We are on the horizon of a new paradigm in the conceptualization, discourse, and treatment of mental health, and it centers on one word: recovery. Sparked by the advocacy of mental health consumers and grounded in the concepts of hope, relationships, meaningful activity, empowerment, self-determination, and education, recovery has become the buzzword in psychiatric and community mental health social work across the globe. Public mental health systems in the United States now actively focus efforts to transform policies and practices to become more recovery-oriented, and the United State’s most influential consortium of mental health practitioners has as its primary goal the creation of a national mental health system in which recovery is fundamental (President’s New Freedom Commission, 2003).

Whereas conventional social work approaches to mental health treatment tend toward individually based therapy and case management of questionable success, there is growing evidence that an investment approach can be more effective at improving the quality of life for people who suffer from mental illness. The social investment approach to mental health social work practice provides opportunities for social inclusion for some of the most marginalized people in society, working with them to overcome the experiences of isolation and stigma that are often the most debilitating effects of mental illness. This chapter provides background on the nature and scope of mental illness, outlines conventional approaches to mental health care in the field of social work, highlights examples of the social investment approach, describes how emergent recovery-based services link with social investment approaches, and offers practical steps to integrate social investment into social work. In particular, the chapter highlights an innovative community mental
health project known as The Village, which incorporates the social enterprise approach as a central component to mental health services. This project not only embodies the social investment strategies discussed in the chapter but also has relevance for mental health policy in general.

The Nature and Scope of Mental Illness

What is “mental illness?” To succinctly define mental illness is challenging because there are a myriad of types of mental illnesses and a wide range in the severity and/or impairment of these conditions. In addition, the concept itself is subject to cultural construction and historical placement. In fact, the task is akin to defining “physical illness,” as diagnoses, causes, and treatments can change wildly over time and place. For the purposes of this chapter, the definition from the Dictionary of Social Work published by the National Association of Social Workers will be used: “Impaired psychosocial or cognitive functioning due to disturbances in any one or more of the following processes: biological, chemical, physiological, genetic, psychological, or social” (Barker, 1999, p. 299). Of course, this definition is open to criticism. For example, it is unclear whether someone who is diagnosed with depression but not impaired in everyday life would be considered “mentally ill.”

As with defining mental illness, it is essential to define its sister term, mental health, especially because the words are often incorrectly used interchangeably. There is an important distinction that points to a shifting paradigm in this field, one that focuses on strengths rather than weaknesses. Because there is no official definition of mental health, this chapter relies on one given by the World Health Organization, that it is: “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and [be] able to make a contribution to her or his community” (World Health Organization [WHO], 2009). According to this description, it is possible for a person to have a mental illness and experience mental health at the same time if they meet the above criteria.

Types of mental illnesses are generally categorized in three main groupings: mood disorders (such as depression or bipolar disorder), psychotic disorders (such as schizophrenia), and anxiety disorders (such as post-traumatic stress disorder; PTSD). There are numerous other conditions, such as personality disorders, mental retardation, and autism, that fall outside the main categories but can be disabling nonetheless. According to the Surgeon General’s report (U.S. Department of Health and Human Services, 1999), half of people with a mental illness have two or more disorders, and these often include a substance abuse disorder.

Because of the variations of mental illnesses, it is not possible to identify a single cause, although efforts are made to categorize, understand, and develop etiologies of distinct mental illnesses. The “Diagnostic and Statistical Manual of Mental Disorder Criteria,” the reference guide conventionally accepted as the authority on mental illness, outlines 374 mental disorders (American Psychiatric
Association [DSM-IV-TR], 2000). It provides detailed information on the causes, symptoms, prognosis, and statistics of particular mental health conditions and is used by psychiatrists, psychologists, social workers, and mental health counselors to assess someone seeking treatment. Every few years, the manual is updated, and the number of categorized mental disorders has risen nearly exponentially since the 1950s.

Mental illness is more widespread than is commonly understood. In the United States, the prevalence of mental illness is approximately 57.7 million people, or more than a quarter of the total population of people age 18 years and older (National Institute of Mental Health [NIMH], 2008). This, however, does not speak to severity or duration. For people with serious mental illness, it is estimated that the prevalence is 6% (NIMH, 2008). Impairment from mental illness is, in fact, the leading cause of disability in the United States and Canada for people ages 15 to 44 years, and 1.5% of people have a serious and persistent mental illness severe enough to need governmental disability support (U.S. Department of Health and Human Services, 1999).

In the United States, there are considerable disparities regarding mental health across ethnicities. People of color, generally speaking, have less access to mental health services, receive less services and services of poorer quality, and are inadequately represented in mental health research (U.S. Department of Health and Human Service. 2001). It is important to emphasize that the prevalence of mental illness is not drastically different between ethnic groups and that the disparities exist because of legacies of racism and discrimination, mistrust of the mental health system, and language, cultural, and communication barriers. Examples of these disparities include a suicide rate for Native American youth that is 50% higher than the national rate, greater risk for PTSD in refugees from Southeast Asian countries, higher rates of depression and anxiety for Latino youth than for other groups, and an overrepresentation of African Americans in populations that have higher rates of mental illness, such as the homeless, incarcerated, and youth in foster care (U.S. Department of Health and Human Services, 2001).

On a global level, the World Health Organization (WHO) asserts that the number of people affected by mental illness is estimated to be in the hundreds of millions and that there are 179 million people who suffer from depression and schizophrenia (WHO, 2009). The most recent WHO report, the Mental Health Atlas (2005), provides a survey of the most current information about global mental health issues, from policy to legislation to treatment capabilities. For example, only 62% of the 193 WHO member states have mental health policies, leaving nearly one-third of the world’s population without a state-initiated mental health policy. This is notable because there is a strong association between state mental health policies and having other supports for people with mental illness, such as a state mental health programs, disability benefits, and community care facilities. Community care facilities exist for 83.3% of the world’s population; however, in the African, Eastern Mediterranean, and Southeast Asian regions, only about half of countries have such facilities. Mental health legislation that ensures human rights
of people with mental illness as well as regulations on care and facilities are present for only 69% of the world’s population. Again, this differs by region, with European countries leading the pack (WHO, 2005). The disparities found in mental health infrastructure between various countries results in many people without support. The disabling effects of mental illness can affect individuals in a multitude of ways, depending on the severity, duration, treatment, and the support structure of an individual. Unemployment, poverty, relationship issues, lack of housing, stigma and discrimination, and difficulty functioning in everyday life are just a few of the many common impairments that affect individuals and families. Communities are also affected by serious mental illness. Recently, as part of a law that was passed in the state of California to provide new funding to mental health systems, one community identified the top issues that resulted from untreated mental illness; these included homelessness, incarceration, and involuntary hospitalization (Berkeley Mental Health, 2005). The impact on societies in terms of “disease burden” (lost productivity caused by impairment from mental illness) is thought to be more than all cancers combined (NIMH, 2009). Moreover, it is argued that this disease burden on people of color in the United States is considerably worse than Whites because of disparities in access to and amount and quality of care (U.S. Department of Health and Human Services, 2001). But as with any discussion of disability, the question arises about which are more important contributors: environmental or individual factors. The Disability Rights Movement made great strides in identifying that the environment plays a significant role in causing impairment.

Over the past 25 years, the United States has experienced a growing focus on mental health like no other time in history. Mental health is no longer marginalized in comparison to other health concerns in the United States, as evidenced by the U.S. Surgeon General’s report on Mental Health (U.S. Department of Health and Human Services, 1999) asserting that mental health is fundamental to overall health. Executive Order 13263 created the New Freedom Commission on Mental Health. This group was charged with addressing problems in the country’s mental health system. The Mental Health Parity Act of 1996 ensures that for members of large health insurance groups, coverage is the same for both physical and mental health treatment.

The focus on mental health is a growing trend extending across the globe. According to the Atlas of Mental Health report, although 70% of countries have a national mental health program covering almost 91% of the global population, 61% of these countries have only developed it since the 1990s. Additionally, 85% of the countries with mental health policies have only developed them in the past 25 years (WHO, 2005). Although there is much that has been started, there is much yet to do to optimally promote mental health in the United States and beyond.

The Social Work Approach to Mental Illness

Social work practice in the area of mental health has transformed over time, from a medical model that emphasized institutionalization to a social model that develops
strengths. These changes have reflected the dominant understanding of mental ill-
ness. Although this section focuses mainly on the history of mental health policy
and practice in the United States with some global trends, the dominant paradigm
of mental illness in any society at any given point will affect treatment, and that
treatment will, in turn, be affected by the paradigm. Therefore, it is important to
note how the conceptualization of mental illness, similarly to the conceptualization
of disability, has changed to understand the transformation toward a rights-based
approach. Structural forces, science, new treatments, legal changes, and populist
movements have all been major contributors. Although the conventional social
work approach in the late 20th and early 21st century has been an expert-based
clinical approach, the paradigm continues to shift to one of recovery, collaboration,
and human rights.

Over the last 300 years, the conceptualization of mental illness has changed
dramatically and so have treatment and policies. During the 17th century and some
of the 18th century in Europe and North America, it was commonly believed that
people with disabilities, including mental illness, were being morally punished for
something they or their families had done (Rothman, 2003). People, therefore,
were either removed from the community into poor houses or jails or lived with
families. It has been said, however, that because conditions were so poor for most
people during the Colonial time, those with mental illness were perhaps no worse
off (Grob, 1973, cited in Trattner, 1999). Then, during the 19th and early 20th
centuries, the conceptualization of mental illness shifted to the idea that it was
caused by society. This new paradigm took hold during the Enlightenment, when
individuals came to be regarded as having fundamental rights. As discussed in
Chapter 5, one of the grandmothers of American social work, Dorothea Dix
(1802–1887) responded by helping to create mental hospitals, also known as asy-
lums, where it was believed that people could receive humane treatment. It is
important to point out, however, that not everyone benefitted from this new para-
digm. African Americans were frequently warehoused in public institutions, receiv-
ing grossly substandard care often for a mental illness diagnosis developed with
racist bias (Jackson, 2003). An example is “drapetomania,” a mental illness diagno-
sis concocted by American doctor Dr. Samuel Cartwright to describe slaves who
escaped captivity.

These asylums were the norm until the mid-20th century, when the medical
model became the dominant paradigm. This model posits that mental illness has
biochemical or organic causes and as such can be treated and possibly cured. It was
heavily influenced by several converging factors: scientific discoveries in brain
chemistry, Sigmund Freud and the development of psychoanalysis, the emergence
of psychotropic drugs, and the number of soldiers returning from World War I
with “shell shock.” These developments in turn influenced government and
spawned successive waves of legislation in the United States. Two of the most nota-
ble are the National Mental Health Act (1946), which established the National
Institute of Mental Health, and the National Community Mental Health Centers
Act (1963), which helped to fund numerous outpatient treatment facilities in the
country. The Americans with Disabilities Act of 1990 was another key piece of legis-
lation because it incorporated mental illness into the range of disabilities covered.
These statutes continued the trend of increasing the rights of people with mental
illness.

A major setback to the forward progress that these laws embodied was
President Reagan’s Omnibus Budget Reconciliation Act in 1985, which had several
unintended consequences. The law gave funding to states via block grants, which
meant that states could use federal funding without constraints imposed by federal
policy, thus effectively stripping away gains from earlier progressive policies. So, at
the same time that people were being released from mental hospitals to receive care
in their own communities (a movement known as deinstitutionalization), these
communities lost the ability to serve them. The de jure policies of the 1960s and
1970s of providing quality care in a person’s community environment became the
de facto reality of a wave of homeless mentally ill in the 1980s.

Throughout these paradigmatic and policy changes in the 20th century, some
people with mental illness publicly protested abuses they had suffered in the
mental health system. Known as the consumer or “ex-patient” movement, its roots
can be traced back to the influential book A Mind That Found Itself (1908) by
Clifford Beers, a psychiatric patient himself who found what is now known as the
National Mental Health Association. The movement picked up momentum during
civil rights efforts of the 1960s and 1970s, when more and more individuals came
together to support each other, form self-help groups, and advocate for mental
health reform. With parts of the movement having ties to the antipsychiatry move-
ment in the 1970s, all consumers, regardless of political affiliation, demanded the
end to stigma and involuntary institutionalization as well as the rights to self-
determination. Although it can be argued that there is much work yet to be done to
transform the mental health system in the United States, the consumer movement
has given voice to people who have been unjustly treated, and this voice has had
major influence on national policy statements (President’s New Freedom
Commission, 2003).

**Social Workers and Mental Health**

The medical model of the past 50 years has resulted in a field dominated by profes-
sional clinical casework/psychotherapy and scientifically measured outcomes.
Mental health is the largest area of practice in social work, and there are more social
workers delivering mental health services in the United States than all other profes-
sions combined (SAMHSA, 2009). This statistic may be misleading, however,
because the field has become saturated with licensed clinical social workers who
conduct psychotherapy in private practice settings, serving a more affluent popula-
tion than is served in public mental health services (Specht & Courtney, 1994).
Similarly, on a global level, the number of social workers working in mental health
varies considerably by how rich the country is. Most countries have an average of
less than one social worker for each 100,000 people, but in the highest income
There is a tension within the field regarding the optimal role for social workers in mental health. Whereas social work education in mental health encourages a wide range of roles for the social worker, such as community organizer, consultant, and job trainer, in practice the professional social worker in mental health is best known as a case manager or therapist (Bentley, 2002). In this role, interventions take place at the micro-level, using a variety of talk therapeutic techniques to reduce symptoms, set goals, monitor progress, and offer referrals to other psychiatric specialists. That said, some social workers themselves often find the medical model to be lacking in the ability to help people recover because the narrow focus on disease-based psychiatric treatment instead of working with the whole person has created a generation of specialist social workers (Jackson, 2001).

Finally, again reflecting the medical model, the current trend in mental health social work is what is known as “evidence-based practice.” This approach to practice emphasizes the use of interventions that have scientific evidence suggesting success in meeting intended outcomes. It is used as a way to legitimize a given practice, and its popularity has steadily risen in the past 20 years as a response to mental health interventions whose outcomes were not measured or verified. Examples include Assertive Community Treatment, Functional Family Therapy, and Supported Employment (Drake et al., 2005).

A discussion of contemporary social work practice in mental health would not be complete without attention given to policy, as the two influence and are influenced by each other. Currently, the major policy in the United States that affects people disabled by mental illness is income maintenance, a policy that provides cash assistance in the United States in the form of Supplementary Security Income and Social Security Disability Insurance, depending on the severity and scope of the disability. Both programs are means-tested public income-maintenance programs comprised of monthly cash payments for people who are deemed mentally or physically disabled and unable to work. People over age 65 years, or blind or disabled people of any age, who are poor can qualify for Supplementary Security Income. Enrollment in Medicaid health insurance is automatic for recipients, guaranteeing a minimal level of health insurance coverage. Social Security Disability Insurance is social insurance program for people who have both a mental health or physical disability and a work history, and recipients are not automatically enrolled in Medicaid. Monthly payments in this program depend on the level of accrued contributions during the time that an individual worked. Although some people are eligible for both programs, recipients of either type of benefit are not eligible for Food Stamps (Social Security Administration, 2003).

Although it has been argued that introduction of income maintenance programs is responsible for the single biggest difference in improving the quality of lives of people with serious mental illness since 1950 (Frank & Glied, 2006), even with this help from the government, it is often not enough to make ends meet. For disabled people on Supplementary Security Income in California, for example,
in (and out) of poverty with social workers as agents of change. One of the most effective ways to support people in poverty is through the Social Investment Approach to Mental Health.

As described in detail in Chapter 1 and in chapters throughout this book, the key characteristics of the social investment approach are that economic development must promote social welfare and that social welfare interventions, in turn, must promote economic development, that interventions are not consumption-based but are productive and driven by consumers, and that human rights are at the forefront of all efforts. This section defines the emergent vision of recovery and how it is linked with the social investment approach and describes an innovative investment approach to mental health treatment called social enterprise, highlighting an example of this strategy in the United States.
The Vision of Recovery

Recovery, at its most basic level, is the concept that people can and do recover from mental illness to lead fulfilling and meaningful lives. Recovery does not necessarily mean the absence of illness; rather, it describes the ability to cope with symptoms of a mental illness and have a quality of life in whatever way is significant for the individual. This position views recovery as analogous to having a permanent physical injury: one can lead a fulfilling life despite the mental illness. Recovery can also be viewed as learning how to effectively cope with not only the symptoms of mental illness but overcoming the negative consequences of it as well (to which social stigma contributes considerably), such as homelessness, unemployment, or problems with primary relationships.

Recovery can be viewed as a personal vision as well as a vision for a mental health system, and definitions of recovery share common characteristics that are strikingly similar across the literature (SAMSHA, 2009; Anthony, 1993; President’s New Freedom Commission, 2003). The fact that they are so alike shows that the recovery vision, initiated and articulated by consumers, seems to have become established and at least generally mutually agreed upon. The definitions include the following core concepts: self-direction, hope, empowerment, nonlinearity (i.e., recovery is a nonlinear process), involvement of supportive personal relationships, and having a meaningful role in society. For an individual, how recovery is defined as well as the journey one chooses to take can be intensely personal, but there are numerous commonly accepted strategies that can facilitate recovery, such as involvement with supportive caring people (professionals, peers, family, or friends), daily planning, involvement in meaningful activity, and gaining knowledge of one’s symptoms and how to respond to them (Mead & Copeland, 2000). For a mental health system, the vision rests on how to transform the current system to a “recovery-based system” that espouses and holds central the main tenants of recovery. It has become a well-articulated goal in mental health systems across the United States since the 1990s (Jacobson, 2004). This is a shift in thinking from previous system transformations, where it has been argued that the focus was on how the physical buildings would change (i.e., mental institutions) instead of how people themselves would change (Anthony, 1993). Consumer involvement and leadership is a major concrete strategy in this campaign, and mental health plans across the country are asked to hire consumers in service, advocacy, policy, and planning roles (Subcommittee on Consumer Issues, President’s New Freedom Commission, 2003).

Social Investment, Recovery, and Rights

The vision of recovery described above harmonizes with the social investment approach in several ways. First and perhaps foremost, both hold that human rights are central to advance each mission. A major violation of human rights is the stigma associated with mental illness (WHO, 2009). It is fueled in part by the media, which
negatively influences public opinion about mental illness considerably (Friedman, 2008). In addition to socially imposed difficulties at many levels, discrimination resulting from stigma prevents many people with serious mental illness from participating in everyday activities, such as having social contacts or having a job. Second, both assert that self-determination is a standard by which to operate any intervention aimed at increasing the welfare of a person. It is of utmost importance that a person has choices in their treatment, not to mention choices about how to participate in society. Self-determination can be achieved not just on the individual level but also on the collective level—that is, consumers as a diverse but distinctive group should be included as equals in policy and services decisions. The recognition that each individual has unique talents that enable himself/herself to have a meaningful and productive role in society is the third similarity of both visions. Recovery and social investment honor the skills and knowledge that each individual possesses and encourages participation in education, community involvement, and employment to develop and ultimately share these talents. Finally, both approaches affirm the importance of the community or, simply put, connections with others. In the social investment approach, this is called social capital, the building of cohesive relationships between people for mutual benefit. In recovery, this can be achieved through mental health support groups that are organized by consumers themselves, also known as “peer support.”

The Role of Social Enterprise

One compelling strategy that is aligned with the social investment approach to mental health care is social enterprise, an innovative way to ameliorate social and economic exclusion. It has widespread practice in Europe and is gaining popularity in Asia and the United States. The social enterprise approach builds on conventional social work practice in mental health such as psychosocial rehabilitation and supported employment, but it differs from these practices by its highly integrative composition.

Generally speaking, a social enterprise is a business that provides social services, produces goods and/or services, and purposefully employs people with disabilities as well as their nondisabled counterparts (Social Firms Europe, 2009). The main goal of a social enterprise is to break social isolation and exclusion using a market-driven business model. There are many terms for social enterprise across the world including: social firms, social cooperatives, community businesses, integration firms, solidarity firms, social-employment firms, and third-sector social economy. Although there are legal and operational variations between and within countries (Ducci et al., 2002), they share a social investment orientation—namely, that economic development for individuals and for the community are mutually inclusive. As opposed to a clinical intervention with an individual in a secluded office, social enterprise offers people opportunities to gain social, psychological, and practical skills in supportive working environments, a therapeutic experience that can do more than therapy alone (De Leonardis & Mauri, 1992). Social enterprises
are supported in part by local governments through laws and subsidies, but they aim to be self-sustaining through generated revenue. In fact, profits from the social enterprise can be re-invested to create more opportunities for mental health consumers.

As mentioned previously, social isolation, poverty, and stigma are consequences of untreated serious mental illness, and social enterprise tackles these debilitating problems with a unique focus on promoting social and economic integration for people with mental health and other disabilities. It is known that social integration, the opposite of isolation, is vital to physical and psychological well-being (Ell, 1984). Formal job-related activities, such as training and labor, and informal activities, such as worker camaraderie, provide myriad of ways to build social capital. Economic integration is achieved by productive contribution to the labor force, an area where people with mental health disabilities have been either previously excluded or not supported sufficiently to maintain participation. Engagement in social enterprise effectively addresses stigma against people with mental illness, as a worker is a worker rather than a “disabled worker” or “mentally ill worker.” His or her status may or may not be known, but the social enterprise is intentionally set up to be status-blind.

Researchers argue that the rise of social enterprise across the globe brings great promise to the promotion of mental health (Leff, 2001). These programs are widespread within Europe (Social Firms Europe, 2009). In Asia, a consortium of researchers and doctors has praised innovative programs that utilize social enterprise as “models of excellence,” highlighting the benefits produced for both the consumer and the community. These projects provide a blend of services and employment to mental health consumers in rural India, Hong Kong, and Singapore (Akiyama et al. 2008).

The use of social enterprise has been well-documented in Italy, where there are over 5,000 social cooperatives (Ducci et al., 2002). Describing the history of social enterprise in Italy means first discussing their process of deinstitutionalization, because the resulting policies set the stage for social investment efforts. Unlike deinstitutionalization in the United States, the main goal of Italian deinstitutionalization was to transform the entire mental health system of the country to empower mental health consumers to be active in their treatment and recovery (De Leonardis & Mauri, 1992). New laws created and governed social enterprises (known in the country as “social cooperatives”), mandating that 30% of people employed in a social cooperative need to be considered disadvantaged in the workplace. Since then, social cooperatives in Italy have grown rapidly and today provide goods and services in many fields, most prominently in arts and crafts, cleaning, catering, agriculture, and the maintenance of buildings, parks, and other public spaces.

Social enterprise is a featured component in an innovative program in the United States that serves people with serious and persistent mental illness. In 1989, the California mental health system was formally challenged to develop innovative mental health programs, and the Mental Health Association of Los Angeles County designed the Village model. Based in the community, the project aims to prevent
recidivism and hospitalization and promote quality of life. An individualized approach characterizes services with the assertion that every person is unique and that treatment should reflect this diversity. Each consumer, or “member,” is part of a service team comprised of an employment specialist, money management, and substance abuse specialists, as well as mental health practitioners who provide conventional psychosocial interventions. Using the improvement of quality of life as a guiding principal, services and support are available whenever and wherever they are needed (The Village Integrated Services, 2008; Levin, 1997).

Integral to the Village experience is employment in one of the agency’s for-profit businesses, which include a credit union, mini-mart, and catering establishment. As members gain skills and confidence, they are placed in community jobs. In addition, many consumers work for the Village permanently in mental health, maintenance, or administrative support positions. Their Employment Department serves all members, not just those who have been referred or choose to participate. The guiding principles state the agency’s belief that participation in work builds self-esteem and self-worth and that members can and should be integrated in work environments (Bender, 2006; The Village Integrated Services Agency, 2008).

The distinctive collaborative attributes and integrated approach of The Village are reflected in positive outcomes and commendations. Researchers have found that the Village’s unique environment, where staff are perceived as supportive and there is significant peer leadership, has more of a positive effect on social integration than an individual’s diagnosis or previous level of psychological, occupational, or social functioning (Levin & Brekke, 1993). A randomized control trial that assigned mental health consumers to either Village services or conventional county-based services showed that after 3 years, Village participants had significantly better financial stability, well-being, friendships, workforce participation, social support, and life satisfaction than members in the comparison group (Chandler et al., 1996). In a subsequent series of studies, it was found that members of the Village had nearly five times higher employment rates than a corresponding program (Chandler et al., 1997a), were less costly to serve than other “high users” of mental health treatment (Chandler et al., 1997b), and had lower hospitalization rates than a comparable cohort (Chandler et al., 1998). The national Substance Abuse and Mental Health Services Administration has honored the Village as an innovative program, and it serves as a training ground for other programs to replicate their model. (The Village Integrated Services Agency, 2008).

The social investment approach builds on conventional mental health interventions—namely, psychosocial rehabilitation and supported employment that are already being practiced, although to a much lesser extent than clinical casework and therapy. Psychosocial rehabilitation is a modality that, like social enterprise, goes beyond individual therapy to build concrete skills in everyday living. It is practiced most often with an individual or group basis to develop skills with the aim of increasing the quality of life for the person with mental illness. Similarly, supported employment is another modality that takes mental health treatment out of the clinic and into the real world. It is a twofold approach of job development and job
support, specifically, for people with mental health disabilities. The President’s New Freedom Commission (2003) has recognized this as a model. Social enterprise takes these approaches several steps further by creating integration. Jobs are not sought out or designed for people disabled by mental illness but, rather, for a general population. Life skills are not taught in isolation but are learned experientially and practiced on the job. Social enterprise fits well with the vision of recovery because it respects the dignity of the person to use their abilities and capacities to create a meaningful life.

The Role of Social Work in the Social Investment Approach

Because of the large numbers of social workers involved in mental health, the field of social work has an important role to play in the development of social investment efforts. Making a shift from a clinical casework/ psychotherapy model to a recovery, rights-based approach to social work mental health practice will require new skills and attitudes. Social workers can be influential on several levels: individual practice, community practice, and policy.

The new role of the social worker in an investment approach to mental health is one of generalist (not specialist), consultant, liaison, and job skills trainer. Practical skills required to carry out this new role include business plan development, financial management, resource acquisition, and team-based work. Valuing the principles of recovery is instrumental to the attitude of the social worker, as well as reframing the nature of professional social work in mental health from that of expert to that of consultant. It is also imperative that these roles be occupied by social workers who are ready, willing, and able to address and remedy the racial, ethnic, and cultural disparities that characterize access to mental health care and service delivery.

On the community level, social workers can work with mental health consumers as well as service organizations to encourage the building of social enterprises. The recommended recipe from social investment projects in Asia is the development of a business and financial management plan, acquisition of start-up money, training industry-specific skills, and identification of how to meet the larger community’s needs with the goods and services provided by social enterprises (Akiyama et al., 2008).

There must be a commitment on the part of policymakers, fueled by social work advocacy on individual, organizational, and leadership levels, to create social enterprise firms similar to those in Europe—namely, businesses that require the hiring of disabled workers. As can be seen from the Italian example, established social enterprise is the result of the convergence of policy and practice. It will take both social work practitioners and social work policy advocates working together with governments to continue the work of recovery-based mental health reform.

There has been the call to individual social workers and the field of social work in general to shift professional orientation from that of expert psychotherapist to a
role that better reflects the nature of social work as a field that should serve the most vulnerable and oppressed in society (Specht & Courtney, 1994). To be sure, there will always be a need for people who want it to get emotional and psychological support from others who are compassionate. When this does not happen through a natural helping system, such as with family members and friends, professional and paraprofessional social workers can be instrumental in helping people in dealing with complex social and interpersonal issues. The emphasis of social work in mental health is already securely oriented to this individual and consumptive way of working, and it is time to expand roles of social workers to adopt social investment strategies to help people with serious mental illness achieve the right to social and economic integration.

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