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Developing a Health Inequalities Approach for Mental Health Social Work

Abstract:

Despite increasing evidence of the impact of health inequalities on mental health (Pickett and Wilkinson, 2015) there is only limited recognition of the potential role for mental health social work in addressing ‘upstream’ as well as ‘downstream’ challenges of poverty, disadvantage and oppression affecting many people experiencing mental health difficulties. This paper presents some of the current evidence concerning mental health inequalities and the opportunities for mental health social workers to promote wellbeing.

A theme throughout the paper is the need to avoid the many examples of dichotomous thinking that frequently characterise thinking about mental health and mental health practice. Additionally the limitations of an individualised recovery discourse are acknowledged. Drawing on Krieger’s (2011) ecosocial model, the social determinants of mental health are considered and the concept of embodiment is examined for its contribution to a more nuanced understanding of the relationship between inequality and health. Finally, the paper offers a version of mental health social work that ‘faces both ways’, involving issues at both the individual and the wider societal level. This includes developing and extending partnerships with service users and carers and with other professional and agencies.

Key words: Mental Health / Social Work / Health Inequalities

Introduction

It is timely to review the contribution of social work to mental health in England in the context of financial ‘austerity’ and crisis in services related to increasing demand and decreasing resources (Buchanan, 2014; Green and Griffiths, 2014), and a concern to ensure parity for mental health in relation to physical health, (RCP, 2015; Centre for Mental Health, 2013). This paper offers a critique of the current situation and proposes an approach to social work and mental health that draws on a health inequalities perspective, relevant to both ‘specialist’ mental health and other settings. The analysis will draw on a wide range of evidence, suggesting the future potential of new alliances and partnerships beyond those usually associated with mental health. The paper will focus primarily on social work and mental health in England, recognising the increasing diversity across the four countries of the UK.

It is acknowledged that the language associated with mental health is contentious. Various terms including mental distress, mental health problems and mental ill-health will be used in an attempt to reflect the range of language that is acceptable to service users, none of which is accepted by all. The term ‘mental disorder’ will be used where necessary to reflect the use of the word in its original context whilst recognising that such a term and the accompanying discourse is contested and problematic (Beresford, 2013:182). The term ‘medical model’ will be used as referring to an explanation for mental health problems and diagnoses based primarily on an aetiology grounded in biological explanations including biochemical and genetic factors. These in turn, are seen to exert a strong and powerful influence on treatment and research (Mosher et al, 2013; Whitaker, 2010), themselves framed within bio-medical discourse. A key issue will concern the need to critique the dichotomous thinking that characterises much of the discourse prevalent in this area.

The discussion will offer a range of perspectives informed by an approach based on health inequalities and the social determinants of health, differentiating between downstream, micro-level determinants, frequently linked to individual lifestyle choices, and upstream determinants, macro-level factors including the wider socio-economic and environmental conditions in which people live (Cameron et al, 2003). This approach can also be seen as offering an inherent critique of the concept of ‘recovery’ as it is widely understood in policy and practice, grounded in a discourse of individual choice and responsibility and positioned within an individualised, neoliberal agenda (Rose, 2014).

Overall the paper draws on an approach grounded in critical realism that ‘accepts reality but also interrogates the ways in which values and interests in society seek to depict reality’ (Rogers and Pilgrim, 2010:19).

The policy context

Current policy on mental health in England is framed within the strategy document ‘No Health without Mental Health’, (HMG/DH, 2011) and the subsequent ‘Five Year Forward View for Mental Health’ (Mental Health Taskforce, 2016). These refer to the unacceptably high costs of poor mental health across the lifespan and the need to promote and maintain the mental health of the nation as central to all aspects of government services. The policy claims to offer both a public mental health strategy and a strategy for social justice with six objectives including improving mental health in the population, increasing rates of recovery and improving physical wellbeing amongst people experiencing mental health difficulties, increasing positive experiences of care and support, and reducing avoidable harm, stigma and discrimination.

This document was preceded by the public health White Paper, *Healthy Lives, Healthy People*, (HM Gov, 2010) that paid equal attention to mental and physical health, acknowledging the influence of Marmot's report (2010), *Fair Society, Healthy Lives*, in addressing the social determinants of health. However the overall agenda for improving health and wellbeing can be seen to rely heavily on 'downstream' individual factors rather than addressing underlying 'upstream' macro-level inequalities (Scott-Samuel and Smith, 2015). Additionally the promotion of health and wellbeing, including giving every child the best start in life, healthy ageing and sustainable communities (Marmot, 2010) has been inevitably compromised by cuts in public sector spending and welfare reforms.

A strong driver underpinning current policies is the continuing move towards the integration of health and social care services, with the creation of Health and Wellbeing Boards and the transfer of responsibility for public health to local authorities, both reinforcing the impetus towards a greater emphasis on the role of the local authority in improving health. The Care Act (2014), repeating the message of health and social care integration, also emphasises the role of the local authority in promoting individual wellbeing as well as the creation of multi-agency Adult Safeguarding Boards. However, progress towards joined up health and social care has been mixed, influenced as much by financial restraint as by the rhetoric of integration embedded in government policy. There are growing concerns that increasing numbers of Health Trusts are in financial difficulty (King's Fund, 2015) and local authority services, including Children's Services and Adult Social Care are facing further cuts in funding, with potentially far-reaching effects on services and people's lives (LGA/ADSS, 2014; McNicoll, 2014).

A particularly contentious element of the Health and Social Care Act (2012) was its potential for accelerating the move towards increasing privatisation and the sweeping organisational changes that accompanied its implementation. Together with the Care Act 2014, the promotion of competition and privatisation, also offer the potential for service fragmentation, rather than integration.

These reforms and their underpinning ideology position social work within a dynamic and complex tension in responding to the increasing level of high profile adult and child safeguarding activity, and the realities of a reactive, resource-constrained and residual service focusing on risk rather than support and prevention (Lymberry, 2014). In respect of mental health, concerns have been expressed by social workers in mental health teams, seconded or employed within Health trusts, that their distinct professional contribution is neither recognised nor valued (Bailey and Liyanage, 2012; Godden et al, 2010). In some areas an increasing emphasis on care management has been understood as effectively reducing social workers to the role of 'street-level bureaucrats' in gatekeeping and the allocation of scarce resources (Spandler and Vick 2005:148). There is also growing evidence of the use of out-of area private healthcare beds, leading to further fragmentation in terms of service users' and workers' experiences (HSCIC, 2015; McNicholl, 2015).

The role of the Approved Mental Health Professional (AMHP) is also a double-edged sword for social work. Local authorities' statutory requirement to ensure the availability of sufficient numbers of accredited AMHPs may contribute to keeping mental health on the social care radar in terms of recognition and funding, but at the same time, AMHPs are constantly struggling to secure sufficient resources for people in crisis needed hospitalisation or appropriate alternative support. These and other challenges, including difficulties in obtaining beds (McNicholl, 2015), are

described by Morriss (2015) as ‘dirty work’. This situation is further exacerbated by increasing numbers of applications for detention under the Mental Health Act (HSCIC, 2015), leading to higher numbers of compulsory admissions, that in turn contribute to less therapeutic and unsafe environments for people needing care. Additionally, despite the extension of the AMHP role to other mental health professionals, there has not been a significant influx of non-social work AMHPs (Parker, 2010; Hudson and Webber, 2012).

Social work in mental health is also practised against a backdrop of conflicting pressures and imperatives. Notwithstanding the policy emphases on personalisation, recovery, user involvement and community or home-based care, the reality is that pharmacology is the primary mode of intervention, supported by psychological therapies. Based mainly on cognitive behavioural therapy, such programmes, whilst beneficial for some, (Hofmann et al, 2012) have been criticised as reinforcing ‘the marginalizing of the socio-political that the practice of diagnosing already entails’ (Teghtsoonian, 2009:34). Such interventions continue to maintain and strengthen an individualised downstream response to mental ill-health (Rogers and Pilgrim, 2010:xiv) in which issues of inequality, diversity and racism are often invisible (Levinson, 2010) and where a social perspective is sidelined.

The development of ‘Think Ahead’ (Clifton and Thorley, 2014), as a mental health version of the Frontline initiative (MacAlister, 2012) for social work training, is offered as the government’s solution to the alleged problem of recruiting social workers to mental health posts. Such initiatives run the risk of further compartmentalising specific areas of practice despite evidence that greater joining-up of social work with children and families and both adult and children’s mental health is required (Ofsted, 2013). Additionally, whilst Think Ahead refers to the

importance of 'economic and social factors' in mental health, 'rising demands for services exacerbated by unemployment, debt and cuts to welfare payments' (Clifton and Thorley, 2014:8), and the value of (unspecified) community-interventions, drawing on theories of co-production, the prevailing emphasis within the proposed programme is on the delivery of effective evidence-based interventions. These include 'relational practices, systemic, attachment based and other therapeutically derived interventions such as family therapy', with no reference to the additional specialist training necessary for these to be applied in practice.

Within this uncertain environment it would be easy to be pessimistic about the future of mental health social work, lacking resources and direction and potentially losing out to the high profile priorities of child and adult safeguarding. Within this dystopic scenario, the role of mental health social workers could be viewed as primarily that of risk assessment and case management, with limited opportunities for social interventions. However as this paper will discuss, social work also has the potential to offer a unique approach, drawing on a social perspective that complements and supports the stated need to address health inequalities and promotes positive mental health within an approach grounded in social justice and human rights. This potential for rethinking social work and mental health, is already evident in key documents including *The Role of the Social Worker in Adult Mental Health Services* (Allen, 2014), *The Knowledge and Skills Statement for Social Workers in Adult Services* (DoH, 2015) and the *Social Work for Better Mental Health* initiative (DoH, 2016). Together these refer to working co-productively and innovatively with local communities, building capacity and resilience, emphasising earlier intervention and prevention and the promotion of active citizenship. Allen also states that the role of social work in mental health should be 'clear within local commissioning strategies

and in the direction set by local health and wellbeing boards' and explicit about 'how social workers add value to improving public mental health....' (2014:25).

In order to move towards a more constructive and positive framing of mental health social work, it is also necessary to look beyond the binary thinking inherent in physical/mental, health/social distinctions. These can be seen as embedded within the current social 'habitus' drawing on Bourdieu's (1997) concept of habitus as meaning 'everyday' patterns of behaviour and thinking, grounded in past experience and wider social structures. Notwithstanding concerns that habitus may be understood as 'too deterministic', Garrett (2013:134) also highlights the potential to reappraise and challenge established patterns of thinking and practice based on a combination of reflexivity and changing social conditions.

Such a process requires looking beyond the realm of conventional psychiatry in order to incorporate a broader knowledge base for practice, creating new alliances and relationships with public health, social epidemiology and community practice. Two intersecting areas will now be explored for their potential to inform new ways of thinking about mental health and social work practice.

Health Inequalities and the Social Determinants of Health

'Health inequalities' is considered here to incorporate the term 'health inequities' that can be found in the literature to denote and describe differences and inequalities that are potentially avoidable and unfair in reflecting the unequal distribution of the social determinants of health (Kawachi et al, 2002).

The social determinants of health have been defined as 'the causes of the causes' (CSDH, 2008:42) of ill-health, that is, the social, economic and environmental

factors that impact on health and wellbeing, reflecting wider inequalities. These inequalities are found between and within countries (Wilkinson and Pickett, 2009), as well as within specific cities or regions, frequently illustrated with reference to mortality and/or morbidity rates. These inequalities are more than the simple difference between the rich and the poor but point to a social gradient in which health or its absence reflects socio-economic status at every level.

Although the term, the 'social determinants of health' has been widely adopted internationally (CSDH, 2008) and recognises, at least partially, the significance of social position including factors such as gender, race and ethnicity, there are concerns that this may be less robust in the recognition of issues such as sexual orientation and gender identity (Fish and Karban, 2015). The term is also recognised as having limitations in failing to adequately address overarching systems of power and may obscure the many and different ways in which political and social action can influence policies and practices (Krieger, 2011).

It is also noticeable that, despite the logical conclusions of endorsing a model of health inequalities, prevailing discourse continues to emphasise individual responsibility in matters such as exercise, diet and smoking. Additionally, references to neuroscience in social policy, particularly in relation to early years, adolescence and older adults, continue to be used to re-enforce the need for citizen responsibility in optimising healthy development whilst minimising the contribution of upstream, macro-level factors (Broer and Pickersgill, 2015). Raphael (2012) also refers to the dangers of biological/genetic explanations of differences in health in obscuring socially unjust living conditions and the public policies that create and maintain them, in turn reinforcing the medicalisation of health and ill-health.

The importance of recognising the accumulation of positive and negative experiences throughout the life courses, is emphasised by the World Health Organisation in confirming that:

'...many of the causes and triggers of mental disorder lie in social, economic, and political spheres – in the conditions of daily life. (WHO, 2014:13)

In England there is evidence that the social gradient of health is particularly pronounced regarding severe mental health difficulties, where the prevalence of psychotic disorders in the population within the lowest quintile of household income is nine times greater than in the highest (Marmot, 2010), a figure unlikely to be accounted for by downward social drift. There is also evidence that the period of economic recession in the UK between 2008 and 2010 was associated with 1001 more suicides than would have been expected based on historical trends; in England two fifths of this rise was associated with male unemployment with greater increases in unemployment in local areas associated with steeper increases in suicides in those areas (Barr et al, 2012). Levels of debt in a population study in England, Wales, and Scotland, were also found to be associated with the experience of some form of mental disorder (Jenkins et al, 2008).

The social gradient for the social distribution of common mental disorders has been found to be more marked in women than in men (McManus et al, 2009) with many women's experiences of economic, social and political disadvantage further compounded by sexual trauma and violence (Williams, 2005). In respect of general psychological wellbeing, scores on the General Health Questionnaire also point to an association between poor mental health and higher levels of deprivation amongst

women (Marmot, 2010). Additionally, there is evidence that social isolation and loneliness are contributory factors affecting physical and mental wellbeing and mortality (Durcan and Bell, 2015).

Social and economic inequalities have also been found to underpin many of the observed racial and ethnic differences in health, providing evidence that health and wellbeing may be further compromised by racism (Karlsen et al, 2005; Karlsen and Nazroo, 2009). The development of a model for the social aetiology of psychosis (Shah et al, 2011) that considers the exposure to individual-level and ecological-level social factors linked to psychosis and their interaction, including the potential risks associated with racial discrimination, urban living and the effects of migration, may offer new insights in this area in future.

Pickett and Wilkinson (2015) and Burns et al (2015) refer to the increasing specificity of evidence relating to mental ill-health and inequality with the higher prevalence of depression, schizophrenia and psychosis in more unequal societies related to low levels of trust, limited community relationships and increased violence. Read et al (2013:205) also assert that 'there is ample evidence that inequality, deprivation and discrimination, filtered through their social and personal meanings are key causal factors in psychosis'.

In summary, evidence suggests that an understanding of the social determinants of health may offer a constructive approach to understanding and responding to mental ill-health. There is also a recognition that the various contributory factors involved are multi-faceted and interact to create a complex and dynamic vicious circle that will be discussed further in this paper. However the precise mechanisms that

underpin these relationships are perhaps less well understood. One approach to articulating these mechanisms will now be considered.

Challenging the binaries – the concept of embodiment

It is important here to further unpick the binaries of physical/mental, medical/social, as the categories created by dichotomous thinking of this kind serve to privilege particular interests (Fook, 2002:73). In particular they are likely to obscure more than they reveal in terms of our understanding of mental distress by maintaining the mutual exclusiveness of mind and body, referred to by Sedgwick as the dualism of ‘mental versus medical symptomology’ (1982:29).

Boyle (2013) points to the challenges in recognising the significance of the body in discourse on mental health and ill-health. Not least, an emphasis on the physical has been used to bolster ‘medical model’ explanations, deflecting attention away from social factors. Instead Boyle argues for the need to acknowledge the embodied experience of mental distress and the interaction of physical and emotional experiences, for example in pain, fatigue and appetite. In short, ‘we are feeling bodies in a social world’ (MPG, 2013:122) and our feelings and experiences reflect our embodied selves in a material world.

The concept of embodiment is also informed by an understanding of the impact of adversity and trauma (Hermann, 1992; Varese et al, 2012) and increasing evidence relating to the ways in which ‘...chronic low level stress *‘gets under the skin’* through the neuro-endocrine, cardiovascular and immune systems, influencing hormone release e.g. cortisol, cholesterol levels, blood pressure and inflammation’ (WHO, 2014).

The concept of embodiment can also be applied in relation to the experience of both physical and social locations and their complex and dynamic interaction across the life course, mediated by class, gender, sexuality and ethnicity. Such factors significantly impact on day-to-day living conditions including housing, employment, diet, access to health and social care and the extent to which these are characterised by material advantage or disadvantage (Raphael, 2012). The incorporation of social and psychological as well as economic experiences, also highlight the importance of social relationships, social inclusion or exclusion and social capital as well as the quality of the environment. For example, a large longitudinal study in 40 disadvantaged London boroughs found that the quantity of social networks was significantly associated with common mental disorders (Bertotti et al, 2013).

Krieger (2011), a social epidemiologist, proposes the use of the term ‘ecosocial’ to incorporate the ecological context within which people live and the social and political economy of health and the social production of disease. Central to this is the concept of embodiment, with Krieger’s claim that we ‘literally embody, biologically, our lived experience, in societal and ecologic context...’ (2011:215).

Ill-health is therefore the outcome of multiple pathways of embodiment, influenced by exposure to adverse and hazardous conditions across the lifespan, including economic and social deprivation, toxic substances, discrimination, violence and trauma as well as inadequate or degrading health care (Krieger, 2011:222-3), many of which are experienced by people with mental health difficulties. Within this model, power, including institutional power and individuals’ capacity to act and challenge, bringing potential for change, is also acknowledged. For example, this might include the development of the mental health service user movement, disability activism and campaigns for reproductive rights.

It is also clear that the experience of mental distress may itself render the individual open to stigma and prejudice with further consequences for wellbeing. Paradoxically there is evidence that the use of medical diagnostic labelling, rather than promoting a 'brain not blame' discourse, instead further highlights the fear of irrational and unpredictable behaviour that is outside the control of the individuals thus diagnosed. This in turn contributes to the 'othering' of those experiencing mental ill-health (Fawcett and Hearn, 2004). Such 'othering' serves to re-enforce dichotomies of well and unwell, predictable and unpredictable and signifies the (artificial) demarcation between those with/without experiences of mental distress. This further perpetuates labelling and stereotyping, with far-reaching consequences for social relationships, social inclusion and human rights.

A vicious circle

It is evident that the socio-economic and other disadvantages associated with poor mental health interact with, and are further reinscribed by the experiences of mental health distress, leading to further inequalities including higher risk of poverty, unemployment and discrimination, thereby becoming both cause and consequence (Campion et al, 2013; Friedl, 2009). Krieger also recognises the pathways in which 'the societal context harms health, with poor health then further undermining possibilities for adequate resources for healthy living.' (2011:215) thus creating a complex and multi-faceted vicious circle. Discrimination may also further reduce social capital and impact on social networks (Webber et al., 2014).

Additionally it is relevant to recognise that notions of class may contribute to diagnostic and treatment bias whereby more serious diagnoses may be applied to poorer than wealthier people, further compounded when issues of ethnicity and

experiences of racism are considered, with the recognised association between minority ethnic status and poverty in the UK (Read et al, 2013:201).

Additionally aspects of disadvantage and exposure to ‘hazards’ are multi-dimensional and need to reflect notions of intersectionality, by which multiple aspects of identity, for example, being a woman, Black or gay, combine and compound creating a unique experience. When racism, sexism and/or homophobia are combined with the additional experience of mental distress as well as other forms of structural and social inequalities, the resulting toxic mix of discrimination and oppression, experienced and enacted intersectionally, is likely to further compromise health and wellbeing (Morrow and Weisser, 2012).

Overall the social determinants of health and notions of embodiment contribute to a wider critique that questions the prevailing level of analysis of the ‘causes of the causes’, seen as residing in social environments and differential exposure to factors influencing health and shifts the analysis towards the ‘political determinants of health’ (Kickbusch, 2015) or ‘the causes of the causes of the causes’, seen by Krieger as necessary to address fundamental obstacles to change (2011: 185). In recognising the features of political-economic systems that serve to promote the interests of those with power and privilege at the expense of those without, Weinstein emphasises that inequality and poverty are intrinsic rather than ‘a by-product, of the neo-liberalism of modern capitalism’ (2014:22). Similarly Raphael (2012) and Teghtsoonian, (2009) acknowledge the role of the market and underpinning ideology in liberal regimes in reducing services and fostering a culture of individual responsibility, within a political discourse that serves to distract attention away from the insidious effects of public policies.

Mental Health Social Work - Where Next?

The analysis offered here can be seen as informing an understanding of the macro environment within which social work practice takes place. However, despite frequent references to both the macro and the micro, they can often become either/or practice domains, with many practitioners in statutory settings under pressure to focus on reactive and individualised work based on safeguarding, care and risk management, at the expense of attending to the wider environment and issues of racism, gender, poverty and social exclusion (Craig, 2013).

In eschewing further binaries, however it may be more appropriate to work with the dynamic between the macro and the micro levels of mental health practice, further developing what Tew et al describe as a *'twintrack approach that involves not just direct work with service users, but also developmental work with families, social systems and communities'* (2012:456). This might also be understood as social work 'facing both ways' to service users and society (Simpkins, 1979:40), including mediating competing ideas about mental health (Weinstein, 2014). Furthermore 'facing both ways' usefully highlights the unique position of social work in both face-to-face relationships with services users and in taking action 'in society', working in organisations and networks and building alliances to challenge health and other inequalities.

So what does this mean for mental health social work informed by a health inequalities perspective? At its most basic social workers in all settings need to address the material aspects of poverty and access to decent housing, recognising

how such factors can contribute to improved mental health and wellbeing. Where appropriate, supporting access to employment, will require working closely with service users to navigate the complexity of employment support and to ensure that work on offer is indeed likely to improve, rather than detract from mental wellbeing.

Still 'client-facing', Tew et al (2012) highlight the need to promote recovery emphasising empowerment, relationships (rebuilding positive personal and social identities, including tackling stigma and discrimination) and social inclusion (connectedness to include both personal and family relationships and wider aspects of social inclusion). Their conclusion points to the need to move away from a reactive, individualising focus in practice to a proactive role, highlighting the potential contribution that social work can offer in promoting recovery in mental health, albeit requiring a shift away from safeguarding and risk management.

However it is also necessary to critique the concept of recovery, as although this developed within the service user movement as a means of establishing personal control and meaning and challenging the power of psychiatry, it is now increasingly mainstreamed and potentially sanitised within mental health systems and services (McDermott, 2014; Rose, 2014). Within services there is a risk that recovery becomes a performance indicator, linked to moving on from mental health services and achieving employment, with timescales linked to service expectations and targets rather than individual circumstances. Such pressures contribute to a 'see, solve and shut' culture (Backwith, 2015: 167) that has no place in mental health (or any other) practice, detracting from a relational approach based on a life course perspective.

Furthermore, challenging individual notions of recovery that fail to recognise wider social and political factors (Williams et al, 2015), society-facing social work requires addressing wider societal issues, including expanding the 'health inequality imagination' (Giles, 2009). In developing this theme, Pockett and Beddoe (2015) refer to expanding presenting problems to include health inequalities and systemic inequities, working with both a 'narrow lens and a wide lens approach' (2015:10), and using the concept of 'embodiment' to aid understanding of the cumulative impact of intergenerational poverty and social impoverishment.

In turn this requires recognising the limitations of a purely psychosocial approach that 'decontextualises everyday life' (Rose and Hatzenbuehler, 2009:462).

Recontextualising the life of people experiencing mental health difficulties also demands identifying 'the capacity of medical accounts of distress to deflect attention from the harm done to the (relatively) powerless by the (relatively) powerful (Boyle, 2013:4). Boyle's analysis points to how, despite the lack of evidence for a traditional medical model of mental ill-health, there is little sign of a paradigm shift. She argues that the 'threat' offered by non-medical explanations of mental distress is neutralised and/or invalidated through strategies adopted by dominant groups, including the pharmaceutical industry, whose treatments further silence and disable people (Read, 2013). This critique is further supported and informed by the knowledge and experiences of mental health service users and survivors that point to the damaging effects of the continuing dominance of the medical model and the potential benefits of a social perspective (Beresford, 2013)

The 'wide lens' also needs to include the global context, building links to global health networks (Pockett and Beddoe, 2015) as well as developing a community social work orientation (Backwith and Mantle, 2009). In the UK there is potential

for new alliances with colleagues from public health, grass roots community initiatives and campaigns with precedents in communities of practice developed in Scotland (Quinn and Knifton, 2009) to reduce mental health stigma and in resistance to ‘austerity’ measures and cuts in mental health services, as described by Moth et al (2015).

Despite the opportunities highlighted within recent documents (Allen, 2014; DoH, 2015; DoH, 2016) it is essential not to underestimate the challenges involved in applying a health inequalities approach in the current climate. In England this would also require rethinking the legalistic over-emphasis on the statutory role of the AMHP (Ramon, 2007) whilst recognising AMHPs’ expertise in protecting rights and promoting a social perspective in crisis situations. Developing new and sustainable relationships and ways of working, based on principles of personalisation and co-production with service user and community groups may also help to transcend fragmented, poorly-funded and increasingly privatised services.

Society-facing mental health social work therefore requires a fresh approach drawing on community work and building links with survivor and activist groups tackling stigma and discrimination, challenging welfare reform and cuts in public spending and services. Such action will challenge the ‘doublethink’ of recognising the structural causes of mental ill-health whilst continuing to practice solely within an individual framework.

Internationally social work’s role in ‘bearing witness’ is recognised, drawing attention to the impact of policies and practices including that of health inequalities on mental health and wellbeing, advocating for respect and social justice and mobilising community populations to offer solutions (IASSW/IFSW, 2014).

Speaking out with and on behalf of those whose lives are most affected by poor mental health is itself an act of resistance (hooks, 1989).

Concluding comments

There is clearly much to be concerned about in relation to the future of mental health social work including changes to social work education, challenges to the profession and an increasingly narrow focus on safeguarding and protection. Such changes, accompanied by an agenda of public sector cuts and welfare reform, impact on services and on those who are most likely to need those services.

A health inequalities perspective for mental health social work provides support for community-focused practice informed by socio-political, psychosocial and ecosocial alternatives, grounded in issues of human rights and social justice. 'Facing both ways' offers a way forward and potential for new insights, creative partnerships with community groups and other professions and disciplines and innovative practice.

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