Social Work And Mental Health: Human Rights, Social Justice, And The Impact Of Public Policy

Even though mental health has constituted a fundamental part of the definition of human wellbeing, this has only recently become a public health priority, both worldwide and at the local level (Stacey & Herron, 2002). Particularly in Australia, where the high burden of morbidity due to mental health issues ranks third (Australian Institute of Health and Welfare, 2018), the government is now paying special attention to the traditional approaches in delivery services, detecting flaws and promoting the development of new strategies to improve the mental health of the population (Stacey & Herron, 2002).

Going back to the colonial times of mental health care in Australia, in which restrictive methods and confinement were inflicted on the suffering person, the lack of basic entitlements and the isolation of people with mental health problems were part of everyday practice (Hungerford et al., 2017). However, from the creation of those first mental institutions, the focus of care has been progressively changing with a dramatic increase over the last thirty years (Green, 2003). These changes started by the very conceptualization of mental health, which was traditionally perceived as the absence of mental illness under the predominant biomedical model (Hungerford et al., 2017). However, a new approach towards a broader perspective has achieved increasingly acceptance. This has been called the population approach (Department of Health and Aged Care, 2000), and it prioritizes developing the individual's potential to build relationships with others (Australian Association of Social Workers, 2014) through interventions in different situations of human being's lives. This implies that the purpose of any intervention in mental health is no longer aimed at seeking the cure, but at promoting wellness, preventing illness, intervening early (Department of Health and Aged Care, 2000) and ultimately enabling a recovery process (Hungerford et al., 2017).

Though this new perspective is promising, the generalised stigma and discrimination continue to be widely present both in community and professional health care environments (Bland, Renouf, & Tullgren, 2009). This essay will elaborate how mental illness is still linked with the violation of human rights that increases social injustices especially for minorities. Despite Australian society having made advances in public policy field, multiple deficiencies prevail, but these can be overcome through professional awareness, public education and governmental commitment.

To begin with, the presence of mental health issues in an individual is strongly associated with basic human rights' violations and social inequalities. The stigma that people with both mental health problems and disabilities heavily carry offers a devalued vision of their capacities (Bland et al., 2009). This often leads them to overlook their entitlements and rights (Drew et al., 2001). Therefore, this causes their systematic and enforced isolation that determines their vulnerable position in social system. The widespread discrimination is clearly illustrated in the poor access to the workforce by people with mental health problems, which has been documented in Australia (Hungerford et al., 2017), as a result, most of them rely on almost exclusively government help. This type of income, limited in quantity and source, greatly reduces the possibility of acquiring adequate health services, food, housing and education, which are determining factors of social justice (Bland et al., 2009). Thus, even though social actors are aware about the universality of human rights, people suffering mental health problems have not

been respected, and without intervention the unavoidable result will be an increasingly bigger disadvantage for them (Drew et al., 2001).

It is important to realize that this obvious violation of human rights in people with mental health issues is further deepened in people with Aboriginal and Torres Strait Islander background, who have suffered an additional component of racism, poverty and marginalization since the colonization took place in their land (Dudgeon, Milroy, & Walker, 2014). It determines lower chances of recovery under the current model of health-illness. Aboriginal and Torres Strait Islander people in Australia were condemned to live in poverty when first colonizers took their land and started to control their lives. Moreover, colonizers subjected them to below minimum wage jobs and confined them to mission areas without welfare (Lucashenko & Kilroy, 2005). All of this is a fundamental barrier to overcome any mental health recovery process. Unfortunately, their situation has not changed significantly (Savage & Gair, 2014), in fact, in today's Australian society this ethnic group still show the highest rates of poverty and unemployment (Dudgeon et al., 2014). The sum of these determining factors are fertile ground for the onset of mental health problems which can hardly be approached only with a biomedical perspective which would be insufficient (Bailey, 2005). As can be seen, the systematic lack of recognition of Aboriginal people's entitlements has resulted in devastating effects in this population and their wellbeing.

Under these circumstances, worldwide organizations have been increasingly aware of the flagrant attack on the rights of people with mental illness (Stacey & Herron, 2002). Therefore, Australian policies have aligned with this trend; consequently, a new approach in mental health delivery services towards a more inclusive, participative and recovery focused view has begun to be implemented (Renouf, & Bland, 2005), and the results have been promising. The United Nations (UN) and the World Health Organization (WHO) have focused their efforts to outline the rights of people with mental health problems and to define the way that the services should be delivered to them, and these have given countries a clear framework to design policies and strategies (Drew et al., 2001). Accordingly, since 1992, the Australian government through the National Mental Health Strategies (NMHS) has tried to unify the state policies regarding this matter and to formulate plans following the same principles of preferring community-based care instead of long-term institutionalization and setting outcomes based on access to various services, and not just a specific treatment (Bland et al., 2009). As a result, the overall picture in mental health services looks not only different but has also generated challenges to stakeholders. Specifically, the Chief Psychiatrist Annual Report 2017-2018, in Queensland, clearly highlighted that since the enactment of the NMHS the rate of seclusion of mental health patients has reduced; in contrast, the number of treatments in the community in patients on a Treatment Authority has increased (Queensland Health, 2018). Hence, the global initiatives in search of improving the health services offered to people who suffer from mental health problems have been progressively adopted by the Australian government, and a change in the landscape is now evident.

Despite recognizing the profound impact that the new policies on mental health have had in recent years, it is undeniable that much remains to be done and to be achieved in favour of fully complying with the objectives that the law sets, particularly about the global trend in deinstitutionalization strategy. Even though its aim is to protect the freedom to exercise the inherent legal capacity of each individual and to promote their integration in communities, the institutional, social and government structures might have not been prepared to respond to the demands that this measure generated (Green, 2003) . Reaching the ideal scenario in which people with mental health problems and disabilities have access to community health services,

inclusion programs, support workers that promote their individuality, and are quickly discharged from psychiatric facilities (Australian Institute of Health and Welfare, 2018) has faced challenges in three main areas.

These are the lack of full understanding about the complexity of mental health problems (Bland et al., 2009) , the poor awareness in families and community about their fundamental role in this strategy (Hungerford et al., 2017), and the absence of government plans to meet the housing demand of all those people who used to live in mental health institutions. First, the health services are trained to deal with the artificial mental illness categorization, in which drug dependency and mental disorders are separated; however, they often discover a mix of different suffering in the same individual (Green, 2003). Second, this deinstitutionalization strategy relies on a collaborative participation of community and family members to support people with mental illness to become active members of society. Instead, most of this supposed support network still has a perception of mental health problems that include danger and incompetence (Hungerford et al., 2017). Consequently, this makes it difficult for them to fully fulfil that role. Finally, a large proportion of people who lived in mental health institutions before the enactment of the new policies are now facing difficulties to get low cost housing and some of them are homeless. In fact, a study in Victoria suggests that at least 30 – 40 % of their patients do not have safe housing to live in once they are ready to be discharge from mental health facilities (Green, 2003). Given these points, effective measures that encompass the most relevant challenges that have emerged from the deinstitutionalization strategy need to be applied, and its objectives should be defined by listening to the needs of the people who have been affected.

A good starting point might be to nurture the curiosity within mental health professionals to put aside the position of spectators in situations of injustice and inequality faced by people with mental health illness (Hungerford et al., 2017). This will open the door to understanding the complexity of mental health and multiply the intervention options. These alternative methods should include strategies of promotion, prevention and early intervention (Department of Health and Aged Care, 2000). Furthermore, educational campaigns about mental health in the community can increase the awareness in the population about the crucial role that they might play in the integration of these people. Given that the beneficial effect of informative programs has been proven, the social sectors that drive them should maximise their efficiency through receiver specificity and campaign continuity (Drew et al., 2001). Similarly, it is necessary to secure a commitment from government to offer not only low-cost rental and supported housing programs, but also assistance services that can guide these vulnerable people to prevent homelessness. Even though strategies to try to avoid the early discharge of mental health facilities, when there is no stable housing, have been implemented, the cost issue forces the reduction of the hospitalization time (Green, 2003). Consequently, the understanding by the mental health professional of these complex scenarios become crucial to prevent these borderline situations. However, the governmental counterpart should also be aware about these realities to deliver comprehensive and flexible housing options (Green, 2003).

As can be seen, mental health care has become a central topic in Australia because of the enormous impact that mental illness causes on the personal and community development of its population (Australian Institute of Health and Welfare, 2018). Nevertheless, the traditional approach in services and support that was offered for years to people with mental illness proved to ignore the entitlements of human beings and to limit the individual potentiality (Hungerford et al., 2017). For this reason, organizations worldwide have agreed to build a new concept of mental health and to consider alternative frameworks of intervention achieving to convey this

trend in most of the countries around the world (Drew et al., 2001). However, the systematic neglect of human rights in people with mental illness and its influence in social inequalities continue to be present (Bland et al., 2009), and the advances in this matter needs to be improved and directed toward community, professional and government engagement.

REFERENCE LIST

1. Australian Association of Social Workers. (2014). Practice Standards for Mental Health Social Workers. Retrieved from https://www.aasw.asn.au/document/item/6739
2. Australian Institute of Health and Welfare. (2018). Mental health services—in brief 2018. Retrieved from https://www.aihw.gov.au/getmedia/0e102c2f-694b-4949-84fb-e5db1c941a58/aihw-hse-211.pdf.aspx?inline=true.
3. Bailey, J. (2005) You're not listening to me! Aboriginal mental health is different — don't you understand? 8th National Rural Health Conference. Retrieved from https://www.ruralhealth.org.au/8thNRHC/Home.htm
4. Bland, R., Renouf, N., & Tullgren, A. (2009). Social work practice in mental health. Crow's Nest NSW: Allen & Unwin.
5. Department of Health and Aged Care. (2000). Promotion, Prevention and Early Intervention for Mental Health—A Monograph. Retrieved from https://familyconcernpublishing.com.au/wp-content/uploads/2013/12/PPEiMentalHealth2000.pdf
6. Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., … Saracen, B. (2011). Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. www.thelancet.com. doi: 10.1016/S0140-6736(11)61458-X
7. Dudgeon, P., Milroy, H., Walker, R. (2014). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Barton ACT, Australia: Commonwealth Copyright Administration.
8. Green, D. (2003). The End of Institutions: Housing and Homelessness. Parity, 16(3), 5-7. Retrieved from https://search-informit-com au.elibrary.jcu.edu.au/documentSummary;dn=053490555906178;res=IELFSC
9. Hungerford, C., Hodgson, D., Bostwick, R., Clancy, R., Murphy, G., Jong, G., Ngune, I. (2017). Mental Health Care, 3rd.Milton, Qld, Australia: Wiley
10. Lucashenko, M., & Kilroy, D. (2005). A Black Woman and a Prison Cell: Working with Murri Women in Queensland Prisons. Brisbane, Australia: Sisters Inside.
11. Renouf, N., & Bland, R. (2005). Navigating stormy waters: Challenges and opportunities for social work in mental health. Australian Social Work, 58(4), 419-430. Retrieved from https://doi.org/10.1111/j.1447-0748.2005.00237.x
12. Stacey, K., & Herron, S. (2002). Enacting policy in mental health promotion and consumer participation. Australian e-Journal for the Advancement of Mental Health, 1(1), 49-65, DOI: 10.5172/jamh.1.1.49
13. Savage, D. & Gair, S., (2014). Hearing and understanding the past in order to strengthen the future. In A.P. Francis, V. Pulla, M.D. Clark, S. Mariscal, & I. Ponnuswami (Eds.). Advancing social work in mental health strengths-based practice (pp. 307-326). Brisbane, Australia: Primrose Hall Publishing Group.
14. Queensland Health. (2018). Chief Psychiatrist Annual report 2017–2018. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0042/729969/CP-Annual-Report-2017-2018_FINAL.pdf