

# **‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work**

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## **Abstract**

This paper offers a critical insight into the dominant discourses of involuntary mental health treatment, and the current Australian political context, from a critical social work and post-structural lens. In doing so, it aims to explore the tensions, complexities, and challenges in practice, demonstrating the unique role of social work, and the opportunities for applying the professional values to progress transformative change in mental health policy and practice. As social work is a discipline that is innately bounding to working within structures and systems, there must be critical engagement with the role of social work as ‘helpers and controllers’ (International Federation of Social Workers & International Association of Schools of Social Work, 2004). Through exploring initiatives around the globe where progress is being made with successful outcomes, this paper reinforces the salient role the profession plays in engaging a transformative shift to a world without involuntary treatment.

## **Key Terms**

Critical social work, involuntary, mental health

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.

## **Introduction**

Globally, the phenomena of increasing mental health diagnoses prevail, and the United Nations (UN) and World Health Organization (WHO) are calling on transformative human rights action, recognising the need for a social understanding of mental distress (UN, 2007; UN, 2017; WHO, 2021; WHO, 2022). Involuntary mental health treatment encompasses the compulsory assessment or treatment of people in mental health services, which is a restrictive practice, and is regulated by state legislation (Australian Institute of Health and Welfare [AIHW], 2023). This includes treatment given in hospitals, such as involuntary hospitalisations; in residential care; or through community based mental health services. Social work practice in mental health in Australia is largely based on the discursively constructed and assumed validity of involuntary treatment, with social workers seeking to improve practice and minimise iatrogenic harm within these frameworks, rather than question their validity or advocate for a world without involuntary treatment (Maylea, 2016; Maylea, 2017; Courtney & Moulding, 2014). Social work has an extensive history of taking a pragmatic approach to mental health treatment, complying with dominant biomedical and neoliberal discourses, with little critical interrogation to the discursive constructions of power, risk, and recovery which flourish in the current mental health system. The social work profession, informed by critical social work theories, does hold potential to challenge these dominant discourses shaping policy and practice, and engage systems in transformative change (Whitaker et al., 2021; Healy, 2014; Renouf, 2020).

## **Theoretical framework**

This paper is grounded in critical social work theories, particularly critical mental health, and critical feminist theories, in addition to Foucault inspired post-structuralism. Critical social work in its broadest sense is concerned with the analysis and transformation of power relations at every level of social work practice, and understanding the structural conditions that perpetuate social issues (Healy, 2014). All critical social work theories share a commitment to the transformation of systems and structures perpetuating inequalities, marginalisation, and discrimination. This transformation is progressed by a commitment to solidarity with

Baldwin: 'Not a crisis of chemical imbalance, a crisis of power imbalance': Involuntary Mental Health Treatment and Critical Social Work.

marginalised and oppressed individuals and communities; an acknowledgement of power imbalances within society and practice settings; and recognition of the influential role of social, economic, and political systems in shaping human experience (Healy, 2014; Renouf, 2020).

Post-structuralism is a transformative paradigm that disconnects us from traditional notions of the real and the shared moral agenda, and in doing so, challenges the structures and knowledges that shapes societal norms, such as the traditional dichotomies concerned with mental health - sane/insane (Whitaker et al., 2021; Simmons, 2020). As Müller (2021) explains, discourse constructs meaning, which constructs what matters, and what matters becomes the shared moral agenda. Post-structuralism is concerned with disrupting the shared moral agenda and elucidating the acceptance of taken-for-granted truths (Simmons, 2020). Thus, post-structuralism problematises constructions of mental health, including within both policy and practice, and is relevant and important for social work practice because of its criticality (Prowell, 2019).

### **The ‘destructive alliance’ of the dominant biomedical and neoliberal discourses**

Discourse both shapes and reflects social work practice, thus an understanding of the dominant discourses within an involuntary mental health context is critical to analysing, resisting, and improving practice and advocating for transformative change (Healy, 2022; Bacchi & Goodwin, 2016; Prowell, 2019). Historically, the biomedical discourse has been one of the most powerful and influential in shaping practice, despite unequivocal evidence of the failures of the current systems that rely on this model (Whitaker et al., 2021; United Nations, 2017). The increasing rates of mental health diagnosis is reflective of the Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> ed.; DSM-5; American Psychiatric Association, 2013) being used to describe experiences and behaviours that are part of the human experience (Tseris, 2019). This is a westernised and hegemonic conceptualisation of mental health which silences other worldviews, such as First Nations worldviews and voices in this space. Although there is not one unifying perspective within a First Nations worldview, mental health is generally

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.

holistically conceptualised as social and emotional wellbeing (Toombs et al, 2020; Ypinazar et al., 2007). However, this perspective, aligned with the values and conceptualisation of mental health from a social work lens, is silenced by the dominant biomedical model. Social workers often experience tensions between the professional values of the profession, such as social justice, human rights, and dignity, and the overreliance of biomedical discourse (Australian Association of Social Workers [AASW], 2020). A key concern and tension for social work, in a setting dominated by the biomedical model, is the reductionist potential of the discourse, which conflicts and contradicts the holistic and systemic approach central to, and advocated for within social work practice (Healy, 2022).

The pervasiveness of biomedical and psychiatric discourse is more comprehensively understood when considering the mutually beneficial relationship between this model and contemporary neoliberal globalisation (Cohen, 2016; Tseris, 2019). The solutions suggested by the biomedical model, such as medication and therapy to *treat* individuals reflect neoliberal ideals of individual responsibility, stability, sociability, and productivity (Tseris, 2019). Beresford (2016, p. 343) refers to the converging of power imbalances that are produced and reinforced by biomedical and neoliberal discourses as a ‘destructive alliance’ that functions to minimise recognition of the social, political, cultural, and economic context and the links to distress as a result of experiences like poverty, violence, discrimination, and marginalisation. This discursive construction creates a restrictive environment which demands conformity and compliance to hegemonic notions, which poses challenges for critical social workers advocating for a transformative shift in practice (Stepney, 2006; Brown, 2021). The dominance of these discourses which shape policy and practice has created ubiquitous tensions for social work practice in striving to apply the professional values and ethics of the profession (Maylea, 2017; Tseris, 2023). Notions of recovery, risk, and power flourish in the current climate to justify involuntary treatment, as these notions fit neatly within the notions of mental health discursively constructed by the dominant biomedical and neoliberal discourse.

Dainius Pūras, the former United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Pūras) elucidated

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.

that progress in transforming mental health is being significantly hindered by the major power imbalances in the system, and the major obstacle being the dominance of the biomedical model (UN, 2017). Pūras noted that despite explicit evidence of the failure of systems where the biomedical model dominates, it continues to prevail, making clear the failure to listen or value the voices of lived experience (UN, 2017). Evident here is the need for radical advocacy and a critical social work perspective which challenges dominant hegemonic and westernised assumptions of what mental illness is, in order to problematise the mental health system and the knowledge base shaping practice (Cohen, 2016; Tseris, 2019). From a critical social work perspective, mental health is viewed from a lens which centres the notions of power and oppression and seeks to understand and elucidate how structural conditions continue to perpetuate social injustices within the scope of the socio-political context.

Psychosocial distress has been and will continue to be part of the human experience, particularly in the face of growing emergencies, social inequalities, and discrimination (UN, 2017). Evidently, conceptualisations of mental health do not exist in a social vacuum (Tseris, 2019). Radical change requires the problematisation of these pervasive discourses, in order to bring greater awareness to social models, encompassing the social determinants of health. By drawing on strategies of critical consciousness and collection action, critical social work advocates against social injustice and for transformation in this space (Healy, 2014).

## **Mental health policy and practice in Australia**

Current mental health policy in Australia is framed within the strategy document, ‘National Mental Health Policy 2008’, and subsequent documents to prevent suicides, and support Australians following the COVID-19 pandemic (Department of Health and Aged Care, n.d.). Each state and territory hold its own legislation, informed by this national strategy. In New South Wales (NSW) the ‘Mental Health Act 2007’ stipulates the conditions for any mental health care, including involuntary treatment. This legislation is centred on the ‘least restrictive care’ for the necessary ‘care, treatment and control’ of service-users (New South Wales Government, 2007, p. 12).

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.

A strong driver which evidently underpins current Australian policies, grounded in biomedical and neoliberal ideals, is the reduction of risk and emphasis on recovery and the responsibility of self, at the expense of attention to the wider environment and social issues. Apparent is the drive to reducing or ‘solving’ mental illness, by increasing access to services or enhancing interventions, rather than acknowledging that psychosocial distress is part of the human experience and is attributable to experiences of social inequalities like poverty, violence, marginalisation, or discrimination. This enables a reactive, risk-averse, resource limited practice context which functions to maintain restrictive practice and involuntary treatment (Karban, 2017). Critical social work fundamentally rejects this justification of involuntary and coercive treatment based on risk (Maylea, 2017). Despite this, social workers in these contexts are bureaucratically governed to manage or minimise risk, which is disempowering and does not align with the values of the profession.

The United Nations (2007) Convention on the Rights of Persons with Disabilities (the Convention) prompted amendments of all Australian states and territories mental health legislation (Maylea, 2016). The Convention explicitly rejects involuntary treatment as it denies people their basic human rights and violates the integrity of individuals. Despite this, involuntary mental health treatment continues to prevail at high rates (AIHW, 2023). Involuntary treatment and strategies to reduce this is not explicitly addressed in Australian policy, despite Australia having the second highest rate of involuntary hospitalisations in a study of 22 countries (Rains et al., 2019). Importantly, there are also high rates of involuntary community treatment in Australia (AIHW, 2023). Globally, involuntary treatment practices are an area of focus for improvement (WHO, 2021; WHO, 2022; UN, 2007; UN, 2017; Patel et al., 2018).

The concept of recovery is also a salient feature of the Australian mental health landscape, with policy initiatives attempting to introduce recovery principles. This is evident in the National Framework for Recovery-Oriented Mental Health Services document (Commonwealth of Australia, 2013), and in the NSW Mental Health Act 2007, which states that people should be ‘supported to pursue their own recovery’ (s. 68). From a critical social work perspective,

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.

recovery is grounded in a social model and an individual's place in society, and empowerment, control, connectedness, and positive identities are critical in this perspective of recovery (Maylea, 2017; Renouf, 2020). Recovery-oriented practice, grounded in a human rights-based paradigm emphasises the importance of self-determination, empowerment, and dignity of risk (Callaghan & Ryan, 2014). However, notions of recovery are also co-opted by neoliberal logics and biomedical discourse, which sustain individualising, decontextualization, and centre on treatment. Courtney and Moulding (2014) have recognised that involuntary treatment, involving coercion, and notions of recovery are paradoxical. As such, the notion of recovery is rejected by some survivor-led critical theorists and activists due to its 'one-size-fits-all-approach' which minimises attention to the diversity of mental distress (Rose, 2018). The pervasiveness of risk aversion and management in mental health policy and systems, also as a result of the dominant biomedical and neoliberal models, minimises the attention to the social model of recovery (Maylea, 2017).

Injustice is explicitly evident and pervasive in the current Australian policy and practice context, particularly in relation to involuntary mental health treatment (Whitaker et al., 2021). Iatrogenic harm prevails in involuntary treatment, and this is evident through the voices of lived experience, which are silenced by biomedical and neoliberal discourse (Wyder et al., 2018; Light et al., 2014). Major reform, grounded in a human rights approach, and thus aligned with social work values, is being advocated for on a global scale by the United Nations and World Health Organisation. A human rights approach to mental health acknowledges that wellbeing cannot be defined by the absence of mental ill health. Instead, the UN (2007; 2017) calls for structural and procedural changes that recognises that the social, political, economic, and physical environments which enable individuals and communities to fully exercise and enjoy their rights and equitable pursuit of their potential.

Baldwin: 'Not a crisis of chemical imbalance, a crisis of power imbalance': Involuntary Mental Health Treatment and Critical Social Work.

## **Drawing on critical social work theories in practice: a ‘twin-track’ approach**

Critical social work theories emphasise that social work should seek to address injustice at every level of their practice, from direct engagement with people with lived experience through to work aimed at challenging the inequitable distribution of resources. Simpkin (1979, p. 40) describes this as ‘working against the system while working within it’. Social workers are often engaging directly on an individual level. Critical social work theories recognise that whilst micro level interventions in isolation will not bring an end to involuntary treatment, it is still a vital part of the process (Maylea, 2017; Healy, 2014; Renouf, 2020). Critical social workers are aware of the unequal power relations that exist and practice to counteract that by drawing on a social model to achieve genuine and therapeutic partnerships with service users by including people in their care and treatment decisions and attempting to minimise the restriction on freedom (Brown, 2021; Maylea, 2016). Supporting individuals to normalise their distress in the context of their social context and experiences functions to increase self-compassion, reduce stigma and allow for a more holistic understanding of mental illness. By articulating the intersections between social injustices and mental health, social workers are helping service-users to understand the connection themselves, which can be empowering, validating, and have positive outcomes (Tseris, 2023). Further to this, supporting the dignity of people can be achieved by hearing their perspectives and creating opportunities for lived knowledge to be heard in team discussions and beyond, offering transparency with people about decisions, and facilitating people to have some control with their care (Kendall, 2014). Resistance in social work practice in this context is essential, and critical reflection is a core skill which encourages reflexive practice, enabling practitioners to recognise the ways their practice reflects power dynamics (Renouf, 2020). From this perspective, critical social work contributes to reducing the experiences of coercion, marginalisation and iatrogenic harm associated with involuntary treatment, alongside challenging social and structural issues, such as poverty, disadvantage, and discrimination. It is important to recognise that critical social work requires significant commitment, as it involves working against, or resisting bureaucratic requirements, which is

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.



challenging to sustain with competing demands. However, so interconnected is the relationship between social inequality and mental health, that any and every action that reduces inequality is positive and has cumulative effectiveness (Renouf, 2020).

Whilst working *within* the system on an individual level, the role of the social work profession must also maintain a focus on critiquing the broader structures and challenging the complex operations of power and risk. Social work can be described as working with the dynamic between the micro and macro level of practice, what Tew et al. (2012, p. 456) describes as a ‘twin-track’ approach. This is also described by Simpkin (1979, p. 40) as facing ‘both ways’, an approach that involves not only direct work with individuals, but also developmental work with communities and systems. This draws attention to the unique position and role of social work in both face-to-face relationships with individuals and in taking action in society to challenge inequalities (Karban, 2017). Disruptive approaches to systems change are the emerging solutions for disrupting deeply embedded structural inequalities in order to create more equitable, sustainable, and thriving societies, where there is no ground for involuntary treatment (MacDougall, 2022a). Evident here is the need for problematising and challenging the biomedical model, and the need for more holistic and integrative approaches to mental health services that contest stigma, build partnerships, and restore power to vulnerable individuals and communities (Whitaker et al., 2021).

At the community and organisation level, there are countless opportunities for implementing alternatives to involuntary treatment. Maylea (2016) draws attention to the numerous alternate models of mental health services that have been developed through co-production between professionals and citizens. Services created and delivered through collaboration with people with lived experience and professional knowledge has been studied and elucidated positive outcomes, including feelings of empowerment, social inclusion, wellbeing, housing and employment, and hope, more so than individuals who received treatment from traditional mainstream services (Maylea, 2016). Survivor led practices centred on the sharing of power between professionals and citizens, aligning with critical social work theories and the interrogation of professional power. Community reorganisation holds great cumulative

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.

potential for better supporting people with mental health and is an achievable model in which social workers can advocate for and progress. As made evident, social work, informed by critical social work theories, holds significant potential for transformation in this space, and a creating a different future for the provision of mental health services.

### **The future for mental health services: engaging critical social work theories to imagine a world without involuntary treatment**

The dominance of the biomedical model functions to minimise a social work voice and attention to the social model, however, the social work profession holds a great deal of power, which can be drawn on to advance a transformative paradigm in mental health. As explored, attention to the dominant discourses and knowledges shaping the policy and practice context is essential, and a post-structural and critical social work lens gives insight into the silences and implicit presuppositions and assumptions within these discourses (Bacchi & Goodwin, 2016). Radical change on the macro level requires the problematisation of the dominant discourses which shape and reflect the policy and practice context. As made evident, this is the biomedical discourse which flourishes in a neoliberal setting. These discourses also stigmatise mental illness, discursively constructing it as a disease, which ‘others’ people with mental ill health, shaping society’s perception of mental health.

Alternatives to involuntary treatment in mental health require a fundamental shift in the way society perceives mental illness. By problematising and challenging these dominant discourses, social work can draw attention to and enhance recognition of the psychosocial stressors, perpetuated by structural issues which create distressing experiences such as poverty, marginalisation, and discrimination, which play a major role in contributing to mental ill health and distress. There are creative initiatives being implemented around the world, which give light to the plethora of possibilities for transformative change and imaging a world without involuntary mental health treatment. These initiatives seek to target mainstream services and challenge the ingrained, taken-for-granted ways of doing and thinking, in order to centre social justice and prioritise the progression of social change (MacDougall et al., 2022b). In doing so,

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.

they also prove that properly resourced voluntary services can create better outcomes, thus rejecting the current discursively constructed justifications of involuntary treatment (Maylea, 2016).

Goodling's (2021) 'Compendium Report: Good Practices in the Council of Europe to Promote Voluntary Measures in Mental Health Services' (Compendium) describes initiatives undertaken, both directly and indirectly, to reduce, prevent, and progress towards elimination of coercive practices in mental health settings. Of particular relevance to critical social work and to this paper, were the 'hybrid' approaches in policy and programming. This refers to practices that don't fit within the binaries of 'hospital' or 'community', but combined efforts in both contexts to ensure better resourcing of communities to transform mental health services (Goodling, 2021). The Compendium reviewed 'hybrid' approaches in Czech Republic, France, Sweden, The Netherlands, and Italy, where there has been investment in alternative practices and an explicit commitment to reduce coercion and involuntary, which have been proven to be effective (Goodling, 2021). As a result of the numerous alternative practices reviewed in the Compendium, Goodling (2021) identified three key factors for success. The first of which being unambiguously seeking to reduce and prevent coercion. This relates back to the micro-level change social workers can create on an individual level, seeking to maximise the choice and control an individual has in their treatment, and advocating for their voice to be heard and valued (Brown, 2021; Kendall, 2014; Tseris, 2023; Renouf, 2020). This connects to the second factor for success, top-down and local-level leadership.

As discussed, the actions of the social work profession have the potential to contribute to or disrupt power imbalances. However, the social model that grounds social work practice can be minimised in a biomedical dominant model. Despite this, social workers still sit closer to the top of the hierarchy of treatment than the individual subject to treatment. By explicitly advocating for the individual's right to autonomy, choice and control, social workers can partake in creating and maintain cultural change within a multi-disciplinary team and a service system as a whole (Brown, 2021). Finally, service user, survivor, peer leadership and involvement are indicated as the third factor of success. As identified earlier, social workers

Baldwin: 'Not a crisis of chemical imbalance, a crisis of power imbalance': Involuntary Mental Health Treatment and Critical Social Work.

are heavily involved in change at the community and organisation level, and alternate models of co-production have been proven to be effective and aligned with the values of social work. Community reorganisation is an achievable and reachable model that social workers can advocate for (Maylea, 2016).

From a macro-level policy perspective, the Compendium identified that the reduction and elimination of involuntary and coercive treatment can be advanced at three interconnecting levels. This included national oversight, such as policies aimed explicitly at addressing involuntary treatment; organisational culture change, aiming to move services towards rights-based treatment; and independent, systemic advocacy, where the promotion of voluntary and coercion-free support is advocated for by the public, politicians, policymakers, and service providers (Goodling, 2021). As referenced earlier, this reinforces and validates the critical role of social work, and the unique position of ‘facing both ways’ (Simpkin, 1979, p. 40). By working within the dynamic of micro and macro level and drawing on the professional values of the social work profession, and critical social work theories, social workers hold the potential to shift to a transformative paradigm in mental health (Tew et al., 2012; Karban, 2017; Whitaker et al., 2021).

Other initiatives, in non-westernised nations are also being taken to improve mental health services. The limitations of individualised, biomedical, and coercive models of mental health treatment have been recognised, particular in low- and middle-income countries where resources are scarce and accessibility to services is limited, in addition to high levels of stigma and discrimination, and the interdependent social determinants of poor health, including poverty, conflict, displacement, and violence (MacDougall et al., 2022b). A recent initiative in Kenya demonstrates the how resources communities and building on strengths has served a ‘disruptive innovation’, that is, a simpler solution with greater access and affordability in comparison to mainstream approaches that function from a top-down, rather than upstream approach (MacDougall et al., 2022b). The CREATE team in Kenya recognised the futility of western driven biomedical models which framed the individual as the problem, instead of poor resourcing and extreme power imbalances. The team address this through a multimodal,

Baldwin: ‘Not a crisis of chemical imbalance, a crisis of power imbalance’: Involuntary Mental Health Treatment and Critical Social Work.

collaborative approach that sought to disrupt this existing model and empower people in the community who were essentially rendered voiceless in mainstream approaches (MacDougall et al., 2022a).

To conclude, whilst there is extensive commitment required and progress to be made, a transformative change in mental health is not disconnected from reality, and social work practice, informed by critical social work theories, plays a salient role in progressing towards a world where involuntary treatment is the absolute exception. A significant paradigm shift has occurred before, in the era of deinstitutionalisation where psychiatric institutions were closed and replaced by models of community mental health treatment (MacKinnon & Coleborne, 2003). The United Nations is calling for an urgent paradigm shift, and the abolishment of involuntary treatment in favour of a social model of disability. A number of examples where this shift is being progressed around the world have been offered, to identify the clear potential for social work, informed by critical theories, in advocating for this change.

Baldwin: 'Not a crisis of chemical imbalance, a crisis of power imbalance': Involuntary Mental Health Treatment and Critical Social Work.

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Baldwin: 'Not a crisis of chemical imbalance, a crisis of power imbalance': Involuntary Mental Health Treatment and Critical Social Work.