Social Work Practice in Mental Health

Cross-Cultural Perspectives

Editors
Abraham Francis
Paula La Rosa
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S.P. Rajeev

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Ph.: 09335202549 • E-mail: lko.books@alliedpublishers.com

Website: www.alliedpublishers.com

ISBN: 978-81-8424-958-3

Published by Sunil Sachdev and printed by Ravi Sachdev at Allied Publishers Pvt. Ltd.
(Printing Division), A-104 Mayapuri Phase II, New Delhi-110064

Foreword

Social work's defining characteristic is complexity, which manifests in: the complex dynamics between the past and the present; intra-psychic mechanisms and their dynamic relationship to the socio-political, economic and cultural life worlds of people; nature-nurture considerations; the challenge of transcending mind-body dualities; and the increasing struggle to retain an ethical commitment to relationship, process and reflexivity in the face of neoliberalism, new managerialism and cyber therapies. The series of chapters in this book makes a contribution to our deeper understanding of various facets of social work in mental health. The complexities elucidated here can be addressed by embracing the power of teamwork, the power of visionary leadership, and the power of reflexivity.

The power of teamwork: People are complex biopsychosocial, spiritual beings. Biopsychosocial factors play a profound role in predisposition, precipitation and perpetuation of mental health problems, and must be considered in assessments and interventions. Structural oppression, exclusion and marginalisation permeate the lives of families and individuals to manifest in a range of what we call psychopathologies. Unfortunately, the popular discourse is on dysfunctional individuals and dysfunctional families, with "dysfunctional societies", being a totally silenced discourse. A full acceptance of this reality contributes to the realisation that we need to bring together micro and macro level interventions, see the inter-relatedness between clinical intervention, policy and social activism, and accept that no one profession, on its own can respond to the complex needs and circumstances of Mental Health Service Users (MHSU). Teamwork should be based on the first principle that: "We are all mental health practitioners", and from thereon specialists in terms of respective disciplines. It is therefore important that all professional disciplines in the mental health setting have a shared set of core knowledge, values and skills. It is, for example, equally important that the social worker in the mental health field understands the various diagnostic categories; differential diagnoses; the politics of the use of the Diagnostic and Statistical Manual; the implications of diagnostic labels for intervention; psycho-pharmacological treatment, their side-effects and what antidotes might be used in the management of side-effects, as it is for the psychiatrist to undertake holistic family assessments, obtain collateral data and engage in family therapy.

When I first began my training in mental health, fresh out of university, I was simply astounded by the consultant psychiatrist who, during ward rounds, would ask me: "So Vishanthie what treatment would you prescribe for this person?" I would look at him, thinking: "You must be crazy, I am a social worker, I am not expected to know that!" But he was serious. In consultations and during one-on-one supervision, I learnt about the

importance of being a sound generalist in a specialised setting. My initial skepticism was challenged when I conducted family education workshops, and when I went on home-visits alone and had to deal with anxious service users and their families, as psychotropic medication often produces very uncomfortable side effects. The consultant's insistence that I know, and my willingness to learn meant that I could speak to the issues with some degree of confidence, know what was within the boundaries of acceptable; inform about antidotes and make more considered decisions about follow up with the psychiatrist. It is yet critical that each team member is reflective enough to appreciate the limits of her/his knowledge. The more one knows the easier this becomes; in knowing we better appreciate what we do not know. We must be guided by the truism: "A little knowledge is dangerous!" We earn our stripes! It is important that the different members of the team know their work, and live the ethical commitment to working with people within a framework of strength, care and compassion.

The power of visionary leadership: The psychiatrist that I worked with in a public health facility was a visionary and altruistic leader. Apart from the vision that we were all first and foremost mental health practitioners, there was the core requisite that we all respect the contribution of each team member. It was a manifestation of non-hierarchical, egalitarian inter-disciplinary theory in action, which is often mere rhetoric. A case conference, for example, would be deemed to be incomplete without the input of the social worker, psychiatric nurse, psychiatrist, occupational therapist and the psychologist, and a discharge would not happen without consultation and consensus. The vision was of a complete and total milieu approach, including opportunities for people of different faiths to hold prayer meetings and services, and an isolation room—beautifully painted with calming music streamed for the distressed person who needed to be isolated from others. From a psychodynamic perspective, it was understanding the power of the therapeutic alliance as providing a holding environment for people in the greatest of distress; those with: debilitating psychoses; post-traumatic stress; suicide, depression and anxiety; organic mental disorders; personality difficulties and transitional life problems. We do not manage a diagnosis; we engage with a person with an illness, so the language ought not to be for example: "a schizophrenic patient" but a "person with schizophrenia". While being mindful about the implications of diagnoses for intervention, the guiding rule was that we work with people beyond the conventional meanings attached to their diagnoses and popularly pre-conceived notions of prognoses, like not investing in someone diagnosed with a personality disorder as the prognosis is deemed to be poor. The joy of witnessing someone with anti-social personality or borderline traits begin to reflect insights and more empathic understanding borne out of a purposeful, caring, sustaining relationship and skilled therapeutic intervention designed to challenge the negative and/or ambivalent constructions of self and the other! Apart from those with acute psychoses, the MHSU dressed in muftis, eat in a dining hall, and the ward was a mixed gender one. Indeed, it was often difficult to tell the difference between the MHSU and staff! There is a taken-for-granted assumption that "nobody is indispensable", which I simply cannot accept as truth. While someone else might easily fill positions and posts,

the dynamic aspect of role functioning, particularly for visionary and altruistic leaders, cannot be replaced. The entire culture and ethos of systems change when such leaders are replaced.

The power of reflexivity: Reflexivity is multi-dimensional. It means developing critical consciousness about how the embodied self plays itself out in the world of practice, and the relationship between the personal and the professional dimensions of our lives; understanding the legal, moral and ethical boundaries of practice with regards to MHSU and the team that we work with; and at the very least it means that we consistently reflect on: "What am I doing? Why am I doing it? Is it in the best interests of the people who I am engaging with (the MHSU)?" Social workers, in mental health, often deal with complex and competing issues with regard to autonomy, self determination and civil liberty vis-à-vis social control, in circumstances where people might have to be certified and hospitalised against their will, if they are in distress and a threat to themselves and/or to others. In doing so, the social worker must be committed to ensuring a least restrictive permissible alternative, and bring to the practice context all of social work's values and commitment to humanising encounters and care. The ability to truly be for the *Other*, sometimes means being for them even against their will insofar, and only insofar, as it is in their interests. On the other end of involuntary containment, is de-institutionalisation policies and practices, linked to the neoliberal agendas of privatisation and cost cutting where the responsibilities of the state are transferred onto families, particularly onto women, who are already in poor and vulnerable positions. The upshot of this is that those in need of mental health services are left without care, treatment and protection to fend for themselves. One witnesses on the streets of Los Angeles, in the USA—one of the richest countries in the world—the consequences of the all too ill-conceived de-institutionalisation policies. Clearly psychotic individuals in public spaces—on the streets, in trams, buses and restaurants, that sends a clear message: *nobody cares!* The personal, as radical feminists have claimed, is political!

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Dr. STEVEN ONKEN Ph.D. has been described as a recovery scholar and practitioner. He would disagree, describing himself as a recovery guide. One can learn from many sources and he is only one such source. Dr. Onken's research focuses on innovative ways to capture an emerging evidence base for peer-to-peer, indigenous and cultural approaches to mental health wellbeing and recovery. In practice, Dr. Onken has helped champion better understanding of, and addressing of, the complicated, interrelated physical, psychological, social and moral impact of trauma in the lives of children, youth, adults and families with complex needs, especially behavioural health and criminal justice. Dr. Onken's scholarship includes sustainable development of self-help and peer support services, trauma informed care system development, adaptations of mental health evidence-based practices, and fostering social networks and supports. Dr. Onken's American collaborations include Arizona, California, Colorado, Guam, Hawai'i, Iowa, Michigan, New York, Oklahoma, Rhode Island, South Carolina, Texas, Utah and Washington and his international collaborations include New Zealand, Switzerland, Canada (French and English provinces), Australia, Scotland, England and Colombia.

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Dr. SUBHASIS BHADRA, M.Phil., Ph.D. in Psychiatric Social Work (NIMHANS, Bangalore), working as Assistant Professor and Head in Department of Social Work, Gautam Buddha University, and started his career from intervention in Gujarat earthquake (2001) and subsequently worked in riots (Gujarat, 2002), Tsunami (2004), Kashmir earthquake and unrest (2005), terrorist attack (Mumbai serial Train Blast, 2006), cyclone Nargis (Myanmar, 2008), Tsunami in Japan (2011), Himalayan Tsunami (Uttarakhand disaster, 2013) through different organisations, like Care India, American Red Cross, International Federation of Red Cross, Oxfam India, Action Aid, International Medical Corps. He supported psychosocial work in a few Asian countries, through training and material development. His research interest includes peace building, life skills education, social work interventions in community, disaster mental health and psychosocial support, and community and school mental health. Dr. Bhadra is actively engaged in various disaster response programmes and delivers guest lectures on disaster management issues in NIDM (National Institute of Disaster Management), New Delhi. In his credit, there are a few academic articles and book chapters published in nationally and internationally reputed publications.

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Dr. TIRELOMODIE-MOROKA is a Senior Lecturer at the University of Botswana, Department of Social Work. She was also a visiting instructor at the Institute of Health Sciences, where she taught theories of health behaviour and behavioural change for 10 years (2003-2013). She is a public health social worker who is broadly-trained in the behavioural and social sciences, and uses this breadth to investigate various dimensions of health behaviour relative to broader social patterns. As team leader of the church-based group, and the Co-Director of the Social and Behavioural Core, she was part of the Capacity Building for HIV Prevention Project between the University of Botswana and

University of Pennsylvania, USA through an NIH grant-Grant Number R24-HD056693 which ended in July 2012. In 2007, she was a recipient of the Social Science Research Council Fellowships Award for HIV/AIDS and Public Health Policy Research in Africa. She has since used results from this fellowship to design intervention training manuals for female sex workers and salon workers and beauticians in Botswana.

Dr. TORMUSA DANIEL ORNGU, Teaches Sociology and Social Work in the Department of Sociology/Social Work in Federal University Lafia, Nasarawa State - Nigeria. He also taught Sociology at Kwararafa University Wukari until 2012 and Social Work at the Benue State University, Makurdi from 2007–2009. He attended University of Jos and Benue State University, Makurdi where he obtained a Diploma in Social Work, B.Sc. Sociology and M. Sc. Sociology. He is currently a Ph.D. candidate at the Benue State University, Makurdi. He is a member of the Nigerian Social Work Educators and Nigerian Association of Social Workers.

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Dr. USHA GEORGE is Dean at the Faculty of Community Services, Ryerson University since 2006. Prior to taking up her current position as Dean of the Faculty of Community Services, Dr. George was Associate Dean at the Faculty of Social Work, University of Toronto, where she was the Royal Bank Chair in Applied Social Work Research and was a Director of the Joint Centre of Excellence for Research on Immigration and Settlement (CERIS). The focus of Dr. George's scholarship is on immigrant settlement, adaptation and integration, diversity and social inclusion and organisation and delivery of settlement and other services for newcomer groups. Dr. George is the author of numerous peer reviewed publications arising out of the studies. Many of these studies have focused on diverse ethnic immigrant groups such as South Asians, Africans, Yugoslavians and Afghan refugees, Mexican immigrants and the Mandarin speaking community. Her book "Immigration and Settlement in Canada" is a recommended reading in Universities across Canada. She has taught numerous graduate courses on immigrant issues and has served on thesis committees at the Masters and Ph.D. levels. She has also presented the findings at national and international conferences and is frequently interviewed by the media and invited to present her research findings at various forums.

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Prof. VISHANTHIE SEWPAUL is a Senior Professor at the University Kwa Zulu Natal (UKZN). She has been actively involved in several national structures on the cutting edge of policy and standards development in social work in post-apartheid South Africa, and in developing social work in Africa. She is currently part of a national taskforce re-writing standards for social work education and training in South Africa. She is the President of the Association of Schools of Social Work in Africa (ASSWA). Vishanthie is former President of the Association of South African Social Work

Education Institutions [ASASWEI]. She is a Vice-President on the IASSW Board. She served as the Co-chair of the Global Standards Joint IASSW/IFSW Committee for Social Work Education and Training and is currently the Co-chair of the Global Social Work Definition Taskforce. She was twice voted one of top thirty researchers at UKZN, and was selected, by the Ministry of Science and Technology, as the 2013 Runner-Up for the Distinguished Women in Science Award (Humanities and Social Sciences) for "her outstanding contribution to building South Africa's scientific and research knowledge base". Throughout her teaching career she has maintained active practice links in several areas. An HIV/AIDS project that she ran was regarded as one of the best practice models that was filmed and screened on national TV (e-TV). Working in close collaboration with students, a community-based, participatory project with children and youth living on the streets of Durban, culminated in the production of a movie based on the narratives of the youth (with the youth as actors) used for schools based intervention in an attempt to prevent children from migrating to the streets. It is the latter schools-based intervention that she is currently engaged in.

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