits from India…as part payment for the contract" (Dickey, 1987, p. 2). Henceforth, the General Hospital became known as the "Rum Hospital". It is not difficult to assume the consequences of the introduction of alcohol into a colony of people entering Australian shores for reasons other than a wonderful new life. Garton (1988) illuminates this succinctly, drawing attention to Samuel Tuke, a Quaker, who at the same time as the Rum Hospital contract occurred in Australia, established a Retreat for lunatics in York (Britain), his intention being to move away from detention (Garton, 1988). Likewise, at the same time in Europe, Pinel (1794 cited in Weiner, 1992) had already introduced the notion of moral treatment in France.

On the other hand, Garton's (1988) Australian account of *Medicine and Madness* cites an example of the work of Bishop Wilson, Tasmanian lunacy reformer and advocate of "moral therapy" (p. 21). Wilson's opinion highlights the differences between the treatment and conditions of the asylums in New South Wales and the new movement in Europe. Touring them "in 1863 [he] dismissed Parramatta Asylum as a frightful old factory prison … Tarban Creek was no better [and] in contravention of every tenet of humane treatment" (Garton, 1988, p. 21). Wilson criticises the deplorable conditions, inadequate hospital administration and the system of "patient classification" (Garton, 1988, p. 21). The passage of legislation followed this condemnation, moving lunacy away from the penal system toward medical and benevolent notions of care and control (Garton, 1988).

Moving forward one hundred and thirty years, there is a general understanding that all these asylum buildings, filled with the cultural life of the times described above, are now closed. The accounts presented here create images of history that do not depict scenes of humanitarian warmth and compassion, but rather an immediate sense of relief that the asylums are closed. This raises several matters from the introductory remarks, guided by Clarke (2005), that viewing these accounts requires contemplation for the cultural and historical representations of their time. Stated at the beginning of this chapter, the interpretation and analysis of these discourses pays attention to other attributions in use for describing mental distress, which is language-use that is uniform and bleak. It is not only the centrality of language in representations of mental distress that contribute to mental health policies, apparent reform and the subsequent practices therein, but also the powerful

and complex layers of culture and society. These policies, together with the discourse, the discussions and the decisions that occur in their making and execution for mental health service provision, carry with them a remaining responsibility that touches us all.

The passage of legislation

In 1843, New South Wales introduced the *Dangerous Lunatics Act*, replacing the Office of Master in Lunacy and the court-based system that had been dealing mainly with the estates of people described as insane, or implying a flawed mind (Cummins, 2003). This Act made "provision for the safe custody of and prevention of offences by persons dangerously insane and for the care and maintenance of persons of unsound mind" (Cummins, 2003, p. 45). The introduction of medical certification by "two legally qualified medical practitioners" also occurred at this time (p. 45). The New South Wales Lunacy Act came into effect in 1878 following consolidation of the Dangerous Lunatics Act of 1868 and the Act to Provide for Custody and Care of Criminal Lunatics 1861. These Acts remained in place for almost one hundred years until the introduction of the New South Wales Mental Health Act of 1958, which brought a change in language from that of lunacy to mental health. Similarly, other Australian states followed with the introduction of various Acts and Amendments, namely Lunacy Acts, Dangerous Lunatics Acts and Inebriates Acts (Cummins, 2003).

Although the legislative journey demonstrates changes in the language, it raises several questions for scrutinising the ideology, policy and practice of examining disruptions over the course of Australia's mental health history. What has legislative reform brought beyond the changes in language and terms used to describe people with a lived experience of mental distress? In what way has this improved the way our health system services people experiencing mental distress? What does this mean for socially just, humanitarian practices as mental health social workers? Given the questions posed in the introductory discussion for this study, and in the following discussion, it appears that change is minimal. This exploration of the evolving passage of the Australian policy context assists understanding for the current climate in mental health service provision with its contemporary influences in MHSW. Hence, Part 2 seeks to address the alternatives for MHSW education, policy and practice, utilising a critical realist framework for advancing a critical-emancipatory perspective. The following socio-historical exploration of the journey of mental health in Australia adds depth to the understanding of the trajectory of contemporary MHSW within this.

A social control perspective

Garton's (1988) study of the social history of insanity in New South Wales provides a different perspective in appreciating the early beginnings of mental distress in Australia. While his investigation of the archival literature is extensive, he believes many more documents have probably been destroyed, making it difficult to ascertain, and justify with certainty and clarity the

period prior to 1920. His access to two thousand letters written by “patients” (Garton, 1988, pp. 6-7) is of prime importance. Although Garton’s study relates primarily to New South Wales, he advises that his exploration of the material for his research facilitates insight into the wider Australian scene in psychiatry and its place in mental distress. This assists in deepening understandings about the meanings attributed to ideology, policy-making and the resulting practices in the mental health arena, which are applicable to, and impact on, MHSW.

Garton (1988) acknowledges the early colonisation period as one where there was little input from the psychiatric enterprise. However, proposing social control theory for attempting to understand the “social impact of institutions” (1988, p. 4), Garton demonstrates there are many unanswered questions about the roles of the various institutions. Also important in most accounts regarding the reform of insanity in Australia is separating the lunatic asylum from the convict system, as well as the development of psychiatry; but the accounts do not address the “social context” and the “themes” in which this has occurred (Garton, 1988, pp. 5-6).

The issue of gender is raised in this study, with Garton (1988, p. 4) noting that there is an “ignor[ing of] the problem of gender” among the themes and context in which mental distress occurs. For example, there was a shift in the “broader social relations” of admissions of people regarded as lunatics in the period from 1880 to 1940 (Garton, 1988, p. 1). In 1880, it was mostly men who “were usually single, rural, itinerant labourers, first apprehended by the police after creating a public disturbance”, whereas by 1940 it was typically women, “most often suicidally depressed domestic servants or housewives, living in a Sydney suburb” (Garton, 1988, p. 1).

There were several changes in the demographic during the same period. There was “a shift in the language of madness” (Garton, 1988, p. 1) from “lunacy” and “idiocy” to “patients”. The language of “alienists” changed to “psychiatrists”. An increase in the numbers of people receiving treatment led to the growth of “private hospitals and clinics [in] out-patient clinics [and] wards of general hospitals” (Garton, 1988, p. 1); hence, the “medicalisation of the field of mental illness [and] mental disease experts – the psychiatric profession”– began (Garton, 1988, p. 2). Garton explores and addresses the expansion of the psychiatric profession in what he phrases “lunacy reform in Australia”, together with the social consequences for people exposed to medical intervention voluntarily or otherwise (Garton, 1988). The argument is compelling in its profound narrative concerning social control. For example, social control historians propose that “psychiatry is one arm of an increasingly active bourgeois state concerned with regulating social relations and repressing working-class resistance for the maintenance of capitalist social order” (Garton, 1988. p. 3). Garton justifies this narrative as a result of the impact of the industrial revolution, stating that it brought changes to the direction of the social fabric; preservation of the “capitalist social order [occurred with the introduction of] professional police forces, prisons, reformatories and lunatic asylums” (1988, p. 3). Hence, with an increase in unemployment, “policing and admissions to institutions of control rose” (Garton, 1988, p. 3); likewise, they fell with an increase in employment.

Australia differs from other countries to some extent. The introduction of lunacy laws and

psychiatry signalled the social order's shift away from the convict system. Nevertheless, the reform movements in Britain and the United States of America, which were occurring at the same time, influenced this shift (Garton, 1988). Therefore, the introduction of medicine to the world of mental distress brought the paradigm of professionalisation, eventually following with the police, nursing, social work and other allied health professions.

The post-war[3] years constitute the next era of mental health in Australia. These years hold important implications for understanding the trajectory of social work from the convict era into the mental health arena.

The birth of mental health social work in Australia

Further to the introduction in this chapter noting there are a variety of interpretations of history, Scott (also sharing that she is a psychiatric social worker) offers some enlightening points in an address to the 70th Anniversary Colloquium of social work at the University of Melbourne, titled *Reflections on Social Work: Past, Present and Future* (Scott, 2011). Scott resonates with Clarke (2005) and others (Charmaz, 2014; Garton, 1988; Lawrence, 1965; Miller & Nichols, 2013) in recounting the historical path of social work in Australia as a "risky endeavour…always contested territory as there are competing narratives, depending on who you are and where you stand" (Scott, 2011, p. 1). Scott further comments on the need to be mindful of "the context of…time and place" in which events occur (2011, p. 1). The development of social work as the precursor to MHSW in Australia is explored next, guided by Scott's astute awareness.

Early social welfare

The main influences for the introduction of social work in Australia came from Britain and the United States of America (Lawrence, 1965; Scott, 2011). Australian social work did not begin as a profession until the 1940s, but the provision of social welfare assistance in the form of charity and benevolence appeared much earlier; for example, the Presbyterian Female Visiting Society in Melbourne began in 1845. By 1851, this group became the Melbourne Ladies Benevolent Society, providing "food, clothing and other necessities to the respectable poor, particularly women, at home" (Dickey, 1987, p. 37). There were similar groups in the other Australian states. Significant historians on the passage of Australia's welfare history (Dickey, 1987; Garton, 1988; Lawrence, 1965; Murphy, 2011) argue that poverty has always been present in Australia, and social welfare work initially appeared in the form of charity and benevolence serviced by women (Lawrence, 1965), as demonstrated above. Australia chose not follow Britain's parish-based Poor Law system of relief in making provisions for the poor, the unemployed, the destitute and the infirm. The early colonists did not want to repeat the British system of workhouses for the poor. They aspired to creating a different society for Australia; one without the symbolism brought by a Poor Law

[3] Post-1945 – after the end of World War II

scheme. Yet notions of deserving and un-deserving poor are scattered throughout the Australian historical literature (Dickey, 1987; Garton, 1988; Lawrence, 1965; Murphy, 2011).

Women in welfare

In the early twentieth century in Australia, the prevailing social view of women was in keeping with other English speaking countries; their place was in the home, not in the world of business or authority. Women undertaking voluntary welfare work were tolerated and even viewed as reputable; they were perceived as more considerate (Lawrence, 1965). Additionally, there was tolerance for women working outside the home if their husbands supported them and a further benefit was women's free labour for agencies lacking in funds (Lawrence, 1965). Although women were accustomed to voluntary work and benevolence, or receiving very low rates of pay for working with the sick, the poor, the reliant and the "reformation of criminals" (Lawrence, 1965, p. 18), their efforts often were not recognised. This raises thoughts about how these women might have viewed those less fortunate than themselves. Did this impact on their caring efforts, given that they received no training and support, and probably very little, if any, recognition? Notwithstanding their charitable, benevolent and philanthropic efforts, the possible impact of this is evident in a statement from Catherine Helen Spence, one of the early social workers in Australia. In 1880, she indicated that "generally it was vice and extravagance and improvidence that brought people to destitution" (Spence, cited in Lawrence, 1965, p. 19). These aspects, together with relatively less training than that for medicine or the higher status professions, were the early hallmarks for the introduction of general social work training. Although social welfare issues are an accepted feature of early Australian society, the population's mental health did not become apparent until the post-war years.

Almoners among a growing nation

Garton's (1988) social historiography, titled *Medicine and Madness*, highlights the passage of Australian welfare from an economic perspective. There was increasing pressure for the provision of social welfare to those experiencing the ravages of the rapidly growing capitalist economy developing alongside the beginnings of an industrialised nation (Garton, 1988). Lawrence (1965) noted that the increasing complexity of social issues resulting from industrialisation influenced worldviews about human service provision. Tensions began to arise around the need for delicacy in debates surrounding the amateur/trained social service provider; debates that occurred over a period of about ten years (Lawrence, 1965). Further tension arose from the belief that "inadequate social work was worse than none" (Lawrence, 1965, p. 31), with Lawrence explaining that "the untrained worker tended to become immersed in 'doing' and 'giving' instead of finding out the facts of the case, particularly how the client saw his [sic] own problem" (1965, p. 31). This situation was viewed as inefficient. Therefore, the training of social workers was mooted but it brought economics into the equation. Interestingly, comparative to current times, training was regarded as

an investment in a thorough assessment of, and intervention in, social problems, and thereby more effective social provision. Over the ten years of debates regarding the amateur versus the trained social welfare worker, “five social work training bodies were formed in Australia…in Sydney, Melbourne and Adelaide…Melbourne and Sydney were concerned with medical social work” (Lawrence, 1965, p. 33). Women, again, featured heavily in this arena with the provision for almoner training for hospital social welfare workers (McMahon, 2003; Miller & Nichols, 2013).

University training commences with mental hygiene in the curriculum

The commencement of academic studies in social work in Australia occurred in Melbourne in 1941. Miss Jocelyn Hyslop, an English psychiatric social worker and academic, arrived in Australia with qualifications in science from the University of London. Her qualifications also included certificates in social science and mental health. Hyslop was a pioneer in the introduction of university social work training in Australia (Scott, 2011). She established the first social work training course at The University of Melbourne. The subject “mental hygiene” was included as part of the curriculum (Miller & Nichols, 2013). Jocelyn Hyslop was highly regarded for her influence upon the professional standing of social work in Victoria.

The documentation regarding the content of the mental hygiene curriculum is not locatable; however, it is assumed the content was most likely situated within the bio-psychiatric, disease-saturated (illness) paradigm for the following reasons. First, the language of the commonly known term “psychiatric social work” tends to lead to the assumption that social work is associated with psychiatry. In addition, the historiography discussed in this chapter establishes psychiatry’s suggestion that the introduction of social workers into health settings locates social work within this paradigm. Second, although now the reference is to the term “mental health social work” (MHSW), there is an immediate understanding of it as the phenomena and activity occurring within the realm of psychiatry.

As stated previously, the literature relating to MHSW education in Australia is limited (Lawrence, 1965; McMahon, 2003; Miller & Nichols, 2013; Scott, 2011). Bland et al. (2009) suggest that although learner social workers had some training in “mental hygiene”, they were not employed in mental hospitals until 1943, with Callan Park in Sydney and Royal Park in Melbourne being the first mental health hospitals to do so. This appears to have been influenced by the suggestion of a psychiatrist in Sydney that social workers are “now recognized as a valuable ally of the psychiatrist in child guidance and adult psychiatric clinics, and in mental hospitals” (Sebire, 1943, cited in Lawrence, 1965, p. 94). Herein lies the first sign of social work receiving the call from psychiatry. Prior to this, the first two qualified social workers “were appointed in 1932 to full-time positions in psychiatric clinics in the Sydney Royal Prince Alfred and the Melbourne Hospitals” (Lawrence, 1965, p. 76).

The post-war years

The post-war distress of returned soldiers brought a new dimension to psychiatry that heralded its entry into the field of its respected medical peers. The returned soldiers' trauma and its impact on their families brought a new dimension to Australian society. During this time, social work was moving from providing charitable, philanthropic almoner support to those "less fortunate", offered mostly by women (Scott, 2011), toward attaining status as a profession. As discussed earlier, professional status brought with it broader notions of social welfare and the introduction of training in medical social work in Victoria (Lawrence, 1965). Psychiatric social work began to follow due to the demands of the post-war years (Lawrence, 1965). Nonetheless, as mentioned earlier in this chapter, the growth of MHSW was relatively slow in comparison to its American counterparts. By "1951 there were only about six qualified psychiatric social workers throughout" Australia (Lawrence, 1965, p. 156), whereas psychiatric social work had formed an association as early as 1926 in America.

In 1944, the Red Cross Society was keen to employ several psychiatric social workers to assist in the rehabilitation of post-war veterans (Lawrence, 1965), but the lack of availability of training for MHSW in Australia meant the Red Cross funded four social workers to attend a mental health course in London (Lawrence, 1965). They sent trained medical social workers while also "support(ing) the move to obtain government aid for social work students…offer(ing) a series of scholarships to train abroad in psychiatric social work" (Lawrence, 1965, pp. 123-124). This supported the view (Lawrence, 1965) that specific mental health training in social work did not occur until after the 1940s. Although MHSW was slow in its inception into the Australian post-war scene in comparison to its British, European and American counterparts, it was nonetheless recognised as required (Lawrence, 1965).

Regardless, the Victorian Minister for Health did not send a senior social worker to London until 1950, with the intention of initiating training for psychiatric social workers upon her return (Lawrence, 1965). This did not occur, apparently due to health matters (Lawrence, 1965). Later, in 1954, Alison Player, a medical social worker from Victoria, went to North America in search of deeper understanding regarding the impact of the effects of "psychological and social factors" (Lawrence, 1965, pp. 156-157) on people's lives. Her aim was to strengthen the Victorian social work training program in psychiatric social work (Lawrence, 1965).

At the same time in Victoria (the 1950s) came the introduction of the Mental Hygiene Authority and the release of the *Stoller Report on Mental Health Facilities and Needs in Australia* (1955 in Lawrence, 1965). The *Stoller Report* identified a "shortage of trained professional staff" (Lawrence, 1965, p. 157), adding weight to the medical profession's momentum for developing the area of psychological medicine (Lawrence, 1965). The *Stoller Report* is significant in understanding the development of the psychiatric social work workforce, because it was instrumental in advocating for the introduction of social workers into community mental health. In fact, "in 1959, W. H Trethowan, Professor of Psychiatry at Sydney University, stated that social workers had an

invaluable and essential part to play in modern psychiatric diagnosis, in working with patients' relatives, and in carrying forward rehabilitation measures" (Lawrence, 1965, p. 167). This is another a moment in time when social work was uncritically complicit in psychiatry.

Victoria was regarded as "leading the way [in Australia's mental health services with the transition] from custody to treatment, from asylums to hospitals and from in-patient to non-residential care" (Lawrence, 1965, p. 156, citing the *Stoller Report*). This was a turning point for policy and in Australian society becoming increasingly aware of mental health issues. Further reports continued pressing for reform in mental health services across other Australian states, together with psychiatry advocating for social workers. The reports on mental health reform, tabled by various Australian state governments suggest the growing need for social workers to work "in close liaison with the medical profession in the total handling of the population…and salaries would need to be commensurate with the skill and value of the profession of psychiatric social work" (Lawrence, 1965, p. 157). These contributions not only legitimised but also embedded psychiatric social work in the now well-established medicalised nature of the mental health scene.

The place of mental health social work in the twentieth and twenty-first centuries

Lawrence's (1965) histiography illuminates the dominance of the medical nature of social work from its earliest beginnings. Even currently, it is conceivable that both medical social work and MHSW are considered social work specialty areas. They both remain common areas of fascination in social work, and perhaps, arguably, this is not surprising given the ongoing dominance of the medical language and landscape that still prevails among all areas of social work. Bio-psychiatric, disease-saturated (illness) language and labelling (Scheff, 2009) are so well versed and understood that they are heavily embedded in the health landscape, thereby bringing a certain familiarity in navigating the complexities of daily practice.

In paying attention to other Australian historical social work writers (Gleeson, 2008; Hughes, 2008; Martin, 1992; McMahon, 2003; Swain, 2008) further to those mentioned so far in this chapter, there are some points worthy of mention in reflecting upon the various perspectives regarding the Australian social work journey and welfare history. To summarise, there is some conjecture as to whether social work training first began in New South Wales or Victoria. There is debate about the domains of professional or amateur social work, with some alluding to Lawrence's (1965) historical account (Hughes, 2008) of the place of religion in social work, suggesting that the Catholic Church is long-established and consistent in its provision of welfare to those in need. Then again, there is the protestant connection with the celebration of the English almoners' benevolent and charitable contributions. Importantly here, Swain (2008, p. 193) asserts that "social workers turn to history with very different purposes in mind", but:

> …more commonly, social workers have seen history in terms of professional genealogy, as an attempt to locate and document the answer to the question "where do

> we come from?"…the attempt to establish a clear aim to professional status, constructing the boundary between the charity worker, commonly depicted as untrained and judgmental, and her university-educated successor. (Swain, 2008, p. 194)

In heeding Swain's message, the purpose in mind for attempting to discover the journey of MHSW is not to ride any boundaries of status but rather to echo Scott's invitation to look at the rear view of past education, policy and practice in assisting our reflection for future recommendations (Scott, 2011; Swain, 2008).

McDonald (2006) puts forward the notion of the "professional project", whereby she seeks to challenge traditionally held notions of social work. Conventional social work, including MHSW, has predominantly chosen to abide by, and adhere to, the expectations of the welfare state while comforted by the ideology of the collective conscience in the provision of welfare services that assist mental wellbeing in the name of "Recovery" (Anthony, 2000). Furthermore, McDonald (2006, p. 9) posits from her "brief tour through the social work journals produced in…Australia, Britain, Canada, New Zealand and the United States" that there are massive changes in state arrangements in welfare provision. She suggests these changes mean we are at a "critical juncture" in social work. The State has moved away from the ideology of collective responsibility for its citizens' welfare toward New Public Management (NPM), whereby "the rise and entrenchment of conservative and neo-liberal politics drive welfare reform in the direction of private responsibility" (McDonald, 2006). McDonald offers some thought-provoking points about the future of social work, which provide rich terrain for examining the place of MHSW within this. She invites further reflection upon the legitimacy of social work as a profession and of the desire for optimism in examining "moments of disruption" (McDonald, 2006, pp. 19-20).

The author expands upon McDonald's (2006) point, positing that it is about seeking to disrupt the status quo in MHSW. In other words, in focusing on the journey of MHSW in Australia, the heavy influence of medical ideology and the presence of the conservative domain of the psychiatric profession are notable. The early beginnings of social welfare work were hospital almoners, introduced to, and influenced by, the medical model; a model that is diagnostic and deficit (problem) based. Even with the 1990s Recovery movement (Anthony, 1993), there remains in mental health social work practice (MHSWP) an association with the comfort and familiarity of the *DSM-5* (APA, 2013) as an influential guide for understanding the assessment and treatment of persons on the continuum of mental distress. The author of this thesis argues that this need not remain. McDonald's optimism embraces the struggle with the reality of change from psychiatric social work to MHSW, seeking to challenge the space of the current conservative notions of psychiatric care, and the institutionalised ideas and practices that continue (Goffman, 1961; McDonald, 2006; Pilgrim, 2015b; Scheff, 2009). This can take place in several distinct ways. The first is a commitment to an accompanying perspective of both/and as opposed to either/or. This means mental health social workers first become "knowing actors" (McDonald, 2006, p. 8) by noting moments in the mental health historical journey, remaining ever mindful of *what lies*

between (this terminology is from the model developed in Chapter 5 of this thesis); otherwise, it is difficult to change what we do not come to appreciate. In addition, embracing ideology in social work that is socially just and humanitarian provides optimism amid the lived experience of the citizens whom mental health social workers serve.

McDonald's (2006) hopefulness assists the refocusing of MHSW toward a critical realist stance that supports and sustains change. An example of the need for MHSW to change its focus from old psychiatric notions of practice is its complicity in policing people with severe mental distress. McDonald calls for social work to move away from these institutionalised practices toward taking responsibility for being "knowing actors" (McDonald, 2006, p. 8), and therefore knowing what is occurring and *what lies between* as we, as mental health social workers, progress with the emancipatory struggle to make a difference as critical thinkers and practitioners. Additionally, deconstructing the historical journey and contemporary institutional ideologies and practices continues to challenge the status quo, keep pace with change, keep it within our spheres of influence, and utilise our discursive talents in moving forth with tact and diplomacy.

The formation of social work's professional body: the Australian Association of Social Workers

In the post-war period, Norma Parker held the office of president of the AASW from 1946-1953 (Lawrence, 1965). Norma held a post-graduate qualification in psychiatric social work, was regarded highly for her "experience, warmth, optimism, and stamina" (Lawrence, 1965, p. 130), and was noted for her contribution to the establishment of the AASW. Alison Player, a leader in the Victorian almoner movement, followed Norma Parker as the AASW president from 1953-1959. During these years, discussions commenced about the need for national training standards, especially given that social work training had now entered universities across the country (Lawrence, 1965). Nonetheless, it was another forty years before standards for social work practice eventuated in national policy for the profession, which occurred in 2003 (AASW, 2003). *Practice Standards for Mental Health Social Workers* came in 2008 (AASW, 2008a), with the curriculum for social work education containing the requirement for content in four core areas, one being mental health, implemented in 2012 (AASW, 2012a,b,c).

Developments related to the opening of AASW state branches, the inclusion of the almoners' association and the exclusion of unqualified people (Lawrence, 1965) occurred during the 1940s and 1950s. Advancement of social workers' professional status was slow for reasons related predominantly to reliance on people's goodwill, given they received no remuneration for their contributions to the administrative aspects of working for the association while continuing to manage heavy caseloads in their low paid employment (Lawrence, 1965). Lawrence's account notes that "outside bodies…dismiss(ed) the association as *just another women's organisation*" (1965, p. 178, emphasis in original), not only because the AASW membership consisted mainly of women but also because its branches in four states were affiliated with the National Council of

Women. This also signifies the social expectations of women in the post-war era. They were held in little regard for their leadership abilities, with the odds stacked against them to navigate heavy workloads while meeting the expectations of home duties.

Registration of the AASW by the Commonwealth Arbitration Court in 1955 and the introduction of the *Code of Ethics* in 1965 are other significant events in the AASW's journey. The Commonwealth Arbitration Court described social work as a profession, stating the AASW was "an organisation of persons 'usually employed for hire or reward in or in connection with the industry of professional social work" (Lawrence, 1965, p. 181). Lawrence notes the first "Interim Code of Ethics" as a document that "reflected the philosophy and general principles of professional social work" (Lawrence, 1965, p. 183). Nipperess (pers.com.) supports Lawrence's account in her "extensive search of the AASW's records" during her doctoral thesis, in which she demonstrates the journey of the inception of the AASW *Code of Ethics*. Nipperess suggests "the first official Code of Ethics came in 1965 (citing Martin, 1966)…[but] there is no public record of either" of these codes (Nipperess, 2013, p. 31). The '"earliest version on record is the 1981 Code, followed by major reviews in 1989, 1999 and, most recently in 2010" (McAuliffe et al., 2015, p. 159).

The AASW now, in 2016, has its own constitution that specifies policies applicable for social work education and professional practice. These are:

1. *Code of Ethics* (AASW, 2010)
2. *Practice Standards* (AASW, 2013)
3. *Practice Standards for School Social Workers* (AASW, 2008b)
4. *Practice Standards for Mental Health Social Workers* (AASW, 2014a)
5. *Supervision Standards* (AASW, 2014b)
6. *Australian Social Work Education and Accreditation Standards* (AASW, 2012a), together with the accompanying six *Guidelines* documents. *Guideline 1.1* applies to mental health curriculum (AASW, 2012b).

Australian Association of Social Workers: the Code of Ethics in mental health social work

The "nature and purpose" of the AASW *Code of Ethics* (AASW, 2010, p. 10) is that it is the guiding policy document for ethical conduct and accountability in all social work practice, including MHSW. The *Code of Ethics* (AASW, 2010) is the "core document which informs and guides" (AASW, 2010, p. 10) social workers' decisions and actions. Although social work offers membership with the AASW, either as a student or upon completion of a formal social work qualification, the social work profession does not require formal registration with a Board. This means that people accessing a social worker's services do not have a formal avenue of redress if they report unethical conduct. The AASW, through its Ethics Complaints Management Process (ECMP), receives and earnestly considers complaints made regarding its members. While it provides a process for complaints to be investigated – this information is made accessible to the public on the AASW website – it can only take action on matters where the social worker is a member of the AASW. In circumstances

where a member is found to have acted unethically or committed an offence by law, that member can be refused membership. However, there is no provision for de-registration of a worker in circumstances where unprofessional or illegal conduct occurs because social work is not a registerable profession. The AASW can report matters of serious criminal conduct to the police for further investigation. It is worth noting that at the time of writing this thesis, the AASW is moving ahead in the quest for registration as a profession, which will align social work with the other allied health professions in Australia. What this means for the registration of mental health social workers is unclear.

Accredited mental health social workers

Currently, social workers with a minimum of two years post-qualified (within the last five years) supervised practice "experience in the mental health or related field" are eligible to apply for accreditation as a mental health social worker. The option to apply for this accreditation offers possibilities for working in the mental health arena, generally in private practice, in order to obtain a provider number for accessing funding from the federal government's public health program, Medicare. Nonetheless, accredited mental health social workers (AMHSWs) are entitled to practice in any settings that offer mental health services, and, as mentioned previously, are required to abide by the *Code of Ethics* (AASW, 2010). It is important to note that mental health issues occur across all areas of social work, not just in the mental health sector; a situation that invites concern about the nature and purpose (AASW, 2010) of ethical and responsible professional conduct in MHSW practice. The *Code* does not specify the bounds for MHSW or AMHSWs, although the *Practice Standards for Mental Health Social Workers* stipulate that these should "be read in conjunction with the AASW's two key foundation documents; the Code of Ethics (2010) and the Practice Standards 2013" (AASW, 2014a, p. 4).

The CDA of these key policy documents, utilising a critical realist stance, forms the analysis for this thesis in Chapter 4, where the possibility for unethical conduct in the provision of services to citizens (Ife, 2012) accessing them is argued. For example, if a private MHSW practitioner is found to have acted inappropriately toward citizens accessing their services, what might this mean for all concerned? This necessitates exploration across not only the rights of citizens to access redress, but also what this means for inappropriate conduct of workers and the profession. Should the circumstances suggest the removal of a mental health social worker, either as an accredited practitioner or from the profession in any organisation (or agency) that offers mental health services? What does this mean if the social worker is not a member of the AASW? What does this mean for citizens with minimal funds who are vulnerable and unaware, and whose only avenue for justice is via the legal system?

The author explores these questions in Chapter 5, together with the iterative focus of a critical realist stance in addressing the ontological notions for MHSW practice. Additionally, the analysis and exploration are underpinned by the moral position that having the confidence of the

citizens mental health social workers serve is paramount in the preservation of our professional presence; being located within psychiatry is not.

Australian Association of Social Work Practice Standards for social workers

The *Practice Standards* (AASW, 2003, 2013) are a national policy document aiming for consistency across the Australian social work scene, guiding social work learners on field placements and graduate social workers. They provide basis for assessment of learners' knowledge and skills as budding practitioners, and then into professional practice. The AASW introduced the first *Practice Standards* in 2003 and updated them in 2013. The first version suggests six main areas of social work practice, "framed in terms of outcomes" (AASW, 2003, p. 4) and concentrating on:

1. Direct Practice
2. Service Management
3. Organisational Development and System Change
4. Policy
5. Research
6. Education and Professional development.

The emphasis changed from six to eight "components of practice" in 2013, as outlined below:

1. Values and ethics
2. Professionalism
3. Culturally responsive and inclusive practice
4. Knowledge for practice
5. Applying knowledge to practice
6. Communication and interpersonal skills
7. Information recording and sharing
8. Professional development and supervision. (AASW, 2013, p. 7)

This change represents a significant historical step; for the first time in Australian social work history, the AASW highlights the importance of acknowledging Australia's Aboriginal and Torres Strait Islander peoples (AASW, 2013, p. 4). The 2013 *Practice Standards* place importance on the significance of the personal, interpersonal, moral and theoretical domains of professionalism – personal, human-focused and relationship-based approaches – which now form the main tenets of social work. This is in contrast to the 2003 version's orientation more toward broad, systemic notions of practice, policy, research and continual improvement.

Background to the introduction of the Australian Association of Social Workers Practice Standards for Mental Health Social Workers

The first set of *Practice Standards for Mental Health Social Workers* (AASW, 2008a) originated in the context of the federal government's national mental health reform agenda from the late 1990s through to the 2000s (Brand, pers.com.). In the 1990s, the federal government-funded *The National Mental Health Education and Training Project*, emanating from the National Mental Health Strategy (Bland et al., 2009; Harries, 1999, 2013), which sought reform in the mental health sector. The project emerged in response to consumer and carer networks calling for change within mental health services (Harries, 1999). Similar to the findings of the *Burdekin Report* (Burdekin et al., 1993) and the recent *Contributing lives, thriving communities Report of the Review of Mental Health Programmes and Services (CLTC)* (NMHC, 2014b), consumer and carer networks "identified consistent negative responses and poor outcomes for people with a mental health problem and their carers who entered the mental health network of care" (Harries, 1999, p. 57). The responses identified social workers (Harries, 1999), prompting the National Mental Health Strategy's objective to implement national practice standards in allied health professions working in mental health, thus highlighting the need for MHSW-specific standards.

Stephen Brand (pers.com.) reports that the Commonwealth Government granted the sum of fifty thousand dollars for a committee to write the competencies for MHSW. This occurred in the context of other allied health professions (nursing, occupational therapy and psychology) already having value systems, philosophies, competencies and practice standards in place. It became apparent at the time that MHSW is integral to acute health and forensic services, yet it had no competencies and practice standards in place like. Brand (pers.com.) tells how a key group of social workers came together from Victoria, Tasmania and Western Australia, namely Professor Robert Bland, Professor Maria Harries, Dr Noel Renouf and Mr Stephen Brand to write a proposal to develop education and practice standards specific to mental health social work. Maria Harries (pers.com.) advises that the AASW endorsed their proposal and the Deakin Human Services Project team was established, resulting in publication of *The Development of Competencies for Mental Health Social Workers: Final Report* (AASW, 1999). This report was the precursor to the first policy for the *Practice Standards for Mental Health Social Workers* (AASW, 2008a), followed by *ASWEAS,* the policy for education standards in MHSW (AASW, 2012a, 2012b). In addition, Brand (pers.com.) and Harries (pers.com.) spoke of the pressing need for Standards (policies) to support AMHSWs in private practice, especially given the federal government Medicare (universal health cover scheme) rebates for their services.

Although accreditation for mental health social workers occurs through peer review, endorsed by the AASW, this applies mainly to social workers choosing to work in private practice, who are afforded the title *Accredited Mental Health Social Worker* (Harries, 2013). Social workers employed in public mental health or non-government mental health services are not required to attain accreditation. However, in another initiative emanating from the National Mental Health

Strategy, they are expected to adhere to the AASW *Practice Standards for Mental Health Social Workers (AASW, 2014a),* the *Code of Ethics* (AASW, 2010) and the *National Practice Standards for the Mental Health Workforce*, released by the Victorian Government in 2013.

Expanding on the prior discussion, the AASW published the second set of *Practice Standards for Mental Health Social Workers* in 2014, aligned with the generic social work *Practice Standards* (AASW 2013), to guide social worker learners in mental health curriculum for education and in the field. These most recent standards stipulate:

> … only those standards where there are specific indicators to illustrate the requirements for mental health social workers are addressed…under the following Practice Standard headings:
>
> - Values and ethics
> - Professionalism
> - Culturally responsive and inclusive practice
> - Knowledge for practice
> - Applying knowledge to practice
> - Professional development and supervision. (AASW, 2014a, p. 6)

Not included in these areas are the two practice Standards (6 and 7) relating to "communication and interpersonal skills" and "information sharing and recording" (AASW, 2014a, p. 6). The author addresses this omission in depth in Chapter 4.

The Australian Social Work Education and Accreditation Standards

Having introduced the first AASW *Practice Standards for Mental Health Social Workers* in 2008, in 2012 the AASW introduced the *Australian Social Work Education and Accreditation Standards* (ASWEAS) (AASW, 2012a), together with specific *Guidelines for the organisational arrangements and governance of social work programs* (AASW, 2012d). These were introduced to guide universities' social work curriculums and program delivery, development of new social work programs, and ongoing program accreditation and review (AASW, 2012a). The AASW stated that these were the "minimum requirements for social work education" (AASW, 2012a, p. 6). There have been several updates since their inception, with the most recent revision produced in 2015. The *ASWEAS* policy "sets out the principles, standards and graduate attributes for social work education in Australia" (AASW, 2012a). The AASW (2012a) advises that national standards for social work education have been in place since the 1960s, by "mutual agreement", but does not state with whom. This gives rise to the assumption that it refers to an ongoing agreement between the AASW and Australian university social work programs; if not, then who are the parties to the agreement?

Until the past decade in Australia, it appears that psychiatric social work had been offered in a variety of formats, for example as one of a number of topics offered as a separate specialist casework topic or as a specific topic in some university curriculums. In other words, each university made a choice about the inclusion of any specific learning about mental health. Furthermore, the

purpose of prior studies in psychiatric social work occurred predominantly to meet the demands of post-war Australian society. From the 1960s onwards, some psychiatric social workers served in the asylums and psychiatric hospitals around the country, but this did not necessarily mean they had any formal training for this work (Lawrence, 1965).

Social work training has evolved in different ways (Lawrence, 1965; Miller & Nichols, 2013; Scott, 2011), however there is now the stipulation that mental health be included in the core curriculum for university-based training in social work in Australia. The *ASWEAS Guideline 1.1: Guidance on essential core curriculum content* (AASW, 2012b) recommends that the content of the mental health curriculum should comprise three main areas:

1. Attitudes and values
2. Knowledge for social work practice
3. Skills for social work practice. (ASWEAS, 2012b, p. 2)

A statement regarding the *Mental health curriculum content* (AASW, 2012b, p. 3) recognises that social workers "in any practice setting will have at least some clients affected by mental health problems of varying severity". This acknowledges that social work with mental distress occurs in a myriad of settings and not solely within the mental health sector. Discussion about this statement centres upon matters relating to the terminology used for the people served by social workers and the need for awareness of sociological perspectives; discussion that is part of the preparation for entry-level MHSW practice (AASW, 2012b).

The author explores the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) in depth in the CDA in Chapter 4, with reference to the *Code of Ethics* (AASW, 2010) where applicable.

The mental health social work journey in Australia

Discussion in this chapter demonstrates a move away from the early days of psychiatric social work predominantly in hospital settings. In the latter part of the twentieth century, the emphasis on asylums for the insane changed focus with the introduction of the consumer and Recovery movements (Anthony, 1993, 2007). Mental health social workers are now commonplace in multi-disciplinary teams, bringing another dimension to social work practice and revealing the changes in MHSW over the preceding century.

As proposed in the CDA in Chapter 4, the demands of the medical nature of events, which are not applicable in contemporary practice, have driven changes over time in the social work journey from psychiatric social work to the current terminology of MHSW. The principled base of social work enables MHSW to re-visit its core values of social justice, rights and reflective practices, leading to a paradigm shift away from the bio-psychiatric, disease-saturated (illness) model and creating a new place in the history of MHSW in Australia that focuses on embracing the multiple possibilities outside that model. A critical realist approach, through its capacity for an

iterative focus between CR as an ideology and the ontological underpinnings for MHSW practice – ideology as praxis – assists this change. Pilgrim (2015b), in *Understanding Mental Health: A critical realist exploration,* provides the sound basis for ideology by comprehending the benefits of a critical realist approach for MHSW, thus melding the knowledge base and values; the essence of social work.

Mental health social work in the twenty-first century

The study of social work is grounded in deep understandings across multiple worldviews and a multitude of areas, for example, society, social capital, economic disadvantage and the implications of notions of power, politics, policy and the relationships that surround these in daily practice. Social work academics and their peers in field practice hold various views about what theories should hold prominence for social work learners.

Some movement in MHSW toward a social constructionist approach became apparent in 2008, as noted within the discourse of the curriculum standards for university education. This set the benchmark for educating social work learners at the tertiary level (AASW, 2008a; AASW, 2012a). Prior to this, the commitment by universities to teach content related to MHSW practice occurred through goodwill; the need for national consistency was lacking. Also, the early years of social work education in Australia were primarily for the purposes of educating medical social workers to work in hospitals. The shift in education from psychiatric social work as a medical pursuit to broadening it to the fundamental notions of socially just and human rights based work occurred as late as the 1990s.

Historical accounts demonstrate the shift away from a purely bio-psychiatric, disease-saturated (illness) perspective. There is a plethora of publications offering a range of literature supporting notions of socially just approaches, which give social work educators of mental health topics the opportunity to provide a variety of perspectives for social work learners to access (Allan et al., 2003; Allan et al., 2009; Adams et al., 2002, 2009; Dominelli, 2002; Finn & Jacobsen, 2003; Ife, 2012; Hugman, 2012; Kirk, 2005; Macfarlane, 2009; Morley, 2012, 2014; Morley & MacFarlane, 2010; Morley et al., 2014; Saleebey, 2005; Tew, 2005; Webb, 2006; Williams, 2005). Among these approaches is the Recovery movement (Anthony, 1993, 2007), whereby respect for the lived experience of citizens with mental distress (Ife, 2012) is a core feature of contemporary MHSW practice. However, even the Recovery paradigm is not necessarily an emancipatory approach (Pilgrim, 2015b), as will be addressed in Part 2 of this thesis.

Moving to new paradigms for mental health social work practice: a critical-emancipatory approach, with a critical realist stance

The literature offering critical perspectives about social work with mental distress is growing. Some powerful insights are emerging that are applicable to MHSW, as discussed in Chapter 2. These contributions offer an alternative worldview to the bio-psychiatric, disease-saturated (illness)

paradigm, sparking curiosity about what critical thinking and critical perspectives can bring to MHSWP. For example, American social worker David Cohen (1990), aligning with the values of social justice and respect for the individual, advocates for the removal of coercion as care in mental health, comprehensively questioning the influence of the pharmaceutical industry (*Big Pharma*).

The Australian academic scene is growing in publications that move into the human rights, relationship-based area purporting critical perspectives in MHSWP (Bay, 1991, 2014; Healy, 2001, 2005, 2012, 2014; Ife, 2012; Macfarlane, 2009; Mendes, 2009; Morley & Macfarlane, 2010). These are invaluable extant resources for social work learners about mental distress and there remains the need for more in Australia. Other writers offer commanding evidence for the attention of social work learner audiences (Breggin, 2014; Brown, 2004, 2007, 2010, 2012; Boyle, 1990; Carlat, 2010; Curra, 2011; Corrigan, 2007; Longden, 2013; O' Hagan, 2004, 2008, 2014; Scheff, 1999, 2009, 2010; Scheff & Retzinger, 1991, Whitaker, 2010). Even so, the well-versed discourse of the bio-psychiatric, disease-saturated (illness) paradigm continues to hold enormous weight in the English-speaking world. Nonetheless, these relatively recent critical thinkers provide social work educators with the opportunity to offer critical perspectives that broaden mental health social work learners' horizons toward more than the entrenched power of the bio-psychiatric, disease-saturated (illness) discourse. For example, it became evident early in my academic career that learners become concerned upon discovering they will not be learning how to diagnose, treat and medicate patients. Following an introductory lecture, a learner inquired as to why they would not be learning how to "eradicate" mental illness. Additionally, judgements connoting "others" demonstrate the fears surrounding people who are believed to be mentally ill; the fear referred to earlier in this chapter in relation to Australian colonial times remains. Herein lies the challenge for seeking and embracing many perspectives among the multi-factorial approach advocated by Shakespeare (2014).

In writing this thesis, the author contends that the concept of CR offers a new direction for re-asserting theory and practice in the mental health arena in a move away from the Recovery approach, which, arguably, works within a medical model. The AASW policy documents – the *ASWEAS* (AASW, 2012a,b,c,d), the *Code of Ethics* (AASW, 2010) and the *Practice Standards* (AASW, 2013), together with the *Practice Standards for Mental Health Social Workers* (AASW, 2008a, 2014a) – provided the core material for analysis in this study. The CDA maintains awareness of the historical context amid the MHSW journey in Australian social work history. In addition, this analysis is not complete without providing the basis for comprehending future possibilities in exploring new directions through the concept of a critical realist perspective. This is in stark contrast to the bio-psychiatric, disease-saturated (illness) paradigm that remains inherent in all areas of social work, mental health being no exception.

Chapter summary

MHSW does not occur in a vacuum – it occurs amid a historical journey and cultural contexts that surround many things; society, institutions and professionalism. Endorsing a critical realist interpretation assists with the exploration of historical ideas and practices, moving them away from mere lineal accounts to offer a sense of the journey, which is less limiting. Further to conceptualising the events and the moments in time where psychiatry entered the mental health scene and the subsequent development of legislation and policy, the matters of gender and culture still require acknowledgement.

This chapter has provided a brief look into the historical journey of MHSW in Australia, which is arguably in its infancy given that the introduction of ethics and practice standards are relatively recent. It is poignant to note that historical accounts remind their readers to reflect upon the narration to inform and assist the way forward in interpreting new paradigms. Although the writing in these accounts reflects the language of the times, it nonetheless portrays discursive elements (Fairclough, 2001b) that have the capacity to impact current understandings about mental distress. The early era in mental distress did not include medical doctors. The discussion highlights the changes in the way it came to be viewed once doctors were involved. While doctors' early intentions may have been honourable, bio-psychiatric, disease-saturated (illness) ideology perhaps brings a different, less honourable dimension to views of lunacy, madness and the illness paradigm, incorporating diagnosis, treatment, intervention and their associated prognostic overtones. Thus, the power and influence of a bio-psychiatric, disease-saturated (illness) discourse takes place among the developments of policy, legislation and practices that are embedded firmly within Australia's social fabric.

While reform, legislation, and the decisive and defining moments in the history of MHSW in Australia have some comparisons with other western nations, a social control perspective, such as that offered by Garton (1988) and others (Dickey, 1987; Foucault, 1973), draws attention to the place of ignorance and stigma in society. This is evident here in accounts from convicts, the poor and those considered "different" (deviant), placing them within the realms of fear or being unproductive, thereby needing to be removed to asylums. While the language has changed, contemporary notions surrounding mental health units as institutions for the apparent care of people experiencing mental anguish still carry negative connotations.

This insight into the MHSW journey in Australia raises questions about the place of women in terms of those seeking mental health services to assist them in times of mental distress (now more commonly due to domestic and family violence), and of those who have become social workers and members of the AASW. Does the old assumption that the AASW is "just another women's organisation" (Lawrence, 1965, p. 178) still carry weight? Has this assumption impacted the length of time taken for social work to become a registered profession? Why did it take until 2013 to give due recognition to Aboriginal and Torres Strait Islanders in the AASW *Practice Standards*? Again, it is necessary to look back through social history to understand the impact of

colonialism on the lived experience among Australia's Aboriginal and Torres Strait Islander populations, who were deemed "different" and outside Australian society.

The author hopes that by taking the critical realist approach to locating the historical journey of MHSW in Australia, demonstrated in this chapter, she is providing a solid basis for the critique of the various accounts, and revelations, of the conditions in which they have occurred. She seeks to move away from reductionist, positivist explanations (Bhaskar & Collier, 1998) about the journey of mental distress in Australia. Such a move is critical for MHSW education, policy and practice because these accounts have the potential to generate new knowledge and understanding about the trajectory of mental distress in Australia. New knowledge, and the reproduction of knowledge that is familiar, brings the potential for influencing MHSW learners' and practitioners perspectives. A critical realist stance offers the space to question the impact of, for example, political and environmental structures on mental distress; the values and beliefs inherent in gendered perspectives; and what the passage of legislation may mean for MHSW practice amid all of this.

CHAPTER 4:
A CRITICAL DISCOURSE ANALYSIS WITH A CRITICAL REALIST STANCE: DOCUMENTS OF SIGNIFICANCE TO MENTAL HEALTH SOCIAL WORK EDUCATION AND PRACTICE

In Chapter 3, the author located the historical journey of mental health social work (MHSW) in Australia. Utilising a critical realist stance and the paradigm of social control theory, she revealed the introduction of the psychiatric enterprise as the foundation for psychiatric social work. This forms the basis for this chapter's critical discourse analysis (CDA) of a selection of documents that hold significance for re-conceptualising psychiatric social work for contemporary MHSW.

Interrogating the data

The documents scoped for this CDA come from two main sources: the Australian Association of Social Workers (AASW, the professional accrediting body for mental health social workers) policy documents that set the requirements for MHSW education and practice standards in Australia; and federal government policy, review and report documents related to the provision of Australia's mental health services. Comparative analysis of the AASW and federal government documents demonstrates the impact of the bio-psychiatric, disease-saturated (illness) paradigm on MHSW education, policy and practice. Analysis of one AASW document, the *AASW Response to the National Mental Health Commission's Report on the National Review of Mental Health Programmes and Services* (AASW, 2015), is included in the federal government documents grouping because it is a direct response to one of them.

As explained in Chapter 2, the CDA method involved the author in a five stage, iterative analytical process of interrogation, exposure, interpretation and integration. Interrogation, exposure and interpretation are designed to disentangle the language and discursive elements attributable to the bio-psychiatric, disease-saturated (illness) model, whereas integration involves integrating the CDA with new language concepts amid a critical-emancipatory approach for contemporary MHSW education and practice. This is re-conceptualised and re-newed in Part 2 of this thesis.

The author undertook the CDA to assist in identifying the constraints that influence MHSW education, practitioner choice and action. The five stages of the CDA, adapted from Fairclough (2001a), were:

> Stage 1: Focus upon a social problem that has a semiotic aspect. This stage focuses on the AASW policies in locating psychiatric social work at the core of current mental health education and practice in the twenty-first century.
>
> Stage 2: Identify the obstacles to the discourse-related issue being examined. This stage introduces the federal government documents as central to identifying obstacles to the social problem being tackled (Fairclough, 2001a) to ascertain a depth of understanding about what this means for MHSW education and practice.

> Stage 3: What does the social order gain from the discourse-related issue? This stage distinguishes the generative mechanisms inherent in the psychiatric and pharmaceutical industries, revealing a need for maintenance of the existing arrangements. Here the author utilises critical realism to un-pack the discourse, divulging the discursive elements and epistemic fallacies that lie within it.
>
> Stage 4: Identify the opportunities for possible ways forward in moving past the discourse-related issue. During this stage, the author moves beyond the obstacles, acknowledging a critical realist stance for MHSW education and practice.
>
> Stage 5: Reflect critically on the analysis in the four prior stages in coming to understand the multiple *layers* that surround mental distress. These layers comprise the notions that surround structures and systems of thought, moments of explanation and social practices (Fairclough, et al., 2004) that serve to reproduce the bio-psychiatric, disease-saturated (illness) model's dominant discourse and practices. The layers weave the course of history, directing service provision in the mental health arena.

Stage 5 is particularly significant for MHSW because it pays attention to what the layers mean for MHSW education and practice, and paves the way for the re-conceptualisation of MHSW education, policy and practice (Part 2).

Restating the imperative of the historiographical narrative discussed in Chapter 3 is integral to the CDA. This narrative places the extant documents within the context of MHSW's historical journey in Australia. It includes uncritical assumptions about "extralinguistic factors" (Wodak & Meyer, 2009, p. 20) – the cultural, social and political notions that impact on ideology – demonstrating that the CDA did not take place in a vacuum. There is intermingling of the language within social and political structures, together with inherent power relations that contribute to, and sustain, the dominant discourse and hegemony in mental health services (Fairclough, 2001b, 2010; Foucault, 1973; Kirk, 2005; Kirk et al., 2013; Pilgrim, 2015a; Tew, 2005). Over the course of history, "discourses determine the way in which a society interprets reality and organizes further discursive and non-discursive practices (i.e. further talking, thinking and acting)" (Wodak & Meyer, 2009, p. 37). Hence, these discourses and the discursive practices within them shape mental health social workers' knowledge and practice to become the reality of the practice domain.

The author took an interpretive stance to both the extant documents and the literature interrogated in this CDA, adopting a focus on the saturation of the language within the literature informing psychiatric, disease-saturated (illness) paradigm to assist in identifying what this means for MHSWP. Critical realism (CR) provided the philosophical framework for the critique to expose misconceptions of knowledge, epistemic fallacies about mental distress, structural and generative mechanisms, and representations that reinforce the problematising (Bacchi, 2009) that occurs in the mental health arena. The critical realist approach enabled the author to pay attention to critical semiotic analysis (CSA) – meaning-making – and the "semiotic conditions" (Fairclough et al., 2004, p. 11) that affect social phenomena, for example favouring specific discourses, and how particular

discourses transpire in organisations and are “filtered” (Fairclough et al., 2004, p. 11) within policy, meetings and reports. Other examples of filtering include strategising by privileging dominant discourse among other networks and employing people who will preserve the status quo (Fairclough et al., 2004). The critical realist approach also enabled the author to uncover the order of the discourse, which is known to influence both ideology and practice (Wodak & Meyer, 2009).

The process of interrogation, exposure, interpretation and integration of the discourse followed critical realist notions of abduction and retroduction (Archer et al., 1998; Archer et al., 1999). Abduction requires oscillating between theory and the data analysis (Archer et al., 1998; Archer et al., 1999; Oliver, 2012; Wodak & Meyer, 2009), supported by the retroductive approach within which exploration moves beyond cause and effect to reveal the generative mechanisms and structural notions that contribute to the current bio-psychiatric, disease-saturated (illness) paradigm in MHSW.

Locating language in this analysis

Harper (1995), in *Discourse analysis and ‘mental health’*, locates the analysis of language within the area of mental and emotional distress by highlighting its power in his suggestion that language is:

> …not seen as descriptive of the world but rather as *constitutive* and is viewed not as a path to finding out about something else (eg about ‘cognitions’) but as something worthy of study in itself because of its effects. (Harper, 1995, pp. 347, 348, emphasis in original)

Accepting Harper’s suggestion that language establishes the foundations on which people interpret the world opens possibilities for recognising the implications and powerful effects of the language of bio-psychiatric, disease-saturated (illness) discourse. Nevertheless, debate continues in the research community about the way people interpret a “piece of talk” as being external to the discourse; however, there is agreement about its pervasiveness (Wetherell, Taylor, & Yates, 2001).

Further to the discussion in Chapter 2, accepting that there are multiple definitions of reality (Charmaz, 2014), together with the complex layers of multi-disciplinary interpretations, it is conceivable that the struggle toward different ways of constituting discursive elements is a challenge. Un-packing some of the definitions of reality through the lens of CR will assist in deepening understanding about nuances that lie amid the multi-disciplines. The main discipline in focus here is psychiatry, yet a depth of understanding goes further than only the professional circles. In addition to the discussion in the opening chapters about the powerful influence of the pharmaceutical industry (*Big Pharma*), there is a need to remain mindful of this and its implications for the conventions that lie among a bio-psychiatric, disease-saturated (illness) approach when focusing on the networks of practices discussed later in Stage 3 of this CDA.

Five stage critical discourse analysis of the Australian Association of Social Workers education and practice standards for mental health social work

Each stage within this CDA has its own section. Stage 1 focuses on the following AASW policy documents:

1. *The Practice Standards for Mental Health Social Workers* (AASW, 2014a)
2. *The Australian Social Work Education and Accreditation Standards V1.4* (ASWEAS) (AASW, 2012a) – the national curriculum that guides tertiary social work education in Australia and provides the benchmark for accreditation processes in many of the schools of social work.
3. *The Australian Social Work Education and Accreditation Standards (ASWEAS) Guideline 1:1: Guidance on essential core curriculum content* (AASW, 2012b)
4. *The Code of Ethics* (AASW, 2010)
5. *The Practice Standards* (AASW, 2013).

The CDA focuses primarily on the *Practice Standards for Mental Health Social Workers* (AASW, 2014a); the policy central to mental health social work practice (MHSWP). Aiming to maintain a consistent and transparent focus on the content and context of the language used within policy documents, given their application in MHSW education and practice, the author intended to compare this document with the inaugural 2008 policy document of the same name (*Practice Standards for Mental Health Social Workers*; AASW, 2008a), the *Practice Standards* (AASW, 2013) and the *Code of Ethics* (AASW, 2010). She refers to the *ASWEAS* (AASW, 2012a,b) policies where applicable. However, her initial comparison of the two *Practice Standards for Mental Health Social Workers* documents found very few, and not relevant, differences. Therefore, only the critique of the 2014 document has been included in this CDA. Two standards of significance for MHSWP (Standard 6, *Communication and interpersonal skills* and Standard 7, *Information recording and sharing*) (AASW, 2013, p. 3) are not included with the *Practice Standards for Mental Health Social Workers* (AASW, 2014a). There is no statement of the reason(s) for their omission; just a note indicating that these standards can be found in the *Practice Standards* (AASW, 2013). The author addresses this issue in this CDA.

The author argues that there is the possibility for unethical conduct in the provision of MHSW services to citizens (Ife, 2012), particularly in the case of private services, and notes the place of policy for education curriculum and pedagogy in addressing the core value of professional integrity in the curriculum.

Stage 1: Focus upon a social problem that has a semiotic aspect

Fairclough (2001b, p. 236) identifies CDA as beginning "from some perception of a discourse-related problem" that has a semiotic aspect. The problem here is a predominance of bio-psychiatric, disease-saturated (illness) paradigm related discourse in the text within the abovementioned policies, which influences the knowledge base and practice for MHSW.

Determined to get as big a picture as possible of the problem, the author focuses not only on the semiotic conditions influencing the problem, but also on the content and context of the discourse involved (Fairclough et al., 2004). The following sub-headings illustrate examples from the text-related discourse within the body of the policies being critiqued.

Australian Association of Social Workers Practice Standards for Mental Health Social Workers (2014)

Preface

The AASW *Practice Standards for Mental Health Social Workers* (2014, p. 4) is prefaced with information for Accredited Mental Health Social Workers (AMHSWs) who provide services that are subsidised through the federal government Medicare program, a public fund for health services in Australia. The discourse in the *Preface* is illustrative of the discourse throughout the entire policy document, revealing adherence to the well-known and understood language of medical ideology; the dominant bio-psychiatric, disease-saturated (illness) paradigm. It is highlighted in bold in the following boxes:

> *It is crucial to establish the **assessment**, **treatment** and other **intervention** knowledge and skills of social workers.* (AASW, 2014a, p. 4)

The words "assessment", "treatment" and "intervention" imply that there will be a medical (ised) assessment, treatment and intervention process. This concurs with the semiotic conditions referred to earlier (Fairclough et al., 2004) because there is a selection, or privileging, of bio-psychiatric, disease-saturated (illness) discourse in interpreting how these events will or should take place; an approach co-opted by psychiatry. This equates with Bacchi's (2009) *What's The Problem Represented to be (WPR)?* in approaching the representation of the discourse as medical in nature. A critical realist interpretation reveals the mechanisms (for example, the professions, politics and ideology) and the structures (bio-psychiatric, disease-saturated (illness) paradigm and *Big Pharma*) that assist in maintaining this approach.

Introduction

The introduction (AASW, 2014a, p. 5) cites health together with the World Health Organisation (WHO) definition as the central tenet for understanding people's mental wellbeing (key text highlighted in bold):

> *Health is a state of **complete** physical, **mental** and social wellbeing and not merely the absence of **disease** and **infirmity**. (AASW, 2014a, p. 5)*

Here, the word preceding this definition is "complete", whereby the meaning immediately attributable to mental wellbeing is one of wholeness, perhaps thoroughness or even being in an absolute state of health. The antonyms to completeness are words such as "deficient", "lacking", "defective" and "imperfect" (Waite, 2012; Waite & Hawker, 2009). The words that soon follow

"complete" ("mental", "disease", "infirmity") imply that illness or similar is present. Fairclough et al. (2004) suggest that among the eight key semiotic conditions, "the inculcation of these discourses in the ways of being [and] identities of social agents" (practitioners and educators) become "their ways of talking" (2004, p. 11). Furthermore, Fairclough et al. (2004, p. 11) claim that language serves as a "filtering device within procedures for selecting these discourses and filtering out others", thereby aiding the approval of certain discourses.

Therefore, this discourse indicates the possibility that mental wellbeing is similar to physical wellbeing, opening the way for a rapid progression to equating a lack of mental wellbeing with disease and illness. This raises the possibility for questioning the comparison with general health. First, what is a complete state of general health? When is this ever so? Does this mean that people with mental health issues are incomplete, deficient or lacking wholeness? In other words, people experiencing mental health issues, in whatever severity they may be, are viewed (the *gaze*) through a different lens to those with general health issues. If we apply a health lens to this argument, a glaring gap appears which suggests that matters of the mind (the soul) are not necessarily those that equate with health but result from many factors. These factors include the broader societal notions put forward by Shakespeare (2014), Pilgrim (2007, 2015a,b; Pilgrim & Bentall, 1999), Tew (2012, 2005), Kirk (2005) and others (Boyle, 1990; Breggin, 1991; Kirk et al., 2013; Macfarlane, 2009; Morley & MacFarlane, 2010; O'Hagan, 2004; Sheehan, 2012; Smith, 1990a,b; Smith & David, 1975). Factors include the socio-economic remnants of capitalism (e.g. unemployment, homelessness, social inequality and injustice); the political and cultural contexts of people's lived experience.

The semiotic conditions (Fairclough et al., 2004) – the filtering and favouring of a mental illness discourse – view people through a mental (medical health) lens rather than an alternative (Boyle, 1990; Gomory, Cohen, & Kirk, 2013; Kirk et al., 2013; Pilgrim, 2015b; Smith, 1990a,b; Tew et al., 2006). This is contested space whereby a broader lens emphasises that "messy reality needs a fair exploration" (Pilgrim, 2015b, p. 1).

In the second paragraph of the introduction, there is a brief reference to the human need for connection and to:

> ***…earn a living*** *and* ***enjoy life.*** (WHO, cited in AASW, 2014a, p. 5)

The implication for people with a lived experience of mental distress is that they should, or perhaps could be, working and enjoying life; if there is unemployment and less joy in life, it must be cause for mental (medical health) concern. Regarding the latter point, Pilgrim (2015b) highlights that this is a circular argument – if we are not happy, then we are unhappy, and thence the bio-psychiatric, disease-saturated (illness) solution proceeds straight to intervention. For example, the initial point about earning a living implies that not earning a living may lead to mental health issues. While this may be the situation at times, this is a concept relative to a person's level of functioning. For example, people with a lived experience that impinges on their capacity to function for a myriad

of reasons outside of their control, such as the debilitating, long-term side effects of medications (Breggin, 1991, 1997, 1998, 1999b, 2001, 2002, 2006, 2008, 2009, 2016; Jureidini et al., 2016; Moncrieff, 2008b, 2009; Moncrieff & Cohen, 2005, 2006, 2009; Whitaker, 2010), may not be able to work but may hope to otherwise.

Additionally, in the neo-liberal context, not earning a living potentially connotes that people with mental health related matters are not productive (or productive enough) and hence do not contribute to the economy. There is a thread of argument from some quarters (for example, the business sector) for concern about the economic effects of people not earning a living. More appropriately, for this MHSW policy, there is the need for clearer articulation of social work values in the discourse. For example, espousing respect for persons and social justice is at the heart of accessing not just a living but also life's pleasures, especially for people marginalised by the social constraints and conditions within the mental health system of coercion and care (Foucault, 1973, 2006a,b; Iliopoulos, 2012; Szasz, 1961, 2010a; Whitaker, 2010).

In the next sentence in this paragraph, the use of words appears at first glance to express genuine concern for people's mental wellbeing:

> ***…protection*** *and* ***restoration*** *of mental health…can be regarded as a* ***vital concern*** *of individuals, communities and societies* ***throughout the world*** *(sourced by the AASW from the WHO 'Mental health: strengthening our response').* (AASW, 2014a, p. 5)

However, the language suggests that there are filters (Fairclough et al., 2004), or the favouring of discourse ("protection" and "restoration") that may implicate the use of restraint, which occurs in situations where there is the possibility of detention under a Mental Health Act. Restraint is indicated through the meaning associated with restoring the need for mental health and protecting people while they are experiencing mental distress. The restoration of mental health, together with the following sentence about it being of "vital concern" to individuals, communities and societies worldwide filters the discourse "within the broader ensemble of social phenomena" (Fairclough et al., 2004, p. 12) regarding the place of people with mental health related matters; they are represented as being a potential global burden. This represents mental distress as an affliction and situates it in a globalised context. Caution must be exercised here when contemplating the requirement of MHSW to be aware of the cultural context because different cultures hold different views about what constitutes mental distress, health and being a social/economic burden. This is particularly pertinent for MHSWP in Australian society, which intersects with a diverse range of cultures. Despite cultural differences, however, one constant is the pervasiveness of the psychiatric-pharmaceutical enterprise, which is recognised across the globe (Pilgrim, 2015b).

Moving further into the introduction, a statement from the World Health Organisation (WHO) bio-psychosocial dimensions of good mental health is utilised to explicate "the multiple factors that can compromise a person's mental health" (AASW, 2014a, p. 5). Examples cited here range

across four areas ("personality", "finances and education", "socio-environmental matters" and the "personal"):

> …***personality***, ***inadequate*** finances and ***education***, *socio-environmental* matters such as ***risks of violence***, and the ***personal***, such as an ***unhealthy lifestyle*** *(AASW, 2014a, p. 5)*.

However, the language used to describe these semiotic conditions features the "inculcation of … discourses in the ways of being" (Fairclough et al., 2004, p. 11); the way the discourse is revealed in the policy creates representations (Bacchi, 2009) about matters that may be cause for mental distress. Hence, this brings with it implications for practice in responding to mental distress. There is a reduction to language that equates with the person – "personality", "inadequate", "risks" and "unhealthy" are inherent. This, as explained in chapters 1 and 2, is the language of pathology. From the standpoint that these are attributable to the person, what does this mean for people with a lived experience who are the subjects of these negative attributions in the mental health arena? This discourse creates ways of being for both practitioner and citizen (Ife, 2012). The practitioner (for example a mental health social worker) comes to understand that citizens in mental distress are unhealthy, inadequate or perhaps a violence risk, while at the same time citizens are attempting to trust the practitioner's services. For example, the professional expertise (integrity) of mental health social workers is to facilitate the creation of safe spaces for citizens, assisting the development of trust. In doing so, the citizen eventually comes to believe, at times tentatively, that they may begin to share their fears about a gambling habit; a habit impacting their finances and their family (or significant other), which has now reached a point where they are experiencing destructive thoughts, negating their capacity for joy. Currently, this person can potentially risk their rights as a citizen and receive a label (diagnosis) that is almost impossible to remove, thereby losing their identity (Becker, 1973; Curra, 2011; Foucault, 2006a,b; Goffman, 1961; Laing, 1985; Szasz, 1961, 1965, 1970, 1973a, 1974, 1978, 1988, 1997a,b, 2010a; Scheff, 1975, 1999, 2006, 2009, 2010). Despite the possibility that their identity *may* have been troubled prior to receiving a diagnostic label, the author, as a mental health social worker, firmly believes that an illness approach will not improve it.

The risk noted here has implications for MHSWP because when citizens access the services of a mental health social worker, they may be referred to the services of either a General Practitioner (GP) or a psychiatrist for further assessment. This may result in a diagnosis, perhaps of a Personality Disorder (PD) because of indulging in an "unhealthy lifestyle" (an apparent personality inadequacy), and being labelled "mentally ill", whether their thoughts are in order or not. Surrounding this scenario is the generative mechanism of the need for services to meet Medicare's government bulk billing requirements, necessitating a code (diagnosis). If the GP or psychiatrist refers the citizen to an accredited mental health social worker (ACMHSW) in private practice, a "Medicare Better Access Plan" is required to enable the citizen to claim funds from Medicare for

services provided (see Diagram 1).

Diagram 1: The never ending bio-psychiatric, disease-saturated (illness) cycle reinforced by legislation

Given the requirement for diagnosis in this cycle, where does this leave the ACMHSW other than to abide by the medical model to ensure payment for their services, particularly noting social justice in the previous gambling example, where the citizen is likely to need access to Medicare funding.

The five paragraphs of the introductory page for the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) contain a multitude of words that support the bio-psychiatric, disease-saturated (illness) discourse – the language of disease, disorder, disability, illness, personality and biology – and thus the bio-psychiatric, disease-saturated (illness) approach. There is brief reference to "social justice grounds" (AASW, 2014a, p. 5), however this is not expanded upon and, arguably, offers no further explanation or clarity as a guiding policy document for standards of practice in MHSW. In addition, the final paragraph of the introductory section states

"best practice ways of working with" (AASW, 2014a, p.5) people and their families, yet there is no information supporting this statement. For example, what is the place of a critical social work approach as *best practice*? The explanatory lines in the final paragraph, incorporating "best practice ways", also denote mental health social workers as "practicing in a specialised area". Yet, accepting the reality that mental distress is seen in any setting where social workers practise, what does this mean for social workers not in a specialised mental health service?

Finally, the introduction contains several dot points that serve as a guide to establishing the "progress for a person with a mental *illness* or *disorder"* (AASW, 2014a, p. 5). Again, this refers to assessment, treatment, mental illness and disorders. The first dot point acknowledges "the quality of the professional relationship" as a key factor influencing the progress of people experiencing any severity of distress, and for ensuring access to services. The relationship, noted as a key factor, adheres to "best practice", but the language filtering through an illness paradigm leaves little doubt about the direction for intervening. That is, the intervention abides by a bio-psychiatric, disease-saturated (illness) paradigm, also bringing possibilities for coercive intervention utilising Mental Health legislation (discussed in later sections of this stage).

The author argues, then, that adhering to social work's core value of respect for persons (AASW, 2014a, p. 6) values and recognises people, as citizens of the State, (Ife, 2012) in their (human) right to seek help via non-medical avenues. For example, some people may seek solace in alternative therapies, such as relaxation through massage, aromatherapy and narrative therapy (White, 2000). A MHSW practitioner who assists people to explore alternatives of their choice is acting with integrity and practising social justice; this is critical-emancipatory MHSWP.

Framework

Values

This section in the *Practice Standards for Mental Health Social Workers* (2014) identifies the core values of social work from the *Code of Ethics* (AASW, 2010), which are:

1. Respect for Persons
2. Social Justice
3. Professional Integrity

These values "give rise to general and ethical responsibilities" (AASW, 2010, p. 12) for all social work professionals. Therefore, they serve as the guide for MHSWP, providing a moral foundation that traverses layers critical to understanding the basis for decision-making in practice situations, which, on occasion, require negotiating dilemmas, the consequences of which can, and do, severely impact people's lives. First is valuing the innate worth and uniqueness of people as human beings and their rights as citizens (Ife, 2012) to participate in society with autonomy and freedom (AASW, 2010). Second is the broader obligation as a MHSW professional to endeavour to "promote" (AASW, 2010, p. 13) socially just circumstances for citizens through advocating for change to oppressive systems and structures, thereby seeking to address ("opposes") "human

rights" violations (AASW, 2010, p. 13). Third is the moral obligation of a professional to act with "integrity" (AASW, 2010, p. 13), which necessitates a presence that demonstrates respect for practising with sincerity, being trustworthy, knowledgeable and skilled, yet humble enough to acknowledge that learning and skill development is a lifelong process requiring a commitment to improving the self-in-practice (AASW, 2010).

These three core values hold the key to opening the door to critical-emancipatory MHSWP that goes beyond practitioners' long-held reservations about challenging the psychiatric enterprise. There are many examples for expedience in making a poignant point. Mental Health legislation is one of them. Various sections within the all the Mental Health Acts in Australia allow for detention and treatment of citizens against their will. The demonstrated accounts of citizens' lived experiences of severe mental distress presented in Chapter 2, which the author has also witnessed in her MHSWP, are testament to this reality. The detention and forced treatment of citizens against their wishes can, and does, severely affect their human right to freedom, and preservation of their identity and dignity (Goffman, 1961). The author contends that these practices are extremely oppressive, disregard dignity and deny citizens the freedom to make choices about the best way forward through difficult times. A critical-emancipatory approach regards the social work values of respect for people and their human rights as socially just and integral to MHSWP, and in accord with the notion of "best practice". Additionally, MHSW practitioners are bound by the *Code of Ethics* (AASW, 2010) and therefore should contest coercive psychiatric interventions. They need to do this with professionalism and without fear. If this is not occurring, MHSW practitioners cannot claim that they truly value human beings' innate worth and citizens' right to autonomy. They are not adhering to the opposing of socially unjust practices, nor are they respectfully preserving citizens' dignity and therefore their identity. Arguably, then, at the most this is un-ethical practice, and at the least it is not abiding by the elements of ethical MHSW practice noted as honourable, trustworthy, knowledgeable and skilled.

The author notes that the Framework section in the *Practice Standards for Mental Health Social Workers* (2014) policy excludes Standards 6 and 7, merely referring its readers to the generic *Practice Standards* (AASW, 2013) for further explanation. The author addresses this issue later in the section titled "Standards".

Definitions and Understandings

This section in the *Practice Standards for Mental Health Social Workers* (2014) discusses the "domain" for MHSWP (the "person with a mental illness"), and sets the "social context" for practice and the broader layer of the "social consequences" for people experiencing mental distress. Outlined on the next page are excerpts from these three areas.

> [The] domain of social work in mental health is that of the person with a mental ***illness*** or ***disorder***…social context and the ***bio-psychosocial consequences*** of mental ***illness***…the ***purpose of practice*** is to promote ***recovery***…enhance the ***development*** of each ***individual's self-determination***…advance ***principles of social justice*** [and later in the same paragraph] …that ***activity begins with the individual.*** (AASW, 2014a, p. 7)

The overarching themes here represent:

- illness
- disorder – implying that practitioners are drawn to conclusions that revolve around bad or incorrigible behaviour (Pilgrim, 2015b)
- Recovery – a concept that has developed within the illness paradigm (Anthony, 2007)
- the individual – the pathologising of people through notions that surround biological and psychological matters.

These themes produce the order of discourse that again represents the phenomena of illness and pathology; the domain and dominance of a medical presence. This is not the language of socially just social work. It implicates and reinforces the individual pathology at the centre of practice when a group or community approach is more appropriate, for example, a whole school approach for a crisis event.

<u>The person</u>

The language used in relation to "the person" clarifies the role of the mental health social worker – "some social workers are sole mental health service providers while others may be part of a team or a unit" (AASW, 2014a, p. 7) – when discussing the parameters of practitioner engagement.

> …engaging with 'the person'…is concerned with ***assessment, intervention*** *or* ***treatment planning****…****outcome monitoring…collaborate*** with the ***relevant professionals*** and ***people who have an impact*** on the person's wellbeing. (AASW, 2014a, p. 7)

Again, the dialogue accords with earlier discussions about the representation of discourse; that the filtering and privileging of discourse favours a bio-psychiatric, disease-saturated (illness) approach. For example, "collaborate with the relevant professionals" (AASW, 2014a, p. 7) does not state which relevant professionals. It is implied that they are predominantly psychiatrists, nurses and other allied health professionals associated with the psychiatric/mental health industry, as well as family and/or significant others associated with the distressed person. It is very unlikely to be referring to other professionals such as chiropractors, speech pathologists or physiotherapists, who could perhaps hold relevance in assisting to improve the distressed person's wellbeing. This invites a question about collaboration with "people who have an impact on the person's wellbeing" (AASW, 2014a, p. 7). Who are these people?

Perhaps there may not necessarily be the need only for mental health professionals. There may be other ways to make a difference to the person's wellbeing by optimising their lived experience away from mental distress. For example, when chronic pain from spinal issues affects mental wellbeing, the services of a chiropractor and/or a physiotherapist may be of benefit. Other therapeutic endeavours may also assist, such as aromatherapy, massage or music. Perhaps a love of music may assist connection with other people in a band, an ensemble or similar. Thus, while being person-centred ("engaging with *the person*") has an important place in MHSWP, the language directs the mental health social worker only to the individual, the psychiatrist or the nurse (or similar allied health professional). These professionals have influence and are automatically afforded legitimacy in the person's life , whereas others who may well begin to connect, or create new connections and bring new meaning to the person's life outside the dominant bio-psychiatric, disease-saturated (illness) sphere of diagnosis, intervention, treatment and planning for more of the same (the status quo) are veiled. The language of the bio-psychiatric, disease-saturated (illness) discourse implies that these others are not considered "relevant professionals" and their endeavours are not "interventions of relevance".

This represents the idea that "the existing state of affairs does not exhaust what is possible" (Chouliaraki & Fairclough, 1999, p. 35). It also raises questions about the effectiveness of the Recovery paradigm. What is recovery? On whose terms? What are the bounds of recovery? Who would define them?

Social context

Importantly, this theme reflects the *Practice Standards for Mental Health Social Workers* (2014) requirement for MHSW practitioners to have awareness about the influences of social circumstances on people's lives. Given the repeated representation of language that has the effect of reinforcing definitions and descriptors within the bio-psychiatric, disease-saturated (illness) paradigm, this moots the personal amid the critical importance of the social context.

> …shapes their experience of mental ***illness***…***problems***…the ***internal*** but also the external factors affecting vulnerability and resilience…***stressors***…impact of ***wider social issues such as economic wellbeing, employment and housing.*** (AASW, 2014a, p. 7)

This focus on the social context has the potential to place emphasis on the person's pathology rather than focusing on the realities that lie among the social "environment", domestic violence being one example. While the social context is inexorably pertinent for MHSW knowledge and practice, this fact is further lost in the translation of the "social consequences" (AASW, 2014a, p. 7) set out on the next page.

Social consequences

> …***social work acts*** on the effect of ***mental illness***…mental health ***problems*** on ***economic security employment*** and ***housing*** …and the potential ***connection*** between ***mental illness*** and broader ***health*** and ***welfare issues***…***child protection, homelessness and domestic violence.*** (AASW, 2014a, p. 7)

These lines take a reductionist approach to MHSWP, inferring that there are individuals with "problems". The representations of these problems (Bacchi, 2009) accord with "mental illness", and therefore bring the potential connection to issues surrounding children, accommodation and living in fear in an intimate (or previous intimate) domestic violence relationship. Although the policy states (AASW, 2014a, p. 7) that these issues are "potentially" in people's lives, much MHSW lies at their intersection, increasing the risk that such issues will be reduced to the contexts and consequences surrounding individual pathology, child rearing, finances, unemployment/ underemployment, vagrancy and disadvantaged relationships, all associated with mental "illness". This situation requires re-adjustment of the lens through which MHSW practitioners view marginalisation and difficulty to sharpen the focus upon the political nature of (human) being; the personal being connected unreservedly to the political. Social issues and situations occur in political and historical contexts involving multiple and competing interests, notwithstanding the impact of neo-liberalism within this (Adams et al., 2002, 2009; Allan et al., 2003; Allan et al., 2009; Bay, 2014; Fook & Gardner, 2007; Gray & Webb, 2013; Hallahan, 2012; Healy, 2012; Ife, 2012; McDonald, 2006; Morley & MacFarlane, 2010; Morley et al., 2014; Pease & Fook, 1999; Webb, 2006; Webb & Gray, 2013).

The discussion in Part 2 addresses MHSW notions for social work learners and advanced practitioners in contributing to the re-construction of people's lives. Re-construction adheres to critical-emancipatory MHSWP that affords potential for people (possibly for the first time) to gain at least a beginning sense of identity and belonging, and some sense of control in their lives. This equates with the human right for people, as citizens (Ife, 2012), to be able to re-evaluate their understanding of what it means to participate in the fabric of life; something that had previously been the source of dilemmas of existence.

In addition, critical-emancipatory MHSWP requires being ever mindful of gendered notions amid the potentially devastating ripple effect of domestic violence and what this means for women experiencing mental distress. Many of these women are accused of being "crazy", labelled with a PD or borderline personality disorder (BPD), and described as "annoying" when in receipt of services it is implied they do not deserve (Smith, 1990a; Smith & David, 1975).

Addressing matters of child protection, domestic violence and homelessness requires reflexivity (Fook, 2012; Fook & Gardner, 2007) that assures information sharing and documentation (Standard 7) to ensure consistent, clear service provision with ethical regard for women's rights. This moves outside the realm of the dominant bio-psychiatric, disease-saturated (illness) discourse, edging toward epistemological and ontological notions grounded within a

critical-emancipatory approach to MHSWP. The author is deeply concerned that Standard 7 is omitted from the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) when it is so crucial to working with mentally distressed women and children.

Standards

This section of the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) policy outlines the six standards which, although generated from the *Practice Standards* (AASW, 2013), relate specifically to MHSWP (AASW, 2014a, pp. 8-25). These standards are:

Standard 1. Values and ethics
Standard 2. Professionalism
Standard 3. Culturally responsive and inclusive practice
Standard 4. Knowledge for practice
Standard 5. Applying knowledge to practice
Standard 8. Professional development and supervision.

Exclusion of Standard 6 and Standard 7

Despite the AASW noting that Standard 6, *Communication and interpersonal skills* and Standard 7, *Information recording and sharing* from the *Practice Standards* (AASW, 2013) are applicable to MHSWP, they are not included in the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) policy. The AASW expects mental health social workers to access these two Standards from the generic *Practice Standards* (AASW, 2013) policy. Regarding Standard 6, a critical element of MHSW is the ability to create an empathic, safe and trusting relationship in practice, which requires higher order communication and interpersonal skills. Several matters for consideration arise from the lack of the AASW offering a MHSWP-specific explanation of Standard 6 in the MHSW policy, not the least of which is clarity and consistency within this policy document. There is also the potential for minimisation of this Standard in practice due to the risk that new learners, as well as practitioners, may not acquire sufficient depth of explanation, which may lead to lack of clarity about the purpose for practice. Thus, there is a lack of identification of all the necessary elements required for working toward creating policy that safeguards the process of generating ethical MHSW policy knowledge for practice. In addition, the author contends there are communication and interpersonal skills that require higher order reflection upon the self-in-practice for application in MHSWP; a situation that holds implications for MHSW education (see Part 2 of this thesis).

Regarding Standard 7 (Information recording and sharing), the author contends that many occasions in MHSWP require knowledge and skills in both documentation and ethical boundaries, thus providing clarity of purpose for practice. Examples of significance here are those situations when practitioners' notes are subpoenaed in a coronial inquiry into suicide, for guardianship matters or for various other orders for treatment that require a depth of knowledge about the intricacies and complexities implicit in ethical, rights-based and socially just mental health practice.

Not acquiring specific knowledge in education about the intricacies and complexities of these situations, assisted via the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) policy, serves to underrepresent the possibilities that occur amid the realities of work, particularly where complications occur in situations of severe mental distress.

Exposing the bio-psychiatric, disease-saturated (illness) discourse in the mental health social work perspectives and approaches in the Practice Standards for Mental Health Social Workers

The following table (Table 1) identifies a selection of words and phrases contained in the six Standards in the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) policy. The table demonstrates the contrast between the domains of MHSW and psychiatry, noting that all the words and phrases contained in the table come from the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) policy. The left column, titled "Bio-psychiatric, disease-saturated (illness) perspective and approach", reveals a variety of words and phrases that are most commonly associated with this paradigm for practice. The right column, titled "Mental Health Social Work perspective and approach", reveals various words and phrases that are most commonly associated with a social work knowledge base and social work practices. Furthermore, to the best of the author's knowledge, only social work professionals compiled the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) policy. These professionals represent a variety of settings associated with MHSW education, the AASW executive and the practice field. Psychiatry did not participate in this policy process, thus the language used in the policy serves to reinforce the dominance and impact of a bio-psychiatric, disease-saturated (illness) approach emanating from within MHSW itself; a major contention of this study.

Table 1: Contrasting the language between psychiatry and mental health social work

Bio-psychiatric, disease-saturated (illness) perspective and approach	**Mental health social work perspective and approach**
Mental *illness*, *disorder*	Contemporary language…consumer context…consistency
Therapeutic relationship	Values the lived experience
Mutuality in *assessment* and *action planning*	Works in partnership
Bio-psychosocial assessment	Inclusive language
Diagnosis and *treatment*	Respects the person's experiences, beliefs and feelings
Recovery	Acts on the social justice issues …supports people to take responsibility for their own recovery
Medico-legal requirements	Recognises the complexity
Duty of care	Promotes rights to participation in decision-making and choice
Supports people to trust and collaborate *with mental health professional or multi-disciplinary mental health team*	Ensures civil and human rights are recognised

Table 1 continued

Bio-psychiatric, disease-saturated (illness) perspective and approach	**Mental health social work perspective and approach**
Is conversant with the role of social work within the organisation….*recognises* the *management* structure of the agency or program *and understands the lines* of professional and administrative *accountability*	Challenges stigma and discrimination
Meets organisational… deadlines…*efficient* completion of… *tasks*	Uses language that conveys hope
Complies with organisational…health and safety policies	Inclusion of people…and their significant others
Ensures the *provision* of *effective services for people with a mental illness*	Relationships…respect…collaboration…compassionate manner
Understands and *clearly states* the *range* of *mental health services within the organisation* and *manages these services according to government and organisational policy*	Analysis…contributes
Develops *formal* and informal *arrangements* …*implementation*	Understands the scope of the social work domain
Supports the *activities* of *other mental health professionals in the organisation* and…other *organisations* or *private professionals*	Culturally appropriate
Evidence-based theories	Developing within…social context
Concepts and theories of human *bio-psychosocial development*	Concepts and theories (that (should) traverse a variety of perspectives and approaches (pluralism/multi-factorial)
Psychopathology…family formation and *functioning…family functioning over time*	Recognition of diversity
Group *behaviour*	Theories of group work
The *impact of illness*	Person's sense of self…issues of stigma…social justice
Relationship between mental health and family *welfare*…potential *compromises* to *children*…significant *others' roles*	The impact of abuse and trauma in the person's life
Application of *disability* concepts to mental *illness*, *treatment* and *rehabilitation*	Strengths perspective…support the process…achieving a better quality of life
Possesses knowledge of mental health *psychopathology*…*illness*, *disease*, *disability*…*disorders* at different life stages…*psychiatric classification*, *major syndromes*…*aetiology*…*dual diagnosis*…*dual disability*	General social work theory
Establish or *confirm facts* or *solve problems*…*facts* to *establish* the *evidence base* for *practice*	Possesses knowledge of society…theories of social justice…. action to counter them
Completes a *comprehensive bio-psychosocial assessment* and *case formulation*…	Broader Australian social and political context including the history of Australian politics and society
Undertakes *a Mental State Examination* and other assessments of *clinical functioning*…to develop a detailed knowledge of…*problems*	Social determinants…sociology of alienation and oppression...history of mutual support and empowerment processes

Table 1 continued	
Bio-psychiatric, disease-saturated (illness) perspective and approach	**Mental health social work perspective and approach**
…use of *outcome* measures, *assessment of psychiatric disability…application of standardised assessment schedules*	The practice paradigms of the other mental health disciplines
…*minimise risk…risk assessment*…potential for the person's *capacity to harm others…establishes* or *confirms* the *likely mental health condition…in the absence of a formal diagnosis, forms a provisional diagnosis until this can be confirmed…focus* on *shared understanding* (whose understanding?) of the *problems*	Research…seeks out…policy…documents areas where policies conflict with the social work professional *Code of Ethics*, or where policy is deficient in addressing the needs of clients
Contracts with the person to *establish a basis* for the *intervention*	Negotiates
…information about the *purpose*, *nature*, *risks* and *likely outcomes* of the *intervention*	*With* the person
Undertakes *case* management…*assessment* of…*treatment team…consults…implementation* of the *service plan…monitors* regularly	Monitors (navigates?) the activity of the team…respectful, inclusive of the needs and wishes…the person…family members
Engages with…key informants (such as) church, police, government agencies, service managers	…principles of mediation, negotiation, assertion and conflict resolution
Analyses the *evidence* (in service development) for options for service delivery needs *in relevant Australian and international research* to meet identified need	Links individuals, carers and family members with support and advocacy…evaluates the outcome of advocacy…advocates with and for people within specialist contexts
Analyses *resource implications* for alternative service responses…consults with *stakeholders* in reviewing alternative approaches…selecting a preferred option. There is no explanation about what the alternatives are here	Challenges organisations or systems of service provision that are disempowering or discriminatory of people with (*mental illness*) and their significant others
…access to the resources required for *service implementation with management*	Supports communication and co-operation…social action…analyses the social, political and cultural context…resolve issues (and) injustice…review…(policy context) determines range of perspectives…seeks feedback…suggests directions for mental health policy development
Solves problems with people who have a *mental illness* and service providers regarding *specific difficulties* encountered by individuals and groups in accessing services	Establishes the need for research or evaluation projects…ongoing process…improving service delivery
…the professional's own *cases…legitimate subject matter* for *research*	Identifies a particular research question...to be investigated
Consults with *professionals who have specialist knowledge* to *help strengthen* the research or *evaluation design* and *process* of *implementation*	…addressing the ethical issues identified for the research…establish the range of perspectives on the research or evaluation project
…findings relevant to best practice What does this mean?	Develops a plan for the dissemination and implementation of project findings

Table 1 continued	
Bio-psychiatric, disease-saturated (illness) perspective and approach	**Mental health social work perspective and approach**
…*formal* and *informal* discussions with colleagues In what context?	Maintains a critical reflective approach to social work practice…aim of improving the currency of knowledge and skills
Reflects on professional activity in relation to the research literature…accesses the research literature to be informed of the *evidence base* for professional *mental health* practice	Identifies personal strengths in skill development and knowledge…areas for personal development in knowledge and skill-base for practice…shares critical reflections on practice
	Critically evaluates research literature…analysis of data
	Maintains reading and exploration of knowledge in relevant research areas to inform practice

Interrogating, exposing, interpreting and integrating the bio-psychiatric, disease-saturated (illness) perspective and approach

Interrogating the words in italics in Table 1's left column brings an immediate familiarity with the language of psychiatry and therefore that of psychiatric social work. The semiotic conditions apparent within this discourse favour a psychiatric discourse for social work practice rather than highlighting features specific to a MHSW discourse. This serves to position and regulate MHSWP within a psychiatric social work paradigm (Fairclough, 2001a,b; Fairclough et al., 2004) situated within a bio-psychiatric, disease-saturated (illness) approach, as explained in *Critical Realism and Semiosis* (Fairclough et al., 2004, p. 16):

> … [s]emiosis is an instance of emergence par excellence and in moving back towards the concrete we attempt to register how meanings emerge in texts…semiotic emergence is tied not only to shifting articulations of discourses, genres and styles as such, but also texts as processes…working together of diverse elements in texts over time and space.

Therefore, in attempting to register how meanings emerge in the discourse (highlighted in Table 1's columns), the genre is one of mental incapacity, illness, mental state examinations, assessment of psychiatric disorder, treatment, risk, clinical functioning, problems (and problem-solving) and ensuring adherence to an apparent evidence base that favours a bio-psychiatric, disease-saturated (illness) discourse. The style sways between the bio-psychiatric, disease-saturated (illness) paradigm and the MHSW attempt to approach practice from valuing people's lived experience, reflecting critically upon practice, recognising complexity and diversity, promoting rights to participate in decision-making and choice among a recognition of civil and human rights, challenging stigma, being inclusive and compassionate, and traversing a variety of perspectives and approaches. The use of "contemporary language" (in the MHSW column) is not expanded, nor are the concepts of "partnership", "process" and "promoting consumer rights" to "participation" (presumably in mental health services).

Hence, there are inconsistencies. On the one hand is the articulation of a commitment to social work's core values of respect for persons, advocating for socially just practices (for example, "evaluates the outcome of advocacy") and acting with integrity by being informed across a variety of perspectives, reflecting on practice and promoting people's right to participate in decisions about their care. On the other hand are competencies for practice that accord with MHSWP being implicit in social control for illness and disorder, framed in terms of complying with organisational policies and legislative requirements, psychopathology, family functioning and mental illness regarded as a disability, thereby affording treatment via an evidence base that values discourse in the bio-psychiatric, disease-saturated (illness) paradigm.

Given that social work's core values are in place to guide ethical MHSWP, these competencies in the Standards keep the individual at the forefront of the MHSW approach; the person-centred approach. The generative mechanisms, being in the bio-psychiatric-pharmaceutical enterprise, and the structural issues that marginalise people result in an impasse in people's capacity to cope amid their unendurable pain. This becomes apparent when experiencing the severe and debilitating side effects of many medications, for example, which presents in unusual thoughts and conversation that reveal the person's trauma (Breggin, 2009; Moncrieff, 2009; Wilkinson, 2005).

Furthermore, where does the moral obligation for MHSWP fit in situations where MHSW practitioners are advocating for citizens' (human) right to participate in decisions about their care, which may mean saying "no" to some treatment(s) because of citizens' fear demonstrated through dissatisfaction, anger or even apathy? At what point, if any, does MHSW leave the domain of psychiatric social work practice guided by bio-psychiatric, disease-saturated (illness) opinion? Clarity is required about where this epistemological and ontological boundary is crossed.

Finally, the following statement in the first Standard, *Values and Ethics*, 1.3 (e) is of high importance in the *Practice Standards for Mental Health Social Workers* (AASW, 2014a, p. 9):

> In situations where ***involuntary treatment is unavoidably indicated, works to minimise*** or ***eliminate*** the use of ***coercion, seclusion and restraint***.

There are several points here. First, this statement, promoted as a Standard for MHSW practice, does not pay close attention to the core values of social work, especially given the aforementioned examples and the inherent inconsistencies argued therein; nor does it adhere to principals of ethical practice. The *Code of Ethics* (AASW, 2010) serves as a *guide* for ethical practice. Therefore, although prescriptive, it is neither complete nor all encompassing. For example, in Section 5, *Ethical Practice: Responsibilities* (AASW, 2010, p. 16), part 5.1.1 (*Respect for human dignity and worth*, AASW, 2010, p. 17) contains several points that guide critical-emancipatory MHSWP, most pertinently:

> (a) …respect for clients and seek to preserve and promote their dignity, individuality, rights… (AASW, 2010, p. 17)

If MHSWP aspires to the core social work value of “Respect of Persons”, together with the ethical imperative of respecting the inherent dignity and worth of people – their human, civil and individual rights – there is a requirement to act using the core social work value of “Professional Integrity”. This accords with the core value of advocacy; social justice for people experiencing the trauma of mental distress, rather than the effects of probable prior trauma in their lives to participate in decisions about their care. How then, in the current bio-psychiatric, disease-saturated (illness) driven mental health system, do MHSW practitioners marry the *Code of Ethics* (AASW, 2010) with the *Practice Standards for Mental Health Social Workers* (AASW, 2014a), to “work to minimise or eliminate the use of coercion, seclusion and restraint” (*Values and Ethics*, 1.3 (e), AASW, 2014a, p. 9)? The author suggests there is a lack of knowledge and confidence among MHSW practitioners to advocate for socially just outcomes for people who try to contest psychiatry’s use of the legislation in imposing orders for their care.

> (b) …respect…needs and desires…within a framework of social justice and human rights. (AASW, 2010, p. 17)

Following on from the previous point, point (b) uses the words “needs and desires” to emphasise MHSW practitioners’ obligation to respect people as citizens (Ife, 2012) with civil and human rights; to enter the process of contesting legislative orders already imposed upon them against their will, or where psychiatry has requested the continuation of orders.

> (c) …value the unique cultural knowledge…lived experience…Aboriginal and Torres Strait Islander peoples, and take these into account in the making of decisions. (AASW, 2010, p. 17)

In accepting Foucault and others’ (Bay, 2014; Chambon & Irving, 1999; Macfarlane, 2009; Morley & Macfarlane, 2010, 2011) arguments about marginalisation and “othering”, there is a need to exercise extreme caution when being witness to coercion, restraint and seclusion in MHSWP. Furthermore, reflection upon the historical journey of human rights abuses of Aboriginal and Torres Strait Islander peoples, and the potential for the same with the current detention of asylum seekers, places MHSW practitioners at the epicentre of igniting socially just actions. In such situations, the question that must be asked is:

At what point does unavoidably indicated involuntary treatment become torture?

> (d) …ensure that clients or their authorised representatives have access to the necessary information and resources to participate in decision-making processes. (AASW, 2010, p. 17)

Point (d) concurs with points made regarding respecting people’s rights to information (also implicit in Standard 7) about mental health legislation; about understanding the process therein when orders are imposed for ongoing involuntary treatment, and therefore their rights to

participation and choice in their care.

> (f) …ensure they understand the communities in which they work, (in particular marginalised groups), by actively engaging, building relationships and participating in activities… (AASW, 2010, p. 17)

Point (f) calls for the understanding of marginalised groups and communities. In the situation of seclusion and restraint against a person's wishes, this may be compounding the person's already marginalised status, for example, if they are an Aboriginal or Torres Strait Islander person, an asylum seeker or refugee, or a woman. The ethical responsibility for MHSWP to ensure access to information and resources is paramount where marginalisation may be at the centre of coercive practices. An example is the current high profile case of marginalised Aboriginal and Torres Strait Islander children and young people incarcerated in the Northern Territory for choices and actions that may well be the result of ongoing and unresolved grief and trauma in their lives. The federal government has announced there will be a Royal Commission to examine the human rights' issues arising from this situation.

Another example is the marginalisation of women in domestic violence where a male perpetrator contacts mental health services for assistance to have his partner "locked up" because she is "crazy". The author has witnessed this many times throughout her MHSW practice. Although this does not mean this always occurs, it has occurred and continues to occur (Findlay, 1975; Longden, 2013; Smith, 1990a,b,c; Smith & David, 1975). This is not only consistent with marginalisation but also holds the potential for being shrouded in patriarchal notions of sexism and misogyny – all of which MHSWP has the knowledge base and skill to contest with the Professional Integrity ethic of care that carries with it diplomacy and tact.

Australian Association of Social Workers Standards for Education in Mental Health Social Work Practice: Australian Social Work Education and Accreditation Standards (ASWEAS)

The following discussion addresses both the value-base and ethical principles that form the knowledge base, via education policy (AASW, 2012,a,b), which guides MHSWP. This reveals the reproductive nature of MHSW education which, for example, contributes to the concerns that Standard 1.3 (e) (*Values and Ethics*) raises for MHSW education, policy and practice.

The AASW MHSW policies for education (AASW, 2012, a,b) invite MHSW learners to the arena of knowledge and values, including experienced practitioners (some of whom may have trained previously in psychiatric social work) returning to advance their prior knowledge and skills for current and future MHSWP. The *ASWEAS Standards* (AASW, 2012a) and supporting *Guideline 1.1* (AAASW, 2012b) guide social work educators to situate curriculum that supports and advances MHSW learners' knowledge base, values and skills for MHSW practice. This means there is a requirement to facilitate an educative process that progresses MHSW learners' understanding about the context and complexities in which social work practice occurs. For example, MHSW practitioners are required to "critically analyse social, political, economic, historical, cultural, legal

and ecological systems" (AASW, 2012a, p. 11), yet *Guideline 1.1* (ASWEAS, 2012) uses the language of bio-psychiatry and pathology to promote a reductionist approach that locates the individual at the centre of their plight. This approach negates the broader critical realist account of the generative mechanisms (Archer et al., 1998; Pilgrim, 2015b) surrounding power relations (Allan et al., 2009; Bay, 2014; Chambon & Irving, 1999; Foucault, 2006b; Morley & Macfarlane, 2010; Pease & Fook, 1999), hegemony (Gramsci in Bates, 1975) and structural notions (Mullaly, 2010) embedded within the context and consequences of mental distress (Bay, 2014; Kirk et al, 2013; Morley & Macfarlane, 2010; Pilgrim, 2015b; Tew, 2005). Where does this contradiction leave a critical-emancipatory approach to MHSW education and the people MHSW practitioners are serving in situations where "involuntary treatment is unavoidably indicated [and they work] to minimise or eliminate the use of coercion, seclusion and restraint" (AASW, 2014a, p. 9)?

Examining *Guideline 1.1, Section 1.2.1, Essential areas of knowledge* (AASW, 2012b, p. 5), reveals from the outset the language of "problems and interventions". Not only does the language of problems imply there are, and will be, "problems", it also serves to reinforce that mental health matters are problematic, when at times they are not, given the aforementioned discussion about generative mechanisms and structural notions. Further exploration again highlights multiple uses of the word "problem(s)", such as behavioural and alcohol problems, resolving mental health problems, and the need for a "basic grasp of a psychiatric diagnostic framework" (followed by a list of the various "conditions") followed by the requirement of needing to learn about mental state examinations (MSEs). Thus, this section of *Guideline 1.1* moves to an overarching focus on intervention through medication, treatment and therapy, implying adherence to legislative requirements for "social work…particularly… involuntary treatment…and guardianship" (AASW, 2012b, p. 6). The discussion does not pursue the possibilities for mental health social workers advocating for people's human rights where they are violated in coercive treatment. Nor does this policy document clearly advocate a social work knowledge base that supports socially just (Finn & Jacobsen, 2003) and human rights practices. Therefore, *Guideline 1.1* requires analysis and critique from a socially just and human rights practice perspective.

Finally, of importance in this section of *Guideline 1.1* (AASW, 2012b), is a short paragraph regarding the place for MHSW in assessing the social and environmental factors, or the context, in which issues pertaining to mental distress can and do occur. Again, however, this focuses only on the individual. Although the section on *Attitudes and Values* does address "respect for the ethic of care [which includes] the right to refuse treatment" (point 9, p. 4), this is followed immediately in the same point by the condition "except in certain circumstances defined in state mental health legislation". This assumes that the legislation is socially just. However, this legislation legitimises the use of coercive care. Therefore, the author argues that it is equally legitimate for MHSW to critically analyse this legislative process as an infringement, if not an abuse, of human rights. She also argues that MHSW must advocate for changes to the law rather than blindly accepting the dominant status quo of the psychiatric enterprise that has played a historical and contemporary

hand in the justification for formulating and enforcing mental health legislation that oppresses, further marginalises and stigmatises people experiencing the effects of prior trauma. This is not withstanding the requirement that other legislation serves to hold accountable people who commit acts that infringe upon the safety and freedom of others. Even though these people, too, may have suffered traumatic events, their wrongdoing need not seek defence amid the realm of mental "illness" legislation (Pilgrim, 2015b; Szasz, 1961), which absolves them of all responsibility. This enters the realm of forensic psychiatry, in which MHSWP is located, which equally requires the critical-emancipatory imperative for situating people amid a trauma-informed approach to assists their journey through their narrative without negating the need for responsibility for their harmful actions.

Despite the discourse calling for respecting people's lived experience and having regard for the broader reasons that contribute to issues pertaining to mental distress, the language provides ample evidence that the bio-psychiatric, disease-saturated (illness) paradigm remains dominant. The AASW *ASWEAS* policies (AASW, 2012a,b) are littered with the language of illness, the "bio" in diagnosis, psychiatric classification, mental state examinations, the behavioural element inherent in psychopathology, and treatment being framed around "therapy". Treatment continues through to the point of coercion, which is supported by legislation, when perhaps alternative options may well be more healing or at the very least have regard for people's civil and human right to participation and choice, as purported in the *Code of Ethics* (AASW, 2010).

Stage 2: Identify obstacles to the discourse-related issue being examined

Fairclough (2001a) posits that this stage identifies the obstacles within the discourse-related issue the researcher is examining by analysing the networks of practices in which it is located and the semiotic aspects amid them. It includes examining the *order* of the discourse, and hence the context and obstacles that may be preventing change. Thus, the author continues her CDA in Stage 2 by identifying the obstacles that locate MHSW education, policy and practice amid a continuing bio-psychiatric, disease-saturated (illness) discourse.

Fairclough (2001b), in *Language and Power*, argues that language "is a part of society, and not somehow external to it…a social process…a socially conditioned process" (p. 19), and that a "text is a product rather than a process" (p. 20). In this situation, the product consists of the policies and Standards for MHSW, which are set by the professional social work association (AASW) and the federal government, thus representing the "values, beliefs, assumptions, and so on" (Fairclough, 2001b, p. 20) of people from several domains. Hence, mental health professionals involved in policy writing are influenced by the traditional, dominant bio-psychiatric, disease-saturated (illness) discourse as well as their practice contexts and lived experiences of mental health phenomena. In essence, mental health social workers are caught in a circular phenomenon whereby they have their own knowledge base, values and beliefs on one hand, while on the other

the dominant discourse of the psychiatry, systems and organisations geared toward working with "the mad, bad and the sad" (Appignanesi, 2009) heavily influences their practice wisdom. This phenomenon also includes the tentacles of *Big Pharma* amid the psychiatric enterprise.

Critical discourse analysis: extant national mental health policy documents, Standards, reviews and reports in scope

The seven federal government documents scoped and analysed were:

1. *The Roadmap for National Mental Health Reform 2012-2022* (COAG, 2012). Compiled by the Council of Australian Governments
2. *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014* (COAG, 2009)
3. *Australian Mental Health Care Classification (AMHCC)* (Commonwealth of Australia, 2015c)
4. *National Practice Standards for the Mental Health Workforce* (Victorian Government, 2013)
5. *Scoping Study on the Implementation of National Standards in Mental Health Services* (ACSQHC, 2014)
6. *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services (CLTC)* (*NMHC,* 2014b). Conducted by the National Mental Health Council.
7. *Australian Government Response to Contributing lives, thriving communities Review of Mental Health Programmes and Services* (Commonwealth of Australia, 2015a).

Included with this analysis is that of the *AASW Response to the National Mental Health Commission's Report on the National Review of Mental Health Programmes and Services* (AASW, 2015) because it deals directly with the federal government review. It is critiqued between *CLTC* (no. 6) and the *Australian Government Response to CLTC (no. 7).*

National Australian mental health policy: the discourse within

The discussion in the opening chapters of this thesis in which the author notes and questions the current state of affairs regarding the mental health of the Australian population is based on statistical data sourced from the above federal government documents. Briefly, recapping this discussion, Australia's federal government, through the coalition of Australian governments (COAG), shares responsibility for overseeing national reform in mental health via public policy for mental health funding and service provision. COAG also responds to the reports (such as those that review mental health services) conducted by various organisations funded by the federal government. State and Territory governments initiate their own policies applicable to their specific needs, but guided essentially by federal policy informed by two federal government organisations that manage the strategies and reforms for mental health in Australia. These are the Australian Institute of Health and Welfare (AIHW) and the National Mental Health Commission (NMHC). In addition, the NMHC, given its "Commission" status by the federal government, is granted authority to report independently to other federal departments, hence the scoping of *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services (CLTC)* (NMHC, 2014b) in this study. As acknowledged in Chapter 1, a number of interest groups

offer submissions and serve on a variety of sub-committees that have some input into the above documents. However, these submissions have not been scoped for this study because its focus is directed to the implications of the federal government policy, reports and reviews that influence MHSW education and practice.

National level documents apply to the broader national focus for mental health service provision in terms of practice standards, the review of service provision quality, classification (diagnoses) of the issues people present to services with, the basis for, and implications of, funding requirements, and measures for reform. Although these national documents inform State and Territory policies, they do not necessarily cover non-government organisations (NGOs) or the private mental health sector. However, the one exception here is the *National Practice Standards for the Mental Health Workforce* (Victorian Government, 2013) because COAG mandates that NGOs and private providers adhere to these Standards. It is noteworthy that many NGO agencies bid for, and receive, federal government funding for the provision of their mental health services, which has implications for service provision. Private providers are not in this position, therefore their adherence to the *National Practice Standards for the Mental Health Workforce* (Victorian Government, 2013) is entirely voluntary. This situation highlights gaps in consistency, ethical accountability and socially just outcomes for people accessing these services.

The above policies and reports, sourced via the AIHW, NMHC and COAG, interrogate, expose, interpret and integrate the particular perspective they represent (Fairclough et al., 2004). The objective is to determine a structural analysis of the order of discourse, its interdiscursive elements, and the linguistic and semiotic aspects that inform the way we think about (and practice) mental health issues in this country. Equally imperative is the context these mental health policies and reports provide for informing mental health practice in all settings, and MHSW, albeit that the AASW releases its own mental health policies applicable to MHSW in Australia, which have been discussed in the prior section of this CDA.

In setting the scene for identifying obstacles to the discourse-related issue in scoping federal government documents, statistics revealed in many of them bring statements about apparent high levels of mental distress in the Australian population, for example, 1 in 5 Australians experience mental distress in any given year. Significantly, these statements are followed immediately by further comments about the federal and state governments' provision of substantial finances toward measures for assisting people in mental distress (ACSQHC, 2014; COAG, 2009; Commonwealth of Australia, 2015c).

The Roadmap for National Mental Health Reform 2012-2022

The *Roadmap for National Mental Health Reform* (herein after the *Roadmap*) is the current policy for mental health reform and is the second national approach to mental health strategy and policy reform in Australia (COAG, 2012). Expanding on discussion in the introduction to this thesis, the first reform in the Australian mental health scene came with the *Human Rights and Mental Illness:*

Report of the National Inquiry Concerning the Human Rights of People with Mental Illness Volume 1 and 2, known as the *Burdekin Report* (Burdekin et al., 1993). The themes emerging from this inquiry have ample relevance among the extant reports and reviews critiqued in this stage of the CDA. In the years between 1993 and 2012, three National Mental Health Plans (COAG, 1993, 1998, 2003) have been released as part of mental health policy reform. The *Roadmap* policy provides the basis for formulating the National Plans, for example, the current *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014* (COAG, 2009) and the forthcoming *Fifth National Mental Health Plan* (COAG, in press).

The *Roadmap* notes the developmental nature of reform, stating that "the journey of mental health reform in this country is an ongoing and evolving one…[to] set us in the right direction" (COAG, 2012, p. 4). Furthermore, the policy preamble states that the "long term aspiration" (COAG, 2012, p. 3), which may be regarded as hope, revolves around "good mental health and wellbeing…maximises opportunities [in lessening] the impact of mental health issues and illness…supports people…their families and carers to live contributing lives" (COAG, 2012, p. 3). In order to achieve this aspiration, the *Roadmap* proposes six Priorities that:

1. Promote person-centred approaches.
2. Improve the mental health and social and emotional wellbeing of all Australians.
3. Prevent mental illness.
4. Focus on early detection and intervention.
5. Improve access to high quality services and supports.
6. Improve the social and economic participation of people with mental illness. (COAG, 2012, p.5)

These Priorities set the agenda for reform in mental health service provision in Australia through to 2022 (COAG, 2012). Therefore, this reform influences the MHSW professional body (the AASW) in determining their priorities among the review, reform and re-newing of policies that apply to MHSW education and practice. In addition, as discussed at various points throughout this thesis, MHSW practitioners are guided by the AASW policies for the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) and the *Code of Ethics* (AASW, 2010). However, there is an expectation that mental health social workers will also have an awareness of the abovementioned six *Roadmap* Priorities for MHSWP. For example, these priorities may form part of the preamble for many Job and Person Specifications that MHSW practitioners are obliged to address in the application and interview process for MHSW (or various other) positions that require MHSW knowledge and skills for practice.

Organisations also expect adherence to the policies applicable at the federal and state levels. At a superficial glance, these priorities appear well intentioned; for example, they have a person-centred approach and a desire to see an improvement in Australians' social and emotional wellbeing. However, closer exploration reveals another dimension. The preamble for the *Roadmap* policy is littered with the language of illness and the clinical manifestations this brings. There is the language of signs and symptoms, of detection and intervention, of treatment, of behavioural

disorder and disability, and of the recurrence of illness and being unwell. The dominant themes here are of sickness, surveillance and disobedience, and therefore, as introduced in Chapter 1, this language begins to enter the realm of deviance, particularly where behaviour is mentioned.

The apparent noble intent of this policy is reform that carries a vision for a mentally healthier society, yet examining this from a health paradigm reveals that it equates with notions of medical health rather than notions of trauma. Mental distress, to the point of severe disturbance, viewed from the perspective of trauma heeds the context of the distressing circumstances that surround most, if not all, unendurable pain. On the other hand, a medical health paradigm such as that of a bio-psychiatric, disease-saturated (illness) approach beholds a reductionist attitude. It ascertains that people with a lived experience, which occurs (often) as a result of prior trauma (in all its forms), become pathologised by the psychiatric enterprise; a system of mental health care that is intent on reform, supposedly to better serve those with a lived experience of mental distress. This is a person-centred approach favouring the psychiatric pathology of signs and symptoms, diagnosis and treatment (at times coercive), and detection and surveillance, for example, in the form of psychiatrist-initiated Community Treatment Orders (CTOs). Authorities approve these orders and psychiatrists are granted legislative power, although CTOs occur most often against people's wishes and hence constitute a violation of their human and civil rights; a situation that does not equate with a person-centred approach that is socially just in terms of respecting relationships, and rights-based, ethical practice.

Nevertheless, albeit briefly, the *Roadmap* policy (see COAG, 2012, p. 20 under *Priority 3: Prevent Mental Illness*) addresses trauma, abuse and associated factors (such as homelessness and social isolation) related to mental distress. Curiously, preceding this in the second line is the statement that "(k)nown risk factors include genetics" (COAG, 2012, p. 20). Therefore, genetics is presented in a way that denotes priority and fact, and reinforces the bio-psychiatric, disease-saturated (illness) paradigm of biology. The language connotes inherited characteristics, a stance that avails diagnosticians with the power to suggest there is a prior family history of "mental illness", and that the "illness" is being passed (down) along the line. Immediately then, MHSW practitioners are directed to the powerful bio-psychiatric, disease-saturated (illness) discourse; a discourse that implicates the very powerful nature of genetics and serves to diminish other possible conceptual understandings, for example that of trauma. This carries the added possibility of being led to believe in the inevitability of genetics. Once this inevitability enters professionals' minds then it inescapably enters conversations. Yet Pilgrim (2015b) and others (Breggin, 2009; Kirk, 2005; Kirk et al., 2013; Moncrieff, 2009; Tew, 2005; Whitaker, 2010) purport that the evidence for genetic factors is highly contested.

When the inevitability of genetics enters conversations, CR assists in extending the argument beyond dichotomous evaluations of human distress that constitute the "circular argument" and the "epistemic fallacy" (Pilgrim, 2015b). The epistemic fallacy is further evident in notions of being "person-centred" because it indirectly blames the individual rather than addressing

the mechanisms that generate and reinforce the psychiatric-pharmaceutical enterprise. A critical-emancipatory MHSW approach adds to the critical realist stance in connoting the multi-factorial (Shakespeare, 2014) sphere that surrounds the inequalities resulting from oppression and marginalisation, for example, such as homelessness, unemployment and domestic violence. Considering the themes that surround the violation of rights, ignorance and discrimination that emerged from the *Burdekin Inquiry* (Burdekin et al., 1993), little had changed between 1993 and 2012 when the *Roadmap* was published.

Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014

Although the date on the *Fourth National Mental Health Plan* (herein after the *Fourth Plan*) has passed, it remains the extant plan in 2016. The author notes here that the current Turnbull Coalition Federal Government has put forward a proposal for the drafting of a *Fifth National Mental Health Plan.* The Honourable Susan Ley (MP), responding in late 2015 to the *CLTC* (NMHC, 2014b), advises of a "bold reform package" that will focus on four main areas, the most significant being the delivery of mental health services through Primary Health Networks (PHNs).

In the meantime, the *Fourth Plan* makes clear that there is a large financial input from the federal and state governments to improve people's lives (COAG, 2009). This plan also states that "significant reform" is occurring with the "growth of community and primary care" (COAG, 2009, p. ii). The theme of "significant" or "bold" reform continues through the plans, as do notions of community and primary care from the late 1990s. The overall intent of the *Fourth Plan* appears to be a desire to recognise the broader social determinants, respect people's lived experiences, respond effectively and review the current legislative arrangements (COAG, 2009). Conversely, the discourse, together with the semiotic conditions, constructs meaning that promotes reform through an illness lens. Thus, notions of reform are filtered through the language of illness and problems, and interventions based on evidence constructed from bio-psychiatric and psychological paradigms. These paradigms are mostly behavioural, so once again reform enters the realm of deviance. The realm of deviance serves to narrow the definitions, descriptions and responses for serving people in distress meaningfully; in a way that makes a difference, which can be seen in the data.

In relation to data, government bodies and professionals have a commitment to collect and collate data on mental distress with the intention of improving service provision and making decisions about meeting targets for budgets, thereby guiding financial decisions for funding. However, as proposed previously in this thesis, current statistics relating to said rates of mental distress in the Australian population are not necessarily accurate given the illness paradigm within which they are collected and collated (Breggin, 1993, 2009; Jureidini et al., 2016; Kirk et al., 2013; Pilgrim, 2015b; Smith, 1990b). A critical realist lens views this polarised and determinist method of data collection and collation as occurring within a circular process situated amid epistemic fallacies surrounding mental health and illness (Archer et al, 1998; Pilgrim, 2015b). Thus, the dominant

illness lens and apparent quantifiable measures (evidence base and data collection) used to understand and work with matters surrounding mental distress (in its varying severity) are identified as obstacles to moving forward with critical-emancipatory intent across the whole mental health industry, and of course for MHSWP.

The Australian Mental Health Care Classification

The *Australian Mental Health Care Classification (AMHCC)* (Commonwealth of Australia, 2015c) initiative is included within this analysis because it has recently completed a consultation process for determining the pricing of federally funded mental health services, particularly given the move away from public hospital care into the community and primary health network. The Independent Hospital Pricing Authority (IHPA), the department responsible for the AMHCC, is "an independent government agency established by the Commonwealth as part of the National Health Reform Act 2011" (Commonwealth of Australia, 2015c, p. 1). Despite being noted as "independent", this department is a government-funded agency working in partnership with the Australian Commission on Safety and Quality in Health Care (ACSQHC); the same authority investigating the implementation of the national Standards policy (addressed in the next section) to determine funding reform for public mental health services. Pertinently, funding remains a central feature of health care.

The *AMHCC* aims "to improve the clinical meaningfulness of the way that mental health care services can be classified, counted and costed" (Commonwealth of Australia, 2015c, p. 1). There are two points here that give cause to identify this element as one of the obstacles amid mental health care because it, too, situates the bio-psychiatric, disease-saturated (illness) paradigm as central to the government's proposed dialectic of strategy and reform in mental health services. The first point refers to "classified" and the second to "counted and costed". The *AMHCC* identifies classification as a necessary method for ensuring consistency and quality of health care. The language within the variety of documents (sourced via the IHPA website) is filtered through a medical lens, for example "treatment", "psychiatric disorder" and "symptoms"; and yet, although inconsistent, there is regard for use of the term "consumer", which is used more often than reference to "patient". Additionally, classifications (diagnoses) for mental health "problems" are referenced from the diagnostic manuals *DSM-5* (APA, 2013) and *ICD-10* (WHO, 2016).

At first glance, the meaning of classification, counting and costs for mental health service provision may not appear particularly relevant to this study. However, the author contends that classifying, counting and costing are rudimentary to the level and quality of care and support; support based heavily on ever tightening purse strings to meet budgetary requirements. This is synonymous with the New Public Management (NPM) (Gray & Webb, 2013) agenda, which impacts heavily not only on predicting the costs of mental health care but also upon the meanings used to classify this care; meanings littered with the language of the bio-psychiatric, disease-saturated (illness) paradigm of care (IHPA, 2016). The early consultation papers for this process

noted there would be “new models of care”, suggesting that a “clinician” does not need to be from a “specific clinical background” and that it “is concerned with the care provided” (IHPA, 2015, p. 9). Tellingly, the document bills the *Royal Australian and New Zealand College of Psychiatrists* early in the list of representatives for governance of this project (IHPA, 2015). Meanwhile, the mental health “consumer*”* is named in the last sentence of this section, the language potentially implying that people are “consuming” services rather than being viewed as citizens with human rights; as human beings to be served by (any) professionals in a way that ensures their dignity and worth amid the costing of their care. In addition to the language used and the order of appearance of actors in the *AMHCC,* there appear to be no new models of care outside the psychiatric enterprise. In other words, the process is circular, confined to psychiatric classification manuals for classification (diagnoses) and coding, which are then costed and funds distributed; and so the cycle continues. The governance for this circular process is powerful, given that the main representation in formulating the classifications for coding, counting and costing comes from psychiatry.

National Practice Standards for the Mental Health Workforce

The federal government Department of Health funds the *National Practice Standards for the Mental Health Workforce* (Victorian Government, 2013), which are published by the Victorian Government on behalf of the Safety and Quality Partnership Standing Committee. The reasons for the Victorian Government publishing this national policy document for a committee funded through the AIHW Mental Health Services in Australia (MHSA) division are neither clear, nor stated. It appears that the Victorian Government has received federal funds to assist in the production of these Standards, which the AASW also endorses.

The Standards policy is in three parts pertaining to *Language*, *Mental health and involuntary care*, and *Values and Attitudes*. The section on *Language* opens with the sentence, “(w)ords and language are important in shaping ideas and framing concepts” (Victorian Government, 2013, .p.5). Later in the same paragraph, it emphasises the need for regarding “person and people with a lived experience, rather than [using] terms such as consumers or service users” (Victorian Government, 2013, p. 5). This demonstrates a commitment to considering people as human beings rather than objects (patients, clients, and terms that imply “the other”) who do little more than consume the services governments and professionals provide; services that may be considered, respectfully, as societal welfare and wellbeing.

Significantly, this is the only policy document examined in this study that at least seeks to address the meaning of language for mental distress. The author posits that the way practitioners think about mental wellbeing, distress and its associated effects contributes, arguably in its entirety, to the way mental health social workers practice.

The second point in the introductory remarks for these Standards regards “mental health and involuntary care” (Victorian Government, 2013, p. 6). On the one hand, these lines clearly

name the “tension regarding upholding human rights”, whereas on the other, practitioners are advised that they “must ensure the relevant…mental health legislation is observed” (Victorian Government, 2013, p. 6). Not only does this create a dilemma for practitioners but, as argued earlier in this analysis, it does not necessarily mean that the legislation is fair and reasonable in terms of human rights. Nonetheless, this section does call for a move toward “less restrictive care [and] minimising the use of involuntary treatment [as] the desired aim” (Victorian Government, 2013, p. 6).

These Standards also address “Values and Attitudes” (Victorian Government, 2013, p. 10) with regard to inviting practitioners to be aware of their own values and to use them in a “positive way at work” (Victorian Government, 2013, p. 10). Amid the stated value of “Respect” is a list of “Attitudes” that are “expected in behaviour towards a situation, person or object”. These are:

- respectful
- compassionate, caring and empathic
- ethical, professional and responsible
- positive, encouraging and hopeful
- open-minded
- self-aware
- culturally aware
- collaborative. (Victorian Government, 2013, p. 10)

This raises the question of the reasoning behind the need to be so explicit in stating attitudes in these Standards. Thus, entering the “place of ideology”, referred to in the introductory remarks for this policy as implicit in mental health practices and therefore needing to be addressed as a practice Standard, there appears to be a lack of professional respect for people experiencing mental distress. This is consistent with the *Burdekin Report* (Burdekin, 1993) and *CLTC* (NMHC, 2014b), and has been discussed earlier using the example of staff attitudes toward people who carry the label “PD”.

The intent of the *National Practice Standards for the Mental Health Workforce* (Victorian Government, 2013) appears to be to encourage practice that is oriented toward recovery-based approaches, with a focus on respecting the individual person (person-centred) as well as caring about the carers. Notwithstanding the honourable intent of these Standards, the language and ideology remain focused largely on a bio-psychiatric, disease-saturated (illness) approach. This means placing psychiatry and clinically-based care at the centre of the lived experience; a situation that demands national dissemination of Standards in a plea to psychiatry and to take responsibility and account for their behaviour (through values and attitudes) toward vulnerable people who are often society’s most marginalised and disadvantaged. Psychiatry is the only group for which these Standards are not mandatory, while the allied health group includes social work. It is imperative to ask here:

> If mental health services professionals are working in an open-minded, respectful, compassionate and hopeful way with people experiencing any level of mental distress,

> is there the need to formalise these attitudes and values in a Standard that is also calling for "upholding human rights" in moving toward "less restrictive care" in the twenty-first century? (Victorian Government, 2013, p. 6)

The Scoping Study on the Implementation of National Standards in Mental Health Services

The *Scoping Study*, released in 2014 by the Australian Commission on Safety and Quality in Health Care (ACSQHC), examines the level of implementation of the Standards of care in public mental health services. Therefore, it carries with it possibilities for reflecting upon what this may mean for the *National Practice Standards for the Mental Health Workforce* (Victorian Government, 2013), discussed in the previous section. The levels of care reported on in the *Scoping Study* provide information that holds implications for the journey of MHSW practitioners wherever they are located in service provision.

The *Scoping Study* examines the "enablers, barriers and challenges" (ACSQHC, 2014, p. 2) to the implementation of the *National Standards in Mental Health Services (NSMHS)*, reporting on perspectives from both service providers and service users. Although the introductory remarks note that the "landscape of mental health service delivery in Australia is complex" (ACSQHC, 2014, p. 13), this is not elaborated upon. While it is judicious to be mindful of the nature of complexity, it is not prudent to hide under a generalised veil of "complexity" as an overarching reason for not confronting the need for ethical (professional) service provision; an ethic of care that surrounds the lived experiences of human beings in emotional distress.

Two main themes are of significance within this *Scoping Study*: staff and people who use the mental health services. Staff are resistant to change, while people who use the services have a lived experience of mental health issues and are seeking support. In Section 5, amid the *Information from service providers,* are several pieces of data that make some noteworthy points. There is an apparent "(l)ack of trained staff" and "people (are) unreceptive to change or training". Another point is that of an "(e)ntrenched workplace culture" whereby "staff attitudes" are implicit in a "general resistance to change" (ACSQHC, 2014, p. 26). With regard to an apparent lack of trained staff, service providers argued on the one hand for more specialist expertise in mental health, while on the other they argued that "it takes staff off line, which greatly adds to cost" (ACSQHC, 2014, p. 26). What is of concern here is that although this is not new information, the tension lies within the way service providers' conscious purpose (their *attitude* to provision) marries with what they actually will or will not (*respectfully, collaboratively, compassionately, empathically*) do as professional practitioners. It is their professional attitudes that serve to reinforce, and inform, the dominant bio-psychiatric, disease-saturated (illness) discourse, which positions the path for new practitioners entering the mental health scene and contributes to an ongoing resistance to considering new possibilities for practice. This is indicated in the dilemma, raised above, by people with a lived experience of mental distress and their subsequent receipt of care.

In contrast, a critical point made by the service providers in this section regards *the*

Applicability of the standards (ACSQHC, 2014, pp. 26-27), wherein they:

> …criticized the language of the NSQHS Standards as being too compliance-oriented, and restricted to medical models. This was considered to make the NSQHS Standards inconsistent with the more flexible approaches advocated within recovery principles in mental health. (ACSQHC, 2014, p. 27)

The key point here is that the inherent dominance of the bio-psychiatric, disease-saturated (illness) discourse raises concerns for the service providers. Interestingly, this paradigm infiltrates a Recovery approach, yet service providers do not make this distinction. Thus, it is not difficult to conclude that there are several reasons for this, one being the probable lack of follow-up questions asked by those leading focus groups with providers and service users. In other words, the people leading the focus groups may not have noticed this inconsistency, therefore this epistemological (and ontological) gap serves, once again, to reinforce the dominant discourse and consequently the resultant services and practices. This is what Freire (1996) refers to as the "conscientization" of professional practice. In other words, Freire articulates that all human beings adopt myths that are inclined to be socially dominant; the process of reflecting on various social norms assists a conscious effort to act differently. Thus, without an awareness of the hegemonic tendencies afforded within the bio-psychiatric, disease-saturated (illness) paradigm, it is confusing and challenging to understand the paradigm's nuances.

As stated earlier, information from the service users is a key aspect of this *Scoping Study*. Although there are some similarities with the service providers regarding "constant changes in the landscape of mental health service delivery" (ACSQHC, 2014, p. 35), low levels of training and the inflexibility of the Standards being in line with a Recovery approach, there are some major differences. The words quoted from one participant reflect a theme of the imbalance of power amid the professionals and those seeking, or forced to access, mental health services; "(t)he doctors and clinicians need to get off their pedestals and patients and carers need to get off their knees" (ACSQHC, 2014, p. 36). This imbalance of power is echoed in service users' concerns about their lack of choice in regard to medication; a concern supported by critical psychiatrists and social workers across other western nations (Breggin, 1993, 2006, 2014, 2016; Kirk et al, 2013; Moncrieff, 2009). Additionally, service users voiced their curiosity about the effectiveness of mental health service provision when asking questions about how many people are being seen in comparison to how many of them are "getting better" (ACSQHC, 2014, p. 38). Another essential point raised by the service users relates to them feeling "safe". Amid a variety of responses discussed in this policy document, the following sentiments link with the earlier points raised about the lack of regard for those whom professionals choose to serve:

- a sense of not being listened to
- their own and other's dignity not being maintained
- overmedication – especially in the early stages where it then impinges on the ability to communicate successfully

- the trauma of being secluded and restrained – leading to avoidance for those with a prior lived experience of this
- of no focus on them as a whole person
- instances of medical issues being ignored because of the psychological issues. (ACSQHC, 2014, p. 41)

It appears from these few brief examples that people with a lived experience of mental distress are further traumatised when either accessing care or receiving care against their will. Again, the issues of seclusion and restraint are raised. It appears that service users believe there is "a lot of work being done" in this area, even though they reported their apprehensions about seclusion and restraint being used "inappropriately" (ACSQHC, 2014, p. 42). Notwithstanding respect for the voices of those with a lived experience in this, it is interesting to note that the writers of this policy document address this issue only very briefly. This raises both ethical and moral concern about the impact of the current bio-psychiatric, disease-saturated (illness) paradigm that dominates mental health care.

Although this *Scoping Study* centres on the implementation of quality mental health service provision, it illuminates several matters relevant to this study, not least of which are the language and thinking of both the service provider and the service user. Comparing the two denotes the enormity of the bio-psychiatric, disease-saturated (illness) nature of mental health service provision and the benefits this accords *Big Pharma* (Breggin, 2009; Breggin et al., 2007; Moncrieff, 2006a, 2009; Pilgrim, 2015b).

Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services

This report (*CLTC*), published by the National Mental Health Commission (NMHC) in 2014, asserts several areas for concern, all of which have relevance for identifying the obstacles that a bio-psychiatric, disease-saturated (illness) paradigm for knowledge and practice brings. Following on from previous discussion regarding the evaluation and ongoing monitoring of funding, the *CLTC* states unashamedly that the "wrong things" (NMHC, 2014b, p. 27) are occurring in funding arrangements. The report notes, for example, that the distribution of funds is disjointed, and that despite the apparent large financial investment in mental health reform and services, there has been little improvement in peoples' access to services, their wellbeing and their rights to citizenship in the community (NMHC, 2014b). This raises perhaps more questions than immediate answers. The previously identified documents for this analysis do not appear to be achieving positive reform. In fact, the data (ABS, 2008, 2015) suggest that Australians' mental health is getting worse. In other words, with all the strategies and all the money, the Australian people's mental wellbeing (or levels of distress) is not improving; it is worsening. Where is MHSWP in this? Social work's critical knowledge base, core values and ethics are touted as fundamental for assisting advanced understandings related to the social determinants that surround mental distress, so where are they in MHSWP?

Similar to the other extant strategies, plans, reports and reviews for mental health reform,

CLTC calls for a person-centred approach (NMHC, 2014b, p. 10) to MHSWP. While this report occasionally uses language laced with bio-psychiatric, disease-saturated (illness) discourse, raising the same concerns already discussed in relation to the other documents, it differs slightly. Its approach is aimed at valuing people as citizens who are worthy of leading "contributing lives" (NMHC, 2014b, p. 4), albeit to "keep them out of avoidable high-cost care…and help grow Australia's wealth", leaving minimal room here other than to ponder upon the neo-liberal ideology seeping through the layers that lie amid distress. Nevertheless, the Commission notes that stigma remains. People have "a poor experience of care", the mental health system does not prioritise their needs and it "uses resources poorly" (NMHC, 2014b, p. 8).

These obstacles to advancing the cause for new ways forward in the mental health arena have implications for MHSW education, policy and practice. Thus, the author contends that a critical-emancipatory MHSW approach, supporting a critical realist stance, accords with a dialectic of knowledge and care. A knowledge base that offers MHSW learners the opportunity to interrogate, expose, interpret and integrate a multi-factorial (Shakespeare, 2014) epistemology through critique maintains an ethical regard for conscientization (Freire, 1996) and invites hope for practice. Discovering paradigms of care that lie amid a trauma-informed approach (Bloom, 2000, 2013; Bloom & Farragher, 2011, 2013; Bloom et al., 2003) and rights-based (Bay, 2014; Finn & Jacobsen, 2003; Gray & Webb, 2013; Ife, 2012; Morley & Macfarlane, 2010; Webb, 2006), with relationships being central to care, brings the potential and multiple possibilities for sustaining hopeful encounters and outcomes – outcomes that are centred within a socially just framework (Finn & Jacobsen, 2003) rather than reductionist notions of finances and productivity. These concepts form the basis of the re-conceptualisation of MHSWP explored in Part 2 of this thesis.

Australian Association of Social Workers policy amid the national agenda: *Australian Association of Social Workers Response to the National Mental Health Commission's Report on the National Review of Mental Health Programmes and Services*

This AASW's (2015) response to the NMHC's (2014b) *CLTC* report is included in the CDA because the AASW is the professional association representing mental health social workers, particularly those with accreditation working in private practice. The intent of the AASW response is to "advocate for the interests of the social work profession and our clients", and most particularly to respond to *Recommendation 13*, which relates to the "Better Access to Mental Health Care scheme under which many Accredited mental health social workers practice" (AASW, 2015, p. 1). Here, the AASW advocates for its accredited MHSW members while at the same time supporting the current bio-psychiatric, disease-saturated (illness) paradigm that is situated within the aforementioned national mental health policies and Standards, and, as argued in this CDA, amid the AASW MHSW policies and Standards. Interestingly, there is no response to anything in the NMHC report (2014b) other than the situation for private MHSW practitioners amid the Better Access to Mental Health Care scheme offering funding for private work. Perhaps the AASW might

have taken this opportunity to respond across several layers that relate to MHSWP, rather than matters relating only to funding. For example, it might have raised the issue of where MHSW is situated in the national agenda for mental health reform in terms of what MHSWP is already doing that is positive, as well as what it can do to contribute to improving the lived experiences of individual people, communities and the whole of society. Perhaps there could be some key statements about how the core values that lie at the heart of social work would assist MHSWP, such as building respectful relationships with people and therefore modelling socially just practice for other professionals. Furthermore, a response could also provide information and examples of how MHSW practitioners utilise critical-emancipatory approaches in practice, for example trauma-informed work, while at the same time adopting a broad view of the multi-factors (Hallahan, 2012; Shakespeare, 2014), such as the marginalisation and stigmatisation, that occurs amid the realities of people's lived experiences.

Responding to *CLTC*, a national document, created the opportunity for MHSW to demonstrate to the nation what it has to offer mental health services – respectful, humane, socially just and ethical (knowledge base for practice) knowledge and skills for MHSWP that to enable mental health social workers to listen genuinely to the voices of citizens experiencing mental distress. The AASW response offered an opportunity to articulate a discourse that situates MHSW in the move away from psychiatric social work, as well as the possibility of advancing the cause for MHSW private providers in their bid for inclusion in the Better Access to Mental Health Care scheme, which advances a humanitarian approach to care.

Australian Government Response to Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services

This *Australian Government Response to CLTC* (Commonwealth of Australia, 2015a) offers five key areas of focus for future change in the delivery and funding of mental health programs. Two points have relevance for this CDA, demonstrating the obstacles that potentially impede real and sustained change for people accessing (or forced to receive) mental health services, notwithstanding the overarching probable good intent of those involved in the pursuit of better service provision – "best practice".

The first point relates to the path these key changes for reform in mental health services have travelled via the advice of the Expert Reference Group (ERG), initiated through the federal government's Minister for Health. The ERG consists of a variety of personnel; an apparent diverse mix of professionals and one consumer. A single consumer voice in a mix of powerful professionals (noting they are mostly professors and doctors), sitting at the "expert" table, suggests the potential for that voice to be minimised or possibly dismissed. Even if that single (consumer) voice is not intentionally missed, minimised or dismissed, this powerful environment carries the potential for semiotic conditions (Fairclough, 1989, 1992a,b, 1995, 2000, 2001a,b, 2003, 2010; Fairclough et al., 2004) that surround the privileging of informed opinions, the implied bio-psychiatric, disease-saturated (illness) discourse, and the subsequent filtering of this discourse for

new arrangements. This whole situation has hegemonic tones (Gramsci in Bates, 1975) and demands that questions about the consumer's comfort level be heard. Was the consumer consulted regularly during discussions in this arrangement (Smith, 1990a,b,c; Smith & David, 1975)?

The second point relates to the broader implications about what this might mean for instigating strategic reform and sustained change from the implied discourse in this document. The discourse connotes the language of mental illness, the burden of costs in dealing with it, and the need for earlier intervention in children and young people's lives. An illness discourse, taking into consideration the arguments already purported in this CDA about the dominance of the psychiatric-*Big Pharma* enterprise, serves to reinforce the current paradigm and therefore the status quo.

Noting the burden of costs, the recommendations in this *Australian Government Response* (Commonwealth of Australia, 2015a) to mental health reform traverse three main themes: the apparent high costs associated with the delivery of services for mental health; the "costs to taxpayers"; and the need to reduce "income and disability support expenditure" (Commonwealth of Australia, 2015a, p. 4). In relation to the first of these, the *Response* cites the example of "$40 billion a year in direct and indirect costs and lost productivity" (Commonwealth of Australia, 2015a, p. 4). This financial focus sets the tone for proposed reform (Fairclough et al., 2004), wherein new reform must occur within current budget estimates. The implied content about what this means for "person-centred" and "self-help" measures (Commonwealth of Australia, 2015a, p. 2) raises concerns for socially just strategies that are committed to real and sustained change.

Regarding earlier intervention in the lives of children and young people, a bio-psychiatric, disease-saturated (illness) paradigm and psychiatric-*Big Pharma* enterprise raises further concerns for real and sustained change. Australian critical psychiatrist Jon Jureidini confirms these concerns, suggesting we are diagnosing and medicating children and young people at ever-increasing rates by *Turning sorrow into sickness* (Sheehan, 2012). There is further cause for concern because the "increasing use of antidepressants may predispose us to further episodes of depression" (Sheehan, 2012, p. 41). Recently, Jureidini, Amsterdam and McHenry (2016) exposed issues within the psychiatric-pharmaceutical enterprise that relate to the un-ethical medicating (Citalopram) of children and young people with a drug that is no better than a placebo, and worse, carries adverse side effects, one of which is the potential for inducing suicidal ideation and completion. This demonstrates clearly, from a critical psychiatric view, the dominance of the bio-psychiatric, disease-saturated (illness) paradigm and psychiatric-*Big Pharma* enterprise in malfeasance that is tantamount to human rights abuse. This revelation opens the door of hope for situating critical-emancipatory MHSW education, policy and practice in the twenty-first century.

Critical-emancipatory mental health social work reflection (thinking) and practice: critiquing "the way things are" for rupturing the status quo

Critical thinking for reflection and practice, questioning "the way things are" for rupturing the status quo, does not occur with ease where there are implicit and inherent power relations at play, let

alone these relations being (well) recognised or understood by those working in practice. Expanding on this point, reflecting on the way things are, is to be thinking about the layers in the multiple factors at play. This requires MHSW practitioners to have the capacity and ability to recognise the implicit and inherent power relations, thereby opening up to the broader structural critique. Foucault (1970), Goffman (1961) and others (Gray & Webb, 2013; Ife, 2012; McDonald, 2006; Mullaly, 2010; Stanford, 2011; Webb, 2006) inform of the institutionalised discourses influencing and legitimising processes that are viewed as the norm. In addition to the institutionalised bio-psychiatric, disease-saturated (illness) discourse are the heavy layers of NPM agenda, risk and capitalist notions of individualism played out in person-centred discourse. The abundance of contemporary discourse regarding risk – its assessment, avoidance and management (Ramon, 2005, 2009) – implicitly thwarts attempts at rupturing the status quo (see Iliopoulos, 2012 on Foucault). The large and looming layer of NPM discourse driving the economic rationalist focus in government policy feeds the frenzy of risk and thus impedes reflection on the multiple layers of practice realities. A critical-emancipatory approach, strengthened with CR, offers direction for moving forward from a more optimistic stance, as addressed in Part 2.

Exposing the representation of bio-psychiatric, disease-saturated (illness) discourse as the dominant paradigm situated in documentation relating to mental health care

Fairclough (2001a, p. 244) clarifies four main concepts that assist with bringing depth to this CDA – "representation, relating, identifying and valuing" – while explaining that the "work of representing, identifying and valuing is done in the course of the text, textually (or texturely) produced in space (from beginning to end, top to bottom)" (Fairclough, 2001a, p. 245). Valuing the text notes how some elements are valued over others (Fairclough, 2001a).

Therefore, by undertaking the process of interrogating, exposing, interpreting and integrating the documents in this CDA, the author has scrutinised the way the text is constructed; a process of representation (Fairclough, 2001a). The texts within the analysed documents are substantially those of a bio-psychiatric, disease-saturated (illness) discourse, *representing* the language of psychiatry, a dominant discourse that is historically, politically, socially and culturally located as an illness model; a "given" (Pilgrim, 2015b). Thus, there is belief without question that this paradigm is the lasting remedy for mental distress; the status quo remains.

The process of relating (Fairclough, 2001a, p. 244) refers to the knowledge relations occurring within the documents and policies for practice. This may be conscious or otherwise, but it is there, serving to reinforce the epistemology of bio-psychiatric, disease-saturated (illness) care as the only perspective for practice. There are occasional efforts noted in the brief references to different notions of understanding that there may be something other than an illness trajectory in mental distress, for example trauma and social determinants. However, these examples are followed by little else about how this could offer better (best) practice, or perhaps how alternative models of care could benefit people, especially when noting they are viewed as

consumers/consuming.

Identifying relates to the way the producers of the text "construct themselves" (Fairclough, 2001a, p. 244). For example, psychiatry constructs itself as the narrator of discourse identifying with psychiatric care, serving, perhaps implicitly, to maintain superiority (dominance) amid the social fabric of care. In addition, given the powerful nature of this dominant discourse, it is plausible that consumer knowledge is grounded in psychiatric-*Big Pharma* understandings of remedies for mental distress (Breggin, 1991, 1993, 1997, 1998, 1999a,b, 2001, 2002, 2006, 2008, 2009, 2011, 2013; Breggin & Breggin, 1994; Breggin & Cohen, 2007; Kirk et al, 2013; Pilgrim, 2015b). Hence, consumers of services and the public (Pilgrim, 2015b) also assist in reinforcing the dominant paradigm.

The structure of the discourse – the way in which it is represented, and how it is related and identified by the narrators – forms the obstacle (Fairclough, 2001b) to anything being epistemologically or ontologically different. Pilgrim's insights confirm this from a critical realist standpoint, positing that "the authoritative view of the clinician *in the know* about the simple facticity of mental disorders [is viewed as] naturally occurring phenomenon" (2015b, pp. 77-78). Indeed, Pilgrim (2015b, also citing Jorm, 2000) suggests that this occurs among "lay people" (including medical educators) the world over. Additionally, if educators lack "mental health literacy…despite that knowledge being highly contested [and they] have no insight into their epistemic fallacy, then they can remain content in the belief that they are experts and lay people are in a state of regrettable ignorance" (Pilgrim, 2015b, p. 78 also citing Goldney et al., 2001). This has implications for social work educators. As proposed throughout this thesis, and addressed in detail in Part 2, a critical-emancipatory position supports the move away from psychiatric social work.

The DSM-5, ICD-10 and Big Pharma

Further to earlier discussions regarding the *DSM-5* (APA, 2013) and the ICD-10 (WHO, 2016), the use of these diagnostic tools by psychiatry and funding bodies to code diagnoses in order to grant funds for mental health service provision in the private sector appears to be more to satisfy the private health insurance industry than to benefit mental health service users. People with private health insurance can only access claims on their insurance with the codes (a DSM/ICD diagnosis) from the treating psychiatrist. In addition, GPs and allied health providers such as ACMHSWs in private practice must enter these codes as part of a *Better Access Plan* (health care plan) so that people can access public health care (Medicare).

This situates MHSW practitioners at the centre of labelling people in mental distress, classifying and coding them, and creating ethical dilemmas for practice. The MHSW practitioner is in the position of being required to adhere to the treating doctor's diagnostic label (Becker, 1973; Curra, 2011; Scheff, 1999, 2009, 2010) to obtain funding for their professional services to people attending their private practices. Where does this leave the core value of "respect for persons" (AASW, 2010, p. 12), given that this is fundamental to developing a professional, trusting relationship? The author's practice experience over several decades with many distressed people

enduring the effects of prior trauma has taught her that the last thing people want is to be identified as depressed, anxious, disordered or any other similar label. This is especially the case with young people. It impacts on people's identity at a time when they are at their most vulnerable, and may already be struggling with the effects of marginalisation, either socially or by the mental health system, particularly when a label of PD is placed upon them whether they agree with it or not. Therefore, MHSWP based in relationships steeped in trust and hope, rather than so often having to address matters related to the label acquired and distress about medication side effects, supports mentally distressed people to seek the change they so often desire. This applies also to those situations where people are on CTOs and have lost any choice about taking medication. They are more distressed about the circumstances surrounding the denial of their (human) rights, which becomes the main focus of practice rather than making efforts toward desired life changes. This is the place where "chronicity" begins; the circular argument amid the epistemic fallacy of illness (Breggin, 1993, 2009; Jureidini et al., 2016; Kirk et al, 2013; Pilgrim, 2015b).

Directing attention back to MHSW policies analysed in Stage 1, there is a requirement in the *ASWEAS* (AASW, 2012a,b) to guide MHSW learners and practitioners. Social work educators are required to provide educational materials relating to bio-psychiatric, disease-saturated (illness) knowledge for beginning or advanced practice, for example, prevalence data, diagnoses (*DSM-5* and *ICD-10*), mental state examinations, psychotropic medication, cognitive-behaviour therapy and "assessment for involuntary treatment [when this] might be necessary" (ASSW, 2012b, p. 6). This, together with the Stage 2 analysis, demonstrates that the psychiatric enterprise, together with the tentacles of *Big Pharma*, constitute the main obstacles (Fairclough, 2001a) hindering navigation of new ways forward in strategic mental health reform. The author argues this need not prevent MHSW from going forward. Indeed, there is a moral imperative in seeking to do so, especially noting the allied health professions' implication in the dominant power relations of the bio-psychiatric, disease-saturated (illness) enterprise. Have they become part of the powerful "burgeoning army of professionals" whose role is to "induce and coerce people into conformity within an array of medical, educational, legal, psychological and social care discourses…within a social construction in which professionals are seen as acting in people's best interests" (Tew, 2005, p. 84)? Will it be only MHSW practitioners and educators who take the necessary steps?

This analysis has demonstrated evidence of the multitude of layers contributing to the long-established bio-psychiatric, disease-saturated (illness) status quo, hence the struggle continues for new and different ways forward. There is the layer of professionals, each attaining their own knowledge base and practices that inform their discourse, most often a bio-psychiatric, disease-saturated (illness) one. There is the layer of social conformity amid the professionals themselves that propagates the status quo. In the main, the author posits that these professionals sincerely believe they are acting in people's best interests. This is the prickly moral and ethical intersection of critical thinking and awareness for the professionals themselves. Amid this sits the powerful layer of *Big Pharma* (Breggin & Cohen, 2007; Carlat, 2010; Greenberg, 2010, 2013; Moncrieff,

2006a,b, 2009; Whitaker, 2010), inherent in the broader structural layer that drives the economy. Additionally, the impact of the NPM realm (Gray & Webb, 2013; Webb, 2006), driven by neo-liberal governments' various politics, policy and perspectives, serves to legitimise the status quo.

Stage 3: What does the social order gain from the discourse-related issue?

This stage explores what the social order gains from a bio-psychiatric, disease-saturated (illness) discourse-related issue. The aim is to question the needs served by maintaining the current order of discourse (Fairclough, 2001a). The specific way in which communication occurs, such as the way mental health professionals interact with one another, forms and informs a certain set of values about psychiatry and the place of pharmaceutical remedies for mental distress, as well as reinforcing them. Accordingly, this equates with ideology and the epistemic fallacies in the dominant ideology, which achieves a "measure of hegemony" (Fairclough, 2001a, p. 238) in preserving the status quo.

Maintaining the "order of things"

Coupled with the caution raised regarding the interpretation of the discourse about the historical journey of psychiatry in working with mental distress (see Chapter 3) is the need for further contemplation about the trajectory to date. Kirk et al. (2013) provide a provocative exploration of historical notions about mental distress, in particular the way historical accounts are postulated; exposing the authors to be either psychiatrists or those employed in institutions chaired by psychiatry, which predominantly employ psychiatrists. Such institutions may be research institutes funded by *Big Pharma*. Breggin (1993, 2009), Whitaker (2010), Greenberg (2010, 2013) and others (Carlat, 2010; Kirsch, 2010; Moncrieff, 2009; Pilgrim, 2015b) support these accounts. This is a powerful layer because historical representations of mental distress that purport to connote the path of history inform contemporary knowledge and practice, in this instance MHSW education and practice.

Maintaining the order of things requires reflection on the current context, with Pilgrim (2015b) invoking a critical realist perspective for examining the contemporary psychiatric enterprise. The following discussion invites a perspective that also strikes at the core of what has led to the current status quo. Kirk et al. (2013, p. 37) remark that despite the "(t)housands of volumes…written over the centuries about the true nature and definition of madness", much confusion remains among professionals, the lay public and even psychiatrists about what madness really is. Significantly, Kirk et al. (2013, p. 38, emphasis in original) elaborate on this point:

> Neither the many theories nor the implied causes of madness have been scientifically validated, perhaps because mad science rests on hundreds of constantly shifting diagnostic categories of "mental illness", which have little in common. Fifty years of scientific efforts revising these categories, quantifying them, and statistically calculating perceived differences among them may not be the best analytic approach for

> understanding what is subsumed under the word *madness* and its many linguistic analogs.

Additionally, Kirk et al. (2013, p. 38) make the following persuasive point about the place of psychiatry in maintaining the order of things, stating that notwithstanding:

> …the failure of scientific attempts to validate the nature or causes of madness, groups with enormous political, ideological, and economic clout have taken up theory about madness in particular: that it is medical/bodily disease.

Elaborating on this, they explain that the language used in some historians' accounts of madness reinforces concepts of mental distress as relating to medicine in one way or another. This implies that the order of things maintained by the psychiatric-*Big Pharma* enterprise remains so; an implication reinforced in many historians' accounts, albeit perhaps unintentionally on occasions. Situated this way, the discourse demonstrates how contexts, concepts and stained visions – the epistemic fallacy Pilgrim (2015b) describes in critical realist explorations of mental health – prevail in the arena of mental distress, the effects of which are traceable to trauma, not genetics or disease. Historical accounts of mental distress that trace its roots to trauma offer a move away from the current dominant bio-psychiatric, disease-saturated (illness) paradigm and its hegemonic effects. Many of these accounts are written by prominent psychiatrists, dating as far back as Szasz (1961) and Laing (1985), and more recently in Bloom and Farragher (2011, 2013), Breggin (2009), Moncrieff (2007b, 2009), Jureidini et al. (2016) and others (Kirsch, 2010; Read & Dillon, 2013; Whitaker, 2010). As revealed in Chapter 2, these accounts tend to receive the label "anti-psychiatry", even though the psychiatrist authors contest this label and make their position clear in questioning the status quo; they are questioning *the order of things*.

Despite Kirk et al.'s (2013) protestations about historians of madness reinforcing a bio-psychiatric, disease-saturated (illness) view, Scull (1989) and Porter (1987), also through the lens of language-use, illustrate pertinent points about psychiatrically-trained historians' biases, which must be considered in accepting the meaning of historical influences on current paradigms. Importantly, they invite caution about contemporary ideology that is essential for making sense of the journey toward understanding the tenets of maintaining the order of things in the mental health arena. Scull (1989, p. 6) proffers that up until the late twentieth century, many historical accounts served to "legitimate the activities of psychiatrists in the present" (p. 6), which is not surprising given that:

> …psychiatric history has been written by amateur historians, and a peculiar group at that – psychiatrists themselves…safe from even moderately searching critical scrutiny…[a] sanitized history…propagated by those whose claim to moral authority over the mad is sanctioned at once by law and by duly certified scientific expertise.

Further to biased historical accounts about mental distress and myths about progress (Scull, 1989), it is crucial to be vigilant about not repeating the mistakes of the past. Scull (1989, p.

6, citing Castel, 1981) informs that memory "is built upon a foundation of forgetfulness…that is anything but random". Scull comments on those who have advised deinstitutionalisation, stating that those honouring the benefits of being in the community must remember the same occurred for "preach[ing] the gospel of retreat from the world and seclusion within the walls of the asylum" (Scull, 1989, p. 7). The author extends these points in Stage 4 and Stage 5 of this CDA and elaborates them in Part 2 to remind MHSW practitioners to be aware of the implications for new ways forward.

Porter (1987) brings another dimension researched from the archives of autobiographical accounts of people with a lived experience of mental distress who noted psychiatry's influence. He argues, similarly to Scull and others (Breggin, 1991; Pilgrim, 2015b), that the arena of mental distress remains contested space. He asks: "(i)s insanity truly a *disease*…or…a badge we pin on people displaying a rather subjectively defined bundle of symptoms and traits, but who at bottom are just mildly or severely different or odd" (Porter, 1987, pp. 8-9)? Porter (1987) ascribes to the pertinence of cultural concepts to the meaning of mental distress. The introduction of cultural mores surrounding a moral obligation to intervene in the lives of people who are different or odd (Porter, 1987) provides the basis for maintaining the order of things through meaning-making via the psychiatric enterprise. According to Porter (1987, p. 20), psychiatrists, for generations, have made it their:

> …daily occupation…lay in watching the zombie-like living death of asylum recidivists and who familiarized themselves with the latest research into the neuropathology of sensory-motor disorders such as ataxia, epilepsy…tertiary syphilis…(and) demanded a degenerationist theory (with) the mad seen as retrogressives, as throwbacks. This in turn matched the mood of a bourgeois socio-political elite anxious about the masses.

It appears this was the time when fear entered the mental health arena, with psychiatry sending warnings about the "degeneracy of the masses" (Porter, 1987, p. 21), suggesting their potential to destroy civilization and rationality. It was the time when psychiatry "established their own rights to treat the disturbed over and against those of the laity, the clergy and, indeed, the medical profession at large" (Porter, 1987, p. 23). Yet Porter (1987) establishes that this time has continued for over two and half centuries from 1750 until today. Thus, the order of things is now the long-established norm, remaining firmly embedded in contemporary western culture.

Comparatively, Pilgrim (2015b, p. 1) discusses the social nature of mental phenomena, making the connection with CR through emphasising the point about "epistemological arguments (being) centre stage" but, while important, often at the expense of ensuring ontological notions of being. Pilgrim (2015b, p. 1) advises the critical realist position that "messy reality needs a fair exploration. And that messy reality includes real oppressive relations from the past impacting on the present, which are discerned or might be shrouded in mystery". Further to the questions raised in the opening lines of this study, which queried the lack of improvement in people's wellbeing despite increasing funds and strategies for mental health reform, Pilgrim (2015b, p. 1) advances

the argument that plentiful promotion of psychiatric theory and practice has failed "monumentally as a medical project" but remains firmly in charge. This critical realist account broadens the scope for informing MHSW practitioners and educators about the social order continuing to "need" mental illness as a persistent problem, requiring (ongoing) intervention from the psychiatric-*Big Pharma* enterprise and the allied health professions, one of which is psychiatric social work.

Stage 4: Identify the opportunities for possible ways forward in moving past the discourse-related issue

This stage addresses matters raised in Stage 2 to maintain clarity and consistency in the analysis and explore ways past the obstacles raised in that discussion. The matters for further discussion in this stage include the way madness is understood, and the way values, beliefs and attitudes in the documents analysed represent the bio-psychiatric, disease-saturated (illness) order of discourse, as well as other layers that impact upon possible ways past the obstacles.

Fairclough (2001a, p. 238) describes this stage as "rather different" from the other stages in that it moves the focus beyond the network of practices in which the discourse is embedded to a closer examination of the "gaps and contradictions that exist" (p. 239), including the gaps and contradictions between "what is said and what is actually done" (p. 263). Fairclough suggests there are "tensions and gaps in particular texts" (2001a, p. 263). For example, in this study the tension lies between the bio-psychiatric, disease-saturated (illness) discourse in the various documents for mental health practice Standards for mental health services in Australia and the gap that actually occurs in practice. While there are gaps and contradictions among the various national mental health policies and practices, of particular relevance in this study are the tensions and gaps for MHSW among these.

Indeed, it remains essential to continue to give credence to a critical realist standpoint within this analysis. While it is crucial to respect Fairclough's epistemological underpinnings as the basis for this study, the author's intention is to extend matters to a critical realist ontological edge, particularly given the need to maintain an emphasis on MHSWP.

Critical realist exploration and interpretation of the possibilities

Exploration and interpretation from a critical realist standpoint suggest that CSA (Fairclough et al., 2004) provides the framework for a critical realist interpretation of the mental health policy documents, utilising ontological notions of the "actual" and the "real" (Ayers, 2011, 2013). In this stage, the author deconstructs the *actual* and the *real* in the interpretive process for seeking new ways forward in moving psychiatric social work into MHSW amid the Australian mental health scene.

In relation to MHSW policy, the *actual* is the bio-psychiatric, disease-saturated (illness) interpretation of MHSWP because the mechanisms and structures are historically located in this phenomenon. The *real* is the mental health social workers' observed phenomenon of bio-

psychiatric, disease-saturated (illness) practice by practitioners (psychiatrists and psychiatric nurses) whose professional training (and hence, knowledge and practices) is grounded in bio-psychiatric, disease-saturated (illness) understandings of human mental distress. Therefore, social workers are influenced by the meanings associated within the dominant discourse in areas where they are supporting people experiencing mental distress. The AASW (2014a) *Practice Standards for Mental Health Social Workers*, grounded in a bio-psychiatric, disease-saturated (illness) discourse, guide MHSWP.

Australian Association of Social Workers Practice Standards for Mental Health Social Workers

A number of important points must be considered when recognising the gaps and tensions between the dominant bio-psychiatric, disease-saturated (illness) discourse inherent in the AASW *Practice Standards for Mental Health Social Workers* (AASW, 2014a) and MHSWP. These points follow on from the Stage 2 discussion. Therefore, this section begins with discussion of the pervasiveness of the discourse in the documentation for MHSW education and practice. Discussion follows about the location of MHSW in the power relations among the different professions in the mental health arena. The section ends with discussion about the place of MHSW amid national mental health policy, practice and culture, and what this means for MHSWP.

The pervasiveness of discourse

Referring to the introductory lines of this chapter, the author focuses this analysis upon the saturation of bio-psychiatric, disease-saturated (illness) language in mental health policies, where the intermingling of language with the social and political structures and their inherent power relations contributes to, and sustains, the bio-psychiatric, disease-saturated (illness) discourse. This creates tensions and gaps in the struggle for critical-emancipatory MHSW. The tension for MHSW here is in the writing of MHSW policy for practice because this does not occur in a vacuum; it cannot occur without reference to the national (and even international) extant documents. On one hand, this is necessary to maintain clarity and consistency in service provision. On the other hand, it requires identifying with the dominant discourse and its inherent practices. Therefore, the bio-psychiatric, disease-saturated (illness) discourse in national documents carries the potential for its pervasiveness in MHSW policies and Standards. The gap here is in what MHSW policy means for MHSWP when national government policies adhere to, and abide by, a bio-psychiatric, disease-saturated (illness) approach.

As emphasised in this CDA, the genre that prevails in the mental health arena is one that uses the language of mental incapacity, illness, mental state examinations, assessment of psychiatric disorders, diagnoses according to the *DSM-5* (APA, 2013), treatment, risk and every other medicalised terminology used in the bio-psychiatric, disease-saturated (illness) approach. Again, the tension lies in the dominance of the language of everyday practice that is viewed as “the norm”, and thus causes a gap for MHSWP. Critical-emancipatory MHSWP offers the space to

contest language and practices that label and situate people accessing (or being forced to receive) mental health services. The author posits that a knowledge base for MHSWP situated within critical social work theory and aided by a critical realist stance can assist critical reflection upon opportunities to open spaces for a different dialogue. This is notwithstanding the reality of MHSW provision, given the intrinsic power relations that sit within an industry that now has global significance and includes profitable ventures from medication, being in partnership with *Big Pharma* (Breggin & Cohen, 2007; Carlat, 2010; Kirk et al., 2013; Moncrieff, 2006a, 2009; Whitaker, 2010).

Power relations and relationships in the mental health arena

The power relations in discursive practices in mental health, as discussed in Stage 2, include those in the differences between professionals, the place of pharmaceutical companies in treatment regimes, the people with a lived experience of mental anguish accessing (or most often receiving) mental health services, and professionals' understanding about service delivery. A critical realist lens reveals not just the epistemological musings about the power differential in professional relationships but their ontological considerations (Sayer, 2000). This relates to understanding the "generative mechanisms" (Bhaskar, 1998) amid the processes, structures and meanings that contribute to creating, (re)producing and representing the bio-psychiatric, disease-saturated (illness) genre within mental health services. While it is important to be mindful of these generative mechanisms, this mindfulness also requires a depth of understanding about the relations between language and practice that goes beyond naïve realism, or even relativity (Sayer, 2000). Therefore, a critical realist approach (Sayer, 2000) invites an exploration that moves beyond potentially obvious ideas about cause and effect to reveal the generative mechanisms that may contribute to a gap in the professional relationships between people served, and those delivering services, in mental health. The power differential in the professional relationship is one such generative mechanism that functions to reinforce the structures that maintain the status quo. The relationship between "client" and "professional" is a mysterious notion, promoting boundaries and a sense of distance from those in mental distress. Given that ethical MHSWP must ensure respect for people's right to privacy and safety in the professional relationship, the layer of professional distance in interpersonal interactions creates othering (Pilgrim, 2015b). Immediately, then, the opportunities for clarifying deeper meaning with those "afflicted" is lost to the power relations inherent in the discourse and practices that function to dominate the encounter.

There are also differences in power between the professional groups within the mental health arena. Mental health social work tends toward the lower end of the stratum in a multi-disciplinary team in a hospital mental health service, for example. Although this is (almost) never explicit, the conversations occurring between the nurse and the psychiatrist, for example, are most often quite different, even exclusive, from those between the mental health social worker and the nurse, or with the psychiatrist. These demonstrated power differentials are not only at work in institutions. They also play out in mental health community settings. Thus, the social world of

working relationships takes on a life of its own (Goffman, 1961). This equates with the bio-psychiatric, disease-saturated (illness) dialogue, and constitutes the network of practices that inform each of the professions in the way they relate to one another. As such, it impacts on the way the professions relate to people in distress.

Mental health policy, practice and culture: the place of mental health social work

The discussion in Stage 2 of this analysis centres on Australian policies specific to MHSW; seven extant federal government mental health documents and the *AASW Response to the National Mental Health Commission's Report on the National Review of Mental Health Programmes and Services* (AASW, 2015), all of which expose the dominance of the bio-psychiatric, disease-saturated (illness) paradigm. These documents are fundamental for guiding practice in the mental health services. Given the dominant bio-psychiatric, disease-saturated (illness) ideology in mental health and the powerful association with *Big Pharma* uncovered in the analysis, it is hardly surprising that this genre pervades the relationships and therefore service provision across all domains of practice, including MHSWP. Tensions and gaps inevitably arise.

There is the tension of the implied status of social work being lower than that of the other professions in the mental health arena. This tension raises the following points. The first is professional relationships. Crucially, the core value of "respect for persons" sits at the heart of social work (AASW, 2010, p. 12). Moreover, tenets within social work theory, the *Code of Ethics* (AASW, 2010) and the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) support a person-centred approach as integral to MHSWP. While the *Practice Standards for Mental Health Social Workers* do not explicitly state the requirement for competence in respecting persons across all manner of professional relationships, it is implied.

Mental health social workers in the main – it would be reductionist to assert "all" – are committed to "collaborat(ing) with the relevant professionals and people who have an impact on the person's wellbeing" (AASW, 2014a, p. 7). The ideology in policy is somewhat different from that in practice, especially given the earlier arguments about the dominance of nursing and psychiatry (power relationships), and the culture in which this occurs. Not only is there often a lack of confidence but there is even a layer of fear in advocating for, and asserting, social work values among the daily bio-psychiatric, disease-saturated (illness) conversations about people's needs. There is also much reticence in asserting a differing perspective about respecting people's needs, which may not be conducive to what the "treating team" is "recommending". As already stated, the importance of relationships with peers and colleagues lies at the heart of practice, perhaps becoming more paramount at times than the focus on the people being served. While this argument treads into moral territory, this is where the place of confidence is paramount.

Confidence in MHSWP is advanced through a knowledge base grounded in multiple perspectives – the multi-factorial nature of things in corporeal needs (Shakespeare, 2014) – what the core values of social work mean for MHSWP, and the opportunities for reflection on these layers and more to assist growth in confidence for practice. Thus, having the capacity to question

the status quo, based in values that support ethical and emancipatory intent, underlies a critical-emancipatory approach. This approach is advanced in Part 2.

A further tension arises in the form of gaps in MHSW education, which the author also elaborates upon in Part 2. The pedagogical implications for MHSW education impact upon the ontological outcomes for social work learners entering the mental health arena as new graduates. Also requiring consideration here is that some post-graduate social workers return to study a Master Degree (or similar program for advanced practitioners) in social work, and may, on occasions, receive recognition of prior learning (RPL) for previous studies in mental health. This raises concerns, given that a bio-psychiatric, disease-saturated (illness) model for practice would have been the predominant approach studied previously. The gap lies in opportunities for challenging old ways and embracing new thinking for practice. Perhaps at best this gap is minimal, which raises the question: Where to from here for MHSW education in relishing the challenge to embrace epistemological and ontological paradigms that support critical-emancipatory MHSWP? Part 2 raises possibilities for re-newing this process.

Stage 5: Reflect critically on the analysis in the four prior stages

Critical discourse analysis: adopting a critical realist stance in assisting with a critically reflexive process

Adopting and maintaining a critically reflexive stance in this study, evidenced through the CDA as the methodological approach, acknowledges the author's commitment to interrogation, exposure, interpretation and integration of the AASW and federal government mental health documents, thus affording depth to the reflection. Bolstering this with critical realist philosophy avoids a reductionist approach. Exploration from a critical realist standpoint, incorporating CSA (Fairclough et al., 2004), provides the framework for interpreting the mental health documents in scope for this study.

Although Fairclough places emphasis on the benefits of CR in his later works with Jessop and Sayer (Fairclough et al., 2004), he reasons that this Stage "is not strictly part of Bhaskar's explanatory critique". Australian critical realist Grant Banfield (2016), however, maintains that this Stage is synonymous with a critical realist stance and that it is indeed critically reflective (pers.com.). Critical realism assists this process by addressing the:

> …substantive explanation of not only what is wrong or inadequate in a system of thought (the bio-psychiatric-pharmaceutical enterprise), but why it is believed (and) considering different modalities of this explanatory form (assists with) how it came to be generated, accepted and reproduced. (Cornell & Parker, 2010)

Hence, the critical realist position is one of critical reflection upon the many layers discussed in this CDA in order to ascertain a depth of understanding about the generative mechanisms contributing to the dominant bio-psychiatric, disease-saturated (illness) – pharmaceutical enterprise for MHSW. Utilising the critical realist ontological notions of the "actual" and the "real" (Ayers, 2011, 2013) demonstrates that the AASW polices for MHSW education and

practice are littered with the dominant bio-psychiatric, disease-saturated (illness) discourse. It also leads to noting the historically-located mechanisms and structures in this phenomenon. The real is an observed phenomenon whereby this dominant discourse, together with the influence of *Big Pharma*, situates the practice paradigm in MHSWP. Practitioners (psychiatrists and nurses) whose professional training (hence, knowledge and practices) is grounded in these dominant understandings of human mental distress thereby influence MHSWP, albeit subtly, through the meanings associated within the dominant bio-psychiatric, disease-saturated (illness) discourse and practices.

Reflection, also being integral to the research process, enables the author to embrace the many threads that weave the study together to offer new ways forward in re-conceptualising the AASW mental health Standards for social work education, policy and practice. Critical realism's explanatory critique (Bhaskar, 2010) assists this process by paying attention to critical-emancipatory notions for MHSWP in being mindful of (reflecting on) possibilities for ways forward for education, policy and practice.

Pilgrim's (2015b) critical realist stance offers the epistemological and ontological edge in broadening the possibilities for MHSW education, policy and practice. Pilgrim asserts that "advantages of combining and reconciling ontological realism, epistemological relativism and judgmental rationality (in getting) the balance right" (Pilgrim, 2015b, p. xi) assists with the struggle toward broadening and appreciating other contexts, and equilibrium regarding mental anguish. If MHSWP is to lead the way in getting the balance right, "(i)ntellectual humility is required" (Pilgrim, 2015b, p. 44), combined with an approach of "curious speculation" (Pilgrim, 2015b, p. 6) that is "respectful of human complexity…and the patient's right to recognition" (Pilgrim, 2015b, p. 7); exploration occurs "in a spirit of humble curiosity or perplexity" (Pilgrim, 2015, p. 40). Such a simple and genuine encounter brings MHSW professionals moments that are more profoundly respectful of human beings than of rushing in with confident explanations and offers of treatment.

Reflection upon the layers

The first of these layers for reflection is the CDA as the process for interrogation, exposure, interpretation and integration. The CDA was undertaken with the imperative that it meet the study's objective – to re-conceptualise mental health social work education and practice in Australia: toward a critical-emancipatory approach. It also focuses on what lies beneath the order of the discourse, for example the discursive elements and the CSA, in identifying the obstacles the bio-psychiatric, disease-saturated (illness) related discourse creates for MHSW education, policy and practice. Therefore, this CDA exposes the epistemological edge regarding the realities (the "real") of power relations held by psychiatry, *Big Pharma* and the organisational structures that support their processes and practices. Equally, the critical realist interpretation of the policy documents serves as the foundation for re-conceptualising MHSW pedagogy for education as well as for policy and practice.

The next layer for reflection relates to the earlier argument in Stage 3 regarding the repetition of history; maintaining the "order of things". If social workers are aware of the mistakes of the past, then they are in a position to commit to maintaining an intermittent rear view about what the historical journey in the mental health arena means for the future. This assists in prompting memories (as proffered by Scull, 2009) relating to the historical, cultural, political and social location of the dominant bio-psychiatric, disease-saturated (illness) paradigm, as demonstrated in Stage 2. Inevitably, this has implications for educating social work learners, the professional development of existing MHSW practitioners, and for reflecting upon, and actioning, ways forward.

Critical-emancipatory perspectives and praxis for mental health social work

Subsequently, reflecting upon ways forward identifies the layer of MHSW education whereby social work educators have an obligation toward pedagogy that provides the historical context for mental health practice, together with an ontological critical realist stance that supports this. While an historical context provides the background about the journey of psychiatry amid the lived experiences of people with mental anguish, this cannot occur in a vacuum of information for MHSW learners that supports only a bio-psychiatric, disease-saturated (illness) paradigm. It must occur within an epistemological framework that enters the realm of critical-emancipatory social work theory, while also endorsing ontological considerations for practice. A critical-emancipatory approach, reinforced with CR, offers this stance. Critical-emancipatory MHSWP approaches parallel socially just notions that respect the plight of human beings in mental distress. These approaches accord with rights and relationship-based practices; approaches with a trauma-informed paradigm for practice that is not limited to binary concepts of care.

This analysis addresses tensions and gaps that have implications for MHSW. There are inherent power relationships implicit in the bio-psychiatric, disease-saturated (illness) approach and reinforced by *Big Pharma* with its heavy reliance on medications as the remedy for finding happiness or controlling aberrant behaviour. The epistemic fallacies inside the bio-psychiatric, disease-saturated (illness) knowledge base, together with the discursive elements that shape attainment of this reductionist knowledge, impact heavily on MHSW. The extant AASW mental health education and practice Standards policies analysed in Stage 1 are testament to this. Further evidence lies within current psychiatric social work practice, touted as "contemporary MHSWP". Nevertheless, this change in language invites the exploration of new possibilities for social work. However, these possibilities can neither be realised nor occur without MHSW practitioners and educators maintaining a focus on critical-emancipatory MHSW as the vision for new ways forward. Part 2 opens up these possibilities through a critical-emancipatory approach to MHSW education, policy and practice. This re-conceptualisation from psychiatric social work to contemporary MHSW is woven from the core values of social work – an ethic of care – which reinforce the reciprocity of knowledge and practice.

Chapter summary

The five stage CDA described in this chapter, in which the author examined the dominant bio-psychiatric, disease-saturated (illness) discourse in the Australian mental health scene using an interpretive lens and a critical realist stance, reveals the heavy influence of the bio-psychiatric-pharmaceutical enterprise on this discourse and hence on MHSW education, policy and practice.

The CDA has exposed the language of the bio-psychiatric, disease-saturated (illness) discourse in key AASW and federal government policy documents, thus enabling identification of obstacles inhibiting change. For example, the *DSM-5* and the *ICD-10* are identified as aiding the reductionist approach of labelling (diagnosing) people within a bio-psychiatric, disease-saturated (illness) paradigm of deviance, biology and genes. This classification system is shown to serve two powerful interest groups; the insurance industry and the pharmaceutical industry. The author has also unveiled how psychiatry, as a network of practices, maintains the status quo. Having identified obstacles to change, the author has adopted CR to explore possibilities for moving past them before reflecting back over the first four stages of the CDA to derive meaning from the findings. This sets the scene for moving forward to re-new and re-conceptualise MHSW through in-depth discussion of the three core foci of MHSW education, policy and practice in Part 2. Thus, the CDA lays the foundation for this re-conceptualisation.

PART 2

RE-CONCEPTUALISING MENTAL HEALTH SOCIAL WORK

CHAPTER 5:
RE-CONCEPTUALISING AND RE-NEWING MENTAL HEALTH SOCIAL WORK EDUCATION

> If social work is to engender and maintain its unique and vital role in problematising simplistic, depoliticised and individualising constructions of mental health and illness, we need to promote more contextualised and holistic understandings of people's experiences. (Morley & Macfarlane, 2010, p. 46)

The future of mental health social work (MHSW) in Australia will inevitably become the history of mental health social workers and educators. The journey ahead necessitates utilising a critical-emancipatory approach espoused in policy, offered in education, and adopted as a guide for practice. Historical moments and pictorial representations in mental health, revealed in the Australian journey in Chapter 3, demonstrate MHSW environments and practices purpose built for serving people (citizens). The path of history in Australia, emanating from Europe and North America, portrays images and an auditory presence of locked doors, jangling keys, padded cells, cold linoleum, screaming, loud laughing, bodies walking around in a drug-induced haze; of people experiencing mental anguish, locked away and hidden from society within purpose built institutions known as "asylums". Today, people experiencing mental anguish, in whatever form, are no longer hidden away and forced to endure rights violations and social injustice in such institutions. However, rights violations and the effects of institutionalised practices inherent in bio-psychiatric, disease-saturated (illness) care, continue, but in other ways such as marginalisation. An example of this is the contemporary notion of Recovery (Anthony, 1993, 2000, 2007, 2011; Anthony & Farkas, 2012) and the expectation that this approach will be central to care, occurring wherever possible within the community.

There is evidence of ongoing suffering (Wilkinson, 2005) and rights violations due to the powerful influence of the bio-psychiatric, disease-saturated (illness) enterprise and its association with the pharmaceutical industry (*Big Pharma*) offering a myriad of chemical remedies (Breggin, 1993, 2009; Breggin & Breggin, 1994; Breggin & Cohen, 2007; Jureidini et al., 2016; Moncrieff, 2009; Smith & David, 1975; Whitaker, 2010). In addition, extant data exposes that people's lived experience is not decreasing but, as shown in Part 1, the state of affairs in the arena of mental distress is worsening (NMHC, 2014b). This is further justified by the author's practice experiences in the mental health arena, beginning in the mid-1980s with work as a psychiatric nurse and continuing throughout the 1990s as a mental health social worker witnessing many social injustices (notwithstanding the professional determination to deal with them). Her introduction to the effects of institutionalisation on both staff and "patients" occurred in the setting of a 300-bed psychiatric hospital at the commencement of deinstitutionalisation. After enduring decades of incarceration, people were expected to suddenly adapt to living in the community. There was a lack of regard for the consequences of such a move, death from exposure being but one example.

The second era of the author's mental health social work practice (MHSWP) occurred briefly in a hospital psychiatric ward, then in community mental health, and revealed other injustices and rights violations relating predominantly to people contesting various orders made under the Mental Health Act, their diagnosis or the severe side effects of medications. These injustices remain an historic, stark reminder of the need for change. The author hopes these social injustices and rights violations activate social work educators', practitioners' and policy-makers' moral obligation to enrich their understandings to re-conceptualise MHSWP; to optimistically grasp, and confidently pursue, critical-emancipatory approaches for being socially just and respectful.

This chapter establishes the foundations and the context for traversing the three core foci for MHSW introduced in Part 1; education (including the pedagogical implications), policy and practice. Although demonstrated here in a lineal manner, this is for explanatory purposes only to assist with clarity of the meaning of the contribution these foci make to MHSW. In reality, the core foci, in their entirety, are fundamental to a critical-emancipatory approach in MHSW and cannot be viewed as lineal. The education of new MHSW learners and advanced practitioners necessitates rigorous, robust pedagogy. Given this, the integration of knowledge and practice for new learners will vary from that of practitioners choosing to return to studies as part of their ongoing professional development in generic social work or MHSW. These advanced practitioners come with established assumptions and practice experiences.

The discussions in this chapter depict the moments where practice varies between new learners and advanced MHSW practitioners. The section on policy addresses the Australian Association of Social Workers (AASW) policies, Standards and ethics that apply to MHSW education and practice, as scoped for the critical discourse analysis (CDA) in Chapter 4. The section on practice introduces specific concepts from the areas of education and policy to aid the call for critical reflection as a core tenet of critical-emancipatory MHSW practice. To aid the clarity of meaning about the term "social work educators", this applies to any social work educators who teach MHSW curriculum or topics specific to MHSW. Social work educators do not necessarily have experience that relates specifically to MHSW.

The CDA of the AASW mental health policies and relevant Australian national government policies revealed the discourse of politicised and individualised constructions, and the network of practices within which MHSW is currently located in Australia. Further work would assist a comparative analysis of other nations in coming to understand the similarities or otherwise with the Australian experience. The author expands upon this in Chapter 6, highlighting that MHSW education, policy and practice occur amid the broader context of political, social, economic and cultural aspects; MHSW is not just about the individualised pathology of the personal. The realms of critical psychiatry, sociology and critical social work offer a sound knowledge base for re-conceptualising psychiatric social work and re-newing MHSW by adopting a critical-emancipatory approach (Appignanesi, 2009; Bay, 2014; Becker, 1973; Bland & Renouf, 2005; Bland et al., 2009; Breggin, 1991, 1997, 2000, 2001, 2002, 2008, 2013; Carlat, 2010; Cohen, 1990, Curra, 2011;

Greenberg, 2010, 2013; Healy, 2001; Jureidini, 2012; Kirk, 2005; Kirsch, 2010; Macfarlane, 2009; Moncrieff, 2009; Morley & MacFarlane, 2010; Oliver, 2012; Rogers & Pilgrim, 2014; Scheff, 1999; Smith, 1990a; Szasz, 1961, 1970, 1977, 1978, 1989, 1997b, 2007, 2010b; Tew, 2005). This critical-emancipatory stance, strengthened by critical realist philosophy, thereby repositions social work in mental health (Morley & MacFarlane, 2010).

In addition to contemporary Australian critical social workers, the contributions of authors calling for changes in MHSW education offer discerning and robust ideas, many of which heavily influence the recommendations for this study (Bainbridge, 1999; Bay, 2014; De Maria, 1992; Macfarlane, 2003, 2006, 2009, 2010, 2011, 2012, 2014; Morley, 2003, 2008, 2009, 2010, 2011, 2013, 2014, 2016). Morley and MacFarlane (2010), and Macfarlane (2009) bring into focus not only the impact of neo-liberalism and its consequences, for example the current preoccupation with evidence-based practice, but also the path to socially just and rights-based approaches applicable to MHSW. Accordingly, Morley and Macfarlane, influenced by Fook's work on critical reflexion and reflective social work (Fook, 2012, Fook & Garder, 2007), entice MHSW learners and practitioners to maintain awareness of critical social work theory and practice. In doing so, Morley et al. (2014) discuss the necessity of exploring MHSW values in the dominant, ever-present discourses when responding to the dilemmas and challenges of daily practice. Additionally, Morley and Macfarlane (2010) discuss the need for a broader MHSW education curriculum than the offerings of the bio-psychiatric, disease-saturated (illness) paradigm. Their invitation to the AASW, given six years ago, follows as a response to the introduction of compulsory mental health curriculum in social work schools across Australia in the recent years, suggesting the need for the AASW to ensure curriculum that offers a universal approach. In addition to the words in the quote opening this chapter, Morley and MacFarlane (2010, pp. 46, 47) argue for the capacity for MHSW to advocate for change:

> Social work has a unique role [in]…the professional repositioning of social work in mental health [and it] must be informed by critical/postmodern theoretical approaches…which emphasise an analysis of power relations, structural inequality, and progressive social change ideals.

Further to this invitation, they note concerns about the possibility of the curriculum being too restrictive in attending to critical perspectives for MHSW practice. While it is certainly probable that many Australian social work programs offer elements of critical, postmodern theoretical approaches, this study proposes that this is haphazard at best. This study seeks to promote Morley and MacFarlane (2010), and Macfarlane's (2009) call for critical perspectives and approaches to inform education, policy and practice in MHSW, while adding to these areas within a critical realist stance that is accessible within critical realist philosophy. In addition, the author of this thesis contends that doing so will offer consistency within MHSW theory, also supporting notions of reflexive practice together with the moral imperative necessary for humane and socially just MHSW – a critical-emancipatory approach.

Exploring the possibilities for moving forward in the twenty-first century away from the influence of bio-psychiatric, disease-saturated (illness) approach toward relationship- and rights-based, socially just MHSW requires two distinct moments – critical reflection and action – in the three aforementioned foci; education, policy and practice. However, education, policy and practice must not head into a vacuum of dichotomous reflection upon ways forward. It is necessary to begin with a rear view reflexion on the course of history, then navigate ways forward, being mindful of historical injustices. This journey needs to proceed with caution (notwithstanding the courage to take some risks) so social work educators and practitioners find pride and confidence as MHSW professionals seeking to *make a difference* to the lives of people – inclusive of whole communities and society overall – who experience the dilemmas of social existence. Hence, the following discussion addresses the three core foci in terms of the pedagogical implications for MHSW education, policy and practice, demonstrating the layers that surround a contextualised and holistic interpretation of MHSW education, policy and practice (Morley & Macfarlane, 2010) as an integrative process that is neither static nor stable – it is ever-changing and open to new interpretations.

Therefore, there is a clear and unambiguous commitment to drilling down into the concepts, opportunities and challenges of adding to the existing research for equipping mental health social workers to practise in any context where mental distress and its resultant experiences are apparent. Indeed, identifying the following concepts that span education, policy and practice affords opportunities and challenges in the quest for new meaning that identifies with the ontological edge in a critical realist standpoint. In this way, commitment to emancipatory intent, also a core tenet of critical realism (CR), aims for a dialectic of knowledge and care.

The place of "critical" as integral to a critical-emancipatory approach in mental health social work education

As noted in Chapter 2, there are a number of local contributions to critical social work perspectives that provide valuable knowledge for contemporary MHSW education and practice in this country (Bainbridge, 1999; Bay, 1991, 2014; Briskman et al., 2009; De Maria, 1992; Fook, 2012; Healy, 2012; Macfarlane, 2009; Martin, 2003; Morley, 2011; Pease & Fook, 1999). Pilgrim's (2015b) detailed critical realist exploration of mental health adds to the work of other critical thinkers in social work, sociology, critical psychiatry, clinical psychology and political philosophy (Breggin, 2016; Cohen, 1990; Gomory & Lacasse, 2003; Juriedini et al., 2016; Kirk, 2005; Kirk et al., 2013; Lacasse, 2014; Moncrieff, 2009; Tew, 2005). One exception to these authors is American journalist Robert Whitaker, who, although not an academic, shocked the author with his ground-breaking text, *The Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs and the Astonishing Rise of Mental Illness* (2010), given that it was one of the early texts in the mental health research journey. Whitaker's work brought the mission for the author to dig deeper – providing the final impetus for this project. Indeed, Whitaker's continuing work that questions the assumptions from which professionals operate in mental health, together with the work of the aforementioned academic

writers, can no longer be ignored. At the very least, what this means for MHSW education (policy and practice) is the acknowledgement of these authors' contributions to broadening perspectives and approaches away from the bio-psychiatric, disease-saturated (illness) enterprise and *Big Pharma* situated within this; away from the positivist and reductionist approaches of bio-psychiatry, which the author believes are touted as "divine interventions".

Foucault's work in re-evaluating the "unexamined rationalities of our profession" (Chambon et al., 1999) as social workers is explained further when noting the historical journey of psychiatric social work (Foucault, 1967). The place of "critical" becomes more urgent with the guidance of feminist theory, whereby several professional women's accounts of their lived experiences of, and research into, the American mental health system (Bland et al., 2009; Bly in Lutes, 2014; Boyle, 2002; Findlay, 1975; Longden, 2013; O'Hagan, 2003, 2004, 2014; Smith, 1990a)[4] reveal an evidence base that cannot be ignored. As noted in chapters 2 and 4, the author posits that a fundamental element of the research process is the need for continuous reflection upon its purpose, and for demonstrating the legitimacy of critical perspectives and approaches within contemporary debates. This position accords with a rigorous and robust process for re-newing and re-conceptualising MHSW curriculum content, policy and practice that addresses a critical-emancipatory approach.

A feminist perspective for mental health social work education

Although this study does not focus directly on women, historical notions discussed in Chapter 3 serve as a reminder that women, and vulnerable, marginalised groups (for example, Aboriginal and Torres Strait Islanders, children and people with impairments that preclude them from a right to a socially just life) have experienced many human rights violations in the mental health arena. Hence, there is a commitment to feminist ideology as vital to understanding the gendered nature of mental health care (Scull, 2009), thereby adhering to a critical-emancipatory approach for MHSW education. Feminist Standpoint theory (Harding, 2008) and feminist ideology (Smith, 1990a) draw mental health social workers' and educators' attention to theory for practice in assisting them to become, or remain, aware of the risks inherent in biased patriarchal phenomena. An example here is via the discourse and the network of practices (Fairclough, 2001a) inherent in the bio-psychiatric, disease-saturated (illness) enterprise relating to women receiving a diagnostic label of personality disorder (PD) or borderline personality disorder (BPD). Critical-emancipatory MHSW education and practice supports the need for mindfulness of the scrutinising (for example, the assessment) of women's lives when mental distress is present for reasons often beyond their control. This is evident within the current national situation in domestic and family violence in Australia where many women are dying at the hands of their intimate partner: "[d]uring 2010-11 and 2011-12, 196 victims were killed by an offender with whom they shared a domestic relationship…nearly two-thirds were female (n=121; 62%)" (Australian Institute of Criminology, 2015). Feminist ideology

[4] Includes one Australian woman

offers the basis for conceptualising the political, economic, cultural, civil and social rights violations occurring in vulnerable and marginalised groups, including women in domestic and family violence situations (Fraser, 2013).

Recovery and consumer movements

A critical-emancipatory approach in MHSW education must address the Recovery (Anthony, 2007) and consumer (MacDonald-Wilson et al., 2013; O'Hagan, 2014) movements. However, there is a cautionary point here. Although the intention of contemporary perspectives and approaches aims to respect peoples' lived experiences of mental distress, little attention is paid to the consumer/patient/service user – the citizen – in maintaining a central and rights-based presence for reclaiming their previous state of wellbeing (Recovery). In other words, the idea of Recovery apparently affords a large degree of autonomy to the consumer through their mental health care journey. However, this soon changes if the treating team believes something else should occur. This is especially so when psychiatrists make orders for coercive treatment, such as Electroconvulsive Therapy (ECT) or Community Treatment Orders (CTOs), using the legislative provisions of a Mental Health Act to support their decisions. As purported amid the CDA of the various policy documents for MHSW, and in this chapter, the bio-psychiatric, disease-saturated (illness) model, together with the powerful presence of *Big Pharma,* remains dominant.

This dominance is also pervasive within the discursive elements amid language and labelling (Scheff, 1999) of citizens (or their families) sometimes willingly adopting a diagnosis as they grapple for answers to their personal plight. This is different for children and young people under the age of eighteen, where their parent(s) may be searching for answers amid their confusion about what is "wrong" with their child. This is tricky territory for social work educators because the potential risk of binary thinking entering conversations looms large. For example, the immediate questions posed become the following: Does this mean Recovery is not a useful concept for people with a lived experience? What is wrong with having a diagnosis? What other language is there? Many people, both professionals and those with a lived experience of mental distress and MHSW, quite often find comfort in a diagnosis (a label) because it provides them with some meaning about mental distress and a strong desire to find answers amid the ostensibly unknown (Kirk et al., 2013; Pilgrim, 2007, 2011, 2015a,b; Pilgrim & Bentall, 1999; Scheff, 1999, 2009, 2010). The place for conversations based in a critical-emancipatory approach is where MHSWP enters, and must occur in, a climate of social work educators modelling relationship-based practice, whereby dignity and respect for diversity of opinions occurs at the same time as making space for alternative understandings (Macfarlane, 2009). In this way, social work educators (in mental health) are opening these spaces, engaging with a socially just approach to knowledge and practice. This type of approach facilitates discussion and conversations that raise awareness about the status quo and therefore the knowledge base to question it. This is the space for critical-emancipatory MHSW.

Mental health social work learner as central to socially just and humane practice

The re-conceptualising of new ways forward for critical-emancipatory MHSW begins with the new learner to social work but is equally applicable to post-graduate mental health social workers. Above all, focusing on learners in MHSW applies specifically to them as budding practitioners or those with experience in the field, not the individual citizens they serve. Therefore, the focus of this study is on mental health social workers as new learners and post-graduates, not on what they need to "do" in "therapy" or suchlike. Despite the availability of a plethora of research and literature detailing endless reasons and remedies that claim to make a difference to the lives of clients, patients, consumers, service-users and the like, it is imperative to keep sight of the broader notions of socially just practice with people as whole groups, whole communities and whole societies, not only as individuals. There is a tendency toward moving the MHSW headset immediately toward a focus upon how to diagnose, assess and treat people, consistent with a bio-psychiatric, disease-saturated (illness) approach. Although usually well intentioned, this takes the heat out of the moral imperative in needing to start with oneself, in the reflexive sense (Fook, 2012), as part of conceptualising what it might be to work with people who are experiencing long-enduring mental distress (Wilkinson, 2005). Hence, the mindset of going straight to thinking about the client/patient must change to beginning with the "self"; a self that requires being a critically reflective practitioner, with a developing and deepening sense of personal and professional identity. This identity must be robust and conscious of the strengths, limitations and boundaries that responsible, ethical, professional MHSW conduct necessitates.

The place of pedagogy in mental health social work education

> It is essential that critical social work education develop analyses to interrogate the power of the state and its extension into the community and develop strategies to enable social workers to find spaces in which to challenge that power. Otherwise, it will be subjected to critique for its lack of reflexivity in analysing the context in which it is being practised. (Pease, 2013, p. 31)

Although Pease (2013) writes from a generic perspective on the *History of Critical and Radical Social Work* in *The New Politics of Social Work* (Gray & Webb, 2013), this is equally appropriate for MHSW learners in critiquing the power relations identified in the CDA as part of their MHSW education. MHSW education that seeks to interrogate the bio-psychiatric, disease-saturated (illness) paradigm in mental health attends to appreciating the *what* and the *how* in the arms of power via the State in the ways it adds to the misery amid mental distress. This section, with the words of Pease as a guide, identifies ways forward for social work educators, learners and experienced practitioners alike.

Engaging social work learners in the process of acquiring knowledge in MHSW requires the curriculum to be inspiring, challenging and thought provoking. This is fundamental for the learning journey for MHSW learners to become competent professionals; that is, having a knowledge base

from which to practice, an ethical imperative that lies within the practice soul and a sense of professional integrity about serving people, not just the employing organisation. Although it is perhaps reasonable to assume that most people undertaking a MHSW topic (AASW, 2012c) are doing so with interest, and hopefully some passion, for many reasons they nonetheless bring long-held beliefs based on assumptions and lived experiences (sometimes also of mental health service). Learners' beliefs, assumptions and lived experiences are held occasionally with reverence, often without question or simply because of the unknown. Therefore, social work educators need to be mindful of these possibilities when facilitating a learning environment that is relatively enjoyable and creates incentive for learning experiences, thus inviting an early commitment for relishing new learning (Freire, 1996; Giroux, 2007; Giroux & McLaren, 1989; hooks, 1994; McLaren & Kincheloe, 2007; Noddings, 2012).

The milieu in aiding the learning of critical-emancipatory perspectives and approaches for mental health social work

Facilitating a learning environment that "feels" safe, stimulating and trusting creates an engaging milieu for thought provoking dialogue. This offers learners opportunities to explore previously long-held assumptions while at the same time engaging in a process of discovery. Engagement, together with discovery, aids the learning process for the sharing of critical-emancipatory approaches, and conveys hope for either current or future MHSWP. Facilitating a learning environment that opens up the possibilities within a critical-emancipatory approach for MHSW practice occurs through offering opportunities for learners to open their minds to new knowledge while at the same time respectfully responding to personal values, attitudes, beliefs and assumptions that new information may (potentially) challenge. The pedagogical intent here is for generating new, or refreshing experienced practitioners', thinking and worldviews that eventually resonate within an open mind. This assists with the development of competence and confidence for MHSWP, and with the theory-practice nexus whereby the process of integration encompasses the ethical imperative that lies within the core values of social work. The social work core values of respect for persons, social justice and professional integrity (AASW, 2010) launch the knowledge-value base underpinning practice, which rigorously positions moral regard for the mental distress of another and preserves critical-emancipatory intent as core practice. Equally, the author contends that while many MHSW learners may agree with this and may espouse that they "have what it takes" to work with mental health issues as a social worker, there is often a layer of naivety in this. Given most learners hold noble intentions for their journey into social work and that they are often curious about MHSW, they are unacquainted with the complexity and ambiguity among the challenges of navigating socially just, relationship- and rights-based practices.

Returning to study, either for career advancement or refreshing knowledge and ideas about practice, brings the strong possibility for cognitive dissonance (Festinger, 1957) to set in quite rapidly (see later section on cognitive dissonance). Cognitive dissonance occurs, for example, when practitioners bear witness to perspectives and approaches that may be foreign to their prior

experiences. Therefore, social work educators must be awake to this possibility, with the pedagogical intent of approaching the learning environment with care and caution for maintaining respect and preserving people's dignity (Rose, 2005) in the education process. Thus, this modelling for practice from social work educators begins in the classroom, serving as a foundation for humane MHSWP in the field.

Mental health social work curriculum requirements in maintaining learner wellbeing: vicarious trauma

As mentioned, there is importance for creating a safe, trustworthy and conducive learning environment within the pedagogical mix. It is essential, then, to appreciate the possibility that some learners may well have prior (or current) experiences of trauma while at the same time participating in curriculum content that carries the risk of vicariously traumatising them further (Cunningham, 2003, 2004; Pearlman & Mac Ian, 1995). Although a desire for new learning may bring excitement and enthusiasm for many, it does not necessarily do so for others. Social work learners may have traumatic lived experiences, whether personal or as a witness from afar. It appears that many learners hold some curiosity about the concept of mental illness. Upon entering a mental health topic in a social work program, they are keen to learn more about "it", particularly where there is some lived experience within this realm. The curiosity is most often about the causes, diagnoses, various treatments and the legislative requirements of working with mental illness. These ideas have evolved from the dominant bio-psychiatric, disease-saturated (illness) paradigm that is characteristic of western society, as exposed in the CDA. When faced with information in the classroom that challenges this status quo, the contradiction can be confronting for some, while others may find it "refreshing". Therefore, it is an explicit requirement that academics pay close attention to the potential for vicarious trauma (VT) to occur in the classroom setting because VT is not confined to the practice field. Cunningham (2004) proposes the possibility that secondary trauma occurs for all learners.

The author extends this argument to assert that the VT issue is even more pressing for learners with a prior traumatic lived experience of mental distress, either their own, or amid their loved ones or significant others. While literature addresses this in the clinical (practice) context (Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995), there is a paucity of information regarding the incidence of VT in the MHSW classroom, although most studies (Cunningham, 2003, 2004; Pearlman & Mac Ian, 1995) caution social work academics to be mindful and aware of the need for learner wellbeing.

MHSW policy related to the mental health curriculum needs to include the teaching of theory regarding the realm of VT, compassion fatigue, secondary trauma and similar to ensure that learner wellbeing is addressed in their educational experience, thereby taking it into field practice. Although social work educators have an ethical responsibility to ensure learners gain an early awareness about VT and its potential effects on the practitioner, social work learners in mental health read, watch, discuss and listen to content in classes that has the potential to cause high

levels of discomfort. Furthermore, the need to develop skills in critical thinking and reflection assist this learning process, which discussed in detail further on in this chapter.

Together with the curriculum requirement for including VT in the mental health curriculum to ensure social work learners' emotional safety, a requirement for the inclusion of knowledge about VT (and its related phenomena) in the AASW education curriculum for MHSW practice is imperative. Indeed, this adds to the knowledge base for MHSW learners as they graduate to practice, working in any area where mental distress is present. While it is vital to ensure MHSW practitioners have a beginning awareness of the potential for VT, knowledge about a trauma-informed, responsive and specific approach in MHSW assists this further (Bloom, 2015, 2016; Bloom & Farragher, 2011) (see later section "A trauma-informed approach").

Cognitive dissonance in the learning environment

Cognitive dissonance in the learning environment presents an important pedagogical challenge. It requires an astute awareness about the intricacies of cognitive dissonance proposed by Festinger (1957). This phenomenon relates to the situation where a person facing a belief, idea or action that differs from their usual understanding can find it distressing, even causing feelings of anger and frustration. Hence, when MHSW learners face new information that is different from the generally well-known language and practices of the bio-psychiatric, disease-saturated (illness) paradigm, there is the possibility for displays of annoyance, frustration and even hostility. As a social work educator in a mental health topic, the author has observed several different types of reactions that present through non-verbal behaviour or in verbal responses, demonstrating the presence of this phenomenon. For example, when there is an appearance of passive aggression, the learner may move from being quite conversational to becoming very quiet, or the opposite may occur. Equally, a learner who has been quiet suddenly starts to ask questions but appears unready to absorb information (knowledge) that differs from their own, perhaps greatly, and they may even voice the struggle they are experiencing. The pedagogical challenge here is to be acutely aware of this phenomenon and the possibility for its occurrence to enable a respectful response where dissonant behaviour occurs. This also assists in preventing these instances from reaching a point where people can quickly retreat into familiarity in a desperate and possibly even determined attempt to feel safe about what they had always believed to be (modernist) ideas surrounding the "truth". Therefore, explicitly and respectfully addressing cognitive dissonance (Festinger, 1957) in the introductory teaching session to assist awareness of it as part of the learning process is necessary. This strategy anticipates the possibilities for its occurrence in meeting the pedagogical challenge and maintaining learner wellbeing.

Cognitive dissonance also has implications for the acquisition of new knowledge in critical thinking. When learners witness new information that may be confronting, and the dissonance is not addressed (or missed), little will change; learners will remain confused and challenged until there is another opportunity for further learning. This may mean that the learner seeks more

information on offer via the reading list for the topic, in later conversations with their peers or from another source outside the learning environment. Nevertheless, it is imperative for the social work educator to remain aware and astute in their efforts to retain people's dignity in the learning process as learners advance their knowledge.

Relationship-based practice in the classroom: social work educator as role model for critical-emancipatory approaches in mental health social work practice

Following on from the above discussion regarding respect for the learner in the learning process, the modelling of respectful relationships (fundamental to MHSWP) begins in the classroom; including the online classroom (regardless of some differences that can present challenges). Technology continues to offer new and less prescriptive ways of overcoming some of the obstacles that face-to-face communication takes for granted (McLoughlin & Lee, 2008; Seimens & Weller, 2011). There are a number of layers for reflection and action in this area, including the intricacies and nuances of neo-liberalism that present moments not always conducive to the ideal learning environment (Schrecker, 2012). Although not an excuse for pedagogical expertise, the politics of institutional life within the university environment is similar to any organisation. Social work educators require skill to navigate the nuances while ensuring they offer a rigorous pedagogical approach. This knowledge and skill lies within the realm of social work practice in the same way as it does for practitioners in the field. For example, social work has a high teaching component in the curriculum, with expectations of keeping up-to-date with further research and publications while attending to the teaching load in servicing ever-increasing numbers of learners. Likewise, in the field, navigating complex situations that require time to reflect carefully upon the layers is laced with pressure to perform within certain time limits and adhere to "evidence-based" practices (this contestable space was opened up in Chapter 4) (Banks, 2012; Ferguson & Lavalette, 2013; Gray & Webb, 2013; Webb, 2006; Weinstein, 2014). All the while, practitioners feel the weight of risk in being held personally accountable if things go wrong. Nonetheless, the realities of these moments remain, hence social work educators need the capacity and resilience to rise to these challenges in ensuring they offer a dynamic learning environment for future and current practising mental health social workers.

A dynamic learning environment accords with the philosophical tenet for social work education in the *Australian Social Work Education and Accreditation Standards (ASWEAS)*, which "fosters a commitment to lifelong learning [while it] aims to maximise opportunities for mutual learning by both student and educator" (AASW, 2012a, p. 20). Here, then, social work educators meet the requirement for delivering MHSW curriculum that has the learner central to the learning process. In this way, the learning encounter is mutually inclusive. Committing to this as a social work educator models relationship-based practices, which are demonstrated in several ways. For example, these may be mutuality of the learning encounter, demonstrating the ability to relate with learners in creating a stimulating and meaningful learning experience; creating opportunities for dialogues to assist this process; maintaining awareness of the potential for the situation to become

tricky; and modelling the art of responding respectfully. Occasionally, situations with the potential to become tricky assist with demonstrating how this might occur in field practice, given there are situations where the citizens being served sometimes become frustrated, or even angry, for reasons that may or may not be within the mental health social worker's sphere of influence. There may also be situations where the social work educator is sharing information that accords with a critical-emancipatory approach in MHSW and MHSWP, which may differ from the well-known and established bio-psychiatric, disease-saturated (illness) discourse. This leads to another layer for modelling relationship-based practice that begins in the classroom. The social work educator models the need for confidence and a level of self-assuredness in demonstrating the art of tact and diplomacy while responding to learner queries, concerns and ponderings. The art of assertiveness aims to prevent situations where learners may otherwise become hostile. The skill of relationship-based practice, amid many, is not only about being "nice" but also about demonstrating emotional intelligence (Cherniss, 2000; Goleman, 1996; Howe, 2008; Mayer & Salovey, 1993; Morrison, 2007; Salovey & Mayer, 1990).

Emotional intelligence for mental health social workers in education pedagogy

Morrison (2007) and Howe (2008) bring emotional intelligence, often referred to as EI or EQ (emotional quotient), into social work from the footsteps of psychologist Daniel Goleman (1996, 2007). This concept, coined from the work of Salovey and Mayer (1990), reached prominence through Goleman (1996) in the mid-1990s. Others have written extensively about EQ, noting its importance for leadership, organisational culture and business skills (Cherniss, 2000; McKee, Boyatzis, & Johnston, 2008). It now has standing in the human services.

The concept of EQ in MHSWP offers social work educators a theoretical basis for aiding MHSW learners to gain knowledge about the self in relationship-based practice, and for assisting the process of critical reflexion in learning and practice. Although Howe (2008) discusses this as an important concept for generic social work, EQ applies equally in MHSW. Howe (2008, p. 187, emphasis in original) states that "conceiving social work as relationship-based links both emotional intelligence and use of the self. Such approaches are less about what we *do* to service users and more about the relationship we have *with* users".

Connecting EQ as a core component of relationship-based practice in a critical-emancipatory approach for MHSWP accords with an approach that respects an ethical bond WITH people, rather than "doing" (Howe, 2008, p. 187) TO, AT or FOR people (O'Connell, Wachtel, & Wachtel, 1998). This, too, incorporates the core values of social work (AASW, 2010), thereby facilitating ethical and just practice WITH not only the citizens mental health social workers serve but also WITH peers and professional colleagues.

This re-newing of relationship-based practice is not new to social work, as emphasised by Howe (2008) who recognises its origins through the earlier social work writers Biestek (1950s) and Hollis (1970s). Therefore, social workers' significant, historic insights combined with the plea for

the re-newing of relationship-based, not just person-centred, MHSWP as a core value broadens the notion of person-centred away from (only) the individual toward ALL people, or as Ife (2012) attests, citizens, in relating to one another. Similarly, this guides mental health social workers' reflections away from individual pathology, which so often equates with a person (person-centred), bio-psychiatric, disease-saturated (illness) approach, toward one that centres citizens as human beings; as people with civil, political and social rights (Ife, 2012). Importantly, this connects with a critical-emancipatory approach because it harmonises with valuing human rights as core components of knowledge and practice. Additionally, this principled action accords with an ethical and moral imperative to conscientiously abide by principles that unite a humane, respectful and compassionate presence when relating to any human being, be they people in distress, professional colleagues and peers, or anyone else (in Freire's 1996 terms, "conscientization"). Not only is this the right thing to do but, put plainly, it is value-based and moral (Gaita, 2002).

Introducing the concept of EQ to learners in the MHSW classroom models its importance for relationship-based practice, aiding critical reflexivity throughout the learning process and critical reflection in practice (Bloom & Farragher, 2013; Fook & Gardner, 2007; Howe, 2008; Morley, 2014), thus making a strong case for adding EQ to the curriculum as a core component of MHSW education. In addition, incorporating EQ (Bloom & Farragher, 2013; Goleman, 1996, 2007; Howe, 2008; Morrison, 2007; Salovey & Mayer, 1990) as a central feature of critically reflexive and reflective practice (Fook, 2012; Fook & Gardner, 2007) creates the opportunity to explore the possibilities of the self-in-learning and the self-in-practice, thus assisting mental health social workers to achieve confidence early in the practice-self. This includes exploring the WHAT in what might work in practice, and HOW this may be achieved; the journey of the self for, and in, practice.

Another important element here is the art of being assertive. This technique, initiated in the learning environment, assists with gaining confidence for practice, while EQ avails the learner of the opportunity to reflect (and discuss) upon its five elements (Goleman, 1996):

1. Self-awareness: beginning with the self, and attaining an awareness of the self for interacting with another.
2. Self-regulation: being able to critically reflect on and keep in check emotions and feelings when presented with tricky situations.
3. Motivation: acting with professional integrity (core value and ethical practice) when facing dilemmas and difficult moments.
4. Empathy: appreciating the plight of another, and remaining mindful that not all people have the same communications skills or understanding that you do.
5. Social skills: being assertive, seeking critically reflective conversations and feedback from the citizens we serve, demonstrating the self-in-action as a competent, ethical MHSW practitioner.

Awareness of these elements and learning assertiveness techniques assists mental health social workers to avoid situations where passive and/or aggressive reactions and responses are unhelpful and unprofessional. Emotionally intelligent and critically reflective practice accords with

the three focus areas of critical-emancipatory MHSWP; it respects the relationship and people's right to express their view without feeling inferior, and ethically, it is socially just. Developing such practice requires time, patience and practice-wisdom; however, early education (and later in supervision) for practice equips the learner earlier for MHSWP in preparation for future challenging situations, one of which may be initiating thought-provoking, inquisitorial conversations regarding the status quo of the bio-psychiatric, disease-saturated (illness) paradigm. Combined with this is a knowledge base for practice that supports a trauma-informed approach.

A trauma-informed approach: beginning with the learning environment

The concept of a trauma-informed approach, introduced in Part 1, notes its significance and importance for MHSW. Given that MHSW practitioners are social work learners as well as regularly witnessing narrative accounts of traumatic situations, and, perhaps having a lived experience, it is necessary to consider what this means for both education and practice.

Further to the earlier discussion that acknowledges the place of contemporary perspectives – those of the Recovery (Anthony, 1993, 2000, 2007, 2011) and consumer movements – a trauma-informed approach together with a critical realist interpretation offers the space to explore alternative understandings (Macfarlane, 2009) in MHSW education and practice, thus placing notions of ideology, power and the lived experience as central tenets. Therefore, this space invites opportunities for dialogue that contextualise the lived experience beyond that of the individual. In Trauma-informed Care and Practice (TICP), its ideological position encompasses notions that assist with the exploration of inherent forces that lie amid the broader structural factors. Comparatively, the Recovery approach, as a paradigm of care, establishes a tension that stretches between a clinical (medical) view of care and the lived experience. Although there is an appreciation for the lived experience, it does not remain a central feature in this paradigm of care when psychiatry calls for some form of restraint. In contrast, TICP brings another dimension. Australian authors Bateman, Henderson, and Kezelman's (2013) position paper, *Trauma Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia,* also citing Bloom and Farragher's (2013) work, identifies principles embedded in key areas that lie outside the medical model.

A TICP approach emphasises an extant knowledge base that addresses power imbalance, the organisational environment and flexibility in care, and features people's lived experience at the centre of this paradigm of care. Drawing from Bateman et al.'s position paper, for example, the table 'Key Features of Trauma-Informed Care and Practice Systems' (2013, pp. 11-13) compares systems that are not "sensitive" with those that are. The language used in this table is consistent with respect for the viewpoint of people with a lived experience and the complex nature of trauma, as well as the impact of organisational culture on people's capacity to transcend the bounds of distress. Additionally, this paper addresses gender (the majority being women who are victims of abuse), culture and the broader health implications that are evident in complex trauma (Bateman et

al., 2013). The key theme here is sensitivity in this paradigm of care. Nevertheless, the medical model is present in this paper, with the inclusion of language pertaining to "early and thoughtful diagnostic evaluation…treatment-resistant illness" (Bateman et al., 2013, p. 11). Recovery is included within the TICP approach and it is coupled with the notion of hope. The distinctive features inherent in a TICP approach offer MHSW learners and practitioners the ideological ground on which to support socially just and humanitarian practices. The author clarifies this in the following discussion and further summarises it in Chapter 6.

Bloom (2013a,b), and Bloom and Farragher (2011, 2013), whose work is in its infancy in Australia, have written extensively about the effects of working with trauma in mental health organisations in America, offering rich understandings for MHSW theory and practice. Their Trauma-informed theory and approaches (Bloom, 2013a.b; Bloom & Farragher, 2011, 2013) have a dual focus: first, on what this means for organisations; and second, what this means for practice in being responsive and specific to people's lived experience of prior or current trauma. Bloom and Farragher's (2011, 2013) Sanctuary Model proposes a way forward for discussing concepts (such as attachment and unresolved grief) surrounding trauma. The author expands upon this model in Chapter 6 as a concept applicable to MHSWP.

Further to the aforementioned need for MHSW learners to acquire knowledge relating to EQ, Bloom and Farragher (2013) advocate emotional intelligence as core to trauma-informed, responsive practice, purporting an approach of non-violence for respectful, emotionally intelligent practice. Bloom's (2013a) work makes a significant contribution to re-conceptualising MHSWP because it sympathises with a critical-emancipatory MHSW approach to the lived experiences of people with traumatic life trajectories, rather than adhering to approaches based in bio-psychiatric, disease-saturated (illness) discourse and practices. A trauma-informed approach steers away from bio-psychiatry toward critical-emancipatory knowledge and practices for MHSW; relationship-based, rights-based and socially just concepts for MHSW, buttressed with (knowledge of) practice approaches.

Maintaining a critically reflective stance is also a fundamental component of a critical-emancipatory approach (Fook, 2012). Learners in MHSW enter the learning process filled with anticipation for gaining, or advancing, their knowledge for practice. As social work educators facilitate opportunities for knowledge attainment, these learners may find a new awareness and appreciation of the presence of trauma in human beings' lives confronting; but this experience offers opportunities for lifelong learning and a practice base conducive to the core values of social work (AASW, 2010). In addition, trauma-informed organisational theory facilitates beginning awareness of the possibilities inherent in power relations, including distinguishing what this means amid the potential for reproduction of dominant discourses in MHSW education. Trauma-informed education assists MHSW practitioners to integrate the self-in-practice while opening their minds to people's lived experience that comes in a variety of ways, some hidden and not immediately discernible. Hence, trauma-informed knowledge assists learner wellbeing and opens up new

opportunities for practice while offering a socially just approach that encourages relationship - and rights-based practice approaches. This is critical-emancipatory MHSW.

Noting the critical-emancipatory potential for MHSW, Bloom and Farragher's (2011, 2013) Sanctuary theory and their model for effecting organisational change is socially just; it fits agreeably with critical-emancipatory MHSWP. They illustrate the experiences that occurs in the professional workforce, which resonates in their use of language to define, describe and discuss ways forward for mental health workforce personnel; a prime consideration for trauma-informed practice. This humanitarian approach to the possible lived experiences amid the workforce as well as for citizens served by MHSW practitioners helps MHSW move away from the notion of othering (Fook, 2012; Pilgrim, 2015b; Wilkinson, 2005) toward one that regards the citizens as human beings with civil and political rights (Ife, 2012). This necessitates mindfulness for social work educators that mental health social workers support people experiencing mental distress in many (organisations) settings; settings where experiences of VT (Cunningham, 2003, 2004; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995) lie amid the workforce as well as the clientele. Bloom and Farragher (2011, 2013) state that this calls for the use of our imaginings to bring more humanity to human services; a timely reminder, given the entrenched culture of human service organisations (HSO), particularly when reflecting upon Goffman's research on institutionalisation (Goffman, 1961). Certainly, a trauma-informed knowledge base would be well placed in the curriculum for MHSW (AASW, 2012a,b,c) and the *Practice Standards for Mental Health Social Workers* (AASW, 2014a). The following words from Bloom and Farragher (2013, p. 2) encompass this position:

> Utopian visions are not new; yet we would argue that in today's world, they are in short supply and are usually greeted with scorn. After eons of intergenerational violence, degradation, confusion, irrationality, deceit, and disaster, humanity is at a crossroad. There is an urgent need for us to adapt in a different way, to change the way we do things, the way we think, how we manage our emotions, and perhaps most importantly, how we treat each other and the complex ecological system in which we are all embedded. We live in a traumatized world that needs to heal if we are to survive.

Thus, in assenting to the urgency to re-conceptualise new ways forward in MHSWP as a humane and just path toward healing, it is imperative that AASW policies supporting MHSW education and practice include trauma-informed approaches. This meets at the intersection of social work's core values (AASW, 2010) and ethical MHSWP. Importantly, it addresses learner wellbeing within the MHSW education milieu, and assists the integration of theory, practice and the pedagogical aim of assisting self-care as central in critical-emancipatory practice.

Critical realist pedagogy for mental health social work practice: a new model for knowledge WITH and FOR practice – bridging the divide

Re-conceptualising MHSWP from a critical-emancipatory approach in MHSW education is grounded in both ideology and practice realities. Diagram 2 illustrates a conceptual understanding that demonstrates the possibilities in the classroom and provides a visual representation for MHSW learners to encourage them to reflect upon and discuss the *how* and *what* for navigating the theory/practice ravine; an issue, argues Oliver (2012), that so often occurs across the university-field divide. The author developed this conceptual model with the intention of creating a visual medium for learners that would assist them to appreciate the intertwining of knowledge WITH and FOR practice. It is an attempt to bring them together rather than seeing them as separate entities. The terms were drawn from the author's prior field experience in the realm of restorative practices (O'Connell et al., 1998). Pedagogically, addressing the university-field ravine early in MHSW serves many purposes, not the least of which is the aim of narrowing the ravine following graduation. Perhaps, too, this offers hope in practice for MHSW learners and practitioners with experience to remain abreast of contemporary debates and confidently question the status quo where required and relevant; for example, questioning the bio-psychiatric, disease-saturated (illness) enterprise.

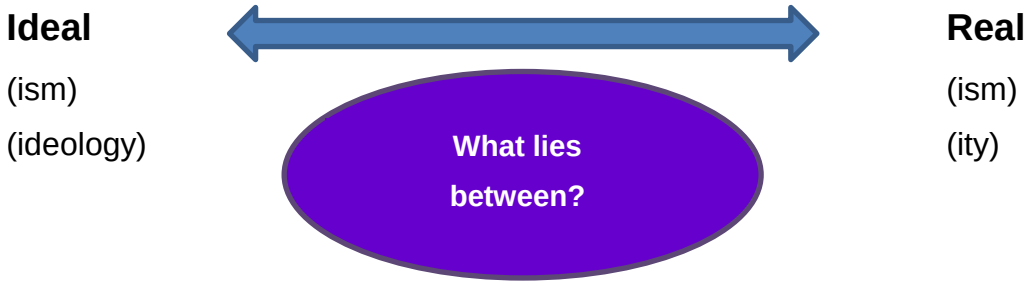

Diagram 2: What lies between - bridging the divide between the ideal and the real

The concept of "ideology" broadens out linguistically to "ideological", "idealism" and even "idealistic"; epistemological terms that equate with the assumption that an existing knowledge base is available to MHSW. The concept of "reality", again for linguistic purposes to make the point, equates with ontological notions that surround the realities ("realism", "the real" and "the actual") and ambiguities amid the complexity of practice. This supports the ontological possibilities a critical realist stance provides (Archer et al., 1998; Bhaskar, 1975, 1979, 1986, 1989, 1991, 1993, 1998, 2000, 2009, 2010; Pilgrim, 2015b)

Reflecting upon "what lies between*"* (terminology the author developed for the model in Diagram 2 and has used throughout the thesis) commits MHSW learners, educators and practitioners to a process that generates dialogue about the journey of knowledge WITH and FOR practice. The knowledge journey encompasses prior knowledge, questioning existing knowledge and attaining new knowledge together with *how* we come to value certain knowledge over other

knowledge, and *what* all this might mean for practice. Additionally, this accords with the way learning is actioned – practice – thereby utilising the process of conscientization (Freire, 1996) and avoiding binary concepts of either/or thinking, instead moving to expansive concepts of both/and thinking for critical-emancipatory MHSWP.

In addition to the earlier discussion in this chapter regarding the milieu, the model provides social work educators with an opportunity to create an emotionally and psychologically safe space in which MHSW learners can reflect on the possibilities and discuss some of the perceived realities of MHSW practice. Similarly, this creates the space for experienced practitioners to reflect on, discuss and reframe their practice experiences. This, once again, models hope amid the learning journey, particularly when contemplating the challenges that occur in MHSW practice; it locates hope as a concept fundamental to MHSW practice. Creating the safe space also utilises the teaching opportunity to summon positivity despite practice complexity.

This conceptual model is in solidarity with a critical-emancipatory paradigm. It also invites a reflective approach in MHSW learning (Fook, 2012; Fook & Gardner, 2007; Morley, 2012, 2014) and models hope for navigating creative possibilities amid the ambiguity and complexity of MHSWP. In addition, this approach creates the space for building confidence in the early career professional, while opening the doors in a less threatening way for experienced post-graduate mental health social workers.

Re-newing mental health social work

Following on from the discussions in Part 1 of this thesis, MHSW is filled with complexity, ambiguity and the messy realities of life whereby Foucault (2006b) and others (Ife, 2012; Macfarlane, 2009; Morley et al., 2014; Pease & Fook, 1999) offer an epistemological grounding for social work educators in facilitating discussions about where the intersection of knowledge and power meets. In doing so, scrutinising the concept of marginalisation assists in questioning modernist assumptions regarding truth, knowledge, power and the institutional effects of these in practice settings (Pease, 2013; Adams et al., 2002, 2009; Allan et al., 2009; Bainbridge, 1999; De Maria, 1992; Finn & Jacobsen, 2003; Hugman, 2012; Macfarlane, 2009; Morley et al., 2014; Parton & O'Byrne, 2000). This moves the position from notions surrounding subjectivity, prejudice and partiality toward a critical-emancipatory approach to notions of "Opening up spaces for alternative understandings" in mental health (Macfarlane, 2009, p. 201).

As detailed in the opening chapters of this thesis, many Australian social work authors offer thought-provoking publications to inspire and motivate MHSW learners and practitioners in this country (Allan et al., 2003; Allan et al., 2009; Bainbridge, 1999; Bay, 2014; De Maria, 1992; Dunk-West & Verity, 2013; Fook, 2012; Fook & Gardner, 2007; Gray & Webb, 2013; Harries, 2013; Healy, 2001, 2012, Hugman, 2012, Ife, 2012; Macfarlane, 2009; Martin, 2003; McDonald, 2006; Mendes, 2009; Morley, 2008, 2012, 2014; Morley & Macfarlane, 2010, 2011; Morley et al., 2014; Nipperess, 2009, 2013; Pease, 2013; Pease & Fook, 1999; Scott, 2011). In addition, a plethora of

international critical thinkers in several disciplines, including critical social work, have made a valuable contribution to advancing knowledge for re-thinking the challenges inherent in problematising mental distress (Allan et al., 2009; Bacchi, 2009; Bay, 2014; Breggin, 2009; Chambon & Irving, 1999; Findlay, 1975; Gray & Webb, 2013; Ife, 2012; Jureidini et al., 2016; Kirk et al, 2013; Longden, 2013; Macfarlane, 2009; Maisel, 2016; Moncrieff, 2009; Morley et al, 2014; Smith, 1990a,b,c; Smith & David, 1975; Webb, 2006; Whitaker, 2010). This epistemological grounding offers a refreshing and contemporary evidence base that provides a critique of the entrenched and powerful bio-psychiatric, disease-saturated (illness) paradigm. It offers the space in MHSW classrooms for extending knowledge for practice, and practice for knowledge, while also sanctioning spirited, respectful debate as part of the learning process.

The author's scrutinising of the extant AASW mental health curriculum, and AASW and federal government Standards for practice in Chapter 4 reveals ample evidence of the dominant bio-psychiatric, disease-saturated (illness) discourse and apparent reproduction of this paradigm in MHSW policies that guide education and practice. Given that the language-use immerses educators and learners alike in a discourse that represents ideas surrounding "problems and disability" (AASW, 2012a, p. 3; Bacchi, 2009), it serves to reinforce the dominant paradigm, which subliminally and characteristically proposes that almost everything is a "problem". In addressing this problem-saturated thinking (Bacchi, 2009), it brings to mind a quote from Henry Ford:

> If you always do what you've always done, you'll always get what you've always got.

The author's adaptation of this quote is a long-established one from practice:

> *If we always think what we always thought, then we'll always get what we always got.*

In other words, the *problem* becomes just that – a problem, or THE problem – when at times there are seemingly impossible moments for people (or whole situations) that they neither view as a problem, nor (even in their lived experience) wish to be viewed this way. This raises questions about the place of assessment in MHSW. Many situations are touted as problems, hence (as stated earlier) leading mental health social workers to think about the problem(s) and therefore actions (MHSWP) that most often centre around the urge to "fix" the so called problem. There are many times when the problem identified by professionals is something else entirely. This is where a bio-psychiatric, disease-saturated (illness) approach situates because the *DSM-5* (APA, 2013) categorises and labels human beings' issues as problems; even mental illness as a problem. Therefore, MHSW, often guided by the *DSM*s, problematises everything that lies within its confines. Questioning this problematising assessment approach will have an impact on MHSW education and the *Practice Standards for Mental Health Social Workers* (AASW, 2014a). Currently, it is argued, MHSW education is situated within the confines of a psychiatric manual that defines almost everything human beings do as some sort of problem – sleep, talk, sexual matters, relationships … – any behaviour that has come to be labelled as abhorrent (or deviant) in some way. This does not accord with the domain of MHSWP in the *Practice Standards for Mental Health*

Social Workers (AASW, 2014a), which requires assessment of the **context** of the situations that present in practice. This, together with the *Trauma Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia* position paper (Bateman, Henderson, & Kezelman, 2013), once again invites mental health social workers to adopt a trauma-informed approach. This position paper supports Bloom & Farragher's trauma-informed approach offering an evidence base for the Australian mental health scene. Significantly, Bateman et al. (2013, p.5) note the need for "[r]esponding appropriately to trauma", in particular noting the complexity of trauma and the importance of using language that does not diagnose and label people. This position paper has much to offer MHSW about the importance of including people in decisions about their care so that trauma, in all its forms – prior, recent or current – is given the opportunity to present itself in the course of a respectful relationship-based, rights-based and socially just assessment of the context. Re-newing the current bio-psychiatric, disease-saturated (illness) social work paradigm to become a critical-emancipatory MHSW approach embeds critical social work knowledge and practice at the heart of MHSWP

A critical realist approach embedded in mental health curriculum

The philosophical concept of CR, introduced in Part 1 of this thesis, supports a critical-emancipatory approach to MHSW, underpinning the re-conceptualising of education, policy and practice. Therefore, there is a conscious shift away from the current bio-psychiatric, disease-saturated (illness) paradigm threaded through current social work education, policy and practice. Seeking a move away from using this paradigm as the means for explaining human experience in mental health, or any other setting where mental health social workers are present, toward a critical-emancipatory approach is supported by relationship- and rights-based, socially just MHSWP. Critical realism offers the platform from which to launch knowledge and practice steeped in this respectful approach. The ontological edge in CR (Bhaskar, 2009; Fairclough, 2001a; Fairclough et al., 2004; Houston, 2001; Oliver, 2012) explained in Stage 5 of the CDA is conducive to critically reflexive MHSWP, which accords with exploring "what lies between" along the continuum of ideology and practice realities. Thus, the critical-emancipatory approach is in harmony with the domain of the *Practice Standards for Mental Health Social Workers* (AASW, 2014a) in coming to comprehend the ***social context*** and the ***social consequences*** of mental distress while meeting the requirements of the *Code of Ethics* (AASW, 2010) to remain ethically principled in socially just practice. This is also in keeping with the core values of social work contained within the extant policies for MHSW, for example: "(l)istening respectfully" to people; "(r)ecognising the complexity of human experience"; "(e)nsur(ing) all civil and human rights are recognised" (AASW, 2014a, p. 8); and acting with professional integrity in doing so (AASW, 2014a). The author argues that embedding a critical realist approach in the MHSW curriculum locates contemporary MHSW education (for practice) at the heart of social work's core values and ethical principles.

Context for practice within a critical realist paradigm

The context for MHSWP (AASW, 2012a, 2014) needs to encompass more than the current notions about an individual's (person-put-at-the-centre) behaviour, Freudian representations of group dynamics and family dysfunction, and imprecise assessment of community culture. The historical journey contributes to a variety of understandings about the context of people's lived experience. However, these representations are not necessarily accurate or sound. Although they provide background knowledge, they remain contested (Breggin, 2009; Dickey, 1966, 1987, 1992; Foucault, 2006a,b; Garton, 1988; Kirk, 2005; Kirk et al., 2013; Pilgrim, 2015b; Scott, 2011; Scull, 1989, 2009; Smith, 1990a,b,c; Whitaker, 2010). Currently, MHSW operates within a neo-liberal climate (Ife, 2012; Webb, 2006) in which free-market economics favour private enterprises above public services. Thus, competitive market relationships rather than other frames of reference impact the structural relationship between policy, education and practice, impacting the teaching, learning, practice and delivery of MHSW. By extension, this relationship impacts the relationship between social work educators, mental health social workers, the citizens they serve and the incumbent system. Neo-liberalism serves to re-inforce the entrenched bio-psychiatric, disease-saturated (illness) enterprise, and the judicial and prison systems as solutions for dealing with either incorrigible behaviour or mental distress in a society that values the status quo. At times, mental health social workers may not understand this behaviour and distress, even though it often results from prior, recent or current trauma (Bloom & Farragher, 2011, 2013). (See the next section and the section titled *Critical social work theory, reflection and emotional intelligence: education for mental health social work practice* for analysis of the impact of neo-liberalism on MHSW policy, education and practice).

A profound example of the place of trauma (and the historical context) in mental distress is evidenced in the compelling extant statistics relating to mental health-related matters within the Aboriginal and Torres Strait Islander population in Australia. Members of this population remain over-represented in the prison system (notwithstanding their deaths in custody), the child protection system, and the health and financial welfare systems. Although this situation has been recognised as a national disgrace, the course of history, coupled with the Aboriginal and Torres Strait Islander people continuing to voice their distress, demonstrates that change has been relatively minor (NMHC, 2014b). A critical realist standpoint, embedded within the broader framework of human-rights, relationship-based and socially just practices aims for a blend of BOTH/AND, rather than either/or thinking for MHSWP, thus making the link with "what lies between" for praxis, as demonstrated in Diagram 2.

Mental health social work policies: a critical-emancipatory approach in the Australian Association of Social Workers Standards for education and practice

In this section, the author seeks to emphasise several matters relating to a critical-emancipatory approach in MHSW policies relating to education and practice. She proposes that the current

Australian Social Work Education and Accreditation Standards V1.4 (ASWEAS) (AASW, 2012a), in particular *Guideline 1:1: Guidance on essential core curriculum content* (AASW, 2012b), require the inclusion of a critical-emancipatory approach. Section 5.6 of *Code of Ethics* (AASW, 2010, p. 40), *Responsibilities to the profession*, appears to support this proposal, noting the requirement for social workers to "strive for and promote excellence in the social work profession (and therefore) will engage in discussion about, and constructive criticism of, the profession, its theories, methods and practices". This offers the space for promoting best practice by engaging in written work and dialogue, offering opportunities to analyse the bio-psychiatric, disease-saturated (illness) approach. Therefore, re-newing the *ASWEAS* MHSW policies to align with a critical-emancipatory standpoint supports the current ethical stance for advancing MHSWP beyond that of a psychiatric approach.

The *ASWEAS* (AASW, 2012a) education policy focuses on social work learning outcomes; graduate skills and attributes. It states that "(t)he goal of social work education is to provide a rigorous program which results in graduates who are competent, effective, skilled, knowledgeable, ethical and confident practitioners" (AASW, 2012a, p. 10). This policy stipulates that content relating to MHSW be "specific curriculum content…in all social work programs" (AASW, 2012a, p. 13), which is detailed in the ASWEAS, *Guideline 1.1* (AASW, 2012b). This recognition of the need for a specific, rigorous MHSW education program with specific graduate learning outcomes of striving for, and promoting, excellence in MHSW practice by engaging "in discussion and constructive criticism of the profession, its theories, methods and practices", reflects a realisation that all social workers will encounter people with mental distress across many of their work settings. Thus, all social workers need training in MHSW. Introducing a new MHSW curriculum, with its emphasis on learning to work with people in a relationship- and rights-based, socially just manner supports the call for critical pedagogy in social work education in Australia, made strikingly clear by De Maria (1992) in the early 1990s. The recent decade continues this call. Australian academics, such as Morley and Macfarlane (2010), Gray and Webb (2013), Ife (2012), Pease (2013), Bland et al. (2009) and Healy (2012) indicate the importance of the inclusion of critical perspectives and approaches in the AASW mental health policies for education and practice. This does not mean, however, that these approaches are adopted to the exclusion of learning about the context and consequences of the bio-psychiatric, disease-saturated (illness) approach in mental health; but, as noted by Bland et al. (2009, 2015), social work educators and practitioners must be conscious of avoiding learning in the education milieu and binary thinking in practice. Achieving this balance requires MHSW education to include learning about a variety of discourses, thus offering a smorgasbord of knowledge available for critique. The critique of discourses enlightens the learning process for education and practice. Therefore, policy that is explicit in advocating the critique of ideologies enhances the learning process in advocating for socially just notions in practice.

De Maria (1992, p. 243) proposes that critical thinking prevents "tak(ing) little for granted" and encouraging this type of thinking in the classroom should be in the spirit of what he calls the

"reflective collective" (1992, p. 244). In essence, this means a whole class approach to conversations about working with complexity rather than only contemplating matters pertaining to the individual. The reflective collective provides the space for introducing critical perspectives, hence thinking critically and creating dialogue about possibilities for practice – the critical-emancipatory possibilities – thus bringing the potential for anticipating myriad structural, economic, political and socio-cultural factors (Shakespeare, 2014). The multi-factorial approach also invites discussion about where the bio-psychiatric, disease-saturated (illness) paradigm is located among these factors. While this seems expansive, there is the danger of reducing the factors to either circular arguments or the epistemic fallacies inherent in this paradigm (Pilgrim, 2015b). When care is taken not to fall into this trap, the discussion broadens the scope for social work learners in reflecting upon possibilities beyond the current climate of individual problems requiring therapy. The scope broadens in several ways. First, it cues learners toward new or refreshed understandings about private pain being closely associated with public issues (Fook & Gardner, 2007; Gray & Webb, 2013; Ife, 2012; Macfarlane, 2009; Morley & Macfarlane, 2010; Morley et al., 2014). Second, therapy is not seen as the only remedy or the most suitable for working with the effects of distress. While therapy may have a place in some instances where trauma is a long-standing feature in current distress, it is not the panacea for all; and sometimes not even in these situations.

Reflection on ethics for mental health social work education and practice

Another layer of critical-emancipatory education and practice is knowledge based in ethics, supported by the Australian social work *Code of Ethics* (AASW, 2010). The *Code* is "the core document which informs and guides the ethical practice of the social work profession" (AASW, 2010, p. 10), therefore social work educators need to ensure that social work learners meet the requirement for attaining knowledge of the *Code*. Section 2.2, *Purpose of the Code* (AASW, 2010, p. 10), identifies seven areas to guide social workers in their purpose for practice. The fourth dot point in this section, "provide social workers with a foundation for ethical reflection and decision making" (AASW, 2010, p. 10), notes the intention to align critical perspectives and approaches as an imperative foundation for ethical decision-making in practice; a statement that supports a critical-emancipatory approach. Therefore, the author proposes that a critical-emancipatory approach be embedded in both the *ASWEAS* mental health curriculum content (AASW, 2012a) and *ASWEAS Guideline 1:1: Guidance on essential core curriculum content*. (AASW, 2012b) This must be explicit beyond the mere mention of practice in the *ASWEAS V1.4* (AASW, 2012a) under the section *Principles for social work education* (p. 9). A critical-emancipatory approach also requires embedding in sections 3.3.4 *Skills for social work practice* and 3.3.5 *Understanding the context of social work practice* (for example, in teaching mental health) (AASW, 2012a, p. 14), as well as in sections 1.1 *Attitudes and values*, 1.2 *Knowledge for social work practice* and 1.3 *Skills for social work practice* of the ASWEAS *Guideline 1.1: Guidance on essential core curriculum*

content (AASW, 2012b). An AASW commitment to this will encourage and support critical pedagogy in MHSW, assisting educators to create opportunities for learners to gain early awareness about a variety of discourses. Critique of the dominant bio-psychiatric, disease-saturated (illness) paradigm, given the dominance of its presence in most settings where social workers are employed, is included in these discourses.

The language and power base privileging critical-emancipatory mental health social work

The power of language in establishing the foundations of the way we view the world was revealed in Chapter 4 (Harper, 1995), as was the importance of the pervasiveness of language (Wetherell et al., 2001). Therefore, in accepting that language is both powerful and pervasive, the discourse revealed in Table 1 demonstrates the presence of the bio-psychiatric, disease-saturated (illness) paradigm in the *ASWEAS* policy (AASW, 2012a,b) and *Practice Standards for Mental Health Social Workers* (AASW, 2014a). Therefore, discourse emphasising language that supports a critical-emancipatory social work standpoint re-news and respects the ethical imperative for preserving relationship-based practice, adhering to rights-based practices and supporting a socially just approach. Embedding these approaches in the AASW MHSW policies and Standards for education and practice will provide clarity for social work educators and learners, taking heed of the contributions from notable critical social work theorists (Bainbridge, 1999; De Maria, 1992; Fook, 2012; Ife, 2012; Macfarlane, 2009; Morley et al., 2014; Pease, 2013; Taylor, 2013).

Discourse locating critical-emancipatory approaches in MHSWP through embedding them in MHSW policy focuses on two distinct points, both of which account for the power (Harper, 1995) and the pervasiveness (Wetherell et al., 2001) of language in MHSW. The first point is that a critical-emancipatory approach will maintain a central focus on social work's core values and ethics as integral to MHSWP. The second point is positioning language for MHSW that familiarises and appropriates a critical-emancipatory paradigm, thereby offering respect for persons and their rights, and socially just approaches; practising with professional integrity. This critical use of language situates MHSW as a profession offering an approach that supports psychiatry and other allied health professions, but from its own critical-emancipatory paradigm rather than the reductionist notions inherent in bio-psychiatry (Kirk et al., 2013; Pilgrim, 2015b; Tew, 2005). In other words, MHSW stands on its own, faithful to the profession's core values. It remains ethical in its discourses while modelling integrity as a profession, espousing the use of respectful language in maintaining people's dignity and their rights as citizens; this too is socially just – based in the dialectic of knowledge and care.

The following examples, although not exhaustive, demonstrate the author's ideas, generated from the CDA and her experience as both a mental health social worker and social work educator, for the *what* and the *how* of establishing the use of words in a paradigm of a critical-emancipatory approach that establishes excellence (best practice) in MHSWP. In addition, it is important to note that social work language (discourse) is not new. It is a call to return to (re-new)

constructions and contexts that are familiar with what we know as being authentic to social work.

*1. **Relationship-based** theory and practice requiring:*

- discourse respecting people as human beings first, and of their lives:
    - life circumstances, situations, lived experiences, emotional/mental distress, trauma
    - discourse that centres upon inclusivity and origins
    - people, citizens, people's lived experiences, diversity, culture, places of meaning.

- discourse conveying hope, and considering the social context and the social consequences of emotional distress:
    - support
    - listen – not just hear – carefully, to the narrative. Stop, wait, listen some more, and take control of the urge to "jump in" and "help" or "fix" things. Not everything is fixable – incarceration for crimes committed against other human beings being one example; however, this does not prevent conversations that assist the path (perhaps long) to new understandings, responsibility and hope for a different future
    - facilitate – conversations; people to make their own decisions about action they want, or need, to take
    - recognise adults, children and young people's strengths, but beyond that of it always being about the individual. This means not reducing assessment to only strengths-based ideas. This also means conversing WITH people about what they believe or want as areas for improvement in their lives, and not reducing their circumstances to weaknesses. This means assisting in situations where fear may lie at the heart of many issues that are occurring
    - remain always mindful of the impact of complexity in the messy reality of people's lives, in which they may not always have the power or knowledge to understand how things might be different. For example, people may want to question their diagnosis or their medication; this is a civil right.

- discourse and practices that approach people (individuals, groups and communities) in ways that are inclusive of their abilities - WITH people, not "to", "at" or "for" them (O'Connell et al., 1998).
- discourse that centres on integrity as a MHSW professional; it is visible and audible:
    - respectful
    - reliable
    - seeks feedback
    - consistent
    - seeks professional development.

*2. **Rights-based** theory and practice embracing discourse:*

- curriculum for MHSW education (AASW, 2012a) that is inclusive of theories to inform social work learners about human rights, for example, as Ife (2012) argues in his third edition of *Human Rights and Social Work: Towards rights-based practice*, the "discursive nature of human rights" (p. 202) lends credence to a process that encompasses participatory democracy. This approach achieves several

objectives: a policy position that affirms a rights-based approach in MHSW; support for a pedagogical approach from a moral standpoint of privileging relationship-based theory and practices that position citizens (Ife, 2012) at the centre of professional encounters, thus avoiding the professional favouring the role of "expert"; and human rights dialogue places people as citizens at the centre of MHSW practice, privileging their lived experiences amid the core of any intrusion into their life. It is important to remind social work educators and practitioners here that trauma lies at the core of people's lived experiences. Therefore, the moral imperative is to operate from a trauma-informed approach (Bloom & Farragher, 2011) where the sanctuary (Bloom, 2013a,b) of the person's soul is of paramount consideration in making practice decisions where human rights violations have occurred, and continue to occur

- situates mental health social workers as political beings, meaning that rights-based perspectives and approaches require a knowledge base that signifies the political context within which MHSW practice occurs. This moves away from pathologising discourse surrounding individuals, families, groups and whole communities
- facilitates human rights theory and practices, including:
    - recognition that people are *citizens* with civil and political rights (Ife, 2012); thereby the Duty of Care (DoC) in MHSW promotes people's right to participate in decisions about their care. In addition, this requires the use of words other than those with a medical orientation; illness, disorder, signs and symptoms, aetiology, intervention, treatment, orders, as well as "best practice" without due reference to an evidence base that supports this. Instead, use words and phrases that demonstrate respect for lived experiences and prior (or current) trauma which may include:
        - open-ended questions, for example:
            - ~ What happened? – Not, what is wrong? This implies pathology – there is something wrong with "you".
            - ~ What is happening for you right now?
            - ~ What would you like to happen next?
            - ~ What do you think/feel needs to happen now/soon/next?
            - ~ How?
            - ~ When?
            - ~ Where?
            - ~ Never using "Why" because the response is usually "I don't know", placing the person in discomfort
        - Respect
        - Rights
        - Identity
        - Lived experience
        - Kindness
        - Compassion
        - Concern
        - Just
        - Responsibility

    - Appreciation.

- discourse and practice that does not support the use of seclusion and restraint in the mental health services, given that this is a human rights issue; it causes intense fear and therefore further trauma for persons placed in these situations (Bloom & Farragher, 2011; Breggin, 2009; Jureidini et al., 2016; Moncrieff, 2009; NMHC, 2014b; Szasz, 1961). People experiencing the trauma associated with severe emotional and mental distress are most often in the position of needing help and support, yet the threat of force denies them the opportunity to be able to access care without fear of the consequences. Hence, in MHSWP, it is unethical to support any practices of seclusion and restraint by mental health professionals, particularly given that this does not abide by the social work *Code of Ethics* (AASW, 2010), such as respect for human dignity and worth, a commitment to socially just notions of care and prioritising citizens' interests in being informed (consent) about determining their care needs
- supporting socially just notions of MHSW, for example, access to services, having choice in what approach(es) are going to be utilised for moving out of the traumatic lived experiences of the past and/or present, for example, narrative work or other therapies that offer opportunities for relaxation and re-centring the soul (for example, aromatherapy or massage)
- supporting critically reflective practice that affords a process of deconstruction and re-construction (Fook & Gardner, 2007; Morley, 2008, 2012, 2014; Morley & Macfarlane, 2008, 2011) that is, exploring commonly held assumptions (values, attitudes and beliefs) about theories and approaches in mental health, which then assists a process of re-constructing creative possibilities for practice.

Creative possibilities come from conversations that incorporate the aforementioned notions of relationship- and rights-based, socially just critical-emancipatory approaches. Amid these discussions, either within the education setting or in the field of practice, lies an emphasis upon being mindful of the impact of the historical journey (deliberated in Chapter 3) to avoid repeating the mistakes of the past (the moral imperative) and to remain courageous in upholding the conscious purpose of social work in the mental health arena.

*3. **Social justice** embedded in discourse for education, policy and practice*

Further to the aforementioned reference to socially just MHSW needing to be amid rights-based theory and discourse, social justice lies at the heart of social work. The concept of social justice needs to be explicit in MHSW policy for education and practice because it demonstrates the importance of focusing upon the representation of people affected by social systems and structures that disadvantage them (AASW, 2010). The *Code of Ethics* (AASW, 2010, p. 13) clearly states that social work "opposes and works to eliminate all violations of human rights and affirms that civil and political rights must be accompanied by economic, social and cultural rights". This suggests that MHSWP requires the professional responsibility of contesting the spaces other professionals do not. Similarly, socially just practice in MHSW seeks to contribute to, and share power through, promoting citizens' participation in "the development and implementation of social policies and services" (AASW, 2010, p. 13).

It is therefore apparent that MHSW has a responsibility toward encouraging change where

mental health service provision crosses the boundaries of human rights; this is the commitment to social justice. For example, MHSWP requires respecting people with a lived experience of mental distress by ensuring their involvement in dialogue that determines their access to services and respectful ways for care to occur. This illustrates the layers of relationships and rights regarded as being within any process of policy making for MHSWP, as well as signifying the importance of the impact of discourse upon policy decisions affecting people's lives.

In addition to these areas, the AASW MHSW policies for education and practice need to include a statement that relates to advocating for a (mental health) social work presence in the making of national policy documents. This needs to occur across all areas of mental health service provision, not just in private practice. Currently, this is not evident, given the recent AASW response (AASW, 2015) to the National Mental Health Commission *CLTC* review (NMHC, 2014b), which only serves the interests of MHSW private providers.

Critical social work theory, reflection and emotional intelligence: education for mental health social work practice

In an era dominated by neo-liberalism and the new public management agenda (Healy, 2014: Morley et al., 2014; Webb, 2006; Webb & Gray, 2013), contemporary mental health policies encompass the influence of managerialist approaches, primarily aimed at reducing spending and handling risk. The effects on MHSWP cannot be denied. This calls for MHSW to be ever more committed to gaining a depth of knowledge for practice dedicated to a critical-emancipatory approach. Gaining this knowledge occurs across the layers already mentioned – gaining knowledge that is sympathetic to relationship- and rights-based discourses, with social justice as an ethical pursuit threaded through these layers. There is another layer here, which is the importance of acquiring knowledge about critical reflection for practice.

Reflective practice is a contemporary theme. Some writers argue it has attained a "cult following" in professional education (Ixer, 1999 cited in Taylor, 2013), although it does not feature as useful for practice. Taylor (2013) notes there are often nebulous and "depoliticized" (p. 83) explanations surrounding the requirement for learners to reflect on their views and approaches relating to practice. Taylor suggests the attention needs to be directed away from just the practitioner and toward broader notions of social justice and "critical political engagement" (2013, p. 83). While this is an agreeable position, it is recommended that we need BOTH/AND, committing to a process that is inclusive of deeper learning about the components of critical reflection (Fook, 2012) together with a critical realist understanding about the broader political mechanisms and structural factors that impact both on practitioners and their practice, as addressed in this study.

Fook (2012) provides further depth for the learning process in advocating the notions of reflexive and reflective practice, while also paying heed to "contextuality" (p. 49). In defining the difference, Fook notes that "(r)eflectivity…refer(s) more to a *process* of reflecting upon practice, whereas reflexivity…refers more to a *stance* of being able to locate oneself in the picture", thereby

coming to understand the effect of their presence in situations. Fook (2012) cites Taylor and White (2000, p. 198) in suggesting that reflexiveness "is potentially more complex than being reflective". Nonetheless, Fook (2012) maintains, the contextual element here is that being reflective in practice can aid reflexivity about one's position, and vice versa. The pivotal point here is that this *process* and *stance* are vital keys in developing a critical-emancipatory approach to practice. Attaining knowledge of the elements within a reflective process brings, and maintains, the focus on the social work learner as a future practitioner, rather than on discussions always needing to be about "client(s)" and approaches relating to them.

Critical reflexion is a process that offers possibilities for learners to become (further) enlightened about the place of "privilege" and where they are situated in this (Pease, 2013). Therefore, critical social work practice in mental health requires an approach that begins with the self. Accordingly, as Pease (2013), Fook (2012) and others (Bay, 2014; Macfarlane, 2009; Morley, 2008, 2012, 2014; Morley & Macfarlane, 2010; Taylor, 2013) encourage, attention must begin first with "Addressing privilege and situating ourselves" (Pease, 2013, p. 35). Pease (2013, p. 35 citing Rossiter, 2000), in calling for more responsiveness in this, writes that:

> Little attention is given to the ways in which the positioning of the professional worker may embody class, race, gender and sexual privilege. Social workers thus need to be aware of how their personal power and privilege is maintained or challenged in their encounters with service users and other workers.

Indeed, this requires social work educators' attention to pedagogy in availing the initial opportunities for social work learners in mental health to commence this process. Hence, MHSW learners enter a process of knowledge acquisition that the social work educator initiates, coming to learn about their own privilege. In doing so, this process aims to achieve two main purposes. First, it facilitates the social work learner in mental health to situate the self at the centre of their learning experience, thus gaining an awareness of their own privilege as a professional, especially given that this impacts upon the accomplishment of a professional relationship in serving to make a difference in citizens' lives (Ife, 2012). The second reason for placing the learner at the centre of the reflexive process is that it directs attention away from reflections that very often tend to surround the "client" and anything to do with their circumstances (problems).

This is an important distinction in being critically reflexive because it also serves to meet the ethical imperative of practising with integrity, honouring people's dignity and respecting their traumatic lived experiences. In essence, then, this process moves amid several layers, which is in and of itself the process of the learning journey; of coming to realise that a conscious awareness of values, attitudes, assumptions and long-held beliefs may not necessarily be conducive to some situations in people's lives to which social workers bear witness. In other words, it takes time to come to know people and gain a comprehensive understanding of the circumstances surrounding their distress.

While some situations may be less than reasonable or agreeable, this does not detract from

the reality of socially just MHSW in assessing, and working with, people's situations. It further supports a trauma-informed approach, as discussed earlier in this chapter. Understanding the concept of PROCESS as an inherent phenomenon assists social work educators, learners and practitioners to work through, and WITH, situations where mental distress from trauma is apparent; at the very least where there may only be a superficial presentation. This also means that social work educators and learners alike have an awareness that it takes time to come to new understandings; learning about difference and diversity of the of people's lives tests the lens through which they view the world (mental models).

Critical reflection, on the other hand, centres on the learner as practitioner in beginning to identify the *what* and *how* of their assumptive world. For example, a number of open-ended questions can be posed in regard to the mental health social worker taking the journey into their own practice potential (or prior practices for advanced practitioners). Some examples of these are given in the next section.

Socratic questions for the reflexive-self in critical-emancipatory mental health social work

The author, following her call for reflexive and reflective social work learners, educators and practitioners, suggests the following questions to assist them in this process.

1. What are my assumptions, values, attitudes and beliefs about any given situation?
    a) Where have these come from? What is my own history?
    b) What impact are they having on my ability to make informed, professional judgements about people within their lived experiences?
2. What are my own past experiences that I bring to the professional encounter, and what might be their potential impact upon any given situation I am working with?
3. How do, or might, these impact, impinge, implicate and inform my decision-making process? This takes account of the ethical edge as well.
4. How will (or might) I know this?
5. What else do I need to be thinking about in order to bring the best possible practice (best practice) encounter?
6. How will I know that my service has been helpful, or otherwise?
7. What will I do with feedback, either positive or not so positive, for future practice?
8. How will I know that I have made a difference?
9. What will help me to advance my current thinking and practice (as a process of continuous improvement)?

These questions are open-ended, bringing a Socratic (Nelson, 2010), open-minded technique to practice encounters and situations, beginning with the self-in-practice as a first goal, rather than focusing on the apparent problems of another as the goal. While many, if not all, of these questions are not new, they serve as a guide for making a clear point; beginning with ourselves as (reflective) practitioners ensures commitment to a process of critical reflectivity and reflexiveness, thereby espousing an integral and consistent approach in MHSWP. This reflexive

practitioner process anticipates the elements relating to the historical trajectory surrounding current practices, existing structural factors and the policy guiding practice. Therefore, critical-emancipatory MHSWP requires a combination of critical reflexion and reflection across the layers surrounding mental distress, given that the resultant effects intrude upon the core of people's existence. This is not an either/or approach but a BOTH/AND approach, moving away from binary thinking (Fook, 2012). It regards the self-in-practice together with approaches in practice that serve citizens more humanely.

Critical reflectivity also guides practice decisions, particularly where those decisions involve ethical dimensions that occasionally require modifications to practice rather than continuing with systematic, repetitive procedures to satisfy various pressures in the workplace, whereby the risk may well be in missing something vital rather than what the risks might be for those accessing services (Webb, 2006). Moving from risk management, an aversive approach to "manage" people requires paying attention to the broader multiple factors (Shakespeare, 2014) that impact on respectful, humane service provision. For instance, adhering to a "tick-box" approach for a mental health assessment (Finch & Poletti, 2014; Gray & Webb, 2013) may occur because of time constraints to satisfy budgetary matters; in other words, the tick-box assessment occurs as a result of reductionist decisions that usually centre on fear relating to the management of risk, and for supposed time efficiency. This is not conducive to socially just motives in MHSWP, particularly when people in mental distress are experiencing other factors that are not immediately evident and therefore not on the tick-box assessment. For example, a person may have experienced abuse of one kind or another, and then are required to respond to a rote assessment procedure. This may prevent the development of trust (relationship-based), therefore minimal information is shared beyond answers within the rote process, possibly impeding empathic responding from the MHSW practitioner. An opportunity to contribute to making a difference is lost or minimised, most importantly for the person experiencing distress. The mental health social worker's capacity to be of service is reduced to practising from a risk aversive approach, rather than responding to risk as part of a critical-emancipatory approach.

Advanced practice in mental health social work

Currently, *ASWEAS* policy (AASW, 2012a,b) assumes that learners are new to the realm of social work. Therefore, inclusion of policy that incorporates curriculum addressing MHSW practitioners with fieldwork experience will assists in moving MHSW education and practice into new directions for education pedagogy. At the time of writing this thesis, the AASW are in the process of advocating for social work to be a registered profession, so it appears this may be the next piece in the mosaic of Australian social work history. The place of registration for MHSW or Accredited Mental Health Social Workers (AMHSWs, is not yet clear. As stated throughout this thesis, mental distress (in all its forms) is not located only within the realm of the mental health sector. Social workers are located in many areas where people present in various states of distress. Therefore,

further education in MHSW professional development is open to all social workers.

Changes to current education policy would require the inclusion of discourse, perhaps framed through the term “professionalism”, in order to build on practitioners’ existing knowledge and skills; a process requiring the inclusion, and expansion, of the variety of concepts revealed in this chapter for practitioners to advance their practice wisdom – thus, a critical-emancipatory approach. The notion of professionalism offers a basis for making some key points relating to the broad scope of MHSW, professional development, ethical responsibility and the commitment to social work’s core values. The author suggests the following outline:

> *Professionalism as a mental health social work practitioner requires the commitment to ongoing learning. A commitment to ongoing learning means that mental health social workers shall take responsibility for advancing their knowledge base, informing their understanding of policies applying to mental health social work, and utilise critical reflection to enhance and evolve practice. This meets with the ethical obligation to maintain the core values and principals of social work; complimented by relationship and rights-based practices, and thereby socially just, committing to a critical-emancipatory approach in mental health social work practice.*

Chapter summary

This chapter provides the foundations for re-conceptualising and re-newing MHSW education, policy and practice in Australia. It argues that a critical-emancipatory approach, coupled with a critical realist stance, facilitates a process addressing both new learners to MHSW and practitioners returning to advance their knowledge and skills for practice. The importance for social work educators in creating a learning environment that models the tenets of relationship- and rights-based practices is demonstrated, as is the imperative for social work learners to gain knowledge and self-awareness for ethical and socially just practice.

Recommendations related specifically to the three broad foci – education, policy and practice – for re-conceptualising ways forward for MHSWP address critical social work theory, a conceptual framework for education and practice, and a trauma-informed approach, encompassing pedagogical points for the classroom and learner wellbeing. The author offers a trauma-informed approach as a way forward for learners and practitioners, noting some have prior lived experiences of mental distress but most especially focusing on their own position as a professional in human service organisations continuously surrounded by stories of trauma and its consequences. A knowledge base informing social work educators and practitioners about trauma invites hope for all the practice possibilities when serving people who are so often the survivors of life events that are beyond comprehension. Therefore, the acquisition of critical social work theory, critical reflection and emotional intelligence provides the foundation for growing learner confidence for practice, thus placing critical-emancipatory practitioners at the front and centre of narrating as advocates and brokers. Additionally, this affords opportunities for respectful dialogue with colleagues and other professionals, including psychiatry, signifying confidence, as mental health social workers, to lead

the way for citizens who sometimes struggle to advocate for themselves, or simply cannot do so.

The concept of VT as it applies to the MHSW learner within the classroom context, supported by theory from a trauma-informed approach, assists social work educators in locating the learner as a *learner*, a *future practitioner* and an *advanced practitioner* at the centre of critical-emancipatory MHSWP.

A new model – what lies between – developed specifically for the classroom and the learner, aids the social work educator with a visual representation relating to ideology and the reality of practice (Diagram 2). This encourages dialogue in the classroom, creates the opportunity for (future) critical reflexion and supports emotional intelligence for the self-in-practice. Overlap amid these areas, described as layers, is in keeping with the notion of BOTH/AND, rather than either/or, one example being that language and power intersect with all of the areas.

The re-conceptualisation and the re-newing of ways forward in MHSW in education, as discussed in this chapter, pre-empts the following chapter, which focuses on re-conceptualising MHSW education, policy and practice.

CHAPTER 6:
RE-CONCEPTUALISING MENTAL HEALTH SOCIAL WORK: EDUCATION, POLICY AND PRACTICE

Chapter 5 has proposed ways forward for re-conceptualising MHSW in education with a number of recommendations made for policy and practice. The author uses this final chapter to comment on the relevance of this study for policy in MHSW as it relates to education and practice. Again, it is important to mention that the dominant discourse of the bio-psychiatric, disease-saturated (illness) paradigm is inherent in MHSW, and that social workers are located in many settings where there are people enduring various levels of mental distress. It is also important to reiterate that there is a plethora of literature espousing and exposing the mental distress of people with lived experiences as being "mentally ill", and that this study presents contemporary debates contesting this "illness" space. These debates reveal the multiple facets of emotional distress, remarking particularly on the presence of prior, current or ongoing trauma. While the author notes that data suggesting mental illness is increasing at exorbitant rates, she adopts a critical realist stance to unveil the circular arguments and epistemic fallacies used to represent and reproduce notions of distress from the dominant bio-psychiatric, disease-saturated (illness) paradigm. These notions implicate MHSW education, policy and practice in reinforcing this paradigm due to use of its language throughout education and practice policy documents. Proposing a critical-emancipatory approach for the re-conceptualisation of MHSW away from its roots in psychiatric social work and moving toward a trauma-informed paradigm offers a way forward for contemporary social work in the twenty-first century. A critical-emancipatory approach proposes the dialectic of knowledge and care, binding the core values of social work together with epistemological concepts and ontological notions for transparent, ethical MHSWP.

Embedding a critical realist standpoint

The historical narrative in this study reveals the journey of psychiatric social work, beginning predominantly with charitable notions of help and progressing to psychiatry's invitation for supporting people to participate in institutional and community care. This signifies the commencement of mental health social workers as agents of the State, in which care has adopted reductionist bio-psychiatric, disease-saturated (illness) accounts centred in protection, risk management and therapy. Both prior and recent reviews and reports commissioned by the federal government disclose a climate of poor mental health service provision, indicating and implicating mental health social workers as part of the problem. This is despite the data noting the increasing numbers of people in (various states of) distress and the extraordinarily high funding allocated to mental health services for assisting them. The author's field practice-wisdom has guided her perception of the dilemma here. Initially, people are motivated to seek help, or do so reluctantly with (robust) encouragement from their family and/or significant other. However, when they are

forced into “care” against their will because psychiatry activates the mental health legislation it explicitly endorses as an apparently legitimate means of “care”, the motivation withers, if not immediately to fear then eventually to loss of hope. The author posits that critical realist philosophy guides mental health social workers in this (and any other) dilemma, assisting them to reflect and act, focusing on:

- knowledge creation of mental distress and its reproduction and representation in practice
- the reproduction of this knowledge in policies for mental health education, Practice Standards and the funding of services
- the effects and the mechanisms that continue to generate knowledge, policy and practices that reinforce dominant discourses and paradigms
- what this means for people attempting to access help amid their lived experience; and
- how to stretch our imaginations, using an open mind, for seeking alternative explanations about people’s distress, and practice approaches centring humanity and social justice as ethical pursuits.

Although these are not necessarily the only areas for focus, a critical realist standpoint pays attention to *how* and *what* knowledge generates from bio-psychiatric, disease-saturated (illness) origins and becomes situated in the MHSW education curriculum; also what this means in terms of the AASW *Practice Standards for Mental Health Social Workers* (AASW, 2014a). As established in the CDA in Chapter 4, critical realism (CR) identifies “generative mechanisms” (Archer et al., 1998; Bhaskar & Collier, 1998) as a means for exposing the network of practices among the psychiatric enterprise, thus including the pharmaceutical industry (*Big Pharma*) in maintaining the social order (Fairclough et al., 2004).

Australian Association of Social Workers policy for mental health social work curriculum in education and practice Standards

The CDA in this study has exposed the inherent bio-psychiatric, disease-saturated (illness) discourse in the AASW *Practice Standards for Mental Health Social Workers* (AASW, 2014a). The author has established that being person-centred is not automatically conducive to humane and just MHSWP. Therefore, she posits a critical-emancipatory approach to address this dilemma. For example, the *Practice Standards for Mental Health Social Workers* suggests that engaging with “the person…is concerned with assessment, intervention or treatment planning as well as progress and outcome monitoring” AASW, 2014a, p. 7), denoting bio-psychiatric, disease-saturated (illness) discourse. Hence, the implication for practice is a focus on treatment, outcomes and monitoring, which has consequences for engagement with the person and therefore the “person’s wellbeing” (AASW, 2014a, p. 7). This is at odds with appropriate and ethical MHSWP to ensure people feel supported as they progress through their lived experience (*Respect for persons*, AASW, 2010, p. 12). The author argues that engaging with “the person” (or people in any situation) requires discourse and practice embracing the relationship-based component of a critical-emancipatory approach as pivotal to people’s improvement (progress) through their lived experience of mental

distress; improvement also is in harmony with wellbeing. Equally, this supports and accords with a rights-based approach, that is, the person's right to participate in decisions relating to their care; an approach not centring on the mental health social worker as the "expert" in this process. This approach is also socially just because it values the person's (or people's) rights and shares the power, ensuring the process is inclusive, as opened up and discussed in depth in Chapter 5.

In addition, the author argues that accommodating a critical-emancipatory approach together with the core components for MHSWP meets the AASW MHSW education curriculum requirement for "practice principles specific to mental health" relating to *Attitudes and values* in the *ASWEAS Guideline 1.1: Guideline on essential core curriculum content* (AASW, 2012b, p. 4). This guideline involves recognising and respecting people's mental distress and with sensitivity and compassion. Thus, re-conceptualising the language of assessment, intervention, treatment and similar requires the inclusion of this approach and its core components in the ASWEAS *Guideline 1.1* (AASW, 2012b) and the *Practice Standards for Mental Health Social Workers* (AASW, 2014a).

The following discussion addresses the element of assessment because the author contends that an assessment is a vital element of (best) practice; it is a *process*, and a critical component of the process of assessment is the development of the working relationship through engaging with the person (or people). Engaging in a meaningful (professional working) relationship for assessing the wider context, thus addressing the complexity of situations, locates MHSW in critical-emancipatory, relationship-based practice, bringing the potential for making a difference to people's lived experience.

The process of assessment as central to relationship-based practice: a cautionary note about the inherent discourse and the network of practices

Further to the importance of engaging with people as fundamental to relationship-based practice, and extending the discussion about the notion of assessment in the CDA in Chapter 4, Stage 1, this discussion invites some cautionary points regarding the ideology, the discourse and the context in which the assessment process takes place in MHSWP. Acknowledging that assessment is a well-known and understood term in any setting where MHSWP occurs, the language of assessment assists clarity among peers, colleagues and the lay public; it is the beginning of the process for MHSWP, mostly via referral from either another agency, GPs or psychiatrists, thereby aiding the subsequent conversations surrounding people's circumstances.

The introductory section for the AASW *Practice Standards for Mental Health Social Workers* (AASW, 2014a) notes the specialisation of mental health social workers and clearly states that the "progress for a person…will be influenced by the…assessment and treatment of mental illness and disorders" (AASW, 2014a, p. 5). This quote, combined with the CDA exposing the language of bio-psychiatry located in assessment, demonstrates the medical (ised) process. A critical realist perspective connotes the semiotic conditions (Fairclough et al., 2004) as the selection, or privileging of, bio-psychiatric, disease-saturated (illness) discourse inherent in the network of practices in which this process occurs. This supports Bacchi's (2009) WPR approach, in

which the meaning of assessment as a process focuses on illness, disorder and associated problems; problematisation that represents the bio-psychiatric enterprise for MHSWP. In other words, MHSWP focuses on assessment as a process *influenced by* people's *progress* in terms of their treatmen*t* for their medical condition. Further to the network of practices that lie amid the assessment process and apply to any setting where mental health social workers are located, are the conversations that occur in the process, noting again the aforementioned comments about the commonality of the term "assessment". However, the commonality also lies in the bio-psychiatric, disease-saturated (illness) discourse inherent in the language-use of illness and disorder, with problematising (Bacchi, 2009; Morley et al., 2014; Pilgrim, 2015b) revealed among the assessment discussions. A critical realist interpretation exposes the mechanisms (for example, bio-psychiatric ideology) and the structures (bio-psychiatric and *Big Pharma*) that assist in maintaining the bio-psychiatric, disease-saturated (illness) approach; in other words, a psychiatric social work approach.

In essence, an assessment, regarded in its gentlest form, is an appraisal of situations. Re-conceptualising this for MHSWP within a critical-emancipatory approach requires mental health social work learners and practitioners to reflect on the process of assessment, in the first instance with curiosity (Pilgrim, 2015b) and an open-mind. Hence, referrals for assessment and the subsequent encounters (relationships) pledge a cautious, considered approach. This moves away from any expectation of needing to be an "expert" in unravelling and problematising (Bacchi, 2009) all manner of situations. Rather, situations entered by a mental health social worker with an open mind, committing to relationship-based practice, and adopting a critically reflective and reflexive lens in this process are consistent with critical-emancipatory MHSWP; they are ethical and socially just. Mental health social workers adopting this approach avoid believing only in what is on the referral for assessment of situations, as well as the time-pressured need for responding in a reactionary, risk-averse manner, which most often ends in either unhelpful or coercive care; unethical and socially unjust care that impinges on people's rights. The *Human rights and mental illness: Report of the National inquiry concerning the human rights of people with mental illness Volume 1 and 2* (the *Burdekin Report*) (Burdekin et al., 1993), and the *Contributing lives, thriving communities Report of the Review of Programmes and Services for Mental Health* (CLTC) (NMHC, 2014b) are testimony to these points. They lay bare people's poor experiences and rights violations in mental health services; experiences in which social work is implicated.

Adopting policy change in the bio-psychiatric, disease-saturated (illness) language for mental health social work: the notion of relationships, rights and social justice as *themes* for practice

The two abovementioned reports highlight the need to adopt a critical-emancipatory paradigm in the education and Standards policies for MHSW, involving a commitment to realign MHSW toward the language and concepts offered in Chapter 5, thus ensuring an inherent discourse that relates across the themes of relationships, rights, social justice, critical reflection and trauma-informed

approaches. The author suggests the following points as examples of a beginning framework that illustrates a discourse for including these themes in all policy applying to MHSW education and practice:

1. Respect for people as human beings, not as *patients* identified (discussed, defined and described) according to their diagnosis, or a label.
2. Person-centred, meaning that people are citizens with civil (and political) rights; they are the experts in their lives, collaborating with mental health social workers as partners and participants in the decision-making process throughout the entirety of their lived experience; of distress and of the services being accessed.
3. Mental health social workers share the power for making a difference WITH people, rather than "to", "at" or "for" them (O'Connell et al., 1998); therefore, advocating mental health care that is not coercive.
4. Mental health social workers value critical reflexivity as inherent to practice, appreciating and respecting their own vulnerabilities as human beings when navigating the ambiguity and complexity of the messy reality of lives. This requires an ethical obligation toward the core social work value of professional integrity (AASW, 2010) for seeking ongoing (career-long) professional development (examples here are supervision and further education) to remain abreast of contemporary debates in MHSW. The need for self-care is also in professional integrity. This shall be explicit in policy for education and the *Practice Standards for Mental Health Social Workers* (AASW, 2014a).
5. Socially just MHSWP threads through relationships, rights and trauma-informed approaches, with critical reflection (reflection-in-action and post-action) (Fook & Gardner, 2007; Schön, 1995) as an empowering concept (Lee, 2001) for traversing *what lies between*.

Pledging allegiance to these themes refutes the dominant bio-psychiatric, disease-saturated (illness) paradigm, thus restoring MHSW in the twenty-first century to a profession with pride in its knowledge base, and the confidence and capacity to act with integrity; the sincere belief among mental health social workers that as a profession, they can contribute to making a difference WITH people. Diagram 3 illustrates these concepts and serves as a tool for social work educators in the classroom.

The author argues that these themes be threaded through policy, thus giving them the capacity to operate in pedagogy and practice. The following discussion advances these themes, providing depth beyond conceptualising them for policy toward the *how* and *what* for practice. These themes offer a basis for further work upon completion of this study.

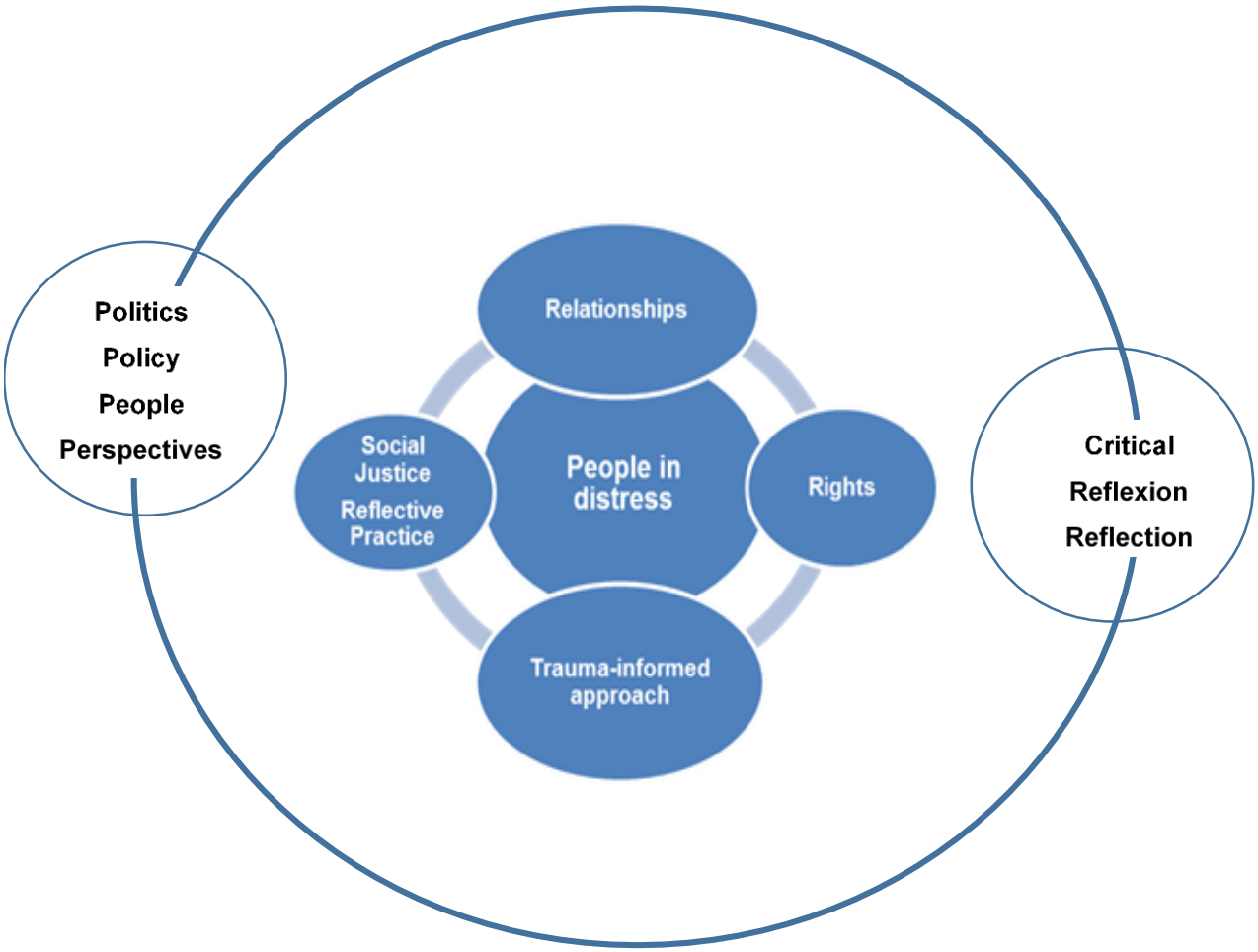

Diagram 3: Re-conceptualised mental health social work

Themes in action for education and practice

The author proposes that great MHSWP begins with the self; the self-in-reflection equals a critically reflective learner and practitioner. This warrants reflection and dialogue-centring values, attitudes and beliefs for negotiating several layers, namely the "Ps"– *politics*, *policy*, *people* and *perspectives*. The Ps traverse all the themes. The author offers the following examples of ideas for education pedagogy and practice:

1. Paying attention to the *politics* of MHSWP requires a knowledge base for either establishing or advancing awareness about all manner of policies connected to mental health service provision. This means, for example, Standards for practice (such as the federal government Standards discussed in the CDA in Chapter 4), and the economic and budget decisions made by (local and state) governments, which impact upon the limits of service provision, and thereby, albeit indirectly, on people's lives.

2. Relatedly, the interpretation of *policy* via wording, directions, strategies and stances influences practice either indirectly or overtly when organisations mandate it. The implications for MHSWP may require advocacy for individuals in effecting social justice, for example rights violations in coercive treatment, to

then advocating for encouraging and influencing changes to mental health legislation.

3. Respecting *people* necessitates the principled action of accepting there is a montage of personalities dancing among the realities of practice, thus entailing the need for confidence and maintaining awareness of the infinite variety of *perspectives* on the practice floor – those we work with as peers and colleagues, and those we serve. The *politics* of power in navigating ways through sometimes very muddy waters brings the critical point that reflection and dialogue (classroom and supervision in the field) upon all these themes and layers, and more, serves many purposes. This denotes further layers – practice, the muddy waters and the professional responsibility (AASW, 2010) – to acquire the confidence for navigating those waters with tact and diplomacy.

4. Holding these themes and the layers amid them to our helping hearts offers spaces for practising from a moral (a critical-emancipatory approach) rather than medical (Maisel, 2016) standpoint, one of these layers being language. Maisel's recent *The Future of Mental Health: Deconstructing the Mental Disorder Paradigm* (Maisel, 2016) offers an inspiring and thoughtful new name for mental health professionals; Human Experience Specialists (HESs). The following discussion offers some key points regarding the language and practice of an HES.

Human Experience Specialist: great – brilliant – social work practice for engaging with people in (varying states of) mental distress

Maisel (2016) emphasises the place of an HES as lying outside bio-psychiatric, disease-saturated (illness) constructions of mental distress, instead focusing on people as souls facing the struggles of life from time to time. The following extract illustrates his position, offering the possibility for MHSW to grasp the authenticity and genuineness in any setting for MHSWP:

> Our human experience specialist is needed for all sorts of reasons. First among them is that virtually all current mental health practitioners – psychiatrists, clinical psychologists, family therapists, mental health counsellors, etc – are by virtue of their training and their very name obliged to focus on the mind of their clients and not on their client's lives. A person is not a brain in a bottle and not a mind in a bottle. He (sic) has a life, a personality, and a world. He (sic) doesn't *catch* depression; he (sic) experiences sadness and suffers. Right now, he (sic) may ask for a pill because he thinks he is going to some sort of doctor. In the future, if he (sic) is provided with a new option, he (sic) may choose to visit a human experience specialist and bravely announce, *I need help with living*. (Maisel, 2016, p. 130)

Continuing with the theme of relationships being at the heart of great – brilliant – practice and starting first with the self, Maisel captures the essence of humanness, not as a clinical presence but as a human being with feelings, fears, thoughts and the capacity for the courage to desire things to be different. Clearly, Maisel (a psychotherapist with a PhD) advocates a paradigm of practice that "shift(s) from *mental disease thinking* to problems in living thinking [also implicating social workers in this, rejecting the DSM, and] prescription pads" (Maisel, 2016, p. 131). While his

concept of problems in living is contested space in this study, indicated via Bacchi's (2009) approach, Maisel's supporting arguments are sound and the extract justifies his stance. The critical-emancipatory intent accords with the themes proposed from this study and emotionally intelligent practice.

Therefore, the HES (Maisel, 2016) sits within the themes in seeking to understand another's plight, combining care and compassion. The HES situates her/himself amid the moral obligation for respectful dialogue. The technical aspect of this, as an example, is through asking open-ended questions and then listening – beyond hearing and immediately looking for (bio-psychiatric, disease-saturated (illness)) diagnoses or solutions. The HES does not try, or desire to be, the expert or diagnostician. It is not their role to seek to label or to treat people's trauma. The HES realises that people are unique individuals; many are the product of environments and a ubiquitous society that acts in ways that do not grasp the innate value of people as human beings. Therefore, in extreme situations, some people are less than easy to understand, are downright difficult, angry, dark, secretive and so on. In choosing to adopt the role of an HES, mental health social workers are choosing to engage with all kinds of human beings with all kinds of unpleasant experiences; all kinds of what would appear to be unreasonable, unpalatable and sometimes even cruel actions in the decisions they make about the way they conduct themselves. Nonetheless, if mental health social workers are serious about having a socially just, rights- and relationship-based presence as HESs, they are obliged to assist in whatever way they can professionally in contributing to making a difference.

Given the mention of extreme situations in MHSWP, how do mental health social workers work with them? They have the potential for contributing to VT and causing frustration in practice, despite good intentions. First, there is the need to reflect critically, as a witness to confronting situations (content or actions), on the values, attitudes and beliefs that surround the situations. Mental health social workers do not have to agree with what has occurred, or may still be occurring. What is needed is practice that is considered carefully, with strategy, not with frustration and disregard. A prior lack of regard and respect is a likely reason for the situation to have become this way. The person has now come to believe that it is reasonable to act in a similar way or is beyond caring. This is from the realm of modelling, discussed in Chapter 5, because HESs can be the first link in the chain of (re) modelling in the presence of people who are on the journey of new beginnings. This of course is not dealing in ideology; it considers the reality of situations where people are not ready to make changes in their life; they do not yet possess what the author terms "the readiness factor". At times, the reality is harsh to witness but this does not mean that intervention, usually via social control, is going to change anything. It is likely to push the person further away, which is not helpful. What the situation requires is a conversation, not counselling or therapy. This is one example of where the place of stigma (deviance) (Corrigan, 2007) enters the world of mental distress. Here, the need is for HOPE. Many people have not been a party to hope or a hopeful (home) life, or even a hopeful society or community around them. Enter the HES.

Trauma-informed and responsive as a critical-emancipatory approach for mental health social work: both/and - *both* relationship- *and* rights-based, *and* socially just

A trauma-informed perspective brings a knowledge base and application for practice. As with the concepts discussed so far in this chapter, trauma-informed work for HESs with a social work degree needs to be stated in the *ASWEAS* policy and guidelines for education curriculum (AASW, 2012a,b) and the *Practice Standards for Mental Health Social Workers* (AASW, 2014a). A trauma-informed approach offers the point of difference for social work as an allied health profession, with its critical-emancipatory contribution also offering the professional presence expected by peers and the public. In addition, it brings a professional presence that affords respect among social workers' peers; a layer that brings hope for MHSW as a profession with clarity, confidence and pride in the pursuit of making a difference. This difference moves away from pathologising individuals and groups, for example, families, communities and society. Critical-emancipatory MHSWP that leads the way in research, dialogue and decision-making in policy and consultation is not to be messianic. Rather, its purpose is to inspire debate and dialogue (Ife, 2012) to keep social work in mental distress moving forward, but always conscious of history, power relations and discourses as reminders; as the "levellers".

The pedagogical implications for the introduction of a trauma-informed perspective for (mental health) social work learners has the potential to associate the discourse of trauma with one that fills the milieu with the presence of language conducive to distress, pain and sorrow (Waite & Hawker, 2009). Medical discourse raises the images and sounds of disease, illness, sickness, disorder, disturbance or disobedience (Waite & Hawker, 2009). It uses the words and language of pathology; of apparent abnormality. Rather, trauma-informed discourse must be filled with the language of hope, challenges, optimism, an appreciation for difficulty, areas for improvement, concern, responsibility, passion and justice.

A trauma-informed perspective and approach facilitates a process for learners to start making connections between knowledge and praxis for themselves as human beings. As approaches for practice unfold, the learning advances in a way that assists new learners to enter MHSW in several ways. It has the capacity to impart the beginnings of respect for people's lived experiences, especially given the earlier contention in this thesis that some MHSW learners come to study social work with a prior lived experience of their own, having been (or remaining) witness to this in another/others' lives. There is a layer of respect afforded to them immediately as people in the learning environment. In this way, social work educators model respect for the lived experiences of prior trauma present in classrooms. Appreciating the WHAT of a trauma-informed approach that is specific and responsive brings the possibility of hope. Perhaps this raises the questions about what hope is and what it means. Then, perhaps, questions about HOW might a trauma-informed perspective and approach provide hope? Although there is not necessarily a definitive answer because of the nature of complexity, the concept of hope anticipates layers filled

with courage and compassion, and a sense of optimism, even when all seems lost. For great, and eventually brilliant, HESs, valuing their own lives (self-reflection first) and then their practice, hope is modelling it as a means of reaching out to another.

The Four Pillars of Sanctuary

A trauma-informed approach in practice brings BOTH the relationship AND a respect for rights to the professional encounter, and is socially just. The concept of Sanctuary, introduced in Chapter 5, encompasses this approach. Bloom and Farragher (2013) developed the Sanctuary Model, grounded in trauma theory, following their observations and experiences in a mental health unit over the course of several years. Its "Four Pillars" of Sanctuary (Bloom & Farragher, 2013, p. 47) are:

1. Trauma Theory
2. Sanctuary Commitments
3. S.E.L.F
4. Sanctuary Toolkit

The central concepts of these four pillars incorporate theory, values, navigating complexity and practical tasks (Bloom & Farragher, 2013, p. 47). The discourse, concepts and ideology surrounding this work summon positiveness, hope and respect for people in any state of mental distress, and clearly advocate "nonviolence" (Bloom & Farragher, 2013, p. 127). HESs (mental health social work practitioners) are enabled to move from a bio-psychiatric, disease-saturated (illness) model pathologising human beings who experience dilemmas of existence toward this well-established framework as contemporary theory for MHSWP in the twenty-first century. The Sanctuary Model forms the basis of the critical-emancipatory approach that enables the move forward. In the following discussion, the author provides some examples she has devised to demonstrate what it means to be trauma-informed. These are critical to re-conceptualising MHSW.

Practice approaches: trauma-informed

A critical-emancipatory approach is inclusive of trauma theory and practice. A trauma-informed approach invites the following:

- *practice wisdom* – opportunities for continuous learning and growth is inherent within policy
- an *acceptance* that ambiguity and uncertainty is implicit in trauma-informed practice
- *appreciating* there are contradictions in situations because of the uniqueness of human beings
- the *commitment* to cease listening to ideas about *resistance*, *dependence* and *psychodynamics*. This discourse is judging of *other*s (thereby fitting with the notion of *othering*), invites frustration for the practitioner, and therefore lack of engagement with people we are serving
- the *obligation* to seek *feedback* as a critical reflective practitioner. This respects people – even in situations where this may not be easy to hear, it must nonetheless be reflected upon rather than wanting to (most often) find a reason (psychodynamic) to place blame on the person(s) we are serving

- a *promise* to the self-in-practice to remain mindful of the possibility for Vicarious Trauma (VT) (Pearlman & Mac Ian, 1995) as an HES/MHSW practitioner witnessing multiple stories of distress, horror, sadness and cruelty. There is the need for looking after the self, both personally and professionally. Examples include mentoring and professional development, as well as seeking enjoyment in passions outside of the work environment.

The place of language in practice

This discussion outlines some key points relating to the paradigms of rights-based and socially just MHSW. A conceptual understanding of these paradigms provides a basis for trauma-informed perspectives and approaches. Australian social worker Ife (2012) theorises a number of critical points about human rights for social work, discussed throughout this study. It is political, occurring within the context of structural factors, for example cultural, social and economic conditions (Ife, 2012). It is about working with the individual within the context of the broader social fabric; rights-based approaches are discursive, therefore the language (Ife, 2012) used to define, describe and discuss people and their circumstances requires careful reflection-in-action (Fook, 2012; Fook & Gardner, 2007). Ife (2012, pp. 255-262) provides some poignant points regarding a variety of language use in social work, describing the following as "labels":

- client
- intervention
- empowerment
- supervision
- interviews.

Ife further notes that the use of these terms in practice causes professional distancing; a point made by many others (Bentley, 2005; Fairclough, 2001a,b; Fairclough et al., 2004; Kirk et al., 2013; Pilgrim, 2015a, 2015b; Scheff, 1999; Scull, 2009; Smith, 1990a, 1990b; Smith & David, 1975; Ussher, 2011; Williams, 2005). This bears testament to the discursive effects of defining, describing and discussing people and their situations. Ife proposes that changing words, for example "client" (Ife, 2012, p. 255) to "citizens" or "people" (Ife, 2012, pp. 256, 257), achieves a rights-based approach (as the author has purported throughout this thesis). This language change moves away from "essentially a top-down approach to wisdom and expertise, motivated by human values, but with an assumption that the professional is in possession of superior knowledge and skills, which are put at the service of the client" (Ife, 2012, p. 256). The lens shifts to regarding the notion of "citizenship" (Ife, 2012, p. 257) as a status that should be afforded to all people regardless of their individual circumstances. Nevertheless, the general principle here is for reflecting about language use in MHSW practice as defining people (and their situations), which demonstrates commitment to humans' right to respectful dialogue as citizens (or people) (Ife suggests this is "Dialogical Praxis" 2012, p. 230) rather than as clients. Ife also points out that reflecting about language is a process that indulges in shared power (Ife, 2012); a "dynamic" and

"liberatory" (Ife, 2012, p. 286) process that is socially just and therefore emancipatory.

Education, policy and practice for mental health social workers/ human experience specialists: a final word

The aim of this study was to re-conceptualise and re-new MHSW education and practice with the intention to move away from the existing use of the bio-psychiatric, disease-saturated (illness) paradigm. The author has demonstrated in detail that the extant policies applicable to MHSW education and practice will benefit from some changes. The benefits will be in a paradigm shift away from the dominant bio-psychiatric, disease-saturated (illness) ideology and discourse inherent in the AASW policy documents, influenced and reinforced by national policy agendas, toward a critical-emancipatory approach.

The three areas proposed for re-conceptualising this move are education (including the pedagogical elements), policy and practice. Pedagogy addresses the educational domain in which both social work educators and social work learners come together to explore a variety of paradigms through conversations and critique; a critically reflexive process (Fook, 2012; Howe, 2008). MHSW policies provide the foundations for curriculum design in MHSW education and the Standards for MHSW practice.

Therefore, the three areas of education, policy and practice have the capacity to provide the basis for achieving this change, and to act as a guide for maintaining and sustaining change. The following *themes*, which the author identified from the CDA and introduced in Chapter 5, demonstrate examples for policy and practice as paradigms specific, and relevant, to MHSW. These themes offer the opportunity for the paradigm shift away from psychiatric social work by offering the conceptual capacity to aid the process of re-conceptualising language for MHSW. They are:

1. Relationship-based theory and practice
2. Rights-based theory and practice
3. Trauma-informed perspectives (knowledge-based) and approaches (practice-based)
4. Reflexive and reflective practice
5. Social justice.

Matters of moral importance for education, policy and practice

Complementing intellectual modesty and humble curiosity is a professional presence of mind (reflexive moments of mindfulness) toward a moral position. This attitude adopts professionalism, thus bringing integrity to MHSW and eliciting the confidence of the citizens mental health social workers serve. This latter point is of paramount importance to the preservation of MHSW professional presence amid colleagues and citizens.

Areas for further work

This study has generated ideas for further research, predominantly in two areas relating to social workers as early career and post-graduate mental health professionals, and the experiences of women in the mental health services.

Mental health social work: professional and developmental aspects

Building on Lawrence's (1965) study, especially given its age, the author suggests:

~ Researching trends in gender in MHSW, given the predominance of women who initially entered MHSW. The outcome of further research may well assist the direction of women as leaders in MHSW, guiding decisions for actioning ways forward for social work in Australia.

~ Exploring the possibility of VT in MHSW learners, utilising a mixed methods approach, thus generating data for education pedagogy and policy change. Further research in the area of VT will also extend an understanding of the occupational health and safety of early career and post-graduate mental health social workers, thereby providing professional development opportunities.

Women's experiences of mental health social workers and mental health services

This research process has highlighted the lived experiences of women seeking the services of mental health, particularly in North America, but also in Australia. There is scope for further work in the following areas:

~ Exploring the journeys of women with lived experiences of the mental health services in Australia, and therefore the implications for MHSW

~ A feminist critique of MHSW with women accessing mental health services in Australia and beyond

~ Re-conceptualising the diagnosis (label) of *Borderline Personality Disorder* for women to explore the paradigm of a trauma-informed approach that traverses relationship- and rights-based, socially just practice

~ Paying attention to the current national crisis in domestic and family violence. A suggested title is, *It's time to pack your bags, and get out of the mental health system: the implications of mental health diagnoses on women experiencing the effects of trauma from domestic violence.*

Papers in draft form eventuating from this study

~ Mental health social work in the 21st Century: A critical-emancipatory paradigm for education and practice

~ Relationship-based theory and practice for mental health social work: new trends

~ Critical realism in mental health social work: What is it? And, what it isn't.

~ Trauma-informed systems of care for mental health social work: personal and professional obligations

~ Trauma-informed practice for mental health social work: the *how* and *what* of policy and practice

~ Re-thinking Recovery in mental health social work: what does this mean for the citizens we serve?

Closing reflection, with an invitation to the social work profession

The central aim of this study is to achieve re-conceptualisation and re-newal of MHSW education,

policy and practice, requiring more than some new knowledge, some new policies or some new pedagogical moments. It requires a certain deep strength, a sense of obligation, a passion and a desire to do things differently if MHSW as a profession is to move away from the current status quo of the bio-psychiatric, disease-saturated (illness) paradigm that is heavily entrenched in MHSW. The bio-psychiatric, disease-saturated (illness) enterprise, together with the tentacles of *Big Pharma* and the apparent contemporary focus on Recovery, is not making a significant difference in people's lives. People, as citizens, continue to suffer the authoritative and righteous demeanour of psychiatry and the allied (aligned) health professions ensconced in our mental health organisations across Australia, despite the good intentions of many. The lack of change raises mindfulness of mental health social work's location among the bio-psychiatric, disease-saturated (illness) paradigm. These concerns have been justified in the CDA.

The author argues that what is needed for MHSW is contextual; a cultural shift toward a critical-emancipatory approach that embraces a trauma-informed paradigm for education and practice, thus inviting mental health social workers to take up responsibility (Jenkins, 1990), as ethical professionals, to work with mental distress in any setting in a relationship- and rights-based, socially just manner. Given that MHSWP is located in any setting where social work occurs, this affects all social workers, and so is a call to all practitioners in the social work profession.

Speaking as an advocate for change, I, the author, as a mental health social worker and social work educator, encourage all my colleagues to join me in making the change needed to improve education and practice in MHSW.

> *May we step forth onto the moral high ground, perhaps in some muddy waters for a time, but nevertheless maintaining the ultimate passion to remain ever hopeful of leading the way for change among our own profession; first and foremost. Then, and only then, may we walk with cleaner steps and clearer vision as we are invited into the lives of people with a lived experience; a vision resplendent with an appreciation for difference and diversity transcending the bounds of bio-psychiatry.*

EPILOGUE

This study began with my noble intent to explore what the Recovery approach means in the twenty-first century for people with a lived experience of mental distress, and where MHSW education and practice are situated within this. The intent changed as the research journey unfolded. Prior field practice as a nurse, beginning in a psychiatric hospital in the mid-1980s, and later in community settings and private practice as an accredited mental health social worker, brought me the burn for this research contribution, given my witnessing of human rights violations in all of these settings. The research process unveiled the dominance of the bio-psychiatric, disease-saturated (illness) paradigm, and the broad tentacles of *Big Pharma* within the bio-psychiatric, disease-saturated (illness) enterprise, revealing also what this means for MHSW education and practice. This further ignited my passion and desire for discovering new ways forward in MHSW, and importantly, revisiting the core values of social work for their contribution to ethical and socially just practice. It was at this point in the research journey the decision came to shift the focus toward social workers as learners in the university setting following the revelation of the potential for the reproduction of knowledge, rooted in bio-psychiatric, disease-saturated (illness) understandings, to begin at university.

My recommendations are situated in critical social work. I advocate a critical-emancipatory approach reinforced with critical realist philosophy for inclusion in the MHSW curriculum and practice Standards. A critical-emancipatory paradigm places new learners, social work practitioners returning to education, and the citizens we serve at the centre of just and ethical education and practice. Respecting that the lived experience of mental distress occurs across all echelons of society brings the understanding that new learners and fellow practitioners are not immune. Hence, the critical-emancipatory paradigm includes a trauma-informed approach for addressing education pedagogy for new learners and established practitioners; and, the practice implications for serving those in mental distress. Although a critical-emancipatory paradigm values social work learners at the beginning of their career in the human services, this approach also invites the moral obligation, in practice, to serve citizens with integrity and compassion. Therefore, the critical-emancipatory approach lies at the heart of relationships, human rights and a trauma-informed paradigm that is specific and responsive to people's experiences of mental distress.

In finalising this research journey, I posit that critical-emancipatory MHSW holds regard for new learners and established practitioners in order that they appreciate people's lived experience, at times seemingly unendurable; it must lie at the core of our learning and all that we practice. This is socially just and ethical practice with professional integrity, respecting people as feeling human beings who are entitled to their rights, and sanctioning their voice amid their care.

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