The Wicked Problem of Violences in Mad Places/Spaces and People
A design concept is the idea behind a design. It is how a designer plans to solve the design problem with which they are challenged - the thinking, reasoning and creativity, and the underlying logic behind the development of a strong graphic design.

Creativity in the design process is often characterised by the occurrence of a significant event—the so-called ‘creative leap’. Sometimes such an event occurs as a sudden insight which the designer immediately recognises as significant, but often it is only in retrospect that the designer (or an observer of the design process) is able to identify a point during the design process at which the key concept begins to emerge (Dorst and Cross 2001).

My initial design concepts for the cover of this issue of ‘The Wicked Problem of “Violences in Mad Places/Spaces and People”’ conjured images reminiscent of artist Edvard Munch’s painting, ‘The Scream’. These first concepts were excitedly discussed between the theme editor, Dyann Ross, and I – that this could be the basis for a strong graphic design. Alas Dyann found that these concepts were not going to successfully visually interpret/communicate the issue theme.

We continued to discuss issues around various instances of violence active in many ‘places/spaces’. The idea of using fabric as a metaphor for ‘the fabric of society’ emerged, and better yet, a fabric with tears – the image of the torn fabric being sufficiently expressive in meaning to encompass the broad content of the articles in this issue. This was an epiphany, bringing logical thinking, reasoning and creativity to develop the design concept.

When we purchase fabric from a store it is pristine. Over time we begin to see evidence of its the wear and tear, just as we see the wear and tear in our society, community, at home, at work. However, the sky in the background of the cover design image expresses the sun’s rays, giving hope that there is help and a better future for those who are affected by violence.

Dyann Ross proposes that: ‘Violence in all its forms, including indirect and invisible, tears at the fabric of society. The tears can be where mad places/spaces and people are resisted and transformed’.

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Submissions of articles, commentaries, reviews and fictional works are subject to double blind peer review and should be emailed to the general article editor. Authors are encouraged to consider and reference papers previously published in Social Alternatives to promote ongoing discussion. Submissions should be double-spaced with page numbers on the bottom right. Academic articles should be approximately 3,000-5,000 words, commentaries and review essays between 800 to 1,500 words, book reviews 800 words, short stories 1,000 words and poetry up to 25 lines. Submissions must include:

- copyright release form
- title page listing contributing authors, contact details, affiliation and short bio of approximately 150 to 200 words
- abstract of approximately 150 to 200 words
- three - five keywords.

Please use Australian/English spelling and follow Harvard referencing. Submit tables, graphs, pictures and diagrams on separate pages. Remove in-text references identifying authors and replace with [name removed for the review process].

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CONTENTS

THEME FOR THIS ISSUE: The Wicked Problem of Violences in Mad Places/Spaces and People

Editor's Introduction
3 The Wicked Problem of Violences in Mad Places/Spaces and People..................Dyann Ross

Commentary
10 Prisons Without Bars and Hospitals with Locked Doors – Some Tyrannies Exercised and Exorcised........Michael Burbank
15 I’m Not Mad!.............................................................................................................Bernie Waterhouse
20 The Intolerable Taboo of Mental Illness.............................................................................Robyn Kemble
24 Shining a Light – Fragments of Stories About Community Spaces That Matter.................................Chloe Warrell and Ann Ingamells

Theme Articles
28 Tracing the Maddening Effects of Abuses of Authority: Rationalities Gone Violent in Mental Health Services and Universities........................................Marilyn Palmer and Dyann Ross
37 Fostering Trauma-Free Mental Health Workplace Cultures and Reducing Seclusion and Restraint ....Dyann Ross, James Campbell and Alex Dyer
46 Towards a Mental Health Model of Practice: Highlighting the Scaffolding That Can Really Help People.......................................................................................Matt Dilges
53 Gatekeeper Versus Concierge: Reworking the Complexities of Acute Mental Health Care Through Metaphor............................................................................................................................Chris Dawber
60 Beyond Madness: Ways to Foster Nonviolence In Human Systems....................................................Marilyn Palmer

General Articles
65 Art and the Arts of Sustainability.......................................................................................John Clammer
71 Ecotopian Spaces: Soundscapes of Environmental Advocacy and Awareness .............Kate Galloway

Short Stories
79 All Talk and No Trousers.................................................................................................Natalie Harman
81 Mother, Mental Health Clinician – Who am I?..............................................................................Ros Stygall

Poetry
9 That dares to speak its name ..................................................................................................Jim Arkell
9 Breath Test............................................................................................................................Ron Pretty
14 Saw devils everywhere ..............................................................................................................Jim Arkell
27 I dreamt after being diagnosed with COPD..............................................................................Jim Arkell
45 Unstable.................................................................................................................................Ron Pretty
52 Alan....................................................................................................................................Graham Rowlands
59 On Christmas..........................................................................................................................Ariel Riveros Pavez
59 I and I live..................................................................................................................Sarah Tobbi Motha
64 Men and women of the jury....................................................................................................Graham Rowlands
70 Bool Lagoon (South-Eastern S.A.).............................................................................................Jules Koch
82 Praise.................................................................................................................................Ron Pretty
82 Which place are you from?............................................................................................Mary Chydiriotis
The Wicked Problem of Violences in Mad Places/Spaces and People

DYANN ROSS

This is an introductory article to a collection of themed papers relating to madness as violence of various kinds by people in powerful, often privileged positions, in human organisations. It presents the theoretical framework by outlining how the abuse of power and usually invisible privilege of people in power has maddening effects on subordinate members of an organisation. This is counter-posed with the more conventional understanding of mental illness being about madness and being the preserve of people labelled as mentally ill. Further, spaces and places such as mental hospitals and universities are shown to be containers of systemic violence to the extent there are no proactive efforts to create trauma-informed cultures and workplaces. What counts as madness needs to be reconsidered in light of this collection of papers about this most wicked of problems.

About Wicked Problems

The moral sophistication and social justice of a society might be measured, if it were possible to measure such things, in the manner in which we treat our most vulnerable people, animals and ecosystems. Issues that relate to the social and moral order of society may be experienced as private troubles but they are ultimately social issues requiring social responses (Mills 1959: 8). The nature of the issues explored in this issue of Social Alternatives is at the centre of many of the socio-economic, environmental and spiritual challenges of our time. Further, the issues are of an order that defy one-dimensional explanations, readily agreeable priorities, language that can only express the sayable, simple solutions that will hold over time for everyone impacted, and our various investments in the issues discussed. As such, the topic of violations in mad places, spaces and people constitutes a wicked problem which refers to ‘concerns emerging from the uncertain and complex interactions between economic, social and environmental systems’ (Palmer 2015: in press n.p.) for which there are no obvious final answers.

Within this complexity Palmer notes:

Systems theory provides a way forward for working with wicked problems, in particular the identification of leverage points for intervention in a system (Meadows 1997). Meadows identifies the ‘mindset or paradigm out of which the goals, rules, feedback structure arise’ as the most effective leverage point. An effective dialogue (and ultimately something like a solution) around a wicked problem might be possible if the power differences and paradigm differences between stakeholders can be made explicit (2015: in press).

This introduction to this edition of Social Alternatives maps the theoretical framework and key points of analysis of the collection of contributions. As a whole, the edition constitutes a political activism in written form that seeks to speak to people in positions of power whose actions may have maddening effects on others who are more often identified as mad or bad. Unless our exercise of power is checked to guard against harming others we are likely to be one of the mad ones – one of the people who are acting violently and who are advantaged by not noticing it or taking responsibility for our actions, even if pointed out to us by an aggrieved person. As Van Dijk notes, typically in democratic societies the use of power is ‘persuasive and manipulative rather than coercive’ (2008: 85) and thus less explicit. For decades the mental health consumer movement has been speaking loud and clear about what is the problem for them (Deegan 1996: 1) and what would help. However, evidence that the dominant actors in the mental health systems of care are listening is hard to find. But the dominant discourses as located in key government reports on mental health are replete with recovery language often co-occurring with arguments for the use of violence (Mental Health Branch 2008: 5). How is this double speak possible? Who is served by it?

Not Mental Illness but Violence as Madness

In this issue, as contributors, we seek to create a space for dialogue and reflection on subjugated discourses relating to the nature and politics of ‘madness’ in Western capitalist-democratic societies such as Australia. We place social power dynamics at the centre of understanding mental health systems of care and other organisations, experiences of mental illness, and organisational violence. The purpose is not to provide
a comprehensive historical, clinical or social analysis of dominant constructions of mental illness. Rather, the focus is placed upon revealing the largely hidden discourses and related unsayable exercises of power by non-mentally ill people, often professionals and managers, in a range of forms of organisational and systemic violence (Mattiesen and Einarsen 2007: 735). These hidden discourses represent a culture of silence (Freire 1970: 12) that enables privileged and advantaged positionings of some people to be maintained at the cost of others who can then be devalued, stigmatised and disadvantaged as a consequence (Repper and Perkins 2009: 120).

Madness as used here refers to the hidden dominant discourses of abuses of legitimate power by people with socially valued identities and positions (Van Dijk 2008: 86). Thus violence as madness is a political marker that is not recognised, but in a contradictory way this non-recognition is part of the mechanisms of power reinforcing itself. How did madness, as more typically referring to the experiences of individuals who are often subject to trauma and abuse (Bloom 1994: 474), become the containers in their personhood of the dominant discourse of mental illness? In this way, the term ‘madness’, which has historical echoes for describing people labelled as mentally ill, is turned upon itself to accent this powerful myth-making contradiction and refers to violence which doesn’t declare itself. Sapouna, strongly influenced by Foucault, argues that:

A meaningful process of de-institutionalisation cannot be achieved unless issues of control and professional power are addressed (2012: 612).

Here, madness refers to violence which is not owned by anyone and thus does not seem to locate in people and as a result no one needs to put themselves forward to be accountable for harm done even if unintended. Rather, these direct or indirect forms of manipulation, injustice and harm can be exercised in the guise of respectable professional practices and organisational policies which can nevertheless harm, discriminate or otherwise demean or control people (Young 1990: 57; Leonard 1997: 95). Thompson writes:

Organisations are dangerous places. They are major sites of power and conflicts of interest and so considerable harm can result from complex and potentially destructive processes that go on between individuals, between groups and between organisations and their employees (2011: 186).

To stay alert to the complexity of behaviours and non-actions that can comprise violence as we refer to it in this collection of articles, we use the term ‘violences’ unless being explicit regarding a particular type of violence. This term also seeks to alert us to the contestable nature of violence and to the confounding dynamics whereby violence can be intertwined with safe, respectful, cooperative interactions within the same relationships, people and systems (Leonard 1997: 179). It will not be the people who are acting in mad ways who will accept that their behaviour is violent. Thus this respectable form of violence is mystified and denied, leaving a vacuum for the impacted person or groups to puzzle at the cruelty visited upon them or to internalise the oppression and blame themselves (Mullaly 2007). Discursive and ideological practices operate to keep organisational violence as one of the last undeclared issues of our time.

In this issue the contributors adopt Foucault’s relational understanding of power, which can be both harmful and productive. Further, we wish to emphasise his idea that where there is power there will be resistance (O’Farrell 2007: n.p.), even if in some circumstances the resisters do not declare their views (Scott 1990: xi). A structural appreciation of the exercises of power as creating inequalities and violences (Thompson 2011: 25) is also proposed. The invisibility of privilege reinforces the unfair advantages that accrue to people not labelled as mentally ill. Madness refers to this unfair advantage of privilege gained by being in a position to define what counts as mad and what counts as rational and socially acceptable (Rothenberg 2005: 98). This in turn can reinforce the status quo in systems of care and education in contemporary Western societies. In the present context, privilege refers to the advantages that accrue to us by virtue of our social standing as professionals, in my case, a social work academic. Privileges such as a high income, a permanent position, status, recognition as being an expert who is valued, accrue to me in this way. This affects how others treat me/us, including how we perceive what power we are able to exercise. As Rothenberg writes ‘members of the privileged group gain many benefits by their affiliation with the dominant side of the power system. This affiliation with power is not identified as such … often it is presented as individual merit’ (2005: 99). This access to privilege positions us (but doesn’t fully determine us) in relation to broader social power relations that are typically unequal (Thompson 2011: 189), such as males/females, heterosexual/gay, rich/poor, expert/lay and mad/sane. Young writes:

The imposition of scientific reason’s dichotomy between subject and object on hierarchical relations of race, gender, class and nationality … has deep and abiding consequences for the structuring of privilege. The privileged groups lose their particularity, in assuming the position of the scientific subject they become disembodied, transcending particularity and materiality, agents of a universal view from nowhere (1990: 127).

Thus, the effects of dominant groups’ actions, which are harmful, discriminatory and unjust, can become unlinked from the social actors. This unlinking allows the abusers of power, if unwilling to be responsible and to make
amends for their actions, to get away with crimes against humanity. The challenge is not lack of sufficient evidence about the maddening effects of violence, but rather it is in keeping the gaze and moral and political pressure on the powerful (Leonard 1997: 43). Equally important is the need to avoid the madness reverting back to victims blaming themselves or being blamed (Thompson 2011: 127) by the dominant people who have extensive vested interests in maintaining the status quo.

**Spaces and Places as Containers of Systemic Violences**

Many of the contributions presented here challenge who is usually constructed as ‘mad’, and several contributors suggest studying upwards at the powerful people (Bell 1978: 14). This is about bringing the attention to those who can use privilege to hide their madness, or even their mental illness, behind a rational exercise of legitimate, positional authority. Part of powerful peoples’ legitimate use of power in the workplace is exactly about the construction of ‘others’ as the problem, and as mad, bad or some mix of these labels. Research by Martinez et al., for example, shows that for people so labelled there can be a loss of regard for their humanity and increased social rejection (2011: 1). The use of diagnosis, clinical risk assessment and other treatment tools in mental health settings is well recognised as part of the mechanisms of professional power that enables the dominant constructions and labelling (Corrigan 2007: 31). One of the maddening effects of these practices can be the displacement of responsibility for harm done through the power to define the norm and themselves/ourselves as ‘normal’, and especially to ensure they/ we aren’t seen to be, or aren’t labelled as, mentally ill (Leonard 1997: 99). For the sake of the sanity (and rationality = right ordering) of society, this intolerable taboo of the care-givers, managers and the intelligentsia as being mentally ill must be avoided at all costs.

The contributors in this edition do not regard the medicalised, individualised and pathologised dominant construction of mental illness (Thompson 2011: 126) to be monolithic, necessarily harmful for clients or universally agreed to and practised. However, we do wish to draw attention to the shadow it leaves unaddressed. This unaddressed shadow is an example of the functional value of violence in organisations which hide and invert who is the problem and who needs to be controlled (Buchanan and Badham 1999: 71). This can be achieved by force if necessary, through legitimate means if all else fails, as enshrined in the Mental Health Act (Queensland Government 2000). Further, systemic violence is not the sole preserve of mental health services but perhaps here the contradiction is more confounding and more firmly entrenched. Universities as the supreme formally legitimated expression or symbol of the intelligentsia of society, where the rational, ethical pursuit of knowledge for the benefit of society is undertaken (Brennan, King and Lebean 2004: 8), can too be places for the exercising of power as violences.

Violences exercised and the resistances to these violences are not restricted to mental health systems and are to varying extents operating in all human systems, including universities, private businesses and multi-national corporations (Towie 2008: 16). Only two organisational examples are highlighted in this edition of Social Alternatives, these being chosen by virtue of the contributors’ professional and sometimes personal experiences of violences. The examples attempt to show how human created spaces and places can be containers for, and perhaps can intensify, systemic violence through spatial dynamics such as ‘placeless power’ and ‘powerless places’ (Earles and Lynn 2012: 8). We suggest this will continue to be so unless collective, concerted non-violent efforts are undertaken to create safe spaces in all the places we work, seek care, engage in learning or from where we do business.

Through explicitly linking workplace/organisational violences and madness, this themed edition of Social Alternatives seeks to unsettle dominant constructions of mental illness as represented in the growing number of classifications provided by the American Psychiatric Association (APA 2013). At the same time, the purpose is not to detract from peoples’ experiences of trauma, loss and distress to which mental health systems of care seek to respond.

People with a lived experience of mental illness who seek care in public (and private) facilities might be served, but perhaps not be surprised by, the exposing of the embedded nature of violences in human systems. What counts as legitimate knowledge and who makes claims of being expert is perhaps nowhere more contested than in the area of mental illness (Frances 2010: 1). The dominant paradigm upon which Western mental health systems are premised is the medical model (Thompson 2011: 125-126), specifically psychiatry. The worldwide mental health consumer rights movement has long protested the damaging effects of an over-reliance on a biochemical approach to treating severe and persisting mental illness (Citizen Commission on Human Rights [CCHR] 2014: n.p.). The concern tends to correlate with the rise, and increasing influence, of multi-national pharmaceutical companies in medicine (Cosgrove and Bursztajn 2010: n.p.) and the related strong adherence to pharmacological treatment. However, it is well recognised that psychiatric medications are ‘dirty’ drugs, so called because of their often troubling, sometimes life threatening side effects (Whitaker 2010).

Bloom’s ideas regarding what constitutes violence in human systems are significant in holding an organisational and cultural perspective on violence as abuses of authorised power that can have maddening dynamics. Sites of systemic violence can be understood as traumatised organisations (Bloom and Farragher 2013: 19) which have as key characteristics a lack of safety for participants/members and a lack of democracy.
and justice in their processes (Bloom 2014: n.p.). The creation of safety, including physical, emotional, social and moral safety (Bloom 1994: 479), both in psycho-personal spaces and socio-cultural spaces, suggests that violence can be tempered, resisted and challenged (see for example the value attributed to staff reflective practice groups in Dawber 2013: 241). However, the systemic nature of violence also suggests that more than individual actions are required to effect cultural change toward what Bloom and Farragher call ‘trauma-informed’ mental health services (2013: 28).

The functional value of violence needs to be recognised. Crane and Matten (2010: 167) identify a range of behaviours adopted by business managers and supervisors for rationalising unethical behaviour. Thus, a manager’s denial of responsibility for harm done as a result of their un-owned bullying toward a colleague can result in the effects being maddening for the victim (de Maria and Jan 1994: 1). Such dynamics are maddening because the person’s experience of being abused is not recognised and further, the discourse can in fact be the opposite where they may be constructed as being the bully! The colleague has to grapple with a dominant abusive use of power as normal, professional and as the correct use of power, and certainly not something that can be challenged if they want to keep your job. Hence the victim can feel distressed, silenced, made wrong and seen to be the problem. This can challenge their sense of fairness but more so their sense of reality.

Going mad can also have a functional value. To allow the possibility that your manager is abusive, that perhaps the whole management group of your workplace is colluding with their abusive behaviour by holding a united front against complaints, can be an impossibly irrational idea. That some of your peers have ostracised you, feel justified in so doing and that you are becoming unsure of your own ability to stay competent, can compound the systemic violence. Scapegoating of staff who whistleblow and who otherwise threaten the status quo is well recognised (de Maria 1999: 1) and for the colleague it will be a struggle not to go mad. To allow the possibility of everybody you know in the organisation colluding with you being marginalised without being seen to be doing anything wrong is harder than going mad.

The gaze of those near to the situation does not look to other actors, as the mad person becomes the container for others failures to act and to avoid violence. More than this, the structural dynamics of inequality and injustice are left unchallenged again.

Standing as Allies with People Who Experience Mental Illness

Mental illness has many causes and while this themed edition of Social Alternatives does not focus substantially on the nature of mental illnesses, authors collectively acknowledge the diversity and authenticity of experiences for people with a lived experience of mental illness. We also acknowledge the highly contested term ‘mental illness’ and the confusion and distress this can have for people given this label/diagnosis. Additionally, we acknowledge the often extremely damaging effects of stigma and the legalised control of some people with mental illness, which can include force in various forms including seclusion and restraint. International speaker and Yale University Professor of Law and Psychology, Saks (2012: n.p.) claims nobody she knows who has been restrained against their wishes when suffering from a terrible illness has found it a positive experience.

The contributors wish to stand as allies with all people who experience mental illness as a devalued, stigmatised human response to their life circumstances. Your/our personal experiences are not the wicked problem.

At the structural or public issue level of the wicked problem, we recognise that violence is condoned by a (patriarchal, capitalist) society (World Medical Association [WMA] 2010: n.p.), is often gender based (Campbell 2011: 1), and has traumatising, life threatening effects including cross links with a higher prevalence of mental illness for survivors (Braaf and Meying 2013: 1). Workplace violence is very similar to domestic and other forms of inter-personal violence in its dynamics, culture of blame and silence and human costs – for example the loss of productivity and health impacts due to workplace stressors (Jackson and Clements 2006: n.p.).

The contributions in Social Alternatives show there is a pressing need to link the micro-level theorising relating to interpersonal violence, organisational violence and broader societal violence. Specifically, the ability to ‘think globally and critically’ while acting ‘locally and dialogically’ might give us something to hold on to, to keep our focus in the intensity of efforts to transform violent interactions and cultures into non-violent relationships and spaces. The organisational and workplace cultural level of human interactions has been insufficiently theorised and could be the new site for the social movements of our time. For this to be so we need to build an appreciation of the nature of indirect power relations alongside direct and bureaucratic forms of power with the aim of then learning how to resist violence and continually negotiate for justice and peace. This is where we need to stand with our allies.

Insider Accounts as Political Activism for Non-Mad Spaces and Places

As Martinez writes:

... We have an unfortunate tradition of separating our work and our politics. Or, more specifically, of
treated our work practice as if it were essentially non-political. This is, of course, an illusion. All work is political. All mental health assessments and interventions are political. The job of progressive health care activists is, first, to recognize [sic] the political nature of everything we do, and secondly, to seek out and practice those forms of politics that will ensure the best possible health care system for all people everywhere (2005: n.p.).

We offer our writing as insider accounts of political activism in helping to create non-mad spaces and places. The activism is about extending the analysis of who and what counts as mental illness and for whose purposes, at whose cost and with what implications for social wellbeing, justice and democracy. This is not so much about activism as being oppositional and confrontational, as this can further reinforce ‘us versus them’ power dynamics. It is an activism more in regard to conscious and collective critically informed efforts to change cultures of violence into cultures of healing and justice.

Costley suggests that the insider is:

In a unique position to study a particular issue in depth and with special knowledge about the issue. You are in a prime position to investigate and to make changes to a practice situation. You can make challenges to the status quo from an informed position ... some work issues are beset with paradox and ambiguity but an insider is often able to unravel and comprehend such intricacies and complications (2010: 3).

Kerstetter, citing Merton (1972), writes that ‘the insider doctrine holds that outsider researchers will never truly understand a culture or situation if they have not experienced it’ (2012: 100). As contributors providing insider accounts, we tend to agree with Kerstetter that the relative nature of writers’ identities, by which she means the insider versus outsider dualism, is not that helpful (2012: 100). At the very least, none of us is outside the cultures of violence we refer to: there is no objective, a-contextual place from which to theorise on this issue. We like the non-fixed and non-dualistic positioning of ‘the space between’ as described by Dwyer and Bucky (cited in Kerstetter 2012: 101).

In the various locales where the reality of violence is occurring and the potentiality of non-violence and safe spaces waits to be claimed, we choose the latter and at this time express our hopefulness in the collective effort of our contributions herein.

Overview of Contributions

An integral aspect of the theme of insider accounts of mad places/spaces and people are the contributions located in the Commentary section of this edition of Social Alternatives. The following four insider accounts are premised in knowledge derived from lived experience where mental health consumers’ voices are centred. As such the contributions are speaking back to many of the structural and cultural issues of violence identified in the research contributions. The stories are foregrounded in the themed edition and collectively challenge current mental health systems of care and dominant discourses of discrimination which hide the mechanisms of power which perpetuate violence and injustice. The insider accounts are as follows:

Michael Burbank frames his writing with opening comments about the violences of mental hospitals with locked doors being of a different order of suffering than prisons. He calls for mental health professionals specifically to reflect on their part in the perpetuation of separations and dualisms that dehumanise and undermine people’s recovery efforts and sense of belonging in society.

Bernie Waterhouse wore the maddening effects of institutional care in her body and her journey of rebuilding her life is told to show how the non-mad people who cared for her in the mental hospital were also the same people who were responsible for much harm and suffering.

Robyn Kemble’s article tells of her experience with mental illness while she was working in a mental health service. She suggests there is an intolerable taboo that adds to the suffering she went through which is akin to a rejection of, or denial of the existence of, a professional care-giver precisely because they have a mental illness.

Chloe Warrell, Ann Ingamells, Marilyn Palmer and Dyann Ross build on the ideas in the editorial introduction to suggest that domestic violence theory is adapted to name the unsayable and to interrogate normalised practices. These normalised practices can hide violences of various kinds including the extent of harm and injustice in mental health systems and universities.

Matt Dilges shows how the context of helping in mental health systems needs to be addressed as an integral aspect of care to avoid causing harm to consumers. He presents some key informing ideas of a mental health model of practice which centre on the clinician’s critical reflective practice. Theories of attachment, development, systems, neuro-biology and sensorimotor psychotherapy, are overviewed to convey a trauma-informed way to work with people with mental illness.

Dyann Ross, James Campbell and Alex Dyer’s article focuses on the very troubling practice of secluding and restraining some people who are mental health inpatients. The organisational and managerial practices of mental hospitals may create violence-prone cultures, which set the scene for the need for seclusion and...
restraint of the most vulnerable members in the system of care.

According to Chris Dawber, there is a tendency toward defensive, self-protective and aggressive practices by mental health service frontline staff trying to manage impossible tensions of systems pressures and consumer needs. He suggests this might be addressed by avoiding a gatekeeper role and adopting the idea of intake workers being concierges.

This mental health themed edition of Social Alternatives concludes with a visionary and summative statement from Marilyn Palmer. Violence is not inevitable and its functionality in some spaces and places does not have to be accepted as the norm that is not to be questioned. The integrity of public services such as mental health care and universities, which prepare the next generation of the professional class, is at stake. The moral quality of society is based on the extent of social justice, democracy, mental health and safety of all people. Achievement of such a society depends on us engaging in dialogue about the maddening effects of violence and how the precipitating factors can be ameliorated, resisted and transformed.

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**THAT DARES TO SPEAK ITS NAME**

Love, after twentyone years of suicidal despair. After confusing the writing with the drinking, and the drinking for the writing, came love. After a momentary loss of breath, a fabled brush with death, after downing downers in the hope of drowning and finally coming up for air and finding him, came love, came love, came love...

_Jim Arkell_
_Maitland, NSW_

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**Breath Test**

Boxer was driving; we were not surprised that Sunday morning to be flagged down and breathalysed. Standard practice, saving lives etcetera. But then the question: Where are you two off to this sunny morning? None of your business, I would have snapped, but Boxer told him, and said as we drove away, No need to fuss; we’ve got nothing to hide.

Privacy is so last century, but I can’t give it up. No twitterverse or Facebook can tempt me: I see the web as threat as well as promise; my lusts and fetishes remain my own. Even watching TV, I always turn the sound off ads. My mobile phone is seldom on, I still write letters, talk only to friends on email. Passé, I know, traders see me as subversive to their paradigm.

A trader like Snowden has opened the box out of which Orwell’s future flies: soon there’ll be no room where lovers can fuck in privacy. Wives and ASIO and Centre Link and all the agencies of government will want to know what they think they’re doing, sharing bodily fluids without a minister’s approval. Nothing of what we do will dodge the cameras, the phone tap, the blue light questions by the roadside.

When every call of every citizen is tracked, when every Facebook like is logged and tabulated, so little choice, so little sense of freedom and happiness is having wants supplied, and wants are manufactured to keep economies afloat with the gadflies paid to run talk shows on TV then Boxer is a willing guest who shows that all’s still well in this best of all possible worlds.

_Ron Pretty_
_Wollongong, NSW_
Prisons Without Bars and Hospitals with Locked Doors – Some Tyrannies Exercised and Exorcised

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This insider account relates how ideas from the recovery movement and literature have provided a language to write about the experience of mental illness. The purpose of the article is not the telling of a comprehensive story, other than for setting the early life context for the writing. Rather, its purpose is to emphasise what is really important for all of us; to feel loved, to be able to express love and to belong – in short, to have a life fulfilled. Madness is any separation from self and others, forced or enforced, where we endure suffering, injustice and stigma.

Introduction

As I wrote this article it occurred to me that from beginning to end it is a tale of relationships, their implications for our existence and their impact on our capacity to grow. It is also about how our sense of connection to a community, to our families and to ourselves, guides and defines the pathways of our lives. The richness, or indeed the paucity, of our lives can be defined by our experience of love. Yet the sense of general belonging as encapsulated in our loving care for ourselves and others can be such a challenge to interpret and understand. It can provide the impetus to save or the force to destroy. Our sense of connection it seems to me is determined by our capacity to understand and interact with others.

Formative Influences in My Life

My life started in a loving and caring family, albeit a dysfunctional one, which was challenged by the impact of alcohol and violence. My father impressed me as a man living a dichotomy, submerged in his own thoughts and actions whilst wading through the confusion generated by his circumstances. He was the personification of complexity as he was an intelligent, caring person growing up in hard circumstances in a country that was busily shuffling their young men off to war. My father was a man full of irony and distress who revisited the violence he experienced onto his sons. My mother was a displaced war bride trying to find her place in a new country without the support of her new husband who was at sea for a considerable amount of her early married life. She was a woman disconnected from and abused by her own family, who was desperately trying to make her way in a new country with a young family. My experience of her was of a woman finally succumbing to the distress, abandonment and suffering from what was referred to in those days as a nervous breakdown. The ramifications of these perhaps not so unusual life challenges during the period were to play out in my life and the lives of my siblings.

We were effectively a family of gypsies only staying in any one location for a maximum of three years. As a family we watched as our mother’s family abused and used their relationship with our parents for financial gain, doing so seemingly without conscience. The truly amazing thing in all this, despite the arguments and turmoil, was the pervasive feeling of love in the household.

Amidst all this was my father who I experienced sometimes as the loving man and other times as the angry man. There is a family tale about my father smashing glasses on the floor in a drunken rage and then pushing me into the broken glass in bare feet (I was seven), telling me to walk through the glass because a man must learn to endure pain. As I got older the rules changed. I would be stood against the wall and be told to square my shoulders, pull my stomach in, stand tall and be asked ‘what’s your name?’ Then I’d be told to be proud of the name and to always defend the rights of the women in the house. This routine of misery would be often followed by a punch in the mouth. I came to understand that my father was desperate for me to fight him and for most of the time I was bloody minded enough not to let him have what he desired, although at times I succumbed and retaliated.

My father, the father I loved, came home from work at 6:30 one morning and collapsed with a massive coronary. He died in my arms and thereby left me as a young man of sixteen distressed, traumatised, guilty, shut off
emotionally and unable to deal with grief. One of the other gifts left by my father, and one that he drummed into my head, was ‘when I die, you may shed a tear but don’t waste too much time’. I love and miss this man and it has taken me forty years of my life to resolve the damage that arose from that relationship.

It should be noted that this was the third violent death that had happened in my immediate environment. The first was a friend in a car accident and the second was another friend in a pub brawl. In my formative years up to my mid-20s death never seemed to be too far away – there was the loss of a cousin who I had been close to since we were children, then there were friends in motorbike accidents and later other friends from overdoses. I perceived the world through a lens of violence where I could not rely on anyone and where everything was fragile and could be torn away in a second.

Losses Further Compounded

I struggled with a sense of disconnection where at times I wanted more from people than they could possibly give and at others times I would close down and create impenetrable barriers so I could remain safe. Needless to say, my intimate relationships became disasters and my internal relationship with myself was chaotic. In turn, my interactions with the world and my environment were frenzied or fearful.

I became a workaholic and descended into a world of substance abuse and risk-taking: I attempted suicide and I created pain for those around me. I felt a pervasive sense of worthlessness that surrounded me like a nebulous cloud threatening to suffocate anyone who came near me. I experienced psychotic breaks and voices. I engaged in criminal behaviour while my poly-substance abuse grew and I committed myself to a pathway of self-destruction. This reached a climax when I was thirty years old with the death of my mother followed closely by the destruction of my dysfunctional marriage, the loss of my business and the calamity of accidents and later other friends from overdoses. I perceived the world through a lens of violence where I could not rely on anyone and where everything was fragile and could be torn away in a second.

For most of my life my focus and energy has been about surviving and learning how to be resilient. I think of mental illness as my life being interrupted by trauma. My experience and that of others who have met the challenge of an interrupted life is that we have done so through relationships that have validated our experiences. Similarly, Wolin and Wolin describe the connection between resilience and relationship as:

... intimate and fulfilling ties to other people. Proof that you can love and be loved, relationships are a direct compensation for the affirmation that troubled families deny the children (1993: 111).

From my perspective, sitting at the heart of relationship is the acceptance of rights and responsibilities for ourselves and others, and this encapsulates itself within the bounds of mutual respect. Moreover, I needed responses from professionals and others that captured an understanding of who I am as a person and what I look like within the context of environment and time. I needed a rich understanding that I am more than a collection of pathologies and deficits and to believe that symptomatology is only a part of who I am for it lacks the capacity to reflect an image of me as complete and integrated.

Through the journey to wellness many people, myself included, have engaged in relationships that were destructive and infantilising or had no capacity for mutual empowerment. For a time, I learnt to see myself through the lens of illness, to bury my personal history and become overwhelmed by pervasive feelings of being alone, isolated and someone who is ‘other than’. The result was a perceived loss of power and choice in most relationships or, more to the point, an internal perception of having no right to even the smallest modicum of basic human dignity and respect. The redefining of feelings and experience into pathologies and deficits effectively trapped me in prisons without bars by separating me from
my personal experience. I now know I am more than a label and yet have often experienced being treated as nothing more than a label.

Symptomatology is the way mental health professionals define the experience of madness – not their own, but other peoples’ madness. They use diagnostic criteria such as suicidal ideation, auditory hallucination, defence mechanisms, denial, thought disorder and emotional dis-regulation. This may give the frame of reference for the professional but at many levels it can remove the person’s experience of life and the impact these experiences make upon them and their situation. To some extent, it excludes the individual's belief systems and feelings. This has been at the core of much suffering and many of the tyrannies done to me and others in the name of care and cure. Interventions which deny my humanity and which deny the validity of my feelings and experiences represent the most maddening violence that I have experienced. This violence can be de-humanising precisely because it occurs in the guise of ‘helping’ by professionals who are experts and who are paid to care.

The process of diagnosis provides a way to name an individual’s distress but symptoms-based descriptions lack the capacity to fully explore a person’s life and experiences (Repper and Perkins 2006: 15). The capacity to pathologise and name behaviours is obviously important within the framework of the medical model. However, non-medical recovery literature alludes to the fact that psychiatrists are constrained by a model of practice that is disease based. Non-medical based recovery models often refer to medical intervention as biological reductionism utilising evidence-based medicine as its only guide. This is in stark contrast to a person centred focus on recovery (Robert et al. 2007). In my experience the answers are not to be found in extremes but in a loose marriage of the two viewpoints.

People are more than a collection of pathologies, symptoms and deficits. It is in my capacity to own and manage my life circumstance that the power to manage and describe my recovery resides. I have found that diagnostic terms may identify personal distress as something separate to the individual. This contrasts with identifying distress as a feeling that is owned and acknowledged by a person and where the capacity to influence the feeling, change the circumstances and move forward is nurtured. In this manner, individual thoughts, feelings and actions are seen as normal responses to real life stressors as opposed to mysterious symptoms that we have no control over. It is in the ability to look at the individual as a whole person and as an integrated citizen that the power can be exercised for self-determination and personal agency.

What Really Helped Me

To sustain life change it is important to recognise that recovery is unique, diverse and dependent on the individual and is something other than a prescriptive tool that describes an outcome. This is key to fostering an environment that is accepting and supports individuals to explore the possibilities of their life, their knowledge of themselves, and their resilience. In consideration of this, the nature of my relationships was of extreme importance in my journey. Over the years I have had numerous conversations with my peers (others with a lived experience of mental illness) where paramount to their recovery were equitable relationships, which provided a different level of connection. A great example of this would be the day I was talking to a mental health consumer who saw a clinician in the distance and quizzed me as to my knowledge of this person. Although they could not remember the clinician’s name, they did remember that this particular clinician stopped to play table tennis during a hospitalisation twelve years previously. They proceeded to relate this encounter in a quite animated manner noting the positive feelings of self worth and equity they had experienced in that interaction. The perception of self worth was generated by the ‘level playing field’ of the table tennis table where the differences and boundaries were diminished, and shared humanity and equity were experienced.

A turning point in my life occurred slowly over a long period of time, which began when I had contact with a psychologist as part of a court ordered assessment of my mental health. She really stretched herself for me. I saw her many times, way beyond what she needed to do and beyond what I could afford to pay. It came to really matter that someone knew me, went out of their way to understand me, and was able to put the pieces together in a way that made sense to me for the first time. She created a safe space with boundaries from which I could come and go without pressure. The door was open. There was a connection that sustains me still even though I haven’t seen her for a long time.

Living a life fulfilled rather than a life interrupted could be seen as individuals exploring and realising their ‘power’ to make real choices and accept real responsibilities. This involves supporting a vision that promotes the concept of recovery as a shared journey with a basis in co-learning and involves engaging in genuinely supportive relationships that are responsive in manner, build on strengths, and are future orientated. Quality of life encompasses life as a holistic process and promotes the individual’s identification of human rights and citizenship. This needs to be inclusive of a person’s right to a meaningful life, a life that includes hope, social and recreational activities and meaningful activity as identified by the individual. It also involves upholding basic rights and responsibilities of all individuals to respect, honesty, courtesy, recognising the dignity of choice and the right to live free from stigma and discrimination.

If we see recovery from mental illness as regaining functionality then that functionality would be in the
achieving or regaining of a sense of personal agency and citizenship. Lysaker and Leonhardt wrote in regard to the concept of agency within the context of severe mental illness that:

At its heart the recovery movement asserts that people are not passive sites where biological and social forces meet but agents who interpret their experiences and whose meaning making plays an essential role in outcome (2012: 165-166).

**Questioning Care Given**

I have found that some of the personal desolation of grappling with mental health issues can be attached to the nature of care. The secondary effect of formalised care for me was the reduction or loss of a sense of personal agency. If we are subject to such care for an extended length of time we may well experience a learned helplessness (Maier et al., 2014: 17-18), or a systematic stripping of our confidence and our identity. It is within this learned helplessness, this loss of self, that some individuals from a lived experience background can and do require unique and complex support structures.

The manner in which care is given is of extreme importance or it can become a negative self-perpetuating cycle. The intention of care should be to promote deep thinking about whom we have become and our future possibilities. Care should be given in a manner that encourages us to explore relational dynamics, to sit with discomfort and to negotiate power. For example, the re-defining of crisis may assist in navigating the pathway to recovery. We could couch crisis in terms of opportunity and change and in turn we might acknowledge the fact that crisis can be transforming. Mutually supportive relationships can be a vehicle to support the exploration of contextually new perceptions of crisis specifically and life generally, and within this the rethinking of experience becomes possible. Quality life changes can encourage people to proactively create environments that support positive outcomes thereby promoting the personal and individual capacity of people. The goal would be to rebuild a sense of community and belonging if they have experienced a disconnection from their social milieu.

The notion of hope (Allot et al., 2002: 13) is an important component to this change of perception. Part of recovery is being around people who see a mental health issue not as a sentence but as a challenge from which to build a new life with increased personal control. The person at the centre of the journey should be seen as potent and potential, not pathology or problem. The impact of appropriate support should not be dismissed yet the challenges to the provision of this support are multiple, perhaps especially for the professional.

The challenge for a professional worker within mental health is to create a space that is conducive to co-learning experiences and to create a process that can be perceived as a shared pathway. This is about sitting within a formal mental health system and maintaining balance between skills and support while suppressing the need to identify as expert in other people’s lives. It is about the ability to walk the fine line between being recovery focused yet not to be neglectful of the person’s needs. Is it possible to meet all these requirements, some of which could be perceived as conflicting?

In an attempt to answer this I would like to share a personal experience that may provide some insight into the capacity to keep a space open that maintains a sense of dignity for the mental health consumer. I was pulled up in a public space for disorderly behaviour by the police. From the outset it was fairly obvious to everyone present, including myself, that I was going to end up in the police car. But whilst we were walking to the car I became extremely distressed and agitated. I suggested to the police officers that it might be good if they gave me five minutes before I got in the car. They were fine with that and as a result I got in the car without need for force.

So let us look at what happened here – for myself and the police the outcome was the same but I had choice and dignity in the situation. This suggests that by maintaining a level of mutual respect and belief that there is capacity within the individual we can achieve the desired outcomes.

To effectively view me as a whole person, a plethora of questions and potentialities arise. One potentiality arises with the capacity to look at the journey to inform what brought me to this point in my life, and using that knowledge, to engage with me in a manner that provides a place for empathetic understanding to occur. Furthermore, there needs to be a recognition that to fully engage with me, it is important to develop an understanding of the trauma and violence I have experienced in my life.

**Violence and Madness**

Violence is a fact in our society. We implicitly and explicitly condone violence and then we blame the victims who can be seen as damaged and in need of treatment. Although the sequel of violence and abuse is profound (Davenport 2007: 259-260), in my experience mental health professionals have often either neglected to ask or ignored the situation. Some educated professionals (with the help of insights from domestic violence and sexual assault programs – for example: Domestic Violence Crisis Service 2014) are recognising and understanding the long term damaging effects of past violence. Questions like ‘What happened to you?’ compared with ‘What’s wrong with you?’ are being asked in more trauma informed systems of care (Bloom 1994: 474). The difficulty is that many mental health consumers, myself included for a long time, have been taught to think of their difficulties as mental illness and been treated with medications, while being offered...
no explanation of the correlation between past violence and current life difficulties.

Consequently, a parallel dissociation occurs as a result where a secondary level of abuse takes place via the incapacity to fully explore with the person the ramifications that a violent and abusive past have had on their current life story. The outcome of this could be an incapacity for the person to develop an internal narrative and generate a fuller understanding of how the past affects the present and can influence the future. If the person’s thinking processes are left without interruption and understanding, people can become stuck and ill equipped to move toward a more fulfilling life.

In my work, I have found much value in the development and maintenance of a place of safety for mental health consumers to recount their personal history. This can afford us a place to grow and share an understanding of the world through each other's experiences. This is about providing a way to interact with people experiencing distress and trauma that is inclusive, collaborative and respectful. Such a space creates potentialities for people to come to a new interpretation and a new idea of themselves, which is something more than symptoms and deficits.

Finally, my personalised theorising also involves some big picture ideas of how we have institutionalised mental health care in the community. However, the community is largely propped up by fears, misinformation, ignorance and prejudice about mental illness. As a society we haven’t worked hard enough to accept people who don’t fit into the mould of the ‘norm’. There seems to be a threat of being separated from the herd, a kind of mob mentality. Yet there is an ‘us’ versus ‘them’ operating which results in certain social groups, people with mental illness being one such group, being labelled as ‘them’ and not part of the ‘us’, the herd, the human family. For me the key point in all of this is that separation between people caused by discrimination is violence. It is more than allowing people to be people and it is more than the acceptance of difference. Separation through discrimination is at the core of violence and it makes people go mad. Love in caring and respectful relationships is the antidote to violence.

References

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Saw devils everywhere
Saw devils everywhere, did poor John F.
especially in my record collection–
whipping me from church to bed and back
to church, obliterating my homosexuality
on the anvil of God’s love and punishment.
I was never sure what he or He meant.

Jim Arkell
Maitland, NSW
I’m Not Mad!

BERNIE WATERHOUSE

A shockingly disturbing personal account into a traumatic and distressing journey with schizophrenia is presented which shows the harm caused by excessive electro-convulsive-therapy and years of continuous hospitalisation. The move towards recovery and what was helpful and was not helpful is outlined, using the idea of the author’s body being politically inscribed by professional power dynamics beyond her control which she reframed and resisted. This is an account of triumph over the medical system and the author’s achievements in study and the work environment, which includes education and advocacy to reduce the stigma and misunderstandings surrounding mental illness in the community.

Introduction

In 1991 at the peak of my career as a personnel manager for a large firm I became very unwell. I was admitted to a private psychiatric hospital where I was diagnosed with schizophrenia. I spent the next five and-a-half years until June 1996 in this psychiatric hospital as a continuous inpatient. When I was discharged, the journey back to wellness was strewn with major obstacles. In addition to coping with the stigma of having a serious mental illness (Millen and Walker 2001: 89), the effects of excessive treatments and years of institutional care were devastating. Sadly, the treatments I received erased my memory prior to January 1996 and stole all my previous life skills, my work skills, my dignity, my confidence and my self-esteem. After years in the mental health system I slowly crawled out of the cycle of psychiatric abuse and control in which I had been trapped and tried to establish a life that I thought a society, often intolerant of difference, would accept as ‘normal’.

The purpose in writing about my story as a survivor of the mental health system in the 1990s is to show the intricate inter-connection between my personal distress and the control and discrimination I experienced at the hands of my psychiatrist and treating team. It is no accident that the whole experience which I present below, was overseen by one person, my psychiatrist, whom I shall refer to here as Dr Smith. I shall use the plural of Dr Smith(s) as a literary device to speak to the broader politics of medical dominance (Coburn 2006: 432) with psychiatry in mental health care a specific example of this dominance. I regard Dr Smith(s) as the mad one(s) in so far as their actions, which caused me (and many others) so much harm, to have been antithetical to what I needed to become well and resume my life. My experience is one that is captured by the idea of social iatrogenesis where:

Sickness [is] produced by medical activity. It is the process through which medical practice enhances sickness by strengthening a morbid society and encouraging people to become consumers of curative … medicine. It is obtained when medical bureaucracy creates ill health by increasing stress, by multiplying disabling dependence, by lowering the levels of tolerance of discomfort, by reducing the leeway that people will not concede to an individual when s/he suffers, and by abolishing the right to self-care (Ask.com 2014).

Clearly, Dr Smith(s) in mental health systems are not alone in their behaviour as I repeatedly experienced what other survivors describe as the extremely troubling abuse and neglect at the hands of many (but not all) mental health staff:

... So many terrible things [can] happen when we are in hospital and it [can] take years to recover from the effects of being personally and collectively ignored, humiliated, misunderstood and misdiagnosed by representatives of the institution of psychiatry (Dewan 2009: 222).

Sartorious claims that:

The public health professionals often have negative attitudes to people with mental illness and will behave accordingly once they are told that a person has an illness about which they have prejudices (2002: 1470).

Sartorious (2002) offers the idea of iatrogenic stigma to describe the highly prescribed clinical/medical practices that can position the person with the diagnosis of mental illness as the problem even as the system of care can seriously compound and add to the person’s experiences of distress. For example, O’Hagan writes of the divide...
between her experience in a mental health facility where she kept a detailed journal and the official records which were kept by the psychiatrist and nurses:

Several years later I read what they had written about me and I couldn’t believe that my journal and their notes referred to the same person and events. The incongruity between these two accounts of my mental distress is disturbing and I believe exposes the fundamental reason why mental health services so often fail to help people (2009: 198).

To this day, I believe a deep injustice has occurred in how I was treated; while the doctor who had the main responsibility for my wellbeing did not at the time, and has not subsequently, taken responsibility for his actions. Crucially, the status quo of medical dominance commands sufficient legitimacy in contemporary Australian society that it is virtually impossible to tell my story of injustice and despair at his hands without seeming mad. This story is all about power and the continuing disabling effects of mental illness that endure well past the actual experience and treatment period. This is in part due to the stigma of a mental illness which was identified by Goffman (cited in Millen and Walker 2001: 89) as a negative attribution of the person diagnosed as mentally ill. Repper and Perkins suggest that:

The concept of stigma focuses attention on the perceptions of the individuals at the expense of an examination of the pervasive and socially constructed exclusion from social and economic life that people experience (2009: 121).

Sayce argues that there is a slippage with the individualistic term of stigma as it helps the powerful people, the medical experts and policy-makers, avoid responsibility for their discriminatory and harmful behaviour (cited in Repper and Perkins 2009: 121).

My Very Political Personal Story

I provide some details of my story here to demonstrate how political much of my experience in hospital care was; and how that politics became deeply inscribed in my body, heart and mind in the most damaging of ways. Here I want to emphasise that the effects of the treatment I received were experienced in my physical/emotional body and soul to such an extent that I literally did not know or remember myself. This is both about me, experienced only by me, but actually says everything about the oppressive nature of the mental health care I received. This in turn links profoundly to the idea of my body having a political surface that is impacted by the oppressive power dynamics of medical experts. This political surface of my body is referred to as the ‘body-without-organs’ (Deleuze and Guattari cited in Thompson 2011: 147). As Fox notes:

On its surface intensities vie and intermingle: from the patterning of the body-without-organs emerges the fabricated, political, ephemerality of identity – the human subject (cited in Thompson 2011: 146).

My identity was deeply impacted and my recovery became about re-making myself spanning from the re-claiming of my memories to my political activism ever since.

Excessive Treatment and Prolonged Hospitalisation

While employed as a Personnel Manager in 1991 I became very unwell. I was displaying psychotic symptoms and my colleagues, friends and family were at a loss as to how to help me. I was seen at a private hospital by a psychiatrist, Dr Smith, who diagnosed me with schizophrenia and transferred me to the psychiatric wing. Dr Smith immediately prescribed anti-psychotic medication and three weeks later also commenced Electro-Convulsive Therapy (ECT). I received ECT from August 1991 until December 1995 almost continuously. During this four years and four months period, I received ECT up to three times a week with few breaks as well as anti-psychotic medication.

ECT is usually given in a course of between six and twelve treatments with the quality of response and the changes in the target symptoms and clinical improvement guiding the number of treatments (Weiner et al. 2001: 176-177). ECT is considered successful when the person experiences reduced or no clinical symptoms which then allow them to be discharged from hospital and experience a quality of life that was not possible prior to the ECT. If the symptoms return, another course of ECT may be considered. Abrams writes that depending on the number, frequency and duration of ECT memory impairment such as retrograde amnesia (memory loss for events preceding ECT) may be experienced (1992: 185).

Starting with my first and second course of ECT given by Dr Smith I developed confusion, disorientation and memory problems that were serious enough for me to be referred to a specialist at a larger public hospital. The conclusion by the specialist was that the problems I was having were due to anti-psychotic medication and probably ECT. Despite this serious confusion, memory problems and delirium, Dr Smith continued this treatment for another four years until I had received 250 treatments. My sister, my sons and friends repeatedly advised my psychiatrist that I was deteriorating and losing my memory, and begged that I be discharged into their care. However, he refused to discuss anything with them. Dr Smith disregarded the knowledgeable, non-medical observers and family with long term knowledge of myself who stated to my psychiatrist that non-medical therapies would be more effective than hospitalisation, medication and ECT. The rights of family and friends to be involved
in their loved ones’ care is covered in the Royal Australian and New Zealand College of Psychiatry’s Code of Ethics which states:

Psychiatrists shall encourage the active participation of the patient’s family (and/or others closely involved with the patient’s non-professional care) in clinical care where considered appropriate, taking confidentiality, cultural features and the patient’s wishes into account (2010: 6).

Dr Smith claimed that I had a positive response to ECT. Yet when I later accessed my clinical notes, other patients, family and friends reported that in the first year of my treatment I was functioning well in my self-care and was able to maintain relationships with family who visited me. After I had been receiving ECT and anti-psychotic medication for twelve months the clinical notes, family, other patients and friends confirmed that I was severely depressed, not wanting to live and unable to care for myself in the most basic of ways. The side effects of ECT have long been established.

One of the first follow-up studies on ECT was conducted over forty years ago by Janis (1950) who concluded that patients exhibited retrograde amnesia after receiving ECT and that in some cases this loss of memory was permanent (cited in Cameron 1994: 178). Furthermore, a study across seven hospitals over a twenty-six month period was completed on the cognitive effects of ECT and provides evidence of retrograde amnesia (Sackeim et al. 2006: 9). Also, key national inquiries such as the Burdekin Report (Human Rights and Equal Opportunity Commission [HREOC] 1993) substantiated grave concerns about the mental health system, excessive treatments and control issues. The whole impetus behind the mental health consumers’ rights movement in Australia is a belief that community care with support was more suitable for patients rather than long term hospitalisation with invasive psychiatric treatment (Pinches 2004: 4).

Considering the deterioration in my condition once ECT commenced, and the need to be a continuous inpatient from 1991 to 1996, I would suggest that ECT became highly inappropriate and completely ineffective. In fact, the process stole my long term memories and with that profound loss, I lost my total sense of self. Moreover, I would suggest that in such situations as this, Dr Smith(s) broke their pledge to the Hippocratic Oath in overseeing such a grave injustice and harm to me in the name of their certainty of: being the expert, being right, and being above question and reproach from my family’s earnest representations on my behalf.

My Fight for Freedom

In December 1995, after four years and four months of ECT and anti-psychotic medications, my health fund submitted my hospital account for review by the Department of Health’s Acute Care Division (ACAC). At that time they had paid approximately $480,000 for acute hospital accommodation which was the largest payout in Australia for this type of acute care. In December 1995, after this query, Dr Smith stopped ECT treatment immediately. From January 1996 my quality of life improved but I can only remember from that point forward.

I recall in early 1996 receiving letters from the ACAC asking me to provide information so that they could make a decision about revoking my acute care certificates. I realised then I had cognitive problems but just thought I was really dumb and was struggling more than others to understand what was happening around me. Incredibly, another unjust power dynamic then came to the fore. The senior hospital staff were very insistent that I seek legal advice to enable me to stay in hospital telling me I ‘would not survive outside of the hospital environment’ and that I needed to ‘come to the dreadful realisation that I would spend most of my life in a psychiatric hospital’. Of course, I was terrified and very appreciative of this unusual concern and relied on them to organise a suitable solicitor on my behalf. I also took the advice of staff on what I should say to the solicitor in order to stay in hospital.

However, the subsequent interview with the solicitor was important in highlighting how I concentrated on concerns of self-harm, my belief that I was unable to survive outside hospital and that I needed inpatient care from my psychiatrist and nurses. Paradoxically, my family commented later that I was much better than last year when I was so sick that I could not talk. I stated to the solicitor that until January 1996 someone had handled my financial and personal affairs but since the ECT had stopped I had been able to learn to do my own health care forms; adding that I had been eating regular meals, reading books and had generally become much better. It was nonsensical that on the one hand I stated there was a massive improvement since ECT had stopped, but that the whole purpose of the interview was to prove I was so ill I could not leave the hospital.

My family tell me these major improvements only occurred when ECT had stopped permanently. I often wonder what would have happened if my health fund had not intervened and the ACAC had not revoked the acute care? I was discharged from hospital mid-1996 but my health fund allowed me to have periods of hospitalisation for the next six months to adjust to being in the outside world after such a long period of hospitalisation. Unfortunately, due to the excessive ECT I had no memory prior to 1996 and I did anything I could think of to get back into hospital in this six month period. I was terrified when I was not in hospital. I had dutifully fallen into the passive patient role and for a long time had allowed myself to be a room number and a schizophrenic and only wanted the safety and security that hospitalisation seemed to offer.
Personal Impact of a Profound Loss of Memory

The political inscribing of my body and mind took various forms but none was as devastating as the profound loss of memory that occurred as a result of ECT. To explain to the reader what it is like to not have long term memory, imagine what it is like being 41 years old with the cognitive ability of an adult but the personal and general knowledge, and social cues of a child of about three or four years of age. You are expected to be equipped to live as a 41 year old with life experiences and some education. Try to comprehend not knowing who you had been as a child, sister, friend, mother or colleague or who you were expected to become. I did not know that I had three brothers and four sisters or where or how old they were. I did not even know where I grew up, went to school or my varied work and travel experiences. Sadly, I had to rely on family and friends to fill in my personal history for me. I still look at my passports with nearly every country in the world stamped in them, and photos of me in New York and Africa and find it so very strange that I had once travelled to these places and that my name is on these passports.

Additionally, mathematics was impossible and I could not do the most basic adding or subtraction. However, in my role as personnel manager, I had evidently been responsible for the wages of approximately 150 men, taxation reports and union negotiations. My understanding of the English language was also lacking and I could only comprehend simple words. For example, if someone said something was ‘hard’ I could understand, but if they used a word like ‘complicated’ I did not understand what the word meant. Once my work role was ‘Computer Room Controller’ for a large organisation but after ECT I did not even know how to turn a computer on or use a mouse, much less type or understand the programs. My mental health case manager taught me to blow-dry my hair and took me out to buy these strange items called ‘make up’ and showed me how to apply them. Trying to cook was just a disaster; however I could evidently do all these things very well prior to ECT. I subsequently threw out hundreds of photos as they were of strange people and places, not friends and life’s special occasions.

My Life in the Community

There is life after an episode of serious mental illness. Frustratingly, it was a journey of a few steps forward and many steps backwards. Although I wanted to surround myself with those who believed the crisis period was over and that I could move onto wellness and take responsibility for decisions in my life, I was caught in the passive patient role. Through this realisation I gradually became aware of my frustration and disillusionment with the system. This built as my struggle to recover continued and manifested over time as a desire to be an advocate for the injustices that occur in mental health systems for many people, myself included. I was aware of my dependence on the very system and people who had caused me so much harm and how this did not serve me. I would ring my doctor or case manager and ask for assistance and expect it all to be taken out of my hands and fixed for me; this after all had been the norm for me for over five years when in hospital.

Conscientious clinicians in the name of ‘concern’ and ‘caring’ had stated repeatedly to me and my family that I needed to ‘come to the dreadful realisation I would never be well’ and that my ‘delusions of curability were childish’. Well-meaning and knowledgeable clinicians called my dreams of getting well and working as ‘grandiose ideas’ and talked about my feelings of ‘hope’ that I could be well as ‘lack of insight’, rather than my insight. This situation has fuelled my belief that the system often makes it easier to stay unwell and dependent on others and that taking the personal responsibility that is required to move towards recovery and independence often feels like an impossible task.

People ask, what was the actual thing that caused or allowed me to move from the passive patient role to recovery? My recovery required surrounding myself with people who looked for my strengths rather than focusing on my weaknesses. They understood that having a mental illness was only a part of who I was and that if I was excited, sad or angry, it was more often due to the ups and downs in my life, as is those with which all people struggle. Also, people listening and offering me choices that were meaningful to me, and encouraging me to take personal responsibility in connecting with activities I would enjoy, increased my self-confidence, self-worth and my connection with my community. Thus, the building effect was one of giving me the motivation to explore and find a world beyond mental illness, psychiatrists, treatments and hospitalisation.

A Message to the Establishment

I want Dr Smith to know that three months after I walked away from his ‘control’ (he said I would die without him) and all the medications, I was working voluntarily for the Salvation Army. I subsequently started studies and to this date have completed two degrees with a grade point average of over six and I am now working full-time. These are ambitions all of which Dr Smith said were impossible. I was employed by a small mental health community agency for a period and am now working for a Mental Health Service as a consumer participation facilitator. This is a systems role where I encourage consumers to have a say in the planning, delivery and evaluation of the service they receive, as well as educating mental health staff on the consumer perspective and recovery-orientated practices. Moreover, I have Master status as a Mental Health First Aid Instructor which allows me to deliver a 16 hour course (co-founded in 2000 by Betty Kitchener OAM and Professor Tony Jorm) that assists in reducing the misunderstandings and stigma surrounding mental illness and also gives people who attend the course the knowledge to assist people struggling with mental health issues.
As psychiatrist Sartorious writes, the iatrogenic stigma of mental illness begins with psychiatrists as the most dominant members of the mental health system:

We psychiatrists and other medical professionals are not sufficiently engaged in fighting stigma and discrimination related to mental illness; what is worse, we may be contributing to it in various ways. It would be useful if all of us were to examine our own behaviour and actions and change them where necessary to reduce stigma. Stigma remains the main obstacle to a better life for the many hundreds of millions of people suffering from mental disorders and their consequences. We must make our contribution to eliminate stigma and fight it in every way possible (2002: 1470).

Unfettered power, even if somewhat tempered by the influence of the mental health consumer movement and multi-disciplinary mental health workforces in Australia (Pinches 2004: 6), is a very dangerous matter. I can say this with quite some authority.

Sadly, it is a fact that I had years of my life and precious memories stolen from me forever through excessive ECT and Dr Smith and other mental health staff’s disregard for safe and just clinical processes. Nevertheless, I want Dr Smith(s) and other professional groups who uphold the power structures that allow such negative outcomes to occur such as I experienced to know – with regard to everything you said about me and others in similar circumstances: you were wrong.

I should be very mad at Dr Smith and the other staff who were my treatment team; but I am not mad. I now have a meaningful life in my community and am surrounded by family, friends and work colleagues who do believe in me. I believe my recovery was in large part delayed and complicated due to how I was treated by Dr Smith in the private mental health facility. My recovery that I have achieved in this time has been enabled and encouraged by the people who know and care for me in various aspects of my everyday life. The violence done to me could have been avoided by all the people who had professional caring roles with me. They needed to really listen deeply, see me in my whole life, and believe in me and hold onto the hope that I could recover even when I had given up on myself.

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The Intolerable Taboo of Mental Illness

ROBYN KEMBLE

The paper presents an account of a mental health clinician’s mad journey in a mad place at a mad time. An intolerable taboo appears to be operating when mental health clinicians themselves become mentally ill, and this phenomenon is used to explore experiences of separation, lack of recognition and lack of support from other mental health colleagues in the workplace. There are two simultaneous needs of grappling with our own shadow and of addressing the overwhelming and insidious shadow of mental health systems to overcome the culture of silence around this issue. The hope that exists for the system and the individual within this system is in facing the truth of our own madness so we may be better placed to help our clients and our colleagues.

Introduction

Very little research has been undertaken into the experiences of mental health staff who themselves experience mental illness. Most constructions of professional workers, where there may be some impact of the work environment on their health, are couched in terms of vicarious trauma or burnout and about the ways in which therapists are affected by their clients (Rothschild 2006: xiii; Jacobowitz 2013: 788). Professionals are encouraged to receive supervision and to undertake self-care (Dawber 2013: 241), and sometimes there is cognisance given to the responsibility of managers to address workplace stress and trauma-causing factors (Jacobowitz 2013: 787). There are, however, a small number of studies that refer to mental health issues for staff. One study found that exposure to clients’ traumatic experiences did not directly affect vicarious trauma and workplace burnout of Australian mental health staff involved in clinical practice. Rather, it was found that work-related stressors best predicted therapist distress (Devilly et al. 2009: 373). Another study (Joyce 2009: 1) showed that where nurses had experienced mental illness and the attached stigma, there was significant prejudice when returning to work, especially from other medical professionals. Joyce (2009: 1) also highlights a noticeable lack of research in this area of concern.

This article presents an insider account of my experience of mental illness while working as a mental health professional in a mental health service some years ago. The account is telling for what is not conveyed or written. How do you put words to the unsayable and that which is not allowable in society? The account is also telling for the way it conveys, quite purposefully, an a-contextualised, isolated experience that could be about anyone anywhere. There is one contextual detail provided here, however, related to my being surrounded by talented and compassionate colleagues who are dedicated to their work with mental health consumers. This example of what could be described as an isolated and disconnected experience from the people around me could perhaps be due in part to my colleagues at the time having little understanding of the struggle and pain of living through deep depression. It is also perhaps about the intolerable taboo in our society of professional caregivers themselves being susceptible to mental illness. Taboo refers to behaviours that are ‘proscribed by society as improper or unacceptable’ (‘Taboo’ 2005: n.p.). In the area of mental health, it can cross-link with the recognised harm caused by stigma, including social stigma (Sayce, cited in Repper and Perkins 2009: 121), to create a double jeopardy.

At the very least in my experience the taboo has the effect of creating a culture of silence (Freire 1970: 12) around the nature and extent of this phenomenon. The main effect of taboo behaviours is social exclusion and for me this manifested as increasing difficulty in remaining in the workplace. Anti-oppressive writers describe social exclusion and the related experience of marginalisation as forms of oppression (Young 1990: 53). Anti-bullying research links such behaviours to ‘mobbing’ or ‘scapegoating’ (Mattiesen and Einarson 2007: 735) where numbers of colleagues, for example, are involved in creating a charged environment around a person with a de-valued identity (Millen and Walker 2001: 89). These behaviours can make the target’s ability to manage their personal situation increasingly difficult.

It is important to re-focus the issue from the private, personal and subjective nature of mental illness, and those being silenced because of the intolerable taboo, toward a focus on our shared responsibility as mental health staff and colleagues. This shared responsibility relates to both the need to do our own healing work (Macy 2007: 15) and also to doing our own work relating
to our prejudices and fears about mental illness. Sullivan (1999: 42) writes about the risk of meta-discrimination towards consumers that can occur when professionals hold prejudices about consumers. She suggests this is a second level of discrimination that is likely to be experienced by consumers by virtue of their client status (Sullivan 1999: 42). Similarly, it is likely that where staff are experiencing mental illness, they can become positioned in similar ways to mental health consumers as the person needing professional help. Thus, staff with mental illness can be subjected to the same dominance of medical power and treatment to ensure conformity to societal norms of behaviour (Thompson 2011: 145) where, similar to the patient role and status, the experience can be very stigmatising and disempowering.

This article further explores the idea of ‘the shadow’ – the hidden intra- and inter-personal dynamics of power – and its value in understanding mental illness. Feminist psychoanalyst Benjamin suggests that this is in part about challenges of recognition between us, where there can be a splitting between largely unconscious forces for separation and connection (1997: 10). I suggest this has a social dimension as much as existing for some as an intra-psychic tension, where there is a social separation and non-recognition of the person constructed as ‘other’. For those of us with professional identities to maintain, acknowledgement of the shadow may or may not be something we are comfortable with. Collective denial, or lack of language to describe a phenomenon, or contestation as to such intra- and inter-personal dynamics, does not make it any less likely to be occurring. Referring to the invisible dynamics of embedded power in organisations, for example, Buchanan and Badham (1999: 57) suggest it is precisely because of such non-recognition of power dynamics that they can be so powerful.

More research is needed to understand how the intolerable taboo functions and this article is an attempt to begin thinking about what are likely to be promising ideas for further research. The subjective experiences of staff with mental illness, particularly when their workplace is in the area of mental health, is an important starting place for establishing the need for this research. An account of aspects of my subjective experience of mental illness is presented in the next section.

**Within a Silent Space Lost in Shadows**

I didn’t want to go to work but I knew I had to; I had promised I would show up and I was determined to be there. I was having trouble feeding my baby – he kept crying and wouldn’t settle. I’ve been crying a lot lately, my lovely daughter holds my head in her little hands and crying and wouldn’t settle. I’ve been crying a lot lately, there. I was having trouble feeding my baby – he kept promised I would show up and I was determined to be there. I didn’t want to go to work but I knew I had to; I had promised I would show up and I was determined to be there. I was having trouble feeding my baby – he kept crying and wouldn’t settle. I’ve been crying a lot lately, my lovely daughter holds my head in her little hands and says ‘poor mummy’ while she pats and kisses my head. This only makes me cry more – what kind of mother am I? I was so desperately tired I cried all the way to the office. I knew I had to speak to someone, I knew I needed help. But I didn’t know how to ask for the help I needed because I didn’t know what help I actually needed!

I started drinking a few beers over the ‘silly season’ – that’s an okay thing to do, right? But the silly season ended four months ago and I am still drinking and chain smoking every night as I pace the back veranda crying and thinking of ways to end the pain – run away? Kill myself? No that’s just stupid! But the thought kept coming. Perhaps I will be lucky enough to get cancer and die that way – then it’s not my fault! What ridiculous thinking – Oh My God, I just need help!

Crying and driving to the office I felt fear and trepidation rising in me, almost strangling, making it difficult to breathe. If my colleagues knew what was happening to me on the inside and if a full assessment was done on me I would probably get a diagnosis, of that I was certain. This thought silenced me even further. Being surrounded by people whose job it is to care for others is the most maddening isolation I have ever known. It feels like there is an invisible brick wall – no, a glass wall, between me and them, as I can see them (but can they see me?). If I could break through the wall I would explain that I am doing the best I know how to do, that every moment of every day I am using self-talk to get motivated, to get up to tend to my children, to make myself use words to communicate to my husband and to remind myself each moment how to move and to get in my car and drive to this office all in a fog that limits my vision and thoughts. The effort that this takes alone is tremendous enough, let alone then being able to manage the multiple layers of life: traffic, noises, remembering, nutrition, being present, showing up – without having a panic attack from going into sensory overload.

On my way to work I had to pull over on the side of the road as I forgot how to drive and put my foot on the brake instead of the accelerator and a car nearly rammed me. It took me at least twenty minutes to remember how to breathe again and stop shaking before I could get back in the car. By then I was very late for my first appointment of the day (again).

At what point, I wondered to myself over and over again, do I share the depth of my despair around this difficult time, and will this simply make me seem more diagnosable? Am I being helpful or hindering as I keep on coping with my severe lack of sleep, chronic forgetfulness and deep self-hatred? Can I explain well enough to work colleagues that I am not completely ridiculous and that whilst I wear my heart on my sleeve, so to speak, I am not able to really expose the full truth of my sadness, or surely I would be rejected from the help I need. I have seen what happens to others – when you are too needy or too much, no one wants to help because you need to help yourself first, right? I know this story as I have read all the self-help books!
Do I share that it isn’t just about how desperate I have become since developing depression and that I have become this pathetic person? Do I share any of my past? Would this help people on the other side of the wall to understand and support me? Would it make any difference if they knew that I felt like I was an unwanted pregnancy – a new baby coming into this busy world and that my own mother was too desperate in her bid to tend to her many children, many of whom were much needier than I, to be able to teach me about self-compassion or self-love? Would this matter to them I wonder – I decide that most likely it would not and all this would do is make me seem even more pathetic and unstable. Do I share about my greatest dream for my life, which was to be a mum, and now I have stuffed this up too? I wonder if this would reach ears that can hear me and hearts that have empathy for me.

The tears have flowed for too long now and the help is not at hand, even the emergency hotline I called when feeling desperate that I might hurt my baby; even this did not elicit the kind of help I needed. Only the response of ‘you are OK, you know what you are doing, you are a professional’. I wanted to scream at her that ‘I DO NOT!’ with a few other choice words, but I am too polite for that.

I finally decide after much soul searching that what I needed to do is allow myself to give in and collapse. So I left my job as a mental health worker. The wall felt impenetrable. Perhaps if I could penetrate the wall within me, perhaps then ... who knows it might have been different ... No-one on the other side of the wall was able to reach me either. Why does it feel like I am invisible? Why does going mad feel more real and doable than breaking through the wall of prejudices and unspoken fears?

Shadows in the Workplace

Each of us holds a complicated blueprint for our journey. Not one of us can escape the layers of self and emotion that drive this evolving, never finished concept of self as we seek to individuate or move toward wholeness (Sanford 1977: 16). While this is my account of a facet of this complexity and how it can play out in the workplace, it is only one aspect of the story. Mental illness is both personal and also a social and relational experience; different for each person and yet with some themes that are common for all of us. Further, none of us is immune from the human experience of mental and emotional suffering. Some of us are more susceptible at times in our lives than others – for example, asylum seekers have extreme levels of trauma and mental/emotional suffering (Briskman et al. 2008: 132). Approximately one in five Australians will experience some form of mental illness – mild, moderate or severe – at various periods in their lives (Better Health Channel 2014: 1) and it is not confined to one social group or level of income (Patel and Kleinman 2003: 609). It is also a highly contested area of human experience, where the cultural differences in the understandings of, and responses to, people with mental illness highlight its socially constructed nature (Repper and Perkins 2009: 120).

The critical question has to be asked – who does it serve to construct some people as mentally ill? Further, for my purposes, how far does the intolerable taboo act as a safeguard for the professional class (Leonard 1997: 55) to avoid being vulnerable to being mentally ill and if mentally ill, covering up this reality to maintain the status quo of privilege, expertise and income? Through this notion of the ‘other’ (Stanley and Wise 1993: 220) as being vulnerable to being mentally ill, there exists the concept of the professional (me) and the patient (other). It is here that the divide begins that separates self from the reality of all that we are: in denying our own madness we deny shadow and hence the wholeness of self (Benjamin 1997: 1).

According to Johnson, the shadow is the dumping ground for all those characteristics of our personality that we disown (2013: ix). What are the shadows of our professional personas that we perhaps do not own and what might be the cost of not owning our shadows or denied aspects of ourselves? Psychodynamic theory suggests that what we do not own about ourselves – for example our own madness – can unconsciously be projected onto others as a negative characteristic (Benjamin 1997: 10). One can then imagine that the madness arising in a colleague can be dismissed as a personality flaw as opposed to someone in need of help. In the later instance, the challenge of accepting one’s own colleague as mentally ill might demand an understanding that may open up a feeling of vulnerability to one’s own experiences of madness.

To honour and accept one’s own shadow can be profound and whole-making and thus can be considered amongst the most important experiences of a lifetime (Johnson 2013: x). Thus, madness can itself be part of a healing process or a person’s struggle for identity and sense-making. In a similar way to the Buddhist idea of inter-being (Hahn 1998: 3), in the integration of self we can embrace the other and allow for a deeper understanding of the human experience. When we explore this human path to wholeness we must then accept that all of us have a shadow self, an experience within ourselves of aspects of self that we do not like. By knowing this aspect of self we can realise what is being affected by the experience of the other person, and can then recognise what our part in this relationship might be. If we do not recognise our part in this reaction, we cannot be available to the other in a caring, empathic way that is healing and supportive. Until one is at peace with oneself and one’s neighbours, the healing powers of the soul cannot be put into effect (Sanford 1977: 57).

Closing Comments

This paper has shared one person’s experience of
psychological breakdown and breakthrough, under the pressure of the outer world and conflict of the inner self. I re-gained my agency and began my healing in my home space with my family and in time returned to work in another place and space. My search for meaning in madness, however, could be any human being’s journey seeking to integrate the fragments of self. Further, this personal journey has highlighted that having mental illness, whilst made more vulnerable by certain social and specifically occupational prejudices, does not mean we have to be defined by them. My sense-making has spanned not only the intra-psychic and the interpersonal aspects but it has also resulted in an appreciation of myself as a person in the bigger picture of what enables social wellbeing. As the World Health Organisation (2012: 4) suggests, an individual’s self-worth is enhanced or diminished depending on social support or economic security at the household level, and in relation to the political environment, social justice experiences or economic growth in a country.

Although this is one person’s story of exploration of the inner world of shadow and self as a professional in a mental health setting, this will always be a human story that can apply in any part of this world in any social, political and personal place. If the intolerable taboo of shadows expression as a hidden form of power is not acknowledged there will always be a seeming impassable space between us.

The separation between ‘us’ and ‘me’, the mad people, and ‘them’, the non-mad ones, is what is maddening – the silence, isolation and othering is what is intolerable. There is no ‘us’ and ‘them’, there is ‘us all’ and at times we may be defined or see ourselves as mentally ill. This experience is enough for us to negotiate without the added layer of prejudice and discrimination, especially from our colleagues and professional peers.

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‘Shining a Light’ is a community development project undertaken with people who live with mental illness who attend several community centres in Brisbane, Queensland to identify what they value about the centres. The title ‘Shining a Light’ was chosen for this project because community centres can be havens for people where they can avoid being stigmatised and categorised as clients receiving a service. The project unfolded through a series of creative activities, conversations, focus groups and presentations. A photographic display shows some of this creative work developed by this project. It shines a light on participants’ resilience, creativity and views at a time when open, relationship-focused and non-hierarchical places are increasingly hard to both find and to fund under neoliberal funding regimes.

Introduction

Community centres were first established in Queensland in the early 1970s. They were the outcome of efforts made by people in local communities to establish meeting places for building the local relationships and skills needed to address local issues, as part of a broader aim to contribute to more just, humane and inclusive communities (Muirhead 2002: 8). According to Blanchard:

The first principle of community development is that the people are not the problem, people are the asset. The second principle is that the leadership needed in every neighbourhood is already there. Community development is about unlocking that asset, releasing people’s potential to move forward together (2012: 1).

Government funding programs have long been crucial for ensuring the necessary funding for community centres to continue and to meet a community need for services. However, in recent years reliance on government funding has become more problematic as state and federal governments in Australia have revised their funding arrangements (now called ‘social investment strategies’) to more insistently reflect the imperatives of the managerial state (Australian Government 2012; Queensland Government 2014).

A number of problems have arisen from this development that undermines the capacity of community centres to maintain their project to foster just, humane and inclusive communities. For instance, eligibility for funding increasingly involves conformity with restrictive managerialist performance requirements such as outcomes reporting and rationalistic accountability criteria (Chenoweth and McAuliffe 2015: 212). Accordingly, in many community centres the community-oriented discourse characteristic of the early phase of their development is being displaced by the dominant professional and market discourses associated with neoliberalism (Ife cited in Chenoweth and McAuliffe, 2015: 211). These requirements and associated change in organisational culture of community centres can diminish the community’s ownership of the community resource.

Rationalisation of funding has been another neoliberal development, where governments prefer to deal with one large service provider in a region (Baum 2014: 94) rather than multiple small providers. This means that some agencies are expanding in size by acquiring more programs and more funds, whilst others are shrinking or even losing their funding – and consequently losing staff, services and, to varying extents, losing heart. Organisations that grew up locally as an outcome of community initiatives, as was the case for the community centres in this commentary, are especially at risk of losing their funding. Ironically, in the neoliberal welfare reform climate, community centre participants are being blamed for their mental illness (Baum 2014: 79) while at the same time the reforms are facilitating diminishing availability of spaces and places where they can be independent and self-determining. This commentary describes aspects of a project which illustrates some of the qualities of community centres that, from participants’ points of view, are at stake as these contextual pressures intensify.

The Shining a Light Project in a Nutshell

‘Shining a Light’ was a collaborative project undertaken by four local community centres in northern Brisbane to examine their efforts to maintain a friendly, welcoming and responsive engagement with both people who live with mental illness and their significant others.
They sought to identify what these community centre participants valued about the centres. A part-time project worker, assisted by an arts worker, ran four consultation sessions in each of the community centres – in all, sixteen sessions involving seventeen participants.

These sessions were lighthearted, creative, fun forums during which participants told stories of their experiences in life and at the community centres. Participants in all the sessions chose to make postcards that depicted aspects of their relationships to their respective community centres. Participants from across the four community centres then came together at a gathering to share their experiences and postcards. An end-of-project session brought together all the participants, staff, project funders and interested others such as mental health professional and community members. In this celebratory, collaborative space, participants talked about their artwork and their experiences the artworks reflected. Some excerpts of the material generated in the project are presented here.

What Our Community Centre Means to Us

Project participants referred to the community centre they attended as ‘a safe house’, ‘a safe zone’, ‘a place to call home’ and ‘a safe haven’. They contrasted this with their experiences beyond the centre, such as: being moved on from the local park for ‘disrupting’ the locals (even when sitting in the park chatting with friends), being labelled as ‘mentally unstable’, being accused of ‘using’ the system and of ‘bludging’ off tax payers. All the participants involved in the project had experienced stigma and shame (Millen and Walker 2001: 89). This underscored the importance to them of having a safe place in their neighbourhood.

One person explained that his community centre decided to close one day a week because of funding shortages. This centre provided shower facilities for those who otherwise did not have access to any. Had he been consulted, he would have advocated for a day other than Monday, elaborating that ‘you don’t smell too good by Monday if you’re homeless’.

In response to questions about what they valued about their community centre and what motivates their participation in it, a number of common themes emerged:

- feeling welcome;
- having access to practical support, food – showers, computer access;
- having a sense of belonging to a community where people support each other;
- meeting with others, making friends and meaningful connections;
- contributing, have opportunities such as employment and volunteering;
- growing and developing through being encouraged to try new things;
- being encouraged when things are tough;
- feeling included and having a sense of belonging;
- being able to help others;
- getting out of the house and having a safe space to spend time in;
- being listened to, and;
- being seen as a person, not just an illness.

Some participants had maintained their relationship to their community centre for approaching twenty years. They did not see themselves as clients or customers, but as valued and contributing community members – as citizens (Baum 2014: 94). They had variously participated in committees, projects, social enterprises and staff recruitment. One participant said: ‘the point is not what the organisation has done for me, but where would it be without me!’ At the same time, this person could acknowledge there were times when the support of the community centre was vital to her wellbeing.

Several participants recognised that their community centre is increasingly under-funded, that staff are leaving and the remaining staff are stressed. They felt increasingly reluctant to ask for staff time to assist them. Nevertheless, most participants thought it important that they be regularly available for others who might be having a bad day, with one person saying ‘some people struggle with voices they hear – I don’t hear voices, but I can be there with someone who does’.

It was a shared concern that some community centres were increasingly restricting access in order to manage paid staff workloads: for example, shorter opening hours and restricting participants’ access to parts of the centre. This has meant that participants meet with each other less and are therefore less able to provide support to each other and experience a sense of community togetherness on a regular basis.

Shining a Light in Pictures

As their artwork below indicates, participants valued their community centres very highly and could point to times when the centre had been a life-saving or life-changing influence for them.
Community Centres as Places for Recovery

Community centres do not explicitly work with a mental health practice framework (Australian Health Ministers’ Advisory Council [AHMAC] 2013). However because their mission is to build communities that are inclusive of all people, their approach is implicitly recovery-oriented. A recovery approach differs from conventional service delivery or treatment approaches (Martinez 2005: n.p.). It addresses peoples’ needs by focusing on what people think is important for their own wellbeing (Queensland Health 2005: 1). The recovery framework of mental health has its origins in the deinstitutionalisation and user-led movements of the 1980s (Pinches 2004: 2) and is described as:

... being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues (AHMAC 2013: 4)

The schism between espoused recovery approaches, community facilities and resources, and the actual funding practice is hard to reconcile where the latter represents the hard end of neoliberal cost cutting, especially in relation to the ‘welfare state’ (Baum 2014: 86). Managerialism, which is informed by economic rationalism, is the mechanism for implementing neoliberal policies (Baum 2014: 87). It requires a closed, tightly structured, efficient, closely audited system with evident, time-limited results and clear staff-client boundaries. On the other hand, recovery requires an open operating system where power and control are devolved and clients as participants form part of a valued community (Bloom 2014: n.p.).

Participants in the ‘Shining a Light’ project claim they do not experience anything like a recovery framework in their engagement with mental health services. They are unequivocal that it is only in local community-based centres that they find the kind of holistic, relational and empowerment-oriented responses that support their wellbeing. It is concerning that participants, including community centre staff and project staff alike, observed that the emerging neoliberal welfare reform requirements are pushing agencies towards both financially unviable situations and towards models of practice that are not people-centered. This view is echoed elsewhere in the literature which reflects on the impacts of such reforms, where commentators are arguing ‘the first and biggest challenge that we have is to re-humanise services’ (Smith-Merry et al. 2010: 16).

Shining a Light on Some Big Questions

If the local, grassroots places such as the community centres go – where will the people go? What places are there left which allow people to be themselves, to be safe, to feel valued and to belong? Who benefits from this state of mis-ethics of care for people?
I dreamt after being diagnosed with COPD

An extraordinary expanse of water tinged with sand, where Mum and I were looking for Dad, late Dad, dead Dad, Dad of the strength of many men but mortal nonetheless, and gone.

At the end of the dream I was all alone.

Someone from school, friendly to me in the dream though not in real life, somebody I haven’t seen for 29 years, was explaining to me the epistemology of the word loss, which he pronounced ‘lots’ and I knew I was in for it, somehow. And how, the water rises, I don’t need to read a dream–analysis book to know rising, threatening water is death; up to my neck, my chest is constricted, there are crocodile eggs around me, bobbing, and I cannot catch my breath-

Jim Arkell
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References

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Tracing the Maddening Effects of Abuses of Authority: Rationalities Gone Violent in Mental Health Services and Universities

Marilyn Palmer and Dyann Ross

Organisations such as mental health systems and universities can be places where violence is part of the business as usual and hence taken-for-granted functionality of the workplaces. The paper challenges dominant perceptions of who is mad and what is dangerous to unsettle the largely unquestioned legitimacy of indirect and mainly, but not always, non-coercive forms of organisational power. To enable this analysis the research and language of domestic violence is presented to help anchor the nature of organisational violence so that it doesn’t get ignored or deferred as non-problematic, as something that just happens somehow separate from peoples’ actions or non-actions. The discursive and material nature of violence in our human organisations can be addressed through tracing the maddening effects it can have on people and by addressing issues of harm, loss and injustice through dialogue, resistance and restorative justice work.

Introduction

This paper draws on literature from the past several decades and personal experiences to generate intentionally agenda-setting theory about violence as the abuse of power in organisations. Our purpose is to encourage dialogue and increase collective confidence to create safe, healing and intelligent spaces and places. We draw on a collective wisdom developed over a combined seventy years of experience as social workers to express our rage at the harm and injustices we see. We then reflexively review some relevant literature and share our guarded optimism for collective efforts to achieve dialogue and non-violence with people in these systems.

This paper has three sections corresponding with the main arguments we wish to present. Firstly, we name the problem of violence in organisations by giving voice to our anger and indignation at what we have read, heard, witnessed and experienced in our personal and professional contact with mental health organisations and universities. Secondly, we take stock and reflexively consider what we know to make sense of the violence by drawing on Bronfenbrenner’s (1979) ecological systems theory. We do this as a way of positioning organisational violence in the same theoretical space as domestic violence to support our understanding of the former. Finally, we complete the paper by presenting some elements of a dialogical, non-violent model for developing non-maddening practices within mental health organisations and universities, absorbing the limitations of the present time/space and the conundrums that leap from our proposals.

Our goal is to illustrate one of the mechanisms by which Capra’s (1982: 466) ‘declining culture’ has been able to resist transformation, namely the unquestioned rationality of power relating to authoritative organisational positions that are legally and socially sanctioned in Australian society. Specifically, we refer to the ideological function of impartiality and its intellectual partner, rationality, in managerial and professional spaces which can together ‘be understood as a regulative ideal of reason’ (Young 1990: 111).

In the two examples which follow, the pivotal rationality where dominant power abuses cohere (not accidentally) tend to mirror and refract the defining feature of the organisations’ client/customer group. Thus, we can think of mental health systems as exhibiting unhealthy, irrational rationalities and universities as exhibiting un-smart, un-intelligent rationalities. That is, they mystify on the basis of their defining feature, which is the contradictory use of power to maintain dominant groups’ interests. For our purposes, one of the ideological and discursive functions of belief in impartiality and rationality is that it:

Legitimates bureaucratic authority and hierarchical decision-making processes, defusing calls for democratic [and inclusive] decision-making ... it functions in our society to legitimate ... authoritarian structure[s] (Young 1990: 112).

Further, these accepted ways of doing business in organisations are cloaked in a respectability (Young 1990: 57) provided by the mystification of power and
status/privilege of the professional and managerial classes. According to Buchanan and Badham (1999: 56) how power is conceptualised is important as well, for conventional understandings of power as possession have led to the ‘relative neglect of its hidden dimensions’ which involve power as relationally exercised and power as ‘embedded’. This latter type employs the ‘mobilisation of bias’ as a mechanism of power in ‘favour of particular groups, interests and topics against others’ (Buchanan and Badham 1999: 56).

Difficulties in gaining an agreed definition of power in the literature and practice contexts and how it operates in organisations should not dissuade us from being:

Alert to ... the less visible and less tangible dimensions of power, embedded or carried in the taken-for-granted procedures and practices of organisations and society as a whole. This is important because invisibility and intangibility cannot be equated with insignificance. On the contrary, the apparently insubstantial elements of power can be extremely potent in skilful hands. In addition, that which cannot be readily seen and described can be extremely difficult to question, challenge or resist (Buchanan and Badham 1999: 57).

An Un-healthy Rationality in Mental Health Systems

In Western cultures it is largely accepted that there is a need for mental health acts and mental institutions and that the mental patients (where this term is a political signifier) are the ones who are mad, often dangerous, who need to be given treatment to cure or at least detain them, by sane professionals in (locked) places that keep the patients safe. This is despite the significant discussions which took place in the 1960s and 1970s (Szasz 1961; Laing 1972) which challenged dominant ideas of mental illness. It was suggested that mental illness was an ‘appropriate response to severe social stress, representing the person’s desperate efforts to maintain his/her integrity in the face of paradoxical and contradictory pressures’ (Capra 1982: 420). For example, in 1972 R. D. Laing noted:

A child born today in the United Kingdom stands a ten times greater chance of being admitted to a mental hospital than to a university ... This can be taken as an indication that we are driving our children mad more effectively than we are genuinely educating them. Perhaps it is our way of educating them that is driving them mad (cited in Capra 1982: 420).

Mental illness is constructed as an inevitable reality that is contained in the identities of people who become patients of the mental health system. Once given, formal diagnoses of mental illness are rarely taken back by those who made them and are almost impossible for those who have them to give them back. The labelling process and related stigma can mark mental patients long after they have received treatment (Corrigan 2007). Stigmatised identities (Millen and Walker 2001: 89) are more readily controlled, including through self-stigma, and a negative self-fulfilling cycle of loss and de-humanisation can keep patients ‘out of mind and out of sight’ (Mental Health Council of Australia [MHCA] 2005: vii). Most historical portrayals of mental patients reinforce public perceptions of the mentally ill as needing a different order of control and treatment than is required for any other type of illness or behaviour. Unlike some mental patients, criminals are afforded the legal right of determinant sentences (Bernstein 2014: n.p.).

There is now the commonly understood iatrogenic effect where hospitals are meant to be places where people get well but instead can be places which make people sick (Dewan 2009: 222). Here, the irrationality of health systems, including mental health services, is exposed. With this exposure comes the uncovering of a violence done to people that is called mental health care but which can lead to many people being injured and some dying (Dept. of Health 2005: 3). It can also lead to significant numbers of health and mental health staff making workers’ compensation claims due to work-related stress and mental health issues (Jackson and Clements 2006: n.p.). Research shows that work-related stress in the mental health system is only partly attributable to violence from mental patients (Nachreiner et al. cited in Jacobowitz 2013: 78). Worryingly, a significant proportion of staff in the mental health workforce cite abuse and poor treatment by their supervisors as one of the main causes for sick leave and inability to work (Jackson and Clements 2006: n.p.).

Deeper and more pervasive though are the effects of a culture of silence relating to the unfair and irrational actions of mental health managers where double standards, in-group favouritism/out-group demonising, ‘us versus them’ language and tit-for-tat dynamics (Axelrod cited in Bloom and Farragher 2013: 248) are the undeclared rules of the power game and everyone knows it. The maddening aspects are multi-faceted but can be perhaps best conveyed symbolically as the collective realisation by subordinates that ‘the emperor has no clothes’. This reference to Anderson’s tale conveys ‘the willingness of people to engage in an unspoken contract to willfully disbelieve what they know to be true’ (The Phrase Finder 2014: n.p.).

Nobody wants to be the person to speak the unspeakable for fear they will have their head chopped off or more accurately be perceived as, and possibly even go, mad. So business as usual occurs by a cultural practice involving a level of seeming that everything is okay and not being seen to notice when it is not (Namie and Lutgen-Sandvik 2010: 349). This informal organisational behaviour can be confounded by a concerted dedication to ensure best practice by developing and reviewing
formal aspects of the mental health service such as the governance structure, clinical practice models and processes. The intermix of informal and formal mechanisms of power, often enacted by the same people, gives a respectability to the workplace (Young 1990: 139) and this in turns helps to legitimise the most rational and most violent of behaviours. Perhaps many subordinate staff maintain the unhealthy status quo due to a naïve hope that we aren’t all mad and if we persist we will create a safe sanctuary (Bloom 1994: 474) for mental patients and staff.

Mental patients are simultaneously made collectively invisible in terms of the failure to ensure their basic human rights are observed and strongly problematised when noticed or referred to in the media and public discourses. This power mechanism of making a person ‘normalised’ when absent and ‘pathological’ when present is recognised as a discursive power dynamic maintaining racism in Australian society (Phoeni cited in Pettman 1992: vii). It involves a shifting of responsibility away from the powerful actors, making those usually absent in the mental health discourse, such as teachers and parents, ‘pathologically present’ when it suits the powerful. For example, a senior source in psychiatry in the United Kingdom claims:

that psychiatrists are not the ones responsible for the epidemic of expanding definitions of mental illness and over-drugging that’s occurring in the country. Instead, said Professor Sir Simon Wessely, teachers, parents, non-profit advocacy groups and poorly run government health services are to blame (Wipond 2014: 1).

Western countries such as Australia tolerate the scapegoating of mental patients as the personification of an intolerable difference that needs controlling through legislation, locked treatment centres and ‘dirty’ medication that doesn’t cure but can cause sometimes life limiting side effects (Citizen Commission on Human Rights [CCHR] 2014: 1). The human suffering and loss that results from this scapegoating and devaluing of people constructed as mental patients is unfathomable and not given credence when the cost is counted by reputable authorities (MHCA 2005: 46).

At the highest level of political discourse in Australia, the pervasive prejudices toward and stigmatising of people with mental illness is evident. In late 2013, the Minister for Health in Queensland gave a press release announcing the requirement to keep all mental hospitals locked (Wardill 2013: 7). The derogatory language of referring to mental patients as ‘killers and rapists’ arguably has set mental health care back decades by reinforcing an (ir)rationality towards people with mental illness and perhaps consolidates a reactive, fear drenched response to an already highly surveilled, stigmatised and controlled social group.

An Un-intelligible Rationality in Universities

Now we turn our attention to universities to further illustrate our claim that modern organisations are discursively constructed and thus are interactive, non-fixed, contested spaces where people act upon/towards others, and are acted upon/towards by others, in ways which can be oppressive and at times, overtly violent. As Fox claims, ‘all organisations are mythologies constituted discursively to serve particular interests of power and contested by other interests of power’ (cited in Leonard 1997: 91).

We briefly analyse universities as the supreme organisational expression of rationality in our society as this is expressed in the pursuit of knowledge and the education of the professional class (Leonard 1997: 99). We do not provide a comprehensive power analysis of universities in Western countries as this has been done well by others (Lafferty and Fleming 2000: 257). We believe educational institutions are as susceptible as mental institutions to the maddening effects of rationalities that can be oppressive to many students and some staff, including academics (Ross 2002). To the extent that an apolitical version of a managerialist agenda and discourse pervades decisions about what counts as legitimate knowledge and who is to be regarded as knowledgeable (Hartman 2000: 19), there is a systemic, undeclared violence operating to some extent in all universities.

The following fictionalised narrative draws on events and encounters with which we are familiar through our own and others’ experiences.

The narrative begins, as these things often do, with an email.

TO: All Faculty Staff
FROM: The Executive Dean, Faculty Human Health and Science
CC: Human Resources

As you will now be aware, the Towards Excellence change management process commences today with a presentation by the Executive Dean. Faculty of Human Health and Science staff are encouraged to attend the information session scheduled for today in the Menzies Lecture Theatre at 3pm. Attached for your information are:

• The Faculty of Human Health and Science Towards Excellence change management proposal (which includes information on the new structure) and

• Relevant Position Descriptions for those positions impacted by the change process.

Please familiarise yourself with the attached documents and those on the dedicated website. If you
are a staff member affected by the proposed changes or a staff member with supervising responsibilities for staff affected by the proposed changes, then you are strongly encouraged to attend today’s meeting and all future meetings concerned with the proposed changes. All other colleagues are welcome to attend.

It came to pass that the Faculty would achieve ‘Excellence’ by combining two Schools into one and achieve efficiencies through redundancies or demotions (in hours, level and salary) of seven staff, who had worked for the university for between 10 and 15 years. The staff affected would hear about the changes for the first time at the meeting (although there had been rumours circulating for weeks) and they had had an hour’s notice to read the documents attached to the email. One of the women demoted had lodged a complaint against the Faculty Manager, a close friend of the Executive Dean, for his comments about having to work in ‘menopause mayhem’. The change management document advised there would be further redundancies offered once the common first year program was operational.

Over the next few months, staff retreated into their offices. There were no farewells offered or asked for. Staff members in the affected schools were advised to update their CVs, be ready to apply for their jobs, while it was rumoured that some lectures were being monitored by management accessing those lectures recorded automatically for uploading to E-teach. If this was happening, it was without lecturers’ formal knowledge or consent.

A Human Services lecturer who was considered difficult with an allegiance to theories considered dated, began to feel excluded. Some students had complained about her lecturing style directly to the Executive Dean rather than to her Head of School and she wondered who was advising students to do this. She discovered that most of her colleagues, but not her, had been invited to an award celebration for the Head of School; she wondered if they had had an hour’s notice to read the documents. One of the women demoted had lodged a complaint against the Faculty Manager, a close friend of the Executive Dean, for his comments about having to work in ‘menopause mayhem’. The change management document advised there would be further redundancies offered once the common first year program was operational.

This story is fictional insofar as this trajectory of events did not occur (as far we know). However, the story captures incidents in universities we have heard about or witnessed. We don’t directly analyse the scenario here, rather we use it as an evocative, non-rationalistic writing device to convey credibility to our arguments (Ellis and Flaherty 1992: 2). To the extent that this story is believable or that readers have experienced elements of the story themselves, we rest our case.

Since the mid-1990s, universities have been subjected to the policies, practices and discourses of neoliberal ideology through the twin imperatives of economic rationalism and managerialism (Lafferty and Fleming 2000: 257). Economic rationalism emanates from a belief that the (supposedly free) market place is the only true and proper determinant of supply and demand needs. According to Pusey, governments use ‘narrow definitions of efficiency and productivity (including privatisation, deregulation and low government spending) as measures of economic success, without regard to government’s traditional economic responsibilities to the public sector and the welfare state’ (cited in Jupp 2002: 141). Its organisational expression, managerialism can assert control of workers through bureaucratisation, risk avoidance and an expectation of adherence to rigid procedures designed to achieve outcomes determined by a dogged belief in rational choice theory (Ogu 2013: 90). The university (as corporation) now argues that decisions should be made by those with positional authority based on the perceived needs and interests of individual staff and students who themselves will be making rational choices which reflect their own interests and needs.

This corporatist-managerialist model of university management (Morris 2005: 387) has largely replaced the traditional collegial model of collaborative decision making which supported groups and individuals coming together through a form of direct participatory democracy to make decisions in the interests of the ‘greater good of all’ rather than the interests of the sum of individuals. No one is naïve enough to believe that this is what actually happened, at least not all of the time. Universities have always been vulnerable to nepotism, favouritism and self-interest (Small 2013: n.p.). However, these democratic activities were deemed aberrant and not endorsed by a belief system which actively supports and encourages
disinterest in the wellbeing of others, and self-interest in the guise of efficiency and accountability. Herein lies the structuring and discursive bases to what we believe are rationalities gone mad to the extent that certain ideologies have become reified, and thus beyond human reproach. Further, this reification seems to occur in direct proportion to the dehumanising of some social groups or staff groups and individuals through the effects of this maddening order of things.

**Linking Micro, Meso and Macro Dynamics of Power Ab/Use**

These points notwithstanding, our interest here is not to keep the analytical focus in this space on people living with the consequences of being labelled mad or bad as if they were themselves the containers of society’s madness. We argue rather that the almost unchallenged focus toward the most politically vulnerable citizens – mental patients in the mental health systems and workers ostracised and expelled from dysfunctional workplaces (both constructed within related politico-cultural discourses) – hides and protects a possibly profound level of organisational violence in all complex human systems. Further, and crucially, we suggest that all human organisations operate to varying extents with a covert and perceived necessary level of violence. We have used mental health services and universities to explore this claim but other human systems are not immune from similar dynamics of violence, including private businesses and multinational corporations (Brueckner and Ross 2010). This is clearly an outrageous statement. What civilised society would condone such a state of affairs? Why would some of our most highly paid and educated professionals and managers allow their workplaces to be abusive for so many of their colleagues and clients or customers? This is about structural violence as oppression, which as Young suggests involves:

> The vast and deep injustices some groups suffer as a consequence of the often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms – in short, the normal processes of everyday life (1990: 41).

How this structural violence is experienced in organisations and individual identities is complex and far from causal and fixed as shall be explained in the next section. The term ‘ab/use’ in the section heading serves to remind us that power can have a productive use as well as being employed in an abusive way (Foucault cited in Sapouna 2012).

We proceed by asking you to visualise the concentric circles of Bronfenbrenner’s (1979) ecological systems theory, an heuristic device used to explain the relationship between the person-in-their-environment, the personal and political, or to take this notion back to earlier roots, between personal troubles and public issues (Mills 1959). In your visualisation, we ask you to place domestic violence in the micro-system layer, our maddening mental health organisations and universities in the meso-systemic layer and the broader social, political, economic and cultural landscapes in the macro-systemic layer. We make maddening organisations our focus but we draw on overt abuse and violence in the micro-systemic layer to illustrate the systemic nature of abuse and violence which plays out across these three layers in much the same way with very different (and very similar) consequences.

It is beyond the scope of this paper to explore in depth the role of violence in the macro-systemic layer other than to note that it is here we locate the structural antecedents to ethnic and gendered violence as well as violence against the natural realm of which human beings are a part (Plumwood 2000: 285). It seems to us self evident to draw parallels between domestic violence, organisational violence and violence against nature. The case for this has already been well developed by others such as Rees (1994), and in particular, the eco-feminist writers (Mies and Shiva 1993: 16) who have been making the links between violence against women and violence against nature for the past several decades.

**Towards a Model and Language for Addressing Organisational Violences**

The language and theorising of domestic violence is adopted in this paper to convey the relational, bodily, place-based nature of violence that we see in organisations. In doing this we are not using domestic violence metaphorically. We are suggesting that both forms of violence emanate from macro-systemic social, political, economic and cultural factors which is an idea reflected in one of the five discourses O’Neill (1998) has recognised which seek to explain domestic violence. O’Neill writes that the construct of ‘wife abuse as a consequence of the normative social system’ is a perspective which:

> ... suggests that violence in general is accepted as being relatively normal in Western society and that violence against wives, although not being the norm for all of society, reflects this and other supporting norms in an internally consistent manner. Wife abuse is thus seen as an extension of the normative social system, a perspective in direct conflict with the pathological discursive position, which holds such behaviour to be abnormal (1998: 470).

In drawing on the theoretical framing of domestic violence we do not intend to take away from the very
real and devastating material, and the bodily effects/nature of domestic violence to suggest that all violence, its manifestations or consequences are the same. Rather, we point to some common elements of violence in families and organisations in which we all, wittingly or not, participate. We take from Bronfenbrenner’s (1979) model the idea that influences across the layers of the system are multi-directional and reciprocal such that violence in families may engender and support violence in organisations and the wider culture, while violence in the wider culture and organisations may engender and support violence in families.

The term ‘domestic violence’ is used here to mean violence against women by their intimate partners. It is framed as one form of intimate violence alongside others such as child abuse and male partner abuse. Domestic violence has been defined by the National Committee on Violence Against Women (NCVAW) as ‘behaviour adopted to control the victim which results in physical, sexual and/or psychological damage, forced social isolation or economic deprivation or behaviour which causes women to live in fear’ (cited in Murray 2002: 154). The parallels between this definition and our earlier descriptions of organisational violence are evident such that organisational violence can be understood as behaviour adopted to control the victim (whether mental patients, students or workers) which results in psychological damage, forced social isolation or economic deprivation or behaviour which causes the person to live in fear. LaViolette (1998: n.p.) has identified other elements of domestic violence, which parallel elements of organisational violence we have witnessed through our practice in maddening organisations. These include insidious psychological abuse, the monopolisation of perception, threats to the victim’s support systems and isolation. The marking of a person as Other (Stanley and Wise 1993: 220) by those with sufficient power (positional or charismatic) in organisations, parallels the marking of women as Other in relationships where there is domestic violence.

Insidious psychological abuse can be established through discursive processes such as labelling, dehumanising and the internalising of stigma (Millen and Walker 2001: 91). For women living with domestic violence this can occur through labels such as ‘bitch’ or ‘slut’ that are forms of verbal abuse which are profound markers of domestic violence (Palmer 2005: 101). In organisations, the labels of ‘incompetent’, ‘difficult’ or ‘mentally ill’ (with the concomitant suggestion they may pose a threat to themselves or others) will suffice. Having been ascribed the label, the person so labelled will struggle to reject or discard it and the monopolisation of perception by the powerful begins. How do you prove as a marked difficult/incompetent/mentally ill person that you are not these things (at least not all of the time, and not necessarily forever), and that an alternative perception of self is equally valid and worthy of consideration? In the absence of dialogical spaces to respectfully explore different perceptions of the self, the dominant individual or group will seek and be given the monopoly to decide who and what you are (Buchanan and Badham 1999: 56).

Where there is domestic violence the threats to the victim’s support system may take the form of real or threatened physical assault to friends or family who seek to intervene. In organisations it can take the form of real or threatened punishment or ostracism of patients’ or workers’ support systems be they family members, fellow patients or sympathetic co-workers and allies. Simplistic binaries of ‘my enemy’s friend is my enemy’ are often invoked to justify extending the violence towards members of the victim’s support system. So, for example, in a university, once someone has been deemed to be the incompetent or difficult Other, supporters who stand alongside them and challenge the dominant construction (or the process by which the construction has been developed in the first place) may be marked as untrustworthy, of poor judgement and face similar treatment. Sadly, as Bloom and Reichert have noted, while bystander intervention can be highly effective where there is witnessed violence:

Listeners tend to exaggerate the victim’s personal responsibility in the traumatic situation. If these strategies do not work to get the victim to stop talking, then the listener will avoid contact with the victim altogether. The reasons for this behaviour are fairly clear. The suffering of victims can threaten the listener’s assumptions about a ‘just world’ in which people get what they deserve (2014: 88).

In situations of domestic violence, the perpetrator engineers isolation from support systems by making friends and family feel unsafe or unwelcome, limiting the victim’s access to money or transport and monitoring phone calls and emails. Similarly, in mental institutions, isolation is imposed through involuntary incarceration or voluntary hospitalisation and locked doors. However, as with domestic violence, isolation from supporters for mental patients and stigmatised workers can be self-imposed and take the form of rejecting visitors or taking sick leave to avoid the embarrassment or the stigma of being deemed mentally ill, unfit or unworthy of employment.

The Discursive and Material Nature of Systemic Violence

There is a discursive and material nature to systemic violence, which we have tried to describe and build an appreciation of to this point. The bodily effects of violence on the people experiencing violence are broad and deep and can be thought of in terms of Post Traumatic Stress Disorder (Jacobowitz 2013: 787) but also in terms of injustice and discrimination (Morris 2007: 12). The material nature of violence is also broad and deep from an individual’s loss of self-worth, employment,
status and sanity as well as the collective experience of violence made evident through the destruction of habitat for threatened species, global warming, war and famine (Plumwood 2000: 286). Human organisation is the means by which people interact and these interactions have real effects within and outside the organisational space.

Violence is intensified in the exercise of power in complex organisational contexts/forms/spaces (Thompson 2011: 189). Thus, in mental health systems the experience of oppression is located in the identities of mental patients. Further, in a different but inter-connected way it is also located in some groupings of mental health workers, for example workers who are themselves deemed mentally ill (see the article by Kemble in this volume). Of particular significance is the normalisation of the oppressive use of power where outspoken staff are marginalised, non-compliant staff are disempowered, new ideas are negated by imperialistic tendencies of senior staff, and workers are attacked for questioning how their managers make decisions or for resisting unsafe or discriminatory work practices.

The vast majority of systemic violence is perpetuated by male supervisors and managers (Zapf and Einarsen cited in Mattiesen and Einarsen 2007: 735). Yet Namie claims that the main pattern of abuse in the workplace is same-sex harassment where 63% of women are harassed by other women and women as a group are bullied at the rate of 80% of the workforce (2003: n.p.). Some perpetrators of violence, but not all, exhibit the characteristic of corporate psychopaths (Boddy 2010: 300). However, the shocking reality is that non-mental patients are responsible for most of the violence in society's key organisations including, but not only, mental hospitals and universities. This violence passes under the radar and is rarely named openly or addressed front on. This is partly because, as we have shown, it is dressed in a rationality and normalcy which is gained through seeming compliance to the very same organisational policies, rules and etiquettes that are enshrined in good governance statements and professional codes of ethics.

The common dynamic of this violence is the way it creates a climate or culture of unsafety, unfairness and a power dynamic that results in one person or whole groups of people being traumatised or otherwise hurt and discriminated against. These victims are locked into abusive relationships with a dominant person or groups who are aggrandised, advantaged and reinforced in their beliefs and the rightness of their behaviour, position, ideas and so on. In human organisations, hierarchical positions tend to be the locations of abuses of authoritative power that serve to reinforce the dominance of those in positional power often without direct interaction with the workforce and clients. Smith describes this as ‘relations of ruling’, which are:

By focusing on violence as madness in complex social systems it is possible to discursively construct mental illness in Western societies as unequal struggles in a diverse range of power relations (Thompson 2011: xvii). Mental health systems are indicative of all other human systems and to demonstrate the embedded, and to some extent, accepted nature of violence in society, some parallels with universities have been explored. While the mission of each of these types of organisation is vastly different, it has been argued that as human systems of organisation there are similar power dynamics evident which can create a range of unsafe relationships which in turn can have the effect of creating demoralised (Crane and Matten 2010: 166) and therefore, more readily controlled or self controlled workforces. This can be seen to occur through the collective failure of people in key positions of authority to take their proper responsibility (Crane and Matten 2010: 167). Hierarchies of power and highly specialised managerialist roles can pass down abuse and undermine others in a systematic way that is not accidental or readily acknowledged.

Justice Work
We draw the paper to a close with the humble acknowledgement that non-violence and peace work, building democracy and ensuring justice and wellbeing in a diversity of places and spaces is occurring to a greater extent than violence and oppression. The challenges though are enormous for the peace work as a large part of its effort has to be about undoing the harm created by violence. It is in the spaces and places where injustice and violence are occurring that the turning point moments exist to undertake the peace work. This often is about the undeclared resistance to violence and as McInytre writes:

Domination-reproducing practices and the freedom struggles opposed to such practices are brought together in the concept [and practice] of resistance (1996: 239).

In extremely violent places where there are entrenched unequal power relations and real danger for anyone seen to be dissenting, the practice of resistance without being seen to resist is sometimes the most we can do (Scott 1990).

The willingness to invite the perpetrators of violence to the dialogue table is a high order aspect of the peace
work required (for example, Brueckner and Ross 2010). Dialogue as democracy and justice at work can only occur between people as equals and in conditions of personal and cultural safety (Ross 2013: 206). Wherever we are is where we can contribute. Business as usual meetings in mental health systems and universities can be spaces to build cultures of safety and dialogue through, for example, respectfully supporting people to follow democratic meeting protocols. Doing our own healing and reparative work (Macy 2007: 15) where we do harm is what we should do if we are serious about violence in our workplaces. Grasping the difference between ‘retributary outrage’ or ‘revenge justice’ and ‘restorative justice’ is important to avoid adding to the violence we witness (Bloom and Farragher 2013: 249).

There are limitations to the analytical tools we have used here; one is that we may have created a picture of violence as one-dimensional and all pervasive to the exclusion of productive and resistive expressions of power. We may have insufficiently acknowledged that there can be pockets of safe, trauma/violence-free spaces and non-violent, critically aware people in the most oppressive of organisations. People’s experiences can be much more varied and messier than this analysis allows and violence can co-exist within the same people and spaces that are, at other moments, safe and non-violent.

We want to unsettle any construction of human organisations as monolithic systems of oppression, and yet also wish to unsettle ideas of organisations as only benign, benevolent places. Our intended, agenda setting position is that in organisations there is a limited commitment to a progressive ethical capacity by people in powerful positions alongside a failure to trace the effects of their power and to be accountable for harm and injustice caused. We hope we have contributed to building an argument for the need for an ethic of love to address lovelessness, which creates an emotional and political vacuum for violence to spread (hooks 2000: 5). Positioning ourselves in all our actions from within an ethic of love will help us strive for just and emancipatory outcomes as hooks writes:

In this society there is no powerful discourse on love emerging either from the politically progressive radicals or from the left. The absence of a sustained focus on love in progressive circles arises from a collective failure to acknowledge the needs of the spirit and an over determined emphasis on material concerns. Without love, our efforts to liberate ourselves and our world community from oppression and exploitation are doomed. As long as we refuse to address fully the place of love in struggles for liberation we will not be able to create a culture of conversion where there is a mass turning away from an ethic of domination. (1994: 243)

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Fostering Trauma-Free Mental Health Workplace Cultures and Reducing Seclusion and Restraint

DYANN ROSS, JAMES CAMPBELL AND ALEX DYER

Literature on the factors which precipitate the use of seclusion and restraint on mental health consumers is typically confined to their behaviour and/or the behaviour and attitudes of the involved clinical staff. These understandings do not sufficiently take account of workplace cultural factors and political influences within a societal context of prejudice against people with mental illness. The elimination of coercive and restrictive clinical practices is called for by mental health carer forums, national and state level mental health reports and policies, and concerned mental health clinicians. The authors argue this will require radical change by all staff in the mental health system as violence is a systemic issue which creates a culture where clinical practices are prone to reinforcing this systemic violence. A mapping template and a warrants schema are presented as examples of tools to enable trauma-informed cultural change in mental health systems.

Introduction: The Problem of Seclusion and Restraint

The problem with the use of seclusion and restraint practices in mental health inpatient facilities in Australia is that they can result in considerable human suffering, including death, for people receiving care (National Association of State Mental Health Program Directors [NASMHPD 2014: n.p.) and injuries for clinical staff providing that care (Fisher 1994: 1584-1591). People receiving care in mental health facilities as inpatients, where this may be without their consent and occurring under the authority of the Mental Health Act 2000, are hereafter referred to as mental health consumers. The article argues there is a need for significant cultural and organisational change to occur in one of the most challenging places where consumers’ basic human rights and dignity can too readily be abused. The change focus needs to be on eliminating the incidences of seclusion and reducing restraint of consumers in public mental health facilities as these practices may indicate systems failure in managerial and clinical practices (NMHCCF 2009: 7).

According to the Mental Health Act (Queensland Government 2000: 109), restraint involves ‘a restrictive intervention that relies on external controls to limit the movements or responses of a person’ and seclusion is defined as ‘the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented’. For the purposes of this paper we acknowledge that calls for the total elimination of restraint, while morally desirable, may not be feasible in some instances due to the need to exercise a duty of care toward the mental health consumer and/or other persons in their proximity.

Our point nevertheless regarding the harm caused by violence, including restraint as a form of violence, still stands (Finke 2001: 186). We do not hereafter separately make this point and use the term ‘seclusion and restraint’ as an umbrella term for the spectrum of behaviours and all levels of violence toward mental health consumers, aware this area needs further research. Further, we wish to acknowledge that clinical staff in mental health inpatient facilities may be potentially morally conflicted as they are responsible on behalf of society for negotiating the tension between the care and control dimensions of their roles (Okitikpi 2011: vii). It is important that as allies to both the clinical staff and mental health consumers we avoid creating an ‘injurious division’ (Reynolds 2012: n.p.) with staff and consumers in seeking to contribute to the issue.

We write from a critical humanist, anti-oppressive theoretical approach (Thompson 2011: xviii), which accents non-violence, equality, democratic and collaborative relationships and trauma-informed clinical practice. This approach is also premised on recovery-oriented values such as respect for peoples’ dignity, self-determination and recognising consumers as experts in their own lives (Queensland Health 2005: 1). The use of seclusion and restraint in the context of providing care for people with mental illness is problematic both ideologically for us and for the people experiencing it (Saks 2012: n.p.). However this is not the main focus of the paper, as a survey of the relevant research leaves us with unanswered questions about the influence of organisational and broader political factors. As Hickie recognises:
Quality mental health care requires time, resources and space to allow health professionals to deliver health care to meet the unique needs of patients. In a nutshell, we do not have what we need to practice people-centric mental health care (cited in NMHCCF 2009: 2).

The Research Gap: The Need to Address Indirect Power Issues

International research that shows the dangers of seclusion and restraint (Sailas and Fenton 2000: 8) was important for helping us as mental health allies to understand the need for change as a professional and ethical priority. We came to realise that concerted efforts to create safe mental health workplaces, and thereby cultural safety, will be central to the elimination of seclusion and reduction of restraint. Cultural safety is the opposite to injustice and violence of all kinds in human organisations (Bloom and Farragher 2013: 250). Violence refers to the use of direct force or intimidation against a person or whole groups of people, specifically people with mental illness (Saks 2012: n.p.). It can also be indirect through inadequate procedures or failure to adhere to democratic workplace processes (Bloom and Farragher 2013: 250) and inadequate funding and resources to ensure quality care for mental health consumers (Mental Health Council of Australia 2005;2011). Violence occurs where a person feels unsafe or demeaned to some extent, possibly even to the extent of their life being threatened. Research shows that violence increases for both staff and consumers where seclusion and restraint are practised (Altimari 1998; Finke 2001: 186). Cultural safety is created by actions and processes that reduce or negate the need for seclusion and restraint; this is a pre-requisite for both clinical staff and consumers’ safety, and well-being in mental health inpatient facilities.

We have yet to find research on the issue that is presented from the experiences of clinical staff seeking to enable the elimination of seclusion and restraint. We believe this is an area of research and scholarship that is urgently needed to help build a language of possibility. First hand, in-depth narrative accounts would also create a sense of the emotionality, humanity, professionalism, challenges and do-ability of breakthroughs in changing mental health workplace cultures that are prone to violence. This approach in future research would seek to build an appreciation of the embodied, lived experience of clinical practice in contemporary mental health. Such a research orientation has its starting point in this exploratory theoretical paper, which situates clinical practices of seclusion and restraint in the larger, complex power dynamics of mental health systems of care. Evidence for this idea of mental health workplaces having violence-prone cultures is provided by reputable national reports into the state of mental health systems of care in Australia (Human Rights and Equal Opportunity Commission 1993; Mental Health Council of Australia 2005; 2011, Dept. of Health (UK) 2005; NASMHPD 2014).

The mental health literature has begun to allude to the need for broader systemic change (Cutcliffe and Riahi 2013: 568), but we found few studies that theorise how power dynamics operating beyond the immediate situation indirectly impact on each seclusion and restraint event. These indirect power dynamics or ‘relations of ruling’ (Smith 1993: 6) relate to the range of effects from broader societal prejudices against people with mental illness (Mental Health Council of Australia 2011) to the largely unscrutinised managerial decisions and practices in mental health systems. Additionally, the political and policy context which impacts indirectly on how clinical staff respond to mental health consumers in inpatient facilities also tends not to be scrutinised. The neoliberalist, medicalised and individualistic bias to mental health policy (Sawyer and Savy 2014: 253-254) which manifests as a micro-managing and containing approach by the Queensland Government to perceived problematic social groups (Wardill 2013) is well recognised.

Background: The Nature and Extent of Human Suffering

Much of the research emerging principally in the United States demonstrates that the use of seclusion and restraint has devastating impacts upon consumers and those who care for them within mental health inpatient facilities. For example, it has been estimated that up to 90% of mental health consumers receiving care through public mental health services have a pre-existing trauma history (Fisher 1994: 1584-1591). In relation to this, the use of seclusion and restraint was found to be not only non-therapeutic but was re-traumatising and increases the risk of physical and emotional injury to consumers and staff (Fisher 1994: 1584-1591). Further, the Hartford Courant publication (Altimari 1998) reveals that in America 142 deaths occurred during or shortly after seclusion and/or restraint over the 10 years preceding 1998.

A national report by carers of people with a lived experience of mental illness who have been subjected to seclusion or restraint in Australian mental health facilities claims:

... the use of seclusion and restraint should be eradicated from use within Australia’s mental health services ... [further] the use of seclusion and restraint is at unacceptably high levels and demonstrates treatment failure when used (NMHCCF 2009: 7).

This claim is supported by mental health consumer accounts of their experiences of being secluded and
restrained in America (Substance Abuse Mental Health Services Administration [SAMHSA] 2014) and includes accounts documented in the influential training resource created by the National Association of State Mental Health Program Directors (National Mental Health Consumer and Carer Forum [NMHCCF] (2014). Such experiences led the Citizen Commission on Human Rights (CCHR) to claim that it is a human right to:

Refuse any treatment the patient considers harmful … [and] no person shall be given psychiatric or psychological treatment against his or her will (2014: n.p.).

How the professional and political responses to the complex tension between individual rights and societal rights are negotiated in specific situations is largely not open to public scrutiny, informed debate or accountability.

Concerted efforts have since been made in the United States to reduce seclusion events with some success, using a range of strategies (SAMSHA 2014). However, the NASMHPD (2014: n.p.) currently estimate through improved data reporting systems that as many as 150 deaths continue to occur in psychiatric and residential mental health facilities each year in the United States.

The human cost of experiencing seclusion and restraint is profound and deeply concerning, this being the case even with the apparent decline in the number of seclusion events on the public record. Australian information on the extent of seclusion and restraint provided by the Mental Health Services in Australia shows a slow decline in the number of events with approximately 10 seclusions for every 1000 bed days in 2013 down from 15 seclusions for every 1000 bed days in 2008 (2014: 1).

On the basis of an estimated proportion of 10 percent of patients being subjected to seclusion and restraint reported in the Clinical Indicator Report for Australia and New Zealand (1998-2005):

It is reasonable to suggest that there are just under 12,000 episodes of seclusion in Australia each year, or put another way, that seclusion occurs 33 times across Australia each day (NMHCCF 2009: 8).

The statistics cannot convey the human suffering even one seclusion event can have on a person. For example, the following real life scenario of a person given the name of Thomas conveys some of the practice context details and harm experienced:

Not confident about his standard of treatment, Thomas refused medication and attempted to leave the ward. According to his medical notes, he was ‘aggressive and argumentative’.

Thomas was consequently reclassified as an involuntary patient and put into seclusion.

The Approval of/Authority for Seclusion form indicated the view that Thomas was secluded in part because he was an absconding risk.

Thomas spent 6 ½ hours in seclusion. Thomas was stripped of his clothing and woke up in seclusion clothed only in his underpants.

No consideration was given to Thomas’s past history of political imprisonment and torture, or his religious beliefs regarding the removal of clothing. Thomas was not provided with an explanation of his change of patient status (voluntary to involuntary) nor why he was being placed in seclusion.

He did not receive a debriefing session after his seclusion experience.

Having supposedly met the criteria for involuntary admission throughout the time he was secluded, Thomas was then found to be well enough to be discharged as a voluntary patient the next day without any follow up planned.

Thomas’s seclusion suggests it was used as a punishment rather than a ‘therapeutic intervention’.

As a result of his involuntary seclusion, Thomas now experiences insomnia, nightmares, stress, tension, pain and a lack of trust in the public mental health care service. He continues to have flashbacks of torture, flashbacks of hospitalisation and now has chronic depression.

Thomas says his life has ‘stood still’ since his hospitalisation (NMHCCF 2009: 9).

Queensland’s Mental Health Policy Context

Since 1997, the National Standards for Mental Health Services have been used in Queensland to guide service development to promote best practice for mental health consumers. For example, Standard 11 ‘Delivery of Care’ promotes the principle that all consumers are entitled to receive the least restrictive care (NMHWG 2007: 26). In 2005, the National Safety Priorities in Mental Health: A National Plan for Reducing Harm was published which identifies four priority areas for improving safety within mental health services including the reduction of and, where possible, elimination of seclusion and restraint. In an effort to identify and implement best practice strategies, the Seclusion and Restraint Project (2007-2009), referred to as the Beacon Project, was established to progress initiatives and work collaboratively with states and territories.
In keeping with the imperatives of the national initiatives, in 2008 Queensland Health demonstrated its commitment to reducing seclusion and restraint through the publication of a policy statement that identified expected outcomes through the implementation of specified strategies. The Queensland Mental Health Clinical collaborative was key in driving the implementation of these strategies, including the development of improved data information collection and performance indicators (Mental Health Branch 2008: 5-6).

The Queensland Government’s policy statement on reducing and where possible eliminating restraint and seclusion states:

Safety is a vital component of quality mental health service delivery [which is demonstrated by a commitment to] a range of initiatives including a Mental Health Clinical collaborative on seclusion and restraint, a state-wide training program, participation in the National Mental Health Seclusion and Restraint Project, and co-ordination and construction of national data standards and performance indicators (Mental Health Branch 2008: i).

Further, the Queensland Health policy document claims that:

Restrain and seclusion are interventions used as a final response to emergency situations where a patient’s risk is assessed to be imminently dangerous to themselves or others and no other less restrictive option is available (Mental Health Branch 2008: 2).

However, this claim is challenged by research that suggests these interventions are not used as a last resort and can in fact be used for relatively minor incidents but with tragic consequences (SAMHSA 2014: n.p.). One such case on the public record was that of David ‘Rocky’ Bennett, aged 38 years, who died in a United Kingdom mental health inpatient unit after being racially abused by a white consumer and lashing out at a nurse. After 25 minutes of restraint by five staff members Rocky died. An inquest into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in the national five year plan, Delivering Race Equality in Mental Health Care (Dept. of Health (UK) 2005: 3).

This is not to deny harm potentially done by mental health consumers’ actions or to absolve individuals of responsibility for their actions, despite the grey legal area that can occur relating to capacity to understand their behaviour in some instances (Traynor 2002: 1).

**Dominant Power Relations and Privilege**

There is a worrying conflation of politics that may possibly occur as a result of neoliberal policies and medicalised approaches to mental health care and stigmatising discourses about people with mental illness (Thompson 2011: 128). It is possible that there is functionality in using seclusion and restraint to manage some mental health consumers’ care as it shifts responsibility from society, governments, mental health systems of care and staff, to the mental health consumer. Hence, the mental health consumer may be constructed as the problem needing to be contained and needing to change their behaviour (Thompson 2011: 127). A different approach where seclusion and restraint is not used as a standard practice requires a radical reconsideration regarding how mental illness is understood and what is needed to support a person’s recovery.

Pease (2010: 170) suggests to address oppression and injustice, where violence is one form of oppression (Young 1990: 57), we need to grasp how violence is the result of dominant groups’ often unearned privilege. An implication is that powerful stakeholders – such as politicians, senior policy makers and advisors, senior staff in the Mental Health Commission and the executive leadership group in mental health services – who have a vested interest in the status quo need to lead and model the change towards non-violence and inclusive, democratic practices. This may require them to let go of some of their privilege, comfort, ideas and resources. Pease recognises that powerful stakeholders will not readily recognise or relinquish their privilege but might be enabled to do so ‘through critical dialogue with those who are oppressed’ (2010: 176).

The continued use of seclusion and restraint may reinforce the undesirability of mental illness in society and sends out the message that coercive measures will and are used to control unacceptable behaviours. Generally, clinical staff recognise the harm done to consumers who are secluded and can identify many of their experiences of seclusion, which are counter-productive to consumers’ recovery (Happell et al. 2012: 333). That the practice continues suggests the involvement of power dynamics beyond the immediate influence of mental health clinical staff (and consumers).

The tendency to focus on the behaviour of the mental health consumer to explain the need to use seclusion and restraint is challenged by recent literature, which argues that violence is an interactive process and not about one person in isolation. Bloom and Farragher, for example, develop the point that violence occurs in groups:

We start with the assumption that violence is a group phenomenon and that when violence has
occurred, the entire group has failed to prevent it, not just the individuals immediately involved. We see the violent person as the weak link in a complex web of interaction that culminates in violence after a cascade of previous, apparently non-violent events has occurred, creating another vicious cycle (2013: 150).

Cutcliffe and Riahi claim that despite the public perception of people with mental illness being violent, 'studies tend to show either a decline in the rates of violence perpetuated by individuals with mental health problems or that the findings are equivocal and inconclusive' (2013: 569). On the other hand, less recognised and debated is the possibility that a violence-prone workplace culture is operating to some extent when staff treat each other unfairly, engage in bullying, harassment, and other forms of behaviour which are not permitted by professional and organisational standards and values (Thompson 2011: 187).

The Possibility of Change in Mental Health Systems

A successful change effort of the order required for this issue to be addressed needs a number of alignments to occur which can make it seem like 'Yes, we can do this!' for a sufficient number and mix of clinical staff within the mental health system and their allies. It requires a conducive political context, progressive policies, supportive managers as well as collaboration with mental health community leaders and interest groups. Few change management references pay sufficient attention to these alignments, especially the amount of emotional investment required to effect change from the inside (see for example, Spector 2013: 158). The change project needs to have a clear goal which people can make a concerted effort toward. For our purposes, the main indicator of the needed broad ranging changes occurring will show as success in reducing the intolerably high level of seclusion and restraint incidences.

At the same time too little credence is given to how all levels of the mental health care system need to change. It is too simplistic to limit change to local actions of clinical staff in the mental health inpatient facilities on the basis, for example, that they tend to make the majority of behaviour which are not permitted by professional and organisational standards and values (Thompson 2011: 13). The assumption is that it is only the rank and file staff who need to change.

The change needs to start at the top of the hierarchy in modelling non-violent and non-coercive management practices towards staff. While writing about the business world, Crane and Matten call for a re-humanising of workplaces ‘by empowering the employee’ (2010: 330). The experience of seclusion and restraint can be dehumanising and disempowering for both staff, who are directly and indirectly involved, and mental health consumers. Sustained change relating to eliminating seclusion and restraint is not possible without a whole of service dedication and concerted collaborative effort over time. For this to occur it would require all aspects of the mental health system to become recovery embedded (Adams and Bateman 2013: 9) and trauma-informed (Bloom and Farragher 2013: 475). Trauma-informed organisations are those places where members explicitly work towards eliminating any behaviours or policies which might harm or traumatisate staff and consumers. Bloom and Farragher’s (2013) work directly links violence with traumatising organisations and Bloom argues that authoritarian leadership practices are the main power dynamic underpinning this violence (2000; 2014: n.p.).

The broader political context also needs to be included in the power dynamics which impact on the use of seclusion and restraint in mental health facilities. For example, in recent years an attempt to move towards having the mental health facility doors open experienced a setback. Clinical efforts to open inpatient facility doors were impeded by the directive from the Minister of Health, Lawrence Springborg, in late 2013 that all mental health facilities in Queensland had to be kept locked at all times. The stigmatising newspaper report commenced with the claim that:

Hundreds of mentally ill patients – including killers and rapists deemed unfit to incarcerate for their crimes – are absconding each year, forcing state-run facilities to adopt a new locked door policy (Wardill 2013: 7).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) issued a press release countering this decision and argued that:

To make this the standard of care for everyone is unnecessarily brutal and goes against the standard of care Queensland has been proud to offer vulnerable patients since introducing de-institutionalisation many years ago (Patton cited in RANZCP 2013: 1).

This reminds us of the very political nature of mental health and of the change process needing to be multi-
faceted and able to negotiate the political power shifts
and nuances.

Further to the already noted use of power which can have
harmful effects, another way power operates in complex
organisations is by making one group of staff more or
less important than other groups of staff (Earles and Lynn
2012: 11). For example, it is well known that community-
Based acute care mental health clinicians are likely to
be regarded with higher esteem by their peers than staff
who work on the mental health wards of hospitals (Carr
2008: 19). The potential for negative constructions of
hospital-based clinicians can have the effect of leaving
them with an unfair burden of responsibility for the use of
seclusion and restraint sanctioned by the mental health
service. This provides further credence for the need for
organisational cultural change over time to create safe,
non-violent, egalitarian, trauma-informed spaces and
places for all clinical and support staff and consumers.

We argue that attention needs to be given to achieving
respect, safety and fair processes within the broader
workplace and organisational setting. Cropanzano,
Bowen and Gilliland describe this as organisational justice
where:

Members’ sense of moral propriety of how they
are treated – is the glue that allows people to
work together effectively. Justice defines the very
essence of individuals’ relationship to employers.
In contrast, injustice is like a corrosive solvent
that can dissolve bonds within the [organisational]
community. Injustice is harmful to individuals
and harmful to organisations (cited in Bloom and
Farragher 2013: 250).

To the extent that violence, both direct and indirect and
coercive as well as subtle, is occurring in mental health
systems it can be understood as interpersonal and
organisational injustice. The complex mix of bureaucratic,
legalistic and clinical practices in public mental health
facilities creates enormous challenges for maintaining
safe and therapeutic care for consumers. This context
has an intricate and ongoing influence on the ability of
staff and consumers to avoid violence and in particular,
to avoid violence relating to seclusion and restraint.

**Keys to Organisational Cultural Change**

Where clinical staff and mental health consumers
experience violence, this will interconnect with other
dynamics of power abuse in the mental health and broader
political system. In such circumstances an ‘organisational
alexithymia’ can occur where ‘an increasing amount of
important information becomes “undiscussable” … [and]
the organisation as a whole becomes … unable to talk
about the issues that are the most emotionally evocative,
that are causing the most problems and that remain,
therefore, unsolvable’ (Bloom and Farragher 2013: 17).

We are indebted to the practice based research work
of Bloom (1994, 2000, 2014) and Bloom and Farragher
(2013) for the work done in naming the nature of
traumatised organisations. A major implication of their
work is there needs to be a dedication to the recovery
work of the whole staff group because otherwise the
trauma creates a reactivity and ongoing cycles of abuse
and suffering. To our knowledge this level of work is not
happening in Australian mental health systems.

In this section we offer two keys that can support on-
the-ground or bottom-up change (Ife 2013: 138) towards
opening the doors through all layers of the mental health
system. The first key is a flexible template for mapping
the main dynamics, levels of influence, resources and
stakeholders. We give this tool the title ‘multi-focal
change template tool’ (see opposite page). The work
that sits within this mapping needs to be undertaken
from a community development approach over time (Ife
2013: 158) within the organisational context. The change
template is populated with some examples of what could
contribute to the elimination of seclusion and the reduction
of restraint.

Space does not permit an elaboration of points in the
template but the ideas are consistent with our preceding
arguments and draw on our combined professional
experiences over many years. Many linked templates may
be needed for different aspects of the issues. Each area
of the template needs to be invested in, and weakness in
one area will alert change agents to what needs attention
or to the possible limits of the change efforts.

The second key concerns establishing warrants or
agreements for the change work where a set of power-
sensitive questions are outlined. We call this key ‘warrants
for trauma-informed and recovery organisations’. These
questions can help change agents to gauge if the
change effort is on-track and if all the relevant people
are sufficiently invested in the change work. This power-
sensitive tool for helping progressive change agents in
mental health systems gauges whether there is sufficient
political will: to consider commencing a change effort; to
persist with it; or to seriously consider stopping change
efforts. The ideas which are adapted from Fox and Miller
(cited in Ross 2013: 202) will allow a power analysis
that will show if there is adoption by the people needed
to legitimate the desired changes and whether they are
sufficiently willing themselves to change.

In practice situations at crucial times, the following
questions might be asked of the powerful people who
are allowing the status quo of seclusion and restraint as
Layer or Focus

Power Relations & Dynamics

Knowledge, Theories, Models, Values, Ethics

Clinical Tools, Processes, Engagement & Interventions

Financial & Other Resources

Workforce Development, Whole of Service Re-formulation

Public Accountability

Embedded consumer led processes and knowledge

Reinforce and respond to consumer, community, and service accountability and service

Launch consumer choice and voice and reframe power

Open the doors of the whole system

Micro: Personal

Relationships are non-violent, respectful, inclusive, negotiated and ensure accountability of powerful party.

Consumers & carers as equal partners.

Staff value not dependent on position in hierarchy.

Free legal aid for consumers.

Range of models of mental illness/wellbeing, critical humanist values, trauma-informed ideas.

Anti-discriminatory behaviour and non-stigmatising language.

Sensory modulation, de-escalation, non-violence, deep listening, care, partnerships based on equality and inclusion, group based therapy, no seclusions and minimal force with restraint, open doors, negotiated safety rules and processes.

Facilities that are dignity enhancing, aesthetic, open and adaptive to changing needs of clients. Funding of changes re staff rostering, staff mix and re-training.

Funding of trauma-informed training to include ALL staff.

Resource sharing with mental health NGOs.

All staff to receive trauma-informed supervision, and to participate in debriefs, dialogue (equal value) meetings, reflective practice groups.

Active promotion of care-based ethics especially of people who are marginalised or are being scapegoated. Active promotion of restorative justice for people causing harm.

Meso: Cultural

Organisational

Team, group and service level debriefs, dialogues about shared concerns without blaming and recriminations, independent person facilitated. Follow through changes monitored.

Cultural safety, anti-bullying and anti-mobbing ideas, systemic thinking, critical organisational theory, code of ethics, conflict of interest.

Build collective moral capacity and responsibility.

Provide consumer centred tools eg Deegan’s computer based interactive resource (2013) to enable shared decision-making.

Identify and address stigmatising and us versus them clinical processes.

Close and decommission seclusion rooms.

Increase safe, welcoming, nature centred spaces for distressed people. Increase consumer allies, companions and advocates and pay for their expertise.

Clinical staff to be regularly rested from inpatient facility work.

Whole of system recovery training and implementation. Establish as a norm the consumer’s wishes being upheld and proactive measures taken to avoid coercion.

External benchmarking and critical friends to improve cultural safety.

Macro: Structural

Societal

Restorative justice commissions of inquiry to address violence on all levels.

Mental health think tanks and community based dialogues to address stigma and fear.

Accent training, practice and research with consumers, clinicians and managers together.

Open the doors of the whole system to demystify and improve accountability and service relevance and responsiveness.

Embed consumer led processes and knowledge to invert status of knowledge and expertise valued.

Consumer in senior management group.
accepted practice – have you:

1. Built a sincere relationship with mental health facility staff and the change agents, families, carers and the mental health consumers impacted by seclusion and restraint?

2. Stayed focused on the relevant shared issues with willing attention to the effect of power imbalances?

3. Ensured you have made substantive contributions to the change effort?

Dialogue with people who are not making substantive contributions may be difficult or unsafe, and if so then the progressive change agents might use the above questions as a reflective tool to determine feasible forward strategies.

Conclusion

Current research into the use of seclusion and restraint in mental health inpatient facilities stops short of asking the hard question of who is responsible for the system of care that allows the use of coercion in the name of care. An argument for turning the focus to the power issues underpinning workplace cultures where violence is occurring, as well as the broader systemic and political influences, was developed to respond to this gap in mental health research and related public debate.

Multi-pronged changes are needed which simultaneously address the violence – both overt and covert – in mental health workplace cultures and the use of seclusion and restraint against mental health consumers. Tracing the influences for each seclusion event to all possible sources may illuminate the many actors who directly and indirectly contribute to current practices. Building the accountability of people in senior positions of power through tools such as the ‘multi-focal change template tool’ and the set of questions to gauge their ‘buy-in’ to creating trauma-free workplaces and clinical practices, may have some value.

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Please direct enquiries about the article to Dyann Ross.

Unstable
Casuarinas, wattle & bottle brush in the scrub along the fore shores where the pale sand stretches from headland to bluff.

The beach is deserted; as yet, no footprint or long boat disturbs the solemn rise & thump of the green glass ocean.

That dark shade floating silent between the stunted t-trees back of the sand dunes leaves no impression; only

the rust-streaked sails of the buccaneer unloading the future will now begin the root and branch erosion of a littoral past and stable.

RON PRETTY
WOLLONGONG, NSW
Towards a Mental Health Model of Practice: Highlighting the Scaffolding That Can Really Help People

Matt Dilges

A grouping of theories and mental health clinical practices are outlined that may help clients to make restorative improvements in their lives. Client-centred partnerships, clinician self-reflection and contextual awareness are key features of the scaffolding needed for a mental health model of practice. The group of explanatory ideas relating to the client’s experiences are: attachment, developmental, systems, neurobiological and psychoanalytic theories, where it is recognised that each have their own limitations as stand-alone theories. Further, the theories need to be located in a power analysis of broader factors which impact on people’s lives. Failure to do so could result in mental health practice colluding with socially unjust and discriminatory power dynamics in mental health systems. Collectively, these theories, when employed through a power sensitive and reflective partnering approach, can provide a way to enable people’s sense of normalcy and wellbeing and thereby resist being labelled and treated as mad.

Introduction: The Politics of Helping

The paper presents the progressive view that mental health clients’ symptoms reflect early life attempts to survive and adapt in circumstances of loss and trauma, are historically (in their life process) functional, and are context specific for each person. What is needed to help people seeking mental health care is very personal within a political context, including the helping context of the public mental health system. The construction of human suffering and trauma as mental illness (Bloom 2000: 67) may have the effect of misunderstanding how what really helps people has many similarities and has a normalcy about it within a recognition of personal needs and differences. The literature is replete with analyses of the danger of pathologising and medicalising responses to life events (Thompson 2011: 125). This dominant approach to helping can show as a tendency to blame the victim (Baum 2014: 79) and focus helping almost exclusively on the person diagnosed as mentally ill separated from their socio-cultural and political context.

For example, Mental Health Acts exclusively focus on individuals deemed to have a mental illness with no recognition given to the social and political nature of mental illness or the contested nature of what constitutes mental illness and appropriate responses (Repper and Perkins 2009: 120).

Further, the omission of the influence of the contextual dimensions of the helping situation can make invisible the discriminatory nature of state sponsored responses to mental illness. This is evidenced by the stigma attached to the people seeking (Millen and Walker 2001: 89) and giving help (MHCA 2011), and the poor resourcing of mental health systems of care in Australia (MHCA 2005: iv). This omission of the contextual influences of helping can have many implications for the person, including that they can experience further harm and trauma from the help givers. This dynamic is an abuse of professional and managerial power and is known as ‘social iatrogenesis’ where the system meant to help people actually does not help (Sartorius 2002: 1470) but rather causes a secondary level of trauma. This is recognised by Sullivan who uses the more political language of ‘meta-discrimination’ (1999: 5) to describe health workers’ biases against their clients. Thus, accounts from mental health survivors of the discrimination, loss and harm they experienced in state run mental health facilities (O’Hagan 2009: 198) need heeding. Their experiences collectively show the power dynamics that need to be addressed in the micro-helping practices with people and in the often discriminatory cultural norms and structural biases of society.

Many personal accounts of secondary trauma are recorded in public reports with the theme being the ‘injustice and despair’ experienced by people seeking help as well as their carers (Mental Health Council of Australia [MHCA] 2005: iii). The author’s own professional experience and these accounts provide the impetus to redouble efforts as a mental health clinician, to develop a non-pathologising, non-medicalised mental health model of practice which can really help people seeking help in the mental health system. It is acknowledged, but not directly addressed here, that a parallel commitment is needed to challenge the cultural and structural dimensions of the
issue of what needs to be done to ensure people really are helped without it costing them further. The inclusion of a power sensitive reflection process by mental health clinicians should, nevertheless, allow some recognition and naming of the contextual influences involved (Fook 2004: 16).

A limitation of the paper is that it does not provide a critical analysis of the theories per se which are used to explain the person’s trauma, life experiences and ways of surviving and adapting that bring them to the attention of the mental health service. The author is aware of the valuable critical analyses, for example, of attachment theory which can be inadequate, even dangerous, if employed without sufficient counterbalancing theories that alert practitioners to abuses of power that may impact on the client (Buchanan 2013: n.p.).

Overview: Towards a Mental Health Model of Practice

The paper seeks to present an overview of a mental health model of practice pending a more comprehensive, critically informed and researched elaboration in future publications. It hopes to show two main aspects of the scaffolding for help to really help – first, the need for a client-centred and partnership approach which is recovery-oriented and inclusive of the person's beingness and needs including the emotional, spiritual, cognitive and embodied (Sanford 1977; Pinches 2004: 9). Once this scaffold is established, the person's recovery will be enabled by an integrated use of: attachment ideas to understand how the person’s relationship experiences influence their emotions and information processing (Crittenden and Landini 2011: 47-52); ideas relating to the person’s development over their life span (Bigner, 1994: 313-315); ideas from neurobiology and memory research to understand the person's internal cognitive working models and somatosensory integration capacities (Schore 2003: 154-157); and systemic and spiritual ideas for explaining how the person makes sense of their experiences (O’Neill 2013: 34-38).

These qualities in turn shape the person’s interactions with the various care-giving systems they engage with from family, schooling, peers, medical, child protection, and of course mental health systems. When the unique mix of the above factors for a person encounter disruption, some people may come to the attention of mental health systems and be diagnosed as mentally ill. A detailed explanation of this complexity of ideas for understanding a person’s situation is not undertaken in this paper as there is an initial need to explicate the scaffolding aspects which establish the interactive, relational and contextual bases for the clinical work between the client and clinician. However, to build an appreciation of the promise of the proposed mental health model of practice, a later section of the paper explores some of the practice issues and implications of the ideas which underpin the model.

Clinical practice in mental health tends to organise around individual risk assessments, diagnosis of the mental illness and pharmacological treatment, and as such continues to adopt the main premises of the medical model (Whitaker 2010). All too often, however, such practice can be experienced as a diagnosis driving the person’s treatment where medication and talking therapies can become a default lens, with social factors being dismissed. Thus, the second aspect of the proposed model accents the dynamics within the helping relationship as one part of the person's social context to be considered. This is to be achieved primarily through learning in the helping relationship as afforded by the clinician’s power-aware reflections. This is encapsulated in a reflective functioning process for being able to identify how clinicians are either helpful (for example, are emotionally self-corrective) or a hindrance (for example, are unaware of their part in a parallel process) mediating the client’s recovery. Here, psychodynamic ideas such as transference and projection have some value when employed with a power sensitive lens and self-reflection by the clinician (Connolly & Noumair 1999: 322). Key questions in the reflective functioning process will be outlined in a later section to show how to enact a power sensitive approach, this being crucial to check for the misuse of professional power and also for the impact of broader discriminatory factors in the helping context with the client.

To adopt this alternative mental health model of practice requires a critical thinking approach (Fook 2004: 16) with high levels of reflective functioning in clinicians, teams and service planners. It is this capacity on the part of the service providers, in this paper specifically the clinician’s capacity, that is the second element of the scaffolding to be secured to ensure the mental health model of practice is enacted with safety, integrity and in a way that strongly supports the client’s own recovery efforts.

The author’s professional experience has often shown that personalised care, which centres on respect for a client’s ‘normalcy’ processes, is not embedded into the structures of mental health case reviews for decision making about clients. Further, the theoretical approach to helping clients is not explicitly elaborated on in models of service documents designed to guide mental health service delivery. Typically, the feedback loops from mental health services regarding trends in what works for clients to government policy making is also poor creating little innovation and change in clinical practices.

It is hoped that the coherency derived from an integrated theoretical model makes transparent to service planners, decision makers and clinicians alike that collectively we need to challenge outdated models of practice, transform mental health service delivery and bridge the current delays the author has witnessed from evidence to practice.
For the purposes of this paper, while the term mental illness is used, the author does not accept dominant views of the way people are constructed and how mental illness is understood and treated (Australian Medical Association [AMA] 2013). The medicalised notion of mental illness is thus unsettled. In its place, ideas of trauma and loss make it possible to engage and work with people without pathologising them, and seeing their experiences as normal to them and as responses to life circumstances (Bloom & Farragher 2013: 250). This paper reframes mental illness as adaptive to peoples’ early and current life context. It emphasises that symptoms have traditionally been functional within the developmental contexts in which they grew up, however are perhaps not adaptive when other systems see this as abnormal and requiring mental health intervention.

Focus on Scaffolding for the Model

A Client-centred Partnership

The idea of client-centred practice is not new (Rogers 1951) but in the context of complex, bureaucratic and legalistic helping systems, to be client-centred can be challenging and in turn, if achieved, can be empowering for the client. Where the client is engaged in a respectful, egalitarian and power-sensitive partnership, the likelihood of the intervention really helping the client is increased (Dominelli cited in Payne 2005: 260). Again, this can also be challenging to achieve and requires a double movement by the clinician of simultaneously being client-focused and also clinician-focused to check for power issues that work against the partnership serving the client.

The author’s mental health model of practice assumes people are to some extent ‘hardwired’ or genetically programmed for social and emotional connections and their primary drive is to belong and be loved. People do not exist in isolation but rather live in a relational context to have their needs met, to grow, and to differentiate while maturing with psychological, interpersonal and social skills. In the clinical setting, clinicians see struggles in these areas and often connection-seeking strategies by clients are labelled attention seeking, manipulation, or abnormal behaviour – even mad! In such circumstances it has been suggested that the ‘love code’ has been broken (Porges 2011: 191-193). It is thereby difficult to have emotional safety to receive love when dis-regulated feelings are occurring and ego-defences are needed for self-protection. When a person is experiencing emotional pain, it is not always possible to give signals of emotional safety, and yet these are needed in order to have proximity with significant others. Proximity is needed for bonding and for the flow of love to be received.

The work of Hellinger best describes the ‘orders of love’ and how they can become interrupted by grief and loss, but also repaired through a therapeutic process called ‘systemic constellations’ (2001: 7-9). Therapeutic approaches such as these are not strongly embraced by the dominant medical model of psychiatry. However they are the heart of what heals people. They restore a powerful felt sense of connection where trauma is re-integrated through arousal from family of origin pain, and disconnection being re-experienced in a safe and therapeutic group process restoring the orders of love (Madelung & Innecken 2004: 44-46). A starting point is to make attachment ideas – the language of love – simple, clear and accessible to mental health clinicians. It may be that many clinicians are already using attachment ideas and skills, but are perhaps unaware of the potential healing power of what they are implicitly doing.

An Introduction to Theories for Recovery

In the context of a trusting and safe therapeutic alliance, the client brings a story that can take many forms. It can be a behavioural sequence of what has happened during a precipitating situational crisis; it can be a personal, developmental, or trauma history; it can be whatever brought them to the clinical session. The Limbic system therapies (Gestalt, Emotional Release Counselling, Expressive, Symbolic and Creative therapies) can support the release of emotion contained in the client’s narrative. Yet the client also brings with them their defences to hold themselves together in face of emotional dis-regulation which impacts on the clinician’s state of mind and actions. These in turn also impact on the client’s state of mind in an ongoing circular causality process in the dyad.

A reflective functioning process (discussed in the next section) is needed to make these circular causality dynamics unfolding in the interpersonal process explicit, so that the right needs are met rather than collusion, avoidance or reinforcement of defences and internal working models in a parallel process (Powell et al. 2014: 260-261). Due to the developmental origins of these defences being laid down, brain enrichment is also required as therapy alone does not meet the threshold for ‘dosage’ effectiveness to rewire and stabilise subcortical functioning (Perry 2008: 39-43). These therapeutic changes occur in the context of clients being supported to redefine themselves in the broader systems and contexts in which they exist in time and culture (Campbell 1949: 36-38). That is, the context is encompassed as an integral part of the recovery work. This concerns where clients have come from, who and what they are connected to and the fields in which the self is emerging into a transformed being in contact with a therapeutic system aware of its obligations to provide such a transparent and supportive framework of care.

In short, the model supports the client to reframe themselves from dominant madness narratives to a personalised narrative of normalcy by exploring their trauma, meaning-making and seeing them in their broader context. Crucially, this needs to occur in a safe relationship with a mental health clinician framing the client’s journey where they proactively work to ensure trauma effects...
of the mental health system (Bloom 2000: 6) are not compounding the client's situation.

Clinician Reflective Functioning Process

Mental health clinicians need to make sense of systemic attachment dynamics and impacting contextual factors through a reflective functioning process. This will assist them to know if they are colluding or reinforcing the client's trauma by acting to meet the wrong needs, or omitting to meet the right ones. As unmet attachment needs drive emotional dis-regulation, which in turn can drive behavioural dis-regulation, then the reflective process should reflect this by asking simple but key questions at these three levels, both of the clinician and of the client. Further, given the power dynamics which intricately affect the helping relationship and the broader context, in particular the mental health system of care, the clinician needs to ask power specific questions of themselves, preferably where this includes the client’s views and feedback about how they experience the partnership. Some examples of questions follow:

1. What is the client doing? What is their objective behaviour – by their own account, by your observations?
2. What is the client feeling? What is their subjective experience – by their own account, by your observations?
3. What is the client needing? How can you meet that need or support them to meet their own needs? What are the resources in the local context?

These same three questions are then used to reflect on the clinician’s own experience, their contributions to the interpersonal process, to discern if they are providing an emotionally supportive experience, or if there is in fact a parallel process reinforcing trauma.

4. What am I doing? What is my non-verbal communication saying? What is the face that the client is seeing from me? Are they seeing a mirror of themselves with empathy?
5. What am I feeling? What is the source of this feeling?
6. What am I needing? How can I ground or centre myself?

Power specific and context questions can include:

7. How far does the client feel empowered?
8. How do they see my way of interacting with them?
9. What other factors are influencing the client’s situation and the helping context?
10. What power issues may be involved, including the mental health system?

In relation to this commitment of taking responsibility for their practice with clients, clinicians need to access professional supervision, including involvement in group based reflective practice groups (Dawber 2013: 241). This is vitally important for providing support to personal focused and client focused reflective processing, and for maintaining a developed appreciation of the power dynamics with clients, in other professional relationships within the workplace and the broader socio-political context. Otherwise this reflective capacity can be impaired within the clinician’s own familial systems and the therapeutic systems in which they work, with their own obstructed needs due to entanglements with the past being unknowingly projected into their own home and work lives (Flaskas and Perlesz 1996: 36-40).

Mental Health Model of Practice Reflections & Implications

Unmet needs (or the reminder of them through implicit memories) can lead to emotional dis-regulation that can then lead to further de-stabilisation in their behaviour. Firstly, over time problem behaviour can lead to chronic maladaptive behavioural patterns recognised as symptoms that are then given a maddening label or diagnosis.

In his work, the author saw clients with a long list of symptoms, sometimes up to 25, diagnoses from numerous clinicians who had failed to recognise the significance of where normalcy drifted into adaptation and survival with defences solidified to hold the individual together in face of unmet needs. The function of the symptoms and contexts in which they developed were overlooked as a treatment focus and had been replaced with a range of talking therapies and medications that did not differentiate attachment styles. Nor were they sensitive to information processing routes and were not even matched to the stages of development or critical functions of the brain being formed at such times that had been left out of the individual’s development. At best, based on a diagnosis, these approaches were stabs in the dark that did not contribute to the client’s recovery and did not seek to understand what had come before and the meanings attached to these experiences in how they had been protective. For example, a person who experiences paranoia has perhaps learned the hard way it is safer not to trust anyone (Crittenden and Landini 2011: 220-224).

While clinicians may not be aware of their client’s attachment style, they may also not be aware of their own and how the two interact. For instance, clinician’s own trauma histories can be activated unknowingly leading to defences they may not be aware of that block them from seeing, let alone scaffolding, to meet the needs of the client. Clinicians are charged with the responsibility to track the relationship and its affective dynamics using a reflection guided process and dialogue.
When clients fail to turn up for appointments or drop out of treatment early, how much of this is conceptualised as a possible avoidance attachment dynamic that the client does not have words or explanation for? Could this represent an implicit fear of intimacy and avoiding self with experiences of negative affect and vulnerability (often learned at a time prior to language and conscious memory)? How much of a client’s behaviour, who presents regularly in distress and crisis, is an ambivalent attachment strategy cuing to have unresolved attachment trauma healed? Clients who have a disorganised attachment (problems with both movements away and towards significant others and who struggle to predict safety and danger) and do not know where or who to turn to (such as those with attachment trauma from foster care), may replace their attachment figures with the medical and psychiatric systems such as the social worker in an emergency department of, or the Homeless Health Outreach workers in, the Mental Health Service (Crittenden & Landini 2011: 177-181).

Without a secure base, for someone who knows how to be ‘Bigger, Strong, Kind, Wise’ (Powell et al. 2014:142) to buffer the perceived threat, a neurological cascade unfolds spreading to the Hypothalamus Pituitary Adrenal Axis (HPA) with a resultant release of adrenalin and cortisol putting the autonomic nervous system into sympathetic arousal (Schore 2003: 256-257). Unresolved attachment trauma can neurologically also present as a similar picture to Attention Deficit and Hyper-activity Disorder (ADHD), begging the question are they one and the same phenomenon? Clients have described this to the author as being ‘like a cyclone building inside of them’ where they are feeling a loss of control after losing connection with their present surroundings and time, disconnection from significant others (potential secure bases), becoming preoccupied with intrusive memories, distracted by extraneous stimuli, with heightened affect/arousal and the need to be hyper-vigilant and primed for fight or flight (restless and impulsive) (Schore 2003: 207-214).

In classroom environments this can interfere with a young person’s learning and memory due to the release of cortisol being toxic to the hippocampus (Perry 2008: 98-101). This bottom-up hijacking also means information processing is greatly reduced (Ogden et al., 2006: 140). The need for comfort and to have feelings organised can be misused to others, being interpreted as the need for distance rather than proximity. In trauma, this can also result in a freeze or dissociative state (Liotti 2004: 476-484). Distress is soon felt though by others through their mirror neurons or they experience firsthand the fight/flight response from their clients. Without being able to make use of relational resources, the client’s automatic defences are employed to achieve a limited degree of emotional regulation. Although we are familiar with the common defences of projection (giving others a direct experience of what it feels like to be them – frightened, terrified, lost, overwhelmed), often companion ego-defences of denial, splitting, and omnipotence (acting in powerful, controlling and prescriptive ways to avoid vulnerability) are commonly recruited.

As a clinician, it is difficult to be aware of this at the time due to their own arousal being affected, in turn triggering their own ego-defences to manage their parallel experience of emotional dis-regulation and autonomic instability. Without this projected material being made sense of, the client’s communications (unbearable, overwhelming and intrusive affects) and their meanings are missed with the client falling through fault lines in mental health services (Conway 2009: 22).

Systems often respond with either big and strong behaviours (mean and frightening) as in restraining a distressed person in the psychiatric facility, being excluded from school or sent to isolation in ‘time out’, or increases in medication, rather than increasing time and patience from clinical staff. Premature discharge can occur to rid the therapeutic system of uncomfortable projected material, or use of the Mental Health Act conditions in a punitive and controlling way similar to an omnipotent ego-defence.

Without a reflective dialogue between the client and the clinician to make sense and meaning of how the client’s response has been not only adaptive, but protective for them in the past, and eliciting what is the true attachment need that is driving their emotions and behaviour, the opportunity for an emotionally corrective experience and healing is lost. When this breakdown occurs between client and clinician, or the projected material from the client results in a parallel process, sometimes acted out between services, the trauma is reinforced rather than resolved. The trauma is then reinforced on multiple levels with the client’s view of themselves; their world and future reinforced, neuro-biologically the wiring and chemistry of the brain become more efficient at this process, and personality traits and defences are again solidified until the next episode.

There is always a next episode as mastery, wholeness, or resolution has not occurred and the client continues to look for evidence to reinforce their beliefs, but hopes for a way out. Unless systems have this awareness – investing in attachment training and quality supervision, and building in attachment assessment and reflective functioning processes into standard assessment procedures, incident reporting, case review/planning processes and into dialogue with the client – mental health services can do more harm than good and are operating in the dark.
The Significance of Spirituality and Meaning Making

Human’s capacity for self-awareness, the impulse to explore and to question their place in the world means their development is strongly linked to finding meaning through moral and spiritual contemplation and practice (Ziegler 2009: 181-184). Rising rates of mental illness, suicidality, emotional and behavioural problems in youth and across society have prompted scientists and expert mental health clinicians to form a Commission for Children at Risk at Dartmouth Medical School to identify flaws in our current conceptual models for promoting healthy development. Their findings note that peoples’ ‘hard-wiring’ for seeking nurturing relationships and spiritual connection are linked to a number of health and happiness factors including higher levels of marital satisfaction, stronger immune systems/protection from disease, more rapid physiological healing, higher self-esteem, and reduced self-harm and substance abuse (Commission for Children at Risk 2003: 70-75).

Making sense and meaning of experiences in overcoming adversity and recovering from mental illness cannot be ignored by clinicians. Everything that happens to people and everyone they meet presents a unique opportunity to choose living a life not conquered by adversity or death and where joy and suffering become part of the way to their spiritual fulfilment (Nouwen 2002: 135-136). Furthermore, clinicians are challenged in this area of making the invisible visible without a language of the soul in mental health work, with psycho-spiritual theory and models missing from their training, and even split off/excluded from their clinical work (O’Neill 2013: 36-38).

Concluding Comment

The paper has presented the scaffolding for a mental health model of practice which has the two key scaffolds of a client-centred partnership and a reflective functioning process by the clinician. A grouping of theories which can build a deep understanding of the client’s trauma and loss issues can enable recovery through a non-pathologising and non-medicalised approach to helping.

Future research and publications will explore and delineate the finer details of the mental health model of practice.

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**ALAN**

He’d appear at university parties rotund in his coarse brown robe a wooden Cross hanging from his neck blessing you with his Bless you Bless you as if his Bless Yous were pious.

He might have been a university student; he might have been a seminary student; he might have been someone whose calling was to bless party animals at parties for you wouldn’t find him anywhere else.

Somehow, you knew his name was Alan but if you wanted to know more (say, what he was studying or where) he’d squeeze his palms together, resting on his paunch if not his laurels & simply say Bless you Bless you.

He might have uttered other words to other people in other places or even to you but, if so, they’ve been lost in the joke & the bliss of his Bless you Bless you & you & you & you.

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**GRAHAM ROWLANDS**

**ADELAIDE, SA**
Gatekeeper Versus Concierge: Reworking the Complexities of Acute Mental Health Care Through Metaphor

CHRIS DAWBER

Gatekeeping is a term associated with the intake function of acute mental health services and involves making key decisions about provision of service to clients. The term can also be seen as a powerful metaphor, invested with both functional and symbolic connotations epitomising the challenges and dilemmas faced by acute care workers. The gatekeeper metaphor is explored and juxtaposed against an alternative metaphor, that of the concierge, which presents a more constructive and inspiring vision of clinical practice. Defensive, self protective and aggressive practices are challenged whilst clinicians are urged to empower themselves by moderating a growing focus on administration, control and risk management through renewed perspectives based on clinical judgment, compassion and care. Intake is redefined as a client focused service and the ‘Concierge’ a way of envisaging a more satisfying professional role for mental health nurses and other acute care clinicians.

‘The gatekeepers are vulnerable though they pretend to stay in control’
(Excerpt from Gatekeepers by Henry B Stevens, 2004)

Introduction

The author has over thirty years experience in mental health nursing; much of that time in acute care settings. A participant observation approach (Douglas 1976) provides the basis for critical analysis of contemporary mental health acute care practice based on the author’s professional journaling along with the reflections of other acute care clinicians. This ethnographic material is supplemented by content analysis of relevant literature.

Australian public mental health services utilise a single point of entry based in acute care teams; with the intention being to streamline intake processes and expedite initial determinations about service provision (Sands 2007: 243). Clinicians working in this role are required to weigh clinical and risk considerations against consumer perceptions of need (Vine 2011), societal (Mental Health Council of Australia [MHCA] 2005: 33) and organisational expectations (New South Wales [NSW] Auditor General 2005: 2). Add to this, constraints on time and resources, ethical and medico-legal considerations, along with a raft of documentation and accountability requirements (Mullen et al. 2008: 85; Deutsch and Rosse 2009) and the process starts to become quite complex. Although all health care decision making is influenced, or hindered (Forster 2005: 56) by non-clinical factors to some degree, tensions arising from these competing considerations converge most noticeably during mental health intake. It is during mental health intake that first impressions are made, the relationship with the consumer begins and the interface between the mental health service and the community is at its most public. In this context, acute care workers come to be viewed as gatekeepers deciding the ‘who’, ‘how’ and ‘what’ of service provision.

Lessons learnt from clinical practice should inform the theories that drive organisational mental health reform (Nolan 1993). Nearly ten years ago a discussion between acute care colleagues about the implications of the gatekeeper function sparked a reflective process that eventually resulted in this article. The conclusion of that original discussion was that the term ‘gatekeeper’ conveyed an administrative, service-based orientation rather than a clinical or consumer focus. The language we use as clinicians not only frames our self view but can limit our functional capacity and construct consumers in ways that support unhealthy paradigms (Summerfield 2001: 148; Hamilton and Manias 2006: 86; Wand 2013: 287); even contributing to the stigma of mental illness (Sartorius 2002: 1470; Hocking 2003: 47). Acute care intake workers faced with competing pressures, ideological and clinical dilemmas and without adequate support and governance, can resort to defensive practices designed to serve and protect themselves and the service, rather than the consumer (Lakeman 2006: 396; Mullen et al. 2008: 85; Deutsch and Rosse 2009). Adopting the concept of the gatekeeper as a metaphor might help us to reflect on the ontology of the acute care role in mental health whilst consideration of an alternative metaphor, such as the concierge, provides an opportunity to review and re-define strategies for promoting best practice (McAllister 1995: 397).
The Evolution of The Gatekeeper in Australian Mental Health

It has been postulated that it was actually economic rationalism rather than clinical or ethical considerations that eventually propelled the rapid move towards deinstitutionalisation in the 1980s (Baldwin 1990: 211; Treatment Advocacy Centre 2010: 2); while failing to allow the development of infrastructure required to support such a shift to community care (Ozdowski 2005: 203; Ibll 2004: 206; Green 2003: 6). This legacy has ongoing implications for mental health care to the current day (Senate Select Committee on Mental Health [SSCMH] 2006: Chapter 2; Fakhourya and Priebaa 2007: 314), with the result that ‘essential services are overwhelmed by the heavy demand they face and they are not able to provide the level of care and support required to assist recovery ... ultimately, it is a failure of systems which is making people sick and is forcing them into the costly acute care sector’ (MHCA 2005: 43).

The way society, and indeed medicine (Pridmore 2013: 1), views mental illness has also changed. Acute mental health services now deal with a range of emotional, situational and social crises not formerly identified as mental illness (Summerfield 2001: 149; Pridmore 2013: 1). In addition, an ageing workforce and shortage of experienced mental health trained staff remain a major concern (Duggan 2007; Vine 2011; Acherstraat 2011: 2). Currently, some of the burden of mental health care transferred to primary health care providers (Commonwealth Department of Health and Ageing 2009: 11), many public acute care services now focus on triage and assessment rather than short term intervention and brief therapy, often leaving consumers dissatisfied (Victorian Heath Department [Vic Health] 2007: 11).

This raft of competing extra-clinical pressures also influences decisions about psychiatric inpatient admission (NSW Auditor General 2005: 8; Vic Heath 2007: 11). Relatively few people actually want to be admitted to a mental health unit [MHU], however ‘the extent to which appropriate care can be given within a community approach is very sensitive to resource constraints and work practices’ (Queensland [Qld] Health, 2005: 3). Most MHUs run at full capacity, focus primarily on containment and risk management, and provide little therapeutic treatment apart from medication (Leung 2002: 33). Consumer perceptions are that MHU nurses are overwhelmed by their workload and, consequently, unavailable and burnt out (SSCMH 2006: 6; Bee et al. 2008: 448). Due to increasing pressure on MHU beds (NSW Auditor General 2005: 2), patients may be discharged to make room for other patients rather than for clinical reasons (Capdevielle and Ritchie 2008: 164). Without effective, integrated community-based acute care, however, the risk of adverse outcomes (Qld Health 2005: 20) and readmission is significantly increased (Heggestad 2001: 196; Kalucy et al. 2005: 74; Wallace and Corderoy 2011; Hyland et al. 2008: 4; Zhang et al. 2011: 582). For example, studies cite 28 day readmission rates of 14-15% (Hyland et al. 2008: 8) with annual readmission rates between 30% (Hyland et al. 2008: 8) and 46% (Zhang et al. 2011: 582).

In acknowledging the influence of economic (Ibell 2004: 198; Capdevielle & Ritchie 2008: 164), organisational (MCHA 2005: 37), and political (Ibell 2004: 257) factors on mental health service delivery, it is important to clarify that whilst ongoing mental health policy reform is necessary at state and federal level (Rosenberg et al. 2009: 194, McGorry 2010) there is a corresponding need for workplace practice and culture to be addressed locally (Forster 2005: 56). The reactive implementation of change, in response to critical incidents and adverse publicity, has resulted in a proliferation of corporately driven risk management mechanisms (Qld Health 2005: 22; Forster 2005: 168). Whilst individual accountability is important, the effect of increasing administrative and documentation processes is less available time for clinicians to engage in meaningful, therapeutic contact with consumers (Drake et al. 2001: 180; Cleary 2004: 57). The resulting theory-practice gap can challenge the integrity and ideals of the caring practitioner (O’Brien 1999: 156) and can lead to the development of stereotyped, administratively driven practices and beliefs that can end up becoming entrenched in workplace subculture. In what might be considered parallel process on a systemic level, clinical aspects of acute care can also become reactive and self-protective (Lakeman 2006: 396). Teams can develop a ‘siege mentality’ where the main goal is protecting the work group from perceived threat. Unless acknowledged and addressed, this defensive position can result in the ultimate embodiment of threat becoming the consumer, particularly those consumers with complex needs, abuse and trauma driven behaviours, drug and alcohol co-morbidities and those who frequently present in crisis. These consumers tend to reinforce clinician frustrations and perceptions of powerlessness resulting in group countertransference and activating the self-protective energy of the team. In acute care settings, the manifestation of this phenomenon is most easily recognised in the framing of clinical interventions in defensive terms such as ‘diverting a referral’ or ‘giving someone the flick’.

The medicalisation of public psychiatry (Szasz 2001: 510) has also contributed to an erosion and devaluing of interpersonal aspects of mental health nursing practice (Barker 2003: 96; Gilburt et al. 2008: 181). It is a matter of concern that research has identified clinical skills deficits in areas such as rapport building, engagement, and communication in general (Fraser 2005: 33; Gilburt et al. 2008: 12; Bee et al. 2008: 451). Factors such as these are accepted as predictors of a positive outcome in psychotherapy (Lambert and Barley 2001: 357) and key elements of the recovery model theoretically underpinning current mental health practice (Johansson and Eklund 2003: 340; Barker and Buchanan-Barker
Gatekeeper Versus Concierge: Implications for Practice

The use of metaphor can help us to review and re-define clinical practice (McAllister 1995: 397). The language of the gatekeeper is one of exclusion. In the United States, the term ‘gatekeeper’ is used to describe a designated clinical position, acting on behalf of the health fund, whose primary role is to screen out services deemed unnecessary for patients (Carlson 2008). The metaphor of the concierge is provided as a way of envisaging an approach to acute care that epitomises a focus on consumers and an inclusive, responsive approach to service provision. A comparison of the gatekeeper and the concierge provides an opportunity to view a clinical role that is less defensive, more consumer focused and more compatible with the standards guiding mental health nursing practice (Marks 2010).

‘The gatekeeper listens to the traveler desperately knocking; but it is dark and the gates must be locked by nightfall. On one level the gatekeeper feels for the traveler, but the town is full and this traveler does not know the password’ (Les Clefs d’Or 2007).

Intake workers are required to screen and prioritise referrals at a time when first impressions and expectations are being set for service users. The requirement to manage persistent or multiple crisis situations can provoke a retreat to protective responses aimed at deterring or deflecting those representing a threat to the work group. Clinicians come to value colleagues who can divert a referral or avoid an assessment under the perception that almost every phone call, fax or conversation in an acute care team relates to some form of crisis or problem needing to be addressed. Relationships with other agencies also suffer as diagnostic criteria, designed for clinical purposes, come to be employed as mechanisms for excluding individuals from service (MHCA 2005: 196). Consumers trying to access the service perceive barriers and resistance (Hamilton and Manias 2006: 86). Meta-discrimination (Sullivan 1999: 3) occurs when clinicians add to a consumer’s stigma through pressured judgment of who is appropriate or worthy of service, and who might be deflected or triaged out (MHCA 2005: 38; Hamilton and Manias 2006: 87).

‘The knocking continues, disconcerting the gatekeeper; what does the stranger want? The gatekeeper daren’t open the gate to find out. The stranger sounds desparate – better wait for the sheriffs to arrive in the morning’ (Les Clefs d’Or 2007). The need to reconcile issues of care and control is an ongoing dilemma for mental health clinicians working in both inpatient and outpatient acute care settings (Sullivan 1999: 42; MHCA 2005: 66; Cuthcliffe et al. 2013: 128) and this dilemma is often played out at the point of intake. Clinicians can err towards control-based approaches, at the expense of care provision, when a focus on gatekeeping replaces that of service delivery (SSCMH 2006: 8). An approach that prioritises crisis response over early intervention means that situations often escalate (Mental Health Commission New Zealand Government [MHCNZ] 2001: 12) requiring involvement of police or other emergency services, before intervention occurs (MCHA 2005: 40; Boscarato et al. 2014: 5).

Acute care services can not only become disconnected from other agencies, but also from other components of their own organisations (Carr 2008: 19). Due to the process of compartmentalisation that has occurred in health care over past decades (SSCMH 2006; Mental Health Commission New South Wales [MHCNSW] 2013: 4), many acute care services are now both physically and operationally separate (MHCNZ 2001: 13; SSCMH 2006). In this context, even other components of the same service can come to represent a threat to the work group (Lloyd et al. 2005: 64), allowing the culture of defensiveness and self-preservation to undermine the continuum of care and lead to disjointed responses in crisis situations. Proactive measures are required to support acute care teams in reconstructing their role as part of an integrated network (Boscarato et al. 2014: 5, 8).

‘The Gatekeeper is tired and their body weary. The heavy oaken gate is adorned with many wrought iron embellishments and the hinges are rusting; it gets harder and harder to open as the days go by’ (Les Clefs d’Or 2007).

If acute care clinicians do not maintain both an individual and collective awareness of the consequences of falling into a gatekeeping role, they risk becoming despondent, disconnected and desensitised. Effective management should acknowledge these issues and provide clinicians with opportunities to reflect on practice in a way that reaffirms a consumer-centred, solution-focused approach to clinical work and challenges unhealthy workplace culture and rhetoric.

The approach of the gatekeeper is a stark contrast to that of the concierge. Picture yourself walking into the foyer of a hotel. The concierge enquires about your journey and wants to know how you are feeling. They/He asks if they/ he can do anything to assist, then advises you about the range of services the hotel has to offer and the places that may be of interest and relevance in the surrounding area.
The concierge provides a demeanour of calm reassurance and maintains composure ... He/she is flexible, disciplined and persistent and is kind and courteous to all customers and staff alike ... Any request will be addressed and if a guest's needs are unable to be met by the concierge, a comprehensive network of contacts means that someone will be able to assist in some way (Les Clefs d’Or 2007).

Mental health nurses account for the majority of acute care intake workers in most services (MHCNZ 2001: 11). Whilst the comparison between mental health intake worker and concierge may appear idealised, greater appreciation might be gained if we reflect on nursing’s tradition of holistic consumer care, and the value it places on interpersonal communication and the therapeutic use of self (Peplau 1992: 13). The Australian mental health nursing standards prescribe professionalism, respect, ethical service delivery, collaboration, individualised care planning and integration (Marks 2010). This set of humanistic perspectives on our work with consumers allows us to share the title of ‘the caring professions’ with our allied health colleagues.

‘The well trained concierge knows that the key to good service involves establishing a professional persona through the development of a system of mutually beneficial interpersonal and interagency alliances’ (Les Clefs d’Or 2007).

The cultivation of inter-departmental and inter-agency relationships promotes collaboration in care and helps mitigate the stress that can arise when agencies feel they are working in isolation or, worse still, in opposition (Watson 1977; Sharrock and Happell 2000: 24). Only a small percentage of people with mental health problems attend public mental health services for treatment, with the vast majority being serviced by primary care providers in the community (AIHW 2011). In acute care mental health settings, mutually beneficial alliances should involve inter-agency liaison systems that are truly representative of, and supported by, the workplace.

‘The good concierge is valued and supported. He/she is continually given tangible support and rewarded by a management that acknowledges the importance of the role’ (Les Clefs d’Or 2007).

Just like the concierge, acute care workers need support in maintaining a professional, consumer-focused approach to service provision. The same principles that should govern consumer care such as supportiveness, collaboration and empowerment, also relate to staff care. Professional development programs for acute care staff should place a greater emphasis on interpersonal aspects of practice, clinical skills development and therapeutic interventions (Boscarato et al. 2014: 8) instead of focusing predominantly on risk management processes, accountability measures and administrative requirements (Drake et al. 2001: 180; Calvert and Palmer 2003: 37). Administratively focused meetings are no substitute for meaningful clinical forums that encourage robust discussion and a positive work place culture (Meehan and Boateng 1997: 123). Protected time should be set aside for mechanisms that facilitate reflective practice so that clinicians have adequate opportunity to explore the interpersonal aspects of their work and professional development (Sherwood et al. 2005: 3). Clinical supervision can help foster a culture of support, greater understanding, compassion and empathy towards consumers (Cleary and Freeman 2006: 985). Clinical supervision has also been shown to increase staff resilience (Proctor 1986; Koivu 2013: 1) and encourage critical thinking about practice (Mantzoukas and Jasper 2004: 926). Despite supervision being mandated for authorised mental health practitioners, however, many acute care clinicians remain wary of and disengaged from this important activity.

‘To be accepted into the Clef d’Or is a significant mark of recognition and respect for a concierge. It is a reflection of the high esteem in which a good concierge is held by their colleagues’ (Les Clefs d’Or 2007).

Acute care clinicians need to acknowledge their part in determining the future direction of their role. It might be wise to reflect on the advice given to consumers about reviewing unhealthy patterns of behaviour, questioning motives and goals, and exploring actions to facilitate personal growth. Acute care work can be a stimulating and rewarding field of mental health nursing requiring highly developed skills, (Fraser 2005: 32; Bee et al. 2008: 448) but many acute care nurses and their colleagues may have been working in gatekeeper mode for too long. Even the most resilient individuals constantly exposed to the negative aspects of the gatekeeper culture, reinforced by mounting non-clinical pressures and with limited support, risk becoming burnt out and cynical. Acute care workers are the public face of the mental health system and need to be supported to maintain their capacity for therapeutic engagement (Bee et al. 2008: 449; Boscarato et al. 2014: 8). There are significant implications for the service and for those it serves when clinicians start to lose hope, adopt defensive practices, and struggle to develop and maintain alliances (MHCA 2005: 67). After all, hope and alliance are key factors determining positive outcomes in mental health care (Seligman 1995: 968; Lambert and Barley 2001: 357).

Conclusion

Acute care teams are comprised of clinicians who choose to work with people in distress. In addition to the emotional labour of their clinical role, they are subject to a range of non-clinical pressures often with limited support and supervision. In many cases, acute care intake workers have come to be seen, and more importantly see themselves, as gatekeepers representing a perpetuation of institutionalised attitudes towards psychiatric care.
The gatekeeper role has evolved at the expense of other important clinical and humanistic aspects of mental health acute care work. The gatekeepers often bear the brunt of frustration and anger directed at a system perceived as struggling to effectively respond to consumer needs.

Whereas the term ‘gatekeeper’ represents a line of defence against threat, the concierge utilizes interpersonal skills to activate a well maintained network of contacts to achieve the best possible outcome for the consumer. The concierge’s image is reinforced by accountability, support and validation; a proud representative of an organisation providing a quality product. Whilst the task of regulating service provision is still an aspect of the concierge role, the underpinning philosophy is consumer focused.

Greater emphasis needs to be placed on clinical and therapeutic aspects of mental health acute care work (Fraser 2005: 32; Vic Health 2007). The onus for this change is shared; managers need to explore more practical ways of promoting service integration, ensuring support and encouraging clinical supervision (for acute care clinicians in particular), whilst acute care clinicians need to reclaim their clinical identity and rediscover the ontology of the caring professions.

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All about him
the events gather
though the people no longer do
and neither do they me
and my virgin journey
to harvest past and present sowings
yes darling
it could mean nothing
if you’d just allow it to
the wait could be endured
the accommodation
the immaculate breech combing
the preparation
of a cute ass of burden
and gifts of myrrh for Gomorrah
and the adoration
of the Magi that was extraneous
except for politics, which never is
the Roman feasts
and our wastrel waistlines
the unities, the concretisation
of good things done
and embraces
and all you think of is future focussed crystals
as no cards are written
and you get Christmas phone texts
from people you no longer know as a name
and annually remember you
drunk with very important hi-there’s
for which we’re all grateful.

I and I live
Diverse, yet one
One race, in humanity
Yes, one human race
I and I live
Diverse identities
Diverse languages
Languages = multicultural lives
Multicultural positive lives, mutually reinforcing ideals
Noble ideals of equality, dignity and freedom for all
I and I live

SARAH TOBHI MOtha
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ARIEL RIVEROS PAVEz
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Beyond Madness: Ways to Foster Nonviolence in Human Systems

Positioned as an epilogue to the themed edition of Social Alternatives on the nature and politics of madness in contemporary Australian society, this article has been inspired by the narratives and analyses of the contributors to this edition. It aims to go beyond madness to explore strategies of resistance to the violence of marginalisation, humiliation and incarceration which often comes before and after a diagnosis of madness. Proposed strategies for resistance include studying up and speaking back to the oppressors; improving the capacity of bystanders to intervene; holding a structural analysis of power and resistance to support social change work; and affirming the value of non-violence and dialogical processes. In this article, resistance to violence is viewed as inevitable, desirable and an act of optimism.

Introduction

Trained as a social worker in the 1970s, I entered practice buoyed with optimism, thinking my colleagues and I would be part of implementing a generous, fair, and inclusive social contract. Differences based on gender, sexual orientation, class, religion, so-called abilities and ethnicity would cease to matter in this evolving society. The sacking of the Australian Labor Prime Minister Gough Whitlam in 1975, and the continuing reign of Joh Bjelke-Peterson's conservative National Party Government in Queensland indicated the struggle wasn't over, but the launch of the journal Social Alternatives in 1977, the maintenance of Medicare, legal aid and free tertiary education, even under a national Liberal government, augured well. How wrong we were. The 1990s intervened and as Australia moved further to the political Right, we witnessed either a reluctant tolerance or overt backlash to feminism, Aboriginal land rights, ecological care, economic fairness and respect for the values we held dear. At the heart of these values was an objection to violence, to assaults on the physical and psychological self at a personal, organisational, structural or cultural level. These values were pejoratively labelled naïve, old fashioned, bleeding heart and black armband. The new way would be the old way with power in the hands of hardline economic and social conservatives, most, but not all of whom, would be white and male.

Violence and Resistance

The power of this edition of Social Alternatives has been to place and keep a gaze on the doers of violence. Violence, like all forms of power, is enacted through relationships in all social spheres; like all forms of power, it can take many different forms. Rees has placed his definition of violence in the context of Australia's history and in doing so, has made the point that we live in a violence-prone culture:

An historical momentum of violence has continued in different contexts: as a means of exerting control in families, in the acceptance of violent competition in some sports, and as part of the fascination with war and other forms of violence in the media. This momentum careers along in the administration of justice and slightly more subtly, in the day-to-day transactions in bureaucracies, whether these are schools, universities, church organisations, hospitals or other institutions (1994: 362).

In this collection of articles, violence has been identified as labelling and stigmatising, manipulating to create dependency, delivering excessive amounts of medication and electro convulsive shocks, and authorising seclusion and restraint. The events and encounters of violence which have been written about are examples of Rees' everyday and commonplace transactions, so embedded within hegemonic discourses of power and control that they are often invisible and unspoken of as violence. In a similar way, Freire defines everyday acts of oppression as violence:

Any situation in which A objectively exploits B or hinders his/her pursuit of self-affirmation as a responsible person is one of oppression. Such a situation in itself constitutes violence … because it interferes with human's ontological and historical vocation to be more fully human (1972: 31).

The epilogue draws the collection of articles in this special issue to a close by defining resistance to violence and considering its strategic use. For Wade 'whenever persons are badly treated, they resist. That is, alongside each history of violence and oppression, there runs a parallel history of prudent, creative and determined...
resistance’ (1997: 23). These acts of resistance may not be obvious and Wade goes on to suggest that ‘any attempt to imagine or establish a life based on respect and equality, on behalf of one’s self or others … represents a de facto form of resistance’ (1997: 25). Offering more detail, Routledge uses the term resistance:

... to refer to any action, imbued with intent, that attempts to challenge, change, or retain particular circumstances relating to societal relations, processes, and/or institutions. These circumstances may involve domination, exploitation, subjection at the material, symbolic or psychological level … Resistances are assembled out of the materials and practices of everyday life, and imply some form of contestation, some juxtaposition of forces … These actions may be open and confrontational, or hidden (see Scott 1985, 1990) and range from the individual to the collective (1997: 69).

Similarly, Bar On defines resistance as ‘practices that respond to oppression and show that the socially marginalized [sic] subjects are not powerless, that they can set limits on or subvert the oppressive forces, and that they can be creative and go beyond the boundaries set for them by their oppression’ (1993: 93). Resistance to violence is an act of optimism: Why resist if you don’t see the possibility of change? Douzinas notes:

I plead guilty to the indictment of avowed optimism. We have entered an age of resistance. New forms, strategies and subjects of resistance and insurrection appear regularly without knowledge of or guidance from Badiou, Zizek or Negri (2014: n.p.).

In the epilogue to this edition of Social Alternatives, I consider four strategies from a myriad available to us for resisting the maddening effects of violence masquerading as rationality in institutions and organisations. The first is claiming the enunciative spaces of critical writing and studying up. The second is promoting and modelling bystander intervention where there is violence. The third strategy is to maintain a macro system analysis of social change so not to lose heart. The final strategy is recognising the role of dialogue and nonviolence in resisting violence.

The Place for Optimism and Some Ways Forward

As contributors to Social Alternatives, we have claimed our enunciative space by identifying everyday violences as overt abuses of power and recognising that the speaking/writing/publishing of them here constitutes an act of resistance. This is not a radical strategy. Talking back or talking smart is a well-documented strategy of resistance used by women living with domestic violence (hooks 1989: 9; Palmer 2005: 121). As contributors to this journal we have sought to write back or write smart in this same tradition.

Singer (1992: 469) notes that ‘part of the tradition of critical writing that postmodernism and feminism inherit … is a tradition of writing as a form of resistance, writing which works not to confirm cohesion, but rather to disrupt, destabilize, denaturalize’. For Richardson, the value of ‘nurturing our own voices’ is that it ‘releases the censorious hold of “science writing” on our consciousness, as well as the arrogance it fosters in our psyche. Writing is validated as a method of knowing’ (2000: 929). Such has been the writing in this issue: where this enunciative space of inter-subjectivity (between the writer and the reader) operates to unsettle meanings and create new ones; a space for staking our claim to our own voice. It is a profound strategy of resistance which requires the time and space to write, along with creativity in locating sites for publication, from formal journals to personal blogs.

Nader (1972) noted how academics have overlooked research as a form of resistance to violence and oppression by continuing to study down, studying people with mental illness, those living in poverty and those deemed wayward or delinquent. She advocated an academic equivalent of talking back, that is studying up and placing the gaze on those who perpetrate violence. It is no easy task to study the people who have expert medical and/or academic credentials and authority. People who have power and privilege have a range of mechanisms for protecting themselves from scrutiny and accusations of being violent/mad and irrational (Gusterson 1997: 115). Embracing the strategy of studying up is an optimistic beginning point for dialogue with powerful people acting in violent ways, notwithstanding the methodological difficulties and the power (and intent) of the powerful to deliberately opt out of dialogue (Giddens and Pierson 1998: 130).

The second strategy of resistance explored here is the naming and facilitating of bystander intervention where there is violence. In this section we identify what this means and suggest that organisations adopt bystander training (Scully and Rowe 2009). Bloom and Reichert provide a definition of bystanders, noting that:

Bystanders are the audience. They are all those present at the scene of an incident who provide or deny support for a behaviour. The victim and perpetrator form a linked figure and the bystanders form the ground against which the perpetration is carried out or prevented. It is useful to note that among acts of perpetration which have been studied, it is the behaviour of the bystanders that determines how far the perpetrator will go in carrying out the act of violence (2014: 88).

People become bystanders to violence either through their own direct observation of events (as witnesses)
or through others’ disclosures about events to them. Whistleblowers are a particular kind of witness/bystander, and the term refers to those who disclose corruption in organisations, usually by going to a higher authority in the organisation or through a recognised third party (De Maria 1996). Like all bystanders who intervene, whistleblowers make a decision to act based on their personal ethics, and their morally informed view that what they have witnessed, or are party to, constitutes a crime, fraud or corruption of some kind.

One of the ways violence is sustained in organisations is through the silencing of witnesses and bystanders, often with threats or actions of reprisal (Alford 2001). However, real or threatened retaliation aside, bystanders can also be discouraged from taking action when, like perpetrators and victims of violence, they use minimisation, denial and rationalisation to convince themselves that things are not ‘that bad’ or that the person actually deserves what is happening to them (Bloom and Reichert 2014: 89). Similarly, Scully and Rowe have noted that:

Many factors contribute to making some bystanders passive in their workplaces: fear of losing friendships, fear of loss of privacy, fear of ‘bad consequences’, fear of getting too involved. Bystanders may believe that nothing good will happen if they speak up. They may fear retaliation or be concerned about embarrassing their workgroup, or a colleague, or their superior (2009: 3).

Bystander intervention and training was explored in a special 2009 issue of the Journal of the International Ombudsman Association. Training bystanders to be active rather than passive members of organisations is identified as a strategy for encouraging a positive workplace culture where standards of professional practice are openly discussed. It can also discourage a workplace culture of intimidation, silences and practices which are at best poor and at worst, dangerous:

A premise of training is not just that individuals become more able to be active bystanders but that the accumulation of many active bystander interventions positively shapes a workplace climate … In a culture where many or all people have experienced bystander training, there may be more support for bystanders (other bystanders who are present might help) and less anti-bystander backlash (Scully and Rowe 2009: 6).

Human service organisations responding to the needs of vulnerable people operating institutions such as care homes, schools and hospitals are well placed also to provide training to consumers and their families or carers, where the organisational culture is explained and the idea of professional practice standards explored. In this way consumers become allies in the process of creating healthy workplace cultures as active bystanders rather than passive witnesses. It is naïve of organisations to assume that codes of conduct and complaints processes are enough. Clearly from the narrative accounts in this issue of Social Alternatives they are not.

A third possible strategy of resistance to organisational violence is for workers and consumers to draw on critical theory to guide, strengthen and sustain activities which challenge the mainstream. Critical theory is a collection of emancipatory theories guiding action by exposing oppressive elements within structures and institutions in society (such as in medicine, education, politics, religion and the media) which restrict and constrain the human subject. The critique extends to the way human needs and desires are manufactured through the mass media and marketing for the purpose of increasing consumption and thereby profit. Critical theory informs a radical analysis of social problems focusing on the economic and social environments which contribute to poverty, mental illness, homelessness, and other problems of daily living. This contrasts with mainstream analyses which blame the individual for their problems, isolating, punishing and stigmatising the vulnerable and disadvantaged for their situation (Mullaly 2002: 16).

Jackson et al. (1989: 71) developed a ‘community development continuum’ to illustrate how people living with hardship or violence can be supported in their recovery and healing through involvement in social change movements informed by critical theory. They note that this ‘might be through participation in the women’s liberation movement, the ecology movement, orthodox political parties or just perhaps the new public health movement’. Further, they claim:

When people with whom we work become passionately involved with others to change social structures they begin to believe in having some measure of power over their own lives. In other words, they are involved in taking control over those things which affect their lives. This ultimately improves their own health and well-being as well as that of others with whom they associate (Jackson et al. 1989: 72).

There is no shortage of social change and intellectual movements which identify the need for the rapidly globalising Western culture to undergo a transformation away from a society which has ‘consistently favoured the yang over the yin – rational knowledge over intuitive wisdom, science over religion, competition over cooperation, exploitation of natural resources over conservation, and so on’ (Capra 1982: 22).

This new paradigm of a rising culture, to use Capra’s language, grew out of the social movements in the West in the 1960s and 1970s which opposed the war in Vietnam and supported civil rights, the feminisms, Indigenous land rights and other forms of anti-oppressive practices...
and institutions. However, as noted at the beginning of this article, conservative ideologies regained ground in the 1990s and coupled with the rise of a nihilistic postmodernism slowed much movement towards change. Should we be surprised? Capra reminded us over thirty years ago that this is an evolutionary process and so we shouldn’t expect it to happen quickly:

While the transformation is taking place the declining culture refuses to change, clinging ever more rigidly to its outdated ideas; nor will the dominant social institutions hand over their leading roles to the new cultural forces. But they will inevitably go on to decline and disintegrate while the rising culture will continue to rise and eventually will assume its leading role. As the turning point approaches the realization that evolutionary changes of this magnitude cannot be prevented by short-term political activities provides our strongest hope for the future (1982: 466).

A key element of this ‘hope for the future’ is non-violence, the fourth and final suggested strategy of resistance to violence. Non-violence literacy includes demonstrating empathy and assertiveness and learning how to engage in a dialogue; to stake a claim to be heard at the same time offering a commitment to hear the voice of the other. Where there is a dialogue there is a generosity in regard to the other and a willingness to shift position (Ross 2002).

Rees (2003: 268) outlines two versions of sovereignty, one which is ‘dialogue oriented and peace-based’ and another which is ‘security oriented and fear-based’. The former describes a society concerned with justice, advocating human rights, inclusive of progressive social movements and responding to fear through dialogue with strangers and assumed enemies. The latter describes a society which uses self-justifying logic, focused on national security, locating power with alliances of the elite and responding to fear with more controls. It is not difficult to see the kind of society we are building in Australia in 2014.

We will need Australia to become dialogue oriented and peace-based if we are going to resist violence at the level of our national sovereignty as well as in communities, organisations and families. Lest we think this is too ambitious, Rees (2003: 180) provides an example of how it can be done. He describes the community responses to two child murders, one in Liverpool England and the other in Trondheim Norway. The defence lawyer who represented the children who killed James Bolger in Liverpool England and from sections of the media across Britain was violent … There was no obvious attempt to reconcile with the past, no evidence of an understanding that refusal to understand or forgive would continue to fracture community relations. A culture of violence and an illiteracy about non-violence was maintained [in Liverpool] (Rees 2003: 180).

Speaking and writing about violences when we experience or witness them is an important step towards building a non-violent, dialogue oriented and peace-based society. As an act of resistance it is enough. However, there are other ways we can resist violence and oppression once we have decided this is something worth doing. Locating spaces where there can be genuine dialogue is the tricky bit, precisely because violence occurs in relationships where one party has deliberately opted out of dialogue.

Refusal of dialogue – an insistence that only one view of the world is possible and that one is already in possession of it – has a particular, and potentially destructive, significance in a world which precisely depends more and more upon it (Giddens and Pierson 1998: 130).

The antidote to violence is non-violence and so our task is to build dialogical spaces where non-violence can be practised. The opportunities to do this are endless because spaces for dialogue need building and rebuilding constantly in families, schools, hospitals, churches, clubs and other human systems and organisations. Our task is to seek out examples of compassion, cooperation, negotiation, advocacy and dialogue at the same time as our practice becomes those examples.

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Men and women of the jury

Asked by Constable Washburn why a search of my client's jeans had revealed two of the deceased's toes wrapped in plastic the defendant answered ‘Satan's toes & Martha's wash'.
I ask you, haven't we all said things better left unsaid?
Dismiss, if you wish, Satan's toes & Martha's wash but don't dismiss my client's statement to Constable Washbone
'I killed one man to save millions. One for millions'.
Men & women of the jury, take care, please take care.
One for all. Dismiss that & you dismiss all Christendom.
In mitigating circumstances & with reduced responsibility my client was re-enacting the sad death of John the Baptist.
Yes, Your Honour. Certainly, certainly. I'll soon be done.
Men & women of the jury, find this Guilty man Not guilty.
I'm booked on tomorrow's jumbo to Calvary, correction, Cairo.
Yes, Your Honour, John & Martha & I will be on our way.
In St Peter's Square John the Baptist will baptise & Martha & I will wash (& dry) Constable Wishbone's toes.
My heart will pump Kuwaiti oil up the Valley of the Kings as the Gang of Four Headless Horsemen of the Apocalypse dismount horses & mount their committee towards Mecca.

GRahAm RoWlAndS
AdelAide, SA


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Art and the Arts of Sustainability

John Clammer

Sustainability has become the buzz-word of our generation. And in many ways correctly so: without sustainability we either do not have a future as a species, or if we do, at best a very impoverished one. But sustainability has many dimensions – ecological, economic, industrial, but also cultural. There are those who argue that it is precisely our civilisation that has got us into the massive problems that our planet now faces. If this is so, then we need to revise and transform it, to find new stories of our place in the world. These come from and constitute culture, and a major part of culture is art, or the arts collectively understood. Here, we will discuss the relationship of art to sustainability and suggest some interesting directions in which this recognition might take us.

The British ‘green’ architect, James Wines, has suggested that ‘without art, the whole idea of sustainability fails’ (Wines 2008: 9). This is an interesting and provocative idea, since in most discourses of sustainability little attention is paid to the role of the arts, whether the visual arts, the performing arts, or literature. Possibly the two exceptions to this (and little discussion of either appears in any of the mainstream sustainability literature) are architecture and design. The former has a fairly clear relationship to sustainability: buildings occupy space, use huge amounts of material in their construction, and equally huge amounts of energy in their running and maintenance. The emerging notions of ‘green architecture’ or ‘ecological architecture’ or even ‘slow architecture’ reflect this – the concern to build and design in ways that use minimum (or recycled) materials, are energy efficient and easy to maintain, are attractive to work or live in and to look at, and whenever possible use natural light and heat in their daily running.

The other area where some big steps have been made is in design, where some important concepts and practices have emerged in recent years, including that of ‘social design’ – designing functional and beautiful objects not just for the rich, but equally for the poor. Practical examples of this include solar-powered cookers, roll-along water carriers for transporting water from wells and rivers to households that can be pulled even by a child and the award winning ‘Life Straw’, a simple device that filters dirty water making it immediately drinkable without using any source of energy other than that of the user. Another important innovation has been the notion of ‘cradle-to-cradle’ design where objects are made in such a way that they are fully recyclable and so, as with nature, there is no such thing as ‘waste’ in the industrial ‘metabolism’ as in the biological one (McDonough and Braungart 2002). The idea of ‘ecological design’ or designing with nature and utilising the idea of biomimicry to produce objects and human habitats that are energy efficient, waste free, and are integrated with other living systems (Edwards 2005: 97-112) summarises these and similar initiatives.

But what of the other arts, including painting, sculpture, pottery, dance, theatre, music and literature? Here, the links are at first sight less obvious, but a little reflection suggests some very promising interactions. The alternative development thinker and critic of capitalism, David Korten, has suggested in a recent major book that the salvation of our society lies in the creation of what he calls ‘new stories’. These are narratives of our being-in-the-world that do not exalt what he calls ‘Empire’ – a civilisation based on domination, exploitation, power, consumption and resource extraction. These new stories should move us towards a different scale of values in which equality, social justice, ecological responsibility and creativity are the core (Korten 2006). He speaks of the need to create new economic, political and cultural stories, but in practice his book dwells almost exclusively on the first two. The question of cultural stories – the unspoken beliefs, assumptions and worldviews that underpin both economic and political frameworks and constitute the substance of our everyday lives – is left largely untouched. But this is a vital issue to which we must direct our attention. What actually constitutes ‘culture’, not in the abstract, but in terms of its actual living components?

The answer must be the arts. We live daily in the context of buildings, objects, music, fashions, foods, décor, hairstyles, and forms of entertainment varying from film to literature to theatre, from comics to the works that we hang on our walls. We utilise textiles as both clothing and decoration, we absorb ourselves in the artefacts and productions of popular culture and we enjoy and exercise ourselves with dancing and its accompanying music. In fact our lives are saturated with the arts, and if we do (as we should) include the ‘crafts’ which no doubt...
include our daily utensils, furniture and accessories, then there should be no doubt about their cultural role. The arts not only provide the material substance of our lives (and incidentally provide livelihoods for many millions), but are also sources of empowerment, identity building, skill development, utopian visions and social and cultural alternatives, and, very importantly, of our fantasy lives; which in turn tell us something important about society. Why at the present moment do we see such interest not in science fiction (itself an important form of fantasy literature), but in magic in the kinds of imaginary worlds embodied in Harry Potter, Narnia, The Lord of the Rings, The Hobbit? Perhaps Max Weber was right, and the ‘iron cage’ of rationalist, scientific, bureaucratic and managerial civilisation that we have built for ourselves turns out to be very unsatisfactory for our subjective, imaginative, erotic and fantasy lives. We need to seek elsewhere for these essential existential sources, and the place to seek for them is in the arts.

The relationship of art to both sustainability and humane and holistic development should be clear if we ask ourselves what kind of future we envisage that we would like to live in, and have our children live in. In every case known to me the answers have to do with the quality of life, not primarily an increase in material wellbeing. Indeed, the very purpose of material expansion (wealth) is not for its own sake, but so that it can in turn be invested in improving the quality of life. This quality is defined in terms of access to and participation in the cultural riches of society. Such access and participation is of course made up of the artistic heritage not only of the society in question, but, in an age of globalisation, the artistic riches of the whole globe.

The arts, and the study of the arts as part of any rounded education, constitute in many ways the fabric of any society, in relation to which political and economic institutions and processes are expressions rather than determinants of the cultural life. These are the sources of individual and collective identity formation and of the kind of empowerment that comes through the recognition that one has expressive and performative capabilities – a recognition that also lies at the heart of art-based therapies for psychological and emotional disorders (Landy and Montgomery 2012: 167-219). One of the pathologies of contemporary civilisation is the tendency for the economic and political to make culture their handmaidens, rather than the other way around. It is for this reason that scholars such as Martha Nussbaum have argued that, especially in an age of increasing scientism, managerialism and domination of everyday life by technology, the humanities play a vital role as the carriers of alternative values that have to do precisely with, as their very name suggests, the humanisation of life. They imply indeed the promotion of dialogue, imagination, ethical perspectives and a notion of citizenship that goes far beyond simply voting in elections and thus are an important part of education for democracy (Nussbaum 2010).

This makes sense if we recognise that the idea of ‘culture’ includes not only institutions, material culture and lifeways, but also emotions, narratives, means of generating and transmitting meaning and values, and a way of grappling with the existential issues that confront all human beings. Any acceptable notion of development or sustainability should include the same elements as valuable in themselves and as means to the enhancement of the quality of life (Clammer 2012). Any ‘new story’ must emerge from these sources: they will not come out of technology, management or science by themselves, but from the imaginative resources of a society, often expressed in non-utilitarian ways. It may be difficult to ‘justify’ ballet, painting or poetry in any narrow economic sense, but this clearly does not mean that they are without value in a much broader cultural sense. The Harvard-based Brazilian social theorist Roberto Mangabeira Unger has argued at length, especially in his lengthy and literally weighty tome False Necessity: Anti-necessitarian social theory in the service of radical democracy (Unger 2001) at least three important things. These are, firstly, that while social structures do indeed have shaping effects, they are not set in concrete, but can be changed. Secondly, that as a result ‘society’ is something in constant process of becoming and is driven constantly by cultural changes. Thirdly, that social alternatives emerge from the imagination. In such a schema, the artist has a critical role – not as a glorified decorator for the rich and powerful, but as a source of new symbols and visions, an embodiment of hope that transcends the limitations and ‘givens’ of the current social, economic and political situation, as the source of creative fantasies that spill over into the re-organisation of everyday life (just think of film, video games, comics, fashions, architectures), and as the driver of cultural change. Cultural change in turn deeply influences social processes and often drives or leads them, and as I have shown at length elsewhere, art movements are an important form of social movement, seriously neglected by scholars of social movements (a major theme in sociology), and significant for their mobilisation of people and resources often with the intention of promoting long term social and political change. Examples include the Surrealists, the Italian Futurists, or the Constructivists and Socialist Realist painters of the early Soviet Union. It is also because they exemplify the principle that cultural change often leads to wider social changes (Clammer 2014).

Many Arts, Many Inspirations for Sustainability

Sustainability is usually (and rightly) thought of in terms of the environment. But there are other forms of sustainability – of cultural traditions, languages, and social institutions. A problem with a great deal of ‘arts activism’ – art activity directed deliberately at promoting some kind of social change – is that it is often disruptive. The arts scholar, Shannon Jackson, puts it like this:

While some social art practice seeks to forge social bonds, many others define their artistic
radicality by the degree to which they disrupt the social ... While the activist orientation of some social practice displays the importance of an anti-institutional stance in political art, I am equally interested in art forms that help us to imagine sustainable social institutions (Jackson 2011: 14).

Her book on this subject is interesting for at least two reasons. The first is that she concentrates mostly on examples of performance and in particular examples of theatre that address issues of social injustice, racism, environmental destruction and what can be broadly seen as human rights issues. Here, she is locating herself in an older tradition, initiated by the Brazilian theatre scholar and social activist Augusto Boal in his seminal book The Theatre of the Oppressed (Boal 2008) and carried forward by many others who have examined closely the use of theatre, dance and other forms of performance (including music) to address and heighten consciousness about human rights abuses, environmental destruction, gender inequalities, and other pressing social issues (for a small sampling of the literature see for example Rae 2009; Jackson and Shapiro-Phim 2008).

One of the reasons Jackson chooses theatre is that it is almost always a communal art form – one that requires in many cases a large cast of actors, designers, technicians, costume and scenery makers, and back and front stage managers and publicity people to make it happen. A performance group of any kind is a small model of society, indeed a mini-society in its own right, where issues of power, expression, participation, hierarchy and so forth have to be worked out both on the stage and behind it. The second is that of all the arts, Jackson finds performance the one most able to address a range of issues including labour, urban planning, welfare, and even such essential but neglected questions as sanitation. This can be equally expressed in non-live performance media such as film or video, and also in music, live or otherwise, as demonstrated for example by the popular group The Refugee All-Stars, a band made up of former West African refugees, whose songs address the refugee experience and the sheer size and global reach of the problem from the inside as it were, from a direct and vivid personal knowledge of the experience.

Others in the field of performance arts have begun to address the vital issue of environmental sustainability. This quest has taken several forms: the writing and production of plays (and dances) that directly address ecological questions, presenting them to audiences as consciousness-raising devices, or letting them emerge out of workshops in which the participants themselves engage with these issues and then develop a performance out of their investigations, debates and experiments, or indeed by questioning the sustainability of theatre itself. This latter idea may seem strange at first until it is realised that theatrical productions use large amounts of materials for scenes, costumes and props, utilise large quantities of electricity for lighting, and frequently employ toxic paints and scenery/props which cannot easily be recycled for subsequent productions. Acting on behalf of the environment has emerged as a new and exciting movement in theatre and poses interesting challenges: how to make itself effective as a means of communication and awareness-raising about environmental issues, and how to do this in an interesting and entertaining way that is not didactic and ‘preachy’, an all too common problem with activist theatre. The growing literature and practice in this vital area illustrates the many innovative ways in which performance and environmental concern can be brought together in ways that are effective as the great German dramatist Bertolt Brecht used to call Lehrstucke or ‘learning plays’ while retaining their artistic integrity as indeed a form of art, not simply as educational tools (for good guides to much that is happening in this expanding field see Arons and May 2012; Besel and Blau 2013).

Much the same can be said of other art forms, including film, and many examples of films are now appearing that address not only the more traditional themes of much ‘Third World’ cinema – colonialism, nationalism, corruption, poverty and social inequalities, but increasingly the new challenges of climate change, resources such as water, mining and its effects on the environment, either individually or as a group of related issues. In the former category is the documentary The 11th Hour, hosted by the Hollywood star Leonardo di Caprio and featuring both filmic material and interviews with many of the contemporary luminaries of ecology, alternative forms of development, and critics of current industrial and energy practices and policies. In the second category is the feature film Even the Rain (2010), dramatising the Bolivian Cochabamba water protests. But it is particularly in the field of literature that engagement with what might be named sustainability even when not called by that word, often appears as literary critiques of colonialism and its oppressions, post-colonial corruption, and the unevenness and violence of so much ‘development’. One of the founders of this field which is usually described under the rubric of ‘Post-Colonial Theory’ (or literature) is undoubtedly the late Edward Said, particularly in his classic books Orientalism (1978) and Culture and Imperialism (1993), which, while not themselves works of creative literature, are detailed studies of the ways in which literature has been used both to represent the ‘Other’ (stressed in the first book), and also the ways in which literature written in the developing world has been the vehicle of critique of those representations. On this basis it can become an imaginative means of resistance to the institutions and practices of first colonialism, and then its successor, globalisation. This has taken the form of both novels, in which genre both African and the Caribbean writers excel, and in poetry, where Latin America has produced two Nobel prize-winning writers (or three if one includes
the Caribbean and the poet Derek Walcott) both of whom have made themes of social justice, underdevelopment and culture central themes of their work – notably Pablo Neruda in Chile and Octavio Paz in Mexico. And amongst the arts I would certainly include what are often rather patronisingly referred to as ‘crafts’, since these are both important means of livelihoods for many and are authentic indigenous expressions of local aesthetics, embodied in weaving, pottery, metalwork, carving, painting and other forms. They also tell us a lot about local power structures and gender relations, since in many parts of the world many crafts are primarily the realm of women, where they exercise not only economic autonomy, but also high levels of artistic creativity (Bartra 2003).

**Arts Education and Management for Sustainability**

The wealthier countries abound in facilities for arts education – in the visual arts, film, dance, theatre, and music. Such facilities are often meagre or non-existent in the developing world. But where they do exist they have proved to have had a huge positive effect on the production of local artists, inspiring imagination, introducing the arts into schools and local communities. Through these means they have created new forms of employment, providing channels for social healing in violently divided societies such as Rwanda, and producing feelings of empowerment amongst those (often very disadvantaged) peoples who discover that they in fact have talent, skills, imagination and the ability to influence their worlds through their artistic productions. In the West, many of these initiatives have taken the form of what is now termed ‘Community Art’ – projects often led by professional artists, but otherwise designed democratically and collectively executed by local people themselves on depressed housing estates, decaying inner-city areas and ethnically divided neighbourhoods, and taking many forms – murals, gardens, statues, and dramas (Crehan 2011). Some of these forms have a long history – going back for example to the work of the great Mexican muralists such as Diego Rivera, whose public paintings were a way of teaching history and inspiring social action in a society where literacy was still (in the 1920s and 1930s) low. In the developing world they have in many cases taken a different form, as we see if we look at three concrete examples, one from India, one from Southeast Asia and one from Africa, all in divided communities that have experienced either the negative effects of ‘development’, brutal civil war, or genocide.

**Cambodia: Morimoto Kikuo**

A second example is of the Japanese master weaver Morimoto Kikuo who stimulated the revival in war torn and traumatised post-Khmer Rouge Cambodia of traditional textile arts. Beginning as a school in Seam Reap (the provincial city adjacent to the famous temples of Angkor Wat) to re-teach these skills to village women who could then take this means of livelihood back with them, the work soon expanded to silk farming to provide a consistent supply to his looms (thereby creating more employment and re-skilling), and a retail centre selling the beautiful products, particularly to tourists visiting the nearby heritage sites. The combined result has been the recovery of a traditional art, re-skilling a generation with rural employment, financial independence for women, and a subtle means of healing in a violently disrupted society.

**Rwanda: Collin Sekajugo**

A third example is the establishment in Rwanda of the Iviuka Arts Center Kigali founded by the artist Collin Sekajugo to provide young artists with a place to work, the chance to hone their skills and a place to exhibit. Rwanda, as is well known, has in the recent past been through one of the most horrifying experiences of genocide in recent history and is still a deeply scarred and traumatised society. The art centre works not only with would-be professional artists, but also with orphans and women, providing workshop space for a jewellery cooperative and a small shop selling the works of the women. In this case art proves to be not only an individual form of therapy, but a collective and social one as well.

**India: Amitava Bhattacharya**

A first example is that of the Bengali artist Amitava Bhattacharya, himself a well known painter who has devoted much of his time to working with depressed Adivasi or tribal communities in central and eastern India, areas also home to large communities of Dalit or ‘Untouchables’, and encouraging artistic production and exploration (Bhattacharya 2012). Many of these communities have seen their traditional land grabbed for mining or dams; others suffer from poverty, social exclusion, and lack of access to education, health care or employment. Many have an indigenous artistic tradition, ignored by the mainstream Indian art community or eroded by the displacement of communities and economic pressures. But others have had little contact with artistic production, and even if they do, do not have the physical materials (paints, canvas, crayons, paper) to carry it out. Bhattacharya’s efforts have been various, but in the remote tribal hamlets of the Chattisgarh district of the state of Madhya Pradesh, his work has been devoted to inspiring the local children to paint (on paper, glass and walls) and in so doing to discover their own creativity, and to find visual ways to comment on their life conditions and the circumstances that are influencing their lives, and the nature that surrounds them and from which they derive much of their livelihoods. The experience as documented by Bhattacharya in his lovely little book A Diary of an Art Master (Bhattacharya 2013) proved to be empowering to the children and their parents, provided a visual means of social critique, assisted in the deepening of appreciation of their natural environment, and by promoting one form of imagination, stimulated others.
Arts Education

Although hardly a priority in most development plans or budgets (even educational ones), the expansion of arts education proves to be an excellent move: providing a widening range of educational opportunities that feed into many significant areas of life after graduation. These include design, sustainable architecture, culturally appropriate fashion, interior decoration, employment as professional musicians, dancers or actors, as theatre managers and drama producers, in television and film, in journalism and in many ancillary activities. This is quite apart from those who have the talent to make their careers as professional artists. Linked intimately to artistic production is the surrounding environment of galleries, museums, theatres, recording studios, dealers, patrons, audiences, magazines and publishers which collectively provide the outlets for art work in its various manifestations. These too are often very underdeveloped in less-than-rich societies. What this all points to is not only the encouragement of arts education, which often proves to be an effective way of indirectly introducing work on environment, social justice and sustainability as well as arts training per se, but also the encouragement of training in arts management for development and sustainability. The area of arts management is now expanding rapidly in the ‘developed’ world, but little thought has as yet gone into how to re-think its basic ideas to suit the conditions of the developing world where the infrastructure of the ‘art world’ is still weak, but where enormous sources of indigenous creativity and traditional arts exist.

This is potentially very important as a growing body of work is emerging that relates arts based education to social justice. Here again many examples exist, all relevant to the relationship between art and sustainability and sustainable development. Mary Stone Hanley and collaborators for example have documented programs and initiatives directed at relating art and sustainability, social justice, inter-ethnic relations and development utilising story-telling, theatre, art museums, music, dance, painting, photography, and film making (Hanley et al 2013). ‘Sustainability’ remains a rather abstract concept until it is operationalised in personal, institutional practices, and art proves to be one of the most effective of these, promoting not only behavioural change, but also a way of expressing emotions. Many people feel anxious, angry, or disturbed in some way about the deepening environmental crisis, climate change, conflict, and persisting injustices, but often have no clear way to express these feelings. The arts provide just such an avenue, and a socially legitimate one as their role is recognised and respected in just about every society. Art can be very important here in two particular contexts. The first is dealing imaginatively and emotionally with the probable coming changes in world society, livelihoods and patterns of consumption. While some will welcome these, others will feel tremendous grief at the loss of old forms, ways of life, expectations, careers, homes and the other elements that make up so much of our taken-for-granted daily lives. The second is that while talk about the ‘Transition Society’ (Hopkins 2008) rightly discusses the economic aspects of the move from an oil dependent society to one which will have to seriously cut energy usage and will have to utilise other, renewable energy sources and modes of transport, little is said about the possible cultural dimensions of such a transition: What will we do in the evenings? What will our forms of entertainment be like? How will lifestyles be impacted? These are all areas that require substantial thinking, for without a sustainable culture, other moves towards sustainability will fail in the long run. Again, it is ultimately the nature of our culture that is at stake.

The Artistic Quality of Human Existence

A number of visionary contemporary educationalists have pointed to the ways in which learning must become transformative if a sustainable future is to be achieved (for example O’Sullivan 1999). While the specific ingredients of this transformed and transformative education vary, what most have in common is the need to provide the imaginative resources to create the ‘new story’ that our civilisation so urgently needs to seek. Let me end by quoting one of these educational theorists of sustainability, Brian Murphy, who in his book on the transformation of ourselves and the world has the following to say:

This process of education will also respect and promote the visionary and artistic character of human existence. Nothing marks our uniqueness as individuals as do imagination and vision – the individual as artist re-creating the universe in the mind and in free expression through the ‘arts’, crafts, media, athletics, horticulture, and the plethora of avenues in the realm of ‘recreation’ and the realm of ‘work’… Imagination and vision are the cutting edge of knowledge. Knowledge is derived from the process of forming reality in the mind, and then questioning this ‘reality’ by re-forming it in the world. Knowledge is merely the present answers to the questions of the imagination. While the process of creating knowledge should be scientific, the process of formulating questions and creating a range of possible answers is a function of imagination, of vision – it is an artistic process (Murphy 1999: 90-1).

This is very close to what the leading peace activist and scholar John Paul Lederach has called ‘the moral imagination’ – the ability to think about and express alternatives that contribute to the wellbeing of the whole, both the human sphere and the biosphere on which we ultimately depend – a process that Lederach sees as being essentially an artistic one (Lederach 2005).

Culture and development are intimately linked – culture as both supporting authentic development (one
genuinely leading to human and planetary wellbeing), and as something to be ‘developed’ itself. As the very medium of our everyday lives, culture, and the arts that constitute a large part of that culture, are the keys to present satisfaction and to a sustainable future. For that future to be viable the arts themselves must become sustainable, and our civilisation itself must be re-oriented to fresh values and practices. The most important mechanisms for doing this exist not only within politics, but very much within the realm of the arts, the cultural space in which our imaginations and expressivity can be given full rein, and through which the re-enchantment of the world might take place.

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Bool Lagoon
(South-Easter S.A.)
camouflaged amidst
the undergrowth
as quiet
as fence posts
the duck shooters
wait
within the sights
of their rifles
they circle
the dawn
suddenly
the horizon splinters
into a labyrinth
of feathers
and blood

JULES KOCH
SOUTH PLYMPTON, SA
Ecotopian Spaces: Soundscapes of Environmental Advocacy and Awareness

KATE GALLOWAY

Environmentally conscious activism events, such as The World Wildlife Federation’s Panda Ball, the local foodways’ festival Soupstock, and singer-songwriter Sarah Harmer’s Escarpment Blues tour, cannot guarantee measurable systemic change, but their soundscapes stimulate connections between audiences and the environmental movement, and generate individual and collective environmentalist activity. The soundscapes of these events are used to create positive sonically-saturated community events where everyday sound and music advocates for the environment. The soundscapes of events that foster environmental awareness comprise diverse sonic features that contribute to the shaping, understanding, and communication of specific messages concerning the environment. Observing the function and formation of event soundscapes imparts a more nuanced understanding of how soundscapes can communicate environmental meaning.

Soundscape, as coined by composer and acoustic ecologist R. Murray Schafer, considers the acoustic environment within which listeners are situated and to which they actively and passively contribute. Soundscape is the aural equivalent to landscape. In the late 1960s, Schafer suggested a radically different concept in The Tuning of the World (1997): the soundscape as a composition to which all of society contributes and in which we must ‘try to hear the acoustic environment as a musical composition’ (205). And, further, that ‘we own responsibility for its composition’ (1978: 205) and ‘compose’ ethically with ecological (human and non-human) relationships in mind. Schafer’s ideal soundscape is one that is free of ‘noise’. Noise, for Schafer, is sound produced by mechanical, electric, or industrial means as a result of humanity’s increasing urban development, often at the expense of the natural world. Schafer formed the World Soundscape Project while he was at Simon Fraser University (Burnaby, British Columbia, Canada). The World Soundscape Project was an interdisciplinary research team to explore and document local and international soundscapes, document diverse acoustic environments, develop the public’s listening sensitivity, and increase public awareness concerning the importance of the soundscape and the potential threat of ‘noise pollution’.

Soundscapes acoustically place people, their experiences, the physical materials of a region, and socio-cultural issues. Social justice events that promote environmental advocacy, charity and awareness are shaped by their soundscapes. These soundscapes are frequently what Mitchell Morris terms ‘ecotopian’ (Morris 1999), that is, they highlight the positive effect of sound and music in the dissemination of environmental messages, information, and awareness. The sounds and music used to promote the positive characteristics of the environment are also used to consolidate a listenership who is united by common ecological values (e.g. recycling programs, community organic gardens, energy conservation, and alternative energy sources). Following Morris, I consider ‘ecotopian spaces’ as idealised spaces where artists and event organisers have the creative agency to effect change in their participants if the participants choose to actively listen. The audiences who attend these events must proactively make modest yet impactful adjustments to their everyday lives. These modest changes have the potential to promote environmental redress.

This article is concerned with the sonic experience of soundscapes regarding advocacy, charity and awareness initiatives that foreground sound and the physical material of place in the communication of socio-environmental information. The environmentally conscious activism events that I address in this article include: the slick large-scale fundraiser the World Wildlife Federation (WWF) gala, the Panda Ball, the local foodways’ festival Soupstock, and singer-songwriter Sarah Harmer’s Escarpment Blues (2006) documentary and eco-tour. The soundscapes experienced through these three eco-initiatives praise the invaluable contributions of the natural environment, and facilitate in a similar manner to the benefit concert phenomena, the simultaneous dissemination of personal artistic promotion and the communication of environmental worldviews. As in benefit concerts that dominated the 1980s, these events do not provide audiences with concrete solutions to the advertised issue, they merely generate awareness. Artists and organisers cannot guarantee that their initiatives will activate change, but they can provide the aesthetic infrastructure and environmental behaviour that
participants can incorporate into their everyday lives if they are moved to do so by an event and its soundscape.

The soundscapes of the contemporary environmentalist movements employ musical rhetoric similar to that of the anti-Vietnam war movement, Civil Rights movement, and other forms of 1960s counter-cultural socio-cultural advocacy. This musical rhetoric includes the solo songs of the singer-songwriter accompanied by acoustic guitar, and a focus on acoustic un-plugged aesthetic with minimal artificial amplification. Although these soundscapes contain diverse sound components and they do not immediately appear to have the power to affect environmental change, soundscapes have the potential to stimulate listeners and cause what Finnish anthropologist Marja-Liisa Honkasalo calls ‘small agency’ (2008: 498). Small agency refers to ‘everyday agency with minimal observable contours […] small, modest ways of acting and knowing’ (Järviiluoma-Mäkelä 2013). This is a form of agency that values small-scale modest repeatable changes and choices made in one’s everyday life that build in impact, layer upon layer.

The modest eco-conscious choices that we make in our lives can be just as effective, or more so, than large scale change initiatives. The soundscapes that the audiences who attend these events consume and create comprise various sonic components (e.g. music, speech, sonic popular culture, everyday sound and noise, sounding bodies, biotic and non-biotic sounds, urban and rural sounds as well as mediated and unmediated sonic events). These manifold types of sounding work together in the communication of awareness to the listening public of the event. These eco-conscious events exhibit varying degrees of small scale advocacy, charity, and awareness – differing kinds of environmental action – but also, they exhibit diverse approaches to experiencing and composing the soundscape.

**Fundraising Soundscapes**

What are the sonic characteristics of the soundscapes for charity and fundraising? The past decade has witnessed an explosion of green marketing efforts in the form of composed soundscapes, sustainability rhetoric and speech, and carefully positioned celebrity endorsement that provides cultural capital to an environmental event, position or organisation. The World Wildlife Federation’s (WWF) Panda Ball, for instance, accrued pop culture clout in 2012 when the gala featured a keynote performance by Canadian singer-songwriter Feist. The event fused Canadian indie-rock with their charity event, creating an aura of cool and in-the-know environmentalism. The Panda Ball has been held annually in Toronto, Canada since 2011, but galas have been held internationally since as early as 2005. WWF advertises their galas as important events that foster environmental discussion and charitable humanitarian support in an intimate and collegial forum. They state ‘our annual gala evening gives our loyal donors and people who are committed to nature conservation, an opportunity to meet over an entertaining dinner, get to know each other, discuss and learn more about the work of WWF’ (World Wildlife Federation n.d.). These galas celebrate a year of conservation, honour environmentalist contributions, and bring together visionaries from the philanthropic and business communities who are leading the next generation of conservation locally and internationally.

During several moments during the WWF Panda Ball, the event aligned particular businesses, organisations and sponsoring individuals with the sonic and identity markers of environmental advocacy. This action rebranded certain businesses as environmental stewards that integrate green attitudes, advertising, rhetoric, and sponsorship that resonate with green consumers. With tickets and sponsorship tables priced outside the accessible range of the majority of the eco-community, the audience was selective, creating an exclusive event with restricted entry thus silencing and excluding many music fans and environmental advocates. But the event, however, did attract current and future investors and donors who could lend their monetary support and position in both society and business towards the cause and organisation. Thus, many attendees were outside the demographic of Feist’s work, but they were aware of her cultural significance in the popular music industry. The attendees that I spoke with at the gala acknowledged that her physical and sonic presence at the event aligned a particular musical genre – and potential fan base demographic – with the environmental cause once her involvement was disseminated publicly through mass media releases by environmental organisations, the sponsoring companies and music industry outlets.

The 2013 Panda Ball was hosted by musician and recording artist Steven Page (formerly of the Canadian rock band Barenaked Ladies and a current member of the WWF Board of Directors), and featured invited speakers including NASA Commander Chris Hadfield and WWF-Canada Environmental Leader Award awardee Michael de Pencier. Additional music was provided by Page and his band who performed both before and after the presentations, speeches, live auction and dinner service. The soundscape of the event was characterised by some participants as coercive, featuring the verbal rhetoric of fundraising and monetary gain directed at the upper echelons of business and industry (Anon.Nov. 2013). It was a soundscape that featured music, but verbal environmental discourse and monetary request dominated the soundscape, producing a complex and coercive ‘cocktail party’ effect.

The stage was placed at the end of a long room and for those sitting at the back, could be visualised on several large screens positioned around the room. Nearing the end of the evening, 14 year old Carly Rose Sonenclar, the runner up in the 2013 X-Factor contest, sang with remarkably mature poise. Musically, none of this
connected with the mandate of the event, which was to raise money and awareness of the WWF’s ‘Last Ice Area Project’. The objective of this project is to protect a large expanse in Canada and Greenland’s north as the present and future habitat of Arctic animals – particularly the polar bear. A short video of the project was presented featuring a non-diegetic soundtrack of Barbara Streisand. A few heartstrings were plucked and many cheques were written.

It felt that this year the entertainment was overshadowed by the giant ice sculptures, the all-vegan dinner menu, and the appearance of Canada’s space hero, Chris Hadfield. There was a disconnect between the music and the mandate of the WWF, while the music seemed incidental to the evening. On the other hand, galas are predictable. An abundance of celebrities, entertainment, opportunities to donate lavishly and a sense of self-satisfaction that a polar bear has been saved, or a tree, or a starving child.

The event articulated the spectrum of eco-conscious sensory experience, but with the high-gloss of socialite fundraising. While the programs advertised the sustainability of the event and visually drew on hyper-real fullpage professional photographic images of picturesque vistas and fuzzy wildlife, they focused unique attention upon the event’s ‘bold statement’ by preparing a vegetarian and ecologically sensitive meal using local Ontario ingredients. I will return to the idea of the place of food and local environmental initiatives in my discussion of Soupstock that follows. On the final page of the printed program, the WWF reiterated its eco-friendly physical content, which was also sonified through repeated public announcements throughout the evening. The program reads:

To minimize the ecological footprint of the Panda Ball, we thank Four Seasons for preparing a vegetarian meal executed with only the best local Ontario ingredients. Reception and dinner wines are also from the local regions.

The event is Bullfrog Powered with 100% green electricity in Aria and Vinci rooms as well as our pre-function areas.

Our tea lights found throughout our event spaces are Nature Soy candles. Not only are they biodegradable but their wicks are also lead-free and made from cotton or paper. Made by nature and crafted by people.
All printed materials for the Panda Ball have been printed on Domtar Earth Choice paper by FSC® certified printer Thistle Printing (Panda Ball 2013: 23).

Through deliberate product placement the Panda Ball emphasises the ecologically conscious event planning that contributed to the event, challenging any possible charges of ‘environmental irony’. Environmental irony is ‘the gulf between expressed environmental beliefs, on one hand, and active participation in ecologically destructive practices, on the other’ (Stoddart 2011: 19). Frequently, ‘green’ artists and events appear on the surface to be environmentally sensitive, but present a complex, incongruent environmental reality. Coldplay and U2, for example, mounted tours with an advertised reduced, or absent, carbon footprint, but continued to participate in the industrial excess and environmental impact of the mega-event stadium world tour. As Mark Pedelty notes:

‘Pop spectacle is clearly at odds with the environment [and] many musicians are just beginning to reconcile the obvious contradictions between their environmental intentions and the actual material effects of their tours’ (Pedelty 2012: 2). Eco-conscious musicians continually struggle to make their music and performance practices more sustainable and directly face the impossibilities of mounting zero-waste events. The sonic and physical materials that contributed to the Panda Ball soundscape created a palpable aesthetic and ethical tension; a tension between environmental conservation and the enhancement of businesses with an eco-friendly makeover.

Eat Locally, Sound Locally

As the webpage for Soupstock loads for the viewer, the banner reads: ‘The Mega-Quarry Proposal Has Been Withdrawn!!!’ The press release that follows announces:

The Canadian Chef’s Congress and David Suzuki Foundation applaud the Highland Companies today for withdrawing its controversial proposal to blast a 2,300-acre limestone Mega-Quarry beneath some of Ontario’s best farmland. The surprise announcement comes exactly one month after over 40,000 supporters attended Soupstock, an event in protest of the Mega-Quarry (Soupstock). Soupstock was held on October 21, 2012 as a free admission daytime community event held at Woodbine Park in Toronto’s Beaches neighbourhood located in the east end of the metropolis adjacent to Lake Ontario (see Maps 1 and 2). At Soupstock, the physical materials of the environment (including the site of the event and the agricultural produce brought into the city) appear to dominate the event, yet the sonic materials of the event served as an auditory glue adhering the ecological issue to the experience of local foodways. The success of the event aligned with a positive political decision in favour of Soupstock’s supported environmental cause, demonstrating that modest local community events have agency in the shaping of environmental politics. Organised by chef Michael Stadtlander, the Canadian Chefs’ Congress, and the David Suzuki Foundation, the name Soupstock is a deliberate name-play on Woodstock in order to invoke connections with 1960s counterculture and the historically established intersections between music, festival culture, and humanitarian advocacy.

All proceeds from Soupstock were donated to the Canadian Chefs’ Congress and the David Suzuki Foundation to build a community of environmentally ethical supporters devoted to stopping the controversial Mega-Quarry. Additional funds were targeted towards other environmental and local sustainable foodways issues. Participants were encouraged to arrive by foot, bike, or public transport, with the event providing on-site bike valet service. The mega-culinary event with a prominent sonic presence was aimed at raising awareness about the Highland Companies’ proposed limestone Mega-Quarry in the Township of Melancthon, 100 kilometres northwest of Toronto, through peaceful educative protest of its environmental impact on local ecosystems and Ontario agricultural lands. It featured more than 150 of Canada’s top chefs who concocted original soups from ingredients donated by local farmers and producers (see Map 2). In order to be a waste-free event, participants were encouraged to bring their own bowls and utensils. In 2011 Foodstock, the predecessor to Soupstock, attracted fewer participants when it took place on a potato farm located across the road from the proposed quarry-site. In 2012, the organisers relocated the event to Toronto in order to connect an urban audience to the source of the local agriculture they consume and mainstream the advocated cause.

Map 1: Location of 2012 Soupstock (Google Maps, linked to on www.soupstock.ca)
Local foodways are positively conflated with sustainable communities and environmentally sensitive living practices, and infused with the defining features of place. The local food movement, which celebrates the geographic emplacement of food production and consumption, has been infused in contemporary popular culture (see Chang 2012). By employing local food and local musics, events like Soupstock, relate to and tune-in to local ecologies, promote community building through environmental action, and articulate a local emotional investment in issues that resonate with the everyday realities of participants. Thus, these events serve a socio-political purpose and move beyond identifying spaces purely concerned with the production and consumption of entertainment. The local food movement is ‘an emergent, politically orientated set of food movements and practices largely orientated around establishing processes which re-localise food system production and consumption’ (Feagan 2007: 24; see also Feenstra 2002). The local foodways movement has found a sensate place alongside music in the contemporary environmentalist conversation, highlighting the multisensory effect of environmentally charged performance events.

Participants at Soupstock simultaneously engaged in the sensate experiences of consuming local foods and sounds while interacting with the local farmers and musicians who produced the tastes and sounds of the event. Important connections were forged between the act of consuming and the human and interpersonal bodies in these processes. The place of food is ‘geographically charged’ (Feagan 2007: 24), conditioned and shaped by locale and its socio-cultural and socio-environmental conditions. As Feagan attests ‘The valorization of place through food (as well as language, crafts, landscapes, etc.) in the culture economy is tightly coupled to spatial ideas of the local community, economy, and territory’ (2007: 27). The sights, sounds, textures, and tastes of place were wed to issues of community and environment throughout the event. The sensory inclusion of local foodways alongside the aurality of Soupstock positioned the event as an inter-arts and multisensory performative gesture, which stressed the importance of local socio-cultural and ecological particularity in the participants' everyday experiences.
Although *Soupstock* focused on peaceful protest through the social consumption of soup – connecting participants through taste to the produce sourced from local agricultural land – the event had a prominent sonic presence. Throughout the day musical performers and speakers were featured onstage and amplified, while unamplified performances took place in locations scattered around the park amongst the sonically bustling information tables and community environmental groups. Advocating for environmentally valuable and sensitive lands was celebrated alongside locally grown and culturally important musicians in non-confrontational ‘culinary protest’. A collection of voices articulated the *Soupstock* soundscape. Hosted by Jeremy Taggart, the former drummer for the Canadian rock band Our Lady Peace and nationally recognised television host and personality George Stroumboulopoulos, ten home-grown musical acts performed, including Jim Cuddy of the folk rock group Blue Rodeo, guitarist Jesse Cook, and independent rock bands Snowblink and Inlet Sound, and were featured alongside local up-and-coming talent. Home-grown music was inextricably linked to home-grown agricultural products. These amplified and unamplified performances contributed to a soundscape saturated by other, more spontaneous, auralities of advocacy, including chanting, speeches, clapping, cheering, and site-specific non-human sounds.

A number of the off-stage performers, who performed while weaving their way through the public spaces of the event, formed groups exclusively for the event (e.g. Artists Against the Mega-Quarry). Some groups named themselves in ways that were thematically connected to the cause (e.g. ‘What about the Fish?’ and ‘Slug and the Spotted Salamanders’) and drew upon musical idioms, styles, and instrumentation associated with imaginings of the rural. By participating in the event, these performers consciously aligned themselves sonically and ideologically with a particular cause. As a collective sonic aggregate, their voices made a mass statement on a specific environmental issue. The music did not necessarily contain specific environmental messages, sounds, or rhetoric, but through their participation these artists and their music became associated with the cause.

The music performed by these groups contributed another layer to the complex soundscape of the event. The live music became enmeshed with environmental rhetoric, hands-on educational activities addressing regional food security, and the consumption of local foodways. The soundscape was also characterised by the presence of the speeches, announcements, information dissemination and conversations between participants. This multi-layered soundscape and performance space had the potential to encourage participants to make modest but impactful agential changes in their everyday practices of engaging with the world. As Pedelty notes: ‘One would hope that such awareness might translate into sustainable lifeways, but as in all things musical, it is mostly an act of faith’ (2012: 116). *Soupstock* provided a multi-sensory environmental demonstration as tastes, touches, smells, sights and sounds merged to persuade audiences to be mindful of their lifestyle choices and the environmental impact of those choices.

**Engaging Spaces, Engaging Soundscapes**

The soundscapes and physical materials of environmental awareness permeate both the on-stage and off-stage work of musicians and activists. For an increasing number of environmentally minded artists their efforts are moving off-stage. Instead of only writing green lyrics composing green sounds that wax poetically on the value of the natural environment, they are establishing foundations, leading conservation drives and events, greening their tours, and engaging with the spaces and soundscapes that musically inspire them. The strong musical presence in these initiatives is changing the face of environmentalism. Singer and songwriter Sarah Harmer exemplifies the persona of a popular music celebrity as environmental politician – where the music, no matter its lyrical and musical content and subject matter is conflated with the environmental politics of a personally significant cause (e.g. for Harmer, the Ontario quarry crisis). Her cultural position and Canadian celebrity status attributes a prominent voice to a specific cause in the crowd of environmental issues.

Harmer was raised on a farm in Burlington adjacent to the Mount Nemo Conservation Area, situated on the edge of the Niagara Escarpment (see Map 3 and Map 4). Designated a UNESCO World Biosphere Reserve 1990, the Niagara Escarpment is an internationally recognised landform and an important region of Ontario’s Greenbelt. It is a ‘landscape of rich biodiversity, home to hundreds of Ontario’s Species at Risk, vital watersheds, agricultural areas and 450 million year old geological history’ (The Niagara Escarpment). Although Harmer has infused her lyrics and music with environmentalist rhetoric and socio-environmental knowledge, it is through her ongoing environmental activism in her public and private life that she has carved out a niche as a politically engaged artist. It is an identity that has saturated the reception of her music and positioned her as a ‘green’ artist.

Harmer’s turn to social activism aligned with the 2005 release of her album *I'm A Mountain* when she initiated a grassroots environmental effort to protect the ecologically sensitive regions of the Niagara Escarpment from increased growth and activity by the quarry industry, founding the NPO PERL (Protecting Escarpment Rural Land). Harmer has voiced her eco-aesthetics and identity as a ‘green’ artist in diverse ways: performing at PERL fundraising events, donating sales to environmental NPOs and NGOs, participating in community debates, discussions, and moratoriums, familiarising herself with the Niagara Escarpment’s official conservancy plans first...
established in the 1970s, and situating herself as a vocal force in political lobbying arena.

The Ontario quarry crisis encompasses a series of proposed quarry expansions and additions throughout Ontario felt by anti-quarry lobbyists to be potentially harmful to the ecologically sensitive environs of these areas and their inhabitants. By combatting the spread of aggregate and limestone mining throughout Canada, anti-quarry events and advocates contribute to the conservation of the nation’s environmental heritage. The proposed location and scale of the Melancthon Mega-Quarry, for example, attracted a coalition of farmers, ‘foodies’, artists, members of the First Nations communities, and environmentalists devoted to counteracting the proposal of an approximately 2,300 acre quarry that would impact the water table, local ecosystems, and regional agriculture. Harmer has been particularly dedicated to the ecologically sensitive conservation region of Mount Nemo, a region which she feels intimately connected to through childhood memories of environmental engagement. Through the arts, social media campaigns, and local food initiatives participants articulated the need to overhaul the Aggregate Resources Act and the Provincial Policy Statement.

Harmer’s message to her audience is that if we become involved and are passionate about an issue we can make a difference. As John Street notes: ‘Pop stars have featured prominently in campaigns about nuclear weapons, civil, gay, women's rights, famine, environmental issues and so on’ (2006: 49). These are artists who are positioned in the public sphere as ‘potential saviour[s] of a world in which conventional forms of political leadership and public policy have failed’ (Street 2006: 49). Ethnomusicologist Jeff Todd Titon advocates for a more sustained and meaningful conversation regarding the role of sound and music to activate change and communicate environmental knowledge where policy and science have been rendered inert, or at least inaccessible to the broader community. As Titon explains, ‘One of the key concepts in the argument for a sound common for all living beings is the ecosystem, an ecological paradigm that stresses the interconnectedness of animals, plants, and minerals within a bounded geographical area’ (2012). The human agents in society need to acknowledge that they are but one group in a larger community of human and non-human agents that need to maintain reciprocal relationships with each other. Harmer’s environment-based artistic work is her contribution to this ethical participation in the community.

In addition to lending her voice, image, and physical presence to numerous benefit concert initiatives Harmer has deliberately positioned herself as the sound and celebrity image of the Ontario quarry crisis, particularly the protection of Mount Nemo and the whole of the Niagara Escarpment. Her 2005 album *I’m a Mountain* serves as a ‘rallying cry’ behind her environmental humanitarian project PERL, a nature land conservancy initiative Harmer co-founded to help protect the Niagara Escarpment. *I’m a Mountain* was recorded in a single room, mainly acoustic, and live off-the-floor, drawing on styles and instrumentation associated with rural living. She approached the recording of the album with the objective to write ‘simple country songs’ about natural content and the ‘smaller things’ in our everyday environment that often go unnoticed but warrant value and attention. Much of the lyrical content from *I’m a Mountain*, including the songs ‘Salamandre’ and her escarpment protest anthem ‘Escarpment Blues’ express her personal connection to, and position on, this particular ecological issue. The destruction of the matting ponds and foraging areas of the Jefferson Salamander, a registered at-risk species through expansion of mining initiatives in the Niagara Escarpment, is granted a greater public sonic presence through song. The funds generated from the sale and use of ‘Escarpment Blues’ – the song that was heralded as the protest song against the quarry – were rerouted towards the cause, providing monetary support for the PERL Foundation’s green aggregate and nature conservancy advocacy.

The *Escarpment Blues* eco-friendly tour sought to explore a specific place from a unique vantage point; combining
hiking, caving, kayaking, and rock climbing with playing live shows along the escarpment route. The tour followed the geological structure of the escarpment thereby bypassing major cities and venues, relying instead on venues in smaller towns and communities; including the communities that were experiencing the impact of the expanding aggregate industry.

The audiovisual audience listens to and views the escarpment as a playground rather than as a ‘restorative’ and ‘spiritual’ place. In the Escarpment Blues documentary we witness Harmer and her band hiking the trails of the Niagara Escarpment with visually stunning videography capturing expansive vistas and magnifying the more subtle aspects of place by zooming in; for instance on the visually saturated vibrant green damp mossy crevasses of the forest floor. Sonically these scenes are saturated by boisterous human conversation, erasing the local soundscape of the natural environment. The soundscape of the escarpment is rarely present, and when it is prominently featured it is the soundscape of the aggregate industry that threatens the escarpment, as the camera and microphone surveys from a distance the local quarries situated along their tour route. In these scenes Harmer and her videographers capture an absence of saturate colour and the noise pollution of aggregate industry. The soundscape of the escarpment is still erased, but in these frames it is erased by the ecological degradation the escarpment tour aims to rehabilitate. Escarpment Blues fails to compose ‘silence’ into the mediascape of the documentary. Silence allows place to speak and sound to the audience.

As the video camera pans across the landscape the escarpment’s soundscape is substituted with overdubbed live performances by Harmer. This soundscape substitution makes it increasingly difficult for audiences to personally connect with place and separate Harmer’s voice from the escarpment. As one respondent noted, she felt that her opinions concerning the aggregate industry in Ontario and her experiences of place were forcibly shaped by Harmer’s sonic and visual message. Harmer’s adoption of sonic tactics and practices of conventional protest, for example, her oration of personally collected and interpreted information concerning the cause, and the repetition of her opinion were associated with the at-risk place. This audience member felt that she was not receiving the whole story or the multivalent perspectives concerning the issue. Certain sounds and physical materials connected to the environmental issues were, in her opinion, purposefully foregrounded; and her viewpoint was carefully shaped by the tour and documentary. Harmer’s profile, potentially, grants her influence as a celebrity-activist because she has access to media resources and venues for information dissemination that the ordinary environmental activist does not. At times, her personal viewpoint saturated the mediascape; resonating louder and with more reach than non-celebrity voices. (Anon. May 2013).

Harmer’s status in the music industry has spurred the interest of the Canadian print and electronic media, securing important news coverage for the quarry crisis. Increased community awareness, education, and involvement facilitated the visibility of her environmentalism and ensured widespread listenership. By mobilising her music and career towards this cause she feels ‘music can get into a lot of different hearts and souls and ears’ and that musicians have a responsibility to use their records, live performances, and identity to attract people towards a particular issue and demonstrate that awareness and participation, even on a small scale, can make a difference.

Conclusion
The soundscapes of events that foster environmental awareness comprise diverse sonic features that contribute to the shaping, understanding, and communication of specific messages concerning the environment. Reebee Garofalo argues that ‘[b]ecause popular music always interacts with its social environment, it often serves as a lightning rod for the political controversies that invariably accompany change. ... Popular music has been connected quite explicitly with social change and political controversy’ (1997: 14-15). The contemporary environmental movement is an example of the ' ... extent to which political positions are called into being by movements that require musicians to perform a particular role' (Peddie 2006: xx). Combined with other instances of public sounding and musicking, the sounds of popular culture contribute to soundscapes that influence local concern for a particular humanitarian cause. The impact of events and initiatives, such as those articulated in this essay rests in the subsequent engagement and activity of the audience once they have resumed their everyday lives outside of the space of performance.

Events like the WWF Panda Ball, Soupstock, and Harmer’s Escarpment Blues tour cannot guarantee measurable systemic change, but their soundscapes can stimulate connections between audiences and the environmental movement, and generate individual and collective environmentalist activity. The soundscapes of these events are used to create positive sonically saturated community events where everyday sound and music advocates for the environment. Observing the function and formation of event soundscapes imparts a more nuanced understanding of how soundscapes can communicate environmental meaning. As non-aggressive forms of resistance (Gersen 2011) in aural form, soundscapes assume an important role in these events, identifying that sonic culture has agency in the contemporary environmental movement.

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All Talk and No Trousers

NATALIE HARMAN

Margot Dillinger: I hope your arms don’t get sore from holding up that pole. Smart of you to tape your voice recorder to it though. I couldn’t do this there. Where you’re standing. On that land. I can’t do anything on that land. Not anymore. You’d comfort me? No. Too risky. We might touch each other. Yes. Might. But might can be a mighty word. Besides. When I lay here I become Monet in his garden. Looking but not seeing. Until it becomes an art form. Like when I used to fork-wrestle. Only peas. Only across a plate. Only my plate. Counting numbers. Seeing numbers. Eating numbers. They aren’t different from us. Numbers. Not peas. Scientists should lump them in with us. Homo numeratus. What? No. I swear. Listen. That’s what you’re being paid to do. Isn’t it? Okay. So. Numbers. They’re connected to us by two common denominators. Half-lives and time. Over time I halved too. That’s my story. The one you’re really after. No. The real story isn’t objectum sexuality. It’s emotional surrogacy. But it doesn’t matter. What matters? What matters is what comes after the story. Will I keep halving from one to 0.5? 0.5 to 0.25? 0.25 to 0.125? 0.125 to 0.065? 0.065 to 0.0325? 0.0325 to 0.01625? 0.01625 to 0.008125? 0.008125 to 0.0040625? 0.0040625 to 0.00203125? (Unintelligible.) Or will I just reoccur? How boring. Anyway. Numbers and us. As in humankind. Halving. Have you ever noticed how numbers reduce? From words bouncing up the throat. Across the tongue. Out the mouth into digits and decimal places snapping and popping from your lips? And over time humans reduce. Fracturing into decimals of themselves. And popping from your lips? And over time humans reduce. Fracturing into decimals of themselves. Becoming unbecomingly. Infinitely and indefinitely. Well. I have been out here for a while. On my own. So maybe I don’t know. Anyway. What do I do? Talk into the little tub into my hand I’m still a lady after all no don’t drop it don’t throw it stretch out and hand it over the edge of my that’s right no I have it I have it I’ve (short pause) fucking wrinkly cigarette craters ground into my skin as it is yes it’s still lit I’m good it’s all good see I’ll blow a smoke ring as a signal (blows a small plume of smoke) Je-SUS aha just as I thought Jesus Christ no it’s fine I’m fine and try to use my arms yes they’re still attached to my body (short pause) got it yes it’s okay give me a moment to that’s right no I have it I have it I’ve (short pause) fucking (short pause) got it yes it’s okay give me a moment to try to use my arms yes they’re still attached to my body aha just as I thought Jesus Christ no it’s fine I’m fine and yes it’s still lit I’m good it’s all good see I’ll blow a smoke ring as a signal (blows a small plume of smoke) Je-SUS
thought in particular. Self-made woman. Self-made
used to stutter. Yes used to. All clear now. There was
chafing. From not speaking for so long. How does it feel?
from being such a thirsty bitch matches the chafing in
have enough of it already around me? Muddy freshwater?
I don't want a bottle of sparkling water. Can't you see I
feeling to it too. Like thigh chafing but in my throat. No.
your money unlike everything else. And there's this other
becomes I did. What? Talk? But I am talking. Oh. You
too. No. Wanting's okay. The real sin is when I want
something we all want something. I'd say we all want
what I'm talking about. Stop arguing. You know I'm right.
then. No? Indecision then. No? Oh. Stop it. You know
what I'm talking about. Stop arguing. You know I'm right.
You want something I want something she wanted something
we all want something. I'd say we all want someone and something but someone are somethings
too. No. Wanting's okay. The real sin is when I want
becomes I did. What? Talk? But I am talking. Oh. You
I'm not stalling. I'm just enjoying talking. Yes talk is cheap
but unlike most cheap junk it's good. You get more for
your money unlike everything else. And there's this other
feeling to it too. Like thigh chafing but in my throat. No.
I don't want a bottle of sparkling water. Can't you see I
have enough of it already around me? Muddy freshwater?
Undrinkable? Doesn't matter. The chafing in my throat
from being such a thirsty bitch matches the chafing in
my head. Mental chafing. I'm feeling it right now. The
chafing. From not speaking for so long. How does it feel?
Thoughts on thoughts on thoughts grinding and bumping
and sometimes gliding but not often. Sometimes they
used to stutter. Yes used to. All clear now. There was
one thought in particular. Self-made woman. Self-made
woman? Self-made woman! Now I know we're made by
everyone else we know until the day they leave and then
we have to make or break ourselves alone. Man-made
woman. We constantly emotionally masturbate to the
thought. (Voice gradually rises into shouting.) Self-made
woman uh self-made woman uh self-made woman uh
uh ah. (Resumes whispering.) But we never reach it. A
maturbatory thought. The real thing until you have the
real thing. You have it and you have it and you have it
until you have it asterisk it asterisk and sometimes you
still have it just because you can. Like eating caviar with
caviar. Anyway. Enough of that. What? How did the
mental chafing feel? I told you. Like a chorus of full stops.
Hey. There's an idea. You should write this to tell it like
I've been saying it. One fragment after another. And
another. And another and. Another. A telegram of thought.
From one mind to another. What? When did it start? The
interview started when you arrived. Oh. Sorry. You mean
the story? She's more than a story. She's her. Well. Once
upon a time it all started with baths. Every night. Until
the water had hollowed out the foam yet the foam still
had a silver lining. Until each of my fingers' tips
permanently mountained and flaked skin-sediment with
a bit of friction. Until the water excused itself past my
plugged fingers. Until the novelty passed with the
warmth. Then when she left for good I simply moved the
water to outside the tub. I hammered and hammered and
hammered until the pipes let go of the tub. What?
How did the baths start? The baths started the night she
whispered to me she was going for a bath. I asked her
why a bath. When you can pee in the shower and leave
pubes in the soap I afterthought. Stripping as she walked
she winked and told me because it's mine and what was
mine was hers and so anywhere that was mine was
where she wanted to be. At the time I thought it was love.
Now? It's the opening line of a murder truth we're writing
together today together yet separately. What? You
thought you were here for my story? Who do you think
I am? This isn't emotional prostitution. No. We're here
for each other. But this isn't emotional surrogacy. It's
I'm giving you something so you can give me something
too. Consider it the real payment. Your bonus. What?
Difficult? How? You don't have to do anything except
listen. Hours? Yeah they can be long but you'll get used
to them. What? Why the bathtub? Why the hammer why
the anvil etcetera. Well her body has been here and I
only want to be wherever her body has been so why not
the bathtub? Really. We were so similar yet different you
know? Even though I hate her now I still always hope
some of her dead skin got jammed in the scratches and
dents at some point and those flakes will fuse into a skin
graft and somehow merge into my skin so I can keep at
least one part of her. Something real. It could happen.
We were so similar yet different. You don't know it so
you can't say it. Anyway. The bathtub. That's where I
wanted to be. What? What did I want to be? I wanted
to be me and I wanted to be her. I wanted to listen and I
wanted to ignore. I wanted my reflection to stop wobbling
in the water and I wanted my reflection to wobble
everywhere it appeared. I wanted to be a Plathian arrow and I wanted to be a splinter wedged inside her thumb-skin. I wanted to think fast and play young alone and I wanted to live slow and die old with her. But what I wanted wasn’t enough. She always held onto my outstretched shins as we tripped like they were two pieces of debris like if she let go she’d be swept away her eyes clenched shut like she was frightened. Now I know she was shielding me from her frightening fantasies. Trying to anchor herself in the present to avoid losing herself in the more-than-possible but she did anyway. Honey all I want is to be on the news one day right there in Wall Street she always said to me every morning. I’m not just going to make it I’m going to make it big she always added. Honey all I want is to be is in my butt-groove in your chair at your dining table watching you I always replied. I know it’s not making a living but it’s still a living I always afterthought. Always swallowing the words like they were the peas I always ate. I wouldn’t have even dreamed of saying it then but now I wish I had because it’s true. We’re not all here to make a living. Some of us are just here to be born wait until we learn to walk and talk so we can go find somewhere to die. No you’re right I’m not nothing I was a parent well we were parents of two chooks. We always pretended they were long-term lovers like us yet a rooster must’ve been putting the “d” into their de facto relationship. They were just like us we both knew it we just never wanted to admit it. All we did was watch our dyke chook children grow up too fast and keep getting knocked up and laying eggs day after day after day but what I actually wanted was jam to sell at the markets. To go into the Arts. The arts are not a way to make a living except for the art of murder and the art of war. Practicing an art, no matter how well or badly, is a way to make your soul grow so the day she came home after several months of no calls no texts no anything knocked up and told me her Wall Street dream wasn’t actually a career to keep my plate filled with peas but a euphemism for gang-bangs and bukkake with so-called businessmen in Kings Cross all I could think was liar liar liar and all I could see was my big break and I knocked her out and gutted her like a fish and I overfed the chooks on her organs until they didn’t eat any more and then I bit into their necks and ripped their heads off and drained their blood into empty jam jars and set it with gelatine sheets not powder and sweetened it even more with sugar raw not refined and it tasted just like raspberry jelly. I’ve always been into the art of preservation. A very human way of making life more bearable. I sold the jam to the old neighbours. Vonnegut. Vonnegut. I jammed the filled jam jars into one of the boxes we used when we moved into her house. Clunked it on their doorstep like it was a baby I couldn’t keep right down to tucking an envelope into one of the front flap folds for cash I never received. The cops couldn’t keep right down to tucking an envelope into one of the boxes we used when we moved into her house. Clunked it on their doorstep like it was a baby I overfed the chooks on her organs until they didn’t eat any more and then I bit into their necks and ripped their heads off and drained their blood into empty jam jars and set it with gelatine sheets not powder and sweetened it even more with sugar raw not refined and it tasted just like raspberry jelly. I’ve always been into the art of preservation. A very human way of making life more bearable. I sold the jam to the old neighbours. Vonnegut. Vonnegut. I jammed the filled jam jars into one of the boxes we used when we moved into her house. Clunked it on their doorstep like it was a baby I couldn’t keep right down to tucking an envelope into one of the front flap folds for cash I never received. The cops couldn’t keep right down to tucking an envelope into one of the boxes we used when we moved into her house. Clunked it on their doorstep like it was a baby I

### SHORT STORY

**Mother, Mental Health Clinician – Who am I?**

**Ros Stygall**

Here I was a clinician and a case manager on a mental health team and I was watching my own son on a downward spiral and I was powerless to do anything. I knew the signs as I worked with people who had a mental illness on a day to day basis and in my professional knowledge I could see that he was unwell. My own mother all her life displayed similar signs.

As a mother I struggled constantly with my thoughts. Is this real? Is he really sick or is he just angry at me? How do I know that what he is saying isn’t true or am I over involved or over sensitive to mental health issues? What did I do wrong and how did I fail him? If I told anyone would they believe me even though I am a mental health clinician? Am I getting judged by the fact I am a mother of someone with a mental illness? Did I drive him to it?

When I asked for a mental health assessment of my son I felt that I had to justify myself. I experienced the pain of waiting hours, days for someone to help me while I feared he would hurt himself badly. I was told nothing could be done and then when they did something they admitted him to hospital. He was released within days still as unwell as before. After perseverance in asking for help and a crisis, finally he was admitted for a six month hospital stay.

This only added to my stress although I tried to sit on every medical assessment and I spoke to everyone involved. I was told that as a mother I was over involved.
I was told that when he was around me he behaved a certain way, that this was not a mental illness. I analysed everything I did. When I was with him I was his mother not the expert. I was his advocate and his support, the one who loved him so much that it hurt. I as a mental health clinician kept it separate from my work as much as possible though to some degree it does affect you. Yes it does make me more compassionate for people I work with. At times I am passionate and will advocate harder for someone. I do listen to their parents or carers and give them the empathy and compassion they deserve. I do find it hard to listen to clinicians speaking in a certain way about their dislike for someone or about the mother who will not stop asking them to do something.

I try to stay grounded and I have remained steadfast as much as I could even when I felt like my world was crumbling. That has rewarded me with seeing my son recover and although forever in the mental health system he is for now sane and living independently. Still working as a mental health clinician sometimes despising a system that treats people as statistics, paperwork and failing in our duty of care but knowing at least from this place I hope to be making a difference.

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**Praise**

the lord upon the children,
droit de seigneur with a white collar
and candles at the altar, the choir
rehearsing the words unspoken:
deliver me into temptation
these my children I have known
and will know again, the church
sustains me down the long aisles
of my professing. My last little flame
flickering in the vestry, my scruples
uprisen on the child’s all-knowing smile.
The Lord – praise Him – knows
my weakness as I prey and weekly
praise forgiveness.

**Which place are you from?**

This is home now
brightly painted room
faded carpet mustard recliners
matching cushions
malodorous wafting odours
rose scented freshener
vanquished
you look vacantly
the screen blurred
your gaze falls on me
follows me around the room
Apo pio meros eisai?
Which place are you from?
stroking my hand seeking connection
meeting of eyes
a shared colour a shared tongue
strange familiarity
brittle fragments of memory like bone
dispersed inside your head
the blithe state of youth
the blue of the ocean
olive groves left behind
faces clear with misplaced names
warm August nights eating figs
ripened by the sun
seasons clear with purpose
soft pallor of young skin now worn
life’s map a destiny
Apo pio meros eisai?

**Mary Chydiriotis,**
**Elwood, Victoria**

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**Ron Pretty,**
**Wollongong, NSW**
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