

# The Recovery Dialogues: A Critical Exploration of Social Inequities in Mental Health Recovery

---

*Marina Morrow, Brenda Jamer and Julia Weisser*

**Principal Investigator:** Marina Morrow, PhD, Associate Professor, Director, Centre for the Study of Gender, Social Inequities and Mental Health (CGSM), Faculty of Health Sciences, Simon Fraser University. **Co-Applicants:** Kim Calsaferrri, Manager-Rehabilitation, Consumer Involvement & Family Support, Vancouver Community Mental Health Services (VCMHS); Darrell Burnham, Executive Director, Coast Mental Health. **Collaborators:** Susan Lynn Hardie, PhD, Senior Policy and Research Analyst, Mental Health Commission of Canada; Simon Davis, PhD, Team Leader, Adult Mental Health Services, VCMHS; Ruth Gump, MA, Peer Researcher, VCMHS; branwen Willow, Peer Researcher; Cat Omura, Peer Researcher. **Staff:** Brenda Jamer, Manager, Research and Administration, CGSM; Julia Weisser, Researcher, CGSM.

## Acknowledgements

The researchers would like to acknowledge the support of Coast Mental Health, Vancouver Community Mental Health Services, Centre for the Study of Gender, Social Inequities and Mental Health, the Mental Health Commission of Canada, and the dedication of the research team and community partners who contributed to this project. We would especially like to thank all the mental health service users and providers who participated in the World Café event. This research was funded by the Canadian Institutes for Health Research (CIHR).

## Rationale

“Recovery” as a term in the mental health field first became commonly used in the 1980s and 1990s. The idea grew out of psychiatric survivor movements (Onken, Craig, Ridgway, Ralph, & Cook, 2007; Ramon, Healy, & Renouf, 2007) as well as the psychiatric rehabilitation movement (Anthony, 1993). At the heart of the concept is the idea that people can and do “get better,” even if they have been labelled as persistently or chronically mentally ill (Markowitz, 2001; Ramon et

al., 2007). Recovery is largely conceptualized as a personal journey, taken by an individual who is being treated for his or her illness and supported as needed (Markowitz, 2001; Ramon et al., 2007).

Definitions of recovery do exist which concentrate on the social and external factors which support a person along his or her journey. However, these definitions and the models that stem from them often lack an explicit recognition of the impact of structural barriers such as racism, sexism, and homophobia on mental health. These factors help perpetuate systemic discrimination based on factors such as racialization<sup>1</sup> of ethnocultural groups, gender, and, sexual orientation (Morrow, Wasik, Cohen, & Perry, 2009; Morrow, Pederson, 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, in press; Collins, von Unger, & Armbrister, 2008; Mill et al, 2007; Ship & Norton, 2001).

Thus, in practice, the degree to which social models of recovery gain traction is hindered by structural barriers such as the lack of community-based mental health resources (e.g., housing, income security, employment) and the ongoing dominance of the biomedical paradigm in mental health (Morrow, 2004; Teghtsoonian, 2008; Walker, 2006). These critiques notwithstanding, very little empirical research has been done on the subject of mental health recovery. 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 community mental health (Morrow & Jamer, 2008).

## Goal

The goal of this research 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 which are grounded in principles of citizen engagement (i.e., valuing the lived

---

<sup>1</sup> “**Racialization** refers to the extension of a racial meaning to a previously unclassified group” (Omi & Winant, 1994 in Joshi, 2006, p.212).

experience and participation of people with mental health issues) and that recognize the impact of social and structural inequities on mental health and recovery.

## Objectives

1. To bring together a Mental Health Recovery Research Team consisting of a collaboration among academics, people with lived experience of mental health issues, decision makers, and community based organizations working in the area of mental health recovery who will be active in all phases of the research;
2. To conduct a scoping review of mental health and other relevant literatures in order to identify current definitions, models, and conceptualizations of recovery and to explore recovery in its intersections with social inequities;
3. To conduct roundtable discussions using a “World Café” approach to foster cross-sectoral communication and a better understanding of the social and structural barriers to mental health recovery and to the implementation of recovery models in practice;
4. To identify the key components of a mental health recovery model that is informed by multiple perspectives and that addresses social and structural inequities;
5. To develop a research agenda identifying key research priorities for future work by the team built on the knowledge created through the proposed exercises.

## Scoping Review

A scoping review<sup>2</sup> was conducted in order to assess the current state of mental health recovery literature in the Western world. Although many definitions of “recovery” exist in the literature, including those that attend to structural barriers in addition to individualistic factors such as empowerment, hope, and autonomy (Jacobson & Greenley, 2001; Jacobson, 2001), very few models explicitly address social and structural inequities such as racism, sexism, poverty, and homophobia (Rossiter & Morrow, in press). Using purposive sampling and a search of social

---

<sup>2</sup> A **scoping review** “aim(s) to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as stand-alone projects in their own right, especially where an area is complex or has not been reviewed comprehensively before” (Mays, Roberts & Popay, 2001, p. 194, in Arksey & O’Malley, 2005).

science databases, both peer-reviewed and grey<sup>3</sup> literature 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 which are taking place regionally, nationally, and internationally and that are relevant to developing recovery models which address social inequities and/or citizen engagement (Weisser, Morrow & Jamer 2011).

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 live with a mental health issue.

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 surrounding 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.

---

<sup>3</sup> **Grey literature** refers to materials that have not been formally published and includes reports written by community groups based on their research (Reid, Brief & LeDrew, 2009, p. 15)

- Examples of innovative recovery work being done in Canada and around the world.

Many concepts which came to the forefront in the scoping review also came to light in the World Café. These include: confusion surrounding the definition and origin of the term “recovery;” the need for meaningful peer support; the need for a social justice model of recovery; and the need for adequate funding for recovery services (which can include services not traditionally thought of as “mental health” services). These and other findings from the World Café are outlined below.

## **Ethics Approval**

Ethics approval was granted by the Research and Ethics Board (REB) of Simon Fraser University, as well as by Vancouver Community Mental Health Services, Vancouver Coastal Health in order to engage a cross-sectoral multi-disciplinary group of mental health experts and stakeholders in concurrent round table discussions employing a World Café methodology.

## **World Café Methodology**

The “World Café” methodology involves concurrent round table discussions which are focused around a set of questions (Brown and Isaacs, 2005). The World Café approach, which has been used internationally, allows for multi-layered discussions which build upon one another – thus allowing space for multiple perspectives and kinds of knowledge (personal, professional, academic) to be expressed and heard (Brown & Isaacs, 2005). The overarching objective of the café was to seek shared understanding about what was meaningful to each individual present, as was relevant to the discussion question. As such, the input of each participant was considered, based on what was true for them, in the context of each discussion. In the World Café approach each participant in the café is meant to represent an aspect of the whole system's diversity, and as each person has the chance to connect in conversation, more of the intelligence inherent in the group is meant to become accessible. We chose this methodology as a way of bringing people together in mental health who do not always have options for dialogue across their different sectors and experiences, with the goal of sharing information in a way that allows for participants

to see their situation in a different light. In turn, this allows for a process of enhancing and broadening each other's perspectives along the way.

A café-like environment of four tables with room for six individuals per table was provided. Participants were supplied with pens and a large sheet of paper and were encouraged to draw and record their conversations to capture free flowing ideas as they emerged. There was a cross-sectoral multi-disciplinary mix of participants at each table. Each table was assigned a facilitator and a reporter, both of whom remained at the same table throughout the café. Each table was provided with a discussion question, and with the help of the facilitator, participants engaged in dialogue addressing this question for about thirty minutes. They then proceeded to a different table with a new question and a new mix of individuals, to expand upon the ideas generated by the last group at that table. The reporters summarized the conversation of the previous group when the new participants arrived, ensuring that any important points were surfaced for possible discussion and further development by the new group.

### *Participants*

The concurrent round table discussion groups were comprised of twenty four mental health experts and stakeholders, including mental health and social service front line workers; mental health and addictions managers; policy makers; people with live experience of mental health issues, family members; and community leaders engaged in mental health work. Many attendees wore several "hats" (such as service user and service provider, family member and policy maker, etc.). Overall, about half of the participants identified as having lived experience of mental health issues, and about half were service providers, managers, or policy makers in the mental health field. Forty-nine people were approached for participation in the café, all of whom were recommended by members of the research team; twenty four attended the event.

### *Discussion Questions*

The discussion questions for the World Café evolved out of dialogue among the research team members, which took place on two separate occasions. At the initial meeting, ideas for how best to identify key components of a recovery model that is responsive to social and structural inequities were put forth by various members of the group and reflected upon by the other members present. The researchers then crafted questions from this discussion and brought them

back to the group for a second meeting and approval. The research team decided upon the following as discussion questions for the World Café:

1. What are some of the social and structural barriers that impact people's mental health recovery?
2. What are the strengths and weaknesses of current mental health recovery models with respect to addressing social and structural inequities?
3. What would components of a recovery model look like that integrated social and structural inequities and how would we get there?
4. How can people's experiences with mental health issues inform the development and practice of recovery? What would it take to support and implement this model?

### *Process*

Prior to commencing the World Café the participants were given three short presentations to set the stage for the discussion. The first presentation was an overview of the findings from the scoping review project, the second presentation was an overview of the concept of recovery and reviewed information about social inequities and mental health, and the third presentation was on the topic of gender and mental health<sup>4</sup>. The presentations were meant to orient the participants to the questions and to provide an overview of the areas of interest.

### *Limitations*

There was a notable absence from members of communities which would have made for a more diverse group of participants. These include organizations with specific mandates such as women's organizations, immigrant and refugee serving organizations and those who serve members of Aboriginal populations as well as those that serve people with mental health issues. While we did have good representation insofar as types of services represented and people with various lived experiences (mental health, addictions, homelessness) and other forms of 'hidden' diversity (e.g. disability, sexual orientation, etc.), more representation from culturally diverse groups, as well as members of the transgender community, would have been preferable.

Although a diverse group of potential participants was approached, the composition of the group

---

<sup>4</sup> The presentations were as follows: 'Mental Health Recovery Scoping Review' by Julia Weisser; 'A Critical Exploration of Social Inequities in Mental Health Recovery' by Marina Morrow, and 'Remembering Social Inequities' by Jennie Williams. Jennie Williams was a visiting scholar from the UK who has an expertise in mental health and gender training.

who did in fact attend inevitably limited the data we were able to obtain about mental health recovery as it relates to social and structural inequities. Ongoing research needs to build in ways to create capacity for fostering representation from culturally diverse groups.

Additionally, the research team recognizes limitations to the ways in which the discussion questions themselves were framed, worded, and asked. The questions were deemed too academic, complicated, or abstract by several participants.

## How We Analyzed the World Café Findings

After the World Café, the note takers from each discussion group wrote up the discussion, flip chart points and comments made on the foolscap at each table, in keeping with World Café methodology (Brown & Isaacs, 2005). The researcher and project coordinator then independently read through the discussion notes from each question, and tracked emerging themes. Two peer researchers also participated in this process with each one independently reviewing the notes from two sets of questions. The principal investigator read through all the notes as well. Thematic analysis was used by all analysts and emerging themes noted. The data analysis team then gathered together to check for reliability by reviewing the themes that emerged from the respective independent analyses described above. Finally, all the members of the research team met twice to review the material for accuracy.

## Findings

Several themes emerged as over-arching and were consistently reflected throughout the four concurrent dialogues of the World Café:

1. The Language of Recovery
2. A Social Justice<sup>5</sup> Approach to Mental Health
  - a. Addressing Sanism<sup>6</sup>

---

<sup>5</sup> A **socially just** society, from a Western point of view, may be described as one in which all groups of people, regardless of background, are included in the political, economic and social decisions of that society (Orlowski, 2009). According to Richardson & Reynolds (2010), we all have a responsibility, collectively, to work towards a just society... social justice includes all areas of social life, not simply human rights and justice systems.

<sup>6</sup> Definitions of **sanism** surfaced as early as the mid 1950's; in general it is thought of as "an irrational prejudice similar in nature to that of prevailing social attitudes of racism, sexism, homophobia and ethnic bigotry" (Perlin, 2003, p.165).

- b. Addressing Power and Control
- 3. Mental Health and Social Policy
  - a. Poverty/Disability Benefits
  - b. Service Mandates and Resource Constraints
- 4. The Role of Peer Workers in Recovery

### *The Language of Recovery*

*“Becoming one’s best self is the life work of us all. I think they either have to drop the term recovery or else make it universal, so that everybody is on the road to recovery from the moment they are born.” (World Café Participant)*

At the World Café, participants indicated that the ways in which people in different parts of the system speak about mental health recovery is a barrier in and of itself. For example, the following participant notes the contradictory ways in which the notion of recovery is taken up:

*“...models, there [are] all these fragmentations - mental health vs. addiction - they don’t speak the same language in terms of recovery. When we talk about mental health and recovery we talk about empowerment; in addiction we talk about the 12-step program. Then when people have both, they access services that are using opposing language. The help may not address what the person needs because of the model of care... people are so over-served in the context of the battle ground for different models”. (World Café Participant)*

The passage above suggests that the concept of recovery is being used differently in different contexts and speaks to concerns about how the fields of mental health and addictions might be using different models and the impact this might have on their clientele.

In general, there was quite a bit of dialogue about the usefulness, or lack thereof, of the term “recovery,” as well as the question: Recovery from what and to what? Participants asked whether or not it is useful to broaden the concept of recovery or whether using the concept of social justice instead of recovery might be more helpful (see below). People also suggested that the language around mental health needs to change, away from such terms as ‘serious’, ‘severe’ and ‘persistent’ mental illness, which was seen as keeping people in a cycle of pathology for which they were ‘rewarded’ with services.

### *A Social Justice Approach to Mental Health*

- a. Addressing Sanism

*“Recovery is not a concept that I really relate to because I don’t think that I’m recovering from my life experiences, I’m incorporating them. I’m not surviving, I’m becoming.” (World Café Participant)*

During the World Café, there was much discussion surrounding the discrimination against people labelled as mentally ill. Although no one explicitly used the term “sanism” to describe this discrimination it struck the research team as an apt description for the experiences being discussed. Further, some participants suggested that a narrow definition of what is mentally “healthy” serves to perpetuate the system and reinforce people’s dependence upon it. Some participants suggested that not only does this narrow definition of “mental health” prop up existing industry (pharmaceutical) it also does not serve people well on their journeys to recovery. It was felt by participants that a broader definition of mental health would be more useful; for example, one that encompassed tolerance of a broader range of unique behaviours in individuals. For example, participants mentioned that their views of mental health did not fit neatly into the kind of diagnostic categories currently used within the mental health care system. Related to this was a parallel discussion about the need to value all types of knowledge and experience (including lived experience).

In the World Café discussion, the idea of a social justice approach to mental health as well as an equity and/or social justice framework for recovery was raised. Interestingly, this approach was tied to discussions about the ways in which society could become more accepting of the full expression of the human condition and experience, rather than consistently using a biomedical lens that some felt unduly pathologized people. Some participants pointed out the fact that the social expectations of “mental health” require that people comport themselves in public in very specific ways; in turn, these expectations get taken up in the conceptualization of “recovery” (i.e. creating certain ideas or standards about what a “recovered” person should look or act like) in order to create more productive members of society. Conversely, some participants at the World Café posited that recovery includes becoming aware of the constraints put on people by society and liberating oneself from mainstream expectations of mental health.

### *b. Addressing Power and Control*

It was noted by participants that people who are entrenched in the mental health system often have very little control over their own lives, which necessarily makes “recovering” difficult or impossible. As depicted in the following quote, the system is designed to perpetuate itself, by upholding dependence upon it:

*“I don’t see the connection between recovery and the mandates of mental health teams. It’s kind of like a self-fulfilling prophecy, because if the mental illness must be “serious and persistent” in order to get funding, how can a person “recover” from it?”  
(World Café participant)*

Examples of power and control issues brought to light at the World Café include the medicalization of mental health, rigid applications of privacy regulations, and the criminalization of people with mental health problems. As one World Café participant noted, recovery can embrace the medical model, but it can also include much more:

*“The system has been very limited in the way it understands mental health. Recovery goes beyond the medical model, in that it includes the medical model but it can include much more. It [recovery] is more holistic and goes away from the reductionist understanding of mental health.”*

A tension that emerged during the World Café discussions was that between the right to privacy of clients in the mental health system versus the rights of family members to have access to information. It was suggested by some that rigid application of privacy regulations can lead to strained relationships between supportive families and professionals, particularly in the case of youths/adolescents. While these regulations are very often necessary, one family member at the World Café felt this denied access to information that would best help parents support their children.

Participants also spoke about the ways in which people with mental health problems are criminalized in ways that can affect their ability to secure housing and employment. For example, people indicated that a police escort to the hospital results in a criminal record. In turn, this record stays with the person and makes access to other supports difficult or impossible.

### ***Mental Health and Social Policy***

World Café participants indicated a variety of ways in which policies and bureaucratic practices, as they exist currently, do not support recovery. This finding can be illustrated in two distinct realms: poverty and disability benefits, and service mandates and resource constraints.

### *a. Poverty/Disability Benefits*

Study participants noted many constraints to recovery enacted through social welfare practices. Participants suggested that the ways in which social assistance and disability benefits are set up serve to trap people in cycles of dependence and poverty, rather than assisting them to move forward with their lives when they are ready and able to do so. Examples raised include the prohibition against accumulation of assets when on disability or income assistance and restrictions related to the amount one can earn in paid work while on benefits (i.e. on income assistance you cannot keep any additional earnings whereas on disability benefits there is a cap on earnings). These were seen as formidable barriers in terms of people being able to improve their financial situations and also as a discouragement from seeking employment.

Participants also discussed other barriers to employment, for example, the cost of a criminal record check which is needed for some forms of employment may be prohibitive for those on benefits; lack of workplace accommodation for mental health disabilities; the lack of a real “living wage” in BC; and stigma/discrimination from employers.

Additionally, restructuring has resulted in changes to services designed to assist people in applying for and maintaining income assistance or disability benefits. One example mentioned by World Café participants includes the “pod” system of financial aid case workers which has been in place since 2002. Consistent case management has been eliminated and replaced with a system in which clients phone a main number and receive assistance from whichever financial aid worker is available. Participants suggested that this effectively precludes the establishment of any kind of relationship with clients based in a contextual understanding of their lives.

### *b. Service Mandates and Resource Constraints*

Several issues related to service mandates and resource constraints were raised during the World Café. It was noted that some people are excluded from receiving much-needed treatment because they do not fall into the increasingly crisis-oriented mandates that organizations must follow. Similarly, Café participants noted that the disconnect between different services/sectors can negatively impact recovery; for example, a 30 day in-patient hospital stay can result in a loss of housing, which can impact a person’s ability to get well.

Additionally, many participants mentioned the ways in which the mental health system ‘rewards’ pathology, and how it is oriented towards crisis rather than prevention, leaving those who are stable but still need help to fall through the cracks. Participants felt that if there were adequate treatment resources available to everyone who needed them, people might feel more free to “get better,” as they would not be worried about the possibility of losing their support systems and access to treatment.

### *The Role of Peer Workers in Recovery*

One of the major findings of the World Café is the need for meaningful roles for persons with lived experience of mental health issues. In the World Café discussions the focus was primarily on people working within the context of mental health, for example, as peer support workers or facilitators, peer specialists, peer researchers, advocates, consultants, board members, or other similar positions. It was argued that these roles should move beyond tokenism and become valued conduits to recovery, both for the people in these positions as well as for those they are supporting.

The role of peer support workers on mental health teams is hotly contested; there are as many approaches to “peer support” as there are peer support workers; as such, it is not surprising that, even within the consumer survivor community there is disagreement over the role of peer support workers. Several participants noted that not a lot of forums exist for the open discussion of this topic. One issue which was raised by some World Café participants was the increasing “corporatization” of peer support workers and their subsequent loss of “peerness.” The words “corporatization” and “loss of peerness” were used by one World Café participant and readily taken up by others, as a way of describing the need to act “normal”, well-socialized, and “professional” when one is a peer support worker on a mental health team, at a drop-in centre, at a hospital, etc. Some participants emphasized that this meant a loss of what it actually means to be a peer.

There are no doubt many advantages to being in this position, not the least of which is being included in the mental health care of those who are unwell and being able to provide one’s peers with support. Consumer/survivor activists and many mental health workers have been pushing

for peer support for years, and many teams incorporate peer support workers' concerns into the care planning of their clients/patients. However, there was a feeling from many of the World Café participants that something is being lost along the way when peer support workers attempt to “fit in” to a mental health team or in a hospital setting. In order to be taken seriously one must present as “professional,” which can in turn create distance between the peer support worker and client, as well as erode the very essence of peer support itself – that is to say, its “peerness.” As well, peer support workers on mental health teams or in hospitals are asked to uphold the values of the medical model, with which they (and their clients) may or may not agree. The World Café opened up space for this dialogue to begin recommending that frank discussion around “peerness” be included in peer support training modules as well as mental health service provider training.

## Discussion

In summary, four key themes or areas of focus emerged from the World Café discussions: the language of recovery, a social justice approach to mental health, mental health and social policy, and the role of peer workers in recovery.

Within these overarching themes participants spoke to the many meanings of recovery and critically asked about the usefulness of the term for encompassing the diversity and complexity of experiences associated with mental health. In general, participants tended to see mental health in a more holistic frame which included an understanding of the role that social and structural supports (like income security, housing, employment) play in ameliorating mental health problems.

Further, participants spoke passionately about the ways in which people with diagnoses of mental illness are pathologized, stigmatized and discriminated against. An ‘illness’ paradigm predominates in mental health, a fact which was reflected in the discussions by the World Café participants, many of whom argued that the medical model, narrowly defined, obscures the whole person’s experience; it reduces a person to his or her diagnosis/ label. An exclusive focus on the medical model in turn creates unnecessary divides between people who are deemed ‘sick’ and those that are deemed ‘well’, which can be internalized by the person who is being labelled –

a process of both systemic as well as internalized oppression. We have looked to the concept of sanism as a way of describing and understanding these experiences. That is, the concept of sanism moves us away from discussions of individual stigma and discrimination to understanding that the very ways in which mental health and mental illness are understood reflect many unexamined biases and beliefs about the inferiority/ability of people with mental illness. Further, the concept of sanism allows a space for questioning the way we label and diagnose behaviours.

In their discussions, participants frequently returned to specific policies or practices in the mental health care system (e.g., disability benefits, barriers to employment) as a way of describing the challenges faced by people accessing care and, in the case of providers, as a way of venting their frustration with practices and policies they felt were unfair or detrimental to people's recovery.

Despite enthusiasm for frameworks of recovery which take a collective approach and which are rooted in the principles of social justice, it was our observation that participants at the World Café seemed to struggle with framing recovery in terms of social and structural inequities; people tended to slip back into discussion around more tangible barriers to recovery, such as lengthy waitlists for psychiatric care versus questioning a system that endorses lengthy waits as an acceptable standard in this first place.

So although participants sometimes gave examples of how sexism, homophobia or poverty might impact recovery or result in inequitable access to services and supports, the conversation typically returned to recovery as an individual journey. The one exception was that participants were able to articulate how individual notions of recovery may not resonate with people from non-dominant ethno-racial groups. For example, in cultures which value collectivity over individuality or inter-dependence over independence, as well as those that hold a place for unique behaviours in a way that contemporary Western society does not. In these instances culture was still viewed more as an individual attribute and discussions of how systemic racism and/or ethnocentrism might be at play in the mental health system were not raised.

We suggest that one way of framing recovery that attends to social and structural inequities is through the lens of intersectionality<sup>7</sup>. Intersectionality allows for an understanding of the intersecting and overlapping experiences of sexism, racism, homophobia, poverty and in this case sanism as these work to undermine recovery for people. Using an intersectionality approach reveals the fact that people’s mental illness symptoms might be linked or produced in simultaneous ways with conditions of poverty, homelessness, and hunger. We can then ask the question of how people’s symptoms might change if the person had a more stable living environment. Intersectionality also allows for an analysis of the ways in which power is at play in the mental health care system, for example, in terms of whose knowledge and what kind of knowledge/evidence is valued. The driving force behind this viewpoint is “the pursuit of social justice” (Weber, 2006).

Finally in view of our observations that the concept of social and structural inequities are not well understood in mental health, we suggest that gender and social inequities training for mental health service providers, such as that currently being provided in the UK through the use of the Gender Equality and Mental Health (GEMH) training module (Williams, 2010) would be useful in the Canadian context. As well, during the group data analysis meetings, research team members emphasized that value placed on knowledge obtained through lived experience needs to be reflected in training programs for service providers and other mental health professionals. This could include a training program which reflects the lived experiences of people with mental illness, as well as one which takes social and structural inequities into account (see point 3 of the Key Components section of this report).

## **Key Components of a Mental Health Recovery Model that Addresses Social and Structural Inequities**

One of the goals of this project was to identify key components of a mental health recovery model that would address social and structural inequities, and that would also be more inclusive

---

<sup>7</sup> **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 & Cormier, 2009, p.3).

of people's lived experiences with mentally ill health. This was a small project, which means the World Café findings are not generalizable on a large scale; however, the fact that we were able to open up space for some important discussions was seen as extremely valuable in and of itself by the participants involved. As a research team, we were also able to identify some preliminary key components as well as specific points of tension in the mental health recovery field, which can be used as jumping-off points for future work and discussions. The following key components are drawn from the responses of World Café participants, recommendations from the literature which came out of the scoping review, and suggested focal points from the research team.

### *1) Working from a Social Justice Framework*

Utilizing a feminist intersectional framework, recovery can be seen through a social justice lens. This is a way of viewing recovery which is equitable, and cuts to the heart of people's differing experiences of mental health and access to services and supports. A framework of interlocking oppressions can include an analysis and understanding of sanism and how power and control functions in the mental health care system. The following are ways in which practices founded in principles of social justice might attenuate social and structural inequities, as well as place value on the social acceptance of the full expression of the human condition:

- i) People with lived experience of mental illness often lack power over their own lives; as such, power and privilege within the mental health system must be discussed and addressed in concrete ways. One example would be to open up spaces for discussion about the ways in which power and privilege are at work in the mental health system (i.e. at staff meetings which include peer support workers, or at case conferences which include mental health service users).
- ii) Recognize the multiple meanings of recovery (political, individual, cultural, etc.) and the ways in which these meanings play out in an intersectional way with all aspects of a person's identity (gender, race, ethnicity, culture, etc.).
- iii) Recognize and provide a space for more productive dialogue about the tension that exists regarding the needs and concerns of family members for access to information as this intersects with the needs of some individuals to retain their right to privacy from their families.

- iv) Support for reflexive/ethical practice as part of the ongoing work of mental health managers and service providers that takes personal experience and social location into account.
- v) Recognize and address the ways in which active discrimination against people diagnosed with mental illness is systemic and the ways in which this is compounded by other experiences of oppression (e.g., sexism, racism, ethnocentrism, homophobia).

## **2) *Making Changes to Mental Health and Social Policy***

### **Addressing Poverty/Lack of Housing**

- i) Social welfare reform: we need to enact changes to the social welfare system that would allow for people to break the cycles of poverty and dependence. This would include: a) raising the rates for social assistance and disability benefits to bring people in line with the cost of living b) allowing people on disability benefits to hold assets and have asset accumulation; c) allowing people more flexibility to go on and off disability benefits.
- ii) Work to ensure that Health Authorities see employment-oriented rehabilitation as critical to the well-being of people with mental health issues. This includes ensuring the retention of supported employment options designed specifically for people with mental illness.

## **3) *Valuing the Role of Peer Support***

### **Retaining 'Peerness'/Valuing Peer Support**

- i) Work to research and evaluate the effectiveness of peer run programs in mental health.
- ii) Develop mechanisms that would allow for more input/involvement from PWLE at all levels of the mental health system.
- iii) Work towards more equitable power structures and decision making models in mental health that recognize the value of peer support and lived experience (e.g., better pay for peer support workers, more than token representation of peer support workers on committees, etc.).
- iv) Peer workers should reflect the diversity of the clientele that they are working with (in terms of culture, race, gender, sexual orientation, etc).
- v) Recognize disclosure risks (i.e. disclosure of mental health issue/psychiatric history) for peer workers.

- vi) Guard against the “corporatization” of peers – that is, work to maintain the authenticity of peer support rather than requiring peer support workers to professionalize.

#### 4) *Gender, Social Inequities and Mental Health Training*

- i) Develop, implement and evaluate gender, social inequity and mental health training for mental health care providers.
- ii) Develop, implement and evaluate gender, social inequity and mental health training for professional schools.

## Conclusion

The above framework is preliminary and will require more dialogue and research. Specifically, suggestions for future research include:

- Develop and evaluate a social inequities mental health training module for health care workers and/or as part of academic training curriculums;
- Focus groups with members of racialized communities to discuss their conceptualizations of recovery;
- An exploration of the concept of “peerness”; peer support workers in systems; professionalization of peer workers;
- Research that would examine the tensions between the rights of individuals and the rights of families vis a vis privacy legislation in mental health.

## Knowledge Exchange Activities

*“...if you do something politically hot through the softer side of artistic practice rather than (the) radical edge, people listen (because of the softer element); relieve it with poetic metaphor, images, touch people’s hearts: open heartedness versus judgement.” (World Café Participant)*

Knowledge exchange was a key component of this project. As such, a number of knowledge exchange activities have been undertaken and are ongoing. These include the development of brief skits/vignettes as a way of representing the findings from the research, as well as the more traditional modes of knowledge exchange (i.e, presentations to key stakeholders, the development of papers, etc.). For more information about our knowledge exchange activities associated with this project see [www.socialinequities.ca](http://www.socialinequities.ca).

***Suggested Citation:***

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

## References

- 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. Retrieved from <http://www.dhh.state.la.us/offices/publications/pubs-305/anthony1993c.pdf>
- Arskey, H. & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, 8(1), 19-32.
- Battersby, L. & Morrow, M. (submitted for review). Challenges in Implementing Recovery-Based Mental Health Care Practices in Psychiatric Tertiary Care Settings in British Columbia.
- Brown, J., & Isaacs, D. (2005). *The World Café : Shaping our futures through conversations that matter*. San Francisco, CA: Berrett-Koehler Publishers.
- 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.
- Hankivsky, O., & Cormier, R. (2009). *Intersectionality: Moving women's health research and policy forward*. Vancouver, BC: Women's Health Research Network.
- Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal*, 24(3), 248-256. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=11315211&site=ehost-live>
- Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4), 482-485.
- Joshi, K. (2006). The Racialization of Hinduism, Islam, and Sikhism in the United States. *Equity & Excellence in Education*, 39, 211-226.
- Markowitz, F.E. (2001, March). Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. *Journal of Health and Social Behavior*, 42(1), 64-79.

- Mays, N., Roberts, E., & Popay, J. (2001). Synthesising research evidence. In N. Fulop, P. Allen, A. Clarke, & N. Black (Eds.), *Studying the organisation and delivery of health services: Research methods*. London: Routledge.
- Mill, J., Austin, W., Chaw-Kant, A. J., Dumont-Smith, C., & Edwards, N. (2007). *The influence of stigma on access to health services by persons with HIV illness*. Edmonton, AB: University of Alberta.
- Morrow, M. (2004). Mental health reform, economic globalization and the practice of citizenship. *Canadian Journal of Community Mental Health*, 23(2), 39-50.
- Morrow, M., Frischmuth, S., & Johnson, A. (2005). *Community based mental health services: Income and housing security*. Canadian Centre for Policy Alternatives, BC Office.
- 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*. (Research project final report. Vancouver: Centre for the Study of Gender, Social Inequities and Mental Health.
- 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.
- 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).
- 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.
- Orlowski, P. (2008). 'That would certainly be spoiling them!': Liberal discourses of social studies teachers and concerns about Aboriginal students. *Canadian Journal of Native Education*, 31(2), 110-129.
- Perlin, M. (2003). 'Things Have Changed': Looking at Non-Institutional Disability Law Through the Sanism Filter. *New York Law School Journal of International and Comparative Law*, 22, 165-175.

- 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.
- Reid, C., Brief, E., & LeDrew, R. (2009). *Our common ground: Cultivating women's health through community based research*. Vancouver, BC: Women's Health Research Network.
- Richardson, C. & Reynolds, V. (2010, draft). 'Here we are, amazingly alive': Holding ourselves together with an ethic of social justice in community work. Unpublished manuscript.
- Rossiter, K., & Morrow, M. (In press). Intersectional frameworks in mental health: Moving from theory to practice. In O. Hankivsky (Ed.), *Health and intersectionality inquiry in Canada*. Vancouver, BC, Canada: UBC Press.
- Ship, S.J. & Norton, L. (2001). HIV/AIDS and Aboriginal women in Canada: A case study. *Canadian Woman Studies*, 21(2), 25-31.
- Teghtsoonian, K. (2008). Managing workplace depression: Contesting the contours of emerging policy in the workplace. In K. Teghtsoonian, & P. Moss (Eds.), *Contesting illnesses: Processes and practices* (pp. 69-89). Toronto: University of Toronto Press.
- Walker, M. (2006). The social construction of mental illness and its implications for the recovery model. *The International Journal of Psychosocial Rehabilitation*, 10(1), 71-87.
- Weber, L. (2006). Reconstructing the landscape of health disparities research: Promoting dialogue and collaboration between feminist intersectional and biomedical paradigms. In A. J. Schultz, & L. Mullings (Eds.), *Gender, race, class and health: Intersectional approaches* (pp. 21-59). Indianapolis: Wiley.
- Weisser, J., Morrow, M., & Jamer, B. (2011). *A Critical Exploration of Social Inequities in the Mental Health Recovery Literature*. Vancouver: Centre for the Study of Gender, Social Inequities and Mental Health (CGSM). <http://www.socialinequities.ca>
- Williams, J. (2010). Inequality Agenda: Training and Consultancy for Mental Health. Retrieved from <http://www.inequalityagenda.co.uk/>