



Responding to changing landscapes in social work education in mental health: Possible ways forward.

Margaret A Carter and Abraham Francis
James Cook University Australia

This paper commences with a definition of mental health and wellbeing, followed by a snapshot of mental health, with particular attention to the evolving landscape of social work education in Australia. A discussion of strength based practices and recovery orientated approaches to mental health and wellbeing sets the scene for contemporary social work practice. The response of higher education to changes in the social work field is highlighted with reference to blended pedagogy as a mode of delivery responsive to both changes in the profession and the shifting demographics of the 21st century learner.

Keywords: mental health; strength based practice; social work; higher education; blended pedagogy; 21st century learner



Introduction: Mental Health and Well-Being

Mental health issues (also referred to as mental difficulties, mental illness, problem behaviour, atypical behaviours) include the wide range of emotional and behavioural disturbances that negatively interfere with a person's ability to meet the requirements of everyday living. According to the problem focused model (also called the medical model or the cause-effect model) of mental health, persons with a mental health diagnosis are generally characterized by a combination of mental difficulties, classified as disorders such as depression, substance abuse and dependence, psychological disorders and internalizing disorders. This problem focused medical model is based on the equation that diagnosis + prescribed intervention = symptom reduction. Aligning diagnosis with prescribed treatment does not alleviate the problem nor does it find solutions to problems (Bannink, 2006).

Contemporary mental health services have been moving away from this deficit model of care toward finding or designing solutions through a multidimensional model of empowerment, strengths building, recovery, and sustainability. According to Pulla (2014), in strength based recovery practices, support is person oriented, values based, interactive, collaborative and transformative, with individuals encouraged and empowered to tell their mental health story and to take ownership of their recovery. "As a process, it follows a complex, unique, and nonlinear path which involves a personal transformation in hopes to live a satisfactory life despite the challenges ahead" (Mariscal, 2014, p. 123). Mental health practitioners examine what preventions, interventions and treatments have worked, have not worked, and what is currently working. The theory of change belongs to the individual not the health practitioner, with personal control emphasised, and the individual's problems placed outside the person.

Recognizing the individual as inseparable from their social environment, these practitioners understand human development as a set of overlapping ecological systems, namely the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Rosa & Tudge, 2013). Practitioners work across these five levels of influence, providing health care advice and education on mental health and wellbeing issues affecting persons living with mental health difficulties and/or substance abuse. The problem orientated medical model concentrating on "pathology, symptoms, weaknesses, problems, or deficits" (Kruger & Francis, 2014, p. 257) is being replaced a de-blaming, strength based recovery model.

The World Health Organization's Mental Health Action Plan 2013-2020, endorsed by the World Health Assembly in 2013, recognizes the important role of mental well-being in attaining health for all people, and advocates for the implementation of strategies aimed at the promotion of help-seeking behaviours, and mental health and social care services in community based settings. National mental health policies and strategies such as the *National Mental Health Plans* (1993 -2014), and the Council of Australian Governments (COAG) National Action Plan on Mental Health (2006, 2011), concentrate on developmentally and culturally appropriate prevention concepts and strategies with the intention of promoting, protecting, and restoring a person's mental health thus enabling entire communities affected by it.

Strength Based Approaches

Concentrating on optimism and strengths, rather than pathology that labels people, strength based



practitioners view problem behaviours as the interaction between members of the systems. Therapeutic change involves client resilience, empowerment, and the promotion of self-management and self-determination. No single person orchestrates the interactional patterns without collaboration within and across systems central to the process. Diagnosis is one voice in this conversation... “the therapists task is to be flexible in allowing a wide range of possible in-session uses for diagnosis with each client rather than insisting on the same diagnostic label based on the therapist’s philosophy” (Gehart, 2014, p. 554).

Writers including Grant and Cadell (2009) and White-Meyers (2014) associate strength based practices with hope, strengths, capacities and abilities. These approaches “are grounded in the principle that individuals have existing competencies to identify and address their own concerns; and can be involved in the process of healing and problem-solving.” (Jose & Vijayalekshmi, 2014, p. 507). Strength based practitioners do not ignore client’s complications and hardship, nor do they relate to individuals solely according to their mental health diagnosis, disorder or illness. While diagnoses are important and provide meaningful insight into people’s symptoms and developmental challenges, diagnostic labelling does not define the person. The challenge for strength based practitioners is to shift their paradigm from the person being defined by their diagnosis to the diagnosis being one facet of the person. This translates to mental health practitioners respectfully and compassionately working with persons as they vision a sense of purpose and meaning in their lives. Persons are scaffolded as they grow and develop adaptive strategies to overcome daily adversities (Pulla & Mariscal, 2013; Mariscal, 2014).

Within the contextual perspective of human development, recovery does not discount symptoms, abandon health services or abolish prescribed medication. Recovery, in which thoughts of hope, optimism and agency take center stage, refers to a sense of meaning in life, or “to the person’s ability to lead a satisfactory life despite the symptoms, stigma, trauma, setbacks, loneliness, despair and alienation” (Mariscal, 2014, p. 123). Such efforts work to adapt and/or eliminate risk factors that contribute to escalating mental difficulties, and advance recovery orientated protective factors ensuring widespread adoption of individual-level, interpersonal relationship-level, community-level, and societal-level prevention, intervention and treatment strategies.

Snapshot of Mental Health Issues in Australia

Hungerford et al. (2015) state that it is of huge concern that approximately 45 percent of Australians aged between 16 and 85 will live with a mental health issue at some point in their lives, and that one in five Australian adults will live with a mental illness (Australian Bureau of Statistics, 2013). The Australian Bureau of Statistics (2013) reports that approximately seventy percent of Australians aged eighteen or older have experienced a low level of psychological distress during their lifespan. Furthermore, the National Survey of Mental Health and Wellbeing (ABS, 2007), reports that 7.3 million Australians aged 16-85 years experienced an anxiety, affective, or substance use disorder at some point in their life. Older persons and women were more proactive in accessing mental health support. The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Department of Health, Canberra, 2015) administered in the homes of over 6,300 families with children and/or adolescents aged 4 to 17 years in the 12 months prior to the survey, showed that 560,000 children and adolescents were assessed with mental disorders, including: attention deficit hyperactivity disorder (7.4%), anxiety disorders (6.9%), major depressive disorder (2.8%), and conduct disorder (2.1%). Persons growing up in low-income families, with parents



and carers with lower levels of education and with higher levels of unemployment, were identified with a higher likelihood of being subject to mental health difficulties.

The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Department of Health, Canberra, 2015) reported rates for depression, self-harm and suicidal thinking in adolescents as alarming, indicating approximately one in ten have engaged in self-harming behaviour, with depression being a leading cause of health service attendances for mental health difficulties among young people. Based on self-report data, nearly one in five 16-17 year old females in this survey met the clinical criteria for depression (Second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra, 2015).

In Australia, there is an emphasis on consumer participation in the spectrum of mental health services, which are underpinned by promotion, prevention and early intervention for those experiencing mental health problems (Commonwealth Department of Health & Aged Care, 2000). There are a number of common themes in mental health policy development, and these can be identified by common principles, which include: utilizing primary health care as a site for services, provision of services by a multidisciplinary workforce, inclusion of, and partnerships with, stakeholders, increasing the quantity and quality of services, that policy should be based on principles of consumer and family participation, that it should address social and economic context for mental illness, that recovery should be promoted, and finally that it takes into account the needs of community in terms of culture (Bland, Renouf, & Tullgren, 2009, p. 70).

Services are delivered to consumers from transdisciplinary disciplines, which consist of an extensive range of professions, such as, Social Workers, Counsellors, Psychologists, Indigenous Health Workers, Nurses, Doctors and Occupational Therapists, and from Government Departments, Non-government Agencies and Private Practitioners. Stacey and Herron (2002) define a consumer as “a person utilising, or who has utilised, a mental health service” (Australian Health Ministers, 1998, p. 25). Nurses and doctors tend to be the first point of contact for people experiencing disturbances in thinking, feeling and behaving. Typically they make appropriate referrals to more specialized professionals such as social workers. Social workers operate collaboratively with health practitioners to share joint decision making regarding provision of care for consumers within multi-disciplinary teams. Tensions may exist within these multi-disciplinary teams, between medical (clinical) and social (critical) models of practice (Chenoweth & McAuliffe; Bland, Renouf, & Tullgren, 2009).

Social Work and Mental Health

Mental health practitioners engage with, educate, intervene, support, advocate for, lead-manage, and offer professional services to persons who are experiencing mental difficulties (Hungerford et al., 2015). The aim of this care is to be efficient and effective, and to provide it in ways that promote dignity, respect, and self-determination, in a manner that improves outcomes for the individual. This requires skills in engagement, active listening, empathy, and relationship building as well as an attitude of care, compassion, respect and sensitivity (Hungerford et al., 2015).

Social work plays a significant role within mental health. A social work practitioner works with their clients, promoting personal agency and intentionally working with clients to find meaning and purpose in their lives. This strengths based multidimensional view of mental health (Saint-Jacques, Turcotte, & Pouliot, 2009; Pulla, 2014; Pulla & Francis, 2014) challenges stigmatizing attitudes, embracing a collaborative, comprehensive health approach at different levels of the



ecological system; individuals, relationship, community, and societal. In social work, strength based practice is “principally about enabling people to function autonomously within society, by collaborating with individuals to identify the resources they have available to them to make the changes they would like to make” (Moloney & Francis, 2014, p. 235).

Beginning with the individual, and extending their work across environmental systems, social workers undertake roles in casework, counselling, advocacy, community engagement and development, and social action to address issues at the personal, community and social level. In all contexts, social workers focus on building capacity for health and wellbeing, responding to systematic issues that may impact mental health and wellbeing. Their work encompasses promoting recovery, restoring individual, family, and community wellbeing; and advocating for social justice (AASW, 2014).

National mental health policies and strategies such as the *National Mental Health Plans* (1993 -2014), and the Council of Australian Governments (COAG) National Action Plan on Mental Health (2006, 2011), concentrate on developmentally and culturally appropriate prevention concepts and strategies with the intention of promoting, protecting, and restoring a person’s mental health thus enabling entire communities affected by it. The 2007-2017 Mental Health Plan provides a proposal for mental health reorganisation over the next decade. The plan is supporting the social context of mental health and advancing the principles of social justice (recovery, community health and self-control), which Social Workers advocate strongly for within mental health practice (Bland et al., 2015).

Landscape of social work education in Australia

“The goal of social work education is to provide a rigorous program which results in graduates who are competent, effective, skilled, knowledgeable, ethical and confident practitioners” (ASWEAS 2012,P.6). The Australian Social Work Education and Accreditation Standards (ASWEAS) Sets out The principles, standards and graduate attributes for social work education In Australia. Australian social work education in mental health focuses on issues of social justice and human rights drawing from theories of critical social work, philosophy and critical sociology and in the recent discussion on mental health there is an increased emphasis laid on “the importance of lived experience and the importance of relationship as a basis for change” (Bland et.al, 2015, p.7). The Australian national mental health policy contributed to the foundations for the development of mental health practice standards in 1992. They were influenced by the United Nations Principles for the Protection of Persons with Mental Illness and were underpinned by a strong commitment to human rights, dignity and empowerment (Bland, Renouf & Tullgren, 2015).

In the late 1990s the Australian Association of Social Workers (AASW) introduced mental health practice standards for social workers that were aligned with the national mental health practice standards. Australian Association of social workers developed Standards for social work direct practice, service management, organisational development and systems change, policy, research and evaluation, and education and professional development (AASW, 1999; 2014). These standards applied to all social workers and are aligned with the AASW social work practice standards (AASW, 2013). A review of the teaching of mental health content in the schools of social work (AASW Project team, 2003 cited in Bland et.al 2015) revealed the variations in the way subject content was delivered and hence AASW has set clear guidelines for mental health content in social work curricula as a condition of program accreditation (AASW,2012). These



standards covered attitudes and values, knowledge and skills. This includes knowledge of currently used diagnostic frameworks and treatment approaches and the implications of these, as well as appropriate interdisciplinary service responses (AASW, 2012).

Standards were developed for social work direct practice, service management, organizational development and systems change, policy, research and evaluation, and education and professional development (Australian Association of Social Workers, 1999; 2014). The AASW accredits social work degrees offered by Higher Education Providers (HEP) throughout Australia. The standards are used as the criteria for the accreditation of a professional social work course with the AASW. Social work programs must demonstrate how they assist students to develop a critical analysis, understanding of, and commitment to this definition of social work. Social work programmes must build on existing research to further develop models for assessing competency. In doing so, social work has the opportunity to lead other disciplines in creating a nuanced approach to assessment of learning outcomes.

For a decade there has been an increased emphasis on recovery and the sociological model of understanding, with awareness of course content being delivered in a safe, respectful, caring and compassionate teaching and learning environment. Australian social work education in mental health reflect this emphasis, focuses predominantly on issues of social justice and human rights drawing from theories of critical social work, philosophy and contemporary ideas. The authors contend that while the mental health context is changing the higher education space requires a specific response from teaching academics in social work education. A critical framework is required for developing a mental health curriculum for social work education, the initial step being embracing a humanistic approach to curriculum development in mental health. This need for social work education is very evident both from practice and literature since mental health literacy is fundamental to social work practice. As Bland et.al (2015) explains:

Recent revisions to the education standards that govern the curriculum in Australian schools of social work (AASW, 2012) acknowledge that mental health literacy is fundamental to all social work practice. The argument is that ‘mental illness is ubiquitous’. Put simply means that no matter where social workers choose to practice they will invariably work with people who have mental health problems” (2015, p. 6)

The two themes emerging from the recent development in mental health in recent years are the importance of lived experience of mental illness and the importance of relationship as a basis for change (Bland et al, 2015). While within social work there are debates and competing arguments around the place of social work practice in mental health, Bland et al. (2015) suggest that these binaries (‘Same Vs Different and Critical Vs Clinical’ (p. 5) should be seen more as a framework to focus on work and alerts the practitioners about the need to consider both these dimensions. In this context Morley and Macfarlane (2010) view that there is a “technicist or competency based approach to practice embedded within the AASW mental health curriculum” (p. 49). They also ask “what knowledge, skills and values are actually essential for social work practice in mental health?” (Morley & Macfarlane, 2010, p. 48). This paradigm has major repercussions for practising social workers and social work educators. Morley and Macfarlane (2010) cautions:

If social work educators privilege medical understandings of causation and treatment in curriculum development, more or less consciously marginalising the relevance of issues related to powerlessness, dispossession, poverty, abuse and violence, low-status work and a range of other social oppressions, then who is going to do this important work? (p. 51)



The social work academics at James Cook University Australia (JCU), an Australian university with tropical campuses located in the north of Australia, have intentionally adopted both a clinical and critical model in designing the subject content in social work education in mental health by incorporating current debates and ideas and places great emphasis on both these perspectives. This design is both a blending of ideas and delivery in social work education in mental health which is in fact a response to the call made by several authors cited in this paper. The essence of this integration is captured in the words of Renouf and Bland (2005) “The profession needs to be able to assert with confidence that the core concerns of the social work - human rights, self-determination, family relationships and welfare, employment, housing, community life chance - are central to mental health” (p. 428). The challenge facing these academics is to refresh the existing program and design an innovative program that reflects these core concerns without losing the spirit of the profession. “We are challenged to be clear about what we do and be able to demonstrate the effectiveness of our actions” (p. 428). This process will generate new knowledge and understanding for social work academics in mental health, transforming paradigms and practice that align with deeper levels of student engagement, experience and learning outcomes.

Revise Refresh and Reposition

The development of the social work curriculum emerges in the context of a number of sweeping changes in mental health occurring within social work in Australia. James Cook University Australia has been offering this subject for a decade now with an increased emphasis on recovery and the sociological model of understanding. Social work and mental health subject has been prepared with support and active involvement from consumers, carer’s and practitioners to reflect the current needs of the field. Hence, it offers an introduction to critical, theoretical and applied issues in relation to mental health practice and provides an overview of mental health practice encompassing contemporary debates and outlooks to practice. This course emphasizes social welfare practice, and social justice and human rights approaches to mental health and furthermore the subject is interwoven with an inter-sectoral analysis, including gender, ethnicity and socioeconomic status. It allows students to critically examine the ideas that inform the questions: *What is health? What is mental health?* (Including historical themes, medical models, sociological models, the social construction of madness and the spectrum of interventions for mental health practice). The content also significantly contributes to the student’s understanding of conceptualisations of mental health and mental illness in relation to human rights and social justice with an overview of mental health legislation and the shaping of social policy in relation to mental health in Australia. This critical and practice oriented application of the theories and concepts make this course very unique. “Social work higher education is currently a very dynamic field responding to a variety of pressures from new national higher education policies and international developments, as well as direct demands from a changing human services sector and diverse practicing profession” (Ozanne & Bigby, 2007, p. 4).

As mentioned previously, the mental health context is changing and the landscape requires a specific response to address this reality. We maintain that one of the ways this could be addressed is by educating the students and by creating sound pedagogical changes. In this paper, the authors argue that the current curriculum in mental health needs to be revised in the context of these societal and community changes and the demands placed on the profession. Such an attempt is being made by James Cook University academics to refresh the curriculum by purposefully including elements such as the recovery framework, lived experience, relationship, strengths based models of practice and delineating the binaries etc. discussed in this paper. This repositioned social



work curriculum in mental health can be delivered successfully by adopting a blended learning pedagogy that will enable students studying social work to meaningfully engage with the subject content and develop the understanding, competencies and expertise required to practice as a social worker in the shifting mental health landscape.

This repositioned social work curriculum in mental health is delivered by innovative blended pedagogical practices. This flexible, yet engaging pedagogy has the potential for engaging students with the changing landscapes of mental health nationally and internationally. The social work and mental health subject has been prepared with support and active involvement from consumers, carer's and practitioners to reflect the current needs of the field. Henceforth, it offers an introduction to critical, theoretical and applied issues in relation to mental health practice and provides an overview of mental health practice encompassing contemporary debates and outlooks to practice.

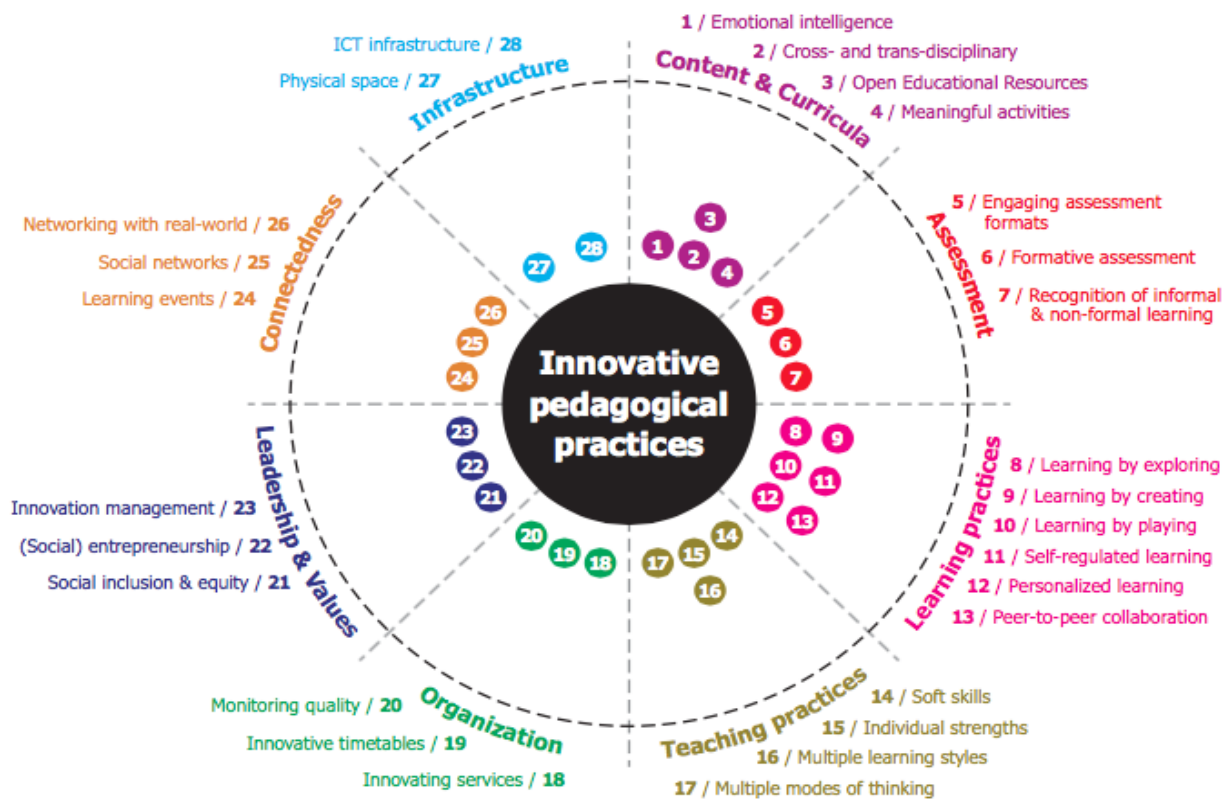
Blended Learning

Blended learning is the intentional systematic integration of face-to-face teaching and learning with the best practices of online, distance and mobile teaching and learning (Bliuc, Goodyear, & Ellis, 2007; Yudko, Hirokawa, & Chi, 2008). The core principles of blended delivery include flexible instruction and learning; face-to-face and online delivery modalities; integrated instructional methods across hybrid contexts; synchronous and asynchronous formats; and partially instructor centred and learner directed spaces (Hamilton & Tee, 2010). Delivered anywhere and anytime, blended learning can incorporate many of the innovative pedagogical practices studied by Johnson, Adams Becker, Estrada, and Freeman (2014) (see Figure 1) in the subject curriculum design. With this creative classroom research model in mind, merit in pedagogy remains a principal predictor of student satisfaction with blended learning (DeBourgh, 2003).

Learning content and acquiring knowledge in blended spaces are constructed and managed within a self-regulated Community of Inquiry (CoI) framework. This structure is "a model devoted specifically to the goal of supporting epistemic engagement" (Shea & Bidjerano, 2010, p. 1722). The goal of the CoI framework is maximising student engagement in order to achieve the highest outcomes. Comprised of social, teaching, and cognitive presence, social presence represents the learner's engagement in synchronous and asynchronous reciprocal interaction. Cognitive presence is the focused construction of knowledge through reflective engagement with the subject content (Garrison, Anderson, & Archer, 2000). Teaching presence involves "the curriculum, approaches and methods; it also moderates, guides, and focuses discourse and tasks" (Garrison & Vaughan, 2008, p. 24). When adopting blended approaches, many of the social work academics at JCU purposefully and systematically create CoI supporting students' active and collaborative engagement with subject material associated with today's social work profession. To ensure evidence best practice, there is an urgent need to align JCU blended standards with the pedagogical practice underpinning the refreshed social work curriculum. This process will assist social work academics strive for continuous improvement through the provision of opportunities to reflect on learning practices which contribute to excellence in blended delivery and improved student outcomes.

Figure 1: Innovative Blended Pedagogical Practices of Blended
Source: Johnson, Adams Becker, Estrada, and Freeman (2014).

Elements of the Creative Classroom Research Model



Conclusion

In this paper we have argued that the mental health and wellbeing landscape is shifting, the social context is going through rapid transformation and the reality of escalating mental health issues is becoming a multifaceted challenge for practitioners. The discussion above reveals that 45 percent of the Australian population is affected by mental health issues in any given year. This is quite alarming both for the practitioners and for academic institutions. Innovative ways of practice and knowing are becoming evident and one is called on to revisit the ideological assumptions, practice frameworks and engagement processes with one's respective service users so that their voice is heard and valued. In this compelling context, there is a greater demand for improved engagement with service users, and in developing a workforce that embraces the spirit of this reality, prepared to be challenged and remain open to be transformed. The ideas discussed in this paper demand attention in the social work higher education curriculum and similarly there is a need to conceptualise innovative ways of engaging with students so that they become more prepared to enter into the work force with "competence, confidence and compassion" (Francis, 2015). Social work higher education has a pivotal role to play in translating these ideas into action and we believe that by introducing a blended pedagogy in mental health education, this can be achieved.



References

- Asher, A. (2001, 29 July). Australia's immigration detention values: Milestones or Motherhood statements? Retrieved from <http://www.ombudsman.gov.au/media>.
- Australian Association of Social Workers. (2012). *Australian social work education and accreditation standards*. Canberra: AASW.
- Australian Association of Social Workers. (2014). Practice standards for mental health social workers. Canberra: AASW. Retrieved from <http://www.aasw.asn.au/document/item/6739>
- Australian Bureau of Statistics (ABS) (2007). The national survey of mental health and wellbeing. Retrieved from www.ncbi.nlm.nih.gov/pubmed/19530016
- Australian Bureau of Statistics. (2013). Causes of death, Australia, 2011. Belconnen, ACT: Commonwealth of Australia. Retrieved March 25, 2014 from <http://www.abs.gov.au/ausstats/abs>
- (See more at: <http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats#sthash.k9ni3IAv.dpuf>)
- Australian Bureau of Statistics (2013). Mental health. Retrieved from <http://www.abs.gov.au/ausstats/abs>
- Australian Government. (2012). *Mental health statement of rights and responsibilities*. Retrieved from <http://www.health.gov.au>
- Australian Government Department of Health. (n. d.). *Fourth national mental health plan. An agenda for collaborative government action in mental health, 2009-2014*. Retrieved from <http://www.health.gov.au>
- Australian Government. (2007). *What is mental illness?* Retrieved from <http://www.health.gov.au>
- Bannink, F. (2006). 1001 solution-focused questions. Handbook for solution focused interviewing (2nd ed.). New York: W.W. Norton & Company.
- Bland, R., Renouf, N., & Tullgren, A. (2009). *Social work practice in mental health: An introduction* (2nd ed.). Crows Nest, NSW, Australia: Allen & Unwin.
- Bliuc, A., Goodyear, P., & Ellis, R. (2007). Research focus and methodological choices in studies into students' experiences of blended learning in higher education. *Internet and Higher Education*, 10, 231-244.
- Burton, L., Westen, D., & Kowalski, R. (2009). *Psychology* (2nd ed.). Australia: John Wiley & Sons Australia, Ltd.
- Canadian Mental Health Association. (n. d.). The relationship between suicide and mental health. Retrieved November 29, 2012 from <http://www.ontario.cmha.ca>
- Cala, V. C., & Soriano, E. (2014). Health education from an ecological perspective: Adaptation of the Bronfenbrenner model from an experience with adolescents. *Procedia - Social and Behavioral Sciences*, 132, 49-57. doi:10.1016/j.sbspro.2014.04.277
- Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect.



- Children and Youth Services Review*, 26(11), 1097-1113. doi:10.1016/j.chilyouth.2004.08.008
- DeBourgh, G. (2003). Predicators of student satisfaction with distance-delivered graduate nursing courses: what matters most? *Journal of Professional Nursing*, 19(3), 149-163.
- Department of Immigration and Border Protection, *Immigration Detention and Community Statistics*).
- Dudgeon, P., Walker, R., Scrine, C., Shepard, C., Calma, T., & Ring, R. (2014). Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander People. *Closing the Gap Clearinghouse*, 12. Retrieved from www.aihw.gov.au/closingthegap
- Erford, B. (2015). *Clinical experiences in counseling*. New Jersey: Pearson.
- Francis, A. P., Pulla, V., Clark, M., Mariscal, E. S., & Ponnuswami, I. (2014). *Advancing social work in mental health through strengths-based practice*. Brisbane, Australia: Primrose Hall Publishing Group.
- Francis, A. (2015) *The social worker as a multidisciplinary team member: Embedding the 3 C's (competence, confidence and compassion) in social work education in mental health*. SWSO 2015, Conference paper presented at East London, South Africa.
- Garrison, D. R., & Vaughan, N. D. (2011). *Blended Learning in Higher Education : Framework, Principles, and Guidelines*. Retrieved from <http://jcu.ebib.com.au/patron/FullRecord.aspx?p=819029>
- Gehart, D. (2014). *Mastering competencies in family therapy. A practical approach to theories and case documentation* (2nd ed.). Belmont, CA: Brooks/Cole.
- Grant, J., & Cadell, S. (2009). Power, pathological worldviews, and the strengths perspective in social work. *Families in Society*, 90(4), 425-430. doi:10.1606/1044-3894.3921
- Hoge, C. W., Milliken, C. S., & Auchterlonie, J. L. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Jama*, 295(9), 1023-1032. doi:10.1001/jama.295.9.1023
- Hungerford, C., Hodgson, D., Clancy, R., Monisse-Redman, M., Bostwick, R., & Jones, T. (2015). *Mental health care: An introduction for health professionals in Australia* (2nd ed.). Milton, Australia: John Wiley & Sons, Australia.
- James Cook University Australia. (2015). *Blended Learning Policy*. In J. C. U. Australia (Ed.). Retrieved from <https://www.jcu.edu.au>
- Johnson, L., Adams Becker, S., Estrada, V., Freeman, A. (2014). *NMC Horizon Report: 2014 Higher Education Edition*. Austin, Texas: The New Media Consortium.
- Jose, S., & Vijayalekshmi, V. (2014). Community mental health: A case study of the Dmphi-Trivandrum Kerala, India. In A. Francis, V. Pulla, M. Clark, E. Mariscal, & I. Ponnuswami (Eds.), *Advancing social work in mental health through strengths-based practice* (pp. 485-516). Brisbane, Queensland: Primrose Hall Publishing Group.
- Kruger, A., & Francis, A. (2014). Findings alternative narratives using strength based approaches in addressing mental health concerns of families and children in clinical practice. In A. Francis, V. Pulla, M. Clark, E. Mariscal, & I. Ponnuswami (Eds.), *Advancing social work in mental health through strengths-based practice* (pp. 253-280). Brisbane, Queensland: Primrose Hall Publishing Group.
- Lawrence, D., Johnson, S., Hafekost, J., Boterhoven, De Haan, K., Sawyer, M., Ainley, J., &



- Zubrick, S. R. (2015). *The mental health of children and adolescents. Report on the second Australian child and adolescent survey of mental health and wellbeing*. Canberra: Department of Health.
- Mariscal, I. (2014). The strengths perspective and the strengths model of case management: Enhancing the recovery of people with psychiatric disabilities. In A. Francis, V. Pulla, M. Clark, E. Mariscal, & I. Ponnuswami (Eds.), *Advancing social work in mental health through strengths-based practice* (pp. 118-176). Brisbane, Queensland: Primrose Hall Publishing Group.
- Martin, G., Swannell, S., Harrison, J., Hazell, P., & Taylor, A. (2010). The Australian national epidemiological study of self-injury (ANESSI). Brisbane, QLD: Centre for Suicide Prevention Studies. Accessed November 23, 2012 from <http://www.suicidepreventionstudies.org>
- Martin, G., Swannell, S. V., Hazell, P. L., Harrison, J. E., & Taylor, A. W. (2010). Self-injury in Australia: A community survey. *Medical Journal of Australia*, 193(9), 506-510.
- McEvoy, P. M., Grove, R., & Slade, T. (2011). Epidemiology of anxiety disorders in the Australian general population: Findings of the 2007 Australian national survey of mental health and wellbeing. *Australian and New Zealand Journal of Psychiatry*, 45(11), 957-967. doi:10.3109/00048674.2011.624083
- Miller, W., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: Guilford.
- Minino, A., Xu, J., & Kochanek, K. (2010). Deaths: National vital statistics reports, 59(2). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_02.pdf
- Moloney, G., & Francis, A. (2014). 'Recognizing the blind spot': An edge for growth and transformation through strengths-based supervision. In A. Francis, V. Pulla, M. Clark, E. Mariscal, & I. Ponnuswami (Eds.), *Advancing social work in mental health through strengths-based practice* (pp. 227-252). Brisbane, Queensland: Primrose Hall Publishing Group.
- Morley, C. & Macfarlane, S. (2010). Repositioning social work in mental health: Challenges and opportunities for critical practice. *Critical Social Work*, 11(2), 46-59.
- Onken, S. (2014). Realizing recovery: A strengths based practice framework. In A. Francis, V. Pulla, M. Clark, E. Mariscal, & I. Ponnuswami (Eds.), *Advancing social work in mental health through strengths-based practice* (pp. 145-176). Brisbane, Queensland: Primrose Hall Publishing Group.
- Ozanne, E., & Bigby, C. (2007). Social work in higher education. *Australian Social Work*, 60(1), 1-4. doi:10.1080/03124070601177965
- Petrakis, M. (2014). Implementing the strengths model in a clinical mental health setting. In A. Francis, V. Pulla, M. Clark, E. Mariscal, & I. Ponnuswami (Eds.), *Advancing social work in mental health through strengths-based practice* (pp. 517-545). Brisbane, Queensland: Primrose Hall Publishing Group.
- Pulla, V. (2014) Strengths based perspectives in mental health. In A. Francis, V. Pulla, M. Clark, E. Mariscal, & I. Ponnuswami (Eds.), *Advancing social work in mental health through strengths-based practice* (pp. 54-77). Brisbane, Queensland: Primrose Hall Publishing Group.
- Pulla, V., & Francis, A. (2014). A strengths approach to mental health. In A. Francis (Ed.), *Social work in mental health: Contexts and theories for practice*. New Delhi, India: Sage
- Queensland Government. (2008). *Queensland plan for mental health 2007-2017*. Brisbane: Queensland Government. Retrieved from: www.health.qld.au/mentalhealth



- Rapp, C., & Goscha, R. (2011). *The strengths model: A recovery-orientated approach in mental health services*. Oxford University Press.
- Renouf, N., & Bland, R. (2005). Navigating stormy waters: Challenges & opportunities for social work & mental health. *Australian Social Work*, 58(4), 419-430.
- Rosa, E. M., & Tudge, J. (2013). Urie Bronfenbrenner's theory of human development: Its evolution from ecology to bioecology. *Journal of Family Theory & Review*, 5(4), 243-258. doi:10.1111/jftr.12022
- Saint-Jacques, M., Turcotte, D., & Pouliot, E. (2009). Adopting a strengths perspective in social work practice with families in difficulty: From theory to practice. *Families in Society*, 90(4), 454-461.
- Saleebey, D. (1996). The strength perspective in social work practice: Extensions and cautions. *Social Work*, 41(30), 296-306.
- Saleebey, D. (2013). (Ed.). *The strengths perspective in social work practice* (6th ed.). Upper Saddle River, Pearson.
- Shea, P., & Bidjerano, T. (2012). Learning presence as a moderator in the community of inquiry model. *Computers & Education*, 59(2), 316-326. doi:10.1016/j.compedu.2012.01.011
- Smith, B., Tang, D., & Nutbeam, D. (2006). WHO health promotion glossary: New terms. *Health Promotion International*, 21(4), 340.
- Stacey, K., & Herron, S. (2002). Enacting policy in mental health promotion and consumer participation. *Australian e-Journal for the Advancement of Mental Health*, 1(1), 49-65.
- White, F., Hayes, B., & Livesey, D. (2016). *Developmental psychology. From infancy to adulthood* (4th ed.). Melbourne: Pearson.
- World Health Organization. (1946). Preamble: Constitution of the World Health Organization. Retrieved from <http://www.who.int>
- World Health Organization. (2013). Mental health action plan 2013-2020. Retrieved from <http://www.who.int>
- World Health Organization. (2012). Depression [Fact sheet No. 369]. Retrieved from <http://www.who.int>
- World Health Organization. (2015). Mental health and older adults [Fact sheet No. 381]. Retrieved from <http://www.who.int>
- Yudko, E., Hirokawa, R., & Chi, R. (2008). Attitudes, belief and attendance in a hybrid course. *Computers & Education*, 50(4), 1217-1227.



International Journal of Innovation, Creativity and Change. www.ijicc.net
Volume 2, Issue 3, May 2016



International Journal of Innovation, Creativity and Change. www.ijicc.net
Volume 2, Issue 3, May 2016