Mental health social work in Northern Ireland and the Republic of Ireland: challenges and opportunities for developing practice

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Drawing on their experience of mental health social work in Northern Ireland and the Republic of Ireland, the authors examine the impact of current legislative and policy change in both jurisdictions. The paper applies Lorenz's theoretical framework to develop a comparative analysis of how global and country specific variables have interacted in shaping mental health social work. The analysis identifies linkages between factors and indicates similarities and differences in mental health social work practice. The paper highlights emerging discourses in this field and explores the impact on practice of developments such as de-institutionalisation, community care, and 'user rights' versus 'public protection'. The article concludes with a review of key challenges facing social workers in both jurisdictions and identifies opportunities for developing mental health social work in ways that can positively respond to change and effectively address the needs of mental health service users and their carers. The analysis provides an opportunity to evaluate Lorenz's theoretical framework and the paper includes a brief critical commentary on its utility as a conceptual tool in comparative social work.

Keywords: Mental Health Social Work; Welfare Regimes; Social Movements; Academic Discourses

Introduction

The current review of mental health legislation in Northern Ireland and the introduction of the Mental Health Act (2001) in the Republic of Ireland will have major implications for service users, carers and professionals. McCabe and Park (1998) have observed that mental health services in Ireland share a common history

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and despite three quarters of a century of separation of the two jurisdictions there are still many similarities in the way these are provided. Although mental health social work has evolved in different ways in the two parts of the island there are also similarities in the challenges presented for social workers by the proposed changes to legislation. The rationale for this paper emerged out of the authors' mutual interest in how these changes engender both challenges and opportunities for mental health social work practice. Together with contributing to debate about the social work 'mission' in mental health it was felt that a comparative analysis would be timely in providing a perspective from which to critically evaluate emerging discourses and identify opportunities for developing practice (Margolin, 1997; Parton, 2000; Leichtentritt et al., 2002). The analysis, while necessarily selective, aims to focus on those factors including the impact of legislative and policy change, the development of community care and user and carer rights which are of particular significance for social work practice and the tensions between its empowering/participatory and regulatory/coercive functions.

There are relatively few theoretical frameworks for undertaking comparative social work or critical evaluations of their utility as conceptual tools (Houston & Campbell, 2001). The authors adopted Lorenz's (1994) comparative framework, as it appeared to be comprehensive in highlighting factors and variables relevant for developing an understanding of social work practice in general. Lorenz (1994), focusing primarily on a European context, has argued that social work in different countries can be made accessible through comparative analysis of a number of broad interrelated factors and perspectives. His comparative framework consists of three main axes including social work's relationship with different types of welfare regimes and the political programmes and ideologies underpinning them; its relationship with different academic discourses; and finally its relationship with social movements. Lorenz assumes 'that the essence of social work cannot be found in any one of the three factors in isolation', but believes that social workers may gain important reference points for addressing practice dilemmas and issues by exploring the dynamics between these factors (1994, p. 9). In order to develop an understanding of contemporary social work practice at the micro-level, Khan and Dominelli (2000) have highlighted the need to also consider the impact of change factors at the global macro-level and their interaction with national political and social variables. Taking such factors into account this paper applies Lorenz's (1994) comparative theoretical framework to analyse how these variables have interacted with national welfare regimes, social movements and academic discourses in shaping mental health social work practice. The comparative analysis explores connections between such variables and highlights similarities and differences in mental health social work in Northern Ireland and the Republic. The discussion concludes with a review of the key challenges and opportunities facing social workers in both parts of Ireland for developing effective practice with service users and carers. In focusing on a distinct and specialised area of practice the analysis aims to transcend Lorenz's (1994)

discussion of social work in broad generic terms and provides an opportunity to test and critically evaluate the merits of his comparative framework.

Mental health social work: the impact of globalisation, de-institutionalisation and the development of community care

Most mental health social work posts in Northern Ireland and the Republic are publicly funded. The majority of the estimated 160 mental health social workers in Northern Ireland work in community based multi-disciplinary mental health teams where they are often managed by staff from other disciplines [DHSS&PS (NI), 2004]. The number of social workers in mental health increases to 270 if Approved Social Workers (ASWs), who carry out statutory duties under the Mental Health (NI) Order, but are employed in other areas of practice such as childcare, are included (Britton *et al*., 1999). A review by Herron (1998) indicated that mental health social workers in Northern Ireland may be involved in a range of tasks including: assessment of need, case management, social history taking, individual and family therapy, advocacy and working at the interface between different professionals and other agencies such as housing and social security. In contrast to the situation in Northern Ireland, mental health social workers in the Republic are not currently involved in carrying out statutory duties. While the number of mental health social work posts has remained relatively low, recent surveys indicate a rise in numbers from 56.4 in 1999 to 95 posts in 2001 (NSWQB, 2002). Guckian and Finnerty (1997) have observed that 'developments have been haphazard' and that up to 1997 some areas in the Republic had yet to recruit any social workers with the effect that the policy-makers' vision of multi-disciplinary community-based mental health care had not been fully realised (1997, p. 102). In other cases, multi-disciplinary teams include small numbers of social workers (sometimes only one) in comparison to the staff numbers of other disciplines. Despite the potential drawbacks of isolation and lack of peer support for social workers working in these conditions, Kirwan and Kirby (2002) have observed that a diversity of mental health social work practices has become established across the country, often developed in response to local need.

Since the late 1980s social work in both parts of Ireland has experienced a process of major change in organisational structures, policies and more recently legislation, all of which have had an impact on practice and relationships with service users. Like other member states of the EU, both parts of the island, albeit in different ways, have been deeply affected by forces usually associated with globalisation and New Right political agendas (Khan & Dominelli, 2000). The most significant factors impacting on social work have included: the application of market principles to welfare, the separation of purchasers from providers of services, managerialism and an emphasis on standards and value for money in service provision (Prior, 1998). Other influencing factors include a growth in social inequality and disadvantage, an increase in racism and in the Northern Ireland context a continuation of endemic problems with sectarianism in spite of the recent peace process (Smyth & Campbell, 1996;

Powell, 1998; Campbell & Healey, 1999; Skehill, 1999). Goodwin (1997) has identified the sometimes covert but occasionally overt dilemmas surrounding the allocation of resources as one of the two central issues in mental health policy facing the liberal democracies. While both governments in Ireland have pursued broadly similar policies of de-institutionalisation and community care these have been introduced at different rates and, as illustrated below, with different implications for mental health social work. The second central issue at the macro-level, according to Goodwin (1997), focuses on how to deal with the tension between protecting the rights of service users while at the same time safeguarding their families and also the wider society. Such tensions have influenced the process of legislative and policy change on both sides of the border with considerable implications for the development of mental health services. Concomitant with de-institutionalisation and the development of community care there has been an increasing focus in both jurisdictions on discourses relating to citizenship, user and carer rights, empowerment and the concept of partnership in planning and delivering health and social services (Powell, 1998; Campbell & Healey, 1999; Skehill, 1999). The following comparative analysis explores in more detail how the various factors outlined have been mediated in each country in shaping the development of mental health social work.

Welfare regimes underpinning mental health service provision

The first of three main reference points in Lorenz's (1994) comparative framework relates to the nature of the state's 'welfare regime'. Lorenz argues that in order to understand social work, it is necessary to take account of the historical context in examining how practice has been 'influenced by the social welfare system in a very complex fashion' (1994, p. 16). In reviewing Ireland's collective history, Robins (1986) has observed that the country, following Partition in 1921, inherited an excessive commitment to the mental hospital—at one stage having a higher ratio of beds per head of population than anywhere else in the world. Like other western European countries, both administrations have struggled with the challenge of shifting the focus of service provision from an institutionalised asylum system to the modern goal of developing community based mental health services (McCabe & Park, 1998). Prior (1993) has described how mental health services in both countries remained broadly similar from Partition until the establishment of the 'Welfare State' in 1948 when Northern Ireland increasingly followed the UK model—a trend reinforced by the imposition of direct rule from Westminster in 1972. Although there continue to be significant differences in funding and organisational structures, mental health services and legislative provision in both countries now seem to be following broadly similar developmental trajectories.

   In Northern Ireland's divided society the state's general response towards meeting health and social care needs has been a policy of technocratisation aimed at de-politicising social problems by creating welfare bureaucracies within the public sector

to address them (Ditch & Morrisey, 1992; Pinkerton & Campbell, 2002). Since 1973 Northern Ireland has had an integrated structure of health and social services managed by four Health & Social Services Boards (McCoy, 1993). The changes resulting from the NHS reforms and transition to a more 'residual' welfare model began to be implemented in Northern Ireland during the early 1990s (Lorenz, 1994, p. 23). These changes, including the ideological shift towards a mixed economy of welfare, the separation of purchasers from providers of service and the development of self-regulating trusts, had a profound impact on mental health services in Northern Ireland (Prior, 1998). The development of a range of largely state funded community based mental health services, particularly in the voluntary sector, was facilitated by the availability of bridging finance and helped to accelerate the pace of de-institutionalisation. Whilst none of the six large Victorian mental health hospitals in Northern Ireland have actually closed, the number of patients in psychiatric beds has fallen from over 5,400 in 1965 to just 1,500 by the mid 1990s (Prior, 1998). The government's regional mental health strategy for 1997–2002 highlighted the need to improve quality standards and to further develop community based services [DHSS (NI), 1997]. However, Campbell and Healey (1999) have expressed doubt as to whether or not community based services in Northern Ireland have expanded sufficiently to avoid difficulties in accessing hospital care by psychiatric patients on a voluntary basis.

In a review of developments in mental health in Northern Ireland, Manktelow (1997) has noted 'marked similarities with the way in which services are now organised here and in the Republic of Ireland' (1997, p. 2). Both countries have continued to be dominated by a 'medical model' of psychiatric care and it is within this context that the social work role has evolved and developed (Powell, 1998; Campbell & Healey, 1999; Manktelow *et al.*, 2002). The welfare system in the Republic of Ireland has been characterised as 'rudimentary' in nature with health and social welfare provision largely maintained by a range of religious and charitable organisations funded by the state but also relying on their own sometimes quite extensive resources (Lorenz, 1994, p. 26). In contrast to the situation in Northern Ireland, where services are provided mainly within the public sector, it has been estimated that, 'a third of the population in the Republic is covered by private health insurance' and can, therefore, avail itself of treatment in private psychiatric hospitals (Browne, 2004, p. 11). As a newly independent state, the level of financial restraint imposed upon the executive in the Republic by a developing economy inhibited any large-scale expansion in publicly provided mental health services during much of the twentieth century (Garvin, 1996). With the growth in the Republic's economy the increased revenue available for health and social care has facilitated a significant increase in the number and range of services delivered directly by public agencies, such as the Health Boards. Paralleling developments in the North, the pace of de-institutionalisation in the Republic has rapidly increased and in-patient bed numbers in the Republic have fallen from 16,661 in 1971 to 3,817 in 2001 (O'Hare & Walsh, 1974; DOHC, 2002). As in Northern Ireland, there has also been a greater emphasis in

the Republic's more recent mental health policy on standardisation of services, quality and accountability (DOH, 1994; DOHC, 1998). While parts of the Republic have experienced rapid development of innovative community-based alternatives to institutional provision it has been argued that continuing funding shortfalls are engendering a general pattern of piecemeal and reactive development (Crowley, 2003; Clarke, 2004). In the Republic, the proportion of the overall health care budget spent on mental healthcare fell from 10.6% in 1990 to 6.8% in 2003 (Saunders *et al*., 2004).

Within the international context both the current Mental Health Order 1986 in Northern Ireland and the Mental Health Act 2001 in the Republic have been viewed as relatively progressive pieces of legislation (Kirwan & Kirby, 2002; Manktelow *et al*., 2002). Although still open to criticism, legislative frameworks in both countries have aimed to contain built-in safeguards designed to protect the rights of patients, including regular medical review and right of appeal to an independent Mental Health Commission [DHSS (NI), 1986; DOHC, 2001]. The European Convention on Human Rights and other international rights-based principles and guidelines were taken into account in the framing of the Republic's Mental Health Act 2001 and are also currently influencing the review of legislation in Northern Ireland (Clarke, 2004).

In Northern Ireland, a person can be detained for assessment if they are suffering from a mental disorder and failure to detain 'would create a substantial likelihood of serious physical harm to himself or other persons' [Article 4, DHSS (NI), 1986]. The process of admission for assessment requires that both a medical recommendation and application founded on this recommendation be completed. While a medical officer, preferably the person's own GP, must complete the medical recommendation, the person's nearest relative or an Approved Social Worker (ASW) can make the application. The number of involuntary admissions to hospital for assessment has risen from 1,028 in 1993 to 1,686 in 2002 (Mental Health Commission for Northern Ireland, 2002). A number of factors may help to explain the rise in compulsory admissions. These include: the relatively slow development of community alternatives to compulsory admissions, a more 'risk averse' culture within health and social services agencies, or simply with increasing de-institutionalisation, a greater number of patients in the community who need to be admitted on a compulsory basis (Wilson *et al*., 2005). ASWs are currently the only professional discipline in Northern Ireland authorised to carry out statutory functions although the current review of legislation there is considering whether mental health professionals other than social workers should be permitted to carry out legal roles.

In the Republic of Ireland, the Mental Health Act 2001 has not been fully implemented at the time of writing and the 1945 Mental Treatment Act still exists as the main legislative basis for the admission of patients to psychiatric care (DOH, 1945; DOHC, 2001). The 1945 Act distinguishes between 'voluntary' and 'involuntary' admissions and sets out the conditions required for the legal detention of involuntary patients (DOH, 1945). Progressive aspects of the 2001 legislation, which is being introduced gradually, include the establishment of a Mental Health Commission designed to protect the interests of involuntary patients

(Clarke, 2004). Saunders *et al*. (2004) have criticised the new legislation as a 'limited exercise in the most basic fulfilment of Ireland's international obligations' and have argued that it fails to include specific provision for voluntary patients and rights to treatment (2004, p. 26). The Republic also has a high rate of involuntary admission relative to other European countries that, according to Saunders *et al*. (2004), might reflect (as in Northern Ireland) inadequate alternative community provision. Unlike their counterparts in Northern Ireland, mental health social workers in the Republic do not carry statutory duties or responsibilities in law in relation to the involuntary admission of patients. The new Mental Health Act 2001, does not bestow any specific duties on mental health social workers. However, it does create the new role of *Authorised Officer* [DOHC, 2001, Section 9(8)], whose function it will be to initiate applications for involuntary detention of patients in situations where a close relative (viewed as the usual applicant under normal circumstances) is unwilling, unavailable or unsuitable to make such an application. Currently, one of the most significant issues facing mental health social workers and the wider social work profession in the Republic is whether or not they wish to be one of the professional groups whose members may be appointed to the role of *Authorised Officer*. Participating in this task could mean that their role would become more like that of their ASW counterparts in Northern Ireland who already undertake statutory duties.

Social movements affecting mental health social work

A second main axis in Lorenz's (1994) framework focuses on 'social movements' which refer to the 'mediating structures modern societies possess between the individual and state', and includes 'the expressions of consumer demands to which social work has always remained nominally responsive' (1994, pp. 107/183). Lorenz (1994) identifies common factors underlying the development of new social movements including voluntary, self-help and service user initiatives that have emerged alongside and in response to political and social changes taking place in the European Union. Lorenz (1994) acknowledges that although similar developments have taken place across Europe particular political and social factors in individual countries may serve to mediate and shape such social movements. In relation to Ireland, one of the most significant factors which has affected the island as a whole for more than 35 years has been the continuing civil and political conflict. The Republic of Ireland did not experience the level of political and sectarian conflict that was experienced in Northern Ireland, although that is not to say it has been unaffected by those events. Alongside the continuing impact of the 'Troubles' on people's mental health and the pervasive influence of sectarianism, particularly in Northern Ireland, mental health social work has been affected to a greater or lesser degree by a range of social movements taking place in civil society throughout Ireland. These include the development of service user and carer involvement in mental health service planning and delivery, and the continuing debate surrounding service users' rights versus public safety considerations in the development of

legislation and policy. While concern has been expressed elsewhere in the British Isles that people from ethnic minorities are more likely to be detained in psychiatric hospitals, there has been little empirical investigation of this issue in either Northern Ireland or the Republic (Browne, 1997). The focus on political and sectarian conflict, in the Northern Ireland context, may have deflected attention away from other discourses and it is therefore perhaps not surprising that the 'lack of recognition of racism as a significant social problem has only recently been acknowledged' (Pinkerton & Campbell, 2002, p. 732).

Research by Loughrey *et al*. (1998) on the impact of the 'Troubles' in Northern Ireland reported considerable evidence of post-traumatic stress disorder within a population still coming to terms with a legacy of more than 30 years of bombings, murder and rioting. The number of patients admitted to hospital for psychiatric treatment in Northern Ireland rose from 7,869 in 1992/1993 to 10,366 in 2001/2002 [DHSS&PS (NI), Information Office, 2003]. During the same period the number of referrals to psychiatric outpatient clinics rose from 11,280 in 1992/1993 to 13,453 in 2001/2002 [DHSS&PS (NI), Information Office, 2003]. Campbell and Healey (1999) have speculated that increased use of mental health services may be linked to the development of the current peace process and a concomitant greater readiness of people to express feelings of pain and suffering. Suicide rates in both parts of Ireland, particularly among young males, are also significantly higher than in the rest of Europe which might suggest common underlying causative factors (McIroy, 2002). There has been a growing recognition on both sides of the border of the continuing detrimental impact of the 'Troubles' and a number of cross-border initiatives have been established to address mental health problems (CAWT, 2004).

Ironically, at a time when service user rights are being emphasised in both jurisdictions, concerns have been expressed about whether these are recognised sufficiently in current legislation or, in the case of Northern Ireland, may be in danger of being eroded by future legislation [DHSS&PS (NI), 2004; Quinn, 2004]. Northern Ireland, in particular, has not been immune to the high profile tragedies and critical inspection reports, which have driven mental health policy and legislation in other parts of the United Kingdom (Sheppard, 1996). Both the Fenton Report (WH&SSB, 1995) into the homicide committed by a patient discharged from psychiatric hospital and the McLernon Report into the suicide of an elderly person have had significant implications for policy and practice [DHSS (NI), 1998b]. Both these reports recommended new policies and procedures intended to promote better practice. However, they might also have helped to reinforce a technocratic approach to service delivery and a more 'risk averse' culture in agencies. In consequence, in the interest of public protection, new legislation in Northern Ireland may be more coercive than hitherto and include such measures as Community Treatment Orders which will adversely affect the rights of patients (Bean & Mounser, 1993; Brown, 2002). Similar concerns surround public safety in the Republic where mental health services are also vulnerable to the type of pressures which Skehill (1999) has observed have led child care social work there to become more risk averse in the aftermath of child abuse

tragedies. Concerns have been expressed in the Republic about the still relatively disempowered position of service users within the new mental health legislation (Saunders *et al.*, 2004). At the same time there is some optimism that user and carer involvement in the planning and delivery of services will gradually have a positive transforming influence on mental health provision (Tams, 2004).

Academic discourses and the development of mental health social work

'Academic discourses', a third main axis within Lorenz's (1994) framework, refers to the broad range of intellectual sources, ideas and concepts which inform social work education and training and in turn help account for the variety of forms of social work practice in different European settings (1994, p. 81). While acknowledging that social work's diversity may have some disadvantages, Lorenz (1994) argues that the 'conceptual fuzziness' underlying these differences might serve as 'a safeguard against the profession becoming defined by its agency settings and by instrumental targets' (1994, p. 104). In fact, in both parts of Ireland, social work occupies a stronger position within the state sector where practice has been greatly influenced by anxieties about public safety and protection and discourses have tended to focus on agency concerns about regulation and control (Skehill, 1999; Parton, 2000; Houston & McCullough, 2001). In the Republic, the ability of social work to engage in a process of reflexive modernisation by positively responding to such discourses has been questioned (Powell, 1998; Skehill, 1999). Similar concerns have been expressed about the future development of social work in Northern Ireland given the deleterious impact of its legalistic and technocratic culture (Houston & McCullough, 2001). Doubts have also been ventilated about the ability of academic institutions in Northern Ireland to shape and influence professional ideology and the social work role in mental health given the relative dominance of government and employer interests (Wilson *et al.*, 2005). As in the rest of the UK, the education and training of social workers in Northern Ireland have been heavily influenced by government and employer agendas. Agencies in Northern Ireland, perhaps for a variety of reasons including funding arrangements and mutual interdependence based on geography, play an even greater role in the joint partnerships with academic institutions which control social work education (Pietroni, 1995). It has been argued that active agency involvement in the provision of social work education in Northern Ireland has created favourable conditions for the development of competence-based approaches to learning, which in turn serve to reinforce the legalistic, procedural and risk averse forms of professional practice felt to be dominant there (Houston & McCullough, 2001; Wilson *et al.*, 2005).

In order to become ASWs, authorised to carry out statutory duties under the Mental Health (NI) Order 1986, social workers in Northern Ireland are required to successfully complete a competence-based post qualifying training course. The ASW role within mental health services has become increasingly important since the introduction of the 1986 legislation and the rise in the number of involuntary

admissions of patients. The number of admissions involving ASWs, rather than nearest relatives, has risen from 522 in 1993 to 1,176 in 2002 (Mental Health Commission for Northern Ireland, 2002). A recent study of ASW practice in Northern Ireland reported that service users and carers had both positive and negative experiences of the ASW service (Manktelow *et al*., 2002). While they generally found ASWs to be caring and sensitive to their needs, criticisms were directed towards poor levels of general psychiatric care and the need to develop community based resources and crisis teams as a way of preventing admission and readmission to hospital (Manktelow *et al*., 2002). The authors of this study concluded that in 'providing an independent voice outside of the medical hegemony, ASWs can protect civil liberties and prevent institutional excess' (Manktelow *et al*., 2002, p. 459). While the ASW role is relatively well-developed, concerns have been expressed about a corresponding lack of development in other areas of practice. A study by Viney (2002), for example, found that within one trust area in Northern Ireland, lack of knowledge about welfare benefits made it difficult for mental health social workers to act effectively as advocates on behalf of service users. Furthermore, Campbell and Healey (1999) have observed that given the history of civil conflict in Northern Ireland, 'it may seem surprising that mental health social workers are generally not well trained to deal with the psychological sequelae of the conflict' (1999, p. 395).

Although employer influence on academic institutions involved in social work education is less direct than in Northern Ireland, employers in the Republic are represented on course advisory committees for social work courses and on the National Social Work Qualifications Board (NSWQB, 2002). At present, however, no post-qualification specialist training course in mental health social work is available to professional social workers in the Republic, nor are candidates for posts in mental health social work usually required to have such training. The relatively small number employed in both the public and private sectors has, in the past, militated against the establishment of a strong voice for social workers in determining how mental health services should be planned, developed and delivered (Browne, 2004). It has not been easy for the small numbers of social workers employed in this field to fully promote the positive contribution the social worker can make within the multi-disciplinary team approach to service delivery (Kirwan & Kirby, 2002). Despite these constraints the practice of mental health social work in the Republic has developed both creatively and qualitatively wherever that has been made possible. Arguably, not having a role in carrying out statutory functions has allowed mental health social workers in the Republic, unlike their counterparts in Northern Ireland, to become more involved in therapeutic forms of practice. Post qualification, significant numbers of mental health social workers in the Republic have availed themselves of further training and developed a variety of forms of therapeutic intervention as part of their social work role. However, a recent survey in the Republic among mental health social workers reported a level of insecurity about their position within multi-disciplinary teams and also highlighted discontent with the level of support and

supervision they were receiving (Quinn, 2004). This survey reported mixed views among social workers about taking on statutory functions with 39% of respondents feeling this role would help to counterbalance the dominance of the medical model and provide better safeguards for service users. However, 45% were against such a step, feeling that this would detract from the therapeutic role of social workers and possibly create value and ethical conflicts (Quinn, 2004).

Strengths, limitations and opportunities for developing mental health social work

This comparative analysis has highlighted the respective strengths of mental health social work in Northern Ireland and the Republic as well as the challenges and constraints which may inhibit its future development. The ASW role has, for example, given social workers in Northern Ireland status and authority within multi-disciplinary teams. The Northern Ireland experience demonstrates that social workers, with their value base and training, can help empower and protect service users by ensuring their rights are safeguarded and that less restrictive options to compulsory hospital admission are considered (Britton *et al*., 1999). At the same time carrying out statutory duties alongside other health care professionals in situations where there are differences in power and status or a lack of community based alternatives to hospital admission can raise significant ethical dilemmas for social workers. Being involved in decisions that affect the liberty of citizens may limit or possibly jeopardise the social worker's ability to work therapeutically with service users or their acceptability as advocates. In contrast to their counterparts in the Republic, commitment to the ASW role may have inhibited mental health social workers, practising within Northern Ireland's legalistic and technocratic culture, from developing other work roles and skills (Wilson *et al*., 2005). The findings from a recent Departmental Review indicated that mental health social workers in Northern Ireland, while not wishing to abandon their statutory roles, have become more dissatisfied with the lack of alternatives to ASW training [DHSS&PS (NI), 2004]. The Review acknowledged the need to create greater opportunities for mental health social workers to undertake therapeutic training at post qualifying level and further develop their role within multi-disciplinary teams [DHSS&PS (NI), 2004]. Given the scale of mental health problems in Northern Ireland there is clearly a strong case for social workers to become more involved in therapeutic work generally as well as more engaged in supporting those who continue to experience the pain and suffering resulting from the legacy of the 'Troubles' [DHSS (NI), 1998a].

At a time when ASWs in Northern Ireland are pondering the prospect of their role being shared with other professional groups, mental health social workers in the Republic are questioning the efficacy of taking on the responsibilities of statutory duties. The employment of social workers in the Republic across a range of service providers has yielded both positive and negative results for the profession. Mental health social workers in the Republic, free of statutory duties, have found their practice developing in a different direction. Although still relatively small in numbers,

social workers with their distinctive knowledge and value base play an increasingly important role within multi-disciplinary teams and contribute a range of therapeutic interventions to meet the needs of service users and their families (Kirwan & Kirby, 2002). As already indicated, the prospect of acquiring statutory functions has received a mixed reception among social workers in the Republic with opinion divided on whether this change is more likely to promote or inhibit social work's empowering/ emancipatory or regulatory/coercive functions (Quinn, 2004). There is a concern that taking on this role may leave social workers in a situation where the need for training in counselling approaches may become less of a priority and the occupational space available for therapeutic and advocacy work more limited. Alternatively, if their role remains divorced from statutory functions there may be less incentive for employers to increase their numbers. In consequence, social workers may be less able to influence the development of mental health services, policy and practice. Furthermore, they may not be as well positioned to safeguard the rights of service users if, as in Northern Ireland, the rate of compulsory admission in the Republic increases with continuing hospital closures and the development of community care.

In recent years, mental health social workers in Ireland, through their respective professional associations (the Irish Association of Social Workers and the British Association of Social Workers), have held a series of joint conferences to discuss practice issues and debate the possible impact on their role of new legislation and policy (Campbell *et al*., 2002; Wilson *et al*., 2004). The prospect of legislative changes has raised serious issues for mental health social workers in both jurisdictions about what should be their distinctive contribution and what theories and paradigms should inform practice. In taking stock of their contribution social workers clearly need to consider the extent to which their role is integrated or alternatively marginalised within existing systems of service delivery. Social workers also need to reflect on the nature and purpose of mental health social work and the form of relationships and alliances they wish to promote and develop with mental health service users, other professional disciplines as well as the broader public. The comparative analysis highlighted that one of the key dilemmas for social workers in both jurisdictions is the extent to which they wish to become or remain involved in statutory work or in other roles such as carrying out therapeutic interventions. Given the continuing debate in mental health surrounding service users' rights versus public safety the issue may not simply be about at what point of the empowering/ emancipatory or regulatory/coercive continuum social work should position itself. A more fundamental question may be whether there will be sufficient scope or opportunities in future in both jurisdictions for social workers to be involved in a range of work including both legalistic and therapeutic forms of practice?

Critical evaluation of comparative framework

While the above study, in the authors' view, helped to confirm the value of comparative social work analysis it also provided an opportunity to evaluate the

strengths and limitations of the conceptual model applied in this instance. The analysis confirmed the importance in comparative work of taking into account the effect of macro level factors such as globalisation, de-institutionalisation and community care on the national systems of welfare in which social work is practised (Esping-Anderson, 1990). Lorenz's framework is valuable in that it attempts to make this diversity accessible by exploring how wider international factors are mediated by key common country specific variables. In emphasising the need to consider the dynamic interaction between these key variables, Lorenz's three-axis typology seems relevant for developing an understanding of social work in any country. It has also been possible using Lorenz's framework to broadly explain the development of mental health social work in Northern Ireland and the Republic and to make meaningful connections and comparisons between the type of welfare system, social movements and academic discourses both within and between these countries.

Although Lorenz's model undoubtedly has considerable merit as a comparative framework this study did raise questions for the authors about its adequacy in capturing the complexity of specialised areas of social work practice and suggested possible refinements to the framework. A significant concern that emerged for the authors in undertaking the analysis centred on how adequately Lorenz's model addressed the issue of power. Although the model emphasises the need to consider the dynamic interaction between welfare systems, social movements and academic discourses, it lacks clarity about the relative weight to be given to each axis and its respective importance in shaping social work practice. This study suggested that in undertaking comparative analysis variables such as statutory requirements, agency resourcing and the nature of social work education and training are also important factors when considering specialisms like mental health social work.

In accepting that the interaction of a range of external factors may account for different forms of social work practice we need to avoid being overly deterministic and mechanistic when evaluating such influences. This analysis has also highlighted the potential power and influence of social workers, individually and collectively, to create and shape their own role. In countries where mental health social work is very well developed and social workers are in a position to exert influence, there are grounds for considering this factor as a separate additional axis within Lorenz's typology. Thus, social work and social workers, rather than being relatively passive variables shaped by external forces, would be evaluated as a fourth axis dynamically interacting with other factors shaping as well as being influenced by their environment. By more explicitly acknowledging the potential of human agency to influence civil society and shape welfare provision, this typology would help to ensure that social workers are accorded adequate consideration. 'Academic discourses', encompassing the range of intellectual sources and disciplines informing social work, are important considerations in any comparative study. However, experience of undertaking the above analysis highlights the importance of adopting a broad enough definition of this factor to satisfactorily embrace its depth and complexity. Pinkerton and Campbell (2002) prefer to use the term 'professional ideology' rather than

'academic discourses' to encompass the range of interests, including those of government and employing agencies, involved with universities and colleges in influencing social work education and training (2002, p. 724). The findings of the above analysis provide further support for this contention and underline the importance of taking into account a wide range of factors in developing an understanding of how mental health social work has developed.

Conclusion

The prospect of change presents a major challenge for social workers in both Northern Ireland and the Republic as it requires consideration of the past and contemplation of the future 'mission' of social work within mental health services. The increasing emphasis on service user rights alongside simultaneous demands for greater public protection represents conflicting discourses in mental health which clearly transcend national boundaries. How they are operationalised in legislation and policy will have a direct bearing on the potential and possibilities for empowering forms of social work practice. As illustrated by the Northern Ireland example, through being involved in carrying out statutory functions social workers, given their distinctive value base, can still play a very significant role in protecting patients' rights. However, in working within this context there is a danger that the social worker's role in advocacy, empowerment and therapeutic work may become marginalised or not seen as an essential component of mental health services. In this situation social work services may become almost indistinguishable from those provided by other professional groups as practitioners attempt to develop roles that are valued not only by service users but also by members of the public, other professionals and policy makers. The paradigmatic 'difference' between the 'social' perspective of the social worker and the 'medical' perspective of other service providers provides scope for social workers to re-assert their distinctive contribution and be creative, adaptable and flexible in their practice during the current change process. However, to effectively utilise the opportunities the current change process presents for re-negotiating their role, mental health social workers need to question and re-assess the degree to which their work, as currently practised, promotes and upholds the core principles and values of the profession. The parallel transitions taking place in Northern Ireland and the Republic offer an opportunity for social workers to engage in useful dialogue and information exchange which could be mutually beneficial. Through working together social workers in both jurisdictions can learn from and provide invaluable support to each other in developing their roles in ways that will help to empower both service users and their carers.

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