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Repositioning Social Work in Mental Health: Challenges and Opportunities for Critical Practice

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Abstract

This paper emerges in response to the recent initiative by the Australian Association of Social Workers (AASW) to mandate the inclusion of specific, clinically based mental health curriculum into qualifying social work programs across Australia. Whilst the authors affirm the importance of an emphasis of mental health in social work education, we further suggest that the professional repositioning of social work in mental health must be informed by critical/postmodern theoretical approaches. 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. The paper concludes by offering an example of critical mental health curriculum.

Background

This paper emerges in response to the recent initiative of the Australian Association of Social Workers (AASW) to mandate the inclusion of specific mental health skills, values and knowledge into qualifying social work programs. The AASW is the national professional body of social work in Australia. In the contemporary context of a globalised society, characterised by disenfranchisement of individuals and groups, growing social and economic hardship for many, and the related impact upon individuals and their mental health (Ferguson, 2008; Fullagar & Gattuso, 2006; Macfarlane, 2009, Rogers & Pilgrim, 2003; Yip, 2006), we affirm the importance of social work curriculum to address mental health issues and concerns. However, we further suggest that social work has a unique and vital role in challenging simplistic, depoliticised and individualising constructions of mental health and illness, and in advancing contextualised and

holistic understandings of people's experiences. In our view to achieve this, curriculum development for social work in the context of mental health, must be informed by critical perspectives which emphasise an analysis of power relations, structural inequality, and progressive social change ideals (see for example, Allan et al., 2009; Coppock & Dunn, 2010; Dewees & Lex, 2008; Ferguson, 2008; Fook, 2002; Hick, Fook & Pozutto, 2005; Mullaly, 2006).

The development of the AASW mental health curriculum emerges in the context of a number of sweeping changes that are occurring within social work in Australia. These changes are also driven to some extent by the AASW, who explicitly identify the goal of improving the financial performance and governance of the professional body as a company (Lonne, 2008b, p. 1). Some of these contextual changes include: an increasing emphasis on a particular form of the professionalisation of social work; social workers becoming more business-like (Lonne, 2008b); and raising the "professional" profile of social work through "strategic initiatives" such as the establishment of a National Registration Committee, whose purpose is to convince government that social workers should be registered to practice in Australia (Lonne, 2008a, p. 1). Other changes include the rapid introduction of Masters qualifying social work programs around Australia, and four new areas of mandatory curriculum that are required to be implemented into all Australian qualifying social work courses. Whilst the mental health curriculum and its implications for social work will be the focus in this paper, as this is the first of the four categories to be implemented, other targeted areas of curriculum development focus upon child protection, working with Indigenous peoples, and cross-cultural work. It is contended that these areas of curriculum development translate "into clear statements of required knowledge, skills, and attitudes for students to demonstrate" (Lonne, 2008a, p. 2). However, in practice, these "narrow specializations" may result in the "compartmentalization of social work", which uncritically responds to market demands and moves away from the historical mission of critical social work (Wehbi & Turcotte, 2007, p. 4).

The mental health educational directive has been derived from the establishment of a National Mental Health Committee by the AASW which oversees the maintenance of the Mental Health Practice Standards. Increases in Australian social workers becoming members of the professional body are believed to be linked to the incentive offered to practitioners by the AASW to qualify them as 'mental health' accredited practitioners. These member practitioners are subsequently eligible for accessing a Medicare¹ rebate for psychologically focused counselling services (Lonne, 2008a). However, the latest Federal budget has indicated that private social work practitioners in Australia will no longer be eligible to claim a Medicare rebate from July 1, 2010. This new development renews questions about the ways in which social work's relevance is marginalised when it becomes professionalised and conservative.

Concerns regarding social workers' abilities to practice effectively in mental health have also been raised in United States and the United Kingdom. Beinecke and Huxley (2009), for example, comment that many practitioners do not have the knowledge or skills necessary to work in mental health settings, "that the required competences are not being taught... and that much work needs to be done to define needed skills and train the teachers and workforce of the future in them" (p. 222). Simpson, Williams, and Segall (2007) suggest that variance in the

¹ Medicare is a Federal government agency that sponsors government funded healthcare in Australia

nature and depth of mental health content across U.S. Master of Social Work courses is cause for concern, and reflects the differing views of academics and practitioners around what ‘essential content’ comprises. In England, the regulatory body for professional social work, the General Social Care Council, has not, to our knowledge, set out detailed mental health curricula content, but has a more generalised mandate that social work students must undertake specific learning and assessment in “human growth, development, mental health and disability” (Department of Health, 2002, p. 3). According to Bland, Renouf, and Tullgren (2009), social work in the U.K. continues to be “unsure of how to address mental health content in social work course curricula” (p. 9) thus, it could be said that Australia is leading the way in the development of specific mental health content for social work students. However, as we explore in this paper, the question then becomes ‘what knowledge, skills and values are actually essential for social work practice in mental health?’

Within this context, this paper raises some fundamental questions about the *purpose* of social work in mental health practice, and considers this issue to be the essence of further debate. Despite the Australian context being used as an example, it is contended that this debate holds broader relevance and currency throughout the Western world. Some of the questions we explore in this paper, and invite an international audience to consider with us include:

- How should social work be (re)positioned in relation to mental health?
 - ‘Is the role of social work simply about responding to industry?’
 - ‘How can we understand and respond to the mental health of women, men, Indigenous communities, older persons, refugees, young people, and so on, *without* privileging a critical/structural agenda?’
- What are the likely consequences for marginalised people of the ways in which social work positions itself in relation to mental health?
- What are the implications of its positioning for social work as a profession?
- Does contemporary practice in mental health require social work to unite with elite and oppressive power relations and structures, such as medical dominance, in order to develop professional recognition?

Firstly, it is important to state that we support the recent moves by our professional body, educators, workers, and community members to open up the topic of social work and mental health and to base this upon principles of the National Mental Health Strategy. This Strategy was adopted in 1992 and reflects a high level of Federal government involvement in the reform of mental health services throughout Australia (Renouf & Bland, 2005). Some of the principles of this Strategy clearly resonate with social work values and approaches, including fostering positive consumer outcomes, encouraging mental health practitioners to learn about and value the lived experience of consumers and carers, valuing the healing potential of relationships between consumers/carers and service providers, privileging of consumer voices, and placing emphasis on consumer participation worker-client partnerships and recovery orientated approaches (Renouf & Bland, 2005).

Similarly, we commend a continued emphasis on human rights and prioritising services according to need. These principles align strongly with the social justice ideals of social work, as does the acknowledgment that mental health service users have a multiplicity of needs including

housing, employment, income security, and other health and welfare issues, rather than reducing these social issues to medical diagnoses, as clinical approach tend to do (Renouf & Bland, 2005).

Competency based education and technicist response

At the same time, however, we are concerned with definitions of social work that construct practice and social work education in terms of technical ‘competencies.’ Certainly social workers need to be ‘competent,’ but what does this actually mean? It is contended that the intention is to “define mental health practice in terms of human encounter rather than as the technical application of skills and knowledge” (Renouf & Bland, 2005, p. 42); however, the lists of mental health competencies developed by our professional body (AASW 2008a, 2008b, 2008c) do in fact constitute a technicist approach to practice, guided by assumptions and values that reflect various, often unstated (and individualist/conservative) theoretical positions (Morley, 2008). The fundamental questions invoked here include: how do we move beyond a mismatch between social work ideals and the limitations of technicist applications? And how might this require both a more holistic approach and critical exploration of underlying assumptions regarding engagement with mental health issues in social work and social work education?

For example, it is not clear what is meant when the AASW education and accreditation standards indicate that social work graduates should be able to “respond appropriately and act accordingly” (AASW, 2008a, p. 2); what is ‘appropriate’ from one theoretical perspective may certainly not be from another. These catch phrases have the potential to be popularist, pragmatist or simply technicist. We need to scrutinise the theoretical frameworks underpinning the assumptions that inform practice, continually interrogating the values that infuse them (Tesh, 1998): an opportunity that is lost in approaches to education which privilege technical learning (Fook, 1995; Morley, 2008; Mullaly, 2002).

Although the simplicity of focusing on a “basic grasp of a psychiatric diagnostic framework” (AASW, 2008b principle 1.4, p. 3), or “the nature of a mental status examination” (AASW, 2008, principle 1.6, p. 4) or an understanding of “contemporary treatment modalities, including the use of psychotropic medication” (AASW, 2008b principle, 1.8, p. 4) may be appealing, there are a number of problems with these content driven approaches to learning about practice, including the artificial separation of practice from theory and context (Fook, 1995; Mullaly, 2002, 2006; Waldegrave, 1990). This approach is problematic even in the most traditional and conservative approaches to social work, and of course highly inappropriate for more critical and progressive approaches to practice which inextricably link the political with the personal, theory with practice, and the moral and ethical dimensions of practice with the purpose of action (Allan, Briskman, and Pease, 2009; Fook, 2002).

How should social work be positioned? A critical response

Another consequence of technicist or competency based approaches to practice that are embedded within the AASW mental health curriculum, is that they may uncritically reproduce dominant ideologies. Since the dominant construction of mental health is informed by the biomedical model, questions are raised about whether social work could be in danger of

becoming complicit with the structures and uncritical power relations that disempower, disenfranchise, and pathologise individual responses to social problems.

Even mainstream mental health policy documents in Australia, such as the VicHealth Mental Health Promotion Framework, are now indicating the necessity to respond to structural factors and social determinants of mental health (Macfarlane, 2009). Despite this, the mental health curriculum propagated by Australia's professional body, appears to have been co-opted into the medical colonisation of social work, and in prioritising a de-contextualised, individualised, clinically-based, pathologising response to mental health.

While the AASW has strongly asserted that it does not intend to write the mental health curriculum, it *does* significantly shape this curriculum; tertiary courses that do not comply risk having their accreditation revoked. This, of course, raises questions about academic independence and the dangers of 'guided academic democracy' in terms of curriculum being developed by professional associations, rather than academic researched, theoretically informed and community debated processes of curriculum development. Clearly, this issue is beyond the scope of this paper, but should be explored and debated elsewhere.

What are the consequences of the shift away from analytic frameworks that critique and challenge structural inequality, to a competency based approach that privileges the illness model and its individual pathology understandings and response to mental health? The centrality of a structural analysis is reflected right across diverse fields of practice. Social workers actively engage in structural analysis of personally experienced problems and are defiantly prepared to take up a position in relation to social justice, equity and human rights issues. Indeed this analysis is perhaps the most defining cornerstone of social work as a professional discipline (Allan et al., 2009; Fook, 2002; Mullaly, 2006).

Quite appropriately, this is reflected in AASW documentation. For example, the AASW education and accreditation standards indicate that the Practice Standards and Code of Ethics should be used to develop "reflective and reflexive practice; structural analysis, critical thinking; and ethical professional behaviour (AASW, 2008c, standard 2.4, p. 6). Another standard indicates that 'Social workers need to be able to critically analyse the structure of society, with particular attention being paid to dimensions of power and disadvantage and the influence of class, gender, age, intellectual and physical ability, sexuality, race, and ethnicity' (AASW, 2008c, standard 4.1.5, p. 11). As this documentation points out: "This understanding requires knowledge of, and the ability to, critically analyse social, political, economic, historical, cultural, and ecological systems" (AASW, 2008c, p. 11).

Despite the profession's espoused commitment to critical practice, which logically extended, assumes a structural analysis of mental health and illness and a critique of dominant social labelling processes, the new, mandatory mental health curriculum appears to capitulate the role of social work, limiting practitioners to a clinical support role for psychiatry. While there may be some capacity to incorporate critical curriculum through the social work assessment and intervention criteria, an implicit assumption remains that as a profession, social work needs to conform to the current medical paradigm in order to achieve professional status and 'survive.' Indeed, this view that has been explicitly articulated by those who believe newly appointed

social work graduates “who define their work from a familiar critique of psychiatry” will “only marginalise their position in the mental health team,” be perceived as less “professional,” and experience painful inter-professional relationships (Renouf & Bland, 2005, p. 424-26). Therefore the choice for social workers is dichotomously constructed as being either “relevant *or* critical” (Renouf & Bland, 2005, p. 426, emphasis added). However, critical postmodern frameworks allow us the conceptual space to transcend this binary thinking in ways that creatively respond to this positioning of critical approaches to social work in mental health as problematic (Fook, 2002; Morley, 2005). Firstly though, it is necessary to revisit the issue of *how* we want social work to be positioned in mental health.

Social work as profession – the technicist medical professional in a field of many?

This raises elementary questions about whether constructions of a professionalism that uncritically embraces the medical model grossly misrepresent what it means to be professional in the context of being a critical social worker. Perhaps responding critically, reflexively and assertively to inter-professional tension, regardless of the discomfort this creates, may be our professional contribution and ethical responsibility - facilitating a more holistic and socially just response from services to people who have been diagnosed with a mental illness. Other disciplines that are based on the medical model do not jettison their approach to practice to make it more acceptable for critical social workers. Therefore, if social work educators privilege medical understandings of causation and treatment in curriculum development, more or less consciously marginalising the relevance of issues related to powerlessness, dispossession, poverty, abuse and violence, low-status work and a range of other social oppressions, then who is going to do this important work?

Why would social work emphasise clinical approaches when other professions seem to have the medical model sufficiently covered? If the role of social work is simply to reproduce other clinical support roles for psychiatry, then we fail to offer our distinctive and critical social work alternative. Not only does this compromise the integrity of our discipline, but just as importantly, our service users receive a far less holistic service response and the social status quo remains unchallenged. In a field cluttered with professional health categories, social workers with their comparatively limited biological and neurological ‘health training’ (which we unequivocally contend should not become our focus) are at risk of simply becoming third rate health workers. This, of course, would be a tragic loss of opportunity and responsibility, particularly when social workers do have a significant and distinctive critical contribution to make, in providing alternate views to the medical paradigm of mental health.

Alignment with the medical model of mental health may appear seductive: ostensibly creating more professional legitimacy for social work and minimising paradigmatic tension with other professionals. It is also politically convenient; in conforming to the individualist and competitive ideologies of neo-liberal capitalism. As with other professionals, social work can become captive of professional inducements such as Medicare. We argue that it is both extremely dangerous and consequential if such professional inducements begin to define our roles and purposes as social workers. For social work, with its social justice roots, the neo-liberal agendas of personal responsibility and victim blaming exacerbate the social problems and individual suffering that we purport to ameliorate. Is social work professionalism simply about

competition and survival within neo-liberal paradigms, or can we maintain our conviction to provide an alternate critical view? It would be worrying indeed, if neo-liberal agendas drew our social work educators, practitioners, and our professional body into a professional discourse of individualism and narrowly prescribed evidence based practice, to the exclusion of other valid forms of knowledge. As social workers, we need to be very wary of setting a default position aligned with what a medicalised, pathology-oriented 'industry' says it wants. Social work should be informed by community need and independently researched need, rather than 'industry defined need.'

Historical attempts by social work to hitch its wagon to models of professionalism uncritically aligned with dominant discourses have had deleterious consequences for social work, and tragically, for the people social workers have claimed to serve. The profession's rhetoric of good intentions and evidence-based objectivity may not, and historically, has not, lead to positive outcomes for service users or the attainment of progressive social change ideals (Macfarlane, 2009).

Quests for "professional respectability" and "a definable body of expert knowledge," have historically resulted in social work's active involvement in the eugenics movements in the early 1900s in which thousands of predominantly poor Americans were subject to sterilisation against their will under the guise of national regeneration (LaPan & Platt, 2005). In Australia, social workers were involved in the carrying out of the Stolen Generations of Aboriginal people by uncritically subscribing to dominant colonialist views. Similar acts of injustice and oppression were suffered by First Nations people in North America and the Maori of Aotearoa/New Zealand, with a host of ramifications that have carried through to the present day (Bull & Alia 2004; McKendrick, 2001).

Similarly, social workers have historically been participatory in constructing domestic violence as a relationship issue rather than an abuse of power, complicit with supporting patriarchal power relations. These misguided attempts to attain professional credibility by complicitly embracing dominant ideology have had disastrous consequences for our human rights and social justice commitments. It is noteworthy that such attempts to increase professional legitimacy have been challenged by more progressive thinkers in the field. For example, Throssell writing in the 1970s, criticised schools of social work for emphasising the pursuit of professional status; he observed a potential paradox for social work "the official dedication to overcoming human misery and yet the failure to do much more than achieve professional advancement" (Throssell, 1975, p. 17). Some thirty years later, Ife and Tessoriero (2006), make the point that community development, and indeed social work, have often operated as euphemisms for continued domination and imposition of dominant mainstream cultural identities.

Will we learn from this instructive history, or will be tempted to repeat the failures of the past, by accepting that the dominant biomedical model of mental health should be used as a basis for informing social work education and practice? Perhaps we need to heed warnings that clinical services have become an elite and professionalised industry that has packaged and commodified personal wellbeing as a product to be consumed (Ife & Tessoriero, 2006). Given that the 'therapeutic state' has often operated to benefit the elite of the helping professionals rather than

the clients it claims to support (Polsky, 1991 cited in Ife & Tesoriero, 2006, p. 245), social work students need to be familiar with the limitations and weaknesses of the medical model of mental health. Despite this, there is a notable lack of critique of this approach within the mental health curriculum practice standards as set out by the AASW (AASW, 2008).

Critical Practice in Mental Health

Social work education (in progressive courses) is informed by critical perspectives and aims to challenge oppression and poverty and arrest structural inequality. Just as contemporary social work aims to be part of the decolonisation of oppressive policies and relationships with Indigenous persons, social work has a similar responsibility to be part of the decolonisation of oppressive practices in mental health. We contend that a critical framework is required for developing mental health curriculum for social work education, and that the 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, 2008).

We contend that in order for social work to responsibly and critically reposition itself as a professional discipline in mental health, its distinctive contribution must be affirmed and celebrated, rather than attempting to gain professional legitimacy by uncritical alignment with the medical model.

In contrast to neo-liberal agendas, we argue that social work should be mission driven (not heteronomous), should empower communities and individuals, focus on prevention and the structural causes of individual problems, decentralise authority, encourage diversity rather than mono-cultural or mono-disciplinary views, and also engage in critical questioning around taken for granted assumptions and path dependency (Osborne & Gaebler, 1992).

Rather than "kowtow"[ing] to the medical dominance, (Stickley, 2006, p. 570) we argue that social workers are charged with the responsibility to voice alternative perspectives even when this departs from dominantly valued notions of professionalism. We agree with Wehbi and Turcotte (2007) who argue that "the political nature of social work education situates social work academics as either agents of the state who perpetuate the status quo, or as agents of transformation who create contexts to question dominant practices" (p. 4)

Repositioning social work in mental health is an opportunity to engage with critical themes in mental health, and to take a unique role. Social work needs to lead the way in constructing critical discourses which represent alternatives to the medical model of mental health. This critical approach is congruent with the clearly articulated and espoused position of many contemporary, cutting edge thinkers within the field of social work (see for example, Allan et al., 2009; Carniol, 2005; Davies & Leonard, 2004; Dominelli, 2002; Ferguson, 2008; Fook, 1993, 2002; Hick et al., 2005; Ife, 2008; Leonard, 1997; Mullaly, 2006; Rossiter, 1996).

It may be true that social work is 'less well prepared to meet specific standards' within the National Mental Health strategy such as 'mental problems and mental disorders' (Renouf & Bland, 2005, p. 423); however, we would argue that a critical analysis does provide specific and much needed theoretical and practical insights in terms of a knowledge, skills, and values base

for mental health. As Macfarlane (2009) points out, critical perspectives ask us to consider how structural oppression such as racism, patriarchy, or poverty may foster the anxiety or depression experienced by increasing numbers of people, or how our contemporary society of mass-consumerism and technological development contributes to alienation and despair. Similarly, critical perspectives highlight that “factors such as oppression, injustice, social exclusion, or abuse at the hands of powerful others may be implicated in the sequences of events that lead up to many people’s experiences of mental or emotional breakdown” (Tew, 2005, p. 71). The fact that patterns of mental health and illness are distributed along the lines of social disadvantage (Macfarlane, 2009; Morley, 2003), including: gender oppression (Bainbridge, 1999; Kravetz, 1986; Matthews, 1984; McLellan, 1995; Williams, 2005); racial discrimination (Brown, 2003, 2008; Mossakowski, 2003); poverty and unemployment (Morrow, Verins, & Willis, 2002; Rogers & Pilgrim, 2003); and the experience of being sexually assaulted (Astbury, 1996; Coker et al., 2002; Helfrich, Fujiura, & Rutkowski-Smitta, 2008; Morley, 2003, 2005; Rummery, 1996), for example, is incontrovertible (Morley, 2003; Rogers & Pilgrim, 2003;).

Critical approaches are vital in linking the social realm with personal experience, and in highlighting how the labelling consistent with psychiatric diagnosis masks social injustices and sources of oppression. Critical social work has much to offer to mental health practice in “challenging and reversing the personal effects of oppression and eliminating self-blame to promote self esteem, personal autonomy and power, rather than participating in, and reproducing social inequality” (Morley, 2003, p. 79) by translating the impact of social injustices into a medical label.

Whilst “madness and distress are real” and the mental ill-health and the suffering it creates do exist (Rogers & Pilgrim, 2003, p. 16), the medical model categorisations and responses to mental illness constitute just one perspective among a plethora of ways to understand human experience (Glasby & Beresford, 2006). Renouf and Bland (2005, *italics in original*) contend that “there has been no well articulated identification of the *distinctive* social work contribution within modern mental health services” (p. 421). We agree, and further posit that the AASW’s curriculum development around mental health social work further distances social work from this goal. Given that dominant contemporary models focus on the maintenance of an inequitable status quo through symptom control, and social work has emancipatory commitments to transformative social change, social justice, and personal liberation, the medical model would seem a problematic alliance for social work. While the addition of knowledge and skills in mental health for social workers may have some benefit, in its current form, the AASW education and accreditation standards for mental health, underscores potentially fundamental changes in the direction of social work education, the role of the AASW in directing academic endeavour, and the repositioning of social work as a third rate health profession. We encourage social work educators, practitioners, and students to engage critically with clinical/medical approaches to social work practice in mental health, and to resist being coopted by global, neo-liberal, and technocratic trends, such as discourses that construct professionalism in narrow and elitist terms, and construct medical dominance and evidence based practice as the ultimate in social work practice and education. Instead, we contend social work should celebrate and promote more contextualised, holistic, and critical understandings of mental health and opportunities for critical practice.

To conclude this paper, we would like to give a very brief example of one attempt to incorporate the AASW's mandated mental health curriculum into a first year social work unit in a progressive, critically-informed Bachelor of Social Work degree. The unit was developed by one of the authors (Selma), not only to incorporate mental health material, but also to provide students with greater understanding of methods of social work practice and fields or contexts of social work practice. The unit begins by drawing students' attention to some of the tensions inherent in attempting to understand and respond to mental ill-health as a social worker. Some of these tensions include learning enough about dominant medical models to be able to work within settings employing those approaches, while teaching and learning about their limitations; acknowledging challenges in working from a critical perspective while encouraging critical approaches as the core business of social work; identifying specific social groups as vulnerable while not casting these groups as deficient; and engaging with issues and concepts in a scholarly academic fashion while remaining mindful of the spiritual, cultural and lived aspects of mental health and illness. Students are encouraged to see these tensions and uncertainties as potentially productive sites of critical engagement. Students are then introduced to the biomedical model, including the various diagnostic categories and symptomatology of various illnesses, followed by consideration of critiques of the biomedical model, consumer and recovery discourses, and an outline of the Australian mental health service delivery and policy context. Students are encouraged to consider the unique role and contribution of social work in relation to mental health. Students have a detailed study guide, which takes them through a wide range of readings. For their first assignment, they are asked to write a critically reflective piece on what they learned from four of the five weekly topics: how their thinking and beliefs were challenged or affirmed, and what the relevance of the topic might be for social work.

The second half of the unit focuses on specific fields of practice, methods of practice relevant to each field, and mental health issues that might arise in those contexts. Topics include homelessness and housing insecurity; poverty and unemployment; working with women, with an emphasis on family violence; rural issues; refugee and resettlement experiences; and social and emotional well-being of Aboriginal Australians. In each of these fields of practice, a critical approach is taken to the experiences of individuals in the context of wider social inequalities such as socio-economic status and gender inequality, oppressive practices such as racism and homophobia, and the role of social work within these contexts. The final assignment asks students to choose a field of practice and write about mental health issues in that field, how a critical approach might inform their practice and engender methods of practice that respond to individual need and work towards social change. They are also asked to consider how each field or context of practice interacts with other fields in the complex experience of everyday life for diverse individuals.

In the first year of running the unit, student evaluations were very positive and exceeded usual expectations for a first-time offering. There is still much improvement to be made; in particular, greater involvement of those who are 'talked about' in the development of course content and materials. In an increasingly crowded curriculum, the choices made by social work educators will never be perfect or complete: they should, however, reflect the distinct nature and contribution of social work as an emancipatory discipline with a critical analysis. This is of paramount importance within the medically dominated field of mental health and illness.

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