

CENTRE FOR THE STUDY OF



**GENDER
SOCIAL INEQUITIES
AND MENTAL HEALTH**

A Critical Exploration of Social Inequities in the Mental Health Recovery Literature

Julia Weisser, Marina Morrow, Brenda Jamer

2011

Acknowledgements

Many thanks to Lupin Battersby, Kim Calsafferri, Kathryn Church, Megan Crouch, Sandra Dawson, Deqa Farah, Ruth Gump, Susan Lynn Hardie, Richard Ingram, Cat Omura, Sri Pendakur, Jennifer Poole, Shiva Reddy, Joy Walcott-Francis and branwen Willow for their assistance with the scoping review research.

This project was funded by the Canadian Institutes of Health Research with additional in kind support from the Centre for the Study of Gender, Social Inequities and Mental Health.



SUGGESTED CITATION:

Weisser, J., Morrow, M., & Jamer, B. (2011). *A Critical Exploration of Social Inequities in the Mental Health Recovery Literature*. Vancouver, BC: Centre for the Study of Gender, Social Inequities and Mental Health (CGSM). <http://www.socialinequities.ca>

Contents

| | |
|--|-----------|
| Executive Summary | 4 |
| Introduction | 8 |
| A Critical Exploration of Social Inequities in Mental Health Recovery | 10 |
| Research Questions | 11 |
| Methodology | 11 |
| Scope of the study | 11 |
| Design of the study | 12 |
| Sampling method | 12 |
| Inclusion/exclusion criteria | 13 |
| Search terms | 14 |
| Data management and charting | 15 |
| Data analysis | 15 |
| Limitations | 15 |
| Results | 16 |
| Literature profile | 16 |
| Literature themes | 16 |
| Related literature | 24 |
| Discussion | 25 |
| Conclusion | 25 |
| Recommendations from the literature | 25 |
| Appendix A: Research Team | 28 |
| Appendix B: Search Terms | 29 |
| References with abstracts/annotations | 32 |
| Bibliography | 62 |

Executive Summary

This scoping review was part of a larger project, ‘A Critical Exploration of Social Inequities in Mental Health Recovery’, which was envisioned by the Centre for the Study of Gender, Social Inequities and Mental Health (CGSM) and made possible by funding from the Canadian Institutes for Health Research (CIHR). The purpose of this project was to facilitate and support the establishment of a collaboration of key experts and stakeholders from the field of mental health including decision makers, service providers, and service users interested in developing new conceptualizations of mental health recovery that are grounded in principles of citizen engagement (i.e., principles that value the participation of people living with mental health issues) and that recognize the impact of social and structural inequities on mental health and recovery.

The scoping review was conducted in order to assess the current state of mental health recovery literature in Canada, the US, the UK, Australia, and New Zealand. Although many definitions of “recovery” exist in the literature, including those that attend to structural barriers such as racism, sexism, poverty, and homophobia, in addition to individualistic factors such as empowerment, hope, and autonomy, very few models of recovery explicitly address social and structural inequities. Using purposive sampling and a search of social science databases, both peer-reviewed and “grey” literature (i.e. any document or material outside the realm of the formal academic publishing process) was reviewed in order to identify: current models and frameworks for mental health recovery; the degree to which they address social and structural inequities; the degree to which the lived experiences of individuals informed the development of current and past models of recovery; how the concept of citizen engagement is taken up in the recovery literature; and opportunities taking place regionally, nationally, and internationally that are relevant to developing recovery models which address social inequities and/or citizen engagement. In total, 71 pieces of literature were included in the scoping review. Of these, 57 are either peer-reviewed academic journal articles or published books and 14 are considered “grey” literature.

Overall, there appear to be four basic levels of understanding of “recovery”: those that take the individual as their focus, those that take external/structural barriers as their focus, those that take the need for (culturally) appropriate services as their focus, and those that advocate for a

complete overhaul of the system, society, and the ways in which we view mental (ill) health. It is these last three which are of most interest to us here and which will be explored further in this review.

Findings include:

- A general focus in the literature on the internal rather than on the external factors associated with recovery; extensive discussion surrounding the meaning/definition of “recovery;”
- Infrequent mention of social and structural inequities in the literature as they pertain to mental health; where mentioned, culture was most frequently discussed, but usually without an analysis of structural racism; most notable was an absence of discussion around gender;
- A focus in the literature on citizen engagement, both as the individual participation of people with lived experience and as a broader political imperative;
- Some discussion in the literature of Aboriginal mental health models;
- Examples of innovative recovery work being done in Canada and around the world.

Additionally, recommendations have been pulled from 15 articles which specifically address the topic of social inequities and mental health recovery. These recommendations, which are outlined below and which have been divided into three sections (Policy, Practices, and Research), can be used to inform future recovery models that are responsive to social inequities, to the knowledge of people with lived experience, and to the concept of citizen engagement.

POLICY

- There are many experiences/conditions that bring people into contact with the mental health care system. In developing policy the question needs to be asked: What are people recovering from? Examples include childhood sexual abuse, a psychotic break, or traumas related to war experienced by recent immigrants and refugees.
- Expand the range of supports that are part of mental health recovery services to include social supports such as housing, income security, employment options, accessible transit systems, paid parental leave, language classes, and educational opportunities.
- Fiscal conservatism must be resisted; recovery and the many supports associated with it must be funded.

- Social and structural determinants of mental health need to be an integral part of any recovery policy.
- People need real opportunities to become engaged members of society/a community. This includes access to work and civic engagement including involvement in the development of mental health policies and programs.

PRACTICES

- Recovery is a collective journey that includes building a sense of community, using pre-existing support networks, fostering family and cultural connections where desired, and overcoming social isolation. Examples of a collective approach to recovery include viewing political activism and connection with one's culture as recovery, and allowing for a "problem-focused and collective orientation to recovery" (Lal, 2010, p.86).
- Service providers require training to better understand the role of social and structural inequities in mental health.
- A new "recovery" language can be explored using narratives, manifestos, or art in addition to models (Jacobson et al, 2010, p.13).
- Multiple definitions of mental (ill) health are needed, as well as for the possibility of recovery as a cultural/spiritual experience.
- Peer workers in mental health should reflect the racial and ethnic diversity of the population.

RESEARCH

- More research is needed to better understand how the concept of recovery is understood in different racial and ethnic communities and whether there are gendered differences in the understanding and uptake of recovery.
- The theoretical and methodological framework of intersectionality (that recognizes the different axes of oppression at work in a particular person's life) should be explored for its applicability to understanding social inequities and recovery.

A review of the recovery literature suggests that much confusion still exists about the concept of recovery and its applicability to mental health and, more specifically, its relevance for different communities. The models and frameworks that do exist fall short on an analysis of the role of gender and other social and structural inequities in mental health problems. This reveals that most of the attention has been given to recovery as an individual journey tied to medical, family

and community supports with less attention being given to the structural changes needed to ensure adequate income, housing and social environments that are free of discrimination. Despite this, there is evidence that new conceptualizations of recovery are emerging which are beginning to address the limitations of this concept for different cultural communities, calling for a more nuanced and in-depth understanding of what it means to “recover.” For your reference, at the end of the scoping review is a complete list of works cited with abstracts/summaries, as well as a bibliography of works consulted.

Introduction

“Recovery recognizes the fact that an individual cannot fully heal in an environment that supports racism, homophobia, sexism, and colonization. Developing a healthy society can be seen as recovery on a collective scale” (Ida, 2007, p.52).

The concept of “recovery” rose to the forefront of the mental health field in the 1980s and 1990s, albeit from two distinctly different sources. One of the precursors of the recovery movement was psychiatric rehabilitation (Anthony, 1993; Deegan, 1988); the other was the psychiatric survivor movement (Cleary & Dowling, 2009). Roughly speaking, two definitions of recovery exist: the “medical” or “clinical” definition of recovery which focuses on symptom remission, and the concept of “life” or “social” recovery which focuses on living well either with or without symptoms (Collier, 2010; Cleary & Dowling, 2009). The term “recovery” is meant to counter stigmatizing and discriminatory discourses about mental illness, by suggesting that anyone, even those termed “chronically” mentally ill, can recover if they are adequately supported (Anthony, 1993).

Many competing frameworks for recovery exist, including those which focus more at the individual level versus those which adopt a social model of recovery. The former models are more popular and are typically described in terms that emphasize individual autonomy, empowerment, hope, and choice. For example, in the Canadian context, the most recent articulation of the components of recovery can be found in the Mental Health Commission of Canada’s (MHCC) framework for a mental health strategy (2009), in which recovery is described as “...a journey of healing that builds on individual, family, cultural and community strengths, and enables people living with mental health problems and illnesses to lead meaningful lives in the community, despite any limitations imposed by their condition” (p. 8). However, many approaches to recovery which concentrate primarily on the individual also recognize the fact that “...no person is an island...access to and experience of valued social roles is the lifeblood of well-being for most people” (Slade, 2009, p. 197). Similarly, Everett et al (2003) point out that “while it is typical for policy to divide the concept of health into internal factors...and external forces...it is neither one nor the other that accounts for health but, instead, it is the interaction between the two” (p.17).

Although social models of recovery emphasize social supports like the need for housing and economic security (Jacobson & Greenley, 2001), what is missing even from these models is an explicit recognition of structural barriers such as racism, sexism, and homophobia, which signal systemic discrimination based on factors such as racialization of ethnocultural groups, gender, and sexual orientation (Morrow, Wasik, Cohen & Perry, 2009; Morrow, Penderson, Smith, Josewski, Jamer, & Battersby, 2010; Battersby & Morrow, submitted for review). Research findings suggest that recovery will be shaped differently by structural and systemic barriers based on gender, race, and other forms and processes of discrimination (Rossiter & Morrow, 2010; Collins, von Unger, & Armbrister, 2008; Mill et al, 2007; Ship & Norton, 2001).

When we use the term “social and structural inequities,” we are referring to unfair and avoidable ways in which members of different groups in society are treated and/or their ability to access services (WHO, 2010; Braveman & Gruskin, 2003). It may be helpful to first define social *inequalities*, which refer to “relatively long-lasting differences among individuals or groups of people that have implications for individual lives” (McMullin, 2010, p.7). An inequality implies a difference without placing judgement upon it; this difference is not assumed to be good or bad in and of itself. An inequity, on the other hand, refers to an unjust distribution of resources and services. According to Braveman & Gruskin (2003), “equity means social justice” (p.254). Health equity is an absence of systematic disparities in health (or in the major social determinants of health) between groups with different social advantage/disadvantage (Braveman & Gruskin, 2003). Inequities, then, exist where such disparities can be found. Finally, social determinants of health, as mentioned above, refer to “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics” (WHO, 2010).

Very little empirical research has been done on the subject of mental health recovery. Casey (2008) and others (Jacobson & Greenley, 2001; Davidson et al, 2005; Liberman & Kopelowicz, 2005) have suggested that the lack of a consistent conceptualization of recovery is a significant barrier to the development of empirical evidence. Although many definitions of “recovery” exist

in the literature, including those that attend to structural barriers such as racism, sexism, poverty, and homophobia, in addition to individualistic factors such as empowerment, hope, and autonomy, very few models of recovery explicitly address social and structural inequities. Further, little attention has been given to the lived experiences of people with mental health issues in order to better understand the effectiveness of recovery models in mental health (Morrow & Jamer, 2008). This scoping review was designed in order to assess the current state of mental health recovery literature, both in Canada as well as in the US, the UK, Australia, and New Zealand. At the end of the scoping review is a complete list of works cited with abstracts/summaries, as well as a bibliography of works consulted.

A Critical Exploration of Social Inequities in Mental Health Recovery

This scoping review was part of a larger project, ‘A Critical Exploration of Social Inequities in Mental Health Recovery’, which was envisioned by the Centre for the Study of Gender, Social Inequities and Mental Health (CGSM) and made possible by funding from the Canadian Institutes for Health Research (CIHR)¹. The purpose of this project was to facilitate and support the establishment of a collaboration of key experts and stakeholders from the field of mental health including decision makers, service providers, and service users interested in developing new conceptualizations of mental health recovery that are grounded in principles of citizen engagement (i.e., principles that value the lived experience and participation of people living with mental health issues) and that recognizes the impact of social and structural inequities on mental health and recovery.

This project had several components, including a World Café². The World Café brought together twenty four people including mental health and social services front line workers, mental health and addictions managers, policy makers, people with lived experience of mental illness, family members, and community leaders engaged in mental health work. Likewise, the research team for this project was comprised of academics, policy makers, mental health and addictions managers, and people with lived experience of mental illness. A full description of the research team can be found in Appendix A. The research also involved creative approaches to knowledge

¹ The Centre is affiliated with the Faculty of Health Sciences at Simon Fraser University, Vancouver, BC. The research for this project was conducted during 2009 and 2010.

² The “**World Café**” methodology involves concurrent round table discussions which are focused around a set of questions that are multi-layered and build upon one another (Brown and Isaacs, 2005).

exchange. A full report on the findings of this project (The Recovery Dialogues: A Critical Exploration of Social Inequities in Mental Health Recovery) can be found on the CGSM website: www.socialinequities.ca

Research Questions

The following questions were used to guide the scoping review research:

- 1) What models/frameworks for mental health recovery exist currently?
- 2) How do existing models/ frameworks and conceptualizations of mental health recovery address social and structural inequities? What are the gaps in the literature? Specifically, how does the literature address:
 - i) Class/poverty/homelessness/etc.
 - ii) Race/ethnicity/immigration/culture/etc.
 - iii) Sex/gender/gender identity
 - iv) Dis/ability
 - v) Sexual orientation/homophobia/heterosexism
 - vi) Colonialism
 - vii) Ageism
- 3) How have people’s lived experiences of mental health problems informed the development of current and past models of recovery? How is the concept of citizen engagement taken up by the recovery literature?
- 4) What opportunities are taking place regionally, nationally, and internationally that are relevant to developing recovery models that address social inequities and/or citizen engagement?

Methodology

Scope of the study

The scope of the review included any literature, peer reviewed or otherwise, from 1980 to the present day originating in Canada, the United States, the United Kingdom, Australia, or New Zealand. This included some “grey” literature, which was defined as any document or material outside the realm of the formal academic publishing process (e.g. community-based research

reports, government documents, theses, websites, policy documents internal to government organizations, discussion papers, mental health recovery “tools” designed for service providers and consumers, etc.).

Design of the study

The methodology used in this study was based on Arksey & O’Malley’s (2005) work which outlines a process for scoping reviews, and was written by policy researchers in the mental health field. A scoping review differs from a systematic review in that it is quicker, broader, and begins with a less highly focused research question (ibid). Arksey & O’Malley outline a methodology which calls for as much rigorousness and transparency as possible; as such, a detailed outline of the search terms used in this scoping review can be found in Appendix B. The five steps for conducting a scoping review (identifying the research question; identifying relevant studies; study selection; charting the data; collating, summarizing and reporting the results) were used as a guiding framework for this scoping review (Arksey & O’Malley, 2005, p. 22).

Intersectionality was the theoretical framework which guided the scoping review. Intersectionality is a perspective which “moves beyond single or typically favoured categories of analysis [e.g., sex, gender, race, and class] to consider simultaneous interactions between different aspects of social identity [e.g., race, ethnicity, Indigeneity, gender, class, sexuality, geography, age, ability, immigration status, religion] as well as the impact of systems and processes of oppression and domination [e.g., racism, classism, sexism, ableism, homophobia]” (Hankivsky et al, 2009, p.3). In order to facilitate the database searches, however, each social inequity (e.g. race, gender, class, etc.) was searched individually.

Due to time limitations, a thorough grey literature search was not conducted. Most of the grey literature gathered came from contacts in mental health organizations currently doing recovery work, and was retrieved either from the web or from internal policy/training documents from mental health organizations.

Sampling method

Different search strategies were required for each research question, as they differed in breadth and scope. For question 2, a database search for peer-reviewed literature on the topic of social inequities and mental health recovery was conducted. For questions 1, 3, and 4, the sampling method used was a form of ‘purposive sampling,’ a common technique in qualitative research. It

is a deliberate method designed to yield results that will answer the research question, by building upon pre-existing sources (Punch, 2005). In the beginning, key articles and key informants were identified which could point towards relevant research models and services. Following this, new articles from both the existing articles' reference lists and the key informants' knowledge base were identified. Due to the nature of the research questions, it was found that different search strategies were necessary for each question, outlined below.

Inclusion/exclusion criteria

For the purposes of the scoping review, the literature that was *included* fell into at least one of four categories, corresponding directly to the four sections research questions:

- Literature that outlines current recovery models, frameworks, and conceptualizations;
- Literature that relates directly to social inequities and the concept of mental health recovery;
- Literature that sheds light on the degree to which the knowledge(s) of people with lived experience were included or honoured in the development of current recovery models, frameworks, and conceptualizations;
- Grey literature or academic literature that highlights any relevant opportunities taking place regionally or nationally vis-a-vis developing recovery models (that address social inequities and/or citizen engagement).

Certain literature was deemed necessary to exclude which was nevertheless relevant to mental health recovery. This was due to the necessity of narrowing the search to include only literature directly related to the mental health recovery “movement” or mental health recovery models and frameworks, which excludes literature which does not use the word “recovery.” For further discussion of this please see the ‘*Related literature*’ section.

Excluded literature included:

- Literature related to social inequities and the mental health system in general;
- Literature related to social inequities, mental health and trauma recovery;
- Literature which, while related to the concept of mental health recovery, did not directly correspond to any particular section of the research question;

- Literature on the topic of “psychiatric rehabilitation,” unless it was also on the topic of mental health recovery and/or unless it had the word “recovery” in the title or the abstract and was otherwise related to social inequities³;
- Literature related primarily to substance use/addictions recovery models.

Search terms

As mentioned earlier, a deliberate database search was conducted for question 2), which relates to social inequities. A search of the following databases was conducted:

- CINAHL⁴ with full text
- PsycINFO
- SocIndex
- Medline with full text
- Women’s Studies International

These 5 databases are standard for social science research. Additionally, a Google Scholar search was also conducted.

Two rounds of searching were done in the databases. The first round used the same keyword search terms for each of the 5 databases. The search combined the phrase “mental health recovery” with the following combinations of keywords:

+ gender OR sex*

+ equ* OR inequ* OR unequ* OR disparit*

+ rac* OR indigenous OR aboriginal

+ age OR disab*

+ class* OR poverty

+ immigr* OR colonial*

+ soci* OR econom* OR polit* OR marginal*

+ concept* OR theor* OR intersect* OR model OR framework

³ “Psychiatric rehabilitation” is both a precursor to the term “recovery,” in the context of mental health, and a current term in the context of certain kinds of care (e.g. tertiary or hospital care).

⁴ CINAHL: Cumulative Index to Nursing and Allied Health Literature

These terms are meant to encompass the social inequities listed in the research question. In accordance with Arksey and O'Malley (2005), these search terms were modified as the scoping review progressed. In the second round of searching, detailed below, several keywords were added (cultur*; divers*, homo*) in order to ensure greater accuracy. As well, "Subject headings" were utilized in addition to keywords⁵. The subject headings used were not the same across the board; they changed according to the database being searched, as each database is set up slightly differently. The search terms for this second round of searching can be found in detail in Appendix B.

Data management and charting

The data was managed using RefWorks, an online bibliographic management program, and through the creation of a research chart in Microsoft Word which detailed the section of the research question addressed by each piece of literature as well as any relevant study characteristics, findings or quotes.

Data analysis

The information contained in the research chart was the foundation of the data analysis and coding process. It was used to answer the research questions, identify over-arching themes, discern gaps in the literature, and pull out any relevant recommendations.

Limitations

Firstly, it must be emphasized that this scoping review encompasses only a fragment of the mental health recovery literature, both academic and "grey." A full examination of the mental health recovery literature was neither possible nor appropriate, considering our focus on social inequities, although attempts were made through purposive sampling to locate both seminal and innovative works in the field. As mentioned previously, due mainly to time constraints neither a full grey literature search nor an examination of particular recovery "tools" (for example, Wellness Recovery Action Plan [WRAP], Recovery Star, etc.) was conducted. This would have made for more well-rounded answers to the research questions, particularly question 4. Additionally, because of the focus on mental health (as opposed to addiction) recovery for this

⁵ The original search terms were developed from a modified list of terms, used by Richard Ingram for a larger CGSM scoping review related to social inequities and mental health/addictions. The second search strategy was developed on advisement of Megan Crouch, Reference Librarian for the Faculty of Health Sciences at Simon Fraser University.

scoping review, many potentially interesting articles written about the intersections between the two, or about dual diagnosis, were excluded. Finally, the focus of this review was literature pertaining to adults, leaving the question of recovery's meaning for youth and older adults open for further exploration.

Results

Literature profile

Over 100 articles were found and reviewed through either the purposive sampling or the database search method. In total, in accordance with the inclusion/exclusion criteria, 71 pieces of literature were included in the scoping review. Of these, 57 are either peer-reviewed academic journal articles or published books and 14 are considered “grey” literature.

Literature themes

Several over-arching themes were discerned from the literature:

- The concept of intersectionality/interlocking axes of oppression;
- The usefulness, or lack thereof, of the term “recovery,” and challenges to the notion of recovery;
- The need for thinking creatively when it comes to envisioning recovery services for the future;
- The need for truly inclusive and culturally appropriate services;
- The concept of second class citizenship for people diagnosed with mental illness;
- The need for a framework that makes use of the social determinants of health and/or the social model of disability;
- The different ways “recovery” is conceptualized and taken up around the world, including differing viewpoints about what a “recovered” person might look like (e.g. from an individualist versus a collectivist worldview);
- The concept of “recovery” as potentially oppressive or harmful;
- The possibility of a collective approach to recovery, and/or cultural (re)integration as recovery;

- A critique of neo-liberalism and the imperative of self-control⁶;
- “Recovery” as a vehicle for social change and critique of the system.

Question 1: What models/frameworks for mental health recovery exist currently?

“The convergence of these two perspectives [“recovery in” versus “recovery from,” or living well with, versus living free from, symptoms] within the past few years has now contributed to a situation in which recovery has come to mean different things to different people, resulting in a remarkable degree of inconsistency in how the notion is used to inform practice” (Davison & Roe, 2007, p.462).

Despite the fact that Western countries are rushing to adopt “recovery” as the wave of the future for mental health (Queensland Alliance, 2010; Cleary & Dowling, 2009), the literature on recovery as a model, framework, or concept is anything but straightforward. This murkiness is due largely to a lack of consensus about the term itself – what it means, how or if it should be measured, and where the problems with it lie. It is also due to confusion surrounding the origins of the concept. Though it is widely accepted to have stemmed on the one hand from the psychiatric rehabilitation movement and/or from professionals’ observations of persons diagnosed with schizophrenia who showed signs of improvement, “recovery” is also equally attributable to the consumer/survivor and service user movement (Anthony, 1993; Casey, 2008; Collier, 2010; Davidson et al, 2005).

The fact that the term is almost always used without any explanation, context, or definition (Davidson et al, 2005), combined with the fact that it can be viewed as either measurable or impervious to measurement depending on the origin of the concept (Deegan, 1988; Farkas et al, 2005; Jacobson, 2001), has led to a kind of recovery backlash. As the argument goes, the term’s ambiguity has rendered it almost meaningless (Roe et al, 2007; Davidson, 2006); for others in the field, the backlash stems from the concept’s potential dangerousness as a giver of false hope (Whitwell, 1999; Peyser, 2001). Still others suspect “recovery” of being either a passing fad or a covert attempt at saving money through the downloading of responsibility from the state to the service user (Dickerson, 2006; Ridgway, 2001; Davidson et al, 2006). Though many service users embrace the term, many also shy away from it for reasons discussed further below.

⁶ Refers both to the expectation that people should be “in control” of themselves and monitor their behaviours appropriately at all times, as well as to the expectation that people take responsibility for their own material well-being whilst subsisting on a social assistance rate whose real value has declined, rather than increased, in recent years (Wilton, 2004).

Regardless, the concept of recovery is still very prominent and it is possible to discern different models and frameworks from the literature.

In response to the charge of meaningless ambiguity, several authors propose distinctions between two types of “recovery,” loosely based on either a professional or a service user outlook. For example, Collier (2010) distinguishes between what she calls “medical” and “life” recovery; Cleary & Dowling (2008) use the terms “clinical” and “social” recovery; Davidson et al (2007) propose “recovery from” versus “recovery in;” and Rodgers, et al (2007) suggest “process” versus “outcome” recovery. Despite the variation in terms used, each of these distinctions honours the differing origins of the “recovery” movement. For professionals, “recovery” is a return to normal functioning, and is therefore quantifiable (Andresen et al, 2003; Farkas et al, 2005); for service users, on the other hand, “recovery” is more of a subjective journey of healing where new facets of self will be developed, rather than a return to one’s “old” self (Deegan, 2003).

Interestingly, regardless of its origin, “recovery” is almost always understood as an individual process – one that can be helped along by professionals, family members, or a community of concern, but that ultimately has to be taken up by the person (Deegan, 2004; Barker, 2001, 2003, 2005). Internal aspects of recovery include concepts such as hope, personal growth, and a positive sense of self; these can be helped along by such supports as family support, peer support, and meaningful activity (Ohio Department of Mental Health, n.d.). External factors, when mentioned, include having enough money to live or a house to live in (Pevalin & Goldberg, 2003; Spaniol et al, 2002). There are also a number of studies which distinguish between “internal” and “external” factors in recovery (Jacobson & Greenley, 2001; Maine Recovery Advisory Group, 1999; Onken et al, 2007; Ridgway, 2001; Trainor et al, 2004), and some go so far as to point out the limitations to a focus on either internal and/or external factors (Mental Health ‘Recovery’ Study Working Group, 2009; Lal, 2010; Rossiter & Morrow, 2010; Ida, 2007). These authors call for a more sophisticated analysis of what might encourage or impede an individual’s recovery from mentally ill health. Overall, there appear to be four basic levels of understanding of “recovery”: those that take the individual as their focus, those that take external/structural barriers as their focus, those that take the need for (culturally) appropriate services as their focus, and those that advocate for a complete overhaul of the system, society,

and the ways in which we view mental (ill) health. It is these last three which are of most interest to us here and which will be explored further in the next section.

Question 2: How do existing models/ frameworks and conceptualizations of mental health recovery address social and structural inequities?

“Without critical analysis of the social forces (such as class, gender, ethnicity) and power relations that shape emotional distress and effect social marginalisation, personal recovery remains very much tied to the assumptions of psy-expertise, psycho-pharmacology and social epidemiology” (O’Brien & Fullagar, 2008, p.7).

One of the more striking findings from the review of the mental health recovery literature is how rarely social inequities are addressed. Unsurprisingly, when social inequities are addressed, it is not to the same degree for all types of inequity; both Morrow & Rossiter (2010) and Lal (2010) discuss the privileging that certain social inequities receive in general scholarship. Jones et al (2007), Lal (2010), Armour et al (2009) and Ida (2007) point to a paucity of recovery models that address culture and ethnicity. Additionally, other social inequities exist which are ignored even more frequently when it comes to mental health recovery, such as gender, sexual orientation, and gender identity. Further, as mentioned previously, when issues such as racism are mentioned, it is usually in the context of the individual who is living with racism’s effects rather than as a structural problem. Although, as mentioned previously, a framework of ‘intersectionality’ is preferable when addressing social inequities, for the purposes of this review the various forms of discrimination that may be faced by individuals who are also said to be mentally ill have been compartmentalized. This has been done both to facilitate the database search as well as to isolate those forms of discrimination which may be overlooked in the literature. When it comes to mental health recovery, the various social inequities identified in the research question are addressed in the literature to roughly the following degree (each social inequity in this figure having been sized according to how often it was addressed in the literature):



Specific concerns have been raised by several authors in regards to social inequities and mental health. Firstly, many authors (Lapsley, 2002; Maine Recovery Advisory Group, 1999; Tse, 2004; Lal, 2010; Armour et al, 2009; Ida, 2007; Jones et al, 2007; Cameron et al, 2008) point to the dearth of culturally appropriate mental health services and call for the use of innovative, holistic programs that include all aspects of health, including spirituality. O’Hagan (2004), Lapsley (2002), Roberts & Wolfson (2004), Lal (2010), Lloyd et al (2004), and Everett et al (2003) point out the many facets of “recovery” in different parts of the world, and how the largely individualistic, Western notion of recovery may be limiting or inappropriate for some service users. For example, if one of the main Western focuses of recovery is autonomy, where does this leave the recovering individual whose cultural background emphasises interdependence and ties to family and community? (Cameron et al, 2008).

O’Brien & Fullagar (2008) and Myers (2010) posit that when the individual is stripped of his or her context – for example, a woman in an abusive relationship or a person experiencing homelessness – the person may experience shame for not “recovering,” thus ironically resulting in a loss, rather than a gain, of self esteem. Similarly, O’Brien & Fullagar (2008), Morrow et al (2009), and the Mental Health 'Recovery' Study Working Group (2009) outline how the neo-liberal imperative to “self-manage” can also lead to undue pressure to “recover”. They also point out that this view of “recovery” conveniently downloads responsibility onto the individual at a time when state support for mental health services is waning (ibid; Wilton, 2004).

Question 3: How have the lived experiences of individuals informed the development of current and past models of recovery? How is the concept of citizen engagement taken up by the recovery literature?

“... we can clearly understand people with mental illness as patients, but only dimly perceive them as fellow citizens” (Trainor et al, 2004, p.15).

Not surprisingly, the degree to which the lived experiences of individuals has informed the development of recovery models depends on the origin of the piece of literature – that is to say, whether it stems from a professional or a service-user outlook on recovery. Deegan (1988, 2003, 2004) is the most oft-cited consumer/survivor vis-a-vis the development of the recovery model, followed by Mead & Copeland (2000), but many nods are made to the consumer/survivor and service user movement in general. The “Tidal Model” is an example of an approach to recovery which was created by professionals (in this case, nurses) in conjunction with people with lived

experience (Barker, 2001, 2003, 2005). Repper (2000) also discusses how mental health nursing can incorporate service users' experiences as well as a social model of disability. In terms of the active role played by people with lived experience, several authors point out the fact that many consumer/survivors are given tokenistic roles and that their experience is therefore present in the recovery movement in name only (Jacobson & Curtis, 2000; Ramon et al, 2007; Bonney & Stickley, 2008). Peer support is identified as an important component of recovery; however, some authors suggest that peer support has been co-opted. That is, the inadvertent consequences of the professionalization of peer support and its incorporation into mainstream mental health services, including all attendant power dynamics has led some authors to call for the creation of "real" peer support opportunities, ones that are truly equitable and based on mutual respect and understanding (Myers, 2010; Fisher, 1994; Fisher & Chamberlin, 2004). For a more nuanced discussion of the "professionalization" of peers and its attendant drawbacks and benefits, please see full report of this project, "The Recovery Dialogues: A Critical Exploration of Social Inequities in Mental Health Recovery."

While many authors mention the idea of citizenship or citizen engagement, that is to say, valuing the lived experience and participation of people with mental health issues, (Lal, 2010; O'Hagan, 2004; Morrow et al, 2009; Onken et al, 2007; Roberts & Wolfson, 2004; Trainor et al, 2004; Mental Health 'Recovery' Study Working Group, 2009), when the idea of citizen engagement is taken up in the recovery literature, it is usually linked to a specific (individualistic) recovery concept such as "empowerment." The concept of citizen engagement may also be found in the "social inclusion" literature (Queensland Alliance, 2010; Mental Health Commission of Canada, 2010; Piat & Sabetti, 2009; Repper & Perkins, 2003; Davidson et al 2001). Stigma, "sanism", or discrimination against people with lived experience is a much discussed topic in the recovery literature (O'Hagan, 2004; Rossiter & Morrow, 2010; Mental Health 'Recovery' Study Working Group, 2009; Trainor et al, 2004), usually in the context of barriers added to an already challenging recovery journey.

Finally, the Mental Health 'Recovery' Study Working Group (2009) asks the question: How can we have recovery when we don't have human rights? For these authors, the violation of human rights imposed upon people with lived experience, such as coercive hospitalization practices or

lack of affordable housing, directly impedes people's ability to recover or to (re)join society in any meaningful way (ibid). In a similar vein, Myers (2010), Onken & Dumont (2002), and Slade (2009) raise the concept of "second class citizenship." These authors effectively question the usefulness of "recovery" tools such as WRAP (Wellness Recovery Action Plan) for people who, denied "social capital," are forced to live in poverty and social isolation due to the extreme nature of their mentally ill health (ibid). They also call for real opportunities for citizen engagement and the acquisition of social capital. "It is insufficient," Slade (2009, p.198) writes, "to simply be geographically in the community in invisible ghettos of dedicated day services and accommodation." As such, it is hardly surprising that the concept of "recovery" is not embraced by some mental health consumer/survivors (Mental Health 'Recovery' Study Working Group, 2009; Jacobson et al, 2010; Lal, 2010), although the term does have positive meaning for many others. In conclusion, we can see that there is a large variation to which people's lived experiences are taken up meaningfully in the literature.

Question 4: What opportunities are taking place regionally, nationally, and internationally that are relevant to developing recovery models (that address social inequities and/or citizen engagement)?

"Segregation and social exclusion follow from an exclusive focus on individual treatment" (Slade, 2009, p.198).

Although there are many interesting developments taking place in Canada, the US, the UK, Australia, and New Zealand, a few have been found which are considered particularly relevant to this project. While this list is by no means exhaustive, it does provide some insight into the current state of critical recovery movements and literature.

In British Columbia, Casey (2008) recommends that we think about the social determinants of health (World Health Organization, 2010) and health promotion when we talk about "recovery," as well as options for culturally relevant services. Currently, Vancouver Community Mental Health Services (a branch of Vancouver Coastal Health, one of five Health Authorities in British Columbia) is doing work around citizen engagement and recovery, working towards incorporating people with lived experience and their family members in a meaningful way both in terms of their involvement on boards and committees and in the development of recovery

services and educational opportunities (K. Calsafferri, personal correspondence, June 2, 2010). They are also currently engaged in ongoing discussions around the future of “recovery” within the organization, including what recovery might look like for older adults and youth, and how to take issues of spirituality, sexuality, and culture into account when developing new content/tools (ibid). Discussions are also being held around the cultural implications of the stigma that may surround seeking help for mental illness, as well as the stress of moving from a more collectivist to an individualist society (S. Pendakur, personal correspondence, June 2, 2010).

There are also several interesting opportunities taking place in Ontario, which has been a leader in Canada in the recovery movement. Of particular interest is the study conducted by Jacobson, Farah, & The Toronto Recovery and Cultural Diversity Community of Practice (2010) which looks at the meaningfulness of “recovery” to different cultural groups in Toronto. This group was able to articulate a “Culturally-Responsive Model of Recovery” (Jacobson et al, 2010) which places the individual in his or her context (family, community, geography, culture, oppression/privilege, social determinants of health, history, etc).

On a national level, The Canadian Mental Health Association (Trainor et al, 2004) has been looking at recovery from a critical perspective for a number of years, which includes an acknowledgment of different cultural frameworks, the valuing of cultural and experiential knowledge, and the fact that some mental illnesses may have better treatment outcomes in developing countries than in Western countries. More recently, the Mental Health Commission of Canada (MHCC) has committed to taking issues of “culture, race, ethnicity, migration, language, sex, gender, sexual orientation, different abilities, socioeconomic status, and religious/spiritual affiliation” into account in their framework: *Toward Recovery & Well-Being* (2009, p.48). This includes recognition of Indigenous views of health and healing (Mental Health Commission of Canada, 2009).

In the United States, the Mental Health America (MHA) Village in Los Angeles, California is an example of an organization which takes a creative and holistic approach to mental health recovery. The Village, as it is known, is unique in that it uses an integrated approach to combine traditional mental health services with employment, housing, money management, and other

services (such as substance use and crisis management) in order to support recovery (Ragins, 1995). One of its most innovative programs is its employment program, which is integrated with its clinical services (Slade, 2009). Participants are given an opportunity to work in a “real” work environment, with its attendant expectations, responsibilities, and financial compensations, without needing to first prove that they are “job ready” (Slade, 2009). Particularly for participants with criminal records, this is a valuable opportunity to gain both skills and actual work experience. For more information please visit their website at www.mhavillage.org.

Overseas, many note-worthy innovations in mental health recovery are taking place in New Zealand. These include a shift from an individualistic focus to one that sees cultural (re)integration itself as an act of “recovery” – not simply as a potential route towards improving mental health outcomes (O’Hagan, 2004; Lapsley et al, 2002; Lloyd & Kopelowicz, 2005; Roberts & Wolfson, 2004). This perspective, along with one that emphasizes citizen engagement, is supported by the New Zealand’s Mental Health Commission (O’Hagan, 2004). Additionally, mental health service providers in New Zealand are expected not only to have a grasp of national and international recovery principles, but also to understand culturally diverse perspectives on mental health, the consumer/survivor movement, and consumer rights (Roberts & Wolfson, 2004).

Related literature

Due to the nature of the searches conducted for this scoping review (that is to say, searches which used the exact word “recovery”), many interesting articles deemed “out-of-scope” were found to speak indirectly to the subject of mental health recovery and social inequities. These can largely be categorized into three camps: those which discuss ethnic and racialized minorities and their experience with the mental health system, those which discuss gender inequality and trauma recovery, and those which outline Aboriginal approaches to mental health care.

The first, concerning ethnic and racialized minorities and the mental health system, outlines the ways in which people from various cultural backgrounds may have difficulty accessing the mental health care they need. This can be for a variety of reasons, including language barriers, cultural worldviews, systemic racism, poverty, or lack of perceived relevance. The second,

concerning trauma recovery, provides insight into the ways in which women, in particular, cope with trauma, sexual abuse, and gender inequality in their lives. Everett et al (2003) found that trauma literature was a useful and analogous way to frame discussions of “recovery” models.

Additionally, there is a third body of literature and an oral tradition of Aboriginal/Indigenous healing practices that relate directly to the concept of recovery. While not explicitly about the mental health recovery movement per se, these articles point to what the “mental health recovery” movement is missing – namely, literature written by/about groups of people for whom the term currently has no currency or meaning. Although it is outside of the purview of this scoping review to discuss such literature in detail, it would be an excellent area for future research, as would a review of substance use and addictions recovery models (perhaps in comparison to mental health recovery models).

Discussion

Conclusion

A review of the recovery literature suggests that much confusion still exists about the concept of recovery and its applicability to mental health and more specifically its relevance for different communities. The models and frameworks that do exist fall short on an analysis of the role of gender and other social and structural inequities in mental health problems. This reveals that most of the attention has been given to recovery as an individual journey tied to medical, family and community supports with less attention being given to the structural changes needed to ensure adequate income, housing and social environments that are free of discrimination. Despite this there is evidence that new conceptualizations of recovery are emerging which are beginning to address the limitations of this concept for different cultural communities, calling for a more nuanced and in-depth understanding of what it means to “recover.”

Recommendations from the literature

“As a movement, recovery should focus more on addressing social inequities and changing systems of mental health services and supports and less on changing the individuals who use these services and supports” (Jacobson et al, 2010, p.13).

Recommendations have been pulled from 15 articles which specifically address the topic of social inequities and mental health recovery. These recommendations, which have been divided

into three sections (Policy, Practices, and Research), can be used to inform future recovery models that are responsive to social inequities, to the knowledge of people with lived experience, and to the concept of citizen engagement.

POLICY

- There are many experiences/conditions that bring people into contact with the mental health care system. In developing policy the question needs to be asked: What are people recovering from? Examples include childhood sexual abuse, a psychotic break, or traumas related to war experienced by recent immigrants and refugees.
- Expand the range of supports that are part of mental health recovery services to include social supports such as housing, income security, employment options, accessible transit systems, paid parental leave, language classes, and educational opportunities.
- Fiscal conservatism must be resisted; recovery and the many supports associated with it must be funded.
- Social and structural determinants of mental health need to be an integral part of any recovery policy.
- People need real opportunities to become engaged members of society/a community. This includes access to work and civic engagement including involvement in the development of mental health policies and programs.

PRACTICES

- Recovery is a collective journey that includes building a sense of community, using pre-existing support networks, fostering family and cultural connections where desired, and overcoming social isolation. Examples of a collective approach to recovery include viewing political activism and connection with one's culture as recovery, and allowing for a "problem-focused and collective orientation to recovery" (Lal, 2010, p.86).
- Service providers require training to better understand the role of social and structural inequities in mental health.
- A new "recovery" language can be explored using narratives, manifestos, or art in addition to models (Jacobson et al, 2010, p.13).
- Multiple definitions of mental (ill) health are needed, as well as for the possibility of recovery as a cultural/spiritual experience.
- Peer workers in mental health should reflect the racial and ethnic diversity of the population.

RESEARCH

- More research is needed to better understand how the concept of recovery is understood in different racial and ethnic communities and whether there are gendered differences in the understanding and uptake of recovery.
- The theoretical and methodological framework of intersectionality (that recognizes the different axes of oppression at work in a particular person's life) should be explored for its applicability to understanding social inequities and recovery.

Appendix A: Research Team

The study, ‘A Critical Exploration of Social Inequities in Mental Health Recovery,’ was envisioned by the Centre for the Study of Gender, Social Inequities and Mental Health (CGSM) and made possible through funding from the Canadian Institutes for Health Research (CIHR). The study’s research team consists of the following individuals: **Principal Investigator:** *Marina Morrow*, PhD, Associate Professor, Faculty of Health Sciences, Simon Fraser University and Director, CGSM. **Co-Applicants:** *Kim Calsafferri*, Mental Health Manager: Rehabilitation, Client and Family Services, Vancouver Community Mental Health Services (VCMHS); *Darrell Burnham*, Executive Director, Coast Foundation. **Collaborators:** *Susan Lynn Hardie*, PhD, Senior Policy and Research Analyst, Mental Health, Mental Health Commission of Canada (MHCC); *Simon Davis*, PhD, Team Leader, Adult Mental Health Services, VCMHS; *Ruth Gumpp*, MA, Peer Researcher, VCMHS; *branwen Willow*, Peer Researcher; *Cat Omura*, Peer Researcher. **Staff:** *Brenda Jamer*, MSc, Manager, Research and Administration, CGSM; *Julia Weisser*, MSW, Researcher, CGSM.

Appendix B: Search Terms

“CINAHL: MH “Rehabilitation + PF” (psychosocial factors) [subject heading, exploded] AND “Recovery” [keyword] AND “mental” [keyword]

PsycINFO: Mental disorders [subject heading, exploded] AND “recovery” AND model OR framework OR movement OR concept* [keywords] with the following combination of keywords:

+ sex* OR gender

+ sex* OR homo*

+ class* OR poverty*

+ disab*

+ rac* OR ethnic*

+ indigenous OR aborigin*

+ immigr* OR colonial*

+ cultur* OR divers*

+ age OR young OR senior OR elderly

+ soci* AND inequ* OR equ*

+econ* OR polit* OR marginal*

Limiters: 1980 onwards; English language; not animals; not subjects under 6 years of age

SocIndex: “Recovery” [subject term - includes “social movements,” “compulsive behaviour,” and “medicalization”] AND mental disorders [keyword] AND mental health [keyword] AND recovery [any field] with the following combination of words [any field]:

+ sex* or gender

+ homo*

- + disab*
- + indigenous OR aborinigal
- + immigr* OR colonial*
- + soci* AND inequ* or equ*
- + class* OR poverty
- + rac* OR ethnic*
- + cultur* OR divers*
- + age OR younger OR elderly OR senior
- + econ* OR polit* OR marginal*

Medline: “Mental disorders” [subject heading, with the following subheadings of “rehabilitation”/ “prevention and control”/ “psychology”] AND “recovery” with the following combination of keywords:

- + sex* OR gender
- + homo*
- + disab*
- + class* OR poverty
- + rac* ethnic*
- + indigenous OR aborigin*
- + cultur* or divers*
- + soci* AND equ* OR inequ*
- + econ* OR polit* OR marginal*
- +immigr* or colonial*

Also - Subject heading combined search: “Mental Disorders (PC/PX/RH)” + “Cultural Diversity” + “Recovery “

Women’s Studies International: A second round of searching was not deemed to be necessary.

Google Scholar: A Google Scholar search was conducted, with the following limiters:

- From 1980 to 2010;
- Categories: Biology, life sciences and environmental sciences; Medicine, pharmacology and veterinary science; Social sciences, arts and humanities
- NOT “substance, addiction”⁷

The search involved the following:

“Mental health recovery” (with all of the words, anywhere in the article)

+ sex OR gender

+ homosexuality

+ class OR poverty

+ race OR ethnicity

+ indigenous OR aboriginal

+ immigration OR colonialism

+ disability

+ age

+ social inequities OR social equality

+ political OR economic OR marginal

⁷ For the purposes of this study, the concept of “recovery” was limited to mental health, rather than addictions/substance use.

References with abstracts/annotations

Note: Abstracts vary in length and comprehensiveness but are the author's own, where available. Where unavailable, a brief annotation has been composed and marked with an asterisk*.

Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian & New Zealand Journal of Psychiatry*, 37(5), 586-594.

Objective: The consumer movement is advocating that rehabilitation services become recovery-orientated. The objectives of this study are to gain a better understanding of the concept of recovery by: (i) identifying a definition of recovery that reflects consumer accounts; and (ii) developing a conceptual model of recovery to guide research, training and inform clinical practice. **Method:** A review was conducted of published experiential accounts of recovery by people with schizophrenia or other serious mental illness, consumer articles on the concept of recovery, and qualitative research and theoretical literature on recovery. Meanings of recovery used by consumers were sought to identify a definition of recovery. Common themes identified in this literature were used to construct a conceptual model reflecting the personal experiences of consumers. **Results:** The definition of recovery used by consumers was identified as psychological recovery from the consequences of the illness. Four key processes of recovery were identified: (i) finding hope; (ii) re-establishment of identity; (iii) finding meaning in life; and (iv) taking responsibility for recovery. Five stages were identified: (i) moratorium; (ii) awareness; (iii) preparation; (iv) rebuilding; and (v) growth. **Conclusion:** A five-stage model compatible with psychological recovery is proposed, which offers a way forward for attaining recovery-orientated outcomes. After further empirical investigation, a version of this model could be utilized in quantitative research, clinical training and consumer education.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11.

Outlines the fundamental services and assumptions of a recovery-oriented mental health system. Community support system; Impact of severe mental illness; Concept of recovery; Recovery-oriented mental health system; Basic assumptions of a recovery-focused mental

health system; Implications for the design of mental health systems.; Outlines the fundamental services and assumptions of a recovery-oriented mental health system. Community support system; Impact of severe mental illness; Concept of recovery; Recovery-oriented mental health system; Basic assumptions of a recovery-focused mental health system; Implications for the design of mental health systems.

Armour, M. P., Bradshaw, W., & Roseborough, D. (2009). African Americans and recovery from severe mental illness. *Social Work in Mental Health*, 7(6), 602-622.

This hermeneutic phenomenological study examined the lived experience of African-American persons recovering from serious and persistent mental illness (SPMI). Semi-structured interviews were conducted at three time points (6, 12, and 18 months) with nine African Americans with SPMI. A culturally sensitive perspective informed the data analysis. Interviews were transcribed, read, and coded to cluster thematic aspects in each case and across cases. Atlas-ti was used to recode transcripts and retrieve quotes to dimensionalize each theme. Four themes were identified: (1) striving for normalcy, (2) striving to stay “up,” (3) coping with the consequences of illness, and (4) leaning on the supports that watch out for and over me. Findings were anonymously reviewed and critiqued by African-American research clinicians. Implications for practice include sensitivity to the intersection of racial oppression and stigma specific to mental illness, attention to meso- and macro-level needs, and client's positive responses to collaborative and personalized relationships with mental health professionals.

Barker, P. (2001). The tidal model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 8, 240-233.

Nursing theories and nursing models have a low profile within psychiatric and mental health nursing in the United Kingdom. This paper describes the philosophical and theoretical background of the Tidal Model, which emerged from a 5-year study of the 'need for psychiatric nursing'. The Tidal Model extends and develops some of the traditional assumptions concerning the centrality of interpersonal relations within nursing practice. The model also integrates discrete processes for re-empowering the person who is disempowered

by mental distress or psychiatric services or both. The paper reports briefly on the ongoing evaluation of the model in practice.

Barker, P. (2003). The tidal model: Psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing, 12*(2), 96-102.

Psychiatric research and practice involves the colonization of the personal experience of problems of human living. From a Western perspective, this process shares many similarities with the subjugation of women, people of colour and people embracing non-Christian faiths and cultures. The Tidal Model is a mental health recovery and reclamation model, developed to provide the framework for discrete alternatives to the colonizing approach of mainstream psychiatric practice. The Model asserts the intrinsic value of personal experience and the centrality of narrative in the development of contextually bound, personally appropriate, mental health care. This paper summarizes the features of the Model, which attempt to address the foci of the more significant critiques of psychiatric practice (and psychiatric nursing), against a background sketch of psychiatric colonization.

Barker, P., & Buchanan-Barker, P. (2005). *The tidal model: A guide for mental health professionals* (1st ed.). East Sussex: Brunner-Routledge.

*This book gives a description and guide of The Tidal Model, which is an approach to recovery-oriented services. The book, which is geared towards mental health professionals, includes the "10 commitments" for individuals who are looking to move forward in their recovery journey. The focus is on active engagement from the consumer as well as learning from the person's story or narrative. This theory was developed in consultation with people with lived experience of the mental health system.

Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing, 15*, 140-153.

Recovery is not a new concept within mental health, although in recent times, it has come to the forefront of the policy agenda. However, there is no universal definition of recovery, and it is a contested concept. The aim of this study was to examine the British literature relating to recovery in mental health. Three contributing groups are identified: service users, health care providers and policy makers. A review of the literature was conducted by accessing all

relevant published texts. A search was conducted using these terms: 'recovery', 'schizophrenia', 'psychosis', 'mental illness' and 'mental health'. Over 170 papers were reviewed. A thematic analysis was conducted. Six main themes emerged, which were examined from the perspective of the stakeholder groups. The dominant themes were identity, the service provision agenda, the social domain, power and control, hope and optimism, risk and responsibility. Consensus was found around the belief that good quality care should be made available to service users to promote recovery both as inpatient or in the community. However, the manner in which recovery was defined and delivered differed between the groups.

Cameron, R. P., Ton, H., Yang, C., Endriga, M.C., Lan, M., & Koike, A.K. (2008). The Transcultural Wellness Center: Rehabilitation and recovery in Asian and Pacific Islander mental health care. *Journal of Social Work in Disability & Rehabilitation*, 7(3), 284-314. Asian and Pacific Islander Americans (APIAs) are a diverse group, representing many cultures of origin, a range of immigration experiences, and varying access to economic and other resources. Despite stereotypes such as the "model minority" and cultural values that stigmatize mental illness and complicate mental health help-seeking, APIAs' psychiatric rehabilitation and recovery needs are significant. These needs are inadequately treated within existing systems of care. Passage of California's Mental Health Services Act (MHSA) in 2004 created the opportunity for Sacramento County to fund a full-service mental health clinic designed to meet the needs of the APIA community. The principles by which this clinic, the Transcultural Wellness Center, was conceptualized, advocated for, and launched is described. This clinic is considered a best practice model within the MHSA system redesign effort.

Casey, R. (2008). Towards promoting recovery in Vancouver community mental health services. *International Journal of Psychosocial Rehabilitation*, 12(2).

The concept of recovery has moved to the centre of mental health policy and service delivery for persons who have been diagnosed with a mental illness in Vancouver BC Canada. This article provides a review of the literature on recovery in mental health. A brief definition of recovery is given, followed by a historical review of the development of the philosophy of recovery with emphasis on the cultural implications of recovery for different

countries and organizations. Much like other community mental health systems Vancouver Community Mental Health Services (VCMHS) has not yet identified a specific model or framework to guide the development of recovery-oriented services. To that end three models and a framework of recovery are presented and possible next steps in integrating recovery are highlighted for VCMHS. The discussion on model development with a focus on the cultural implications and the process of implementing recovery has relevance for the development of mental health services internationally (Schinkel & Dorrer, 2007).

Cleary, A., & Dowling, M. (2009). The road to recovery. *Mental Health Practice, 12*(5), 28-31.

The article explores the principal concepts of recovery in mental health. Recovery in mental health encompasses interpersonal skills, collaborative working and sharing knowledge. Practices that are recovery-oriented call for a redefinition of the role of the professional. Recovery-oriented services represent a philosophical approach to service delivery that complements other specific interventions provided to ameliorate the symptoms of illness.

Collier, E. (2010). Confusion of recovery: One solution. *International Journal of Mental Health Nursing, 19*, 16-21.

This paper questions the current mental health discourse that offers new definitions of the concept of 'recovery' and offers a different perspective that aims to clarify its meaning. Confusion is caused when medical language continues to be used in discussions that aim to challenge traditional medical understanding of the term 'recovery' (meaning cure). Medical and non-medical concepts of recovery are referred to interchangeably in many narratives and the common references to and acceptance of the Harding et al. papers and similar that report on how people can 'get better' from schizophrenia perpetuates this confusion. In this paper, it is suggested that 'recovery' should not be viewed as having new meaning, but that two different concepts have been confused, with the same word having been used to describe two completely different things altogether. This means that what is referred to in this paper as 'medical' recovery (traditional definitions of recovery that aims for cure), becomes subordinate to 'life' recovery (personal development and change) in which psychiatric classification might have no part in a person's understanding of their experience and where improving 'symptoms' could be irrelevant in the personal process of growth and discovery.

Daley, A. (2010). Being recognized, accepted, and affirmed: Self-disclosure of Lesbian/Queer sexuality within psychiatric and mental health service settings. *Social Work in Mental Health*, 8(4), 336-355.

This article explores the relationship between self-disclosure of lesbian/queer (LQ) sexuality and well-being and recovery as described by women who either identify as consumer/survivors of psychiatric and mental health services and/or who work as mental health service providers within hospital- and community-based psychiatric and mental health service settings. I explore the relationship between self-disclosure and well-being and recovery by examining three points that frame women's ideas and experiences of self-disclosure including: (a) The negation and dismissal of lesbian/queer sexuality as an identity, (b) the closing off or compartmentalizing of concerns by lesbian/queer women, and (c) sexuality as a potential source of stress and/or support for lesbian/queer women.

Davidson, L., Stayner, D. A., Nickou, C., Styron, T. H., Rowe, M., & Chinman, M. L. (2001). 'Simply to be let in': Inclusion as a basis for recovery. *Psychiatric Rehabilitation Journal*, 24(4), 375.

Argues for the adoption of a broad conceptual framework of inclusion based on a disability paradigm for mentally ill people. Paradigm that neither alienates or requires people to succeed; Outline of approaches to treatment, rehabilitation and recovery; Three elements of friendship, reciprocity and hopefulness; Foundation of efforts for recovery.

Davidson, L., Lawless, M. S., & Leary, F. (2005). Concepts of recovery: Competing or complementary? *Current Opinion in Psychiatry*, 18(6), 664-667.

Purpose of review: Within the last 5 years, concepts of recovery have taken center stage in psychiatry as the overarching goal of mental health services. In the course of this shift towards recovery, clinicians and consumers (and many others) have struggled to make the concept of recovery both measurable and meaningful. The clinical concept of recovery has focused upon the remission of symptoms and restoration of functioning. A rehabilitation model of recovery has been a more subjective and consumer-oriented concept that focuses on the full lives that are lived within the context of enduring disability.

Recent findings: A review of the literature addressing the concepts of recovery over the last

2 years demonstrates that authors are rarely explicit about the perspective of recovery from which they are writing. Almost all of the representative papers, however, struggled with how best to define, measure and validate recovery in its broadest terms. Several authors reviewed the history of recovery and offered conceptual discussions of either their first-person experiences or implications for mental health practice. Other authors, regardless of their perspective on recovery, sought to more concretely define criteria for recovery, for the purposes of recovery measure development or more rigorous research of the concept.

Summary: As authors struggle to reconcile these often competing concepts of recovery, we suggest that both concepts are useful for different purposes and populations and that the synthesis of the two will offer a broader perspective on life with, after, or despite mental illness.

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research & Practice*, 36(5), 480-487. doi:10.1037/0735-7028.36.5.480

The notion of recovery has become a dominant force in mental health policy, evident in reports of the Surgeon General and President's New Freedom Commission. In both reports, recovery is stipulated as the overarching goal of care and foundation for reforms at state and local levels. Little consensus exists regarding the nature of recovery in mental illness, however, or about the most effective ways to promote it. The authors offer a conceptual framework for distinguishing between various uses of the term, provide a definition of recovery in mental health, and conclude with a discussion of the implications of this concept for meaningful reform.

Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57(May), 640-645.

The notion of "recovery" has recently taken center stage in guiding mental health policy and practice. However, it is not yet clear what the term means and what is to be entailed in transforming the nation's mental health system to promote it. The authors discuss the various meanings of recovery as applied to mental illness and list the top ten concerns encountered in efforts to articulate and implement recovery-oriented care. These concerns include the

following: recovery is old news, recovery-oriented care adds to the burden of already stretched providers, recovery involves cure, recovery happens to very few people, recovery represents an irresponsible fad, recovery happens only after and as a result of active treatment, recovery-oriented care is implemented only through the addition of new resources, recovery-oriented care is neither reimbursable nor evidence based, recovery-oriented care devalues the role of professional intervention, and recovery-oriented care increases providers' exposure to risk and liability. These concerns are addressed through discussion of the two overarching challenges that they pose, namely the issues of resources and risk.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459-470.

Background: There is an increasing global commitment to recovery as the expectation for people with mental illness. There remains, however, little consensus on what recovery means in relation to mental illness. **Aims:** To contribute to current efforts to tease apart the various aspects of recovery appearing in the psychiatric literature by describing two conceptualizations of recovery from and recovery in mental illness. **Method:** Review of empirical literature on recovery and use of the term in clinical and rehabilitative practice. **Results:** Two potentially complementary meanings of recovery were identified. The first meaning of recovery from mental illness derives from over 30 years of longitudinal clinical research, which has shown that improvement is just as common, if not more so, than progressive deterioration. The second meaning of recovery in derives from the Mental Health Consumer/Survivor Movement, and refers instead to a person's rights to self-determination and inclusion in community life despite continuing to suffer from mental illness. **Conclusions:** The implications for practice of each of these concepts of recovery, as well as for that group of individuals for which neither concepts may apply, are discussed.

Davis, S. (2006). Ch. 12: Rehabilitation and recovery and Ch. 14: Diversity and cultural competence. *Community mental health in Canada: Theory, policy and practice*. Vancouver, BC: UBC Press.

* Ch.12 provides an overview of recovery models and frameworks, specifically in the

context of community mental health. Ch.14 discusses cultural competence as well as barriers to care for members of minority populations. The focus here is on the mental health of ethnic/racial minorities and immigrants/refugees, as well as sexual minorities. The focus of the two chapters are separate, in the sense that cultural diversity/social inequities are not explicitly mentioned in the "Recovery and Rehabilitation" chapter, although there is mention of external factors/barriers to recovery as well as structural inequities.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11-19.

Distinguishes between recovery and rehabilitation. It is argued that psychiatrically disabled adults do not get rehabilitated, but rather they recover a new and valued sense of self and of purpose. Through the recovery process they become active and responsible participants in their own rehabilitation project. The experiences of recovery as lived by a physically disabled man and a psychiatrically disabled woman are discussed. Recommendations for creating rehabilitation environments that facilitate the recovery process are given.

Deegan, P. E. (2003). *Recovery as a journey of the heart*. Pat Deegan, PhD & Associates, LLC.

* In this paper Deegan discusses how the heart can harden as a coping strategy, and how mental health professionals can help nurture the person's recovery journey through patience, perseverance, and hope.

Deegn, P. E. (2003). *Recovery as a self-directed process of healing and transformation*. Pat Deegan, PhD & Associates, LLC.

* In this paper Deegan discusses the misconception that recovery means returning to one's former self, and how there is no one way to "do" recovery.

Deegan, P. E. (2004). *I don't think it was my treatment plan that made me well: Self-directed recovery, peer support and the role of the mental health professional*. Pat Deegan, PhD & Associates, LLC.

* In this paper Deegan explores the concept of recovery as self-directed, and how professionals must allow for the fact that the person is the expert in his or her own life,

capable of uncovering his or her own strategies and inner resilience for recovery. Professionals can help by providing resources and support.

Dickerson, F. B. (2006). Disquieting aspects of the recovery paradigm. *Psychiatric Services*, 57(May), 647-647.

* A commentary on Davidson et al's (2006) article (The top ten concerns about recovery encountered in mental health system transformation). Dickerson concisely raises concerns about whether or not the enthusiasm for "recovery" is simply a downloading of the responsibility on to the consumer, and also whether enough money has been put into the recovery movement for recovery to be a genuinely plausible option for consumers. How, she asks, is a person supposed to recover when they are living in poverty or with homelessness? "Learning to live better in the face of mental illness doesn't alter that reality" (p. 647).

Everett, B., Adams, B., Johnson, J., Kurzawa, G., Quigley, M., & Wright, M. (2003). *Recovery rediscovered: Implications for the Ontario mental health system*. Ontario, Canada: Canadian Mental Health Association, Ontario Division.

* This report asks tough questions about recovery: the lack of consistency surrounding its definition, the importance of its recent popularity as a model, and the implications for the mental health system, Ontario's in particular. In answer to the question: What are people recovering from? This report points to complexities beyond "mental health problems." People may be recovering from trauma or post-traumatic stress (particularly in the case of recent immigrants and refugees), discrimination, or from negative experiences with the psychiatric system itself. This report uses trauma literature as a framework for recommendations designed to make Ontario truly recovery-focused.

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal*, 41(2), 141-158.

In the decades of the 1990s many mental health programs and the systems that fund these programs have identified themselves as recovery-oriented. A program that is grounded in a vision of recovery is based on the notion that a majority of people can grow beyond the

catastrophe of a severe mental illness and lead a meaningful life in their own community. First person accounts of recovery and empirical research have led to a developing consensus about the service delivery values underlying recovery. The emphasis on recovery-oriented programming has been concurrent with a focus in the field on evidence-based practices. We propose that evidence based practices be implemented in a manner that is recovery compatible. Program dimensions for evidence based practice, such as program mission, policies, procedures, record keeping and staffing should be consistent with recovery values in order for a program to be considered to be recovery-oriented. This article describes the critical dimensions of such value based practice, regardless of the service the recovery oriented mental health programs provide (e.g., treatment, case management, rehabilitation). The aim of this first attempt at conceptualizing recovery-oriented mental health programs is to both provide direction to those involved in program implementation of evidence based mental health practices, as well as providing a stimulus for further discussion in the field.

Fisher, D. (1994). Health care reform based on an empowerment model of recovery by people with psychiatric disabilities. *Hospital & Community Psychiatry*, 45(9), 913-915.

People with psychiatric disabilities have articulated a model of recovery that encourages their empowerment by emphasizing consumer redefined goals, liberty, self-control of symptoms, peer support, elimination of discrimination, and provision of adequate material and social supports. Application of this model to health care reform requires public education to fight discrimination, an end to the use of involuntary interventions in the name of treatment, further development of services run by survivors-consumers and other alternatives to psychiatric hospitalization, and increased involvement of survivors-consumers in decisions related to their treatment and support. To promote empowerment of people with mental health problems, health care reform should include affordable, universal coverage without exclusions for preexisting high-risk conditions, parity of mental health benefits with other benefits, which includes coverage for voluntary services only, and incentives for funding long-term care, alternatives to hospitalization, and holistic healing services.

Fisher, D. B., & Chamberlin, J. (2004). *Consumer-directed transformation to a recovery-based mental health system*. USA: National Empowerment Centre; Substance Abuse and Mental

Health Services Administration; U.S. Department of Health and Human Services.

Today's mental health system has failed to facilitate recovery of most people labeled with severe mental illnesses, leading to increasing expressions of dissatisfaction by people using services, their families, and administrators. Only a fundamental change of the very culture of the system will ensure that the changes made in policy, training, services, and research will lead to genuine recovery. In accordance with the President's New Freedom Commission on Mental Health report, mental health consumers and survivors, representing diverse cultural backgrounds, should play a leading role in designing and implementing the transformation to a recovery-based mental health system. This paper provides an outline of how consumers/survivors can catalyze a transformation of the mental health system from one based on an institutional culture of control and exclusion to one based on a recovery culture of self-determination and community participation. At the national policy level, this paper recommends that consumers develop and implement a National Recovery Initiative. At the State and local policy levels, State and local recovery initiatives are recommended. On the direct service level, the paper provides a road map for developing services, financing, and supports that are based on self-determination and recovery.

A recovery-based mental health system would embrace the following values:

- Self-determination
- Empowering relationships based on trust, understanding, and respect
- Meaningful roles in society
- Elimination of stigma and discrimination

Changing the mental health system to one that is based on the principles of recovery will require a concerted effort of consumers and allies working to bring about changes in beliefs and practices at every level of the system. The building of these alliances will require the practice of recovery principles of trust, understanding, and respect by all parties involved.

Ida, D. J. (2007). Cultural competency and recovery within diverse populations. *Psychiatric Rehabilitation Journal*, 31(1), 49-53.

Recovery for diverse populations with mental health problems includes communities of color, those with limited English proficiency and individuals who are lesbian, gay, bisexual

or transgender (LGBT). The process of healing and recovery must take into consideration the critical role of culture and language and look at the individual within the context of an environment that is influenced by racism, sexism, colonization, homophobia, and poverty as well as the stigma and shame associated with having a mental illness. Recovery must assess the impact of isolation brought about by cultural and language barriers and work towards reducing the negative influence it has on the emotional and physical well-being of the person. It is imperative that recovery occur at multiple levels and involves the person in recovery, the service provider, the larger community and the system that establishes policies that often work against those who do not fit the mold of what mainstream society considers being "the norm." Recovery must respect the cultural and language backgrounds of the individual. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

Jacobson, N., & Curtis, L. (Spring 2000). Recovery as policy in mental health services:

Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, 23(4), 333-342.

The concept of recovery has emerged as a significant paradigm in the field of public mental health services. This paper outlines how the concept is being implemented in the policies and practices of mental health systems in the United States. After a brief overview of the historical background of recovery and a description of the common themes that have emerged across the range of its definitions, the paper describes the specific strategies being used by the states to implement recovery principles. The authors conclude by raising key questions about the implications of adopting recovery as system policy.

Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives.

Psychiatric Rehabilitation Journal, 24(3), 248-256.

This paper applies the technique of dimensional analysis to recovery narratives in order to examine the uniqueness of the recovery process. It finds that there are four central dimensions involved in recovery: self, others, the system, and the problem. The recovery process is made up of component processes that correspond to these dimensions: recognizing the problem, transforming the self, reconciling the system, and reaching out to others. The paper concludes by suggesting how understanding these dimensions and processes may aid practice and policy.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52*(4), 482-5.

This paper describes a conceptual model of recovery from mental illness developed to aid the state of Wisconsin in moving toward its goal of developing a "recovery-oriented" mental health system. In the model, recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment, and connection—and external conditions that facilitate recovery—implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services. The aim of the model is to link the abstract concepts that define recovery with specific strategies that systems, agencies, and individuals can use to facilitate it.

Jacobson, N., Farah, D., & The Toronto Recovery and Cultural Diversity Community of Practice. (2010). *Recovery through the lens of cultural diversity*. Toronto, Ontario, Canada: Community Resource Connections of Toronto; Centre for Addiction and Mental Health; Wellesley Institute.

In the mental health field, the word “recovery” has gained popular currency but its exact meaning – and relevance – for different people and cultures has not always been clarified. Equitable and responsive policies and services need to be informed by the diverse communities they serve in order to be effective. This report describes what recovery means from the perspectives of three cultural groups: Caribbean, Somali and Tamil and, in so doing, suggests how a culturally-responsive model of recovery can help mental health organizations meet the needs of Toronto’s multicultural population.

Jones, L. V., Hardiman, E. R., & Carpenter, J. (2007). Mental health recovery: A strengths-based approach to culturally relevant services for African Americans. *Journal of Human Behavior in the Social Environment, 15*(2-3), 251-269.

Strengths-based approaches that emphasize culturally competent services and naturally occurring community support may be more appropriate than traditional mental health services for African American adults with psychiatric disabilities. An examination of the literature on service utilization and treatment needs for this population highlights the paucity of empirical studies in these areas, while an exploration of the literature related to psychiatric recovery, a prominent strengths-based framework, reveals insufficient

application of the approach to the specific interests of African American service recipients. We suggest that recovery is in fact highly compatible with such culturally relevant approaches as the Afrocentric model, and argue that the concept of recovery may therefore provide a resonant and particularly useful framework for practice with this population. Implications for research, practice and policy are discussed.

Lal, S. (2010). Prescribing recovery as the new mantra for mental health: Does one prescription serve all? *Canadian Journal of Occupational Therapy*, 77(2), 82-89.

Background. "Recovery" is the new mantra for reforming the mental health system and occupational therapists have embraced the change. Purpose. To critically examine the concept of recovery across five dimensions: clarity, simplicity, generality, accessibility, and importance. Key Issues. The implicit assumption that the recovery concept is universally applicable is challenged. This examination raises concerns about the application of the recovery concept cross culturally, across the lifespan, and at different levels of service delivery. Implications. The meaning and application of the recovery concept will need to be cautiously applied to populations traditionally underserved by the mental health care system, including seniors, visible minorities, children and youth, recent immigrants, and refugees. Research exploring the meaning and process of recovery across diverse groups and at different levels of service delivery is needed. Occupational therapists must continue to critically examine the concept of recovery to position our field thoughtfully and inclusively within mental health care reform.

Lapsley, H., Waimarie Nikora, L., & Black, R. (2002). *"Kia mauri tau!" Narratives of recovery from disabling mental health problems*. Wellington, New Zealand: University of Waikato Mental Health Narratives Project/Mental Health Commission of New Zealand.

*For this project the investigators sought out participants who identified as currently or formerly having a mental health issue/struggle serious enough to be considered disabling, and who have "recovered" their mental health. Some debate around including or excluding participants who currently used psychotropic medications; the authors eventually decided to include them, so long as the participants themselves considered themselves "recovered." 40 narratives were gathered from Maori and non-Maori alike, with data analysis focusing on both the similarities and differences in these narratives. Many pertinent themes came up

including: family, culture, spirituality, healers, rituals, faith, living with stigma, etc. both for Maori and non-Maori participants. There was also discussion around the knowledge(s) of persons with lived experience about their own recovery. There was also quite a bit of discussion of narrative therapy/the importance of stories to various cultures.

Liberman, R. P., & Kopelowicz, A. (June 2005). Recovery from schizophrenia: A concept in search of research. *Psychiatric Services, 56*(6).

With the emergence of evidence based pharmacotherapy and psychosocial services for schizophrenia, optimal symptom and functional outcomes are now more readily available to practitioners and consumers. To what extent do these advances in treatment and rehabilitation presage recovery from schizophrenia as a realistic goal for the 21st century? In this article we distinguish the process of recovering from recovery as an outcome, summarize the feasibility of recovery as a therapeutic goal, provide an operational definition of recovery to facilitate research on this topic, assemble recent findings that reflect the validity of symptomatic remission and normative functioning in defining recovery, identify factors that may impede or promote recovery, and generate hypotheses that may have heuristic value in a research agenda on recovery from schizophrenia.

Lloyd, C., Tse, S., & Bassett, H. (2004). Mental health recovery and occupational therapy in Australia and New Zealand. *International Journal of Therapy & Rehabilitation, 11*(2), 64-70.

Every individual with mental illness has the right to be safe and cared for. Most people will receive the love and care from their families and friends, but they will also expect mental-health professionals, occupational therapists and the community to work together to provide the necessary services to support their recovery from mental illness. This article highlights the development of the recovery approach for people with mental illness in Australia and New Zealand. The implications of recovery concepts for occupational therapy, in the areas of individualized approach, participation of service users and carers, person-centred assessment and intervention, intersectoral links and mental-health promotion, are discussed. There are a number of key areas requiring further research and debate, notably the most effective means of implementing and evaluating recovery-focused interventions.

Maine Recovery Advisory Group (1999). Recovery Advisory Group Recovery Model: A work in progress [website]. Retrieved from <http://mhsip.org/recovery/index.html> (June 7, 2010).

Mead, S., & Copeland, M. E. (2000). What recovery means to us: Consumers' perspective. *Community Mental Health Journal*, 36(3), 315-328.

In this article two consumer leaders use their own experiences to explain the meaning and significance of recovery. They emphasize the importance of hope, personal responsibility, education, advocacy, and peer support. They also address controversial issues, such as the nature of the therapeutic relationship, the place of medications in symptom control, and the need for attitudinal changes in mental health professionals.

Mental Health Commission of Canada. (2009). *Toward recovery & well-being: A framework for a mental health strategy for Canada*. Calgary, AB: Mental Health Commission of Canada.

*Outlines the 7 goals of the Mental Health Strategy. For this review particular attention was paid to Goal Three, which mentions culture, race, ethnicity, migration (status), language, sex, gender, sexual orientation, abilities, socio-economic status, religious/spiritual affiliation, and includes a discussion around aboriginal views of health/healing. The concept of cultural safety is raised, as a complement to "cultural competence"; this involves recognizing structural barriers as well as the person's own (cultural) view of health/healing.

Mental Health Commission of Canada. (2010). *Roundtable on social inclusion June 10-22, 2010: Background paper summary*. Unpublished manuscript.

Mental Health 'Recovery' Study Working Group. (2009). *Mental health 'recovery': Users and refusers*. Toronto: Wellesley Institute.

Executive Summary: Mental Health "Recovery": Users and Refusers is the final report of a study that asked the question: what do psychiatric survivors in Toronto think about mental health "recovery"? This research recognizes the emergence of "recovery" as the new "talk" of community mental health services not just here but in the United States, the United Kingdom, and New Zealand. It addresses the fact that amidst a surge of "recovery" related research there are few critical voices especially from the people "recovery" promises to "heal" and "help." Thus, our primary concern has been to make psychiatric survivors central

in both directing this study and acting as participants. Some members of our advisory committee were located in community organizations; some were in the university; most spanned both. Some members identified as psychiatric survivors; some did not. Both of our staff/consultants were consumers of mental health services. Their status as “peers” was fundamental to the conversations that we opened up with study participants around the meaning/s of mental health recovery. We generated our data through focus group conversations held in seven community organizations that are on the “front-line” of service delivery. We analyzed our data through an iterative process of reading, talking together and writing about what participants said as recorded by our note-taker. In this way, we moved from a list of key themes/ quotes prevalent across groups to three lines of argument that constitutes a distinctive “take” on “recovery” in Toronto. The first situates “recovery” as a personal journey. Through their own efforts and achievements, individuals link personal care with self-esteem and positive thinking to achieve hope. The second argument situates “recovery” as a social process in which people address the need for tangible resources such as jobs, income, housing, safety and education. Giving and receiving peer support is fundamental to this view. The third argument takes “recovery” as critique – and targets a range of institutions: medicine/psychiatry, health care, medication/drugs, and the police. It opens terrain for recovering “recovery” from its increasing professionalization within community mental health. Clearly, even though “recovery” is increasingly powerful in organizing the operation of the service system, it has no single meaning – and no unified constituency.

Morrow, M., Wasik, A., Cohen, M., & Perry, K. (2009). Removing barriers to work: Building economic security for people with mental illness. *Critical Social Policy*, 29(4), 655-676. Using findings from two studies conducted in British Columbia, Canada, that examined income and employment supports for people with psychiatric disabilities we argue that economic security is essential for mental health recovery, and that supported employment and social enterprise models are well suited to support these goals. We contend that the aims and values underlying neo-liberalism, with its attendant welfare state restructuring, undermine the progressive vision of recovery and the practice of citizenship for people with psychiatric disabilities.

Mulvale, G., & Bartram, M. (Fall 2009). Recovery in the Canadian context: Feedback on the framework for mental health strategy development. *Canadian Journal of Community Mental Health, 28*(2), 7-15.

The Mental Health Commission of Canada is developing a strategy to transform the mental health system in Canada. National consultations held in spring 2009 provided feedback on a proposed framework of goals for the strategy. The first goal discusses a recovery orientation for people living with mental health problems and illnesses. Consultation participants strongly supported a recovery orientation but raised a number of concerns, especially for children, youth, and seniors. In response, the strategy will position recovery as part of a comprehensive approach that includes promoting the best possible mental health and well-being across the lifespan.

Myers, N. L. (2010). Culture of recovery? Schizophrenia, the United States' mental health system, and the American ethos of the self-made man. ProQuest Information & Learning. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 70*(8). At the turn of the 21st century, the American Recovery Movement - a group of concerned "consumers" (or users of the mental health system), researchers, policymakers, and family members of people with psychiatric disabilities - demanded changes be made to the institutional culture and treatment processes of the United States mental health care system. The Recovery Movement fundamentally believed that the healing experiences of people diagnosed with severe psychiatric disabilities were profoundly shaped by the cultural context in which they lived. Many medical anthropologists similarly argued that people's experience of mental distress may be socially mitigated by the way the cultural context in which they live attempts to understand and treat that distress (Kleinman 1980; Kleinman 1999; Jenkins and Barrett 2004; Good, Hyde et al. 2008). The Recovery Movement thus sought to promote a "culture of healing" rather than a "culture of recovery" within the "traditional" mental health system by making it more "recovery-oriented." As part of this culture shift, the American Recovery Movement aimed to guide Americans with schizophrenia away from their role as a "crazy" person with a "chronic" psychiatric disability and towards the role of a "healthy" citizen who demonstrated civic virtue to gain access to the rights and interconnectedness of valued citizens. To do so, recovery advocates

detailed a process of self-cultivation for people with schizophrenia unwittingly based on the classic American "journey of the self-made man," which they called the "journey of recovery." This journey included: establishing and maintaining an acceptable level of self-control and rationality, exhibiting an ability to act in one's own self-interest, and working hard in some kind of meaningful occupation. This dissertation examined attempts to enact such a journey for members of Horizons, a psychosocial rehabilitation organization in the United States that was attempting to become more "recovery-oriented" by changing its organizational policies and offering peer services (or consumer run services). As I analyzed the ways the "journey of recovery" was easy or difficult for members and staff at Horizons, I came to realize that the journey of recovery articulated by the American Recovery Movement - as it was presented at Horizons — was, in three specific ways, a cultural mismatch between an institutional prescription for "healthy citizenship" and the actual needs and capabilities of Horizons' members with schizophrenia. First, the Recovery Movement largely ignored the limitations of the intensely stressful everyday situation from which many people with schizophrenia were expected to commence their journeys of recovery. Second, recovery advocates glossed over the stress embedded in the expectations of self-control, autonomy, and hard work demanded by the journey of recovery. Finally, the Recovery Movement never overtly addressed the lack of "social capital" available to people with schizophrenia living in the United States. These oversights had repercussions for Horizons' members and staff as they worked to implement the ideas of the Recovery Movement in a real-world setting and will ultimately need to be addressed for "recovery-oriented services" to move forward.

O'Brien, W., & Fullagar, S. (2008). Rethinking the relapse cycle of depression and recovery: A qualitative investigation of women's experiences. *Social Alternatives*, 27(4), 6-13.

In 2003 the National Mental Health Plan 2003-2008 became the first national mental health policy in Australia to adopt a specific recovery focus. Service delivery in both federal and state policies is now driven by a 'recovery' orientation that also raises questions about how mental health and illness are conceptualised and responded to in practice. We argue that there is a need for more critical engagement with the meaning of 'recovery' as it is often used in a self-evident way to signify a better way forward for mental health policy. This

article is informed by and informs research that is currently being conducted into women's recovery from depression. Our preliminary analysis offers a critical perspective on the discourses and assumptions that inform the 'relapse cycle' in women's depression that makes recovery so problematic. We consider how the 'imperative to recover' may in fact be implicated in perpetuating the cycle of recovery and relapse that characterises the chronicity of many women's experiences of depression. Hence, our focus identifies the gendered experience of recovery and the implications that arise for policy and practice when the social context of depression and recovery is largely ignored.

O'Hagan, M. (2004). Guest editorial - recovery in New Zealand: Lessons for Australia?

Australian e-Journal for the Advancement of Mental Health (AeJAMH), 3(1), 1-3.

*Summary: The author discusses the way "Recovery" has been taken up in New Zealand and how this approach might be emulated by other countries, particularly Australia. Since New Zealand takes its commitment to anti-colonialist approaches to service delivery seriously, it had to redefine "recovery" in order to move it away from what was viewed as an "American" definition; that is to say, a move from a largely individualistic framework towards one that embraces cultural diversity and citizen engagement.

Ohio Department of Mental Health. (unknown). *Ohio department of mental health's emerging best practices in mental health recovery process*. Retrieved 06/07, 2010, from mhrecovery.com/overview.htm

* The Office of Consumer Services, Ohio Department of Mental Health developed a Recovery Process Model and Emerging Best Practices to define and enhance the quality of mental health services in Ohio. Nine "essential care components" were identified: Clinical care, family support, peer support & relationships, work/meaningful activity, power & control, stigma, community involvement, access to resources, and education. Emerging best practices were identified after consultation with a diverse working group of consumers, family members and mental health professionals; these best practices can be measured and assessed.

Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). *Mental health recovery: What helps and what hinders? A national research project for the development of*

recovery facilitating system performance indicators. Phase one research report: A national study of consumer perspectives on what helps and hinders mental health recovery.

Alexandria, VA, USA: National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center (NTAC).

Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators evolved from collaborative efforts among a number of state mental health authorities (SMHAs). These states were interested in developing a measure related to recovery as one of a set of indicators that can be used to assess the performance of state and local mental health systems and providers. The specific aims of this project came to be:

- To increase knowledge about what facilitates or hinders recovery from psychiatric disabilities,
- To devise a core set of systems-level indicators that measure critical elements and processes of a recovery-facilitating environment, and
- To integrate items that assess recovery-orientation into a multi-state "report card" of mental health system performance measures, in order to generate comparable data across state and local mental health systems and encourage the evolution of recovery oriented systems.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, 31(1), 9-22.

As mental health recovery gains traction, many people have put forward varying definitions. Few attempts have been made to create a dimensional analysis of the recovery literature that assesses the growing consensus about what recovery is or what its definition should entail. This paper incorporates an ecological framework to take the individual's life context into account while emphasizing both the reestablishment of one's mental health (i.e., first order change) and the mitigation of the oppressive nature of barriers imposed by the greater community (i.e., second order change) so that people may experience social integration and community inclusion.

Pevalin, D. J., & Goldberg, D. P. (2003). Social precursors to onset and recovery from episodes of common mental illness. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences*, 33(2), 299-306.

Social disadvantage and lack of social support have been identified as important risk factors for the onset and continuance of episodes of common mental illness. This study aimed to identify the social precursors to episodes of and recovery from common mental illness in a large, general population sample over eight yearly intervals. The analytical samples were drawn from those aged ≥ 16 in the British Household Panel Survey from 1991 to 1998. The samples were: (1) onset - over 42,000 paired years from 10,204 persons; (2) recovery - over 10,000 paired years from 4,878 persons; and (3) 1,812 spells with observed onset and recovery. Markov and discrete-time complementary log-log models were used. Common mental illness was measured using the 12-item General Health Questionnaire. Sex, age, changes in marital and employment status, physical health, family care and social support were all associated with differential rates of onset and recovery. Severity of disorder was associated with less likelihood of recovery and longer time to recovery. The study confirms many previous findings concerning social factors associated with onset and recovery. Low social support acted as expected by increasing chances of onset and decreasing chances of recovery... (PsycINFO Database Record (c) 2010 APA, all rights reserved)

Peyser, H. (2001). Commentary: What is recovery? *Psychiatric Services*, 52(4), 486-487.

*The author, a medical doctor, criticizes Jacobson and Greene's article in the same periodical (What is recovery?) for not being scientific, merely "hopeful." Furthermore, he goes on to say that the concept of "recovery" as outlined by Jacobson and Greene is potentially harmful, as it promotes "empowerment" and "freedom" for individuals who may not be able to use these concepts effectively due to the extreme nature of their illnesses. In other words, people do not know what is good for them when they are ill and therefore if they are empowered to make their own choices, they may never recover.

Piat, M., & Sabetti, J. (2009). The development of a recovery-oriented mental health system in Canada: What the experience of commonwealth countries tells us. *Canadian Journal of Community Mental Health*, 28(2), 17-33.

This article examines how the recovery concept has been introduced into national mental

health policies in New Zealand, Australia, and England. Five overall themes are identified as critical in shifting to a recovery-oriented system: restructuring of mental-health services, promoting mental health and preventing mental illness, developing and training the workforce, cultivating consumer participation and leadership, and establishing outcome-oriented and measurable practices. These issues are vital in the uptake of recovery and should guide the overall direction of the Canadian Mental Health Commission's mental health strategy.

Poole, J. (2007). *Behind the rhetoric of hope: A critical analysis of recovery discourses in Ontario*. (PhD, University of Toronto).

* A critical exploration of what “recovery” means currently in Ontario: what it is, who is speaking about it, who is doing it, who has claims on it. The author conducts an analysis of recovery texts and interviews with key informants, and suggests that “in Ontario, recovery is a deeply contested discursive terrain” (p.iii). Several distinct local discourses were identified, including: “Hope and faith talk,” “Story talk,” “Marketing talk,” “War talk,” “Turf talk,” “Professional talk,” and “Training talk.” Uses a Foucauldian lens informed by the methodology of Fairclough & Jager.

Queensland Alliance. (2010). *From discrimination to social inclusion: A review of the literature on anti stigma initiatives in mental health*. Australia: Queensland Alliance.

*A report written by Neasa Martin from Canada and commissioned by the Queensland Alliance for Australia, with an eye towards the development of a national anti-stigma/social inclusion campaign. The consultant undertook a review of similar campaigns/policy reports throughout the Western world in order to make recommendations for Australia.

Ragins, M. (1995). *Recovery with severe mental illness: Changing from a medical model to a Psychosocial Rehabilitation Model*. Exploring Recovery: The Collected Village Writings of Mark Ragins. Retrieved 12/13, 2010, from <http://www.mhavillage.org/Web%20Articles/5RecoverywithSevereMentalIllnessChangingfromaMedModtoaPsyRehabMod.pdf>

*This article outlines ways in which Psychosocial Rehabilitation can be used in a mental health context. Different conceptualizations of the term “recovery” are also explored. The

author uses as example The Village Integrated Services Agency in New York State, which he helped to found. This organization has expanded the psychosocial rehabilitation model to include both typical services like social, vocational, clubhouse and housing, and generally segregated services like money management/payee, substance abuse, case management teams, medication, crisis response and even hospitalization all within a managed care, capitated funding scheme.

Ramon, S., Healy, B., & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry*, 53(2), 108-122.

The language of recovery is now widely used in mental health policy, services, and research. Yet the term has disparate antecedents, and is used in a variety of ways. Some of the history of the use of the term recovery is surveyed, with particular attention to the new meaning of the term, especially as identified by service users, supported and taken up to various degrees by research and in the professional literature. Policy and practice in two countries--Australia and the United Kingdom--are examined to determine the manner and extent to which the concept of recovery is evident. In its new meaning, the concept of recovery has the potential to bring about profound and needed changes in mental health theory and practice. It is being taken up differently in different settings. It is clear that--at least in Australia and the United Kingdom--there are promising new recovery models and practices that support recovery, but the widespread use of recovery language is not enough to ensure that the core principles of the recovery model are implemented.

Repper, J. (2000). Adjusting the focus of mental health nursing: Incorporating service users' experiences of recovery. *Journal of Mental Health*, 9(6), 575-587.

Mental health nursing is currently torn by passionate debate about its proper focus and function, with the two dominant 'camps' competing for ascendancy. Although both traditions stress the need to involve service users in their own care, the hegemonic nature of these professional theories tends to relegate the expertise of those who experience mental health problems. This paper considers service users' views and experiences, particularly their accounts of recovery, and finds a place for both approaches. Users also highlight the

importance of strategies for social inclusion (facilitating access to roles, responsibilities, relationships and communities) an area of work that has not been prioritised by mental health nurses in either approach. Service users differ from each other and have a range of different roles in different settings. In developing their own strategies for living they need choices, multiple perspectives, a range of approaches and skills. It is not for us to create single models or fixed ways of acting upon them, but for service users to use a range of resources - including the different strategies that nurses make available - in ways most useful to them. In providing the most helpful environment for recovery, mental health nursing theorists must move from competition to cooperation, from criticising others to self-criticism. We must also incorporate strategies for social inclusion, but if we are to promote diversity in communities, we must first embrace diversity in our own area of work.

Repper, J., & Perkins, R. (2003). Ch. 12: Involving service-users in mental health services. *Social inclusion and recovery: A model for mental health practice* (pp. 183-202). China: Bailliere Tindall (Elsevier Science Limited).

* This chapter discusses a variety of ways in which service users can be meaningfully included or involved in mental health services. There is discussion of peer involvement on boards, in planning, and in research.

Ridgway, P. (Spring 2001). ReStorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, 24(4), 335-343.

This qualitative study examines first person accounts of recovery from psychiatric disability. Common themes and patterns are identified and findings are linked to narrative and resiliency theories. Implications for policy, practice, and research are provided.

Roberts, G., & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment*, 10, 37-49.

'Recovery' is usually taken as broadly equivalent to 'getting back to normal' or 'cure', and by these standards few people with severe mental illness recover. At the heart of the growing interest in recovery is a radical redefinition of what recovery means to those with severe mental health problems. Redefinition of recovery as a process of personal discovery, of how to live (and to live well) with enduring symptoms and vulnerabilities opens the

possibility of recovery to all. The 'recovery movement' argues that this reconceptualisation is personally empowering, raising realistic hope for a better life alongside whatever remains of illness and vulnerability. This paper explores the background and defining features of the international recovery movement, its influence and impact on contemporary psychiatric practice, and steps towards developing recovery-based practice and services.

Rodgers, M. L., Norell, D. M., Roll, J. M., & Dyck, D. G. (2007). An overview of mental health recovery. *Primary Psychiatry, 14*(12), 76-85.

Empirical evidence and personal accounts have demonstrated that many people with severe and persistent mental illness can lead satisfying, meaningful lives. This phenomenon has been termed recovery. A variety of definitions of recovery have been proposed. Lack of consensus on conceptual and definitional issues complicate the measurement and study of recovery. The development of qualitative and quantitative measures of recovery is enriching research on recovery. The integration of recovery goals with evidence-based practices has recently been endorsed. However, relatively little empirical research has addressed the extent to which current evidence-based practices impact recovery. This article chronicles the history of the current focus on recovery in mental health, summarizes available process and outcome definitions, describes current research methods utilized in the recovery literature, and provides a clinical model that integrates recovery with an evidence-based practice perspective. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

Roe, D., Rudnick, A., & Gill, K. J. (2007). The concept of "being in recovery." *Psychiatric Rehabilitation Journal, 30*(3), 171-173.

The article focuses on the conceptualization of recovery in psychiatric rehabilitation and mental health care. The concept of recovery proves that people with severe mental illness can live a meaningful life despite the limits of their psychiatric disorder. Though it has been accepted by the state and federal authorities in the United States, it has also been challenged and criticized for not adequately evidence-based and for setting impractical expectations.; The article focuses on the conceptualization of recovery in psychiatric rehabilitation and mental health care. The concept of recovery proves that people with severe mental illness can live a meaningful life despite the limits of their psychiatric disorder. Though it has been

accepted by the state and federal authorities in the United States, it has also been challenged and criticized for not adequately evidence-based and for setting impractical expectations.

Rossiter, K., & Morrow, M. (In press). Intersectional frameworks in mental health: Moving from theory to practice. In O. Hankivksy (Ed.), *Health and intersectionality inquiry in Canada*. Vancouver, BC, Canada: UBC Press.

*The authors address the dearth of literature on the topic of how the concept of intersectionality can be applied to mental health. They point out the fact that certain social locations are studied more than others, which creates an uneven picture of social inequities and mental health. Additionally, certain mental health issues are studied more than others. In terms of mental health recovery, even social models of recovery don't tend to take social inequities into account. Also addressed in this article: the link between recovery and stigma; the ways in which the theoretical framework of intersectionality can be operationalized; the links between recovery, inclusion, and citizenship; and the inadequacy of "cultural competency" models vis-a-vis structural racism and macro-level factors.

Schmidt, G. (Fall 2000). Barriers to recovery in a First Nations community. *Canadian Journal of Community Mental Health, 19*(2), 75-87.

The practice of psychiatric rehabilitation is a concept and method that developed in urban-based settings. It has become a widely used guiding principle in mental health practice. This research examines how psychiatric rehabilitation fits within a remote First Nations community. Ten people - service providers, consumers, and family members - were interviewed to gather information about their perceptions of and experiences within the mental health system. The interview material was examined using content analysis. The results suggest that geographic and economic factors create serious barriers to application of the psychiatric rehabilitation method in a remote First Nations community.

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge, UK: Cambridge University Press.

In this book, Mike Slade outlines mental health services as they currently exist, with an eye towards making them truly recovery-oriented. "Personal recovery" is defined in contrast to "clinical recovery" and explored in great detail, with an emphasis on the UK as well as an

outline of the current policies in other Western countries. Many aspects of the journey of recovery are examined, including: support from mental health professionals; peer support; community-building and social inclusion; spirituality and healing; medication and personal choice, etc. The goal of the book is to move towards a mental health system which is helpful for everyone who needs it.

Spaniol, L., Wewiorski, N. J., Gagne, C., & Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry*, 14(4), 327-336.

To facilitate future research on recovery from schizophrenia a qualitative, longitudinal analysis was conducted with individuals participating in rehabilitation to identify themes associated with improvement in functioning and subjective experience. Twelve individuals with a diagnosis of schizophrenia or schizoaffective disorder were randomly selected from a just concluded two-year study of psychiatric rehabilitation. Each individual was followed for an additional four years. Every four to eight months each person participated in a semistructured, audiotaped interview about his or her current life experiences. Tapes were evaluated independently by three assessors for themes and phases that emerged from these life experiences. The qualitative analysis characterized the process of recovery as having phases, dimensions, indicators, and barriers to recovery. This empirically derived description of the process of recovery, from the perspective of people who are experiencing it, can be used to generate research hypotheses for future studies to further our understanding and to promote recovery from schizophrenia.

Trainor, J., Pomeroy, E., & Pape, B. (2004). *A framework for support: 3rd edition*. Toronto: Canadian Mental Health Association.

* The 3rd Edition of "A Framework for Support" by the CMHA begins by acknowledging the "gap between what we know we can do and what we are actually doing" (p.3); its goal is to focus on the knowledge(s) we do have in order to move beyond this gap. It provides an overview of the framework model, as well as an explanation of the 3 pillars: Community Resource Base, Knowledge Resource Base, Personal Resource Base. It also introduces the idea of the consumer as an engaged citizen, and "recovery's partners" (p.23).

Tse, S. (2004). Use of the recovery approach to support Chinese immigrants recovering from mental illness: A New Zealand perspective. *American Journal of Psychiatric Rehabilitation*, 7(1), 53-68.

Recovery has become a popular concept in mental health services. The Mental Health Commission in New Zealand has recently endorsed the recovery approach as an approach to working with people suffering from mental health problems. Ten recovery-based competencies were developed by the Commission as the underpinning principles for training of mental health professionals and delivery of mental health services. The ethnic composition of the New Zealand population has become increasingly diverse in recent years, including a rapid rise in the number of Chinese immigrants. Immigration is a stressful experience and it may result in changes in mental health. One vignette is used to discuss how health professionals can use the recovery-based competencies to help Chinese New Zealand immigrants with mental illness (re)gain their healthy life roles and (re)integrate into society. Further research is required to help identify specific intervention methods that contribute to successful recovery among Chinese immigrants with mental illness.

(PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

Whitwell, D. (1999). The myth of recovery from mental illness. *Psychiatric Bulletin*, 23(10), 621-622.

*The author posits that it is potentially dangerous to use the term "recovery" because it implies, to most people who hear the term, a return to normal or pre-illness functioning. In this way we are setting people up for failure because this type of recovery is not possible from major mental illness.

World Health Organization (WHO). (2010). *Backgrounder 3: Key concepts*. Retrieved May 18, 2010, from http://www.who.int/social_determinants/final_report/key_concepts_en.pdf

*Summary: This background paper defines health inequities/inequalities, introduces the concepts of: social gradient, social 'determinants' of health, drivers of health inequities, primary health care and health equity in all policies. While it does not mention mental health specifically, the concepts can be applied to mental health and would provide a framework in which to examine the impact of social inequities on mental health (recovery).

Bibliography

- Anderson, S., Allen, P., Peckham, S., & Goodwin, N. (2008). Asking the right questions: Scoping studies in the commissioning of research on the organisation and delivery of health services. *Health Research Policy and Systems*, 6(7), 1-12.
- Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, 8(1), 19-32.
- Aveyard, H. (2007). *Doing a literature review in health and social care: A practical guide*. Berkshire, UK: Open University Press/McGraw-Hill Education.
- Battersby & Morrow (submitted for review). Challenges in Implementing Recovery-Based Mental Health Care Practices in Psychiatric Tertiary Care Settings in British Columbia.
- Beresford, P. (2005). Redistributing profit and loss: The new economics of the market and social welfare. *Critical Social Policy*, 25(4), 464-482.
- Braveman, P. & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, 57, 254-258.
- Brown, J. & Isaacs, D. (2005). *The World Cafe: Shaping our futures through conversations that matter*. San Francisco: Berrett-Koehler Publishers.
- Burman, E., & Chantler, K. (2003). Across and between: Reflections on researching 'race', gender and mental health. *Feminism & Psychology*, 13(3), 302-309.
- Canadian Mental Health Association Vancouver-Burnaby Branch. (2010). Recovery and success. Retrieved 07/29, 2010, from <http://vancouver-burnaby.cmha.bc.ca/success>
- Collins, P. Y., von Unger, H., & Armbrister, A. (2008). Church ladies, good girls, and locas: Stigma and the intersection of gender, ethnicity, mental illness, and sexuality in relation to HIV risk. *Social Science and Medicine*, 67, 389-397.

- Davis, K., Drey, N., & Gould, D. (2009). What are scoping studies? A review of the nursing literature. *International Journal of Nursing Studies*, 46, 1386-1400.
- Hagell, A., & Dowling, S. B. (1999). *Scoping review of literature on the health and care of mentally disordered offenders* No. CRD Report 16. York, UK: University of York.
- Hankivsky, O., & Cormier, R. (2009). *Intersectionality: Moving women's health research and policy forward*. Vancouver, BC: Women's Health Research Network.
- Health and Welfare Canada. (1988). *Mental health for Canadians: Striking a balance*. Ottawa: Ministry of Supply and Services Canada.
- Johnston, B., Nimmo, S., Baughan, P., & Kearney, N. (unknown). *A scoping review of palliative care in Scotland - final report*. Scotland, UK: Cancer Care Research Centre.
- McMullin, J. (2010). *Understanding social inequality: Intersections of class, age, gender, ethnicity, and race in Canada* (2nd ed.). Don Mills, Ontario: Oxford University Press.
- Mill, J., Austin, W., Chaw-Kant, A. J., Dumont-Smith, C., Edwards, N., & et al. (2007). *The Influence of Stigma on Access to Health Services by Persons with HIV Illness*. Edmonton, AB: University of Alberta.
- Morrow, M., & Jamer, B. (2008). Making meaning in a 'Post-institutional' age: Reflections on the experience of (de) institutionalization. *International Journal of Psychosocial Rehabilitation*, 12(1)
- Morrow, M., Hankivsky, O., & Varcoe, C. (Eds.). (2007). *Women's health in Canada: Critical perspectives on theory and policy*. Toronto, ON: University of Toronto Press.
- Morrow, M., Pederson, A., Smith, J., Josewski, V., Jamer, B., & Battersby, L. (2010). *Relocating mental health care in British Columbia: Riverview Hospital redevelopment, regionalization and gender in psychiatric and social care*. Vancouver: Centre for the Study of Gender, Social Inequities and Mental Health.

Punch, K. (2005). *Introduction to social research* (2nd ed.). London, UK: Sage Publications Ltd.

Ship, S. J., & Norton, L. (2001). HIV/AIDS and Aboriginal Women in Canada. *Canadian Woman Studies*, 21(2), 25-31.

This is survivor research (2009). In Sweeney A., Beresford P., Faulkner A., Nettle M. and Rose D. (Eds.). Herefordshire, UK: PCCS Books Ltd.

Vancouver Coastal Health (2007). *Dialogue on the Recovery Philosophy*. Vancouver, BC: Author.

Vancouver Coastal Health (2007). *Dialogue on the Recovery Philosophy: Deepening Our Understanding*. Vancouver, BC: Author.

Wilton, R. (2004). More responsibility, less control: Psychiatric survivors and welfare state restructuring. *Disability and Society*, 19(4), 371-385.