The Routledge International Handbook of Mad Studies

Peter Beresford, Jasna Russo

The professional regulation of madness in nursing and social work

Publication details
Jennifer Poole, Chris Chapman, Sonia Meerai, Joanne Azevedo, Abir Gebara, Nargis Hussaini, Rebecca Ballen

How to cite: Jennifer Poole, Chris Chapman, Sonia Meerai, Joanne Azevedo, Abir Gebara, Nargis Hussaini, Rebecca Ballen. 05 Nov 2021, The professional regulation of madness in nursing and social work from: The Routledge International Handbook of Mad Studies Routledge Accessed on: 31 Aug 2023

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: https://www.routledgehandbooks.com/legal-notices/terms

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
19

THE PROFESSIONAL REGULATION OF MADNESS IN NURSING AND SOCIAL WORK

Jennifer Poole, Chris Chapman, Sonia Meerai, Joanne Azevedo, Abir Gebara, Nargis Hussaini, and Rebecca Ballen

Introduction

According to the Canadian Association of Social Workers’ (CASW) Guidelines for ethical practice (2005), social workers shall not discriminate against any person

on the basis of age, abilities, ethnic background, gender, language, marital status, national ancestry, political affiliation, race, religion, sexual orientation or socio-economic status.

(CASW, 2005: 24)

Social workers are also expected/encouraged to participate in social action by striving to

identify, document and advocate for the prevention and elimination of domination or exploitation of, and discrimination against, any person…

(CASW, 2005: 24)

Despite these very clear guidelines, our research has found that social workers may actively discriminate against each other both intentionally and unintentionally when it comes to issues of ‘mental health’, madness and distress. In the name of protecting ‘public safety’, some workers have been disciplined, and some barred from their profession when judged as ‘unfit’ to practice. Some have been publicly humiliated, named in professional communications and branded as ‘incompetent’. All participants in our study have seen their own sense of health and wellbeing worsen or collapse. Indeed, we have argued (Chapman et al, 2016: 43):

The regulation of who is and isn’t ‘fit’ to practice as a helping professional connects up to a wider problematic or field of political, ethical, and scholarly concern. That problematic is this: although framed as apolitical scientific phenomema, in everyday real life psychiatric diagnoses morally and politically disqualify people from being imaginable
as “competent” human beings. Countless systems are implicated in this extralocal problematic, including many systems that are peopled by helping professionals.

It follows that in the province of Ontario, regulatory colleges for social workers, social service workers and nurses have a formal Fitness to Practice process, ‘peopled’ by those who seek to ‘help’. Part III of the 1998 Social Work and Social Service Act (SWSSA) states:

Fitness to Practice Committee will hold a hearing to determine any allegation of incapacity on the part of a member of the College. The Fitness to Practice Committee may, after a hearing, find a member of the College to be incapacitated if, in its opinion, the member is suffering from a physical or mental condition or disorder such that the member is unfit to continue to carry out his or her professional responsibilities.

Similarly, the CNO states:

The Fitness to Practice Committee determines whether a nurse is incapacitated and suffering from a physical or mental condition or disorder that is affecting, or could affect, her or his practice.

Both colleges, then, specifically name “mental condition or disorder” as a possible cause of unfitness. As such, the colleges’ position themselves as guardians of public safety and position individual (psychiatrized) professionals as potentially “incapacitated” and dangerous (Chapman et al, 2016: 44).

About the study

Into this context of ‘fitness’ and ‘regulation’ was born our research study. Phase I detailed the case studies of two nurses with suspected ‘mental health issues’ and how they were reported to and disciplined by their respective professional regulatory college in Ontario. The study charted the college reporting process and the subsequent serious health and social effects on the individuals (Chapman et al, 2016).

Using an approach informed by Institutional Ethnography, Phase II sought a wider pool of respondents to better understand the experience of nurses and social workers both prior to being reported to a ‘fitness to practice committee’ and after. We report on these findings in this chapter.

Literature and orientation

According to the Accommodation for Ontarians with Disabilities Act (AODA, 2005), a ‘mental health issue’ may be episodic or invisible, but it is a disability legally entitled to accommodation. According to Oldfield (2015), workers who are higher up in their organization’s hierarchy will be more successful at gaining such accommodations (see also Dyck and Jongbloed, 2000). In contrast, workers in precarious, shift and contract jobs (as is often the case in allied health) are often less successful (Schultz et al, 2011). Literature on health and work for such allied health professionals highlights the high probability of work burnout, distress, compassion fatigue, as well as negative physiological and mental health outcomes (see Ketelaar et al, 2014; Ray et al, 2013; Skovholt and Trotter-Mathison, 2011; Veage et al, 2014). The literature also highlights
The professional regulation of madness

The importance of self-care for such professionals (Oldfield, 2015). Yet we have found that if a nurse who is practicing self-care and seeking support discloses their mental distress at work, they may be reported to/by management, found ‘unfit’ to practice, ‘disciplined’ and suspended by their regulatory college. The subsequent adverse health and social effects of this include: an increase in distress, often resulting in costly emergency room visits and hospital stays and, if found ‘unfit’ to work by the college, a loss of wages/employment/housing resulting in economic distress and further precarity (Chapman et al, 2016).

At the same time, regulatory colleges may prioritize the ‘duty to protect’ the public over the duty to accommodate the mental disability of an allied health worker. This duty to protect is rooted in the notion that the issue or disability not only undermines the allied health worker’s ability to perform but it also makes the worker a ‘risk’ to the public. Regulators need to make sure the public ‘trusts’ their professionals, that those professionals are ‘well’ enough to work and are ‘managing’ their own distress and/or feelings in ‘productive’ ways. In short, helping professionals are not allowed to feel, to ‘hurt’ or show distress. Especially at work, they are not actually supposed to be human. This dynamic interacts and interlocks with other forms of oppression in countless ways such as the notion that women, gay men, and transfeminine folks are “too emotional” for example. Additionally, Badwall (2015) notes how this dynamic also plays out for racialized social workers who experience racism on the job.

Importantly, and according to the Ontario Human Rights Commission, the practice of discounting accommodation and disciplining ‘feelings’ may be in violation of human rights and disability law. Allied health professionals are thus caught betwixt and between; coping with inevitable job/life mental distress yet living with the threat of report and suspension by their regulatory college if they disclose to seek support or accommodation.

We count ourselves into this group, for we all identify as ‘health’ or helping professionals living with various forms and experiences of (pathologizable) distress. Some of it has been diagnosed and documented, making some of us, like the workers in our study, into patients and users of the ‘mental health’ system. Some of it is related to the work we do, the trauma we have experienced and the oppressions that have shaped our lives. Some of the labels we have refused, when we could or had a choice, which is more possible the more privileged you are in interlocking arenas of oppression. This multiplicity of understandings and responses to ‘mental health’ is embraced in the field that is Mad Studies (LeFrançois et al, 2013), but we do not all identify as mad. As some of us have written elsewhere (Meerai et al, 2016), to identify as mad may also be possible only with access to white privilege. And yet, for the purposes of this chapter, our work is clearly informed by a mad stance, one that believes and honours the experience of those who have been othered, labelled or ostracized because of their past/present behavior or ‘mental illness’, diagnosis, distress, or the suspicion of its presence.

The research process

From this stance, we set about recruiting nurses and social workers/social service workers. We used non-probability sampling techniques and specifically snowball and convenience sampling through social media, flyers and word of mouth. Participants all had a reporting/accommodation/discipline experience in the workplace or with their professional colleges. Participants were diverse in terms of age (25–60), mostly Canadian citizens who identified as women, with Bachelor’s and Master’s degrees in social work (50% of our group) or nursing (50%). Eight participants identified as racialized and one identified as Indigenous. Over 50% of participants
were registered with their respective college, but for some participants, registration with the college had been or was suspended.

The interviews were guided by the qualitative methodology known as Institutional Ethnography (IE). Utilized during Phase 1 and developed by Dorothy Smith (2005), Institutional Ethnography seeks to explore a ‘problematic’ such as being reported to a college, establishing the series of events that led to the problematic and making visible the ‘regimes of ruling’ that govern the process. Although we do not strictly follow IE in this chapter, it guided our mapping out of the 14 participants’ experiences before, during and after being reported.

**Findings part 1: Before the report is made**

In this first section of our findings, we chart the common experiences that happen before a report to the college for a ‘mental health issue’. Following Burstow (2015), the path to being reported is not linear or predictable, and yet the 14 participants related resonant experiences.

‘Better not be broken’: The pressure to manage one’s own mental health

We start with what we call an expectation of self-regulation and management. Otherwise known in the literature as managerialism (and neoliberalism), this expectation demands:

…alteration of the self, rather than the institution. Change is largely redirected from the collective to the individual actor.

*(Clegg, 2008 as cited in Barnoff et al, 2017: 8)*

“In the neoliberal institution, the preferred subjectivity is for employees to become entrepreneurial, competitive, and self-governing individuals, characterized as self-sufficient, self-directing, and enterprising” (Clarke, 2010; Clegg, 2008; Morrish, 2014, as cited in Barnoff et al, 2017: 8).

This managerial focus on self-regulation and self-direction was described by most participants. For social/service workers who want to continue their membership with the college, for example,

we have to do a self-evaluation every year where we write down our goals, and though we don’t have to send it in, it can be audited at any time.

A similar process exists for nurses, with requirements to carry out learning plans and a warning about ‘random’ audits if members are not managing their own learning, evaluations and/or any issues that may arise. We come back to this random assessment later in the findings section.

Participants explained the expectation is “that you’d be able to handle it all and if you can’t handle it then maybe you shouldn’t be in this field”. Another noted, “Sure, you can be a social worker, but you better not be a lemon, right? Better not be broken”. They added that the message they had received time and again in the field was, “you know, you really should be keeping your personal stuff at home. We don’t really want to see that at work”.

These experiences often contradict the publicly expressed and often anti-oppressive values of the profession or employer, reminding us of the work of Wilson and Beresford (2000). As one participant summarized,
The professional regulation of madness

staff just have to be doing the most work possible in the least amount of time. So, it’s basically a factory. So, they don’t have time for our, whatever issues we might have going on. Like they don’t care. ’Cause all they hear is that we’re not gonna be able to work at the speed that they want us to work at.

‘Not here to protect us’

Given the neoliberal focus outlined above, it was not surprising to find that all the participants experienced a lack of accommodation and support either from their employer or from their college. A participant noted,

I was dealing with some anxiety from stuff in the past and then also from the stuff that I was dealing with at work. Instead of asking me if I needed accommodations, they told me that they didn’t think I could do my job.

A social worker explained to us that

My doctor wrote them [the employer] more notes saying, ‘You need to accommodate this person’ … He was writing letters saying this employee is ready to return to work, if you could accommodate this … And they just refused. They would not even answer.

And a nurse who specifically asked their employer to be accommodated “was told that it-it could not accommodate me for less clients or less patients …”. A social worker explained that without any accommodation or support, they wondered what the actual benefits of registering with a college might be:

they make that clear to us that it’s in our best interest to be registered with a college. Legally, in many places, you can’t work unless you are a registered social worker, but there are no benefits to us… the College is there to protect the public, not to protect us.

Fear of report to employer or college

With an emphasis on ‘self-regulation’ and a lack of accommodation/supports, it also came as no surprise to us that all the participants spoke about the fear of being reported (for the first time) or of being reported again. This fear of report was palpable in the interviews, shaping workers’ ways of being at work and home, of relating, trusting as well as all aspects of their health and wellness. It also impacted where they were applying to work:

Even when I have applied to places at X, I was told don’t disclose that you’re a person with lived experience … they usually don’t come out as having lived experience until they’ve been hired. That’s what I was always told. Don’t tell them before you’re hired.

we’re humans so … our mental health fluctuates … so whether we’re going through something work related or personal related I would fear that if I was reported … that would be just, I don’t actually have words to describe how awful that would be personally.
Similarly, a participant noted, “I don’t think that I know of a single nurse that would ever claim to the college that they had a problem because they’d be too afraid of the repercussions of it”.

‘They taught me how to lie’

This fear can then lead to a set of common practices we call strategic dishonesty. As described by one participant,

I know that there have been times where I’ve not been fully honest enough, and saying I have a doctor’s appointment where actually I need to go to a different type of appointment.

Another participant felt this practice was a lot more common than a lot of people talk about … people feel like they can’t … really speak freely about needing accommodations. Without being stigmatized, without the idea of them not doing their jobs properly or being like lesser in regards to the work that they do.

Tragically, for one participant who did choose to be honest about their issues and disclose, “…if I had known it would play out like this, I would’ve never disclosed”. This person had disclosed because they needed support, but “I didn’t think, it would come with more serious repercussions”. They added:

The college has taught me how to lie; it’s a horrible, horrible thing to say, it has taught me how to lie to people and how to be dishonest. Because me being honest, being upfront got me in trouble, more trouble so that’s what taught me how to keep things close to my chest and how not to trust people.

After a similar experience, a nursing participant explained, “And I still don’t trust people … That’s what got me into trouble…”. Detailing what the long-term effects of this disclosure and subsequent response entailed, this participant explained:

Cause what ended up happening when something like this happens, you build shame. And then you start to be secretive about everything. And then you start living alone. And the more you live alone you start to make that the norm. And you don’t open up. And the more you don’t open up the more you bottle up inside. And the more you bottle up inside the worse it gets.

With such ramifications for being honest, it becomes very possible that a worker might practice the opposite. Summing up all the experiences that can lead to a report, one participant said, “It just feels like they just push until you know, rise to it or you go on medical leave or you quit or you get fired”.

Findings part 2: Discipline without report to the college

To recap, we have explained that participants are pressured to self-manage, are working without support or accommodation and in great fear. Now we turn to the kinds of disciplinary
experiences they shared with us that take place prior to or instead of a direct report to a regulatory college. It is crucial to note that all but one of the participants we met with had been disciplined or formally punished for experiencing ‘mental health issues’ in the present or in the past.

One form of discipline is the ‘random’ audit/assessment. As introduced earlier, nurses registered with the college do a learning plan every year. They can be randomly called for an assessment. According to one participant, this was part of a disciplinary response to their ‘mental health issues’. The participant explained, “…they emailed me and said ya know your name’s come up, we want to see your learning plan so I had to submit that”. It did not feel particularly random.

A second common form of discipline is a ‘warning’ from an employer. A social worker explained that, “there’s basically different levels of disciplining somebody … at my agency it’s a verbal warning and then it’s a written warning. And then it can go to a second written warning which then turns into the work plan sometimes. And if you don’t end up doing well on the work plan then you’re basically asked to leave, like you’re fired”. Again, please note that none of these participants had ever had a client, patient, or member of the public express concern about their work or behaviour. These disciplinary measures were in response only to concerns that supervisors or co-workers had upon hearing about a diagnosis, witnessing distress, or in response to a request for accommodation.3

Another participant explained what was in the warning letters from their employer. “There was stuff in the letters about maybe she shouldn’t be working in this field. This field is very difficult, it’s very challenging, and not everybody can do this kind of work”. This same participant then had to go through a process called ‘performance management’ with weekly meetings with their manager and constant scrutiny of all their work:

Every day she was on me … I’ve never heard of anybody else having to go through this. She would go through every single bit of my work, every pen stroke. Every single [week] I would have supervision with her. It would go from one in the afternoon until five PM. And I would have crying fits ... And she wouldn’t let me leave the room. She would say, ‘Oh, no... you’re just being too emotional, you need to just stay here. Just pull yourself together so we can get through this work’. It was so condescending and so humiliating...

The report and its aftermath

It is at this point, when workers are being assessed, warned or heavily ‘managed’ that they may also be reported to the college, and there are multiple ways for this to happen. Here we focus on two routes in particular; self-disclosure and manager report. It is crucial to note again that NONE of the participants in our study were ever reported to their employer or college by a patient or service user.

Further, by self-disclosure we do not mean that any of our participants decided to call their respective college and suggest they were unfit to practice. Self-disclosure can be a casual conversation between peers at work about an experience of distress long ago. Self-disclosure can be a conscious request for support or accommodation or, as explained below, it can also be prompted by an advisor or mental health professional.

…it was recommended by my doctor, him and I had many conversations, and we decided to report, and I did. I told them what was going on and from there everything,
even though I was in recovery for a year and a half. They [the employer] still reported me to the college, and my colleagues then came to me and questioned my fitness to practice.

Similarly, a social worker described,

I thought if I was honest about the stuff that was going on in my life, they would probably be more understanding given the fact that we’re a mental health agency. So that was thrown in my face real quick.

Additionally, a nursing participant agreed that telling her manager wasn’t well received ... I poured my heart out and I can still – she didn’t support me. So, I went to my union rep and I suppose it all came out and resurfaced and it got to upper management it got to the chief nursing manager and they had to report me to the college of nurses … I never had a patient complain in 33 years. And then it came to this.

Conversely, the report can be made directly by a manager, without any prior ‘evidence’ or documentation. In one case, a previously ‘kind’ nursing manager inquired as to a nurse’s health after a bad fall at work and subsequently decided to make a report to the college.

The manager said, “Are you being followed?” And I made the mistake of saying, “Yes”. And she said, “Well what are you doing?” And I said, “I’m taking medication”. Even though it wasn’t her right to know, she asked me, “What medication are you on?” And I said … Right away that sent alarm bells, and red flags.

For nurses, any suspected fitness to practice issue related to mental health goes to:

the medical committee: the medical committee then decides what areas they have looked at and if this is a valid thing or it’s not a valid thing. And suppose that it is a valid thing and there’s evidence and it questions your practice it then goes on to another committee … and then they respond whether they want to appear in front of the college … most people will take whatever the college recommends and go from there, most people do not want to appear before the college.

Once brought before the college, the person is explicitly evaluated for fitness to practice, which partly involves the gathering of evidence from ‘experts’. Shockingly, however, participants commonly described how their college would refuse any ‘evidence’ suggesting that they were fit to practice. One participant explained, “I got letters from a minister that I got counseling from, a psychologist, a clinical psychiatrist, a social worker that I was getting support after care, even the folks that I got treatment from, nothing, nothing was acceptable”. For another, “They refused my doctor’s diagnosis … He is a psychiatrist that teaches at X. He is a practicing doctor with a license, right? But they refused to accept that”. One participant detailed the grueling experience of being evaluated by her college’s psychiatrist:

[The college’s psychiatrist] interviewed me a total of four times. And interviews were anywhere from two to six hours long. I guess he just didn’t find anything. And by the time I was kind of disoriented. You’re doing 15-hour shifts, and then you’re being asked all these psychological questions. So, I reached in for my bag, and he goes,
‘What are you doing?’ I’m like, ‘Oh, I’m just getting Tylenol. My back’s kind of sore.’
So, he writes in the interview, ‘The client reaches into her bag for pain relievers’. They watch your every move. They write everything about you from the minute you walk into the door. The way you’re walking. Your posture. How you’re sitting. What you’re wearing.

For the participants in our study who were then found to be ‘unfit’ to practice, their names may be publicly shared in various formats. For social workers/social service workers, we learned that “We do have a College newsletter that writes you up and shares with other registered social workers and social service workers who have lost their registration as a result of some indiscretion”. For some nurses in our study, their names were published on a website: “…they have a website called ‘find a nurse’; what they would do is, they would publish your name on this website, the entire world could see, your name would get published and they would also have restrictions to practice…”. For one nurse that had such restrictions on their practice for more than five years:

I was unable to get a job because I had restrictions on my license … and that whole time my life has been affected, and I was unable to work, unable to purchase a home, unable to be in a relationship, fell into severe depression … tried to commit suicide, like there was so many things that a committee makes one decision and doesn’t realize the effects it has on that person…

Indeed, all of the participants who had been reported to their college and found unfit because of their ‘mental health issues’ experienced severe and lasting suffering. Listening to these stories of denigration and violence, even in a research interview, was extremely difficult. Experiencing it first-hand, of course, is much more devastating. Participants described it as “the most horrific experience I’ve ever had to go through in my life”, and “I probably have had some significant traumatic events in my life, this, going through the college is probably the most, right up at the top…”. And the suffering is long-lasting:

I feel as though I’m still suffering. I feel as though I haven’t really had a chance and I’m going to feel as though I’m going to carry this until my death, and I want a chance to properly heal because I don’t want to take this until I die. It’s right there sitting inside me and I’m still suffering.

Discussion

Our study has thus far taught us many things. We have learned that the helping professions may not be so very helpful when it comes to issues related to distress and disability. We have learned that there is an active and well-designed system of discrimination directed at workers expected to manage themselves in ‘productive’ ways. We have also learned that, in the name of public safety, there may be no room to feel, no room to ask for support or accommodation and no room for refusal or evidence that opposes the idea that those of us with ‘mental health issues’ are unfit, incompetent or, worse, threats to society.

It would appear the helping professions are sites of what Procknow calls ‘sane supremacy’, as this inevitably interlocks with white supremacy, cis-heteropatriarchy, and capitalist denigrations of precarious and working class people. We agree that “political, academic, social, and mainstream media realms” as well as employers and regulatory bodies “collude to shore up ‘saneness’
as normative, and those falling outside the prescribed ‘sane’ boundaries are non-normative” (2017: 913)

In addition to sane supremacy, it would also appear that another ‘regime of ruling’ (Burston, 2015) is at work. The discourse of ‘protection of public safety’ is a useful tool in settler states, providing cover for rights violations and legal discrimination against those imagined to pose a threat, whether real or perceived. No actual harm or threat to the public initiated any of the degradations and violence that our participants were subjected to. Rather, perceived threat is often used to justify the unfair treatment of people living in poverty, racialized people, and those with mental health diagnoses. This happens only based on stereotypes. In the absence of actual harm or threat, this is “mental health profiling”, a legally recognized human rights violation (Ontario Human Rights Commission, nd).

Mental health profiling is any action taken for reasons of safety, security or public protection that relies on stereotypes about a person's mental health or addiction instead of on reasonable grounds, to single out a person for greater scrutiny or different treatment.

(OHRC, nd)

Such profiling can happen in conjunction with racial profiling or criminal profiling. It can also happen when behavior is judged as ‘different’ than a carefully constructed rational norm even though it does not present any concern for service users or the public. Without a doubt, our participants were subjected to mental health profiling. In a climate of neoliberal managerialism, they were surveilled and randomly assessed, with any hint of difficulty or distress taken as a reason to ‘single out a person for greater scrutiny or different treatment’. That scrutiny has its own process and its own desired ends and is based on negative assumptions about mad folk and those with disabilities or experiences of distress. It assumes that we are a threat to ‘public safety’, relying on long debunked sanist stereotypes (Perlin, 1992) that persons with experiences of diagnosis or distress are more likely to perpetrate violence. Scholars of Mad and Disability studies have long provided evidence to the contrary, however: people with psychiatric diagnoses are considerably more likely to be the victims of violence but are not statistically any more likely to commit violence (Erevelles and Minear, 2010; Joseph, 2016; Spivakovsky, 2017; Steele, 2016).

This brings us to epistemic injustice. Citing Fricker (2007), LeBlanc and Kinsella (2016) explain epistemic injustice occurs in the helping professions when a person is insulted or wronged in their capacity as knower. Such a person or group of people will be ‘unfairly depicted as intellectually inferior or lacking in credibility’ (Medina, 2012) by those deemed more powerful. According to Fricker (2007, 2010), this can present itself as testimonial injustice or when a speaker’s capacity to know and share their knowledge is in question because the hearer holds prejudicial feelings towards the speaker’s identity. Epistemic injustice may also present as hermeneutical injustice when the same applies to groups of people trying to articulate their social experiences (Fricker, 2007; Medina, 2012). In our participants’ accounts, when they were disciplined or reported to their regulatory colleges for sharing their distress or diagnosis, they were subjected to epistemic injustice; they were depicted as lacking in credibility, competence and ‘fitness to practice’ by hearers who had already decided that they – or people ‘like them’ – were dangerous and a threat to public safety. It does not matter what participants did or said, or what evidence they provided to the contrary, they had already been assumed guilty by a system founded on neoliberalism, managerialism, surveillance and interlocking forms
of oppression including sane supremacy. They had already been found epistemically untrustworthy, epistemically disposable and extraneous.

**Conclusion**

Thank you so much for your work ... It [is] more a sense of relief that yes, there will be something out there for people like that. And just my heart was just shining, like alive to know that we haven’t been forgotten.

For all these reasons, we seek epistemic justice for those we interviewed, for those reading this who share in these experiences and for all those who fear what may befall them as a result of being ‘registered’ helping professionals who dare to want support. Those who shared their time, experience and suffering speak the truth. They are to be heard and to be listened to very carefully, for they tell cautionary tales about the violence that the so-called helping professions are capable of. Lives are shattered by the disciplinary tactics of employers and regulators. When participants’ experience with our professional bodies is so “horrible” that their recommendation is to lie about their madness, it is clear that something is very wrong in nursing and social work. And if these professions are so harsh on their workers – how must they be on those who are patients? The resonance between these stories and those of others subjected to the gaze and regulations of the helping professions points to the fact that something is very wrong much more broadly. How is it that our social structures that appear to be set up to support, help, and accommodate are so frequently violent, intrusive, and oppressive? What must we take from these stories of helping professionals who have never had service users or patients formally complain about their work but who are nevertheless treated as a threat to the public? What can this teach us about how humans are regularly differentiated and siphoned into categories of worthy and unworthy, fit and unfit, valuable and disposable?

In terms of the future of this research, our next step will be to detail what participants suggested needs to happen now, how system-wide advocacy needs to bring regulatory law in line with disability law and how participants have imagined a radically distinct system based on caring for one another instead of naming and shaming. One participant summarized this as “let’s get rid of the reporting and have supporting.” We could not agree more.

**Notes**

1 We want to formally recognize the late Dr. Bonnie Burstow for bringing three of us together. By invitation from Dr. Burstow, Rebecca, Chris and Jennifer participated in a project focused on using Institutional Ethnography to better understand the machinations of psychiatry. Thus, began phase 1 of our work together, resulting in our joint publication in 2016.

2 This phenomenon is common among service users’ navigations of unjust helping systems (see for example Dean Spade’s (2013) work on trans surgeries or Jennifer Clarke’s research (2012) on Afro-Caribbean moms ‘cooperating’ with child protection services.

3 In sharp contrast, research shows that service users/clients prefer to work with somebody who has lived experience of life difficulties and distress (see for example Jijian Voronka’s work).

**References**


The professional regulation of madness

