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## MAD STUDIES IS MADDENING SOCIAL WORK

### Abstract

This article explores the role and place of mad studies within social work theory, education, and practice. This includes a discussion of the role social workers have played in the past and continue to play in the present in relation to oppressive practices within mental health services; a role that includes serving as passive assistants to biogenetic psychiatric expertise and a turning away from the profession's social expertise, all to the detriment of mad people. The interconnection between racism, colonialism, imperialism and psychiatrization is then discussed as it relates to the current treatment of mad people of colour within European and white settler state contexts. This is followed by a discussion of the potential contribution of mad theory to social work education and practice. Repositioning social workers as embracing their social expertise, a call towards developing a more thorough social justice leadership in mental health is explored. Mad studies, existing at the edges of transdisciplinary theoretical and methodological understandings, offers a potential in social work for fundamentally anti-oppressive, anti-sanist and anti-racist approaches to service provision. In effect, this article engages in the maddening of social work, through the incorporation of mad studies into critical social work theory, education, and practice.

**Key words:** mad studies, mad theory, social justice, maddening social work, epistemic justice

### Introduction

This article is an introduction to mad studies and the maddening of social work. However, we do not write this as experts in mad studies. Mad studies is now an emerged field which has evolved and continues to evolve mainly out of collaborative conversation within mad communities (LeFrançois 2015; Gorman, LeFrançois 2018), and as such, no one person, group of persons or particular community owns or may claim authority over it (Costa 2014). Instead, we write this article as activist scholars who feel strongly that the time has come – or perhaps is long overdue – to madden social work (Poole

*et al.* 2012). With this lens and positioning always in mind, we explore the role and place of mad studies within social work theory, education, and practice.

What follows is a discussion of the role social workers have played in the past and continue to play in the present in relation to oppressive practices within mental health services. This is a role that includes one of subservience to psychiatric authority and biomedical-informed diagnoses, interventions, and treatments. As we will argue, this role as passive assistants to biogenetic psychiatric expertise and the turning away from *social* work expertise (LeFrançois *et al.* 2016) is all to the detriment of those who have been deemed mad and who are under the (psychiatric) social worker gaze within mental health services, or related services within the psy-complex (LeFrançois 2013; Gorman, LeFrançois 2018; LeFrançois, Voronka 2022). Mad studies, existing at the edges of transdisciplinary theoretical and methodological understandings, offers a potential in social work for fundamentally anti-oppressive, anti-sanist and anti-racist approaches to service provision. In effect, mad studies puts the 'social' back into mental health social work. As such, we discuss here the developments, achievement, challenges and question the possibilities of mad studies within social work.

Before proceeding, however, it may be helpful for readers who are unfamiliar with mad studies to discuss the terminology we use in this article. To refer to those who have been psychiatrized as 'mad' or to discuss the intense and/or varied emotions, thoughts, actions, crises, problems in living, behaviours and alternative experiences of reality as 'madness' may be read as offensive by some. Indeed, this terminology may even invoke anger or distress in some, including mental health professionals, sane-identified people as well as by some who have been psychiatrized. These strong reactions are often connected to the terms 'mad' and 'madness' having been used historically as derogatory identifiers, as well as their association with the asylums of old, for example Bedlam in England (Porter 2003; Lawrence 2018) or the Toronto Hospital for the Insane in Canada (Reaume 2009). That being the case, why do we use this terminology within mad social movements and within mad studies? For the most part, these terms are being used to make a political statement, including the marking of these terms as reclaimed by those who have been most harmed by them when uttered by sanists (Fabris 2011, 2013; Poole *et al.* 2012; Meerei *et al.* 2016). The term 'Mad', in particular has been reclaimed perhaps similar to the term 'queer', and both 'queer' and 'Mad' when uttered in spaces where they are usually only used pejoratively, grab attention and invoke the type of intense reactions that allow for politicized discussions and consciousness raising to take place. Hence, the use of this terminology is a strategy of social justice.

However, we also want to make clear that when mad people take on this politicized terminology, it is not about pointing to or claiming an essentialized identity, nor is there such a thing as a 'representative' mad person (Donskoy 2015). Instead, 'mad' and 'madness' are taken on in heterogynous ways. To attempt to reduce all of the ways in which we make sense of our experiences into one fixed category and/or term, we risk masking the variances that our bodies carry, how we experience madness, and how mental health services respond differently to certain bodies and minds (Voronka

2016). Simply put, people use “M/mad” to mean different things and to perform certain actions, including destabilizing identity categories. For example, some people write the term ‘Mad’ with a capital ‘M’, some people write the word ‘mad’ with a small ‘m’. Those denote differences in terms of how the term is understood and the meanings being placed on it. The capitalized term ‘Mad’ usually denotes a more politicized notion of the ways of which mad subjects have been oppressed historically and into the present. Some people use the term “mad” to talk about alternative experiences of reality, or distress or euphoria or other unusual or intense experiences that have been pathologized; they may be using the term ‘mad’ to refer to those actual experiences. Some people use the term mad instead to suggest that they do not believe there is something about their thoughts, behaviours or feelings that actually can or should be deemed mad, so the usage may be in some ways seem contradictory. However, what that argument suggests is that all thoughts, feelings, and behaviours form part of a range of experiences that constitutes what it means to be human (Burstow 2013; Coppock, LeFrançois 2014) or sentient, and therefore we should not categorize or dichotomize some people as ‘crazy’ or ‘abnormal’ and others as ‘normal’. Gorman (2013: 277) adds to this argument that mad people of colour, in particular, are likely to refer to these experiences as “just life.” Fabris (2013:139) makes the following observations about the meanings contained in the terms ‘madness’, ‘Mad’, and ‘mad’:

For me “madness” is just “sound mind” (i.e., these divisive terms are false, and if anyone wishes to they could rationalize or understand any other person). I propose the proper noun “Mad” to mean the group of us considered crazy or deemed ill by sanists (who create these categories through an interpreting “stare”: Fabris, 2011) and are politically conscious of this. Thus, “Mad” is a historical rather than a descriptive or essential category, proposed for political action and discussion.

Fabris (2013: 139) further distinguishes the use of the term ‘mad’ thus:

Unlike my term “Mad”, this word [“mad”] in lower case is used by many activists and writers, often as a more general or social term (and therefore a claimable word, as in “queer” or “Queer” theory) to describe or reclaim experiences that clinicians dubiously identify as symptoms of a theoretical “mental illness” or “mental disorder”.

For those readers who are new to mad studies, and who have no experience interacting with mad people or mad social movements, the different ways that people use this terminology may be confusing. However, the context of what is being said may often help in appreciating the ontological assumptions of the speaker and the meaning(s) they are placing on the words they choose to use. For this reason, it is important to keep in mind the heterogenous nature of the claiming of mad as an identifier and the reclaiming of the terms ‘mad’ and ‘madness’. Again, Mad identity itself cannot be essentialized and the danger is that outsiders may find it easier to comprehend by engaging in such essentialism. As in Mills and LeFrançois (2018: 520), we use the terms ‘mad’ and ‘madness’

in this article “as reclaimed signifiers and as concepts that unsettle, contest and challenge normalcy and biological reductionism”.

## The Emergence of Mad Studies

Mad studies has emerged primarily from within mad communities, which comprises or has evolved from several social movements, including the psychiatric survivor movement, the ex-patient movement, and other politicized movements organizing around the experiences of psychiatric oppression (Diamond 2013). Mad movements are usually characterized by activism, but also by research and alternative practices which often include mutual aid. What these communities have in common is the experience of their members having been deemed mad, having experienced oppression within mental health services and, to varying degrees, contesting both psychiatry and psychiatrization. From these grassroots movements, and with a strong influence from critical disability studies, several members of the mad community in Toronto in conversation with each other (Gorman, LeFrançois 2018; LeFrançois, Peddle 2022) discussed the need for a field of study – mad studies – that would be separate from disability studies, and that would exist not just in academia but would also be immersed within community.

Although the naming of ‘mad studies’ took place over a decade and half ago, the actual intellectual work, alternative interventions and activism has a long history in Canada as well as within other spaces around the world, reaching at least as far back as the 1970s<sup>1</sup> (Beckman, Davies 2013; Davies, MPA Documentary Collective 2013). There are numerous examples of psychiatric survivors, for example, engaging in mutual support, researching what was happening to each other and theorizing their experiences (Chamberlin 1978; Rose *et al.* 1998a, 1998b; Beckman, Davies 2013). By this, we are not referring to the consumerist notion of services users ‘having a voice’ or service user involvement initiatives that lead to tokenism (Armstrong, LeFrançois 2022). Nor are we referring to people deemed mad being asked to narrate their experiences for public consumption as “disability tourism” or “patient porn” (Costa *et al.* 2012: 94; Voronka 2019). Instead, we are referring to the theorizing of experiences and the developing of interventions that are both about supporting each other as well as educating others around issues of psychiatric oppression. This is a crucial point of distinction that relates directly to epistemic justice (LeBlanc, Kinsella 2016). That is, typically within psychiatry there is a form of epistemic injustice that takes place where people who have been deemed mad are understood and treated as not being knowledgeable (Donskoy 2015),

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<sup>1</sup> This is to say that collective activism against psychiatric oppression and the forming of mad social movements can be traced back to 1970–1971 in Canada with the emergence of the Mental Patients Association (MPA) in Vancouver. Such communities may have formed earlier throughout history, however, if so, they remain undocumented or otherwise erased. There is, however, an even longer history of individual activism against psychiatric oppression by patients and ex-patients that dates back centuries (see LeBlanc, St-Amand 2013; Burstow 2015).

of not being knowledge holders (Liegghio 2013), unless the knowledge that is conveyed is wholly consistent with psychiatric understandings. Conversely, in mad studies, we are centering and valuing the knowledge(s), in its many forms, that is emanating from mad communities and people who have been deemed mad.

In suggesting that we need mad studies in universities – an academic discipline that takes place in the community as well as in academia – and, as we bring in mad community knowledge(s), we do so by deconstructing what is considered to constitute knowledge and widening that which is allowable (Mills, LeFrançois 2018). In doing so, we start to breakdown longstanding enlightenment notions of rationality as well as racist and sanist understandings of Reason (Bruce 2017, 2021) that has not only underpinned most knowledge within academia but has also aggressively barred alternative knowledge constructions. With this in mind, mad studies in academic and professional places opens space to “resist normalcy and disrupt the dominant sanist and racist definitions of madness” (LeFrançois, Voronka 2022: 2). It challenges, calls out, and disrupts the very processes of knowledge production that aim to contain, cure, and profit from those deemed mad (LeFrançois, Voronka 2022).

## Why Mad Studies?

Some readers may be asking, *but why mad studies?* Why might it be necessary to have a field of study that centers the understandings of those deemed mad? Why would social work be interested in such knowledge and understandings? Given social work’s commitments to anti-racism and anti-oppression, it becomes of utmost importance that there is an awareness that many service users experience mental health services as oppressive and violent (Fabris 2011; Kanani 2011; Poole *et al.* 2012; LeFrançois 2013; LeFrançois *et al.* 2013; Liegghio 2013; Voronka 2013; Shimrat 2013; Ben-Moshe *et al.* 2014; Burstow *et al.* 2014; Donskoy 2015; LeBlanc, Kinsella 2016; Russo, Sweeney 2016). That being said, there are some people that indicate that psychiatrization and psychiatric drugs help them, and there are even some people that feel that electroshock does improve their mood, despite any permanent memory loss that might be associated with it (Fabris 2011; Weitz 2013; van Daalen-Smith *et al.* 2014; Healy 2016). There are some positive experiences indicated by a minority of people in the psychiatric system. Yet, it is these stories of the few that tend to get a platform in the media and within other venues provided by the psychiatric system (Costa *et al.* 2012; White, Pike 2013; Wipond, 2013, 2023), all at the expense of those who have been harmed. Ignored by the neoliberal status quo within mental health services and hidden from mainstream media are the many others who have very different stories to tell about their experiences and who theorize the harms caused by psychiatric diagnoses and interventions both inside and outside hospitals (see, for example, Stastny, Lehmann 2007; Russo, Sweeney 2016; Green, Ubozoh 2019; Luongo 2021; Wipond, 2023, to name a few). Thus, mad studies offers a platform to start to deconstruct the violence within mainstream mental health services as well as finding

ways to acknowledge existing alternatives and create new ones that are neither violent nor oppressive (see, for examples, Russo, Sweeney 2016). Moreover, mad studies, with its roots in critical disability studies, offers a platform to begin accepting (mad) peoples' differences in a way that does not pathologize and individualize experiences. Distress, euphoria, and other altered states of mind are pathologized as 'symptoms' within mental health services, whereas within mad social movements these experiences are instead mostly understood as existing within the range of thoughts, feelings and behaviours that make up what it is to be sentient, or in Gorman's (2013) terms what is 'just life'. In addition, this range of thoughts, feelings and behaviours may be experienced on a continuum from very positive to deeply disturbing and painful, rather than being always understood, as in psychiatry authority, as wholly negative and needing eradication through any means.

## Deconstructing Biomedicalism in Psychiatric Social Work

Not only is this range of sentient experiences pathologized in people within mental health services but they are also individualized by understanding the source of the 'symptoms' as emanating from within the biochemistry of mad bodies and minds. That is, the etiology of psychiatric disorders is *theorized* within the biomedical model as chemical and hereditary in nature. This theory elaborates the belief that the 'problem' is to be found within our individual brains, within our genes, within our biochemistry. Individualizing the 'problem' thus, reproduces neoliberal and capitalist agendas (Cohen 2016) in allowing the violences that take place in the real world to be ignored. Our distress and altered states that may result from real outside world experiences such as, for example, systemic racism, colonialism, child abuse, transphobia, environmental degradation, alienation, rape, dis/ableism, dispossession/occupation, intimate partner abuse, war, homophobia/heterosexism, inequitable labour practices, sexism, forced migration, un(der)employment, islamophobia, poverty, ageism, hunger, and shrinking or non-existent welfare provisions, amongst other violences. And yet, these real world violences are individualized instead, pointing the finger at brains, genes and biochemistry rather than at the capitalist greed and other neoliberal and/or socially unjust currents that provoke these forms of violence. In effect, this is the 'broken brain' model that is used in psychiatry and that is so aptly described by Indigenous scholars Chrisjohn, McKay and Smith (2017) as both racist and perpetuating colonial myths, whilst obscuring what is often state-sanctioned and capitalist-driven violence. We cover up and move our attention away from structural and systemic madness-provoking social injustices by narrowing our gaze microscopically onto individual brains, synapses, receptors, bodily chemicals and genes.

But what of respect for psychiatric expertise and medical authority? Aren't 'mental illnesses' known to be caused by chemical imbalances in the brain and genetics? In actual fact, despite much research having been conducted in order to confirm the role of chemicals, the medical research community concluded, some time ago, that the chemical

imbalance theory of mental illness is not tenable (Lacasse, Leo 2005; Moncrieff 2009). That is, after vast amounts of research funding (mostly provided by the pharmaceutical industry but also from government grants) being used to produce research to confirm this theory, it has been concluded by the psychiatric profession itself that the theory that an imbalance of certain chemicals in the brain are the cause of ‘mental disorders’ is wrong. Indeed, Pies (2011: 186) a mainstream psychiatrist, quite bluntly states that “(i)n truth, the ‘chemical imbalance’ claim was always a kind of urban legend – never a theory seriously propounded by well-informed psychiatrists”. Despite this acknowledgement from the profession of psychiatry itself, many individual psychiatrists in practice continue to tell their patients that they have a chemical imbalance in their brains that is making them ‘mentally ill’. Why might this be the case? This is a question that has not been adequately addressed in the research literature, so it is not entirely clear why this misinformation continues to be given by mental health professions (including social workers) to mad people on hospital wards, in clinics and in other community mental health settings. Anecdotally, some psychiatrists have admitted<sup>2</sup> that the practice continues for two main reasons, either: a) their colleagues haven’t read any of the literature, and do not realize the medical community is no longer accepting this theory of a chemical imbalance; or, b) other colleagues are well aware that the theory has been discounted but they believe the chemical imbalance claims nonetheless provide for an easy explanation for patients that increase their compliance with treatment. Indeed, this is something that psychiatrists have freely acknowledged: using the language of ‘chemical imbalances’ at least suggests to patients that psychiatrists know what they are doing (Whitaker, Cosgrove 2015). Despite the lack of evidence, it has become biomedical rhetoric that justifies psychiatric intervention and drug treatment as valid medical practice. In 2010, psychiatrist Daniel Carlat declared:

I say that [“chemical imbalances in the brain”] not because I really believe it, because I know that the evidence isn’t really there for us to understand the mechanism. I think I say that because patients want to know something, and they want to know that we as physicians have some basic understanding of what we’re doing when we’re prescribing medications. And they certainly don’t want to hear that a psychiatrist essentially has no idea how these medications work (Cohen 2016: 61).

Further, Moncrieff (2009) points out claims by psychiatrists that chemical imbalances, and subsequent psychopharmaceutical interventions as effective treatment, are moral judgements rather than being evidence-based and are made to control patient behaviour into compliance. That is, mad people in the mental health system are seen as more likely to agree to take their psychiatric drugs if they believe they have a chemical imbalance in their brains and that the drugs will rectify that imbalance. If there wasn’t a chemical imbalance, what would motivate anyone to take the pills? However, to falsely claim that a patient has a chemical imbalance in their brain is contrary to medical ethics. It is

<sup>2</sup> Based on a confidential conversation with a group of psychiatrists.

a form of violence that is blatant dishonesty, and another form of psychiatric coercion used to gain (uninformed) consent to treatment from patients. If, however, it is simply a matter of the individual psychiatrist being uninformed, that too represents unethical practice as all medical practitioners are expected to remain abreast of what is generally accepted knowledge in their professions. When social workers repeat this chemical imbalance claim, they too are engaging in unethical practice that is also based on either dishonesty or ill-informed subservience to psychiatric judgement.

Similarly, it is also often claimed that ‘mental illnesses’ are genetic. However, the medical research community has not demonstrated this to be the case either. That is, there is no scientific proof that genes or hereditary factors play a role in causing mental disorders. Massive amounts of research have been undertaken over the past 50 years or so (Breggin 2014), and yet, no single gene or cluster of genes has ever been shown scientifically to cause any specific mental disorder in the DSM. So how is it that “the biomedical model understands experiences of madness and distress as the result of brain dysfunction or genetics that should be chemically or surgically treated” (Russo 2018: 6)? “Even the Chair of the task force responsible for producing the Diagnostic and Statistical Manual of Mental Disorders...has confirmed that no biomarkers of any single psychiatric diagnosis have been identified” (Russo 2018: 12). Despite this, we have a system with the frontline of treatment being psychiatric drugs (Breggin 2014; Mills 2014) and electroshock (van Daalen-Smith *et al.* 2014), which is completely ideologically locked into a biomedical explanation of people’s experiences, and hence, biomedical forms of treatment. Moreover, prevailing biomedical interventions neglect to consider that these ‘treatments’ not only affect people’s minds and bodies, but also influence their entire lives and shape their identities (Russo 2018), including how they are understood and treated by others both within and outside of medical and inter-related systems. This is experienced as oppressive for many people.

## **Psychiatric Social Work, Neocolonialism and Racism: Toward an Anti-Racist Praxis**

Modern psychiatry developed in conjunction with modern colonialism, and the two are intrinsically intertwined with commitments to scientific racism. Kanani (2011) highlights the ways in which the intersectional social construction of race and madness has significantly shaped the lives of racialized people with psychiatric histories. Constructions of psychiatry as an objective and scientific discipline has been “the key to its ability to maintain power over Indigenous and non-Western understandings of mental health” (Kanani 2011: 3). This has allowed psychiatry to exert control over people who display behaviour deemed deviant and/or abnormal at the same time as reproducing colonial logics of white supremacy. Moreover, the use of psychiatry as a means of maintaining social order is also apparent when considering the experiences of black people, where racist stereotypes continue to lead to black service users being seen and treated as more



dangerous than other patients, and subjected to more coercive, involuntary, and invasive treatments (Kanani 2011; Keating 2016).

We also know that the sexual abuse of racialized inmates occurs in psychiatric inpatient facilities. As Williams *et al.* (2001) highlight, the sexual assault and rape of (racialized) women incarcerated in psychiatric facilities are usual occurrences with low rates of reporting or investigations and few consequences for the perpetrators. Epistemic injustice ensures people who are deemed mad are less likely to be believed by hospital administrators or staff and the police when reporting being raped, whether the rape was committed by another patient, a nurse, a social worker, an orderly or a psychiatrist. Instead, patient disclosures are interpreted as suspect, 'manipulative,' untrue or 'confused,' especially for those diagnosed with personality disorders or psychotic disorders. Black, Indigenous women, trans or gender-nonconforming service users of colour may be treated with even greater suspicion. This form of violence – being disbelieved and dismissed as 'mad' and 'lacking insight' – is a form of sanist violence that is rampant in psychiatric wards, outpatient clinics and within the general public. This form of violence is perpetuated by social workers, and, for this reason, the profession must become accountable for its interconnectedness with psychiatric oppression and its bolstering of sanism in these contexts.

It is important to understand that racism and psychiatric oppression cannot be separated and, in order to engage with mad theory, we must always and already incorporate an understanding of racism and anti-black sanism (Meerei *et al.* 2016). In this way, mad theory allows social work to simultaneously address sanist violence and racist violence being enacted on mad bodies and minds. White social workers in settler colonial states must remain accountable to social work's historical role in colonial violence and engage in decolonial practices, given the ways in which white supremacy and settler logics continue to dominate the treatment of Black, Indigenous and service users of colour. So, too, white readers from European countries must acknowledge and remain accountable to the role played by their country in advancing colonialism and imperialism, whilst combating the racist logics that informed those practice. This remains of crucial importance given the ways that previously colonized people who are now living in European countries are overrepresented in the most intrusive and involuntary forms of treatment (Care Quality Commission 2011, 2022), representing neocolonial violence enacted on racialized bodies and minds in European countries.

## **Mad Theory, Maddening Social Work Education and Practice**

For the most part, university education within the helping professions, including social work, adheres to a top-down approach to teaching from the perspective of professional

understandings of mad people's experiences, using the DSM or ICD<sup>3</sup>, rather than learning from the people who have had those experiences firsthand. Incorporating mad knowledge and mad theory into social work education means giving students the opportunity to learn from those who have been psychiatrized, those who have witnessed and experienced psychiatric oppression and anti-black sanism. Mad studies in social work is about becoming emersed in mad theory and mad perspectives, rather than trying to 'save' or 'fix' mad people. Students are asked to imagine how they will incorporate this new learning from mad perspectives into practice once they graduate, given the constraints of current biomedical dominance. Students are challenged to envision social work practice that is anti- sanist and anti-racist (MacPhee, Wilson Norrad 2022). In response, students in mad studies courses are igniting class discussions with extraordinary ideas about revisioning practice for social workers in various mental health settings.

Most typically, social work practice in mental health exudes a level of paternalistic domination, shrouded in benevolence (Gebhard *et al.* 2022); ultimately the social work role in mental health is one of social control enforcers. Brown (2021: 648) asserts that often, social workers are "compliant to the values of neoliberalism" and its constructions of mental health, as they are expected to "accept and support the biomedicalization, pathologization, individualization, responsabilization, and privatization of services". Essentially, social workers are active participants in the very services that are ultimately experienced by people as oppressive in a context of an increasing authority of biomedicalism and neoliberal policy regimes (Brown 2021). Thus, the concern is the ways in which social work has become disconnected from its roots in social justice, and its narrow role within an oppressive mental health system. Furthermore, the specific impact of neoliberal restraint on social justice in mental health services has pressured social workers to adopt medicalized, short-term, strategies under efficiency-based models legitimized by claims of "evidence based" practice. Beresford (2018: 17) suggests a "necessary rupture" from the biomedical model and an incorporation of other understandings and disciplines beyond medical dominance. Incorporating mad theory, and centering the knowledges of those deemed mad, into social work practice is a way to disrupt this neoliberal trend, nurture the 'necessary rupture' and reintroduce a social justice praxis.

Those who have experience within mental health systems have invaluable insights despite sanist stereotypes of mad people lacking any insight whatsoever. Indeed, mad knowledge can be crucial in providing perspectives that challenge the narrative surrounding madness. Mad knowledge can teach us a lot about human experience and how to support persons experiencing distress or crises, if they require support at all. Mad theory acknowledges and values mad people's experiences and does not deny, but rather, believes them when they disclose being harmed within mental health services.

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<sup>3</sup> The DSM is the Diagnostic and Statistical Manual of Psychiatric Disorders, published by the American Psychiatric Association. ICD is the International Classification of Diseases and Related Health Problems, published by the World Health Organization.

Therefore, using a Mad theoretical lens within social work practice is to believe, value, and acknowledge the stories, descriptions and analyses that people provide. This is particularly important because people may experience crises, alternative experiences of reality or extreme states of mind that may seem unusual and unbelievable, and it may be difficult for others to acknowledge and understand. Mad methodology suggests that there is a way of acknowledging that someone is suffering and has been harmed even if you cannot fully 'make sense' of what it is they have experienced. Mad theory is a kind of 'knowing' that starts with mad people and mad communities. In social work, learning from services users has always been an important value, and we argue here that it must be extended to service users who have been deemed mad, opening up a willingness to grapple with and learn from epistemes that may be hitherto unknown and perhaps even disturbing.

Arguably, being a genuine leader in social justice as a social worker means being able to take a back seat, learn from people, and engage in helping activities that people are asking for help with. We argue here that social workers must take a stance of humility and sincerely open up to learning from those who have been marginalized, including those who have been deemed Mad and labelled as incompetent (Cranford 2022). Moving beyond sanist stereotypes of incompetence, we must embrace epistemic justice (LeBlanc, Kinsella 2016), where people who have been deemed mad are honored for their experience, expertise, theorizations, and interventions. This may mean stripping social work of the 'expert' and 'professional' role (Cranford 2022). Social work has a longstanding paternalistic stance, bolstered by professionalization, where assumptions of biomedical expertise get in the way of engaging in emancipatory practice in mental health. It is in changing our mindset from a medicalized response toward a social justice response that we may begin to effect positive change in social work and turn away from a longstanding oppressive practice in mental health.

## Discussion

In calling for the maddening of social work we are not only suggesting the need to teach and practice social work from a mad studies lens. We are also acknowledging that this call is likely to anger some social work practitioners and academics who work from an order perspective (Mullaly 2002) and are thus wedded to individualistic, coercive, controlling, pathologizing and neoliberal interventions. It may even anger some more progressive social workers who have not been willing to apply their same anti-racist and anti-oppressive analyses to social work interventions in mental health settings. However, given the long history of oppression of people deemed mad within psychiatric social work, we are also suggesting that the time is long overdue to support mad communities and end psychiatric hegemony in social work. Those within social work who truly take up anti-racist, anti-oppressive and emancipatory perspectives, who value collectivism, participatory democracy, solidarity, community development and the *social* within

social work, are being asked now to step up and end the continued oppression that mad people have been experiencing at the hands of social workers.

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